

Pregnant Women and Opioid Use Disorder

RECOVERY U

Pregnant Women and Opioid Use Disorder



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UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH



Wisconsin
Department of Health Services

Welcome to this online training module on Pregnant Women and Opioid Use Disorder. This training on Pregnant Women and Opioid Use Disorder is a part of Recovery U: An online learning community through the continuing studies of the University of Wisconsin-Madison and Wisconsin Voices for Recovery.

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Pregnancy can be a very special time for women, for women with opioid use disorder it can be very scary, but this can also be a time for motivation and change. Recovery Coaches can be the link to helping these women find sustainable recovery that will enhance their and their children's lives. This webinar will hopefully help you gain insight how to best serve this population. Thank you for taking the time to learn more about helping pregnant women with OUD.

Module Goals

1. Identify the unique challenges that pregnant women with opioid use disorder (OUD) face and describe how to best support these women in overcoming barriers to recovery.
2. Describe Neonatal Abstinence Syndrome.
3. Outline the medication-assisted treatment (MAT) options appropriate for pregnant women with OUD.
4. Summarize the reporting requirements related to pregnant women with OUD.
5. Describe the services needed for pregnant women with OUD to promote recovery.



All resources and references are located in the Resources tab of this presentation.

By the end of this Learning Module, you will be able to:

1. Identify the unique challenges that pregnant women with opioid use disorder (OUD) face and describe how to best support these women in overcoming barriers to recovery.
2. Understand neonatal abstinence syndrome.
3. Outline the medication-assisted treatment (MAT) options appropriate for pregnant women with OUD to provide women and clinicians with evidence-based information to make the optimal informed decision.
4. Summarize the reporting requirements related to pregnant women with OUD to alleviate fear of legal actions and having children taken away.
5. Describe the services needed for pregnant women with OUD to promote recovery.

Theme 1: Scope of the Problem



In this section, I discuss the scope of the issue that women who have found themselves pregnant during their opioid drug use, or are taking prescription opioids for legitimate reasons and found themselves pregnant. These pregnancies may be planned at times, but more often than not, they are not planned and can be a terrifying time for women. They know that they are taking opioids, they may have a drug addiction and now they are bringing new life into the world.

**Theme 1:
Scope of
Problem**

How Many Women are Affected?

Substance Abuse and Mental Health Services Administration:

From 2009 to 2012, the use of opioids in pregnancy increased from 3.4 to 5.8 per 1,000 children born in the U.S. hospitals.

National Survey on Drug Use and Health:

From 2007 to 2012, "past month" opioid use was reported by 21,000 pregnant women ages 15-44 years.


The Substance Abuse and Mental Health Services Administration reports from 2009 to 2012 the national data revealed the use of opioids in pregnancy increased from 3.4 to 5.8 babies per 1,000 that were born in hospitals. We know that number is from 2012 and it has gone up tremendously since then as the number of women between the ages of 15-44, child bearing ages, using opioids continues to increase.

The National Survey on Drug Use and Health reported on average from 2007 to 2012, 21,000 women who were pregnant ages 15-44, admitted to misusing opioids in the past month. While the number of pregnant women who have admitted to opioid use during pregnancy in the last month is less than the number of women nationally who have admitted to opioid use, the numbers continue to rise.

**Theme 1:
Scope of
Problem**

Increased Risks

- Premature Labor
- Exposure to infections and other diseases
- Low birth weight of fetus
- Neonatal Abstinence Syndrome
- Inability to provide care for child/ren
- Risk of overdose
- Unclear is the risk of long-term developmental problems for the child



If a mother found out she was pregnant, while using and does not get into recovery while pregnant she faces dangerous outcomes that could occur:

- She could go into labor early and have a premature pregnancy, or depending on the timeframe in which she goes into early labor, she could lose the baby.
- The mother and fetus could be exposed to bacterial infections, HIV/AIDS or Hepatitis C.
- The fetus may be restricted in its growth or have low birth weight
- The baby, after it is born, could experience Neonatal Abstinence Syndrome, which I will explain later in this training.
- The mother may be unable to care for child or other children in the home,

- leading to children being placed out of home or possibly experience negligence.
- An overdose would lead to mother's and fetus' death.
 - The fetus could have developmental issues with brain or spine or have heart defects that affect the way the heart works.
 - The fetus could have a birth defect in its abdomen called gastroschisis which is a condition consisting of the intestines coming out of a small hole by the belly button.
 - The long-term effects opioid use during pregnancy on the child have yet to be determined. More longitudinal studies will need to be done.



In 2017, an independent contractor working with The Department of Health Services of Wisconsin, coordinated and performed a state-wide needs assessment to gain insight on how to develop a model that addresses aggregated needs of infants and women experiencing opioid-exposed pregnancies that are high risk. The comprehensive model will encompass social supports, and wrap-around health care.

A sample of 24 women representing four of the five regions in Wisconsin were interviewed or participated in focus groups. During this needs assessment, these critical concerns were expressed by women that were or are pregnant and have opioid use disorder, that need to be addressed to have the best possible outcomes.

Trusting Relationships

- Stigma free, non-judgmental, compassionate, evidence-based care
- The ability to feel safe
- Self-efficacy and hope



“Addiction may be the most stigmatized condition in the US and around the world (Room, 2005)”. “The World Health Organization (WHO) did a study that found that drug “addiction” is the most stigmatized social problem in the world”.

“Stigmatized attitudes in health care professionals toward people with Substance Use Disorders can be detrimental to people trying to access the services and support they need. Although people with mental illness are also a stigmatized population, the stigma associated with alcohol and other substances is worse. As a result of this public stigma, people with substance use disorders also stigmatize themselves. Consequently, self-stigma and sensitivity to the negative attitudes of their providers may contribute to the poorer health outcomes, avoidance of medical services, and ultimately the disability and increased mortality seen in people with Substance Use Disorders.”

Women who are pregnant and have Substance Use Disorder are judged even more so... Many people think that it is their responsibility to stop using once they become pregnant and judge them if they are keep using. These women need to feel like they can share with someone anything and they will not be condemned for it.

Women who are pregnant need to feel safe, and to feel that their children are safe as well. Women reported that the clinics they attended for medication-assisted treatment presented various concerns for them including violence, cleanliness and lack of respect by their providers. Having a Recovery Coach to advocate for them to be able to get their needs met and feel safe may contribute to their success.

Women expressed the need to feel empowered to do things for themselves and their children; to know that they have challenges ahead with being a new mother or mother

again and struggling with addiction. They need to have hope that they are fully capable of being a good, stable mother in spite of all the challenges and to feel supported by their peers, family and community in doing so. As a Recovery Coach working with these women, it is essential that we treat them as capable, independent women while being patient with the various needs they present.

**Theme 2:
Needs**

Advocacy

- Advocate for pregnant women who need assistance navigating through various systems.
- Provide help so they understand their legal rights.



Throughout Wisconsin, each health care system is different. It is important that we have knowledge of where a pregnant woman would go for treatment for their Substance Use Disorder and advocate for them to get priority care. Pregnant women should be able to get in quickly to a medication-assisted treatment program. If they are unable to get in quickly, then I suggest contacting the state opioid authority and making a report to them. I would also encourage that a Recovery Coach advocate for any other services that a pregnant woman needs to have a healthy pregnancy and healthy baby such as doctor care and communication between their treatment provider and their OB/GYN.

Having a good understanding of legal rights for mothers and their children and where the mother can access legal advice in your area is recommended. Many women not only have the barrier of learning to trust their provider is not going to turn them in for using during pregnancy, but they also may fear the family or father of the child will try and take the baby from them. It will help the mother have less anxiety over these issues if we are able to guide them to legal people who can help them understand their legal rights. Each region in Wisconsin should have their own legal resources to assist you in finding help for the woman you are working with.

- Pregnant women want to know what to expect and how to prepare for the birth of the child.
- Expectant mothers desire communication about the progress of their baby and themselves.
- Women need to make informed choices.
- Pregnant women want to know how to get access to resources in their communities.



Women who are pregnant or were pregnant with OUD expressed during the needs assessment that they wished that their providers were more interested in what was going on in their lives, in addition to wanting their providers to share more with them about the effects of drugs, smoking and alcohol could possibly have on them or their babies. They want to be educated on the risks and the implications. The more conversations they could have about how labor and delivery would go for them, the more comfortable they would feel moving forward. Women believed that many appointments were rushed and some of the information and education that should have been shared with them to better prepare them for the birth of their child was lacking.

Expectant mothers want to talk about and know what is happening with their body and their growing babies at the different stages of development. When a woman is having heartbeat checks or ultrasounds, they want a play-by-play description from the doctor or provider so that they do not have to ask all the questions. As a coach we can encourage more communication between the provider and the expectant mother.

Giving resources to a mother after she had a baby is not the most ideal time as many woman stated. They want to have the information and make the proper phone calls or be able to ask the questions before the situation comes up. Educating a woman on what a high risk pregnancy is may be a good start. They might be told they are high risk, but they don't know what that means to them. If a coach, doctor or therapist can explain to the mother what the neonatal intensive care expectations are prior to that becoming a reality, mothers can better prepare themselves and any other family members that may be involved as the mother may have other responsibilities at home she needs to be a part of as well.

Having knowledge of various resources for housing for this population, child care information, legal support and transportation is highly suggested. Although it is different in each area, I will share later on some of the essentials. It's suggested to begin to compile a list of resources that will specifically link women who are pregnant to services.

**Theme 2:
Needs**

Holistic Care

- Coordination of care services.
- Communication among service providers.
- Prioritization of maternal and fetal / child well-being.
- Addressing simultaneously co-occurring substance use and mental health disorders, and trauma.
- Integration of multiple psycho-social and medical services.



One woman shared: “I recommend access to a holistic model of care, like the HOPE CONSORTIUM. The HOPE Coordinator worked with me when I needed to be in the hospital from the 19th week of my pregnancy until I delivered. She helped so I would not lose my home when I could not make the mortgage payments... raised money to bring my children to visit me in the hospital... helped me to apply for and receive Temporary Assistance to Needy Families (TANF) benefits... and, is helping me to get my driver’s license back.”

To encourage a holistic care approach, the Recovery Coach can serve as the bridge for all service providers of the woman who is pregnant. The coach should know first hand all the people involved in the woman’s life and it is helpful to make a list of all people and ensure the appropriate releases of information get signed by the expectant mother so all her service providers can speak freely with one another to communicate about Mom and baby’s care to best support the family. Recovery coaches or peer support was identified as being absent in the coordination of care concerning pregnant women, we now have the opportunity to fill that gap.

If the mother is on medication-assisted treatment, it is crucial that the OB/GYN and the

provider of MAT have releases signed to communicate with each other. If a woman is having issues with her dose, the doctor can advocate that her dose be adjusted accordingly, as well as if she is having issues physically and reports to her MAT provider, they can communicate with the OB/GYN to examine the woman to see if she is medically stable.

A holistic care approach puts mother and child as a priority. Their well-being is synonymous with one another. A healthy mother, makes a healthy child and the more a child is healthy, the less a mother has to worry about. The more healthy and supported a mother is, the better chance of that child growing up feeling loved, safe, and nurtured.

When people with addiction issues are addressed at one time, that person has a better chance of having success in sustained recovery. If we do not give a person tools to cope with trauma, and her primary coping skill she was using, she will either return to use or remain in fight or flight mode while trying to get through her PTSD symptoms. Some people use substances to treat their mental health symptoms so if we treat their mental health, then they may be less likely to use substances to cope with them.

Many services will be needed to support a mother who is struggling with substance use disorder. Exploring and connecting the various social and medical services each individual woman will need is a role the recovery coach can play.

**Theme 2:
Needs**

Challenges

- Information and Education
- Releases of Information
- Connecting women to community resources



As with any person we are working with and attempting to help, there will always be challenges. We can only do the best we can with the tools we have at our disposal.

We are not doctors. We may not know every medical term for what a woman is going through during her pregnancy and how to support them, but we can ask questions and help the woman we are working with to remember the questions she wanted to ask of her doctor. If you can, attend the doctor's appointments and be that second set of ears that hears something the doctor shares because we are not as emotionally attached to the situation. We can also assist the person we are working with in doing further exploration of the information the doctor has shared with her. Doctors may not share information as early as we like. It is suggested that we support the person we are working with get through the information being shared at the time when it is shared, and use those opportunities in the future to ask that doctors do more explaining earlier on.

It may not always be easy to get the releases that our coachee needs right away, if at all, so we do the best we can in trying to coordinate that care or encouraging the person we are working with to do that. We are not miracle workers and knowing the important people that need to be involved and need the releases is half the battle.

Not all areas of Wisconsin are going to have all the resources that we need. Sometimes the Recovery Coach itself is the closest thing to treatment or recovery in certain areas. We do the best we can with linking the women we are working with with appropriate resources and that is all we can do. Knowledge of these resources is ideal and maybe creating a "wish list" along the way to see if there is room for growth in your community down the road for the resources you have found to be lacking.

Theme 3: Neonatal Abstinence Syndrome (NAS)

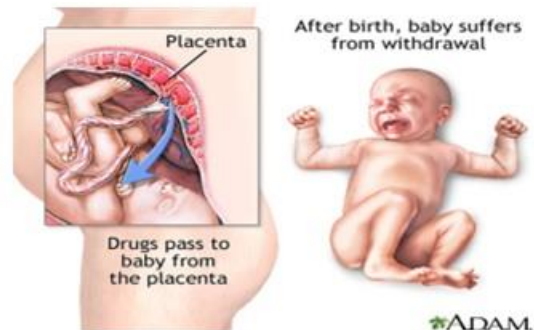


Now, I am going to talk about Neonatal Abstinence Syndrome. I will describe what it is, what are the symptoms typically associated with it, how Neonatal Abstinence Syndrome is treated, and whether or not Neonatal Abstinence Syndrome has long-term consequences.

Theme 3:
NAS

What is Neonatal Abstinence Syndrome (NAS)?

NAS encompasses a group of issues experienced by a newborn as a result of exposure to certain substances while growing in the womb.



Neonatal Abstinence Syndrome, or NAS can be described as a group of issues that a newborn may experience as a result of being exposed to substances while growing in the womb. It is dysregulation of three systems in the body: gastrointestinal, central and autonomic.

NAS has the potential to occur for a newborn infant if the mother participates in illicit opioid drug use, prescription opioids such as codeine or oxycodone or took medication-assisted treatment such as buprenorphine or methadone. Substances such as the ones listed as well as others, pass through the placenta in the mother to the infant in the womb, and the fetus becomes dependent on them. NAS affects 50 to 80% of all infants who have opioid exposure in utero.

If the mother is taking Medication-assisted treatment up to the birth of the child or using substances up to at least a week before giving birth, the infant may experience withdrawal symptoms until all the medication or substances are cleared from its system.

Opioids appear to be the sole cause for NAS, but other substances (alcohol, nicotine, benzodiazepines, cocaine, amphetamines and marijuana) can contribute to the severity of the symptoms the infant experiences.

Theme 3: NAS		Possible Symptoms of NAS	
Fever	Seizures	Irritability	
Diarrhea	Slow weight gain	Increased muscle tone	
Excessive sucking	Trembling	Sleep problems	
Sweating	Blotchy skin	Stuffy nose	
Vomiting	Excessive crying	Rapid breathing	
Poor feeding	Hyperactive reflexes		

Every infant experiences NAS differently and the severity of NAS depends on several things. It is difficult to pin point exactly what makes an infant have more or less discomfort, although there are some correlations that have been discovered along the way. Some things that may effect severity include: How quickly the infant's body can

process through the substances, what specific drug or drugs the mother used during pregnancy, how long the mother used substances during pregnancy and the amount, and whether or not the infant was carried to full term.

The symptoms include: Fever, Diarrhea, excessive sucking, sweating, vomiting, poor feeding, seizures, slow weight gain, trembling, blotchy skin, excessive crying, hyperactive reflexes, irritability, increased muscle tone, sleep problems, stuff nose and rapid breathing.

Usually symptoms begin to show up about one to three days after the infant has been born, although some cases have been observed to begin up to a week after birth. The infant will then need to be cared for in the Neonatal Intensive Care Unit until the child can be safely monitored at home, usually after about a week.

This time can be very stressful and creates a lot of shame for the women we are working with. If we are able to still work with them during this time, it is important to support and encourage mom to continue in recovery and that her child is getting the best possible care by being in the hospital for its care at this time. Watching an infant go through withdrawal can create extreme shame and guilt and sometimes when people are experiencing these feelings, we don't make the best decisions.

Theme 3:
NAS

How is NAS treated?

- Treatment depends on the drug or drugs causing NAS.
- Symptom severity scores and overall newborn health affect the treatment.
- Additional medical issues may need to be addressed if the baby was born pre-term.

The drug or drugs that the mother used during pregnancy, the abstinence scores and health of infant and whether or not the baby was carried to full term have direct

impacts on the course of treatment for the infant.

Due to increased irritability and fussiness, it is suggested that babies be wrapped tightly in blankets or swaddled, the environment kept quiet and free of much stimuli, and rocking the infant soothes his/her discomfort. At times, babies need low doses of methadone or morphine to taper from in order to ease discomfort.

If the baby was born early, he/she may have developmental issues or low birth weight. The NICU may try to put infants on a high calorie diet, the infant may need to remain in the NICU longer than if only being treated for NAS. NAS can last for one week to six months.

**Theme 3:
NAS**

Does NAS have long term consequences?

Maternal OUD and fetal exposure to opioids present short-term neonatal complications, including NAS.

There is no clear evidence on long-term childhood outcomes, but the existing data are extremely limited; well-designed research is urgently needed.

Logan, Brown & Hayes, 2013

Eunice Kennedy Shriver National Institute of Child Health and Human Development, Executive Summary, 2017, https://journals.lww.com/greenjournal/Fulltext/2017/07000/Opioid_Use_in_Pregnancy,_Neonatal_Abstinence.4.aspx

It is important to remember that an infant is not addicted to a drug, nor is it safe to say that an infant will develop addiction later on in life. When a child is born with NAS, they have a physiological dependence on the substances the mother was taken. In order to be considered to be a person with an addiction he/she has to fit criteria and withdrawal alone does not encompass that criteria.

“Maternal opiate dependence and prenatal fetal exposure present short-term neonatal complications, most notably NAS, but there is very little known about potential opiate dependent effects, either direct or withdrawal related, that could have pre- or early postnatal developmental programming (Logan, Brown & Hayes, 2013)”.

Logan Brown and Hayes (2013) report it is unclear whether or not NAS has long term

effects on infants. Although there are more studies being done, there is not enough evidence at this point to report there are long term-irreversible effects of NAS. Studies have shown there is a correlation between opioid use in pregnancy and cognitive and motor delays, however the data is not complete as they have not been able to follow these children throughout a lifespan.

1.17 Theme 4: Pregnant Women with OUD: MAT

Theme 4: Medication- Assisted Treatment (MAT)



**Theme 4:
MAT**

Evidence-based MAT for pregnant women with OUD

- MAT improves maternal and fetal outcomes.
- Treatment with MAT (methadone or buprenorphine) is recommended during pregnancy. [Learn More...](#)
- Discontinuation of the existing MAT during pregnancy carries a high risk of relapse and is not recommended.

- Methadone
- Buprenorphine
- Monoprodukt (without naloxone) is recommended
- Naltrexone is not recommended during pregnancy
 - It can be continued though in women who received this MAT prior to pregnancy if the risk of not stopping it outweighs the risk of continuation
 - Requires a discussion between the clinician and patient, and patient's informed consent.

Many people in recovery may have ideas and experiences that may have led them to their ideas about Medication-Assisted Treatment. Although we want to support a mother in making the best choice for her and her child, it is important to recognize that MAT is highly suggested during pregnancy. If a mother abruptly stops using illicit substances while pregnant, the withdrawal can cause her to lose her baby, put her baby into stress mode or cause pre-term labor. Getting on medication-assisted treatment the earliest as possible during pregnancy can assist both mother and fetus in having a stable and healthy pregnancy. Mother and fetus face far more challenges if illicit substance use continues during pregnancy. There have been instances in which “medically supervised withdrawal can be considered under the care of a physician experienced in perinatal addiction treatment and with informed consent if a woman does not accept MAT (*Medication Assisted Treatment*, 2017).”.

In this section I am going to discuss the medication-assisted treatment that is currently approved for pregnant women, as well as what MAT looks like for the mother after the baby is born and answer questions about breastfeeding.

Methadone

- Used for 40 years to treat pregnant women with OUD.
- It can ONLY be prescribed in a federally-licensed “methadone clinic,” which requires initially daily visits to obtain medication.
- *In an emergency, it can also be prescribed short-term in hospital settings.*
- The mother’s dose should be stabilized to having no withdrawal symptoms as quickly as possible.
- Studies show that methadone dramatically improves maternal-fetal outcomes.
- *Its daily dose does not correlate with severity of NAS symptoms.*

Methadone has been the gold standard of care of medication-assisted treatment for pregnant women for the past 40 years and is a full opioid agonist.

Methadone is prescribed in an outpatient setting in most circumstances, unless on an emergency 72-hour hospital visit to alleviate withdrawal symptoms, or if a mother is admitted to the hospital for an unknown length of stay. A mother would need to find a clinic near her to be able to get the methadone, in addition she may have to attend the clinic daily to get her medication.

Methadone has been shown to cause symptoms of NAS lasting longer in infants. Studies show the dose of methadone does not correlate with severity of NAS symptoms, although a split dose during pregnancy has correlated to having less severe NAS symptoms.

In order for Methadone treatment to be effective, the mother’s dose needs to be stabilized as quickly as possible to deter illicit substance use and reinforce remaining in treatment.

It’s important for us to know the nearest places mothers can receive Methadone treatment and to implement a plan for transportation and the time commitment. Ideally the mother would be supported in having comprehensive care within the MAT clinic.

Buprenorphine

- Buprenorphine is approved for treatment of OUD in pregnant women.
- It is recommended during pregnancy as a monoprodut (without additional naloxone) to minimize potential impact of naloxone on the fetus.
- Buprenorphine can be prescribed in any outpatient program/clinic, including a primary care doctor's office, as long as the prescriber obtained a special "waiver".
- Studies show that NAS duration can be shorter and symptoms less severe when the mother is treated with buprenorphine compared to methadone.

Buprenorphine has recently, over the past 15 years, been approved for treatment of pregnant women using opioids. It is a partial opioid agonist, thus creating a less likelihood of overdose.

Buprenorphine, versus Suboxone is recommended because it does not contain the naloxone, which may cause withdrawal and there is not enough research to determine if Naloxone is harmful to the fetus.

Buprenorphine can be prescribed in various settings as opposed to methadone. If it is prescribed at a daily dosing clinic, the mother would have the opportunity to get more take-home doses sooner versus the take-home guidelines in place for methadone. Doctors in outpatient treatment centers can prescribe Buprenorphine as well as some private practice doctors and some primary care doctors are now being trained.

NAS is shorter and less severe with buprenorphine as it has less binding qualities than methadone does.

As with any medication that can be ingested by others or small children in the home, it is recommended that all medications that can cause harm be placed in a lock box when they are not in use.

After the baby is born...

- Close communication with the addiction treatment and MAT prescriber is essential.
- Provide extra support to the mother if her infant is diagnosed with NAS, especially if s/he needs care in the Neonatal Intensive Care Unit (NICU).
- Continuation of MAT after the baby is born is recommended to prevent relapse.

A mother may need higher doses of MAT while pregnant due to some babies “taking” some of the mother’s medication and causing a higher tolerance in mother. It is important that mother’s providers are aware of when the baby is born so her dose of medication can be examined and adjusted if needed. She may feel overmedicated after having the baby if her dose is now too high making it difficult for her to carry out her tasks as a mother or new mother.

While the infant is in the Neonatal Intensive Care Unit, Mom will need extra support through her emotions of watching her infant experience these things, shame for thinking she caused her child to go through these symptoms and feeling helpless that she cannot fix things. Helping mom and supporting her in getting to the clinic for her medication daily if needed, caring for other children that may be in the home, remembering and getting to other appointments she may have, and being mindful of Mom’s sleep deprivation and self care, and possible post partum depression. In addition she may need appropriate pain management and support during the time she may have a prescription for narcotics. She just birthed a child and having a baby in the NICU can be extremely stressful in addition to the physical pain she may be experiencing.

If a mother chooses to discontinue taking her MAT after her child is born, it is recommended that she do so with the direction of her provider of MAT and her Primary Care Provider to ensure continuation in recovery and to reduce the risk of having severe withdrawal which may lead to her not be able to function as a mother or provoke her to re-engage in drug use to reduce symptoms of withdrawal. As coaches we need to be supporting these mothers through an appropriate detoxification plan. Please note that remaining on MAT after the baby is born until mother is stable is ideal to ensure longer, sustained recovery and reduce risk of relapse.

Breastfeeding

- Breastfeeding is a special bonding time that promotes physical and emotional health in mother and child.
- Breastfeeding should be encouraged in women treated with MAT for OUD.
- MAT levels tend to be low in breast milk.
- Breastfeeding while on MAT may help reduce symptoms in infants experiencing.
- Breastfeeding is contraindicated (not recommended) for women who:
 - *Have hepatitis B or C and cracked or bleeding nipples*
 - *Have HIV infection*
 - *Are actively using alcohol or drugs*
 - *Are prescribed certain medications*

Breastfeeding is a special time for mother and infant and can create bonding, as well as promote physical and emotional health in mother and child. Breast milk can provide many natural nutrients to the child. Many women who are pregnant and taking MAT want to know if it is safe to breastfeed.

Methadone and buprenorphine levels are low in breast milk and pose minimal risk to the infant.

If the infant experienced or is experiencing NAS, breastfeeding may help minimize some of the symptoms of NAS. If the mother has transitioned from Subutex to Suboxone after having her infant, there is no evidence supporting that breastfeeding should be avoided at this point.

There are certain situations where it is not recommended to breast feed. If a mother is still using illicit substances or alcohol, it is not suggested that they breastfeed as it will pass through to the infant in small amounts. If a mother has been diagnosed with AIDS/HIV, hepatitis B or C has TB or dry and cracked nipples, it is not recommended to breastfeed. There are places that provide donated breast milk from mothers who have lost their infant and want to give back or are overproducing. These women are screened to ensure that they are not using and the milk is deemed safe so there are alternatives for an infant to still receive breast milk. When we are coaching these women, we can look into breast milk donor programs.

Theme 5: Reporting Requirements



It is important to know the laws and reporting requirements surrounding mothers who use substances during pregnancy. This segment will review these issues and give you some baseline background information for some of the fear of why women are not forthcoming about their substance use during pregnancy but also opportunities for advocacy.

- Medical professional organizations oppose punitive approaches to substance use/addiction because they deter women from seeking help.
- The goal should be treatment & recovery, not punitive actions against the pregnant woman.
- Healthcare professionals should be aware of the laws and regulations related to the care of pregnant women with OUD.
- In Wisconsin, substance use during pregnancy can be considered "child abuse" under certain circumstances.

Although substance use during pregnancy is considered child abuse in Wisconsin and subsequently grounds for a civil commitment, prosecuting a mother for use during pregnancy is not the way to promote recovery and support the mother and infant bond. The American Medical Association, American Society for Addiction Medicine, American Academy of Pediatrics, American Academy of Family Physicians, and Wisconsin Medical Society advocate for improved prenatal care and treatment options for women and fetuses, rather than using punitive measures and utilizing drug analyses to ensure abstinence during pregnancy.

The Wisconsin Association for Perinatal Care informs us that Wisconsin's Act 292 gives social workers and other healthcare professionals extreme amount of discretion in whether or not they choose to report pregnant women who test positive for illicit substance. Healthcare professionals are not required to report women to Child Protective Services (CPS), but are encouraged to have a discussion and work with women about solutions to their positive results.

The Wisconsin Association for Perinatal Care reiterates, "Health professionals MAY report, but they are not required to." Best practice is to support a mother in seeking the help they need and be a trusted person in their life to be a vehicle for that change. Studies show that alcohol and drug use does not diminish with incarceration or the threat of incarceration. Other sources indicate having and partaking in prenatal care can reduce the negative effects of substance use during pregnancy.

The Cocaine Mom Law

In 1998, Wisconsin enacted the Cocaine Mom Law, intended to protect children's health and well-being.

A mother who was prosecuted for child abuse due to drug use during pregnancy challenged the law. Although it was deemed "unconstitutional" by the circuit court, the state appealed and currently the law remains in effect.

There are misconceptions about reporting requirements because of the "Cocaine mom law". This law was enacted in 1998 and some women have been persecuted for Child Abuse as a result of this law.

The Cocaine Mom Law was intended to protect women and children's health and well-being. The law pertains to unborn fetuses who, as a result of their mother's persistent and habitual "lack of self control" in regard to substance use, place their fetus at risk for injuries. The law presumes that these unborn babies are in need of protection and the law was created to do that. In many instances the goal is to get the mother into treatment so she and the infant can have a safe and healthy pregnancy.

This law is being challenged for being vague by a mother that was prosecuted for child abuse due to use during pregnancy. The current status according to the Wisconsin Department of Justice (DOJ) is "Act 292 was put back into full effect following the State's successful application for a stay of the District Court's order enjoining enforcement. It remains in effect pending the Seventh Circuit Court of Appeals' decision on the merits (WIS DOJ, 2018)".

Provider Support in Accessing Treatment

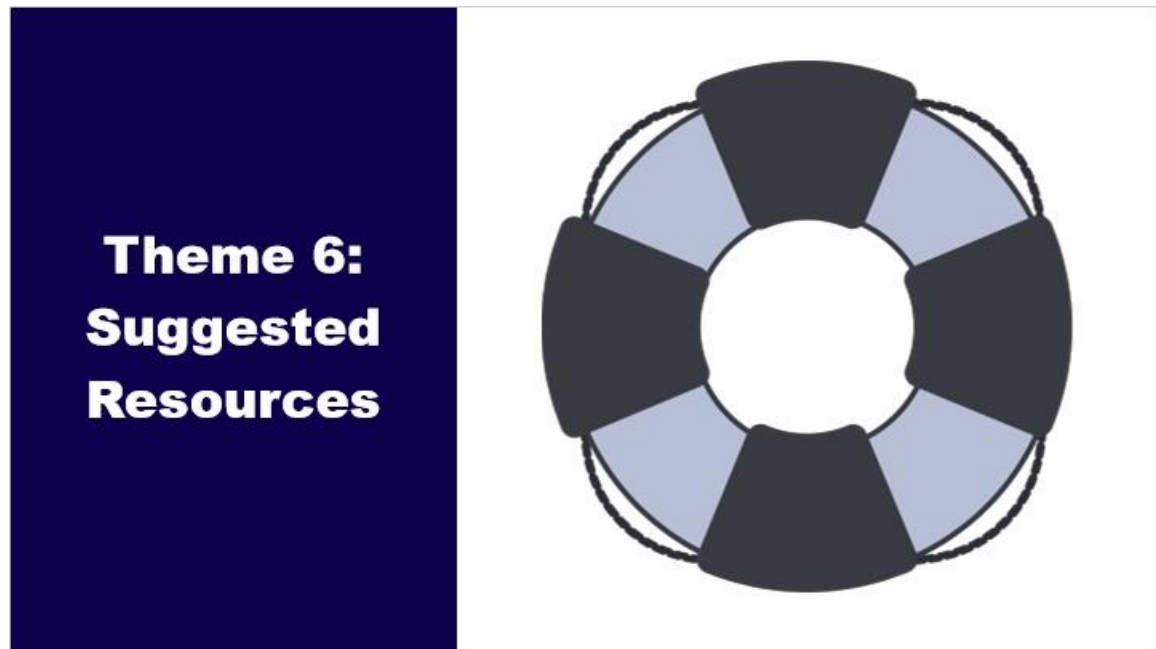
- A positive drug screen can be used as a tool to identify use, but ultimately gives the healthcare professionals an opportunity to work with the mother on getting into treatment.
- Recovery Coaches can help advocate for and support a mother if she is reported to Child Protective Services for having a positive cord test.
- Doctors can still work with a mother on getting into recovery even after a report is made.

It is strongly suggested that Healthcare Organizations and providers have a solid policy in place regarding expectant mothers and positive drug screens. A positive drug screen can be used as a tool to identify use, but ultimately give the healthcare professionals an opportunity to work with the mother on getting into treatment. This may be a time that a Recovery Coach would come into the woman's life.

Many healthcare professionals can get confused as to whether or not consent is needed to obtain a drug screen analysis, even if there is suspicion. There does need to be consent from the expectant mother. If the mother does consent to the drug screen analysis, and it is positive for Schedule I or Schedule II drugs, then the doctor also needs to provide, in writing, the explanation of the results and if the doctor is going to report the positive drug screen to Child Protective Services.

Reporting laws are more stringent if a child or a fetus has been found to have substances in his/her system or umbilical cord, and no consent is needed for that test to be done. If the test is found to be positive, it has to be reported to Child Protective Services, as well as a written explanation given to the mother or guardian that it was found to be positive and will be reported to Child Protective Services. Even in this situation, providers still have an opportunity to cooperate with mother and infant, as a team to facilitate their getting the help they need. Providers can work alongside mother, addiction specialist, and the Obstetrician/Gynecologist. Recovery Coaches can help advocate for and support a mother if she is reported to Child Protective Services for having a positive cord test. Working with the mother on getting into recovery to maintain or regain custody of their child if CPS gets involved.

Doctors can still work with a mother on getting into recovery even after a report is made by explaining their responsibilities pertaining to the law, but being open to helping the woman still seek treatment and help. Healthcare professionals can help by bringing providers together to advocate for the woman and infant and work together. There are better results when professionals work with patients into getting into treatment, and not forcing into treatment, or having the threat of legal ramifications. Another way to work with women struggling with substance use, or have found to have positive infant and cord tests can write an Amicus Brief to judges about how the Cocaine Mothers Law does not work well for women.



As with most of the people we get to work with, being able to help a woman who is pregnant get access to many services is our goal. Here are some suggested resources that women who are pregnant can benefit from.

1.29 Public Health

Theme 6:
Resources

Public Health

Local health departments offer many resources to aid individuals effected by chronic and communicable diseases located at:

<https://www.dhs.wisconsin.gov/lh-depts/counties.htm>

The Department of Health Services offers many trainings pertaining to the issues the populations we work with face such as trauma, housing issues, data and reporting for community issues and prevention techniques. Each county has a different office. If you follow the link provided, you can find your local office. DHS also offers home visiting nurses in areas that would be able to follow a pregnant woman for a longer period of time depending on if it's the first child or an additional child. Home visiting nurses can provide case management services, advocacy and additional support to the recovery coach. The referral application for home visiting nurses can also be found on the website: <https://www.dhs.wisconsin.gov/lh-depts/counties.htm>

Women, Infants, and Children (WIC)

The Women, Infants and Children program offers healthcare referrals, nutrition education, and supplemental foods such as formula, juice and cereal to low income families.

If the mother is pregnant, not breastfeeding or breastfeeding, a Wisconsin resident, income eligible, her children qualify up to the time the child is five years.

<https://www.fns.usda.gov/wic/women-infants-and-children-wic>

WIC is a federally funded program that offers health care referrals, nutrition-education, and supplemental foods such as formula, juice and cereal to low income families. If the mother is pregnant, not breastfeeding or breast feeding, her children qualify up to the time the child is five years of age. Visit their website to find a local WIC office in your county.

Public Assistance

There is help in Wisconsin for child care, food share, insurance, energy assistance and prescription help for those who qualify.

<https://access.wisconsin.gov>

Many of the women we may work with have multiple needs. There is help in Wisconsin

for Child Care, food share, insurance, energy assistance and prescription help for those who qualify. Visit [access.gov](https://www.access.gov) and assist your coachee in getting some of these issues resolved. The local job center in your county can also help your coachee get connected with services and apply for these programs. In addition, there is financial assistance referred to as W-2 or TANIF that women may qualify if they are unable to work that the job center can get them connected with as well.

Theme 6: Resources

Other Needs

- Support Groups
- Safe Housing
- Domestic Abuse Services
- Mental Health Services
- Transportation
- Baby Necessities
- Clothing
- Legal Needs
- Treatment for Substance Use Disorders
- Behavioral therapy
- MAT

Pregnant women have specific needs that a traditional support group for recovery may not be able to meet. If there is not a woman specific group for pregnant women struggling with substance use issues, it may be an opportunity to start a peer and volunteer-led support group.

Many women do not have safe housing. They are homeless, living with people they used with or are in unsafe living environments. Each county should have a low-income housing agency that can connect your Coachee with resources for housing and applying for these services. Also it would be good to be aware of the sober housing that can work with women who are pregnant or have children.

Some women may struggle with domestic-abuse situations. Familiarize yourself with the Shelters and helplines in your area for domestic abuse.

Mental health providers can sometimes have lengthy waiting lists. If the woman you are working with needs these services, it is suggested to get them an appointment as soon

as possible as the wait time to get in can be 8-16 weeks. Become familiar with the providers in your area for mental health.

Women who are on state insurance can access to Medical Transport Management services. It is a statewide transport service that is set up to assist people in getting to their medical, substance abuse and mental health appointments. It is covered by state insurance. They do need a 48-hour notice so encourage your coachee to plan ahead for their rides. Also, they do not transport infants and children. Child care might be an issue for women who have to attend appointments and can't bring their children with an MTM ride. Get to know your local transportation services.

Baby items such as diapers, bottles, strollers and car seats are sometimes items provided by local agencies and coalitions. Be on the look out for these types of resources for your coachees.

Women and children may need clothing. Second hand stores such as Salvation Army, St. Vincent's or Goodwill may offer voucher programs for them to be able to obtain clothing.

Each county has different services in regard to legal assistance for matters such as custody issues, restraining orders or evictions. Try to find out what your local resources are in this regard.

It is important to know the places where women who are pregnant can go for medication-assisted treatment, Inpatient treatment, outpatient treatment and/or therapy services and groups in your respective areas to help the woman you are with access services. Usually pregnant women are to be taken for priority for treatment services.

Module Review

1. We identified the unique challenges that pregnant women with opioid use disorder face and described how to support these women in navigating through barriers.
2. We described and understand Neonatal Abstinence Syndrome.
3. We named and identified medication-assisted treatment appropriate for pregnant women, to provide them with information to make the best decision for themselves and their child.
4. We identified Wisconsin's reporting requirements regarding substance use during pregnancy.
5. We defined the services that we need to connect pregnant women to and described how we can help.



All resources and references are located in the Resources tab of this presentation.

Thanks again for taking the time to watch this training and learn more about how to work with pregnant women and opioid disorder. Hopefully:

- Now we have awareness of the unique challenges that pregnant women with opioid use disorder face and how to support these women in navigating through barriers.
- We now understand Neonatal Abstinence Syndrome.
- Now we have knowledge of medication-assisted treatment appropriate for pregnant women, to be able to provide them with information to make the best decision for themselves and their child.
- We are now aware of Wisconsin's reporting requirements regarding substance use during pregnancy.
- We are now aware of the services that we need to link pregnant women to and how we can help.



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