Effectively Treating Opioid Use Disorder in Pregnancy

Marci Waggoner, WHNP-BC, AGPCNP-BC
Andreas Bienert, Ph.D., LPC, LSATP, CSAC, NCC

Marci Waggoner, a licensed Nurse Practitioner who is double board certified in Women’s Health and Adult Primary Care. She completed both undergraduate and graduate studies at Virginia Commonwealth University in Richmond, Virginia. Marci has more than 20 years of experience working in private and academic medicine settings, both inpatient and outpatient, in high-risk obstetrics including the stabilization of pregnant inmates with MAT. She joined Master Center for Addiction Medicine in 2019 and serves in the role as Associate Medical Director. She continues to treat those who are impacted by the disease of addiction, while focusing on education, and learning how to live with the chronic disease of addiction. Marci is a member of the American Academy of Nurse Practitioners (AANP), Association of Women’s Health, Obstetrics and Neonatal Nursing (AWHONN) and American Society of Addiction Medicine (ASAM). She has recently joined with Virginia Commonwealth University Institute for Drug & Alcohol Studies in assisting with a study aimed towards the pregnant woman with Opioid Use Disorder (OUD) and the impact of educational materials pre and postnatal.

Dr. Bienert is a Licensed Professional Counselor, Licensed Substance Abuse Treatment Practitioner and Certified Substance Abuse Counselor in the state of Virginia, and a Nationally Certified Counselor. Dr. Bienert has worked in the mental health and substance abuse field since 2005. He is recognized for his work within inpatient and outpatient levels of care helping individuals overcome addiction and trauma, and has worked with adolescents, adults, in addition to couples and families in various treatment settings. This experience has also led him to pursue further training and expertise, including neurofeedback training and EMDR to aid individuals in the recovery process. Dr. Bienert joined Master Center for Addiction Medicine in 2019 where he serves as Chief Clinical Officer. He is also known for his work as an educator and supervisor of graduate counseling students at Colorado Christian University. Dr. Bienert is a member of the American Counseling Association, the Virginia Counselors Association, the National Association of Addiction Professionals, and the Association for Counselor Education & Supervision.
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Objectives
The participant will be able to understand the unique needs and challenges of pregnant women with opioid use disorder.
The participant will be able to apply information and treatment guidelines on opioid agonist pharmacotherapy.
The participant will be able to construct a treatment plan supporting pregnant women with opioid use disorder effectively within their recovery process.

Background
Epidemiology

- The nation’s opioid epidemic continues to compromise the health and well-being of individuals, families, and communities. Federal policymakers and agencies are developing, implementing, and funding strategies focused on turning the tide (U.S. Department of Health and Human Services [HHS], 2016) to address opioid misuse, opioid use disorder (OUD), fatal and non-fatal drug overdoses, prenatal substance exposure, dissolution or breakup of families, and financial ruin experienced in communities nationwide.
- In 2015, more than 27 million people in the United States reported current use of an illicit drug or misuse of prescription drugs in the past 30 days (Center for Behavioral Health Statistics and Quality [CBHSQ], 2016).
- The number of women of childbearing age, defined as ages 15–44, who reported past-month heroin use increased to 109,000 in 2013–2014, an increase of 31 percent from 2011–2012 (CBHSQ, 2015, Table 6.71A).
- The number of women ages 15–44 who reported past-month misuse of prescription pain relievers such as OxyContin increased to 98,000 in the same period, an increase of 5.3 percent (CBHSQ, 2015, Table 6.71A).
What does current research tell us about Pregnancy and Contraception for Pregnant Women with Opioid Use Disorder?

- Nearly **9 out of 10 pregnancies** among women with OUD are unplanned.
- It is not common for a woman to have an unplanned pregnancy as her health improves after starting OUD pharmacotherapy and behavioral therapy. The chances of becoming pregnant increase as treatment for OUD becomes more effective.
- Only about **50%** of women in treatment for OUD and other substance use disorders (including alcohol) are using contraception. This compares with about **80%** of women in the general population who use contraception.
- Discussing family planning options with women with OUD and making these options available to them when they begin treatment can reduce unplanned pregnancies.

**Case Study 1**
• Women with OUD and their infants face **critical barriers** to optimal care such as legal consequences in several states with statutes that sanction pregnant women with OUD. The goal of these efforts is to protect the fetus or infant from opioid exposure (Guttmacher Institute, 2017) but these legal consequences may drive women away from available care, seeking care or continuing to engage in care thereby potentially leading to worse outcomes for both the fetus and mother (Angelotta, Weiss, Angelotta & Friedman, 2016).

• **Shame** associated with OUD during pregnancy and motherhood and the misinformation among healthcare professionals and systems that results in reluctance to provide care for such women, are also significant barriers.

• Together, these barriers can **prevent** women from receiving essential prenatal care or treatment for their OUD until they are close to delivery or in labor.

• Barriers can also prevent the woman from receiving essential care during the postpartum period.

• Without treatment, pregnant women with OUD face increased risks of preterm delivery, low infant birth weight, and transmitting HIV to their infants (Binder & Vavrinková, 2008).
• Pregnancy may motivate women to seek, continue, or change their treatment, but pregnancy can also be a stressful time.

• Women who are in treatment for OUD and have recently discovered they are pregnant may be concerned about fetal exposure to tobacco, alcohol, or prescription medications. They may also think they should discontinue medications to treat OUD. They may worry that exposing their babies to these medications increases the risk of neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS).

• Women receiving medications to treat OUD do not have to stop their OUD medications before or during pregnancy. For most women, it is recommended to continue OUD medications during pregnancy to avoid relapse, which could further endanger both the woman and the fetus (SAMHSA, 2016).

• Withdrawal can increase the patient’s risk for a return to substance use, preterm labor and birth, and miscarriage. Remaining on OUD medication is generally the safest choice for both the mother and the developing fetus.

How can pregnancy affect treatment for OUD?

• Medications for OUD reduce relapse rates. Relapse puts mother and infant at high risk of adverse health effects, including overdose, infectious diseases, and other health impacts. On the other hand, more research is needed to understand the longer-term risks of medications for OUD on the developing brain. For most women with OUD, exerts agree that the benefits of medications for OUD outweigh the potential risks (SAMHSA, 2018).

• The distribution of medications through the body is affected by pregnancy weight gain and a woman’s altered metabolism. Therefore, medication doses to treat OUD frequently need to be adjusted as the pregnancy progresses.

• Ensuring that women with OUD are living stable lives in a safe home environment can promote success in both recovery and planning a family.

How can pregnancy affect treatment for OUD?
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- Types of screenings vary. The World Health Organization’s (WHO’s) Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy recommends that healthcare professionals ask all pregnant women about their use of alcohol and other substances (i.e., past, present, prescribed, licit, and illicit use) as early as possible in the pregnancy and at every follow-up visit (WHO, 2014).
- Healthcare professionals need to determine whether any of their pregnant patients are currently taking (or have recently taken) methadone, buprenorphine or other long-acting opioids.
- Interviews and Instruments:
  A complete substance use history is essential to establishing a safe and appropriate treatment plan that the woman and the healthcare professionals can agree on (Federation of State Medical Boards [FSMB], 2013). This history combines interviews and results from standardized assessment instruments. Ideally, the history would include (SAMHSA, 2015): The nature of the patient’s SUDs.
  - Underlying or co-occurring diseases or conditions.
  - The effect of opioid use on the patient’s physical and psychological functioning.
  - Outcomes of past treatment episodes

### Screenings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Substance/ Health Problem Screened</th>
<th># of Items</th>
<th>Method of Administration</th>
<th>Training in Administration Necessary?</th>
<th>Validation Sample(s)</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>4Ps Plus* and Integrated 5Ps</td>
<td>Integrated 5Ps: Violence, mental health, tobacco, alcohol, and illicit substances</td>
<td>5</td>
<td>Paper-and-pencil</td>
<td>No</td>
<td>Inpatient and outpatient</td>
<td>87%</td>
<td>76%</td>
</tr>
<tr>
<td>Substance Use Risk Profile—Pregnancy (SURP-P)</td>
<td>Alcohol and substances</td>
<td>3</td>
<td>Paper-and-pencil</td>
<td>No</td>
<td>Prenatal clinic</td>
<td>Low risk: 80–100% High risk: 48–100%</td>
<td>Low risk: 61–64% High risk: 84–86%</td>
</tr>
<tr>
<td>Tolerance, Annoyed, Cut-down, Eye-opener (T-ACE)</td>
<td>Alcohol</td>
<td>4</td>
<td>Paper-and-pencil</td>
<td>No</td>
<td>Prenatal clinic</td>
<td>60–91%</td>
<td>37–79%</td>
</tr>
<tr>
<td>Tolerance, Worried, Eye-opener, Amnesia, K(Cut-down (TWEAK)</td>
<td>Alcohol</td>
<td>5</td>
<td>Paper-and-pencil</td>
<td>No</td>
<td>Prenatal clinic</td>
<td>59–92%</td>
<td>64–92%</td>
</tr>
</tbody>
</table>
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<table>
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<tr>
<th>Medication Assisted Treatment (MAT) During Pregnancy</th>
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<tbody>
<tr>
<td>• A pregnant woman with OUD should be offered MAT consisting of pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions.</td>
</tr>
<tr>
<td>• Pharmacotherapy, combined with behavioral interventions, helps people who misuse opioids avoid experiencing withdrawal symptoms or overwhelming cravings when the opioid misuse is stopped.</td>
</tr>
<tr>
<td>• By blocking cyclic withdrawal symptoms associated with the misuse of short-acting opioids, methadone or buprenorphine can provide a more stabilized intrauterine environment.</td>
</tr>
<tr>
<td>• In addition, starting on pharmacotherapy can help the pregnant woman stop injecting drugs, a primary route of infection for people who use drugs. By controlling the symptoms of OUD (e.g., withdrawal, cravings), the pregnant woman can regain control, reengage in important obligations and activities in her life, and rebuild a stable social environment for herself and her family.</td>
</tr>
<tr>
<td>• Behavioral interventions are also recommended to provide maximum support for long-term recovery.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Medication Assisted Treatment (MAT) During Pregnancy</th>
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</thead>
<tbody>
<tr>
<td>• Conversations about informed consent with pregnant women who have OUD or who are on pharmacotherapy for opioid use can be complex.</td>
</tr>
<tr>
<td>• Treatment plans need to be individualized.</td>
</tr>
<tr>
<td>• Healthcare professionals should educate women and their family members about potential legal, social, and medical consequences of each treatment option, specifically the risks of NAS.</td>
</tr>
<tr>
<td>• Initiating pharmacotherapy needs to be individualized to each patient’s medical condition.</td>
</tr>
<tr>
<td>• Currently, research indicates no known risk of increased birth defects associated with the use of buprenorphine or methadone.</td>
</tr>
</tbody>
</table>
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- **Patient Selection:**
  May be preferable for patients who are new to treatment because it is easier to transfer from buprenorphine to methadone (it can be very difficult to transfer from methadone to buprenorphine), who do not like or want methadone, or who have requested this medication.

- **Dispensing:**
  May be prescribed in an office setting with weekly or biweekly prescribing/dispensing or provided in an opioid treatment program.

- **Risk of Medication Interaction:**
  Few known interactions with other medications; risk of interaction is greatest with central nervous system (CNS) depressants and CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, atazanavir). If these medications must be used, the clinic should monitor the patient daily for increased effect of buprenorphine; healthcare professionals should be aware that the development of sign and symptom varies and depends on a variety of factors. Other agonist/antagonist medications (e.g., butorphanol, dezocine, nalbuphine, pentazocine) and full antagonists will result in precipitated withdrawal.

- **Starting Dose:**
  2-4 mg

- **Target Dose:**
  Daily, 16 mg or product equivalent to 16 mg, is the most common dosage. The optimal dose will be determined by regular assessment of the individual and her response to treatment.

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**Buprenorphine**

- **Risk of NAS:**
  Approximately 50% of exposed neonates are treated for NAS; NAS may be milder with buprenorphine compared with full mu opioid agonists such as most opioid analgesics and methadone.

- **Time to NAS Onset:**
  American Academy of Pediatrics (AAP) recommends monitoring prenatally opioid-exposed neonates for a minimum of 4–7 days after delivery (Hudak, Tan, & AAP, 2012).

- **Duration of NAS:**
  Most studies show shorter NAS duration compared with methadone.

- **Neurodevelopmental Outcomes of Exposed Children:**
  Available research suggests there is not a linear cause and effect relationship between prenatal buprenorphine exposure and developmental problems when compared with other opioids; the research base is limited.

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**Buprenorphine**
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Other forms of Medication Assisted Treatment (MAT)

- Methadone
- Subutex
- Naltrexone
- Naloxone

Other forms of Medication Assisted Treatment (MAT)

- High Risk for Relapse!
- Ask yourself – why?
- Provide reassurance to the patient regarding safety of use of MAT, specifically Buprenorphine

Tapering
• **NAS/NOWS** refers to the behavioral and physiological symptoms of withdrawal in infants who were exposed in utero to substances such as opioids, tobacco, and benzodiazepines before birth. NAS/NOWS is an expected and treatable condition following in utero exposure to such substances.

• Pregnant women with OUD and other infant caregivers need to be told about the possibility of NAS/NOWS. They should also be informed about the fact that longer term risks on the infant are not fully known. The information they receive should be explain what to expect, describe how to care for an infant with NAS/NOWS, and reassure them that treatment for NAS/NOWS is available.

• Screening for NAS/NOWS after delivery is critical for improving neonatal outcomes (ASAM, 2017).

• Pregnant women with OUD need to know that reducing the medication dose to treat OUD will not reduce NAS/NOWS expression or severity (SAMHSA, 2018).

• It is important for healthcare professionals to explain that the occurrence of NAS/NOWS does not mean that the woman needs to stop medications to treat her OUD.

• **Women with OUD frequently misuse other substances that can exacerbate NAS.**

• Nicotine and benzodiazepines may worsen the symptoms of NAS

• Healthcare professionals should provide behavioral support to reduce, and ideally stop, the misuse of other substances. Among the interventions that reduce and end other substance use are cognitive behavioral approaches—including motivational interviewing and dialectical behavioral therapy—and contingency management.
Women in treatment for OUD tend to have larger and healthier babies and are more likely to reach full-term deliveries than women receiving no treatment for their OUD.

Concern about a small increased risk of birth defects associated with medications to treat OUD taken during pregnancy should be weighed against the clear risks associated with the ongoing misuse of opioids by a pregnant woman.

To prevent birth defects that are due to a low folic acid, women who are planning a pregnancy or are already pregnant should take 1mg of colic acid or a prenatal vitamin with 1mg of folic acid daily.

Other factors such as poor prenatal nutrition, lack of prenatal maternal care, unstable home environments, and maternal use of alcohol, tobacco, or benzodiazepines can impact a child’s development.

Behavioral health disorders among pregnant and postpartum women can complicate birth, infant, child, and maternal outcomes. These issues impact not only the mother but her ability to care for her own and the infant’s basic needs and can affect the child’s cognitive and emotional development.

Intervening early, offering, integrated services and support, and promoting responsiveness, caring relationships can prevent or reverse damaging developmental health effects to the child.

Providing a stable home environment, ensuring good nutrition, and engaging in play can add to other protective factors that shape a child’s developmental and health milestones across the lifespan.
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Best Healthcare Treatment Practices

- As soon as a pregnancy is determined:
  - Establish a good working relationship with an obstetrics/gynecological (OB/GYN) team.
  - Refer women to doctors or midwives who are experienced and knowledgeable about the care of women with OUD.
  - Have women sign a consent form that complies with 42 CFR Part 2 for the release of confidential substance use disorder patient records. This will enable the PUD treatment team to coordinate with a woman’s OB/GYN team.
  - Refer pregnant women for prenatal care as early as possible. Prenatal care can help prevent complications and inform women about important steps they can take to protect their infant and ensure healthy pregnancy (EKSNI, 2017).
  - Women with OUD may also be prescribed other medication for additional health issues. Discuss their medical history in detail and assess the risks and benefits of taking medications during pregnancy.

Best Healthcare Treatment Practices

- Give women information about behaviors that promote a healthy pregnancy:
  - Encourage women to maintain a healthy weight during the pregnancy or to establish a healthy weight before becoming pregnant.
  - Encourage women to stay active and maintain the same exercise regimen they had before their pregnancy.
  - Advise women to quit smoking and stop alcohol use before becoming pregnant. Quitting smoking increases the odds of long-term recovery from other substances, whereas continued smoking following treatment increases the likelihood of return to substance use, sudden infant death syndrome, preterm birth, and other birth defects. Drinking during pregnancy can cause miscarriage, stillbirth, and a range of disabilities for the baby (ACOG, 2017).
  - Discuss what sort of support system the woman has at home and how she has prepared for the arrival of her infant. Provide information about childbirth and parenting classes and set up referrals to additional in-home support for after delivery.
**Best Healthcare Treatment Practices**

- **Continue to address underlying causes for OUD:**
  - Encourage women to seek behavioral therapy or counseling, and make a referral, preferably a warm handoff. Counseling can motivate women to continue with treatment while enhancing coping skills and reducing the risk of a return to substance use.
  - Address each woman’s history including past trauma and illicit and licit substance use before and during pregnancy. Pay special attention to high-risk behaviors such as injection drug use and current exposure to domestic violence. Screen and test women at risk for HIV or hepatitis B and C (SAMHSA, 2016).
  - Screen for and be prepared to address depression, anxiety, and other mental health diagnoses for the women under your care. Rates for these conditions may be higher for pregnant women receiving OUD treatment than they are for other pregnant women. Healthcare professionals who provide medications to treat OUD may be the most qualified to address mental health concerns, but these discussions must be coordinated with the OB/GYN team to determine who will prescribe medications, including medications to treat OUD during pregnancy.

- **Discuss labor, delivery, and infant care before the baby is born:**
  - Discuss safe options for treating pain during delivery or in the short term afterward and arrange for delivery at a facility prepared to monitor, evaluate for, and treat NAS/NOWS.
  - Explain the benefits of breastfeeding, particularly the evidence that shows it can decrease NAS/NOWS severity, reduce the infant’s need for medical treatment, and decrease the length of medical treatment and hospitalization (ASAM, 2015).
  - Support women by offering information about how to care for their infants when they return home after delivery (breastfeeding, safe sleep practices), and parenting classes in the community.
Best Healthcare Treatment Practices

- What are the primary postnatal concerns?
  
  The period after delivery may be particularly difficult because of stress, fatigue, hormonal changes, postpartum depression, and other mental health issues.
  
  - Depression and anxiety are common in women with OUD, and a new mother may also experience depression and anxiety after giving birth. Screen regularly for these conditions. Counseling or other types of support can help women maintain their recovery.
  
  - Maintain a close relationship with new mothers and offer additional support such as information about parenting classes, new mother support groups, lactation, childcare, and other community supports.
  
  - Actively connect new mothers to these services when not available within your organization. Coordination of services is key.
  
  - Because the postpartum period is stressful for women, be prepared to address the risk of return to substance use during this time. Loss of child custody (placement) also increases this risk significantly (ACOG, 2017).
  
  - Review the medication dose to treat OUD before discharge and periodically after delivery. Look for signs of lethargy and excessive sleepiness in the mother.

- A return to substance use is a common occurrence among people with a SUD
  
  - Returning to substance use is a common occurrence with OUD especially early in treatment when the medication dose is still being stabilized and the woman is acquiring basic skills to cope with triggers and cravings.
  
  - Given that returning to substance use is predictable and common, doing so should not be viewed as a setback or failure, but as an indication of the need to reassess the patient and adjust the treatment plan.
  
  - Such adjustments may include engaging community and behavioral supports.
  
  - Many people find that, for lasting recovery, they need to control stress, avoid places and situations where they once used drugs (triggers), and even end relationships with people involved with drugs. When making these changes, people in recovery may find that peers—such as other mothers in recovery who experienced a pregnancy affected by OUD—can help them in a way that healthcare professionals cannot.
  
  - Personal safety and adequate food and housing are also essential to both short and long-term recovery.

Return to Opioid Use During Pregnancy

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- Alcohol
- Benzodiazepines
- Stimulants
- Cannabis

What about other substances?

Relapse Risk Implications

- While pregnancy may present a strong motivation to seek and comply with treatment for OUD, many women relapse within the first year of childbirth
  - From 2010 to 2017, the rates of opioid-related diagnoses such as OUD among new mothers at delivery have increased 131% (Hirai et al., 2021)
  - The rate of babies born with neonatal abstinence syndrome has increased to 82% of those exposed in utero and affects all demographic groups and geographic locations (Hirai et al., 2021; SAMHSA).
  - Stigma, Shame, and misinformation exacerbate the growing national problem as many healthcare professionals are reluctant to provide essential care and support to women after giving birth (SAMHSA, 2018).
  - Women with OUD may experience a host of mental health challenges, including anxiety, depression, post-traumatic stress disorder.
- The first year after giving birth, rates of opioid relapse, overdose, and death increase substantially as compared to the year before delivery (Schiff et al., 2018).
Rankin, Mendoza & Grisham (2022) identified 7 themes, which categorically informed relapse risk:
1) Childhood Bond
2) Mother-Infant Attachment
3) Birth Support
4) Child-Protective Services
5) Breastfeeding
6) Mental Health
7) Recovery Planning

Relapse Risk Implications

Childhood Bond
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Mother/Infant Attachment

Birth Support
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For new parents with OUD, the risk of relapse is greater the year after giving birth (as compared to the year before giving birth). Contributing factors:

- Sleep Deprivation
- Caring for high-needs infant
- Decreased coping mechanisms
- Postpartum depression and anxiety
- Lack of social support
- Postpartum pain

It is essential for healthcare workers to explore these factors fully and assess for needs.

Multiple systems may need consideration to guarantee that new parents are afforded the necessary, equitable, and consistent support needed as they transition to parenthood and maintain sobriety.

Relapse Risk Implications (Summary)

- Medications are only part of the treatment
- Engaging in community services: AA, NA, SMART Recovery, Dharma recovery, Women for Sobriety, Celebrate Recovery
- Utilizing Certified Peer Recovery Coaches
- Education about the Disease of Addiction
- Counseling, Behavioral Therapy
- Offering support and guidance throughout the process in a non-judgmental manner

Support
Case Study 2

Questions/Discussion
References


References (cont.)


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