Perinatal Addiction: Providing Compassionate and Competent Care

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Objectives
- Participants will be able to describe the neurochemical basis of opiate addiction.
- Participants will be able to describe several of the common emotions experienced by families whose lives are impacted by perinatal substance abuse.

Outline
- Scope of the Problem
- What is opiate addiction?
- Treatment options for pregnant women
- Complicating factors
- Common emotions
- What to Do?
- Points of emphasis

The Numbers

Source: "CDC VitalSigns" Nov 2011

Amount of prescription painkillers sold by state per 10,000 people (2010)

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)
In 2010, enough prescription painkillers were prescribed to medicate every American adult around-the-clock for one month.

**Drug Take Back Day Stats**
- September 2010
  - ME 7,850 lbs / US 241,506 lbs
- April 2011
  - ME 11,920 lbs / US 376,593 lbs
- October 2011
  - ME 14,140 lbs / US 377,086 lbs
- Total
  - ME 33,910 lbs / US 995,185 lbs

**Scope of the Problem**

**DHHS DAB reporting Data**
- 2005: 165
- 2006: 201
- 2007: 274
- 2008: 343
- 2009: 451
- 2010: 572
- 2011: 667
- 2011: 118 assigned to ARP
- 2011: 179 referred to PHN
- 2011: 72 comp. no int. req.
- 2011: 298 CPS assessment
- 2011: 667 total

**Number and Percent of Birth Hospitalization Discharges on Which Drug Withdrawal Syndrome in Newborn was Noted, Maine Hospital Discharges, Maine Residents, 2000-2009**
Addiction: Why Don’t They Just Quit?

Addiction

- Substance dependence is a pattern of substance use that leads to clinically significant impairment or distress shown by 3 or more of the following in a 12 month period.

- Tolerance (need for more to achieve intoxication or diminished effect from same dose)
- Withdrawal (symptoms of withdrawal or use to relieve/avoid withdrawal)
- Use of the substance in larger amount or for longer time period than was intended
- Persistent desire or unsuccessful efforts to cut down or control substance use
- A great deal of time is spent in activities related to obtaining, using, and recovering from the substance
- Important social, occupational, or recreational activities are given up or reduced because of the substance use
- Use continues despite knowledge of having a persistent or recurrent problem that is likely to have been caused or exacerbated by the substance

Addiction

- A chronic, often relapsing brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual who is addicted and to those around them.
- Although the initial decision to take drugs is voluntary for most people, the brain changes that occur over time challenge a person’s self control and ability to resist intense impulses urging them to take drugs.

http://www.drugabuse.gov/publications/infofacts/understandingdrugabuse

Addiction

- Addiction is characterized by:
  - inability to consistently abstain
  - behavioral control impairment
  - craving
  - Translated recognition of significant problems with one’s behaviors and interpersonal ramifications
  - Emotional response dysfunction

- Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

American Society of Addiction Medicine 2011

Psychology of Addiction

Classical Conditioning
Psychology of Addiction

Classical Conditioning
- How Addiction Works
- Behavior becomes reflexive, without thought or consideration of consequence
- How do you break the association (extinction)?
  - Passage of time has little effect on strength of the Conditioned Response
  - Repeated presentation of the Conditioned Stimulus without the Unconditioned Response

Operant Conditioning
- Behavior (increase or decrease) becomes contingent on consequence of that behavior
- Effectiveness of consequence is dependent on satiation/deprivation for that consequence
- Immediate consequence has more impact than delayed
- More predictable/frequent consequence has more impact than less predictable/frequent
- Size/amount of consequence determines effectiveness
- Extinction occurs when a behavior is no longer reinforced

Neurobiology of Addiction

Reward Pathway

- Prefrontal cortex
- Nucleus accumbens
- VTA

Terminal branches of axon
- Dendrites
- Axon
- Neuronal Impulse
- Myelin sheath
- Cell body (the cell's life support center)
Opiate Treatment

- **Abstinence**
  - Focus is on refraining from use of the substance

- **Harm-Reduction**
  - Focus is on minimizing risk taking behavior and reducing adverse consequences of the behavior

- **Chronic Disease**
  - Focus is on integrated, coordinated, multi-system, multi-level care with particular attention to enhancing the motivation of the patient to adhere to treatment
Addiction is Similar to Other Chronic Illnesses Because:

- It has biological and behavioral components, both of which must be addressed during treatment.
- Recovery from it—protracted abstinence and restored functioning—is often a long-term process requiring repeated episodes of treatment.
- Relapses can occur during or after treatment, and signal a need for treatment adjustment or reinstatement.
- Participation in support programs during and following treatment can be helpful in sustaining long-term recovery.

### Relapse Rates Are Similar for Drug Addiction & Other Chronic Illnesses

<table>
<thead>
<tr>
<th>Illness</th>
<th>Percent of Patients Who Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Addiction</td>
<td>40 to 60%</td>
</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>40 to 60%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50 to 70%</td>
</tr>
<tr>
<td>Asthma</td>
<td>50 to 70%</td>
</tr>
</tbody>
</table>

Methadone - full opiate agonist
- Binds strongly to opioid receptors and replaces the natural opioid system that has been damaged by stimulating normal dopamine production and regulation.
- Blocks other opiates from binding to receptors and inducing a euphoric high

**Opiate Replacement Therapy**

- **Methadone- full opiate agonist**
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**Opiate Replacement Therapy**

- **State and Federal regulations**
- **Clinic based**
- **Mandatory counseling**
- **Take homes possible (up to 6)**
  - Call backs, stability assessment
- **Upper limit determined by patient needs**

**Buprenorphine- partial opioid agonist**
- Binds to opioid receptors also, but does not produce as strong an effect.
- Sold as Suboxone® or Subutex®
  - Suboxone contains combination of buprenorphine and naloxone (an opioid antagonist, which binds to opiate receptors but does not produce an effect).
  - Subutex is often prescribed for pregnant women (not FDA approved- YET), since naloxone is contraindicated in pregnancy.

**Opiate Replacement Therapy**

- **Office based (including PCPs)**
- **Up to 100 patients per physician**
- **No specific requirements for counseling**
Pregnancy Considerations

- The continual cycle of intoxication/withdrawal can have significant adverse effects on a developing fetus
- Methadone is the gold standard treatment for a pregnant woman who is opiate dependent
- Babies born to women on ORT (compared to illicit users or attempts at abstinence) are born full term, appropriate size, and healthy

Complicating factors
- Polysubstance use/abuse/dependance
- Co-morbid psychiatric diagnoses
- Co-morbid psychosocial stressors
- Developmental Delay

Case Examples

Case 1:
- 18 y.o. mom G1P1, 30 y.o. dad
- MGF initiated mom into drug use so he could sexually abuse her
- Mom has used “as long as I can remember”
- Sexual abuse continued until mom was 10, then foster care for 7 yrs
- Multiple placements including psych hosp x3
- Relationship with dad for 2 yrs
- Initiated methadone 3 months ago, ongoing cannabis, periodic benzos
- Presents as being a young teen

Case 2:
- 21 y.o. mom G1P1
- 6 m.o. foster care due to MGM chronic schizophrenia
- Adopted quickly (likely 1-2 yrs) by relative
- 12 y.o. relative relinquished custody “wasn’t working out”, re-enter foster care
- 12-18 y.o. 32 group home placements, multiple psych hosp
- Dx ADHD, PTSD, Psychosis → many meds, suicidal/depressed/cutting
- “no one wanted me, I was all alone”
- 18-21 y.o. Unstable living, cannabis, homeless
- Relationship with dad 9 months, baby born 34 wks GA

Case 3:
- 23 y.o. mom G1P1, 19 y.o. dad
- 1 y.o. MSGF cocaine user, burned down family home when mom/MGM inside
- 2 y.o. MSGF rapes mom
- 4 y.o. MSGF’s primary caregivers due to MGM school, MSGF physically abusive to mom, punched her in mouth, repeatedly hung her by feet over staircase
- 9 moves by 3rd grade
- 12 y.o. 5 deaths in family inc 3 y.o. cousin with brain cancer
- 12 y.o. MGM begins to exhibit bizarre behavior, ultimately dx paranoid schizophrenia, mom begins etoh/pot
- 12-14 y.o. cutting, chronic medical problems with hospitalization
- 14 y.o. mom raped
- 16-18 y.o. family reclusive (no school) due to mom’s paranoia, acute anxiety for mom, ridiculed by MGM
- Signs on inside of all windows saying men would come in to rape mom
- 16-18 y.o. foster care, MGM psych hosp, mom began opiates with a friend at 17, then used with BF
- 20 y.o. Move with new BF, homeless, IV heroin, attempted rape
- 22 y.o. meets dad, both opiate users, pregnant 3 months later, enters methadone tx at approx 12 wks GA
Case Examples

Case 4:
- 22 y.o. mom 1 P/L, 19 y.o. dad
- 4 y.o. MGP’s divorced, live with MGP
- 6 y.o. MGP abandon mom, foster care, then MGF
- 12 y.o. MGF physically abusive, return to MGP
- 13 y.o. begin cannabis
- 16 y.o. DHHS removed back to MGF
- 17 y.o. begin crystal meth, ongoing polysubstance abuse
- Cocaine, cannabis, benzos, OTC cold meds, IV opiates and meth
- 18 y.o. met and married man later discovered to be RSO
- Psych dx include Bipolar dx, PTSD, ADHD, ODD, Anxiety, Borderline Personality D/O
- Met dad 7 months ago at ARC, pregnancy discovered 7 wks later
- 9 wks GA IV Ritalin, entered buprenorphine tx, ongoing cannabis
- 16 wks, mutual assault, mom changed
- 28 wks, non-compliant with buprenorphine program requirements, off program
- ? Pregnancy outcome

Complicating Factors

Adverse Childhood Experiences

Vincent Felitti, MD

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- An incarcerated household member

Complicating Factors

Prior Experience Drives Reaction

Complicating Factors

Neurosequential Model of Therapeutics

Common emotions parents encounter in the hospital

- Guilt for “causing” the infant’s withdrawal
- Shame related to their addiction
- Fear of how they will be treated by medical staff
- Anxiety regarding their child’s well-being
- Anger regarding being “told” how to care for infant
- Frustration with inability to meet infant’s needs on their own
- Fear of losing their child to CPS
- Fear of not knowing what to expect
- Frustration with lack of control
- Anxiety related to level of knowledge of support system
- Isolation being far from home/supports/resources

"Non-anxious inquiry by an interested person is an intervention in itself."
– Vincent Filetti, MD

http://www.cdc.gov/nccdphp/ace/
What to Do?
Practice from a trauma informed perspective

Reading from "Power, Control, and the "Difficult" Patient: Hidden Dimensions to Caring for Survivors of Sexual Abuse" by A. Skinner, PhD- 2010

What to Do?
Consider the Stage of Change

What to Do?
Give them a new experience
(Regardless of venue or discipline)
60 hr stay x Q1H rounding = 60 opportunities
5 day NAS observation = approx 96 opp.
25 day NAS treatment = approx 600 opp.

What to Do?
Consider the Developmental Level

Lesson Learned
"What did you take away from the meeting?"
Take Home Messages for Parents

- The past can’t be changed, but the present and the future can.
- The emotions they experience are normal.
- Despite their addiction, they are human beings and deserve to be treated with respect.
- We are competent, experienced caregivers for babies with NAS and their families.
- We are willing to teach them how to care for their infant, if they are willing to be taught.
- Most DAB reports result in baby going home with parents, and DHHS workers can be a resource to help the family.
- We want the parents to be active members of the treatment team for their baby, and feel positive about their role as parent.
- Making use of formal and informal supports is critical to their success in the short term and the long term.

Take Home Messages for Staff

- Addiction is not a morally based weakness or personality flaw.
- The language we use with each other and with the families we serve has more power than we may realize.
- Even brief interventions can be effective and beneficial. Motivational interviewing is key.
- These families are not easy to work with! Other Axis I and Axis II diagnoses are often present. Taking care of yourself will allow you to continue taking care of them.
- Know your own stuff/biases/baggage.
- Do not underestimate the complexity of emotions felt by a mother (or father) of an infant who is experiencing withdrawal.
- Knowledge is power and the experiences of the educated vs the non-educated are vastly different.
- Families who are affected by substance abuse are best served by knowledgeable, competent, and compassionate caregivers who recognize that addiction is a neurologically based disease and is treatable.

Creating a common language

Drug exposed vs. drug affected vs. NAS

- Drug/substance exposure happens when a pregnant woman ingests some licit or illicit substance.
- A baby becomes drug affected when that substance (licit or illicit) creates a condition in the baby that except for the exposure to the substance, would otherwise be absent.
- When a baby experiences a constellation of clinically significant withdrawal symptoms, a diagnosis of Neonatal Abstinence Syndrome is made (may be iatrogenic).

These babies are NOT “Addicted”

1. Not an accurate term
2. Labeling = Limiting
3. Language imparts meaning

Creating a common language

You can’t help those for whom you have contempt.

Questions?

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