The NAS Epidemic:

Preserving the Dignity and Worth of Mother and Baby

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Agenda:

- Identify the scope of opioid use and misuse among women, risks during pregnancy, and available treatment options for clients.
- Describe opportunities for creating integrated systems at both the individual and community practice levels when working with opioid dependent pregnant clients.
- Explore barriers to effective treatment including access to care, conflicting treatment approaches, and punitive social welfare policies.
A note about our evolving language

- **NAS or Neonatal Abstinence Syndrome**
  - a non-specific term to describe an infant exhibiting signs of physiologic withdrawal from any of the following: alcohol, tobacco, prescription medications (multiple classes), and illicit substances.

- **NOWS or Neonatal Opioid Withdrawal Syndrome**
  - More specifically identifies the number of infants experiencing withdrawal from opioid exposure in utero.

- **Addict, Abuse, Addicted, Abuser**
  - Use Substance Use Disorder instead

- **Addicted Baby**
  - This does not fit the definition of SUD or “addiction” as there is no behavioral component to the physiological symptoms an infant experiences.
  - Babies are substance-exposed and physically dependent
Overview of Opioids

- Opioids are a class of drugs historically used as painkillers.
- They have great potential for misuse. Repeated use of opioids greatly increases the risk of developing an opioid use disorder.
- Prescription Opioids: doctors prescribe for pain relief, but they are frequently diverted for improper use.
- In the 2013 & 2014 National Survey on Drug Use and Health (NSDUH), 50.5% of people who misused prescription painkillers got them from a friend or relative for free, and 22.1% got them from a doctor.
- Consistent use of opioids results in increased tolerance (needing more for the same result) & the person may not be able to maintain the source for the drugs. This can cause them to turn to the black market for these drugs & even switch from prescription drugs to cheaper & more risky substitutes like heroin. (“Opioids,” 2016)
The Scope of the Epidemic

According to the National Survey on Drug Use and Health (NSDUH) in 2014:

- 4.3 million Americans engaged in non-medical use of prescription painkillers in the last month.
- Approximately 1.9 million Americans met criteria for prescription painkillers use disorder based on their use in the past year.
- 1.4 million people used prescription painkillers non-medically for the first time in the past year.
- The average age for prescription painkiller first-time use was 21.2 in the past year.
- Admissions to treatment for primary pain reliever use increased in 2012 to 972K from low-mid-700s in previous years.

Though non-medical use in young people (18-25) has declined 2002-2013, it is still the second most prevalent illicit use category and significantly more than other categories of prescription abuse.

(Center for Behavioral Health Statistics and Quality, 2015)
What changed?

  - Possible causes: increased marketing, change in prescribing habit from use for acute pain to use for chronic pain, cultural change to focus on pain as the 5th vital sign
- Primary care providers now account for about half of the pain prescriptions in the US
- Prescribing variability region to region ("Injury Prevention," 2016)
Opioid Use & Women

- A rising problem for women of reproductive age with 7 out of 10 drug related overdose deaths including some form of prescription painkiller (CDC, 2013).
- Females are more likely to receive opioid prescriptions for issues like chronic pain and they tend to develop drug dependency faster than their male counterparts (Salter & Ridley, 2015).
- Prescribing disparities exist among women living in poverty. 39% of women on Medicaid fill an opioid prescription at a pharmacy compared to 28% of women with private insurance (CDC, 2015).
- TEDS Report 2014 shows data from admissions. More women were admitted to treatment for prescription painkiller use than men (19% v. 12%).
- Overdose deaths among women due to the use of prescription opioids has increased since 2007, and has surpassed deaths from motor vehicle-related accidents; with a “5-fold increase between 1999 and 2010, totaling 47,935 during that period” (CDC, 2013, SAMHSA, 2016).
Women of reproductive age who filled an opioid prescription

2008-2012

<table>
<thead>
<tr>
<th>Privately Insured</th>
<th>Medicaid Enrolled</th>
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<tr>
<td>28%</td>
<td>39%</td>
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(Patrick, 2016) and (CDC, 2015)
Opioid Use & Pregnancy

- Includes the use of heroin and/or the misuse of prescription opioid medications (ACOG, 2012).
- Untreated heroin use can cause pre-term labor and even fetal death. The concern is neonatal withdrawal and the “addicted baby” however this term is misleading and stigmatizing. Addiction is described as a set of compulsive behaviors that continue despite adverse consequences while the withdrawal symptoms in newborns are associated with evidence of only physiological dependence (Newman, 2013).
- On average, between 50-60 percent of opioid-exposed infants will experience NAS and require some form of pharmacological intervention (Salter & Ridley, 2015 & ASTHO, 2014).
- Because of the dangers of detox during pregnancy, the current standard of care includes the use of medication-assisted therapy (ACOG, 2012; SAMHSA, 2018).
- Practitioners disagree with treatment options and such ideological disagreement creates conflicts among providers and community resources, leading to improper/incomplete care for mothers and babies, including pregnant women being treated with non-therapeutic levels of medication to limit exposure to the fetus (Jones, et al, 2008).
Disagreement is often based on values, not necessarily the science.

- Treatment options include Medication Assisted Therapy which departs from the traditional abstinence-only option.

- Harm Reduction is a strengths-based and client-centered helping strategy that is utilized in both prevention and practice models (Bigler, 2005).

- The first step of understanding harm reduction is clarifying what it is not. It is not giving clients carte blanche to slip further into addiction and despair. It is working with clients by supporting autonomy, increasing options, and reducing risks.
Defined Differently

- “Harm reduction is a helping strategy that suggests the most pragmatic way to engage people in {any} positive change is to focus on making risky behaviors less risky, without necessarily insisting that the behavior be changed” (Davis, p. 1, 2013).

- The key to a building on client change is to extract a single measurable behavioral change from the broad process of recovery that will allow the client to experience a small, incremental success.

- If we frame it as such, can you think of some ways that you’ve used this in your practice with people or programming?
Social Workers:

- Create safety plans for women and their children in abusive relationships without demanding that client “abstain” from the relationship.

- Teach a homeless client street survival skills, how to obtain food or resources, and how to stay warm during winter months.

- Work with a client to reduce cigarette smoking during her pregnancy.

- Facilitate training on binge drinking and the risks of using drugs and alcohol to college professors/students or provide resources to students.

- Provide education on LGBT issues to prevent bullying or facilitating support groups for those questioning orientation to prevent isolation, or potential self-harm.
The Rationale for Opioid-assisted Therapy During Pregnancy

- 2005 – 2010, NIH and NIDA sponsored a multi-site national study concerning opioid use among pregnant women. The following were suggested:

1. Prevent Opioid withdrawal or symptoms
2. Provide MAT for stabilization
3. Mitigate euphoria and desire/craving to use illicit opiates and other drugs, while stabilizing the environment for the fetus and limiting exposure to illicit drugs (Jones, et. al., 2008).

- "Prevent complications of illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient of associating with a drug culture. . . Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists and requires collaboration with the pediatric care team" (ACOG, 2014).

- Women are able to shift focus to healing, relationships, preparing to parent, however a crucial component of psychosocial interventions and support are needed in addition to the pharmacological interventions for sustained success (Jones, et al., 2008).
Medication-Assisted Therapy (MAT)

- Ceasing opioid use during pregnancy may result in pre-term labor, risks to fetus, and loss of pregnancy. Pregnant women who stop using opioids and relapse have increased risk of overdose (SAMHSA, 2016).
- MAT or Medication Assisted Therapy is considered best practice (ACOG, 2012), but includes both medication and behavioral therapies (SAMSHA, 2014).
- Opioid agonist or agonist-antagonist combination medication is introduced to create a steady-state, avoiding the intoxication-withdrawal cycle (methadone, buprenorphine, or buprenorphine-naloxone combinations).
- Methadone has been used for decades to treat opioid dependency and multiple studies prove it to be a safe option during pregnancy, however one risk includes NAS (SAMHSA, 2008).
- Another treatment option for women is buprenorphine, which acts on the same receptors as morphine and heroin. Buprenorphine is prescribed by approved and specially trained physicians in an office setting which leads to increased patient compliance and reduced stigma. However, this drug has not been studied as extensively in pregnant women long-term and, as such, may require additional informed consent (ACOG, 2012 & SAMSHA 2008).
- Unfortunate stigma associated with MAT (enabling drug use, substituting, not true recovery)
MAT is consistent with Strengths Approach

- **Choice**: Clients’ readiness for change; worker uses clients’ capacities and provides options and encourages self-efficacy.

- **Empowerment**: Increase one’s capacity to take control of her situation by “meeting the client where the client is”

- **Dialogue and Collaboration**: Based on empathy and inclusion- relationship is central to trust and the vehicle for change.

- **Redefine Successful Outcomes**: Measuring and affirming positive outcomes as – any reduction in risky behaviors or use, and not by total abstinence. Emphasizes incremental change and “in a hierarchy with the more feasible options at one end (eg measures to keep people healthy) and less feasible but desirable options at the other end.”

- **Dignity and Worth**: Harm Reduction avoids the stigma associated with drug use, approaches clients with compassion and without judgment
**Methadone**

- Reduces fluctuations in maternal serum opioid levels, so it protects a fetus from repeated withdrawal episodes (TIP, 43, 2015).
- Induction monitoring, if prior stabilization (remain, Withdrawal overlaps with pregnancy, split dosing later in pregnancy, continued during labor and delivery, require 70% more meds post delivery, discuss stress and dose reduction if overmedicated (Jones, et al., 2008).
- Methadone maintenance includes prenatal care, reduces the risk of obstetrical and fetal complications.
- There is “no compelling evidence” that maternal dose predicts symptoms of NAS, thus higher doses are recommended because they are related to illicit substance use, compliance with prenatal care, prolonged gestation, and improved growth of the infant (TIP, 43, 2015).

**Buprenorphine**

- May provide less drug interactions, fewer overdose risks, less severe NAS, and more flexibility in dosing and treatment schedules (ACOG, 2012).
- Infants exposed are likely have shorter treatment stays and less medication to treat the symptoms of NAS compared to infants exposed to methadone (Jones, et al., 2010).
- Subutex (buprenorphine) or Suboxone (buprenorphine + naloxone) to avoid prenatal exposure to naloxone; More complex induction; less sedation; Less acute withdrawal possible to hold dose during labor, require less additional opioids post delivery (Jones, et al., 2008).
- Recent research indicates that buprenorphine produces outcomes similar to methadone and a less severe NAS. No significant adverse maternal or neonatal outcomes related to the use of buprenorphine + naloxone have been reported (Debelak, Morrone, O’Grady, & Jones, 2013 & ACOG 2014).
Emerging Research: Detox as a Choice

Bell & Towers Study (2016). Over 600 patients in 4 categories.

Utilized 4 methods of detox:
1. Acute detoxification of incarcerated patients;
2. Inpatient detoxification with intense outpatient follow-up management;
3. Inpatient detoxification without intense outpatient follow-up management; &
4. Slow outpatient buprenorphine detoxification

“600 patients have been reported to detoxify from opiates during pregnancy with no report of fetal harm related to the process. These data highly suggest that detoxification of opiate-addicted pregnant patients is not harmful. The rate of neonatal abstinence syndrome is high but primarily when no continued long-term follow-up occurs.”

“Whether this treatment management should become common practice in obstetrics will take further study as to whether detoxification/long-term behavioral health programs can be universally developed, implemented, and funded.”

Newest guideline from SAMHSA is clear (SAMHSA, 2018, p. 34):

“**Medically supervised Withdrawal is NOT Recommended.**

Pregnant women with OUD, with or without a history of pharmacotherapy for OUD, should be advised that medically supervised withdrawal from opioids is associated with high rates of return to substance use and is not the recommended course of treatment.”
NASW Support and Ethical Responsibility

- NASW policy states, “All reasonable avenues to address ATOD problems must be considered, including psychosocial treatments, medications, alternatives to incarceration, and harm-reduction approaches” (2009, p.33).

- NASW Standards for Social Work Practice with Clients with Substance Use Disorders affirms, “The harm reduction approach is consistent with the social work value of self-determination and ‘meeting the client where the client is.’”

- Dignity and worth in action (acknowledge the prevailing social and political stigma of vulnerable populations).
Bigler (2005) states: Personhood stands above moral judgments regarding risky or socially negative behaviors. The worker keeps her/his own values in perspective and seeks humane solutions to difficult and perhaps even personally challenging problems. A person is not left to suffer simply because the experience, the disease, or the harm is a natural consequence of her/his own behavioral choices. (p. 76)

Move away from a moral model of understanding complex individual and social problems within the macro context.

“Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing” (ACOG, 2011).

A more effective treatment approach requires coordinated community intervention focused not only on the health of the newborn but the dignity and worth of the pregnant woman. This can be achieved through interagency collaboration with social service providers, women’s health providers, and pediatric care providers.
In 2012, among hospital related stays for substance use, 60% were related to NAS with one-fourth involving opioids (Finger et al., 2015, & SAMHSA, 2016).

NAS is a result of fetal exposure to certain drugs, primarily opioids, and manifests as clinical symptoms in newborns with withdrawal. Symptoms may include uncoordinated sucking reflexes leading to poor feeding, neurological excitability, gastrointestinal dysfunction, and a high-pitched cry (Association of State and Territorial Health Officials, 2014).

While NAS is not ideal, it may pose less harm to a pregnant mother and her baby than detoxification or the behaviors associated with high-risk drug use such as frequent physical withdrawal, exposure to infectious disease, tainted street drugs, criminal activity, or violence.

NAS is treatable and anticipated in pregnant women using opioids, including those being treated on methadone (Terplan, Kennedy-Hendricks, & Chisolm, 2015). NAS develops in “55-94% of drug-exposed infants (University of Iowa Children’s Hospital, 2013).
Finnegan Score: Determines Treatment

Symptoms are influenced by a variety of factors, including the type of opioid, when the mother uses during pregnancy and when she engages in the treatment system, genetic factors, and exposure to other substances (smoking) (SAMHSA, 2016).

The Finnegan Score is a measure of 21 symptoms that are most frequently observed in opiate-exposed infants in three categories:

<table>
<thead>
<tr>
<th>CENTRAL NERVOUS SYSTEM</th>
<th>METABOLIC</th>
<th>GASTROINTESTINAL</th>
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<tbody>
<tr>
<td>high pitched cry (continuous)</td>
<td>sweating</td>
<td>sucking</td>
</tr>
<tr>
<td>sleep after feeding</td>
<td>fever</td>
<td>feeding</td>
</tr>
<tr>
<td>hyperactive reflexes</td>
<td>yawning</td>
<td>regurgitation</td>
</tr>
<tr>
<td>tremors</td>
<td>mottling</td>
<td>loose stools</td>
</tr>
<tr>
<td>muscle tone/jerks/convulsions</td>
<td>nasal stuffiness</td>
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The score indicates the degree of severity and monitors changes over frequent re-evaluations. Initial scoring is 2 hours post delivery and typically done q4h. A total of 3 scorings of 24 or greater prompts intervention.

(The Indiana NAS Task Force uses a standard of “2 or 3 Finnegan scores of 24 or greater” to define NAS)

Other rating scales to consider. (SAMHSA, 2018, p. 79.)

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Description</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finnegan Neonatal Abstinence Scoring System (Finnegan Scale)</td>
<td>• Dates from the 1970s</td>
<td>Original: Finnegan, Kron, Connaughton, &amp; Emich, 1975 Most recent: Finnegan &amp; Kaltenbach, 1992</td>
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<tr>
<td></td>
<td>• Was first scale for NAS</td>
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<tr>
<td>MOTHER NAS Scale (a modified Finnegan Scale)</td>
<td>• Contains 28 items, of which 19 are used for scoring and medication decisions</td>
<td>Jones et al., 2010b</td>
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<td></td>
<td>• Eliminates many symptoms listed in Finnegan Scale (e.g., myoclonic jerks, mottling, nasal flaring, watery stools)</td>
<td></td>
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<tr>
<td></td>
<td>• Adds 2 items: irritability and failure to thrive</td>
<td></td>
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<tr>
<td>Neonatal Narcotic Withdrawal Index</td>
<td>• Evaluates NAS on a 7-item scale</td>
<td>Green &amp; Suffet, 1981</td>
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<tr>
<td></td>
<td>• Assigns weights of 0 to 2 points per item</td>
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<tr>
<td></td>
<td>• Provides some validity data</td>
<td></td>
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<tr>
<td>Withdrawal Assessment Tool (WAT-1)</td>
<td>• Assesses signs of opioid and benzodiazepine withdrawal</td>
<td>Franck, Harris, Soetenga, Amling, &amp; Curley, 2008; Kaltenbach &amp; Jones, 2016</td>
</tr>
<tr>
<td>Neonatal Withdrawal Inventory</td>
<td>• Provides a sequence of care procedures</td>
<td>Zahorodny et al., 1998</td>
</tr>
<tr>
<td></td>
<td>• Uses an 8-point scale to make withdrawal evaluation</td>
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NAS Treatment

Non-Pharmacological Standards
includes relieving infant symptoms and supporting maternal bonding and may include the following:

- Swaddling,
- rocking,
- reduced stimuli in environment (light & noise),
- breast feeding (may reduce need for intervention)
- bottle feed or pacifier in between to assist with sucking reflex, and
- rooming together

Pharmacological treatment
primarily intended to relieve NAS symptoms and its associated complications, such as fever, weight loss, and seizures” (SAMHSA, 2016).

- This may be morphine as first line of treatment or methadone followed by tapering off schedule based on symptoms (University of Iowa Children's Hospital, 2013).
- In a 2010 study, infants with NAS required less therapy and shorter hospital stays when roomed with their mother on a postnatal unit than when admitted to a traditional neonatal care unit (Saiki, Lee, Hannam, & Greenough, 2010).
Case study: Ann

What suggestions do you have to improve the system of care for pregnant women on medication assisted therapy?

What organizational and community-based policies are barriers in your community?

Barriers and Treatment Issues

• Access to treatment in general
• Access to Long-Acting Reversible Contraception
• Availability of family-centered, residential treatment for pregnant women
• Housing resources often have policies prohibiting admission of clients on MAT & pregnant clients
• 30-day Transition off insurance is inadequate for tapered detox or completing primary treatment
• Affordability of MAT without insurance coverage
• Access to MAT provider
• Transportation to frequent appointments, distant clinics, etc.
• Fear of arrest, incarceration, or DCS referral
## Competing Values in Programming & Policy

<table>
<thead>
<tr>
<th>Values</th>
<th>vs.</th>
<th>Values</th>
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<tbody>
<tr>
<td>Undeserving</td>
<td>Deserving</td>
<td>Social Responsibility</td>
</tr>
<tr>
<td>Individual Responsibility</td>
<td></td>
<td>Social Change</td>
</tr>
<tr>
<td>Individual Change</td>
<td></td>
<td>Social Support</td>
</tr>
<tr>
<td>Self-sufficiency</td>
<td></td>
<td>Prevention</td>
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<tr>
<td>Crisis Response</td>
<td></td>
<td>Empathy</td>
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<tr>
<td>Sympathy</td>
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<td>Trust</td>
</tr>
<tr>
<td>Suspicion</td>
<td></td>
<td>Rationality (Segal, 2014)</td>
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<tr>
<td>Emotions</td>
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State Legislation

Passed/Proposed

- Alabama—2016. Act 2016-399. A legal prescription prevents prosecution under the existing Child Abuse Act
- North Carolina—2015, SB297 introduced, referred to committee
- Ohio—2013, HB394 passed. Modifying offense of “corrupting another with drugs”
- Tennessee—2014. PC820 signed into law with sunset date 7-1-16. Misdemeanor charge for exposing fetus to narcotics.

Failed

- Alabama—2015, 2016 (3 separate bills)
- Colorado—2016
- Louisiana—2016
- Mississippi—2015, 2016
- Missouri—2013, 2016
- New Jersey—2014
- Oklahoma—2015
- Tennessee—2016 (to make PC820 permanent)
- West Virginia—2016
Recently proposed statutory responses:

- Reported 1-12-18: Big Horn (Montana) County Attorney plans to issue restraining orders against pregnant women and will prosecute them for contempt of court if they test positive for alcohol or drugs.

- This is a shift to civil prosecution, rather than criminal. It is opposed by the ACLU of MT and treatment providers in Montana in addition to ACOG, the American Academy of Pediatrics, ASAM, NOFAS, and the March of Dimes.

State Legislatures

- Tennessee House (no Senate Bill proposed) HB 1381
  - Criminal Offenses - As introduced, provides that a woman may be prosecuted for assault for the illegal use of a narcotic drug while pregnant, if her child is born addicted to or harmed by the narcotic drug

- No apparent Indiana legislation pending
Evidence-Based Points of Intervention
**Treatment Interventions**

- **Promote comprehensive medication-assisted therapy** (MAT) which includes: prenatal care, individual & group therapy, resource allocation, psychosocial support, parent-skills training, & family education. Expand access to MAT by advocating for Medicaid coverage & increasing provider capacity.

- **Expand access to family-centered, residential treatment.** This is part of the SAMHSA Pregnant & Postpartum Women Initiative (PPW).

- **Expand universal screening** (SBIRT) for substance use & addiction in pregnancy, as well as reproductive justice among social service providers, medical students, OBGYNs, & pediatric nurses & physicians.

- **Assist & encourage smoking reduction** for pregnant patients. Cigarette smoking increases the incidence of NAS (Patrick, et al., 2015; SAMHSA, 2018)

- **Standardized scoring**& interventions for NAS in hospitals. This reduces length of treatment & length of stay (Patrick, 2014; SAMHSA, 2018)
Policy Interventions

- Educate elected officials & policy makers on treatment options & advocate for fair policies that preserve the relationship between mothers & babies by promoting bonding & attachment & discouraging separation.

- Continue Medicaid coverage for at least one year post delivery to ensure completion of treatment plan & continuity of care.

- Increase access to long-acting reversible contraception (LARC) (see TN county health departments Primary Prevention Initiative in which Sevier County recorded a 92% reduction in NAS nine months after implementing PPI for more information) (SAMHSA, 2018, p. 59)

- Continue vigorous opposition to fetal assault laws & advocacy for clients at the macro level.

- Reduce stigma through education about MAT & NAS.
Presentation References


• Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. (2008). Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214

• Substance Abuse and Mental Health Services Administration, Advancing the Care of Pregnant and Parenting Women With Opioid Use Disorder and Their Infants: A Foundation for Clinical Guidance, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

