

Screening for and Discussing Substance Use with Pregnant People

Why Words Matter

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Maryland Addiction Consultative Services MOMS Program

Maryland Addiction Consultation Service for Maternal Opioid Misuse (MACS for MOMs)

Provides support to maternal health providers and their practices in addressing the needs of their pregnant and postpartum patients with substance use disorders (SUD), particularly opioid use disorder (OUD).

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and pregnancy
- Assistance with addiction and behavioral health resources and referrals
- MACS for MOMs TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning

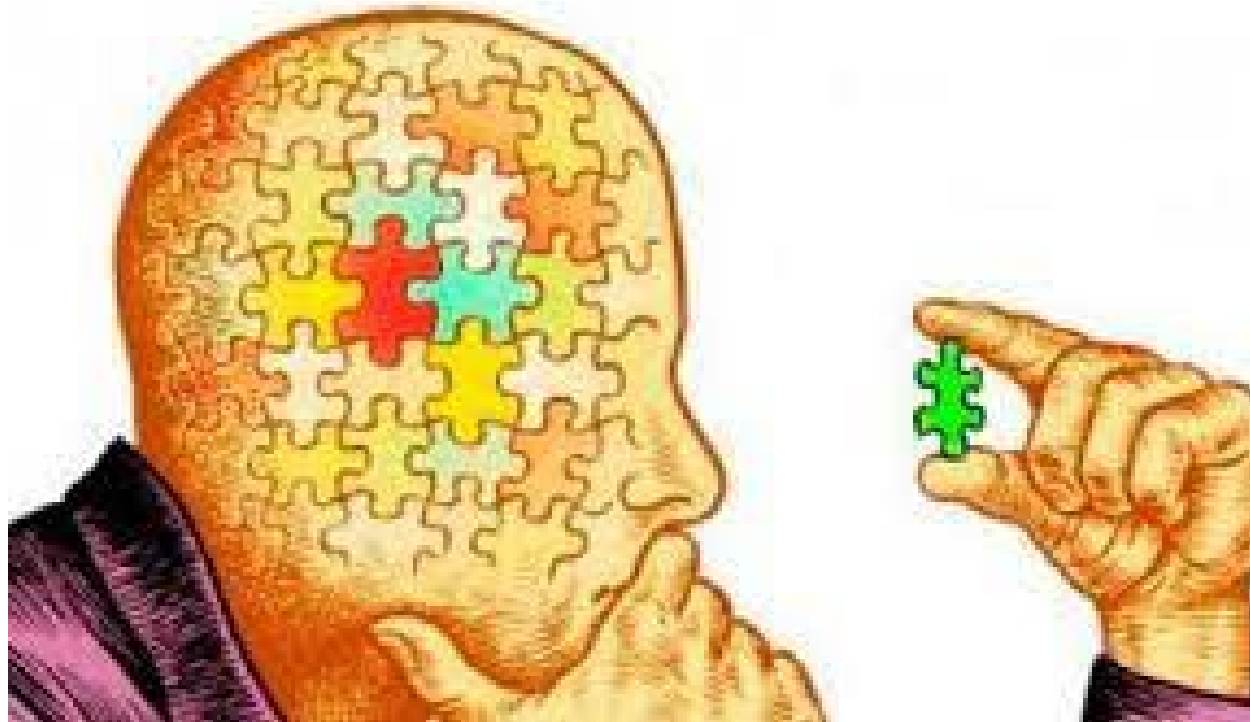
Disclosures

I have no disclosures

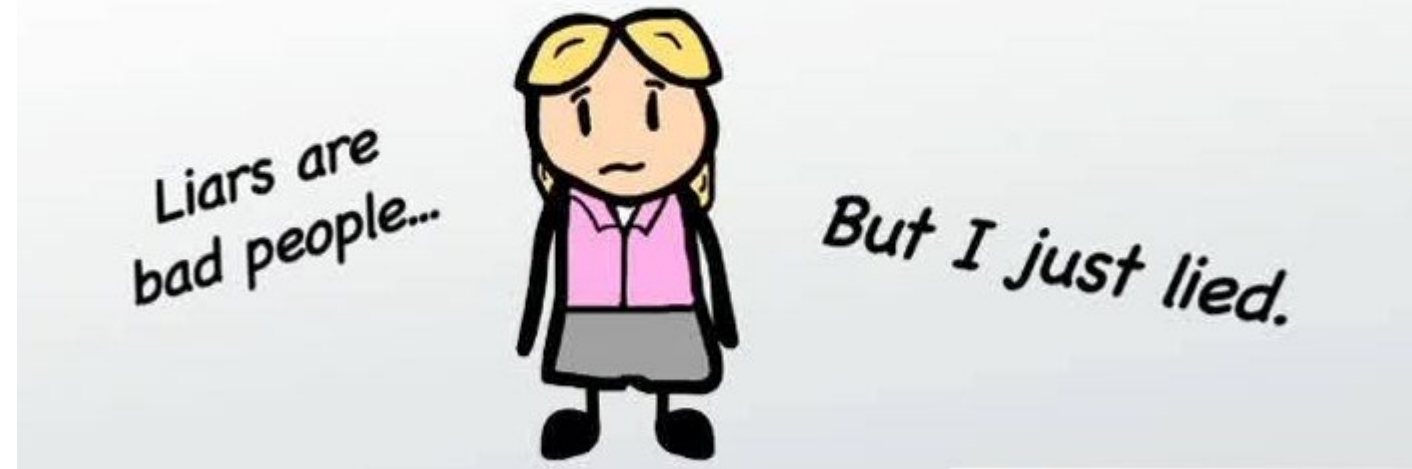
Learning Objectives

- Recognize and address stigma related to substance use in pregnancy
- Learn to use person-first language
- Understand the purpose of screening for substance use in pregnancy
- Evaluate the benefits of harm reduction

Why do we need this talk?



COGNITIVE DISSONANCE



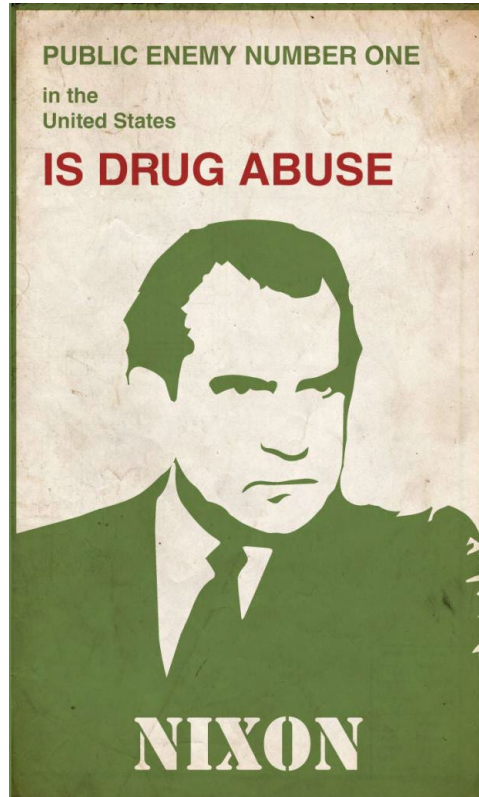
The state of having inconsistent thoughts, beliefs or attitudes, especially as related to behavioral decision and attitude changes

Historical context: Criminalization of pregnancy



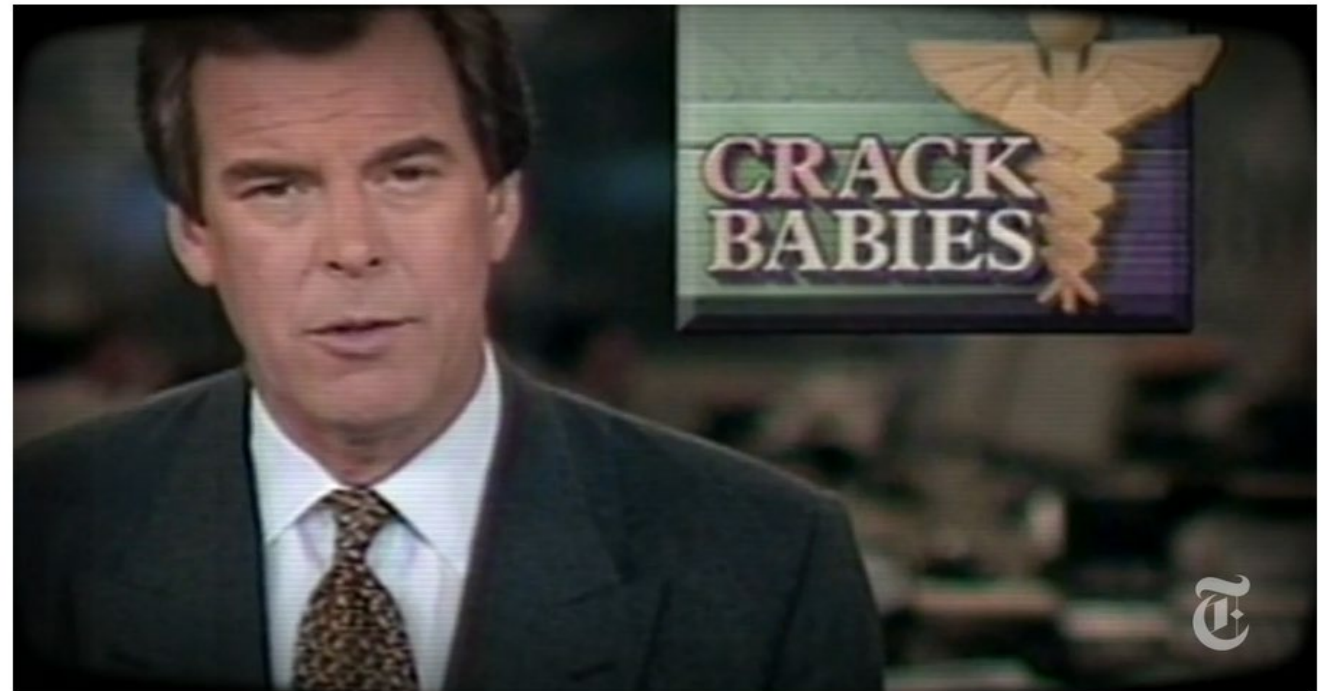
Personhood laws

- 1973 – Roe v Wade made abortion legal.
 - Majority opinion: “If suggestion of personhood is established, Roe’s case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the 14th amendment”.
- 1973 + 1 week – first Human Life Amendment is proposed



The New York Times

Revisiting the 'Crack Babies' Epidemic That Was Not



“Crack babies”

- Truth
 - Poorly designed study
 - No physiologic basis
 - Good long-term outcomes
 - Dr. Chasnoff later expressed remorse
- Consequences
 - Media frenzy
 - Long-term consequences for society



HEALTH

A Tide of Opioid-Dependent Newborns Forces Doctors to Rethink Treatment

By CATHERINE SAINT LOUIS JULY 13, 2017



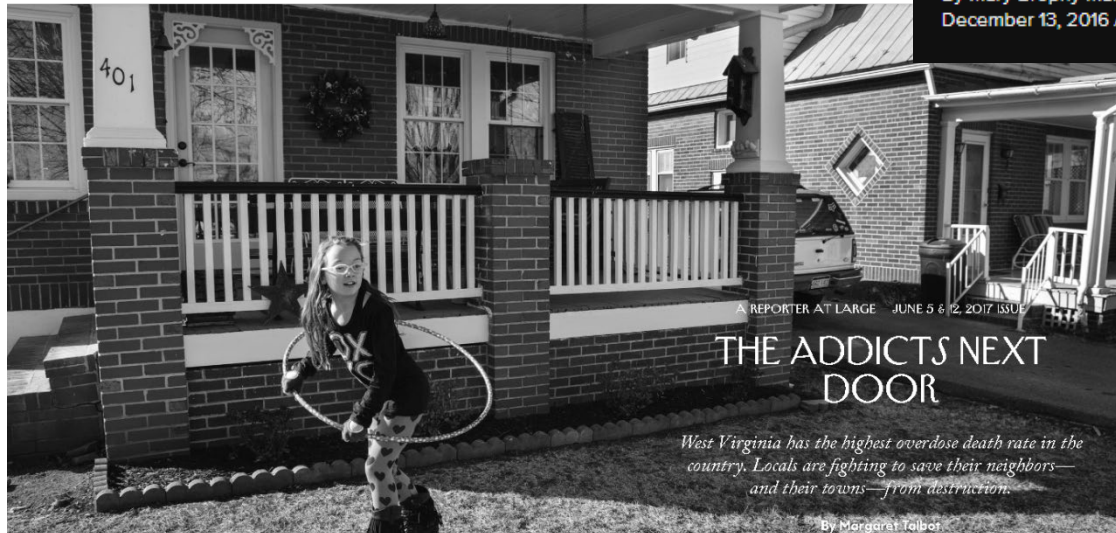
The most vulnerable victims of America's opioid epidemic

Helpless & Hooked

A REUTERS INVESTIGATION

THE
NEW YORKER

News Culture Books Business & Tech Humor Cartoons Magazine Video Podcasts Archive Goings On



A REPORTER AT LARGE JUNE 5 & 12, 2017 ISSUE

THE ADDICTS NEXT DOOR

West Virginia has the highest overdose death rate in the country. Locals are fighting to save their neighbors—and their towns—from destruction.

By Margaret Talbot

HEALTH

Doctors track "an explosion" of newborns addicted to opioids

By Mary Brophy Marcus

December 13, 2016 / 9:37 AM EST / CBS News



Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

TAST WEEK in this city, Greater Southeast Community Hospital released a 2-week-old baby to

EXPLICIT BIASES

- * AWARE of THOUGHTS & EMOTIONS TOWARDS a SPECIFIC GROUP

- ~ HATE SPEECH
- ~ DISCRIMINATION
- ~ PREJUDICE



IMPLICIT BIASES

- * GUT REACTIONS OCCUR w/in MILLISECONDS

- * UNCONSCIOUS ATTITUDE & BELIEFS

- └ FEELINGS
- └ BEHAVIOR
- └ JUDGEMENT

- * UNAWARE (SUBCONSCIOUS)

- * can DIRECTLY AFFECT HEALTHCARE OUTCOMES & PATIENT SATISFACTION

Common stigma toward patients with SUD

- Dangerous
- Unpredictable
- Incapable of managing treatment
- Caused their own condition
- Can stop if they wanted to
- Are difficult to work with
- Do not care about their babies

Extent of the Problem: Healthcare Professionals

- Rates of stigma high among public and healthcare professionals

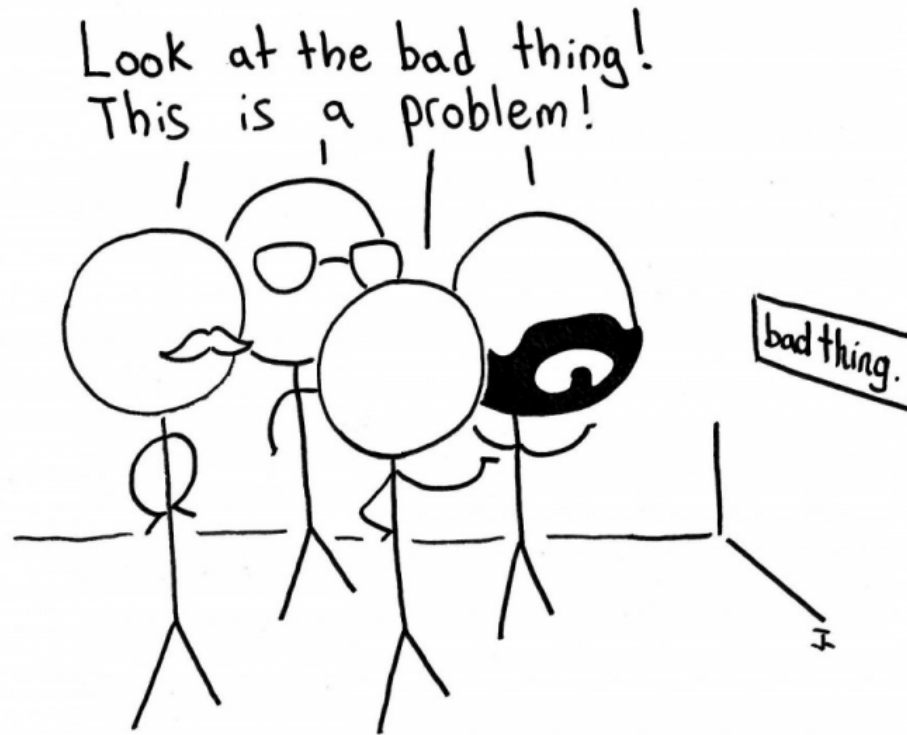
Kennedy-Hendricks, et. al. (family practice, internal medicine, pediatrics)	
Beliefs about population	Endorsed
People addicted to Rx pain medication are more dangerous than the general population	66.4%
Landlords should be allowed to deny housing to a person addicted to Rx pain medication	37.5%
Perceptions of effectiveness of opioid addiction treatment options	
Most people addicted to Rx pain medication can, with treatment, get well and return to productive lives	69.2%
Effective treatment options are available to help people who are addicted to Rx pain medication	57.8%

Why are patients with SUD stigmatized?

- Progress with some mental illnesses (depression)
 - Focus on improving mental health
- SUD-related stigma remains
 - Stems from belief that addiction is a moral failing
 - Compared to other psychiatric disorders, patients with SUD are more often blamed

<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>

So what can we do?



Substance Use Disorder

- A **chronic, relapsing** disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain (NIDA)

Addiction is a brain disease whose visible symptoms are behaviors

Examining our own bias

- The Diabetes rule
 - Substitute SUD with diabetes in a clinical scenario and consider whether your decision would be the same
 - Example: the patient was non-compliant with her insulin regimen, which caused her to go into DKA. Would you....
 - Report her to child protective services?
 - Stop prescribing her medication?

Words Matter

Sticks and Stones
May break your bones
But Words?
Oh Words . . .
Will break your Soul.

What is Person-First Language?

- Maintains the integrity of individuals as whole human beings – by removing language that equates a person to their condition or has negative connotations”
 - Neutral tone
 - Distinguishes person from his or her diagnosis

Instead of “drug user”, they are “a person who uses drugs”

Terms to avoid	Terms to Use	Why?
Addict User Drug Abuser Junkie Alcoholic/Drunk	Person with (OUD, AUD, SUD, etc) Person in recovery Patient	Person-first language is humanizing Shows that the person HAS a medical problem rather than IS the problem
Habit	Substance Use Disorder Drug addiction	Implies a choice Undermines severity/medical nature of the disease
Abuse	For illicit drugs: Use For Rx medications: misuse or use other than prescribed	Accurate terminology consistent with medical disorder Less of a negative connotation

<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>

Terms to avoid	Terms to Use	Why?
Clean/dirty	<p>For tox results: Testing negative/positive for...</p> <p>For describing a person: In recovery... Abstinent from... Person so uses drugs...</p>	Associated with negative connotation
Methadone clinic	Opioid treatment program	Clinic can have a negative connotation
Medication Assisted Treatment (MAT)	Medication for treatment of OUD (MOUD)	“Assisted treatment” undervalues the role of medication

<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>

I AM NOT AN ADDICT



Terms to avoid	Terms to Use	Why?
Addicted	Neonatal Opioid Withdrawal Syndrome Neonatal Abstinence Syndrome	Medical accuracy and less stigmatizing

Words Effect Behavior

- Survey of 516 providers attending mental health care/addiction conference
- Vignette using “substance abuser” versus “SUD”
- “Abuser” associated with greater perception of blame and deserving of punishment

Strength Based Approach to Documenting

- “Focus on what is strong instead of what is wrong”
- Examples:
 - **Stigmatizing: “Patient arrived 30 minutes late and agitated”**
 - **Strength based: “Despite having transportation and childcare issues, Ms. Smith attended her appointment today”**
 - **Stigmatizing: “Patient relapsed again”**
 - **Strength based: “Ms. Smith presented today to seek care and reports that she is motivated to achieve sustained recovery”**



People will **forget**
what you **said**, people
will forget what you
did, but people will
never forget how you
made them **feel**.

-Maya Angelou

TRAUMA-INFORMED CARE:

What does it look like?

@therecoverycenterusa



Language and Communication

Helpers use non-judgmental and empathetic language. They avoid making assumptions about an individual's past experiences. For instance, instead of asking, "What's wrong with you?" they might ask, "What happened to you?"



Providing Choices

In healthcare settings, offering choices to patients can be empowering. For example, allowing a patient to choose their meal preferences or the time of their therapy sessions gives them a sense of control.



Sensory-Friendly Environments

Recognizing that sensory sensitivities can be triggered by trauma, trauma-informed care might involve providing calming sensory rooms or ensuring that lighting and noise levels are adjustable to individual preferences.



Active Listening

Helpers actively listen to individuals without interrupting or rushing through appointments. They validate their feelings and experiences.



Training and Self-Care

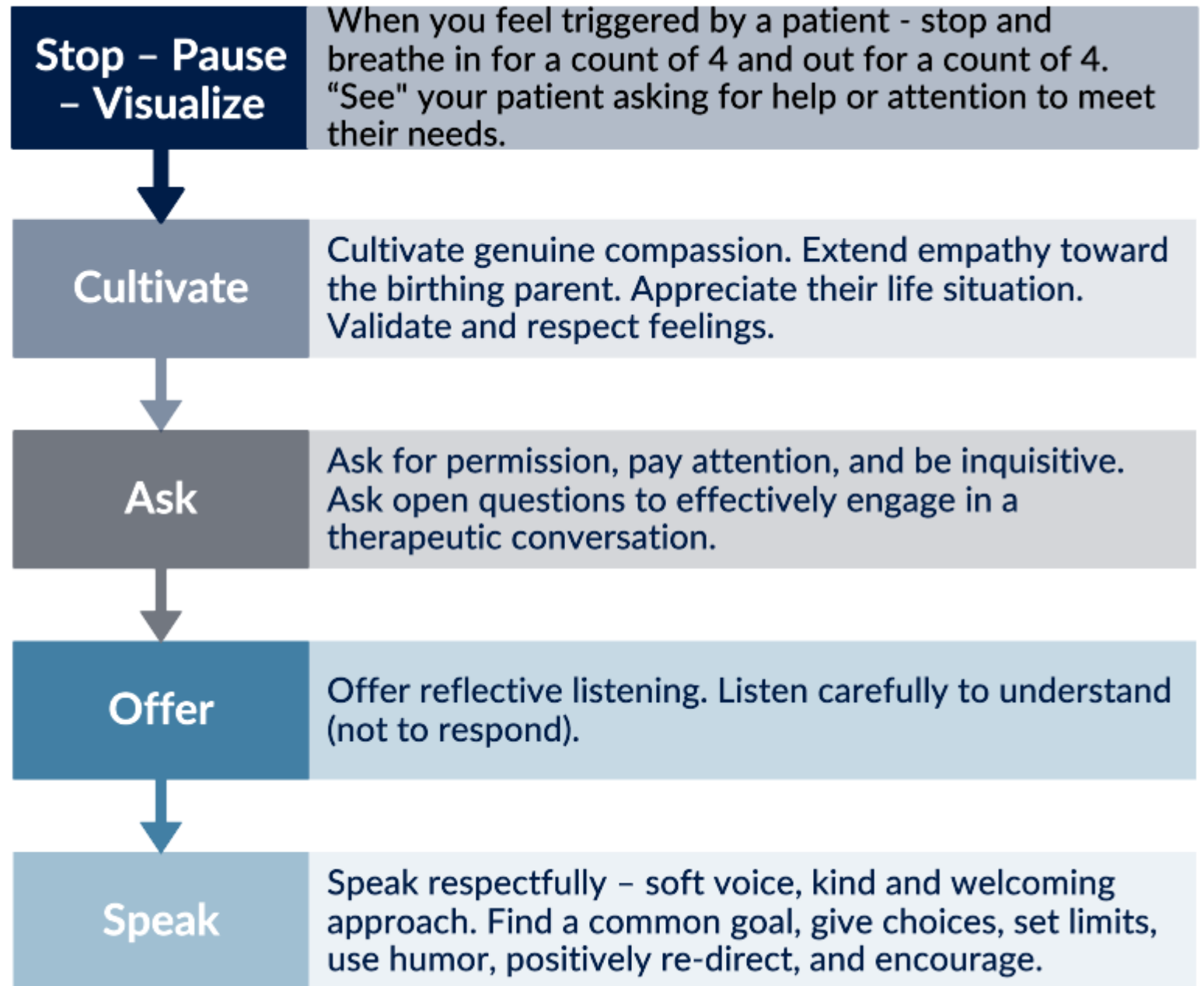
Healthcare staff are trained in trauma-informed care principles and are encouraged to practice self-care to prevent burnout. This ensures that they can provide the best possible care to their patients.



De-escalation Techniques

In situations where patients may become agitated or distressed, trauma-informed care involves de-escalation techniques that prioritize safety and minimize re-traumatization.

Trauma Responsive Care



Trauma Responsive Care: Cultivating Empathy

- Recognize that trauma is shown through behaviors
- Change the question from “what is wrong with you” to “what happened to you”

Trauma Responsive Care: Connection

- Recognize self-protective behaviors
- Listen to understand
- Acknowledge strengths
- Name emotions (yours and the patient's)
- Be true to your word
- Avoid surprises

"There is always light, if only we are
brave enough to see it – if only we
are brave enough to be it."

-AMANDA GORMAN



Screening and testing



© 1988 MARLETTE—ATLANTA CONSTITUTION

'So this is how he knows if we've been bad or good! . . .'

Purpose of Screening/Testing

- *Testing should result in a **medical “good”**, not merely the capture and stigmatization of those with a disease. The good should pertain to the **mother and the fetus**.*
- *Physicians should advocate for universal screening only as strongly as they advocate for social support and addiction care services for those subsequently identified.*

Always ask yourself "what is the medical benefit of this test for my patient?"

Timing of Testing

- As early as possible in prenatal care
- Do not use it to “catch” people
- **Only send the test if the outcome will change your clinical management**



“Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests.”

Interpretation

- Misinterpretation is common
- Two separate studies evaluating physician interpretation of UDT
 - Only 30% answered more than half of the questions correctly



Accuracy of Three Screening Tools for Prenatal Substance Use

Victoria H. Coleman-Cowger, PhD, Emmanuel A. Oga, MD, MPH, Erica N. Peters, PhD, Kathleen E. Trocin, MPH, Bartosz Koszowski, PharmD, PhD, and Katrina Mark, MD

Table 3. Validity Indices for the 4P's Plus, NIDA Quick Screen, and SURP-P

	4 P's Plus	NIDA Quick Screen ASSIST	SURP-P
Sensitivity*	91.2 (85.7–95.1)	83.5 (76.8–89.0)	93.1 (88.0–96.5)
Specificity*	28.6 (23.7–33.9)	80.8 (76.0–85.0)	21.0 (16.7–25.9)
Positive predictive value*	39.0 (34.0–44.1)	68.4 (61.3–74.9)	37.0 (32.3–41.9)
Negative predictive value*	86.7 (78.6–92.5)	90.8 (86.8–93.9)	85.9 (76.2–92.7)
Sensitivity†	94.7 (88.5–97.4)	85.4 (76.4–89.5)	95.4 (90.7–98.4)
Specificity†	28.7 (23.8–33.6)	76.1 (71.4–80.6)	21.1 (17.3–26.1)
Positive predictive value†	32.6 (28.9–38.8)	56.4 (50.1–64.4)	30.6 (27.3–36.5)
Negative predictive value†	93.6 (85.7–96.7)	93.5 (88.8–95.2)	92.7 (84.8–97.3)
Sensitivity‡	90.2 (84.5–93.8)	79.7 (71.2–84.2)	92.4 (87.6–95.8)
Specificity‡	29.6 (24.4–35.2)	82.8 (78.1–87.1)	21.8 (17.4–27.2)
Positive predictive value‡	44.1 (39.7–50.0)	74.0 (67.8–80.4)	42.0 (38.0–47.9)
Negative predictive value‡	83.0 (73.4–88.9)	86.9 (81.3–89.7)	82.3 (72.1–90.0)

Data are % (95% CI).

* Reference standard: hair test results.

† Reference standard: urine test results.

‡ Reference standard: hair and urine test results combined; positive on either urine or hair sample testing.

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are confidential.
- A single "YES" to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
___ No ___ Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
___ No ___ Yes
3. Does your *Partner* have a problem with alcohol or drug use?
___ No ___ Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
___ No ___ Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
___ No ___ Yes

Unpacking the laws

- Federal Child Abuse Prevention and Treatment Act (CAPTA)
- Requires that substance exposed newborns receive a "Plan of Safe Care" (POSC)
- Family Law §5-704.2 (Maryland law)
 - Maryland's response to CAPTA and need for POSC
 - Defines substance exposed newborn and when to report to child welfare

<https://health.maryland.gov/bha>

SEN Definition

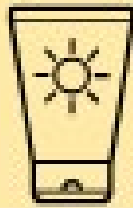
- Displays positive toxicology test for controlled substance as evidenced by an appropriate test after birth
- Displays effects of controlled substance use or symptoms of withdrawal resulting from the prenatal controlled substance exposure as determined by medical personnel
- Displays effects of FASD

Unpacking the laws

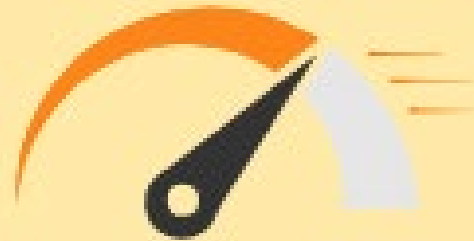
- The law gives guidance on who to report, but not who to test
- **THERE IS NO MANDATE TO TEST PREGNANT PEOPLE OR THEIR BABIES**

Harm Reduction

HARM REDUCTION



SUNSCREEN



SPEED LIMIT



BICYCLE HELMET



SEATBELT

Principles of Ethics



BENEFICENCE

Is this decision helping my patient?



NONMALEFICENCE

Does this decision have the possibility of harming my patient?



JUSTICE

Would I feel this way/make this decision if the patient were not pregnant?
...if this were a different chronic medical issue instead of substance use?
Am I holding other parents/caregivers to the same standard?

Principles of Ethics



AUTONOMY

Is this what the patient wants? Are they aware of all options?

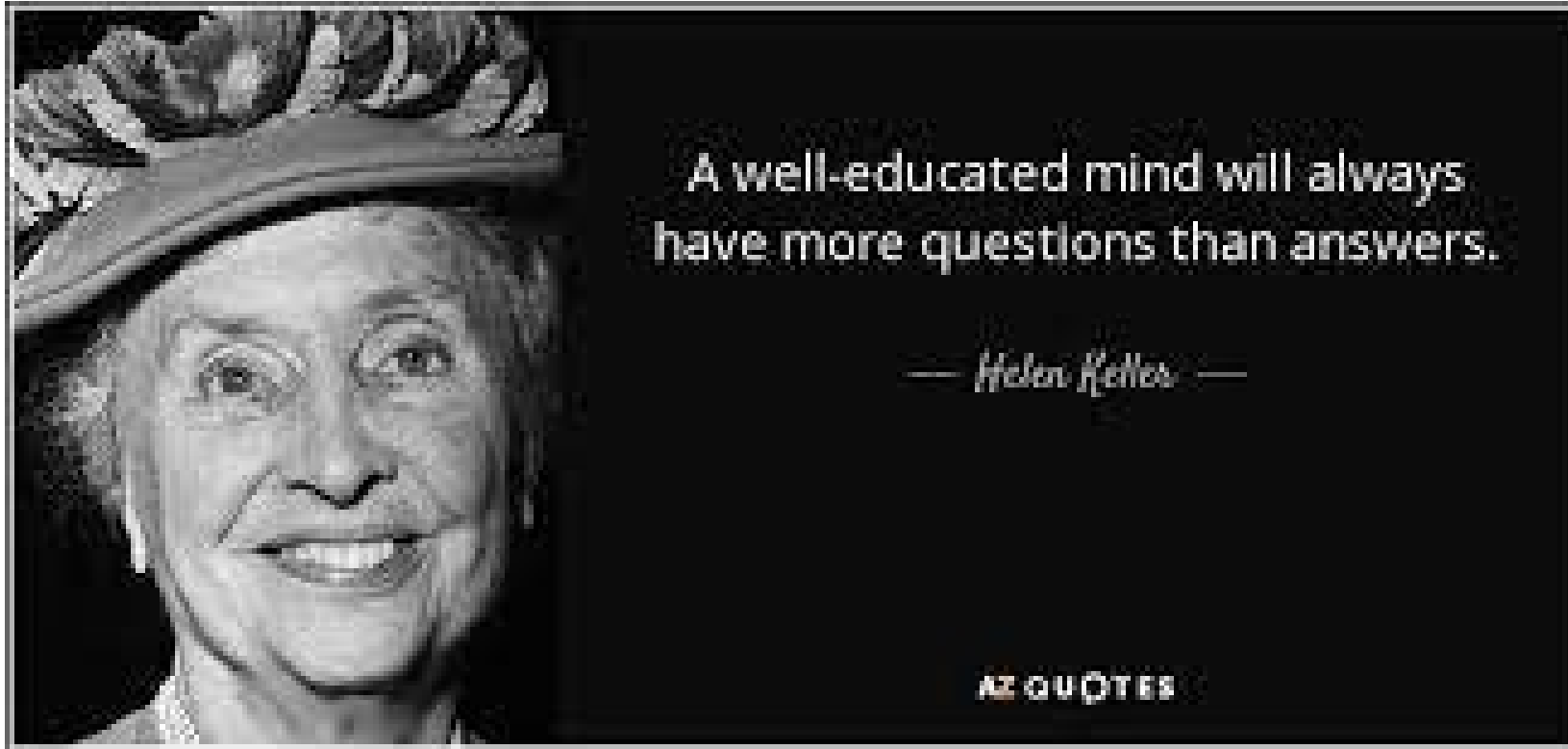
Reframing the concept of “noncompliance”

Ask yourself: *Is my responsibility to save or to serve?*





Be curious, not judgemental



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