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VOL.8 ISSUE: COMPREHENSIVE TREATMENT FOR PREGNANCY/ OTHER WOMEN'S NEEDS BY: ANN JAMIESON AND ALBERT RIOS

FEBRUARY ISSUE: COMPREHENSIVE TREATMENT FOR PREGNANCY AND OTHER WOMEN'S NEEDS

WOMEN WITH OUD ARE AT RISK FOR POOR REPRODUCTIVE AND SEXUAL HEALTH OUTCOMES; OTP STAFF AND PROVIDERS SUGGEST EFFECTIVE INTERVENTIONS

March 3, 2021
At Forum

Women with opioid use disorder (OUD) face many challenges, among them the risk of poor outcomes in conditions involving reproductive and sexual health (RSH). Factors contributing to risk include less use of contraceptives, a higher incidence of unintended pregnancies, and an increased chance of contracting sexually transmitted infections and passing them on.

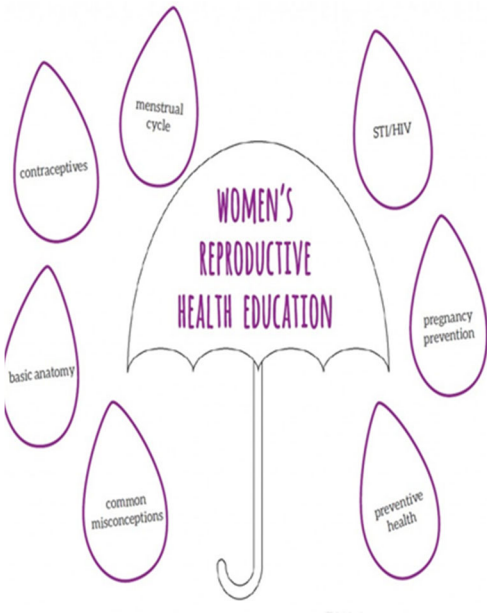
WHAT CAN BE DONE TO HELP THESE WOMEN?

This article highlights a study from the September/October issue of Journal of Addiction Medicine addressing this question. In planning their study, researchers chose opioid treatment programs (OTPs) as their study site. Their reasons:

Their "unique setting and structure" gives OTPs an opportunity to improve access to health care services. Access could "enhance patient-centered care, treatment retention, and recovery outcomes."

OTPs are accredited, certified, registered, and monitored by respected agencies.

RSH interventions carried out in OTPs might be especially useful in reducing unplanned pregnancies and fetal opioid exposures. They could also help improve the health of women in their reproductive years who have OUD. Previous studies have shown women to be receptive to using contraception if offered onsite during treatment for substance use disorders.



Contact between OTP staff and patients is a frequent, often daily occurrence, providing opportunities for developing trusting relationships. This is important because "women may be more likely to use RSH services in an environment where they trust their providers and the support staff."

RSH services include contraception, pregnancy testing, HIV/STI testing, perinatal depression screening, and cervical cancer testing (Pap smear).

The study was supported by grants from the National Institutes of Health, the National Institute on Drug Abuse, and several other groups.

THE STUDY

Integrating Reproductive and Sexual Health Education and Services into Opioid Use Disorder Treatment Programs: A Qualitative Study is part of a larger study using mixed methods.

The objective of the study was to better understand factors that could influence the use and effectiveness of intervention, at all levels—patient, provider, and organization—when treating women at OTPs.

Study participants were providers and staff (nurses, counselors, medical directors, program directors, office manager, administrative assistants) at nine OTPs in North Carolina.

The study's first author, Stacey L. Klaman, PhD, MPH, currently a postdoctoral research fellow at Family

Health Centers of San Diego's Laura Rodriguez Research Institute, conducted 31 structured interviews based on the guide the team had developed. The interviews took place between November and December 2017, and were audio-recorded, transcribed, coded, then analyzed to identify key themes. Each interview lasted approximately 45 minutes. During the interviews, participants shared their perspectives about integrating reproductive and sexual health education and services into existing treatment programs.

- Participants (providers and support staff) acknowledged that women in OTPs need access to RSH services and education. But most participants reported they didn't talk with the women about their needs in these areas, or about pregnancy intentions. Nor did they know if women of reproductive age needed counseling about family planning.

- Transportation and childcare needs were the most important barriers to accessing OUD treatment. Unmet needs in these areas probably would hinder patients from taking part in RSH education and services as well. Commented a support staff member: "Transportation is probably the biggest issue I see, a lot of them don't have licenses or don't have cars." From a counselor: "A lot of times we have people who can't really stay here because they got kids at home, they got a babysitter just … to come here and get back home."
- Group settings and tangible incentives would make it easier to participate in RSH education sessions–but not in RSH services.

Steps that might mitigate important barriers:

- Public transit passes, or coverage for transportation
- Onsite childcare
- RSH education
- Services with flexible or expanded hours

GENDER DISPARITIES IN OPIOID TREATMENT PROGRESS IN METHADONE VERSUS COUNSELING

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BACKGROUND

In the United States, the high dropout rate (75%) in opioid use disorder (OUD) treatment among women and racial/ethnic minorities calls for understanding factors that contribute to making progress in treatment. Whereas counseling and medication for OUD (MOUD, e.g. methadone, buprenorphine, naltrexone) is considered the gold standard of care in substance use disorder (SUD) treatment, many individuals with OUD receive either counseling or methadone-only services. This study evaluates gender disparities in treatment plan progress in methadone- compared to counseling-based programs in one of the largest SUD treatment systems in the United States.

CONCLUSIONS

We found significant gender disparities in completing OUD treatment plans at discharge when receiving methadone vs. counseling. Latinas were the most vulnerable to disparities in both outcomes (making progress and completing treatment plan). Methadone has proven effective to treat OUD (e.g., increase engagement [28, 31, 49], reduce overdose and relapses [30, 52], yet female clients, and Latinas in particular, report less progress in Methadone-based programs compared to counseling-only treatment. Overall, these findings may be explained by the potential differences in minority women's comprehensive service needs (mental health therapy, childcare services, etc.), program treatment approaches (drug-free recovery or methadone maintenance), and quality of care (culturally and linguistically responsive care). It is critical to develop evidence-based and culturally responsive OUD treatment interventions that further address the significant challenges that SUD programs face to ensure women equally benefit from OUD treatment regardless of the service delivery type.

RELEVANT CARF STANDARDS

2.B.12. Program policies and procedures allow for waiving the admission criteria of physical dependence or a one-year history of addiction when the person seeking admission meets one of the following criteria:

d. Pregnant women who do not exhibit objective signs of opioid withdrawal or physiological dependence.

WOMENAND PREGNANCY SERVICES

2.B.27. When providing services to women, the program
a. Provides respectful and safe treatment.
b. Provides counseling regarding:
1) Women's health issues

2) Intimate partner abuse or family violence
3) Sexual abuse
4) Reproductive health issues
5) Gender expression or identity or sexual orientation

c. Assigns counselors and specialized staff based on the characteristics and needs of women.

d. Provides or makes referrals for all women served and their partners, as appropriate, for:

1.) Reproductive health services
2.) Parenting skills

Intent Statements

27.a. The safety of women should be a primary concern for the program. All women should feel safe while in the facility. The emotional climate is one that is respectful of women and ensures the maintenance of their dignity. Procedures regarding the appropriate use of the physical space should be established for restrooms and observable drug screening that meets the needs of the women.

27.c. The program ensures that staff members are sensitive to the specific needs of women. All staff members should receive competency-based training in the characteristics and needs of the women participating in their particular program. The option of single-sex group therapy based on gender identity or expression, or sexual orientation should be available and each OTP's space should meet the needs of female patients.

2.B.28. Pregnant patients seeking treatment from an opioid treatment program are:

a. Given priority admissions, or
b. The reason for denying admissions to any pregnant patient is documented.

2.B.29. With respect to medication use for patients who are pregnant, opioid addicted, and in opioid treatment, the program:

a. Ensures that the initial methadone dose for a newly pregnant patient and the subsequent induction and maintenance dosing strategy reflect the same effective dosing protocols used for all other patients.
b. Monitors the methadone dose carefully, especially during the third trimester.
c. Maintains patients who become pregnant during treatment on the pre-pregnancy dosage, if effective, and are managed with the same dosing principles used with nonpregnant patients.
d. Ensures that if a pregnant patient elects to withdraw from methadone:
1) A physician experienced in addiction medicine supervises the withdrawal process.
2) Regular fetal assessments, as appropriate for gestational age, are part of the withdrawal process.
3) Withdrawal is not initiated before 14 weeks or after 32 weeks of gestation.

Intent Statement

29.b. Pregnancy-induced changes in the rate at which methadone is metabolized or eliminated from the system may necessitate either an increased or split dose, especially during the third trimester.

2.B.30. The program provides pregnant patients:

a. Education on medically supervised withdrawal (MSW).
b. Education regarding the impact of MSW services on the health and welfare of unborn children.

Intent Statements

CARF does not endorse the detoxification of pregnant patients. However, CARF recognizes that this practice may take place in limited circumstances. Education regarding medically supervised withdrawal should be provided to pregnant patients.

Pregnant patients who chose to withdraw from treatment against medical advice may do so under direct supervision of a physician experienced in addiction medicine.

Pregnant patients are encouraged to consider ongoing maintenance treatment after delivery. MSW after pregnancy should occur only when clinically indicated or requested by the patient (Federal guidelines for Opioid Treatment Programs March 2015, p.31).

2.B.31. The program has a mechanism to to support the decision to breastfeed during medication-assisted-treatment, unless medically contraindicated.

2.B.32. The program ensures that every pregnant patient has the opportunity for prenatal care either:

a. On site, or
b. By referral to appropriate healthcare providers.

2.B.33. If appropriate prenatal care is not available on site or by referral, or the pregnant patient cannot afford care or refuses prenatal services, the program:

a. Offers the patient basic prenatal instruction on:
1) Maternal care
2) Physical care
3) Dietary care
b. Documents the provision of these services in the clinical record.

2.B.34. If a pregnant patient refuses direct prenatal services or referral for such care, the program documents that these services were offered but refused.

2.B.36. The program implements policies and procedures, including informed consent, to ensure care coordination with the providers of primary care for the new mother and well-baby care for the infant, as appropriate.

2.B.37. If a pregnant patient is discharged:
a. The program identifies the specific physician or authorized healthcare professional, as appropriate, to whom the patient is being discharged.
b. The name, address, and telephone number of the provider caring for the patient after discharge are recorded in the patient's record.

2.B.38. When providing MSW services to pregnant patients whose withdrawal symptoms cannot be eliminated, referrals to inpatient medical programs are made.

2.E.24. Voluntary medically supervised withdrawal from MAT treatment includes:
c. Reviews of the results of a pregnancy test of women of childbearing age.

2.E.25. When medically supervised withdrawal is conducted against medical advice or done by involuntary administrative withdrawal, the program documents:
c. Results of a pregnancy test of women of childbearing age are reviewed.

Mandatory Training

For Counselors, Case Managers, Program Directors, and Administrative staff:

1. A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders https://bit.ly/3svpASB
2. Women and mental health https://bit.ly/3cfO8qo

For Medical staff:

1. Pregnancy - Substance Use Disorders and Recommended Treatments for Recovery https://bit.ly/3oj1vbK
2. Women and Heart Disease - Gender Issues in Heart Research and Health https://bit.ly/30Tn50Y

All program directors must submit all training certificates by the end of the month after collecting from all employees. Submit to Wendy@marichealth.com.

Resources

Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants
SAMHSA

The nation's opioid epidemic continues to compromise the health and well-being of individuals, families, and communities. Federal policymakers and agencies are developing, implementing, and funding strategies focused on turning the tide (U.S. Department of Health and Human Services [HHS], 2016]) to address opioid misuse, opioid use disorder (OUD), fatal and non-fatal drug overdoses, prenatal substance exposure, dissolution or breakup of families, and financial ruin experienced in communities nationwide.

See SAMHSA's Effective Interventions and Guidelines for increasing access to quality care for pregnant women with opioid use disorder:
https://bit.ly/3FKR5dw

Human Resource Corner

With Omicron numbers rising, we would like to remind all staff of the incentives provided upon completing your vaccination and booster. Each employee that receives the vaccine while working for the Company receives three additional paid vacation days. Also, upon completing your booster you will receive one more additional paid vacation day.

Having your booster, when eligible, also will qualify full-time employees for the emergency paid sick leave if you test positive for the COVID virus.

Thank you to all employees that have taken the vaccine and received your additional benefits. If you have received your vaccine, please send a copy of your record to Kacie.enyart@marichealth.com.

One more quick reminder – open enrollment is coming very soon. I will be sending out communication on dates by the first week in February.

Kacie Enyart, SHRM-CP

Professional Accomplishments

Please join me in congratulating our colleagues for their amazing professional accomplishments:
In Santa Fe, NM: Lisa Del Monico passed her NCMHCE exam and now has obtained LPCC License.
In San Antonio, TX: Catherine Rodriguez completed her licensure and is now an independently licensed LCDC!
In Lexington, NC: Achovia Jones earned her Master's degree in Mental Health and Rehabilitation Counseling!
In Rowan, NC: Holly Gallagher earned her 2nd Master's degree, this one in Addiction Studies!
In Española, NM: Destini Gomez earned her Bachelor's degree in Nursing!

Congratulations! Way to go!!!!