Women in Recovery Specialty Online Training Series
Part One:
Substance Use Disorder (SUD) in Women with a Focus on Pregnant and Parenting Persons

Presented by:
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Chat:
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Disclosures
Dr. Ramsey has no significant financial
disclosures

Learning Objectives
1. Summarize the epidemiology of SUD in women, with a focus on
opioid use disorder (OUD)
2. Discuss stigma towards women who use drugs, particularly
pregnant and parenting persons, and discuss the role of language
in stigmatization
3. Describe harm reduction practices and trauma-informed care to
engage persons with SUD more effectively and sensitively
4. Discuss medication for opioid use disorder (MOUD) options and
best practices in pregnant and breastfeeding persons

Epidemiology of SUD in
Women, with a Focus on
OUD: Background for
Understanding Your
Patient/Client

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The First Opioid Epidemic Among Women in the US

- First surviving records of OUD (opium addiction) date from the end of the 18th century.
- Morphine was isolated in 1804, heroin was synthesized in 1874, and dependence to these opioids became more common after their commercial production.
- Throughout the early 1800s, opioid and coca (cocaine) based products were marketed as (unregulated) "medicinal tonics" for use with women and children for common maladies (cough and fatigue, respectively); doctors commonly prescribed opiates for middle- and upper-class white women for "nervousness" and "female problems." By the end of the 19th century, women comprised 77% of the individuals using opium and morphine.
- An increase in the incidence of OUD among women was noted as early as the 19th century, however, infants were not thought to be affected because it was believed that morphine use among women was associated with sterility and loss of sexual desire.
- This fallacy was corrected with the first reported case of an affected neonate with opioid withdrawal at birth in 1875, labeled "congenital morphinism"; in 1903, the Journal of the American Medical Association (JAMA) published a physician's letter reporting successful treatment of congenital morphinism with morphine in an infant.

Historical View of SUD

- TIM: Dr. Benjamin Rush published his book entitled, "Inquiry in the Effects of Ardent Spirits Upon the Human Body and Mind," the first book to describe use disorder as a disease that required treatment and recommended setting up special hospitals ("sober houses") to do so.
- Of AUD, Dr. Rush said, "The use of strong drink is at first due to free agency. From habit it takes place and from necessity.
- In the early 1900s, heroin was seen as a potential solution to the increasing problem of morphine addiction, and the philanthropic St. James Society mounted a campaign to mail free heroin samples to physicians to "prove its value." In 1914, the Harrison Act regulated and taxed the production, importation, and distribution of opiate and cocaine products. In Supreme Court cases United States v. Doremus and Webb et al. v. United States in March 1919, the Court upheld the constitutionality of the Harrison Act and ruled that a physician might not write prescriptions for a person with SUD "to keep him comfortable by maintaining his customary use."
- During the time of Prohibition, SUD was recategorized as a "moral depravity" rather than as a medical illness or disease; laws were enforced unevenly with communities of color and persons of lower socioeconomic status experiencing increased enforcement; we have yet to undo the damage that framework did for the understanding of and treatment for SUD.

Opioid Overdose Deaths Pre-COVID-19

- Presented by Kelly S. Ramsey, MD, MPH, MA, FACP, FASAM
Provisional data from CDC’s National Center for Health Statistics indicate that there were an estimated 100,306 drug overdose deaths in the United States during 12-month period ending in April 2021, an increase of 28.5% from the 78,056 deaths during the same period the year before.
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Marijuana Use and Women

Past Month Marijuana Use Among Women

Significant Increase in Marijuana Use Among Adult Women >=26 yo

Methamphetamine Use and Women

Methamphetamine Use Among Women

Misuse of Prescription Stimulants Among Women

Misuse of Prescription Opioids by Women

Source of Opioid Pain Prescriptions Among Women for Misuse

Misuse of Prescription Opioid Subtypes by Women
### Medical Consequences of Opioid Use for Women

- **Medical Consequences**
  - Women's use of heroin increased to similar rates in men
  - 1960s: 4.1 Male to Female by 2010s: 1:1 Male to Female
  - Greater risk of contracting Hepatitis C and HIV with IV heroin use
  - May be more likely to inject with a previously used needle (or share needles with a male partner)
  - More likely to be prescribed prescription opioids for pain than men
  - Greater likelihood of reporting chronic pain
  - Women are less likely to die of prescription opioid overdose but:
    - Women: 596% increase in overdose between 1999 and 2016
    - Men: 312% increase in overdose during the same time period
  - 2016 study showed women who died from opioid overdose were three times less likely to receive naloxone than men

### Opioid Use Disorder Among Women and MOUD

#### Opioid Use Disorder Among Women

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>2010</td>
<td>1.5%</td>
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<tr>
<td>2015</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Persons on MOUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>500</td>
</tr>
<tr>
<td>2015</td>
<td>600</td>
</tr>
</tbody>
</table>

### Polysubstance Use and Major Depressive Episodes (MDE), and Serious Mental Illness (SMI) in Women

#### Marijuana Use with Other Substance Use, MDE, and SMI in Women

<table>
<thead>
<tr>
<th>Substance</th>
<th>MDE</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>10%</td>
<td>5%</td>
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</tbody>
</table>

#### Opioid Use with Other Substance Use, MDE, and SMI in Women

<table>
<thead>
<tr>
<th>Substance</th>
<th>MDE</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>20%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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Mental Health Issues and Women

SMI Among Women Is Increasing

Substance Use Among Adults 18 and Older by Mental Health Status, 2020

Co-occurring Substance Use, SUD, and Mental Illness in Women

Co-occurring SUD and Any Mental Illness in Adult Women

Co-occurring Substance Use and Mental Illness Among Adult Women

Depression
- Male: Female differences in psychiatric disorders and their relationship to the onset of substance use emerge in adolescence
- Adolescent males are at higher risk of substance use than adolescent females
- Conduct disorder and ADD increase risk in adolescent males
- One Australian study showed alcohol use to have fun
- Adolescent females drank to cope with depressed moods
- Adult women with SUD have been shown to have higher prevalence of depressive and anxiety disorders compared to men
- Women with SUD are more likely than men to be diagnosed with multiple co-occurring psychiatric disorders

PTSD/Trauma
- Trauma exposure, posttraumatic stress disorder, and substance use
- Women are more likely to report a history of trauma
- Particularly childhood sexual trauma
- PTSD due to childhood sexual trauma and other sexual abuse
- Women exposed to trauma: 1.85x more likely to develop alcohol dependence
- Women exposed to trauma with PTSD: 3.54x more likely to develop alcohol dependence
- Substance use in women with PTSD may lead to an increase in depression, anxiety, and engaging in risky sexual behaviors

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Co-occurring Disorders: High Prevalence/
High Treatment Gaps

SUD is Associated with Suicidality Among Adult
Women >=18 yo

Mental Health Disorders and SUD Among
Women: High Prevalence/High Treatment Gaps

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Substance Use Among Pregnant Persons

Past Month Substance Use Among
Pregnant Persons

Marijuana Use by Pregnancy Status

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Substance Use, Pregnancy, and Mental Health Issues

Daily or Almost Daily Marijuana Use by Pregnancy Status

Past Year Substance Use and Mental Health Issues,
Pregnant Persons Aged 15-44 yo, by Marijuana Use Status

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**Pregnancy and Prescription Opioid Misuse Among SUD Treatment Admissions**

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**Prevalence of Opioid Use Disorder Per 1000 Delivery Hospitalizations**

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**Substance Use Among Pregnant Persons**

Substance Use Progressively Decreases During Pregnancy by Trimester

Teasing Out Substance Use vs. SUD in Pregnant Persons

- The vast majority of pregnant persons are motivated to maximize their own health and the health of their developing fetus
- Those pregnant persons who can't cut back or quit using, likely have a substance use disorder
- Continued use in pregnancy could indicate a substance use disorder
Maternal Mortality in the US

Maternal Mortality due to Fatal Overdose: MA Data

Vulnerabilities for Developing SUD

- Genetic predisposition (40-60% of risk)
- Concomitant mental health diagnoses: bipolar disorder, anxiety (panic disorder, PTSD, social anxiety), major depression, ADHD, personality disorders (borderline, antisocial, antisocial conduct disorder especially in adolescence); whether undiagnosed or undertreated or untreated or treated inappropriately
- History of trauma and/or abuse: preadolescent sexual trauma (especially females), victim/witness to violence (males/females)
- Poor coping mechanisms; escapism
- Impulsivity: plays a role in the initiation of substance use
- Sensation/novelty seeking play a role in the initiation of substance use
- Environmental triggers/sensory cues: triggers to use/resume use
- Lack of homeostatic reward regulation; reward "deficiency": orientation towards pleasurable rewards, priming of the brain by early substance use

The Role of Trauma: Adverse Childhood Experiences and Outcomes
What Is Trauma?

Exposure to actual or threatened death, serious injury, or sexual violence in one or more of four ways:

- directly experiencing the event
- witnessing, in person, the event occurring to others
- learning that such an event happened to a close family member or friend
- experiencing repeated or extreme exposure to aversive details of such events (i.e., first responders)

Trauma’s Effects

Pregnant Persons with SUD

- Mental Health:
  - 2/3 with co-occurring mental health diagnoses (MDD, GAD, PTSD)
  - Majority with childhood trauma (pre-adolescent sexual or physical trauma)
  - High level of IPV (intimate partner violence) in the last year
- Reproductive Health:
  - Unplanned pregnancy (80-90%); low rates of contraception use
- Other Substance Use:
  - Tobacco use: ~75%
  - Other SUD (if OUD present): 78%
- Social Functioning:
  - Inadequate social supports; social isolation; exposure to poor parenting models

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Barriers to SUD Treatment for Women

- Women experience more barriers to treatment than men
  - Social stigma and discrimination
  - Number one reason for not seeking treatment
  - Less likely to be screened in primary care and MH settings for SUDs
  - Lack of treatment services for pregnant persons
  - Lack of childcare services for parenting persons
  - Economic barriers
  - Lack of insurance
  - Lack of transportation or funds for transportation
  - Trauma histories
  - Intimate partner violence (IPV)

MOUD: Understanding the Use of Diverted Buprenorphine

Barriers to Buprenorphine Access

- Problems finding a provider who can prescribe buprenorphine and the high costs associated with obtaining a prescription were common barriers to access among those who had used diverted buprenorphine (33%) and prescribed buprenorphine (38%).

- 81% of participants who used diverted buprenorphine said they would be encouraged to get a prescription and stop seeking diverted buprenorphine if it were easier to access a buprenorphine-prescribing provider.
Stigma and People Who Use Drugs (PWUD)

Stigma in Healthcare Settings
- Includes attitudes, behaviors, and structures that may lead to prejudice or discrimination against people with mental health diagnoses and substance use disorders.
- Perpetuates stereotypes and assigns labels like dangerous, noncompliant, or incapable of managing treatment.
- Can be internalized and make people feel unwelcome, judged, or unworthy of seeking or receiving services.

Consider the Relationship of Stigma and Trauma
- Most people have experienced trauma.
- People with a substance use disorder (SUD) are more likely to have experienced trauma, including trauma in healthcare or pharmacy settings.
- Trauma impacts physical health; neurobiology; and cognitive, social, and emotional functioning.
- Perceived “high-risk behaviors” can be a way of coping with trauma.
- Consider how past experiences of trauma, violence, layers of disadvantage and stigma affect how a person engages with providers and pharmacists.

Stigma and PWUD
- Healthcare providers have high levels of stigma and bad feelings towards people who use drugs, in part from derogatory or dehumanizing language.
- Studies indicate that the language used corresponds with providing poorer treatment.

What We Say and How We Say It Matters: Bad Language Perpetuates Stigma
- The words we use matter. Choosing words like “heroin addiction” can perpetuate stigmatizing language.
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Use Strengths-Based Language in Speech and in Documentation

<table>
<thead>
<tr>
<th>Substance Used</th>
<th>Strengths-Based</th>
</tr>
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<tbody>
<tr>
<td>Addict</td>
<td>Recovery</td>
</tr>
<tr>
<td>Parental Relapse</td>
<td>Healthy</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Personal Growth</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Resilience</td>
</tr>
<tr>
<td>Expectation</td>
<td>Visionary</td>
</tr>
<tr>
<td>Parent</td>
<td>Parenting</td>
</tr>
<tr>
<td>Substance</td>
<td>Strengths</td>
</tr>
</tbody>
</table>

Stigma: Then and Now

What Does Stigma Look Like?
What Does Stigma Look Like?

- Misrepresentation of NOWS: “newborn’s death sentence”, “drug addicted baby”
- Pitting parent VERSUS child, rather than seeing birth parent and child as a dyad

Stigma and Engagement (or Lack Thereof) in Prenatal Care

- “Research has identified the stigma around NAS [NOWS] and substance use disorders in general as a significant barrier to treatment for pregnant women [persons]. Many mothers [pregnant persons] do not self-disclose their drug use during pregnancy due to stigma, complicating the treatment process. In addition, when they do reach out for help, they often encounter misinformation, denial, inaction, and even judgmental and punitive attitudes toward their substance use. In some cases, policies that inflate punitive responses to pregnant women [persons] with substance use disorders may also create barriers to treatment.
- In 2013, 40 leading medical experts sent a letter to several prominent news outlets describing how sensationalized terminology commonly used in the media to describe NAS [NOWS] is medically inaccurate and reinforces stigma. Drug-addicted babies, for example, is not an accurate description of babies born with NAS [NOWS]. These newborns may exhibit physiologic dependence, but they cannot exhibit the compulsive behaviors associated with addictive disorders. This language is successful at eliciting a strong emotional response but may also help to reinforce many of the negative attitudes that discourage women [pregnant persons] from accessing the treatment they need.”

Substance Use Disorder Treatment During Pregnancy: Most Pregnant Persons Receive No Treatment

<table>
<thead>
<tr>
<th>NSDUH 2007-2014</th>
<th>Pregnant</th>
<th>Not pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Treatment</td>
<td>744,361</td>
<td>43,293,606</td>
</tr>
<tr>
<td></td>
<td>30.2%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Received Treatment</td>
<td>87,388</td>
<td>2,938,403</td>
</tr>
<tr>
<td></td>
<td>11.7%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>
Low Birth Weight Outcomes for Persons with SUD in Pregnancy

<table>
<thead>
<tr>
<th>LOW BIRTH WEIGHT</th>
<th>PNC</th>
<th>No PNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No drug use</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Drug Use</td>
<td>19%</td>
<td>48%</td>
</tr>
</tbody>
</table>

How Stigma Leads to Punishment of Persons of Childbearing Age

- **Stigma**: a mark of disgrace associated with a particular circumstance, quality, or person
- **Dehumanization**: the process of depriving a person or group of positive human qualities
- **Discrimination**: the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex
- **Prejudice**: preconceived opinion that is not based on reason or actual experience
- **Punishment**: the infliction or imposition of a penalty as retribution for an offense

Stigma → Dehumanization → Discrimination/Prejudice → Punishment

State Policies on Substance Use During Pregnancy

- 24 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and 3 consider it grounds for civil commitment.
- 25 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use.
- 19 states have either created or funded drug treatment programs specifically targeted to those who are pregnant, and 17 states and the District of Columbia provide pregnant people with priority access to state-funded drug treatment programs.
- 10 states prohibit publicly funded drug treatment programs from discriminating against pregnant people.
Punishment of Pregnant Persons: Is This Utilizing Best Practices?

- **Discriminatory**: persons of color and poor persons are more likely to be prosecuted, despite white persons being more likely to use during pregnancy

- **Not evidence-based**: risks of illicit substances are often exaggerated in comparison to the risks of legal substances

- **Unintended consequences**: punitive policies drive pregnant persons away from SUD treatment and prenatal care

- **Engagement**: in prenatal care counteracts the adverse effects of substance use during pregnancy

NYS DOH AIDS Institute Recommendations for Improving Language and Establishing Stigma-Free, Supportive, Service Delivery Environments

- Use person-first language: examples “person who uses drugs”, “woman who uses drugs”; NOT “drug addict” or “drug abuser” or “dope fiend”

- Use identity-affirming language: encourage positive talk instead of negative talk

- Establish a welcoming environment: create a “safe space”

- Recognize the value of offering representation of the communities served

- Be on the alert for judgmental language: examples “clean”, “dirty”, “infectious”

- Use quality improvement to dismantle stigma

- Promote ongoing discussions regarding stigma

- Document agency policies, practices, and progress toward eliminating stigma

Harm Reduction Practices and Trauma-informed Care
Evolution of Approaches to SUD Treatment

Historical Approach to SUD Treatment: The Stick
- Change is motivated by discomfort
- If you make PWUD feel badly enough, they will change
- People have to hit bottom before they are ready for change
- Someone who continues to use is in denial
- The best way to break through the denial is through confrontation
- Effectively, people don’t change unless they have suffered enough (“you better or else…”)
- If the stick is big enough, no carrot is needed...

A Better Approach to SUD Treatment: The Carrot
- People, in general, are ambivalent about change
- PWUD continue their substance use because of their ambivalence
- All change contains an element of ambivalence
- Resolving ambivalence in the direction of change is a key element in motivational interviewing
- Motivation for change can be fostered by an accepting, empowering, and safe atmosphere
- Person-centered approaches enhance motivation and reduce risk

Motivation

The Historical View of Motivation
- It is a static client trait
- Either the client had it or the client did not have it
- The provider/counselor/facilitator has no influence on it
- The view of motivation as static led to blaming clients for tension or discord in the therapeutic relationship
- Clients who disagreed with diagnoses, did not adhere to treatment plans, or refused to accept labels, like “alcoholic,” or “drug addicted,” were seen as difficult, manipulative, or resistant

The Modern Concept of Motivation
- It is a key to change
- It is multidimensional
- It is dynamic and fluctuating
- It is influenced by the provider/counselor/facilitator’s style
- It can be modified
- It is the facilitator’s task to elicit and enhance motivation
- “Lack of motivation” is a challenge for the therapeutic facilitator’s skills, not a fault for which to blame our clients

What Affects Motivation and the Ability to Effect Change?

Resilience and Self-efficacy

Motivation Is Multidimensional
- Motivation includes clients’ internal desires, needs, and values
- It includes external pressures, demands, and reinforcers (positive and negative) that influence clients and their perceptions about the risks and benefits of engaging in substance use behaviors
- Two components of motivation predict good treatment outcomes: the importance clients associate with changes and their confidence in their ability to make changes

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Ambivalence and the Transtheoretical Model

The Concept of Ambivalence
- Ambivalence is normal
- People usually enter treatment with conflicting and fluctuating motivations
- People want to change, but don’t want to change
- Working with ambivalence is working with the heart of the problem
- Counseling depends on the person’s current stage of change for each substance; mismatched counseling and stage of change lead to an ineffective interaction

Recovery Is Individualized

A process of change through which individuals improve their health and wellness, live a self‐directed life, and strive to reach their full potential.

Health: overcoming or managing one’s disease(s) or symptoms;

Home: a stable and safe place to live;

Purpose: meaningful daily activities and the independence, income, and resources to participate in society; and

Community: relationships and social networks that provide support, friendship, love, and hope.

What Is Person-Centered Care?

From SAMHSA:

Person-centered care—also known as patient centered care—means consumers have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.

Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is core planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.

Effective person-centered care planning strengthens the voice of the individual, builds recovery, and fosters recovery. It is important to note that while person-centered planning is respectful and responsive to the needs of the individual, it also occurs within the professional responsibilities of providers and care teams.

Harm reduction is a strategy employed in person-centered care.
Best Practice: Motivational Interviewing: Principles of Person-Centered Care

- Services exist for patients
- Change is self-change
- People are experts on themselves
- We don’t have to make change happen
- We don’t have to come up with good ideas
  - People have their own strengths, motivations, and resources that are vital in order for change to occur
- Change requires partnership
- It is important to understand the person’s perspective
- Change is not a power struggle
- Motivation is evoked
- We cannot take away people’s choice about their behavior

Components of Patient-Centered and Family-Centered Care

Why Does Trauma Matter in Your Work?

Women Who Are Abused Are

- 2.6x more likely to use tranquilizers, sleeping pills, or sedatives
- 3.2x more likely to use anti-depressants
- 2.2x more likely to use (or misuse) prescription drugs

Consequences of IPV Trauma
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Trauma-informed Care

4 Rs of Trauma-informed Care
- Realizing the widespread impact of trauma
- Recognizing signs and symptoms of trauma in people, including patients, their families, staff and clinical team members
- Responding by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeking to actively resist Re-traumatization

General Principles of Trauma-Informed Care
- Universal Trauma Precautions
- Ability to adapt
- One trauma is not ALL trauma!
- Anticipate shame and stigma

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What Is Harm Reduction?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. It is based on a strong commitment to public health and human rights.

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Harm Reduction Principles
- Substance use exists along a continuum, abstinence is ONE of many possible goals
- Substance-related harm(s) cannot be assumed
- People who use drugs (PWUD) are more than their substance use; their substance use is just one of their attributes
- Targeting risk and harms to PWUD, understanding the roots of these risks, and tailoring interventions to reduce them
- Acknowledging the significance of any positive change that PWUD make in their lives
- Accepting PWUD as they are and treating them with dignity and compassion
- Protecting the human rights of PWUD
- Maintaining transparency in decisions about interventions as well as their successes and failures

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FACP, FASAM
What Does Harm Reduction Mean for PWUD?

Meeting people where they are at: not forcing PWUD to be where you want them to be and not leaving them behind

Harm reduction lies on the treatment continuum: with active use at one end and (perhaps) sustained abstinence from all substances on the other end

Change is positive: embrace it and encourage self-efficacy and resilience

Keeping patients alive is harm reduction: using buprenorphine intermittently to decrease heroin use is harm reduction as it decreases the risk of death by overdose (i.e., “dead drug users don’t recover”)

Ask About Substance Use

* Assume substance use is occurring (normalize it)
* Ask nonjudgmentally, with curiosity, and be aware of your face and tone
* Don’t necessarily expect people to be honest with you at first; you must earn trust
* LISTEN: everyone has a story

*USPSTF Recommendation for ALL Adults in Primary Care

The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

Identifying SUD During Pregnancy

* Universal screening (not risk-based screening): identify at risk persons early; utilize motivational interviewing; normalize questions and embed in EMR; use validated screening tools (DAST, MAST, 4 P’s Plus, CRAFFT; for adolescents)
* Urine toxicology NOT recommended for screening: for myriad reasons (short detection window, confirmation testing needed, may not capture intermittent or binge use, may capture one-time use, ethical issues)
* Patient/Provider Barriers to Screening: patient fear of discrimination/mistreatment/CPS; provider lack of training/time/knowledge regarding how to address positive results
If a Person Is Actively Using or Is Known to Have an SUD...
What Should a Visit Look Like?

- Ask about their substance use
- Assess risk for overdose: dispense or prescribe naloxone; dispense fentanyl test strips
- Assess need for PEP (post-exposure prophylaxis) or PrEP (pre-exposure prophylaxis): initiate or refer for services
- Vaccinate for HAV, HBV, Tdap, COVID-19, et cetera: give vaccines or refer for services
- Test and treat for HCV, HIV: warm handoff and linkage to care if treatment not available onsite
- Dispense or prescribe condoms
- Refer to a SSP (syringe services program) or prescribe needles/syringes: warm handoff with a specific referral (give a brochure with a specific location and specific hours of the program)
- Make a safety plan (see slide 69): counsel on not using alone: advise regarding the Never Use Alone hotline (see slide 70)
- Counsel on medication for opioid use disorder (MOUD) to decrease risk of overdose (counter any voiced internalized stigma by the person regarding MOUD with facts)
- Address any other acute needs of the person
- Above all, listen and be nonjudgmental

NYS DOH Guidance: Build a Safety Plan

Overdose Risks for PWUD and COVID-19

Risks for OD
- Using alone (due to social/physical distancing):
  - Increased risk for overdose (no observer present to give naloxone leads to more fatal overdoses)
  - Increased triggers for return to use with increased mental health symptoms and despair due to social isolation

Innovative Harm Reduction Practices During COVID-19
- Virtual naloxone trainings:
  - Calendar @ https://oasas.ny.gov/keywords/naloxone
- Mail-order naloxone and other harm reduction supplies directly to the homes of PWUD (www.nextdistrio.org)
- Never Use Alone overdose prevention call line:
  - 1-800-484-3731 (https://neverusealone.com/)
Standard of Care for the Treatment of OUD During Pregnancy and Post-Partum

- MOUD with either methadone or buprenorphine: pregnant persons do not need to meet DSM-V criteria for OUD to receive MOUD
- MOUD endorsed by CDC, WHO, SAMHSA, ACOG, ASAM, AAFP, AAP (essentially all professional medical organizations)
- Access to behavioral counseling, as an adjunctive treatment, if needed
  - Either with the MOUD provider/staff or by referral to mental health or an SUD program or a dual diagnosis program (outpatient)

MOUD During Pregnancy: Most Pregnant Persons Receive No Pharmacotherapy

- Only half of pregnant women in treatment receive pharmacotherapy

Barriers to Treatment for Pregnant Persons

- Racial and Ethnic Disparities in the MOUD Among Pregnant Persons in Massachusetts
- Association of Pregnancy Status with Treatment Access for Opioid Use Disorder

Presented by Kelly S. Ramsey, MD, MPH, MA, FACP, FASAM
No Role for Medically Assisted Withdrawal ("Detoxification") for OUD During Pregnancy

"Withdrawal management has been found to be inferior in effectiveness over pharmacotherapy with opioid agonists and increases the risk of relapse without fetal or maternal benefit." (ASAM); increased rates of NOWS; increased rates of return to use; increased access to MOUD with opioid agonists is associated with a reduction in heroin overdose deaths. Offering MOUD in pregnancy increases treatment retention, # of OB visits attended (OB engagement), and in-hospital deliveries.

Benefits of MOUD in Pregnancy

**Pregnant Person Benefits**
- 70% reduction in maternal overdose deaths
- Decrease in acquisition/transmission of HIV, HCV, HBV
- Increased engagement in prenatal care and SUD treatment
- Improved maternal outcomes

**Fetal Benefits**
- Decrease in fetal stress due to stable opioid levels
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

Goals for MOUD and MOUD Options

**Goals for MOUD**
- Decrease risk for fatal and nonfatal overdoses
- Eliminate OWS
- Decrease opioid cravings
- Increase patient functionality
- Normalize brain anatomy and physiology
- Decrease transmission/acquisition of viral infections (HBV, HCV, HIV) and infection complications (abscesses, cellulitis, endocarditis)

**3 FDA Approved Medications**
- Methadone: opioid full agonist; must be dispensed from an OTP; associated with decreased mortality
- Buprenorphine: opioid partial agonist; Schedule III drug; requires DEA "X" waiver to prescribe (no educational requirement if intent is to prescribe to <=30 patients at any given time); associated with decreased mortality
- Naltrexone: opioid antagonist; not a controlled substance; not associated with decreased mortality

Presented by Kelly S. Ramsey, MD, MPH, MA, FACP, FASAM
MOUD: Methadone v. Buprenorphine

**Methadone**
- Historical Pregnancy Category C (weigh birth parental benefits vs. fetal risks)
- No risk of precipitating opioid withdrawal
- Historically, has been the gold standard treatment in pregnancy
- Potential for prolonged QT
- May require split dosing
- May contribute to low birth weight compared with buprenorphine

**Buprenorphine**
- Historical Pregnancy Category C (weigh birth parental benefits vs. fetal risks)
- Gaining first-line recognition for OUD treatment in pregnant persons
- Retention and engagement in care for pregnant persons may now favor buprenorphine over methadone, particularly with the addition of telemedicine as an option for delivering care
- More flexible dosing (more times per day)
- Less severe NOWS
- Some neonatal outcomes better
- Reduced risk of overdose during induction and in children exposed to buprenorphine

MOUD: Mechanism of Action and Mu Opioid Receptor Activity

NYS OASAS/DOH Best Practice: Prescribing Buprenorphine

Prescribers should ensure continued access to buprenorphine even in the absence of counseling.

Prescribers should ensure immediate and continued access to buprenorphine for patients who, at the time may be unwilling or unable to participate in counseling or other formal psychosocial services.

Prescribers should not discharge patients solely based on the use of prescribed or unprescribed substances including, but not limited to, cannabis and benzodiazepines.

Prescribers should ensure continued access to buprenorphine even in the presence of other drug use.

Prescribers should strive to minimize diversion and avoid allowing concerns about diversion to prevent them from treating OUD.
MOUD During Pregnancy, Intrapartum Care, Postpartum Care: Dosing

**Pregnancy:** dose to the comfort level of the pregnant person (no withdrawal symptoms, no opioid cravings); the dose likely will increase during the pregnancy due to increased metabolism and increased circulating blood volume; educate pregnant persons that neither a higher methadone dose nor a higher buprenorphine dose is associated with an increased risk of NOWS.

**Intrapartum Care:** continue the methadone or buprenorphine dose through labor and postpartum at the prenatal dose; most labor pain and c-section pain can be managed with regional anesthesia, non-opioids, an increased dose of methadone or buprenorphine, or, if necessary, by using opioids IN ADDITION TO the prenatal methadone or buprenorphine dose.

**Postpartum Care:** continue prenatal dose of methadone or buprenorphine; individualize dose decrease; if opioid pain management is needed requirements will be higher than for someone without opioid tolerance/physiological dependence to opioids.

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The 4th Trimester: Post-Partum Care

**Reality check...**
- caring for a newborn, breastfeeding, bonding
- mood changes, sleep disturbance, physiologic changes
- cultural norms; pressure to be the "ideal parent"
- social isolation
- stigma
- often child welfare authorities are involved...

**Less focus on the person who gave birth**
- shift of attention from the birth parent (prenatal care) to the baby (pediatric care)
- 40% of persons who give birth miss their postpartum visit (ACOG, 5/2018)
- care often shifts to social service agencies (WIC, etc.)
- often the MOUD provider is the only continuity of care for the birth parent
- remember contraception (long-acting reversible contraception, LARC)?

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MOUD: How Long Should Patients Remain on MOUD?

- LONG ENOUGH...!!! As long as the patient receives benefit from taking the medication, the patient should stay on the medication
- it is different for every patient, but...return to use rates and fatal overdose rates are higher for shorter courses of treatment and for no treatment
- At a minimum, patients should remain on MOUD for 6-12 months; but, in reality, MOUD is often much longer, and, often chronic
- Per one study, the average duration on buprenorphine treatment: 8-9 years
- OUD is a CHRONIC condition, and, like other chronic conditions, may require medication CHRONICALLY (think long term v. lifetime, but NOT short term); like a person with diabetes needing insulin for life to manage their diabetes
MOTHER Study: Outcomes at 36 Months

- n=96
- No pattern of differences in physical or behavioral development to support medication superiority (methadone v. buprenorphine)
- No pattern of differences for infants treated for NOWS v. infants who did not receive treatment for NOWS
- Results indicate children born in the MOTHER study are following a path of normal development in terms of growth, cognitive and psychological development

Breastfeeding

Methadone and buprenorphine are safe for breastfeeding: <1% parental opioid intake transmitted to breast milk

Published guidelines from ACOG, AAP, and the Academy of Breastfeeding Medicine (ABM) all support breastfeeding for persons on opioid agonist therapy for OUD

Parental benefits of breastfeeding: increased oxytocin levels lead to decreased stress and increased bonding which lower return to use risk

Newborn benefits of breastfeeding: reduction in the need for pharmacologic treatment of NOWS and shorter hospital stays

Breastfeeding more controversial with active use of EtOH and MJ

Defining NOWS: A Brief Word…

Neonatal Opioid Withdrawal Syndrome (NOWS) often results when a pregnant person uses opioids during pregnancy: “an expected and treatable consequence of opioid exposure in utero” (ACOG, 2016 and GAO, 2015)

NOWS is defined by alterations in the:
- CNS (central nervous system): high-pitched crying, irritability, exaggerated reflexes, tremors, tight muscles, sleep disturbance
- Autonomic nervous system: sweating, fever, yawning, sneezing
- Gastrointestinal distress: poor feeding, vomiting, loose stool
- Signs of respiratory distress: nasal congestion and rapid breathing

NOWS is NOT like fetal alcohol spectrum disorders (FASD)

NOWS is treatable (often with non-pharmacological treatment): it is physiological withdrawal only, not “addiction” (absence of compulsion/associated behaviors)

NOWS and treatment for NOWS are not known to have long-term effects; interactions between the caregiver and the child can impact resiliency/risk with potential long-term effects in some cases if they are separated rather than being kept together
Pregnant Persons with SUD: Addressing Their Needs

- Pregnant persons with SUD have a unique set of needs across multiple domains; domains that affect both obstetric health and outcomes and SUD treatment.
- Care needs to address all those complex needs, ideally, with co-located, integrated services.

From ACOG Committee Opinion: Opioid Use and OUD in Pregnancy

"...it is important to advocate for this often-marginalized group [pregnant persons with OUD] of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women [persons] with OUD who seek prenatal care are not criminalized.

Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with SUD to discourage the separation of parents from their children solely based on SUD, either suspected or confirmed."

ACOG Committee Opinion: Opioid Use and OUD in Pregnancy; August 2017, p. 3

Substance Use Disorder (SUD) in Women with a Focus on Pregnant and Parenting Persons: Understanding Stigma and Barriers to Care Conclusions

- There is a complex milieu of factors that underlie SUD in women.
- Understanding the principles and practical application of person-centered care, harm reduction, and trauma-informed care leads to better outcomes in our patients/clients.
- For pregnant persons with SUD, engagement in prenatal care improves outcomes, regardless of substance use or engagement in SUD treatment; decreasing stigma increases engagement in care.
- Pregnant persons and parenting persons with SUD experience discrimination and scrutiny on an unparalleled level.
- MOUD is the standard of care for all persons with OUD, including pregnant persons.
- Care, ideally, is co-located, multidisciplinary, non-judgmental, and patient-centered; if care is not co-located, a warm handoff facilitates care engagement.

**Remember:** substance use and/or SUD in and of itself is not an indicator of child abuse or maltreatment or neglect.
Women in Recovery Specialty Online Training
Series: Substance Use Disorder (SUD) in Women with a Focus on Pregnant and Parenting Persons

March 17, 2022

Questions?
Kelly.Ramsey@oasas.ny.gov

March 23rd, 2022
Grounding Techniques for Dysregulated Clients
By: Jean Campbell, LCSW, SEP, TEP

March 25th, 2022
Women in Recovery Specialty Online Training Series: Engaging Women of Color in Addiction Treatment
By: Edwina Taylor-Flowers, LPC, MAC

April 8th, 2022
Women in Recovery Specialty Online Training Series: Adapting and Addressing Tobacco Use with Telehealth for the Pregnant Population
By: Laurie Adams, TTS

April 20th, 2022
Harm Reduction for Skeptics: Practical Applications for Alcohol Use Disorders
By: Cyndi Turner, LCSW, LSATP, MAC and Craig James, LCSW, LSATP, MAC

Cost to Watch: $25
CE Hours Available: 1.5 CEs

Presented by Kelly S. Ramsey, MD, MPH, MA, FACP, FASAM
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Thank You

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www.naadac.org/webinars

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