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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

COMPASSIONATE CARE: CONSIDERATIONS WHEN WORKING WITH FAMILIES WITH OPIOID USE DISORDER

MS. MASITSA MUHANJI

VANIA RUDOLF, MD, MPH, DFASAM
ADDICTION RECOVERY SERVICES,
SWEDISH MEDICAL CENTER, SEATTLE, WA
ASSISTANT PROFESSOR,
UNIVERSITY OF WASHINGTON, SEATTLE, WA

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project ECHO

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Mark Duncan MD
Barb McCann PhD
Rick Ries MD
Kari Stephens PhD
Cameron Casey
Betsy Payn
Diana Roll
Cara Towle MSN RN

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OBJECTIVES

- Understand impact of opioid use disorder on women, infants and families while discussing stigma, myths and truths

- Innovative, trauma-responsive and compassionate access to care
- Ways to promote wellness and healing for patients and providers

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UW PACC REGISTRATION

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STIGMA

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

Punishment

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WOMEN, 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

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FEAR, DISCRIMINATION, BARRIERS TO CARE

Fear: *being judged, harming baby, losing custody of their children, legal repercussions/ incarceration*

Discrimination: pregnant women with SUD are *the most likely group to be discriminated against and treated harshly for their substance use*

Barriers to care: *shame, lack of resources, bias, funds/insurance, sober support, transportation, childcare, criminalization, punishment*

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ALTERNATIVES TO STIGMA/PUNISHMENT?

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MYTH #1 "ADDICTION JUST HAPPENS"

- Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

- People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

- Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

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TRUTH #1 – ADDICTION DOES NOT JUST HAPPEN

The disease drives the behavior not the other way around!

Stigma, Discrimination and Prejudice – women with OUD

- Fear (being judged, harming baby, losing custody of their children, being incarcerated)
- Negative attitudes, perceptions, judgment

→ *It is unethical and cruel to punish women for the chronic illness of substance use disorder*

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MYTH #2 “ADDICTION IS A CHOICE”

Strong relationship between:

- Trauma
- Adverse childhood experiences
- Genetics
- Chronic medical conditions
- Opioid prescriptions
- Lack of social support

And

High-risk behaviors and addiction

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WHAT IS TRAUMA?

- Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources.
  - Single event or multiple over time (complex, prolonged)
  - Experiences that are shocking, overwhelming such as abuse, neglect, violence, disaster, etc.

  - Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.

→ Poor physical and mental health, obsessive behaviors, substance use, social dysfunction

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ADVERSE CHILDHOOD EXPERIENCES

- "A comprehensive assessment of children's health should include a careful *past exposure to adverse conditions and maltreatment*. history of their Interventions aimed at reducing these exposures may result in better child health"

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TRUTH #2 ADDICTION IS NOT A CHOICE

Individuals > 4 ACES; certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life

- *2-4 fold increase in poor health, tobacco smoking and sexually transmitted disease*
- *4-12 fold risk for alcohol and other substance use disorders, depression, suicide attempt, high risk behaviors*
- *Strong relationship between ACE, violence , trauma and addiction*

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TRAUMA APPROACH:

"You're not bad, you're not sick. You're injured."

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization." (SAMHSA)

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TRAUMA-INFORMED CARE (TIC)

A strength-based approach and a cultural shift to appreciate/respond to each person's set of circumstances and needs – *"meeting where they are", when and where they need it.*

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TRAUMA-INFORMED CARE (TIC)

Changing the conversation from "what is wrong?" to "what happened?"

Examples:

"What is wrong with this woman… how could she use drugs during pregnancy?"

→**"I wonder what happened to this woman to affect her life this way and the impact it has had on her health and pregnancy?"**

"How can she use heroin and call herself a mother?"

→**"I can appreciate the vulnerability and the courage she has to reach out for help and talk about her use."**

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

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TRAUMA-INFORMED COMMUNICATION

Compassionate rapport-building: listen, respect, support/validate, give space/time, assist

- **Awareness:** Appreciate the role of trauma
- **Safety:** Place priority on physical and emotional safety
- **Trustworthiness**: Optimizing trustworthiness and maintaining boundaries
- **Choice:** Respect autonomy
- **Collaboration/Empowerment:** Inspiring empowerment and skill-building

***Motivational Interviewing*:**

A mindful patient-centered approach to elicit behavior changes via emphasizing autonomy with compassionate presence, listening, openness

- ***OARS+I*** (Open-ended questions, Affirmations, Reflections, Summaries, Asking permission to provide Information)

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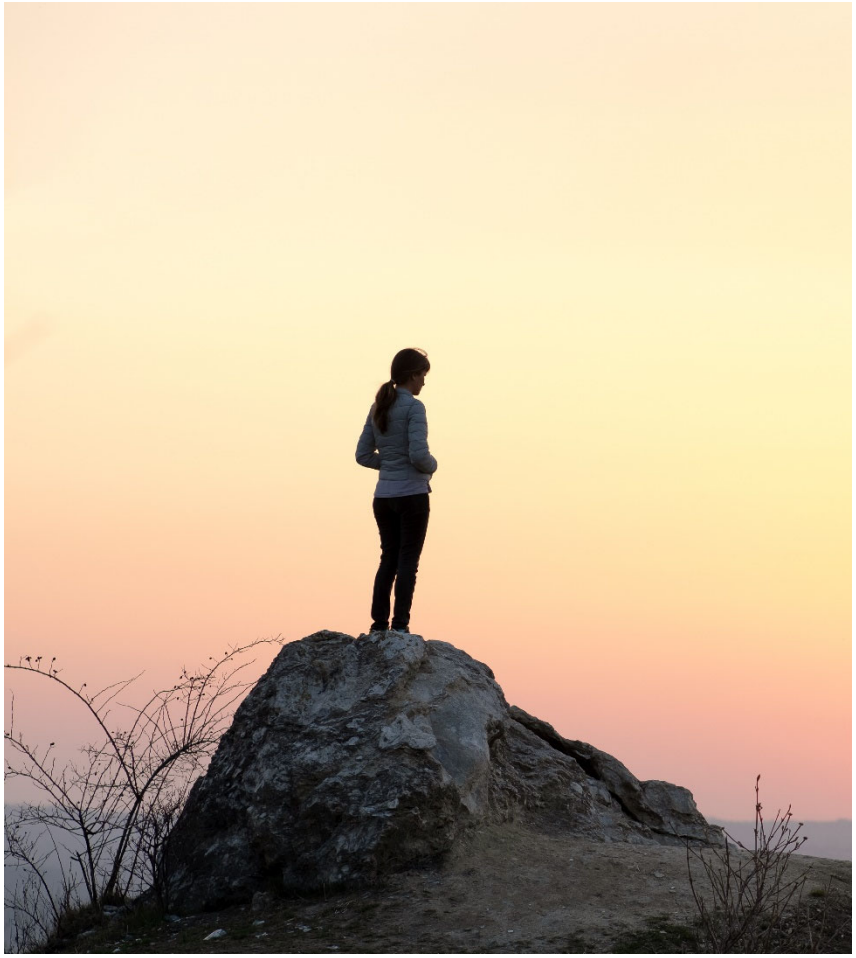
MYTH #3 “I AM STRONG ENOUGH TO DO IT ON MY OWN”

- Pregnancy is a “crisis”
- Pregnancy is an opportune time to seek help and engage in treatment

Barriers to Care:

- Shame, guilt
- Fear of judgment or legal consequence
- Mistrust
- Lack or limited resources
- Limited family or community support, isolation
- Poor past experiences with the medical system
- Stigma
- Healthcare provider bias/knowledge



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TRUTH #3 WOMAN EMPOWERMENT: PATIENTS AND PROVIDERS!

- I have strength within me
- I am brave in challenging times
- I am bold and resilient
- I am courageous
- I love my baby

Shared goals: Both mother and provider want a healthy baby

Compassionate, trauma-informed approach and openness are crucial!

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MYTH #4 “ALL I NEED IS DETOX. I DON’T WANT MY BABY BORN ADDICTED”

Pregnant women who are physically dependent on opioids *should receive treatment using methadone or buprenorphine rather than withdrawal management* or psychosocial treatment alone.

A medical examination and psychosocial assessment are recommended when evaluating pregnant women for opioid use disorder. However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.

Opioid Use and Opioid Use Disorder in Pregnancy (Joint with the American Society of Addiction Medicine) (Obstet Gynecol 2017;130:e81–94)

National Practice Guideline for the Treatment of Opioid Use Disorder, ASAM 2020

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TRUTH #4 EVIDENCE-BASED TREATMENT

For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, ranging from 59% to more than 90%, and poorer outcomes.

Relapse poses grave risks, including communicable disease transmission, accidental overdose because of loss of tolerance, obstetric complications, and lack of prenatal care.

Opioid Use and Opioid Use Disorder in Pregnancy (Joint with the American Society of Addiction Medicine) (Obstet Gynecol 2017;130:e81–94)

National Practice Guideline for the Treatment of Opioid Use Disorder, ASAM 2020:e81–94)

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TRUTH #4 EVIDENCE-BASED TREATMENT

Opioid detoxification not recommended because:

- Decreased neonatal birth weight
- Decreased prenatal care, poorer obstetrical outcomes
- Illicit drug relapse
- Resumption of high risk behaviors (IVDU, prostitution, criminal activity)

Medication for Addiction Treatment (MAT) with methadone or buprenorphine - standard of care

- ***Reported success rates 63-82%***
- ***FYI same success rates of other chronic disease like asthma and DM***

TRUTH #4 ACCESS TO TREATMENT

- *Access to care*: Compassionate longitudinal and comprehensive collaborative care (perinatal care + 4th trim, mental health, SUD treatment, peer support)
- Longitudinal framework -> innovative value-based model
  - *Perinatal Bundle (perinatal, mental health and SUD services*
  - *Evidence-based MOUD*
  - *Optimizing postpartum support resources for mom, dad, baby*
  - *Self care and advocacy*
  - *Tobacco cessation*
  - *LARC*
  - *Overdose/SI prevention*
  - *Maternal mortality education and prevention*

- COMPASSION postpartum floor 5 day stay-> *decrease in NAS incidence, decrease need for pharmacotherapy and LOS, support for birthing moms, baby, family*

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TRUTH #4 ACCESS TO COMPASSIONATE COMPREHENSIVE CARE

- ***Perinatal Addiction Consultation Service (PACS):***
  - - 40 visits (2016)
  - - 152 visits (2017)
  - - 340 visits (2018),
  - >400 visits (2019)
  - *>500 visits (2020), , ongoing PACS presence removes barriers*
- ***Peer to Peer Support Line***
- ***E-Consult Support***

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TRUTH #4 BABIES CANNOT BE "BORN ADDICTED"

- Explain evidence-based therapy with methadone or buprenorphine as the standard of care
- Trauma-informed, compassionate approach
- Provide education on NOWS/NAS
- Validate autonomy; discuss expectations; set shared goals
- Normalize care to encourage early mothering behaviors with bonding, breastfeeding, rooming in

– ***Truth***: Methadone/buprenorphine dose is not associated with NAS/NOWS severity

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MYTH #5 "I CAN'T BREASTFEED MY BABY IF I'M ON MEDICATION"

Truth: Breastfeeding is SAFE with methadone and buprenorphine!

- ENCOURAGE lactation!!!
- Nursing promotes bonding
- Educate that minimal (< 1%) medication is excreted in breast milk
- "Mother's love" is the miracle medication

Let the mother be the best treatment for her child and let her child be the best treatment for her mother

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TRUTH #5 BREASTFEEDING IS SAFE
MOTHER'S LOVE IS THE MIRACLE TREATMENT

- Culture of non-judgment and acceptance
- Remove barriers to keep mom and baby together, team-centered approach and need for pharmacologic treatment
- Empower the new mother with kindness and compassion
- Encourage breastfeeding, lactation, tobacco cessation
- First-line treatment for infants at risk for NAS/NOWS is non-pharm care-> reduces scores

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NEONATAL OPIATE WITHDRAWAL SYNDROME (NOWS)

- NOWS rates: fivefold increase, from 2.8 per 1000 births in 2004 to 14.1 per 1000 births in 2014 (TNA Winkleman, AAAP 2018)
- Sharp increase in health care spending due to increase in hospital length of stay ($1.5-$2.0 billion 2012-14)
- Protecting Our Infants Act-> focus on maternal opioid use and NOWS
- Treatment recommendations limited to hospital settings
- Much less focus on discharge planning
- Recently more emphasis on holistic, non-pharmacological approaches

TRUTH #5 ZERO SEPARATION WITH COMPASSION

COMPASSION:

Community **O**f **M**aternal **PA**renting **S**upport for **S**ubstance **I**mpacted **WO**men and **N**ewborns - 5- day extended postpartum floor stay for moms and babies

- NOWS education for patients, providers, nurses
- Mom-baby-FOB/family support → rooming-in
- Addiction/MAT stabilization/daily patient-centered rounding
- Bonding, breastfeeding, skin-to-skin, quiet environment
- Tobacco cessation, LARC
- Discharge coordination, timely SW/CPS collaboration-> Chemically Using Pregnant Women (CUPW 26 day), Pregnant and Parenting Women (PPW 6mo)

TRUTH #5 ZERO SEPARATION WITH COMPASSION

Community Of Maternal PArenting Support for Substance Impacted WOmen and Newborns

A total of 40 women with OUD on methadone (40-250mg/d), 60% homeless

- 20 women/baby couplets with standard postpartum floor discharge Day 1-3
  - ***80% babies* received morphine and prolonged NICU** stay; NICU ***LOS 18 days***
  - ***50%*** babies discharged to foster care
- 20 women/baby couplets with COMPASSION 5-day postpartum floor stay
  - ***80%* babies did not receive morphine/NICU** admission; NICU ***LOS 3.2 days***
  - ***80%*** babies discharged with mom, mostly PPW

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TRUTH #5 LONGITUDINAL HEALING WITH COMPASSION

Support Women Across the Lifespan

- ***OB Outreach Clinic*** - Validate autonomy and respect patient's choices while providing evidence-based care

- ***Supportive group care model for women****:*

  Monthly group MAT visits

  Weekly zoom MAT visits

  Postpartum and parenting, women of all ages/stages (babies welcome)

  Father, family support

  → *MAT, mental health, motherhood and recovery support*

- **March of Dimes partnership-** supportive group model for pregnant and parenting women

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TRUTH #5 “I DON’T WANT CPS TO TAKE MY BABY”

- Validate patient’s feelings and importance of addressing fear around CPS prior to delivery
- Be present, reflective listening
- Ask for permission to discuss and offer information
- Provide education on process of screening and care coordination
- Acknowledge team effort, patient-centered approach and opportunity to outline a safe plan of care for mom, baby and family

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TRUTH #5“I DON’T WANT CPS TO TAKE MY BABY”

Social Work/CPS: formulate safe discharge plan with trauma-informed approach

- SW/CPS involvement/discussion
- 5S- sobriety, support, safety, self-efficacy, satisfaction
- 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

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PROVIDER SUPPORT/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 ($p < .001$).

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PROVIDER SUPPORT/OUTREACH

- ***Washington Summit***, *"Treating Pregnant and Parenting Women With Opioid Use Disorder", Aug 8th 2018*
  - 105 attendees, results pending

- ***Washington Mental Health and Opioid Use Disorder Summit***, Jan 22nd-23rd 2020
  - 167 attendees, results pending

- ***National Women and Addiction Summit***, Jan 24th-25th 2020
  - 335 attendees, results pending

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ADDICTION RECOVERY SERVICES WELLNESS PROJECT

- Staff pre-intervention survey: January 2019

Goals:

- ***Burnout:*** decrease work hours, revamp FTE expectations, increase provider salary
- ***Compassion fatigue:*** mindfulness workshops, gratitude wall for staff (SUDP, RN, MD); effort to appreciate the positive impact and meaningful work contributions
- ***Secondary trauma:*** supportive environment, mentality, compassionate communication, growth mindset, vulnerability and courage

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ADDICTION RECOVERY SERVICES WELLNESS PROJECT

- Self- care and self-efficacy focus:
  - "Berry Wednesday"- fresh berries for staff every Wednesday
  - "Walk the Talk" – 15-20 minutes interdisciplinary walks
  - Team huddles for daily reflections, laughter
  - Gratitude and mindfulness
  - Staff appreciation at work, finding meaning in what we do
  - Potlucks, celebrating diversity, Black Lives Matter
  - Dedicated vacation and family time; flexibility in work schedule
  - Setting healthy boundaries to separate work and personal life

- Post-intervention survey March 2020

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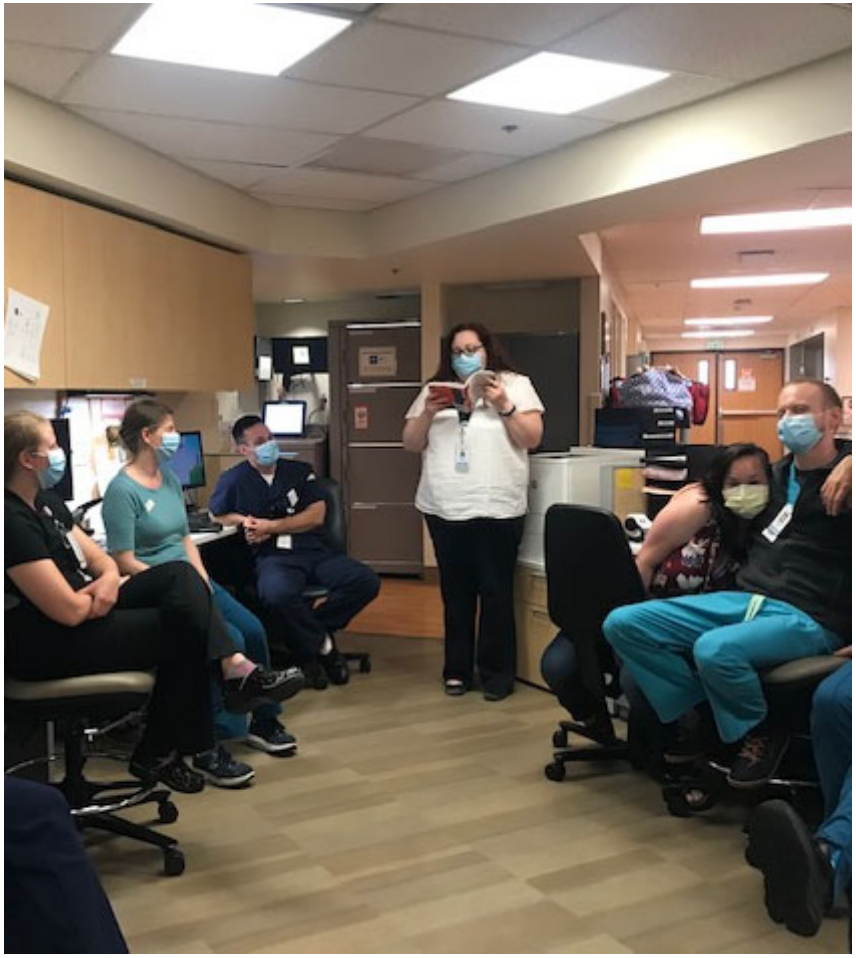
ARS TEAM HUDDLES

- Be a healer
- Be mindful
- It's about retraining your attention
- Be a better listener, show empathy
- Being aware of & letting go of distractions
- Having a kind, open, curious attitude to your present moment experience with your patient
- Being present, humble



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ADDICTION RECOVERY SERVICES WELLNESS PROJECT

ARS Wellness Survey Data (January 2019 - March 2020)

How much do you agree or disagree with these statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I feel comfortable to talk about burnout at my workplace					
MD (Jan 2019)			40%	60%	
MD (Mar 2020)				50%	50%
I feel comfortable to talk about compassion fatigue at my workplace					
MD (Jan 2019)			40%	60%	
MD (Mar 2020)				25%	75%
I feel comfortable to talk about secondary trauma at my workplace					
MD (Jan 2019)			50%	50%	
MD (Mar 2020)			20%	80%	
I feel I am at increased risk to experience burnout at my workplace					
MD (Jan 2019)		20%		60%	20%
MD (Mar 2020)	25%	25%		50%	
I feel I am at increased risk to experience compassion fatigue at my workplace					
MD (Jan 2019)		20%	20%	40%	20%
MD (Mar 2020)	25%	50%		25%	

ARS Wellness Survey Data (January 2019 - March 2020)

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ADDICTION RECOVERY SERVICES WELLNESS PROJECT

How much do you agree or disagree with these statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I feel I am at increased risk to experience secondary trauma at my workplace					
MD (Jan 2019)			50%	80%	20%
MD (Mar 2020)				50%	
I often feel tired and overworked at the end of my workday					
MD (Jan 2019)				100%	
MD (Mar 2020)		25%	25%	50%	
I feel that my wellness and quality of life suffers if I feel tired and overworked at my workplace					
MD (Jan 2019)		20%		80%	
MD (Mar 2020)		25%	25%	50%	
I want to change things at my workplace to improve wellness, compassion fatigue and secondary trauma					
MD (Jan 2019)		20%		60%	20%
I feel that we have been improving things at my workplace to promote wellness, compassion fatigue and secondary trauma					
MD (Mar 2020)				25%	75%
I am willing to participate in regular sessions to address and improve wellness, compassion fatigue and secondary trauma					
MD (Jan 2019)				80%	20%
I feel that we have been improving things at my workplace to improve trauma-informed care and secondary trauma					
MD (Mar 2020)				25%	75%
I have the skills and the knowledge to address burnout					
MD (Jan 2019)		40%	40%	20%	
MD (Mar 2020)			25%	25%	50%

- **ARS Wellness Survey Data (January 2019 - March 2020)**

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WELLNESS TIPS

- Intention and efforts for **preventing** stress and burnout, mindfulness
- **Self-care -** nurture physically, mentally, spiritually, and emotionally
- Notice self burnout with realistic **recognition**
- **Supportive help** and talking with others about issues and stressors
- **Professional resources**
- Saying ***no*** with compassion: forming firm **Boundaries** to avoid increased stress and problems
- Using **Humor** and **Laughter**
- Finding **Non-Medical Hobbies: potluck, social gatherings**

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TAKE HOME POINTS

"The mother is more scared than you are"

Dr. Jim Walsh

- Trauma-informed care and non-judgmental caring encourages treatment engagement
- Zero Separation and COMPASSION improve mom/baby outcomes

Meeting needs of vulnerable and disadvantaged women
Community Effort
Woman Empowerment

- Together we can make a difference
- Yes, We Can

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THANK YOU!

Ms. Masitsa Muhanji
Vania.Rudolf@swedish.org
Swedish Medical Center, Seattle, WA

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Questions?

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