Harm Reduction and Prenatal Care

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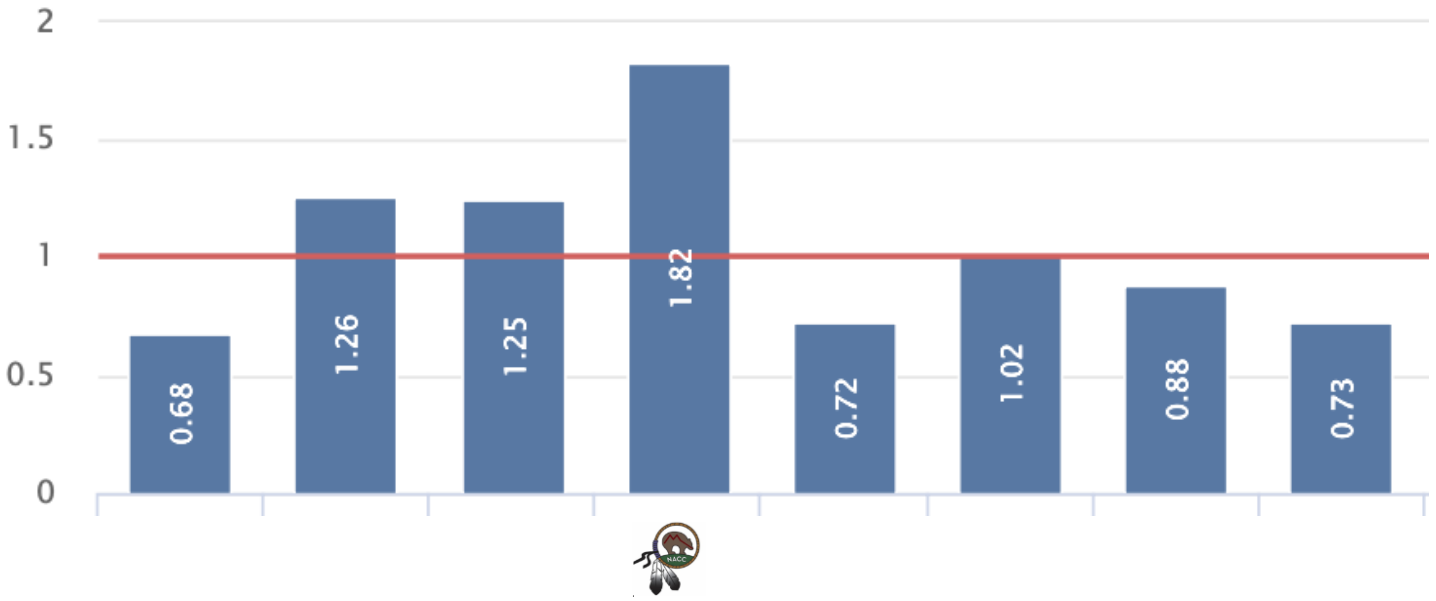
Objectives

- Identify the features of harm reduction in relation to pregnancy care
- Apply cultural humility and trauma informed care when giving care to pregnant women
- Formulate an approach for treating pregnant woman with SUD regardless of their readiness to be sober

Who are we?

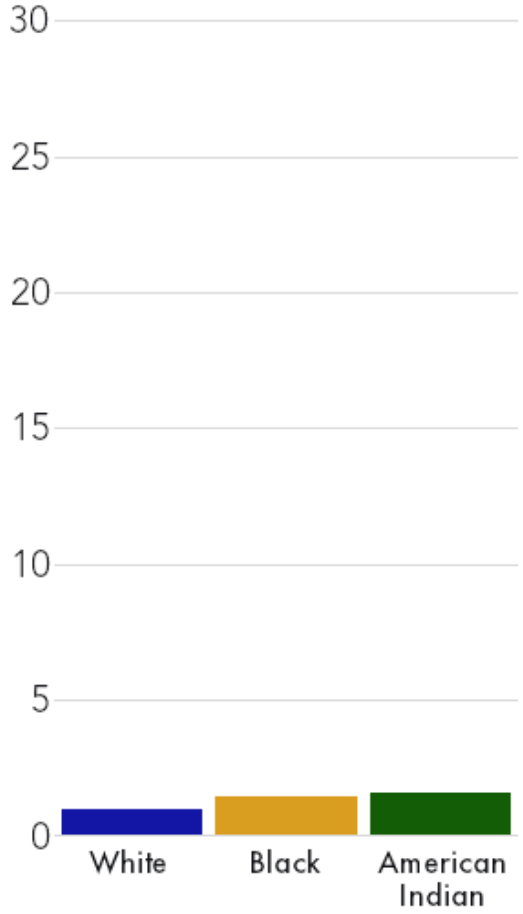
- Native American Community Clinic in Minneapolis
- Federally Qualified Health Center
- Integrated Primary medical care, behavioral health, chemical health and dental care
- 87% Native American

Where we were at?

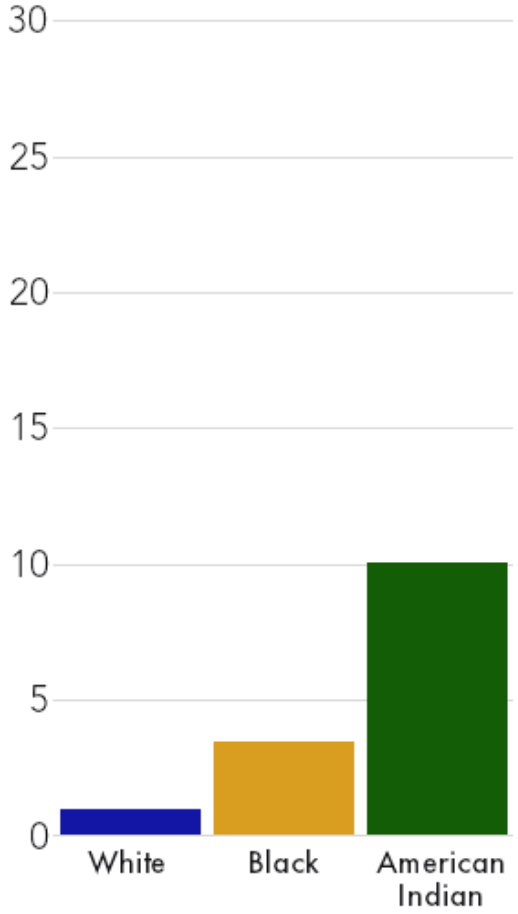


- High avoidable ED visits
- High Chemical Dependency and MH issues
- High health disparities
- High overdose rates
- Not connected to our whole community

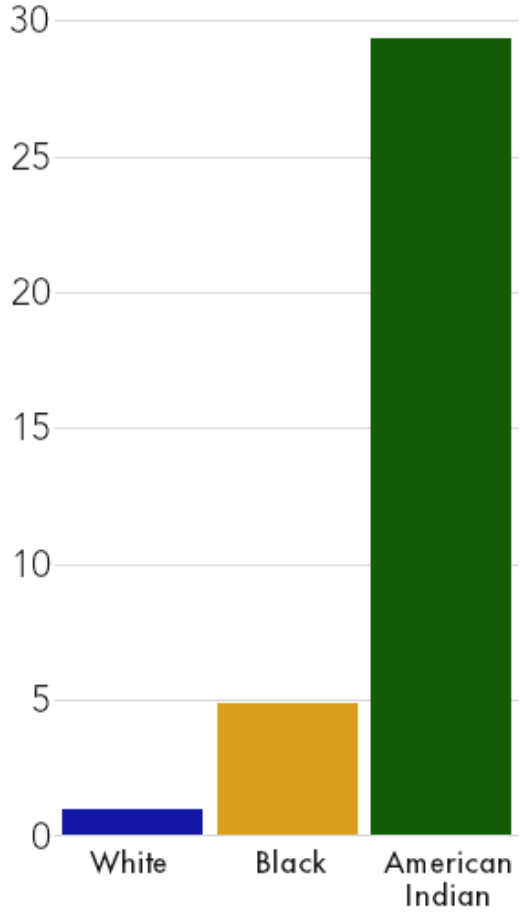
Race Disparities in Drug Overdose Mortality, 2021



United States
(all drugs OD)



Minnesota
(opioid OD)



Minneapolis
(opioid OD)

(per 100,000 residents). Minneapolis Health Department/John P. Moore

Racial disparities in Opioid Use

- Substance use and mortality disproportionately affects BIPOC people living in Minnesota, which subsequently affects BIPOC communities through the loss of a parent or a child
- Native Americans in MN are 7.8 times as likely to die during or within the year after their pregnancy.
- Native Americans in MN have an 8 fold increase in Neonatal Abstinence syndrome
- Native Americans and Black people in MN have 1.5 to two times the infant mortality rate as non-Hispanic whites.

First Do No Harm: Barriers to Prenatal Care

- Stigma and fear of punitive interventions are barriers to prenatal care and substance use disorder treatment (American College of Obstetrics and Gynecologists, 2011)
- Pregnant people often delay care or don’t receive care due to concerns for legal retribution including the loss of their children through CPS reporting
- Pregnant people don’t trust providers to treat them with respect
- Healthcare has been weaponized against people who use drugs, and more so against BIPOC communities
- General stigma that substance users are bad parents or can’t care for their children
- Internalized stigma and shame – wanting to “get clean” before seeking care

Risks are amplified during pregnancy

- Death risk from overdose is amplified by stigma, when people hide their substance use, they are more at risk
- Stigma prevents pregnant people from seeking prenatal care which amplifies the risks from infections (endocarditis, cellulitis and STI’s) and violence

Mandated reporting

- In July 2021 MN mandated reporting laws were changed
- Providers who are “providing or collaborating with other professionals to provide the woman with prenatal care, postpartum care, or other health care services, including of the women’s infant” are now exempt.*
- If people are lost to follow up, the professional is required to report

- *Section 260E.31 of Reporting of Prenatal Exposure to Controlled Substances.

What does this mean?

- The law makes it possible for CPS to meet the goal of keeping children safe while removing barriers to prenatal care
  - Patients can engage earlier with primary providers without the fear of mandated reporting
  - Patients are more likely to connect with MAT and other treatment options
  - Regardless of sobriety, prenatal care allows for healthier babies
  - Important to communicate to patients what to expect at delivery

Continued barriers

- Still a lot of fear and uncertainty for pregnant people who are using
- Variation in experience and competency of individual providers
- Not all providers have a harm reduction approach

From “Do No Harm” to Harm Reduction

- Harm reduction does not “allow” patients to use drugs
- Harm reduction allows patients to seek help without judgement or punitive responses.

Defining Harm Reduction

“harm reduction”: a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use.

Harm Reduction: a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

(National Harm Reduction Coalition, 2020)

Harm Reduction around us

- Harm Reduction is an accepted practice for risky behaviors
  - Helmets for motorcycles and bicycles
  - Sunscreen for outdoor activities
  - Nicotine replacement for smokers
  - Designated drivers when going out drinking

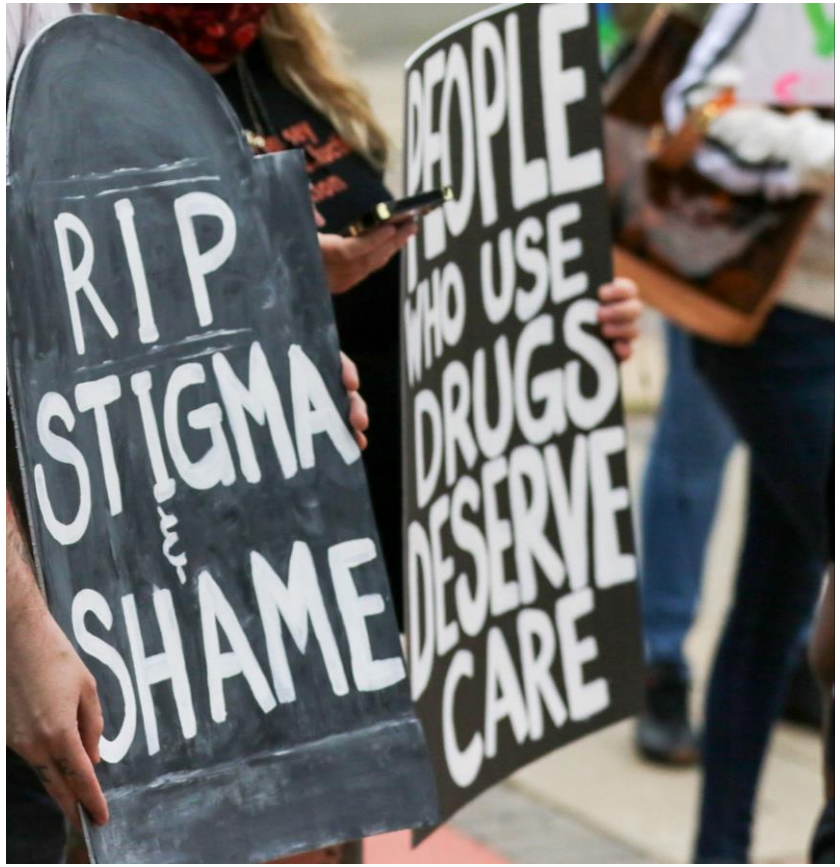
Language matters

- Person with Substance Use Disorder or SUD
- Person who uses/injects drugs (PWUD/PWID)
- Prenatal substance exposure
- Physiological dependence

- Value Neutral
- Focuses on effects NOT consequences

Stigma

"Stigma toward people who use drugs is written into our laws, child protective service and social service systems. Despite widespread acceptance that substance use is a health condition and not a character flaw, stigma against people who use drugs is still socially acceptable and commonplace."



NATIONAL
HARM REDUCTION
COALITION

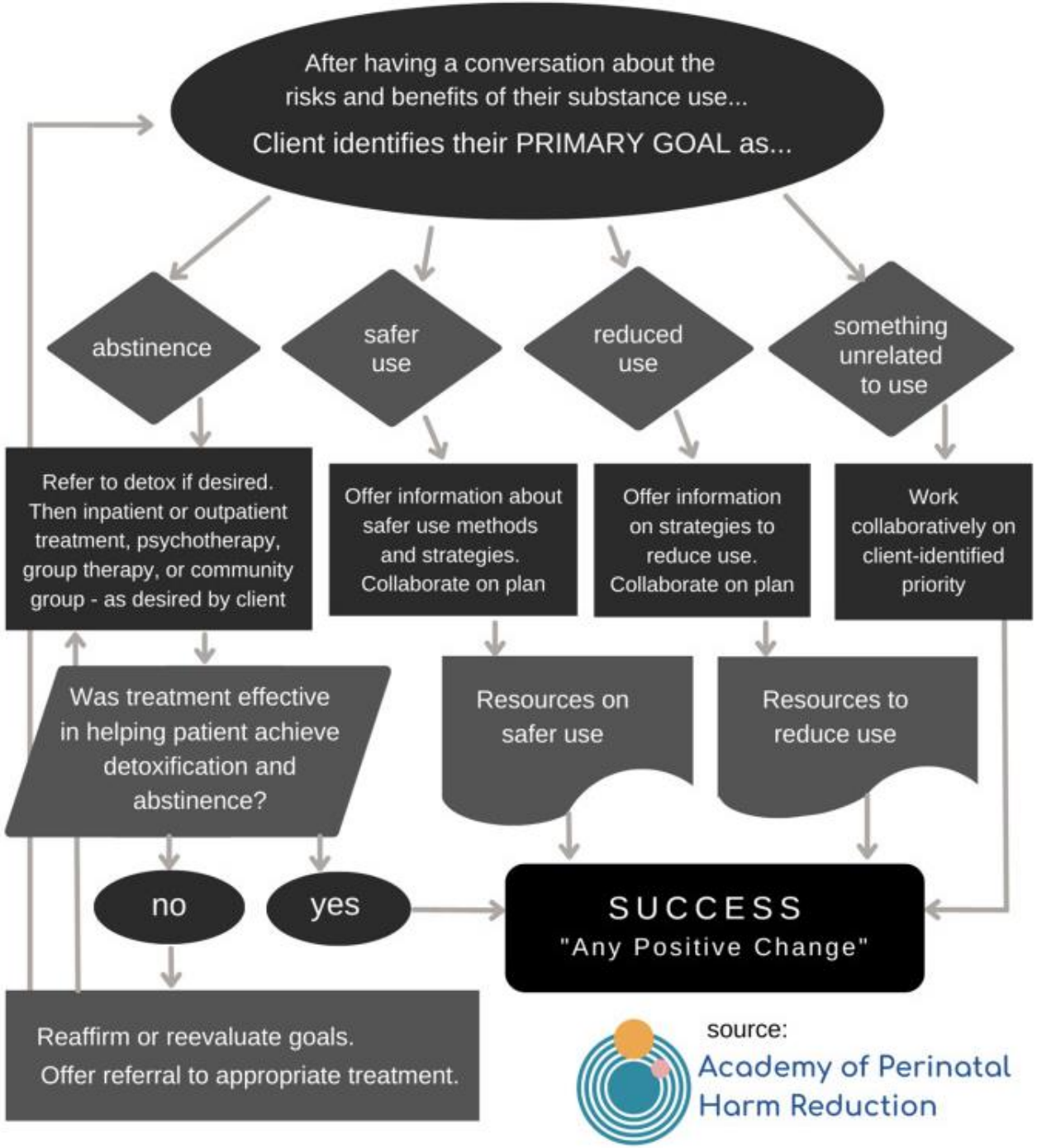
Harm Reduction for Drug Use

- Medications for Opioid Use Disorder MOUD– buprenorphine, methadone and naltrexone (helps to reduce use and cravings)
- Safer use services - Syringe services and smoking supplies (helps to reduce infections and transmissible disease)
- Naloxone education and distribution (helps to reduce overdose)
- Health care access for concerns related to substance use (abscesses, HIV/HCV screening, chemical dependency care coordination, including referrals to detox and treatment)

Meeting Patients Where They’re At

- Cultural humility – Recognize one’s world view and biases, and consciously deemphasizes them,; builds honest and trustworthy relationship;, and neutralize power imbalances; addresses systemic inequities
- Trauma informed care provides a safe, collaborative space that empowers patients to make choices regarding their own care.

Using Harm Reduction for for People Using Drugs



Harm Reduction and Pregnancy

- Only 20-25% of people are using are ready to stop
- Many people who become pregnant and are using were not expecting it
- Partner with patients in their goal to go home with baby
- Transparently talking about mandated reporting and CPS at the first meeting
- Offer support in navigating those concerns
- Get on the same side of the problem

- People using substances are often lost to follow-up at some point in their pregnancy
  - Ongoing attempts to reach them should be made
  - Accept that relapse is a part of the journey – celebrate incremental change
  - Keep the door open to reconnect

Urine toxicology

- Avoid routine testing, offer clear criteria for testing
  - Offer and explain any limitations/benefits
- Labor and Delivery (L&D) policies/mandated reporting
  - A positive urine toxicology during pregnancy often dictates a CPS assessment

Integrating harm reduction to engage care

- Trying to reduce stigma and provide support
  - Getting women in the door – creates connections
  - Address stigma and shame
  - No routine toxicology
  - Information on mandated reporting
    - Most women are not aware of the laws changing

CPS and Reporting

- Discuss mandated reporting at the first visit
  - Discuss when reports need to be made
  - Offer Project Child, social supports
    - If women are in treatment programs, have ongoing and consistent appointments with their medical team, are engaged with MAT by 32 weeks, it can support women who used through their pregnancy show stability

  If a report is made
  - CPS staff screen the reports
  - If there is no existing CPS case the report is filed
- Discuss how CPS might get involved when they intersect with the health system
  - Visits to other providers
  - Mothers are often tested at the time of delivery
  - Chemical use is a relevant part of the OB record
  - Realistically, CPS will screen them at delivery

Harm Reduction Services

- MAT (Medication Assisted Treatment) – medication first
  - Abstinence shows a lower success rate, talk them through the decision
- Syringe services (including “rigs”)
- Naloxone education and distribution
- Walk-in appointments for concerns related to substance use related (abscesses, HIV/HCV screening, chemical dependency care coordination, including referrals to detox and treatment)

Increased Blood Borne and Sexually Transmitted Infections

- Drug use is often associated with an increased risk of infection some of which is related to sharing needles or sex work
- Ensure patients have access to syringes, condoms, and other supplies
- Screen for infections monthly
    - Hepatitis C – baby needs to be tested at 6 and 18 months. Offer mother treatment after delivery
    - Syphilis –important to treat as soon as possible during pregnancy d/t risk of congenital syphilis
    - HIV –antiretrovirals prevent vertical transmission
    - Gonorrhea/Chlamydia/Trichomonas – may cause preterm delivery, test and treat
    - Herpes – important to take antivirals prior to vaginal delivery to prevent transmission

Talking to patients/assessing risks

- Review use history and assess and educate regarding safer use
- Have they tried buprenorphine before and how did it work for them
- How long do they expect to be on medication
    - Discuss stress and risks of baby's first years
- Knowledge and concerns about CPS and mandated reporting

Talking to patients/assessing risks

- Are people around them supportive or using, assess stigma
    - Especially partner
- Do they have housing, basic resources
- Assess for sexual trafficking/sex work
- Assess for infections
- Ask about safety
- Mental health

Medical Treatment options

- Opioid agonist pharmacotherapy
  - Methadone
  - Buprenorphine
- Alternatives
  - Naltrexone
  - Medication assisted withdrawal

Opioid agonist pharmacotherapy

- Prevents opioid withdrawal symptoms
- Decreases risk of overdose
- Decreases risk of infection
- Improves engagement in prenatal care
- Improves participation in treatment programs.
- Reduces risk of relapse
- Reduces risk of complications of opioid use in pregnancy
  - Growth restriction, infection, injury, overdose, preterm birth
- Neonatal abstinence syndrome is possible

Induction options for buprenorphine

- Standard: short or long
- Microinduction
- Macroinduction

- Counsel patient on potential danger of withdrawal to pregnancy
- Partner with hospital to offer opiate assisted induction
- Consider outpatient opiate assisted induction in specific circumstances

Considerations for Prenatal Care

- Medication first – ensure access to buprenorphine/methadone if interested
- Assess infectious disease risk (sex work/trafficking, ongoing use)
  - More frequent STI screening (monthly if ongoing use)
- Schedule 20 week ultrasound with perinatology
- Collaborate with perinatology on patients with ongoing use
  - growth scans every four weeks with weekly or twice weekly monitoring after 32 weeks.
  - Consider delivery at 37-39 weeks with ongoing use
- Consider a doula, or parental advocate
- Support them where they are
  - Housing and basic resources
  - Mental Health and Safety (Domestic Violence, Sex Work, Sex Trafficking)
  - Provide information on pregnancy care, include information on what to do if they don't seek care. care
  - Discuss things to look for in later trimesters

Considerations for Perinatal Care

- Evaluate and plan for withdrawal
- Plan for pain management, OB tour
- Continue buprenorphine or methadone as previously taken (may supplement)
- Pain management:
  - Continue MOUD, consider changing dosing
  - Early epidural
  - Increased pain medication if cesarean section (discuss triggers)
- Consider adequate staff education at Labor and Delivery
  - Trauma informed care, cultural humility, harm reduction
- Plan for Neonatal Abstinence Syndrome
  - Eat Sleep Console
  - Plan for baby to be under observation for 5 days at delivery

Considerations for Postpartum

- Make a relapse plan before delivery and at their post-partum visit
- Ensure naloxone is available
- Educate on safer use and parenting
  - Offer a lock box
  - Discuss never being alone with child while using
- Access to parent support groups

Considerations for Breastfeeding

- ACOG does not recommend discouraging breastfeeding solely based on suspected or confirmed SUD
- Recommended for parents on Suboxone and methadone
- Decreases severity of neonatal abstinence syndrome symptoms
- Transparent conversations about when it is not recommended
  - using illicit drugs,
  - HIV infection
  - Hepatitis C if bleeding nipples
- Advise women to suspend breastfeeding in the event of a relapse.
- Review hospital protocols

Outreach

- Outreach starts off as anonymous conversations with outreach staff/nurses about prenatal care
  - Offer resources, bags of supplies, including prenatal vitamins
- Discussing importance of prenatal care, discussing all of the options with women
  - Hospitals, clinics
- Discuss things to look for in especially in later trimesters
  - Kick counts, signs of labor, when to go to L&D

Peer Recovery Specialists

- Peer Recovery Specialists have some formal training but mostly rely on their own lived experiences with problematic substance use to connect with and support others
- Mutual, reciprocal relationship between two equals who share similar experiences.
- Lack of power dynamic makes it easier to build trust
- Provide linkage to resources
- Provide support and encouragement as patients work towards *their* goals

Peer Support Roles in Different Settings

- Clinic
- Hospital
- SUD treatment programs
- RCO's (Recovery Community Organizations)

PRS services billable to Medicaid through SUD treatment programs, RCO's, and counties.

Implementing Peer Services

Challenges:

- Peer role is much different than traditional clinical roles
- Background checks
- May visibly stand out from other staff in both appearance and behaviors

Examples of PRS support in Perinatal Care

Patient 1: Pregnant woman flown into hospital from ND very sick, endocarditis, late second trimester pregnancy

- Infant emergently delivered, PRS connected with patient while in ICU, baby in NICU.

Patient 2: NACC patient who uses fentanyl, unsheltered and pregnant.

Patient 3: Previous NACC patient, pregnant and wanting to stop using fentanyl. Collaborated with patient and primary doctor- plan was for patient to go to Fairview West Bank hospital for medically supervised suboxone initiation.

Peer led Harm Reduction Services at NACC

- Street Outreach
  - Meeting people where they are at, literally
- Weekly HIV Testing Events
- Harm Reduction Group
- Volunteer Hours

Resources

1. 1. Velander JR. Suboxone: Rationale, Science, Misconceptions. *Ochsner J*. 2018;18(1):23–29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855417/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4407806/citedby/
3. *Minnesota Department of Health*. Indicator Dashboards Opioid Dashboard. (n.d.). Retrieved January 19, 2022, from https://www.health.state.mn.us/opioiddashboard
4. Hawk, M., Coulter, R.W.S., Egan, J.E. *et al.* Harm reduction principles for healthcare settings. *Harm Reduct J* **14,** 70 (2017) doi:10.1186/s12954-017-0196-4
5. https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0196-4
6. Ho, Amy Faith, Move over Hippocrates: Harm reduction as the new paradigm for health care. Stat, May 30 2017.
7. https://www.statnews.com/2017/05/30/harm-reduction-health-care/
8. Nadelmann, E., LaSalle, L. Two steps forward, one step back: current harm reduction policy and politics in the United States. *Harm Reduct J* **14,** 37 (2017) doi:10.1186/s12954-017-0157-y https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0157-y
9. Elarabi HF, Radwan DN, Adem A, Marsden J, Lee AJ. Polysubstance Use in Adults With Opioid Use Disorder Receiving Buprenorphine Maintenance. J Addict Med. 2023 Jan-Feb 01;17(1):74-78. doi: 10.1097/ADM.0000000000001039. Epub 2022 Jul 8. PMID: 35793664.
10. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38
11. https://www.health.state.mn.us/docs/communities/titlev/amindian.pdf
12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10692246/
13. National Harm Reduction Coalition, 2020.
14. Puccio, Joelle. They will never forget how you made them feel, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10692246/#:~:text=Developed%20by%20the%20Academy%20of,therapeutic%20relationships%20with%20their%20patients.

Thank you!

Questions?