THE ETHICS OF MEDICATION-ASSISTED RECOVERY: STRENGTHENING THE MOTHER-INFANT BOND

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3:15-4:45 pm
AGENDA

• Identify the scope of opioid misuse among women, pregnancy risks, and ethical concerns with MAT.

• Discuss evidence-based non-pharmacological interventions that reduce NAS and support the mother-infant dyad.

• Explore potential ethical conflicts for social workers supporting a harm reduction approach toward this population.
• 8.4 million females (or 6.6 percent) ages 18 and older reported misuse of prescription drugs in the previous year, according to the 2016 National Survey on Drug Use and Health. (Center for Behavioral Health Statistics and Quality, 2017)

• The number of women with opioid use disorder at labor & delivery quadrupled from 1999-2014. (1.5 to 6.5 per 1000 deliveries)
PREGNANCY RISKS

Neonatal Abstinence Syndrome (NAS)

- In 2012, among hospital related stays for substance use, 60% were related to NAS with one-fourth involving opioids (Fingar et al., 2015, & SAMHSA, 2016).

- A 2014 study revealed that 76,742 women, had been prescribed an opioid during pregnancy (Bateman et al., 2014).

- 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 (ASTHO, 2014).
THE RATIONALE FOR MAT DURING PREGNANCY

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 baby and limiting exposure to illicit drugs (Jones et. al., 2008).
4. Shift focus to recovery process including building parenting skills, prenatal care, nutritional support, and post-delivery planning; avoid high-risk behaviors associated with drug use.

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, 2017).

SAMHSA (2018) strongly recommends the use of MAT to treat OUD in pregnant women and suggests “treatment without any pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and the consequences such as risk of overdose” (p. 25).
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 substance-exposed infants” (University of Iowa Children’s Hospital, 2013).

NAS may pose less harm to a pregnant mother and her baby than non-medically supervised 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 (ACOG, 2017; Watson & Mallory, 2017).

The current recommended approach for pregnant women with OUD is medication-assisted treatment (MAT). (SAMHSA, 2018)
NAS TREATMENT & FOSTERING SECURE BONDS

NON-PHARMACOLOGIC STANDARDS

includes relieving infant symptoms and supporting maternal bonding and may include the following:

• Swaddling,
• rocking,
• reduced stimuli in environment (light & noise),
• breast feeding (if stable in medication-assisted recovery)
• bottle feed or pacifier in between to assist with sucking reflex, and
• rooming together

PHARMACOLOGIC INTERVENTIONS

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).
INTEGRATED TREATMENT

https://youtu.be/7IFLrd8zudo

6 minute video from:
Texas Department of State Health Services
• **Values**: Beliefs about right and wrong.

• **Ethics**: What *should or should not be done*.

• **Ethical Dilemmas**: Problematic situations whose possible solutions offer imperfect answers on what ethically *should be done*.

• **Ambiguity**: View of different perspectives – solutions are unclear.

• Kirst-Ashman & Hull
DISCUSSION ACTIVITY

• Review the principles from the NASW Code of Ethics that follow each core value.

• As you discuss with your partner, what ethical conflicts can arise when working with pregnant women in MAT?
ethical concerns

- Safety concerns for infant at delivery and post-partum (rapid detox)
- Child abuse reporting policies & social policies that criminalize substance misuse
- Client Vulnerability & lack of infrastructure to support recovery (wrap around)
- Definitional debates about Non-Abstinence based therapies
- Stigmas that impact help-seeking, family connection, and public opinion (internalized stigma)
  - Language used alters perceptions
- Trauma History, Promoting secure attachment during sensitive periods, toxic stress
- Promoting self-efficacy vs. Paternalism
- Checking self-awareness for our own biases
Move away from a moral model of understanding; view 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).

• Validating incremental change, redefining success, and utilizing positive language such as Medication-Assisted Recovery with clients is paramount (White, 2012).

• The assertion that recovery from opioid misuse begins when medication management ends is discriminatory, and “recovery from no other chronic health condition rests on such a proposition” (White, 2012, p. 204).
# Hierarchy of Ethical Rights

<table>
<thead>
<tr>
<th>Principle</th>
<th>Ethical Rights - People Have the Right to:</th>
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<tbody>
<tr>
<td>1 E</td>
<td>Exist with their basic needs met.</td>
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<tr>
<td>2 T</td>
<td>Treatment that is fair and equal.</td>
</tr>
<tr>
<td>3 H</td>
<td>Have free choice and freedom.</td>
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<tr>
<td>4 I</td>
<td>Injury that is minimal or least harm.</td>
</tr>
<tr>
<td>5 C</td>
<td>Cultivate a good quality of life.</td>
</tr>
<tr>
<td>6 S</td>
<td>Secure their privacy and confidentiality.</td>
</tr>
<tr>
<td>7 U</td>
<td>Understand the truth and full disclosure.</td>
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</tbody>
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![Diagram showing the hierarchy of ethical rights](image)
MAT IS CONSISTENT WITH SOCIAL WORK VALUES

- **Dignity and Relationships**: When we advance the dignity of a mother, dignity extends to her baby — and sustains a meaningful and healing connection.

- **Self-Determination and Empowerment**: Honoring self-determination allows autonomy to rest with the client; this creates an impetus for empowerment. It intentionally shifts the orientation away from pathology and honors client choice. We must also consider the ecological context in which her choice is made.

- **Social Justice and Advocacy**: Unworthy vs. worthy translates to the collective policy response (Collins and Garlington, 2017). Stigma limits accessibility and contributes to poorer health outcomes. Pregnant women of color are “least likely to be able to defend themselves and the least able to conform to the white middle-class standard of motherhood” (Van Wormer & Davis, 2018). **Competent** social workers must advocate for restorative policies that elevate dignity and strengthen the relationship between mothers and babies.

- Ethical practitioners act with **Integrity** and engage in critical examinations of personal beliefs alongside professional values within a strengths-based framework. Discernment of these concepts enables practitioners to weigh the benefits of a least harm perspective and creates the space to view a pregnant woman within the context of her strengths. Practicing in this space honors the dignity and worth of both a mother and her baby. This perspective is paramount to effectively engage clients, foster belonging, and sustain recovery.

(Watson, Mallory, & Crossland, in press)
PRESENTATION REFERENCES


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.


