OVERCOMING STIGMA WITH COMPASSION + CARING

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No Disclosures

Objectives

- Substance use disorder in pregnant and parenting women
- Stigma
- Provider bias
- Ways to promote compassion and caring while breaking discrimination and prejudice

SUD and Stigma - *terrifying*

- A social process which can reinforce relations of power and control
- Leads to status loss and discrimination for the stigmatized
- Leads to stereotypes, labeling

- Link and Phelan

Stigma

- Discrimination and Prejudice
- Mark of disgrace or infamy with SUD
- Negative attitudes, perceptions

Punishment

Immoral, unethical and cruel to punish women for the chronic illness of substance use disorder

Alternatives to Punishment?

Alternatives to Punishment?

Compassionate comprehensive care (prenatal care + SUD treatment)

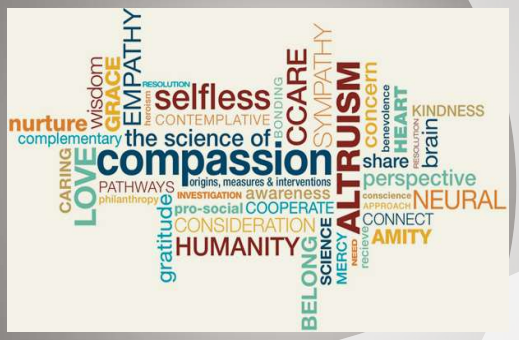
Overcoming SUD stigma: language

Empathy, openness, outreach

Compassion - what is it?

Concern for the alleviation of suffering of sentient beings (self and others)

- Three components:
  - ***Kindness*** - treating self/others with care and understanding; involves active soothing and comforting
  - ***Mindfulness*** - requires noticing the suffering of self/others without avoidance or aversion
  - ***Common humanity*** - seeing the experience of self/others as part of larger human experience



Mindful - taking time for what matters

Mindfulness - paying attention to present moment experience without judgment

Compassion and mindfulness

- Paying attention to experience in the present moment
- Relating to experience without judgment or resistance (mindfulness)
- Relating to the experiencer with the desire to alleviate suffering (compassion)
- Understanding the nature of both experience and the experiencer (wisdom)

Compassion and mindfulness

- Beautiful dance:
  - Mindfulness accepts painful experience without resistance
  - Compassion facilitates active soothing, sensitivity to caring, helping and deep commitment to try to relieve/prevent suffering

Oxytocin- supports caretaking, nurturance, affection, social bonding; promotes trust, balance

Compassionate Comprehensive Care

Trauma informed, Culturally sensitive, Kind, Welcoming, Compassionate, Respectful

- Longitudinal SUP framework -> innovative model of care
- Bundle of prenatal and SUD services
- Optimizing postpartum support resources
- Mom-baby dyad, extended postpartum floor 5 day stay-> *decrease in NAS incidence, need for pharmacotherapy and LOS*
- Mental health emphasis
- Self care and advocacy
- Tobacco cessation
- LARC
- Maternal mortality education and prevention

Provider bias – words matter

Terminology to use

- Substance use disorder
- A person with substance use disorder, drug use
- Person in recovery
- Positive drug screen
- A woman with SUD
- A baby/infant born to a mother with SUD

Terminology to avoid

- Drug abuse
- Drug addict, druggie, junkie, crackhead
- Clean, sober
- Dirty urine
- An addict mother, these moms
- These babies

SUP Advocacy and Leadership = compassionate care + better outcomes

- Respect, understanding
- Compassion, empathy
- Love, caring, gentle
- Dignity, equity
- Kindness, thoughtful
- Warmth, openness
- Mindful, supportive
- Nonjudgmental, trustworthy
- Cultural humility, presence
- Social justice, humanity

Compassion, openness, outreach

- ***Provider attitudes tool*** (Swedish, 2016: stigma, compassion, knowledge, comfort level of care, referral to treatment)
- ***High risk OB conference***, *"Embracing Challenges and Compassion in the Care of Chemically Dependent Patients March 18th, 2016. Pre/post intervention, 60 minutes SUP education:*
  - 95/114: decreased stigma 9% ($p < .015$); improved compassion 6% ($p < .036$); increased 22% knowledge, 18% comfort level of care, and 17% referral to treatment ($p < .001$) and improved attitude scores 13% ($p < .006$).
- ***Washington Section of AWHONN***, *"Caring for the Pregnant Woman with Chemical Dependency and Her Newborn" May 23rd, 2017. Pre/post intervention, 120 minutes SUP education:*
  - 91/105: improved 13% stigma ($p < .001$) and 14% compassion ($p < .001$). Providers demonstrated increased 31% knowledge ($p < .001$), improved 24% comfort level of care ($p < .001$), and 17% attitude scores ($p < .001$).
- ***Washington Summit***, *"Treating Pregnant and Parenting Women With Opioid Use Disorder", Aug 8th 2018*
  - 105 attendees, results pending

Substance Use in Pregnancy

"The mother is more scared than you are"
(Dr. Jim Walsh)

- Guilt
- Shame
- Fear
- Isolation

- *Barriers to care:*
  - Stigma, chronic stress, economic challenges, lack of social support and resources, trauma, physical/emotional strain of pregnancy

Substance Use in Pregnancy

Nurturing bond with your patient:

- Opportunity for personal growth
- Harnessing desire for change
- Courage to try to make things right
- Tap into strength/resilience
- Efforts to make sure baby will thrive
- Commitment to a goal

Screening

4 P's (plus smoking): Parents, Partner, Past, Pregnancy, Smoking

NIDA Quick Screen

In the past year how many times have you drunk >4 alcoholic drinks per day?
Used tobacco?
Taken illegal drugs or prescription drugs for nonmedical reasons?

Single Question Screen

"In the last year, have you ever drunk or used drugs more than you meant to?"
"Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen

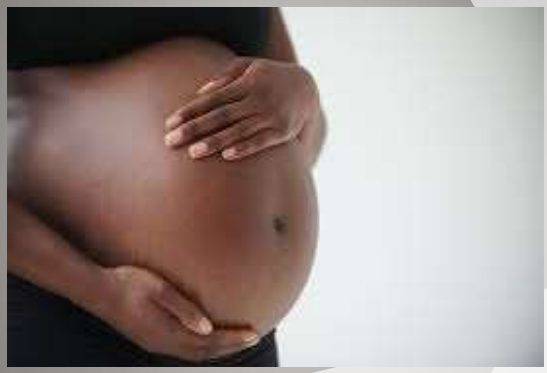
Opioid Use Disorder in Pregnancy

Medication Assisted Treatment = the evidence-based standard of care

Compared to heroin, methadone maintenance is associated with:

- Improved/consistent prenatal care
- Reduced maternal complications
- Improved fetal growth
- Reduced fetal mortality
- Increased likelihood that the baby will be discharged home with its mother

The narcotic-dependent mother: fetal and neonatal consequences. Kandall SR, et al Early Hum Dev. 1977 Oct;1(2):159-69.
Differential effects of maternal heroin and methadone use on birthweight. Kandall SR, et al. Pediatrics. 1976 Nov;58(5):681-5.



Opioid Use in Pregnancy Case

28yo G3P1102 at GA 25w, recently diagnosed pregnancy, presenting to triage with painful contractions. Discloses active opioid use, 1g IV heroin daily x 2 years. Unable to stop use. Last heroin- 6 hours ago.

No prenatal care (one ED visit+US). Poor sober support. Homelessness, living in a car with her using partner. CPS case.

Moderate withdrawal and very sick: sweats, chills, restlessness, anxiety, nausea, diarrhea.

Worried about baby, asking for treatment.

Opioid Use in Pregnancy

- *Nurse's healing power is a magical tool*
- Nursing/provider support facilitates timely obstetrical, mental health and treatment evaluation
- Initiation of MAT: Methadone stabilization
  - *20-30 mg + incremental 5-10 mg every 6 hours as needed*
- Care coordination- social work, psychosocial services
- Safe discharge plan-> recovery engagement
- Smoking cessation, mental health, prenatal care
- Overdose prevention
  - *discharge with intranasal narcan (2ml pre-filled syringe)*

McCarthy 2005, Bakstad 2009, Dryden 2009, Jones 2010, Peles 2012, Bogen 2013, Finnegan 2013, Cleary 2013, Jones 2013, Maeda 2014, Whiteman 2014, McCarthy 2015, McCarthy 2017.

Opioid/Stimulant Use in Pregnancy

29yo G3P2002 unknown GA with no prenatal care presents to triage with hypertensive urgency (BP 186/130), HR 132, abdominal pain, contractions and vaginal bleeding. Reports IVDU- methamphetamine, cocaine and heroin, last use 2-3 hrs. PTA.

- Category 3 tracing
- STAT IV, T&S, CBC, coags, PIH, P/C, utox
- Bedside US- 28w by BPD
- While attempting IV access to take to OR for CS, FHR dropped and unable to be picked up further.
- Fetal demise as well as large placental abruption (no previa) confirmed by US

Opioid/Stimulant Use in Pregnancy

- Methamphetamine/cocaine intoxication- diaphoresis, HTN, tachycardia, severe agitation, psychosis.
- L&D Admission-> delivery of demised infant
- Continued vaginal bleeding-> T&C 4 units PRBCs, transfused 2+2 units PRBCS
- Magnesium 4 g x 1, 2 g/hr seizure prophylaxis
- Hydromorphone prn pain
- Nifedipine 20mg PO until IV access for Hydralazine

Stimulant Use in Pregnancy- intrapartum/postpartum

- Hypertensive urgency and tachycardia not responding to hydralazine, nifedipine and enalapril.
- Avoid Labetalol, beta blockers->unopposed alpha-adrenergic vasoconstriction
- Ativan 1 mg IV to reduce CNS cathecholamine release
- Oral Clonidine 0.1-.2 mg Q2H prn >BP 160/110, tachycardia- alpha 2 agonist, central action, decreases vascular resistance, lowers BP, HR
- *Soothing nursing presence*

Stimulant Use in Pregnancy

Emotional state- minimize stimulation, support care

- Sedatives/antiphychotics- seroquel, hydroxyzine, mirtazapine
- Validated pain from losing child
- Provided reassurance- silent presence, dark room
- Emotional heartache- poor sober support, abusive currently using partner, legal problems
- "I am sick and addiction is illness"
- "I am judged as an addict every day, I didn't have a chance"

Yes, addiction is chronic brain disease and it is treatable. Sometimes reaching out for help is the hardest step.

Substance Use Complications

- Poor prenatal care
- Poor fetal growth
- Preterm labor/delivery
- Preterm rupture of membranes
- Placental abruption
- Antepartum hemorrhage
- Low birth weight

Secondary to poor health behaviors in addition to repeated episodes of in utero toxicity/withdrawal

Pregnancy - Motivation for Change

Chemically dependent women:

- Understanding that substance use in pregnancy is harmful
- Projection toward hope of cessation- "I am strong and can do it on my own, I can stop" is typical initial strategy
- Willingness to come forward for care
- Courage to seek help for substance use
- Mental health- "I can restart my bipolar meds once I quit heroin"

Opioid Use Disorder (OUD), Mental Health and L&D Case

35yo G4P3012 at 39w4d by 1st trim US with Hep C, OUD, on methadone, bipolar dis on Zyprexa, h/o DVT (on Heparin) presenting for IOL for GHT-> preE w/o severe features.

- Acute emotional dysregulation and escalating agitation- declining psych meds, BP checks, minimal RN care
- IOL- Misoprostol 25 mcg PO x 2-> Foley bulb 30 cc -> Epidural -> Augmentation-> SVD
- Shoulder dystocia x 45 secs (McRoberts and suprapubic pressure)
- Uterine atony (pitocin, bimanual uterine massage)
- Acute postpartum psychosis- refusing psych meds

Opioid Use Disorder (OUD), Mental Health and Labor

Sick moms + mental health dis-> challenging situations

- Take a deep breath- "you can handle anything"!
- Safe care tools- *silent healing presence, compassionate care and kindness*
- Soft voice and kind RN support- *encourage medical adherence*
- Healthy expectations/limits- *guidance on postpartum care, nursery supervision and CPS involvement*
- "I was horrible to everyone, that was not me. I am sorry."
- *Practice gratitude*

Pain and Addiction - scary.....

- Addiction/opioid use disorder already established
- Patient's fear - under treatment
- Nurses fear - over treatment
- Medical provider's fear - how to adequately treat
- What do we do? – team approach, don't be a lone ranger, ask for help

Pain and Addiction - scary.....

- Team effort- *you have it all to treat and support*!
- Timely, adequate pain management:
  - does not worsen addiction
  - decreases chance of relapse
  - usually decreases overall opioid requirement
  - facilitates provider-patient alliance
  - enhances safe, trusting environment for staff and patient

Intrapartum Pain Management

Integrative Medicine Approaches:

- Aromatherapy (lavender, chamomile)
- Music therapy (soothing ambient sounds)
- Mindfulness, meditation
- Visualization, imagery, safe place
- Relaxation, stress reduction
- Breathing exercises
- Massage therapy
- Hydrotherapy (bathtub, shower, jets)

Pain management – OUD and vaginal delivery

- Reassurance for goal of adequate pain relief
- Continue maintenance pharmacotherapy
- Acetaminophen 1000mg Q6H in early labor
- Early epidural decreases intrapartum IV opioids
- Post delivery: acetaminophen 650-1000mg Q6H and ibuprofen 600mg Q6H x 24-48 hours
- Scheduled stool softeners

Education: breastfeeding, mom-baby dyad, bonding, neonatal transition

Pain management – OUD and cesarean delivery

- Discuss expectations, analgesia and plan of care-> *opportune time to build trust and reassure*
- Acetaminophen 1000mg 30-60min prior to OR
- Pre-op gabapentin 100-300mg→*less opioid analgesic use x first 24hrs.*
- Neuraxial anesthesia; prolonged epidural
- Transversus Abdominis Plane (TAP) regional block
- Opioid pain management – high affinity opioids, aggressive dosing
  - Severe, intractable pain: hydromorphone PCA: dose 0.6-1.8 q8min
  - PO hydromorphone 2-4mg Q4H, in addition 2-4 mg Q4H prn pain > 8/10 (3-5 days)
  - Discharge medications: doses for 3-5 days

Pain management – OUD and cesarean delivery

Non-opioid management: *scheduled medications!!!*

- Acetaminophen 650-1000mg Q6H (PO/IV)
- Ketorolac 30mg Q6H x 4 doses →ibuprofen 600mg Q6H
- Lidocaine patch, gel
- Gabapentin 100-200mg Q8H
- Hydroxyzine 25-50mg Q6H nausea/vomiting (dysphoria/anxiety D2, 5HT2A)
- Scheduled stool softeners
- Naloxone at discharge (overdose education/prevention)

Alford 2006, Moore 2011, Esiamian L2012, Holbrook 2015.

Pain management – OUD and cesarean delivery

Non-pharmacological pain management

- Nutrition, hydration, ambulation, self care
- Tobacco cessation
- Stress reduction (mindfulness, visualization, relaxation)
- Effective SW, CPS collaboration
- Compassionate care, reassurance, positive affirmations
- Rooming-in, breastfeeding, mom-baby dyad, "mother's love"
- Gratitude

Jones 2006, Meyer 2007, Wright 2009, Jones 2009, Meyer 2010, Wright 2010, Hoeflich 2012, Chandler 2013, Chisolm 2013, Sen 2016.

Pain Management in Action

30yo G3P2011 at GA 38w6d by 1st trim US w h/o IVDU, CS x 1 2014, bioprosthetic mitral valve for endocarditis 2014, admitted for opioid use disorder and methadone stabilization. Limited prenatal care, wanting to leave AMA, agreed to stay for "baby's sake".

- Transferred to FH for newly maternal thrombocytopenia, moderate prosthetic valvular MR and higher level of MFM and cardiology care.
- Uncomplicated rLTCS

Pain Management in Action

Pain management:

- Pre-medicated acetaminophen 1000 mg
- TAP block in OR
- PCA hydromorphone x 6-12 hrs
- Hydromorphone 4 mg Q2-3H (2-4 mg Q4H prn)
- IBN 600 mg Q6H
- Acetaminophen 1000 mg Q6H
- Gabapentin 200 mg Q8H
- Scheduled Colace 250 mg BID and Miralax qd
- D/c POD#3

Social Services/Care Coordination

Social Work: formulate safe discharge plan

- CPS involvement/discussion (5S- sobriety, support, safety, satisfaction, self-efficacy)
- Active recovery engagement, housing, WIC, child care, transportation
- Positive affirmations- "I really appreciate your efforts to make healthy decisions and bond with baby"
- Short and long-term benefits of sobriety

Birth Spacing and LARC

Interpregnancy interval: time between a live birth and conception of next pregnancy
- Birth spacing < 18 months: increased risk PTB 1.9%, low birth weight 3.3%, IUGR 1.5%
- Highest risk < 6 months

Long Acting Reversible Contraception (LARC) evidence: Colorado initiative
- Birth rate decreased 45% (ages 15-19) and 19.4% (ages 20-24)
- Decrease in preterm birth 12%

Swedish Addiction Recovery Service (Ballard, Seattle):
- 97% LARC w/ Nexplanon
- Postplacental IUD

Conde-Agudelo 2008, Potter 2016, Tomlin 2016, Moniz 2016, Heller 2016, Harney 2017, Hofler 2017, Dietrich 2017, Woo 2017.

Evidence Based Interventions for Neonatal Abstinence Syndrome

- Mom-baby dyad

- Breastfeeding
- Maternal Rooming In
- Adequate pain management
- Divided Dosing?
- Smoking Cessation

Wright 2009, Jones 2009, Meyer 2010, Wright 2010, Hoeflich 2012, Chandler 2013, Chisolm 2013, Sen 2016.

Breastfeeding

Is Breastfeeding Safe?

- Do we recommend moms on Methadone and Buprenorphine to breastfeed?
  - YES!
- Newborns ingest minimal amount of mom's maintenance medication- less than 1% of the morphine given to treat neonatal withdrawal

J Human Lactation 2004; 20: 62. Methadone Maintenance and Lactation: A Review of the Literature and Current Managment Guidelines. Jansson LM, Velez M

Is Lactation/Breastfeeding Beneficial?

Maternal benefits:

- early maternal nurturing interactions
- motivation to do well
- parental involvement and bonding
- pain control
- recovery engagement
- sober/social support
- decrease negative psychosocial stressors

Is Lactation/Breastfeeding Beneficial?

Infant benefits:

- provision of nursing/caregiving interventions
- early nurturing interactions/support neurodevelopmental and physiological stability
- optimal non-pharmacologic NAS remedy
- associated with lower NAS scores
- less likely to require pharmacologic treatment
- shorter LOS (12.5 vs 18.5 days)

Postpartum Support for Mom-Baby Dyad

Mother's love = best NAS care

- Maternal involvement, close uninterrupted infant contact- favorable experience for mom, bonding time
- With rooming-in program, the proportion of infants requiring pharmacotherapy decreased from 83.3% -> 14.3% (*P*<.001)
- Engaging and supporting moms in providing care to their baby, decreases length of stay- from 25 days to <8 days (*P*<.001)
- Recovery activities and supports help moms stay in treatment and continue MAT

Breastfeeding among Mothers on Opioid Maintenance Treatment: A Literature Review. Tsai LC, Doan TJ J Hum Lact. 2016 Aug;32(3):521-9
Rooming-in care for infants of opioid-dependent mother: Can Fam Physician. 2015 Dec; 61(12): e555-e561.

Bringing it all together case

40yo G5P3013 37w1d 33w US w limited care, IVDU, GHTN, HCV, tobacco and methamphetamine use disorder, admits to Ballard for methadone stabilization.

Stabilized on Methadone 95 mg BID, NRT, non-using partner. Engages in CUPW; develops IHCP and preE w/o SF-> IOL.

- SVD
- BTL

Bringing it all together case

Post-BTL analgesia:

- PO hydromorphone 4-6 mg Q4H x 24hr.-> 2-4 mg Q4H prn-> off opiates POD#3
- IBN 600 mg Q6H
- Acetaminophen 1000 mg Q6H
- Gabapentin 200 mg Q8H
- Lidocaine patch
- Stool softeners Colace 250 mg BID and Miralax qd

PP Course:

LARC- PPD#2 Nexplanon

Nicotine replacement therapy, tobacco cessation

CPS guidance and SW/CDP program support

Mom-baby dyad, 5- day extended postpartum stay. Rooming in- quality time, holding baby, exclusively breastfed

No NAS pharmacologic treatment

Both baby and mom discharged on PPD#5 to 6 month PPW

Positive affirmations, gratitude

Breaking stigma - It takes a village

- Compassionate care
- Breaking shame and guilt
- Positive affirmations
- Addiction recovery- lifetime journey
- Openness and encouragement
- Empowering humility, positive change
- Reaching out for help- longitudinal team effort

- *Yes, we can!*

THANK YOU!

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