DISCLAIMER

- This session was conducted for members of county-based teams in CA that are working to expand access to Medications for Addiction Treatment in jails and drug courts. The project is funded through California's Department of Health Care Services (DHCS) with State Opioid Response funding from SAMHSA. The content is being made available to all interested parties. Please note this content has not been professionally edited and the session was conducted using Zoom.
- In the case of any security issues that may occur, this session will immediately end. A separate email will be sent to all participants with further instruction.
- Any data and information collected through polls and chats will only be used to inform future webinar/learning collaborative topics and to provide DHCS with evaluation results.

POSITION STATEMENT ON MAT MEDICATIONS AND BH INTERVENTIONS

- Medications for Addiction Treatment (MAT), using the 3 FDA-approved MAT medications, is an evidence-based practice proven effective for helping people stabilize and recover from opioid use disorder and for preventing death from opioid overdose[i]. These medications act to restore dopamine depleted in the brain from opioid misuse. Therapy, counseling, and support interventions are advisable in conjunction with MAT to support stability and recovery as well, though the lack of access to these interventions should not lead to delay or discontinuation of access to the MAT medications[ii]. For those with moderate to severe opioid use disorder in the early stages of MAT, low levels of dopamine in the brain mean that they may have difficulty attending to, and thus may not benefit from, cognitive-based interventions. Other evidence-based interventions such as Motivational Interviewing/Engagement or Seeking Safety may be most useful in engaging and responding to people in the early stages of treatment and recovery. A person-centered treatment planning approach that considers the timing – and type – of behavioral intervention(s) that meets the person where they are in terms of their ability to benefit from the treatment is key.

[i] https://www.samhsa.gov/medication-assisted-treatment
[ii] https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

DHCS
California Department of HealthCareServices

HMA

Addressing the Needs of Justice Involved Pregnant Persons with SUD

June 22nd, 2022

INTRODUCTIONS

WELCOME & INTRODUCTION – WHY WE ARE HERE

Deb Werner, MA, PMP
Senior Program Director, AHP
Coach, Subject Matter Expert

CHATTERFALL

How do you feel when you see a pregnant person smoking, drinking or using other substances?

- Wait to press enter

WHAT WE CAN DO

- Engagement, engagement, engagement
- Understand gender differences in substance use, treatment needs and recovery supports
- Create specialized protocols for pregnant persons including access to MOUD
- Build connections
- Fight the stigma

Knowledge is Power.

HMA PRESENTER

Helen DuPlessis, MD, MPH
Principal
Subject Matter Expert

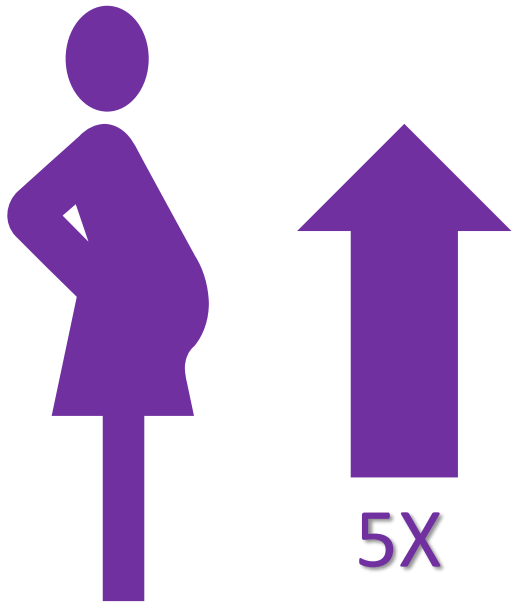
LEARNING OBJECTIVES

- Discuss the epidemiology of pregnant persons with SUD and in the criminal justice system
- Discuss the importance of Trauma Informed Care when working with the justice involved population
- Describe key considerations for use of the three primary, FDA-approved medications for addictions treatment for OUD
- Describe at least one long term and three short term effects of SUD on affected newborns

PREGNANCY IN THE CRIMINAL JUSTICE SYSTEM

Throughout this presentation, the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing people identify as mothers or women. We believe all birthing people are equally deserving of patient-centered care that helps them attain their full potential and live authentic, healthy lives

EPIDEMIOLOGY OF SUD DURING PREGNANCY

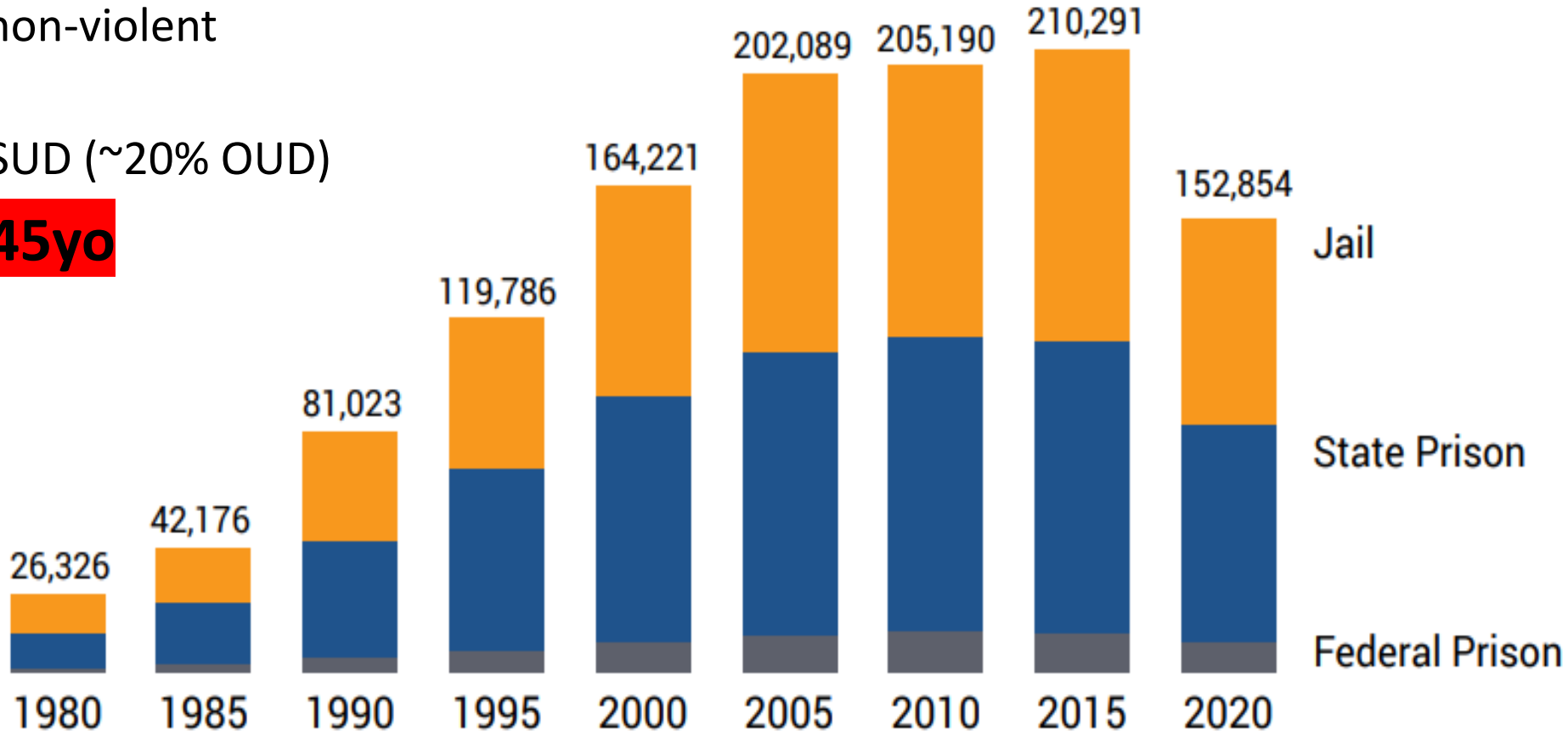


- SAMHSA data: Each year, > 400,000 infants are exposed to alcohol and other potential substance of abuse during pregnancy
- Number of pregnant women with OUD increased from 1.5/1000 → 8.2/1000 live births (1999-2017)
- Twenty-seven percent (27%) of pregnant women with SUD reported they wanted to cut down or stop using but didn't not know how
- Eight percent (8%) of women with OUD/SUD receive needed treatment (most are never screened)

Sources: SAMHSA and National Survey on Drug use and Health, 2019

WOMEN IN CARCERAL SETTINGS

- > 60% for non-violent crimes
- 72% have SUD (~20% OUD)
- 74% are **<45yo**



Sources: Bureau of Justice Statistics: *Historical Corrections Statistics in the United States, 1850-1984;* Prison and Jail Inmates at Midyear Series (1997-2020), Prisoners Series (1980-2020). Washington, DC.

PREGNANT WOMEN IN CARCERAL SETTINGS

- In a study done in 2016-2017, 4% were pregnant entering prison; 3% entering jail
- While the rate of pregnant women may be stable, the number of women incarcerated (pre-COVID) has increased
- Jails & prisons are required to provide healthcare
  - 8th amendment- prohibits cruel and unusual punishment
  - SAMHSA has standards for pregnant females with OUD
  - National Commission on Correctional Health Care (NCCHC) has standards for pregnant incarcerated women.

Nevertheless, individual jails and prisons often do not have adequate written policies on the care of these women, or reproductive wellness, in general

SOURCES: https://nida.nih.gov/publications/drugfacts/criminal-justice
Multiple sources from the Advocacy and Research on Reproductive Wellness of Incarcerated People. arrwip.org

WE CAN'T TREATE WHAT WE DON'T FIND: VALIDATED SCREENING TOOLS

+ Screen for pregnancy
+ Validated screening tools exist for specific populations including pregnant women
+ Screening for co-morbid conditions and suicide is also critical

General Population	Pregnant Women	Youth
+ National Institute for Drug Addiction (NIDA) – Quick Screen + Tobacco, Alcohol, Prescription, and other Substances (TAPS) + AUDIT (Alcohol only) + *Patient History Questionnaire (PHQ-9)* + *General Anxiety Disorder (GAD-7)* + *PTSD Checklist (PCL-5)* + *Columbia Suicide Severity Rating Scale (C-CCRS)*	+ NIDA – Quick Screen + 4 P's plus (license fee) + Substance Use Risk Profile – Pregnancy (SURP) + CRAFFT – for 12 -26 yo women (Car, Relax, Alone, Forget, Friend/Family, Trouble) + *Perinatal Mood and Anxiety Disorder (PMAD) – Edinburgh, PHQ-9*	+ Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) (12-17yo) + Screening to Brief Intervention (S2BI) (12-17yo) + Problem oriented screening instrument for Teens (POSIT) + CRAFFT + *PHQ-9-adapted, Center for Epidemiologic Studies Depression Scale (CESDS)*

OPPORTUNITIES TO SUPPORT WOMEN WITH SUD IN CJ SYSTEM

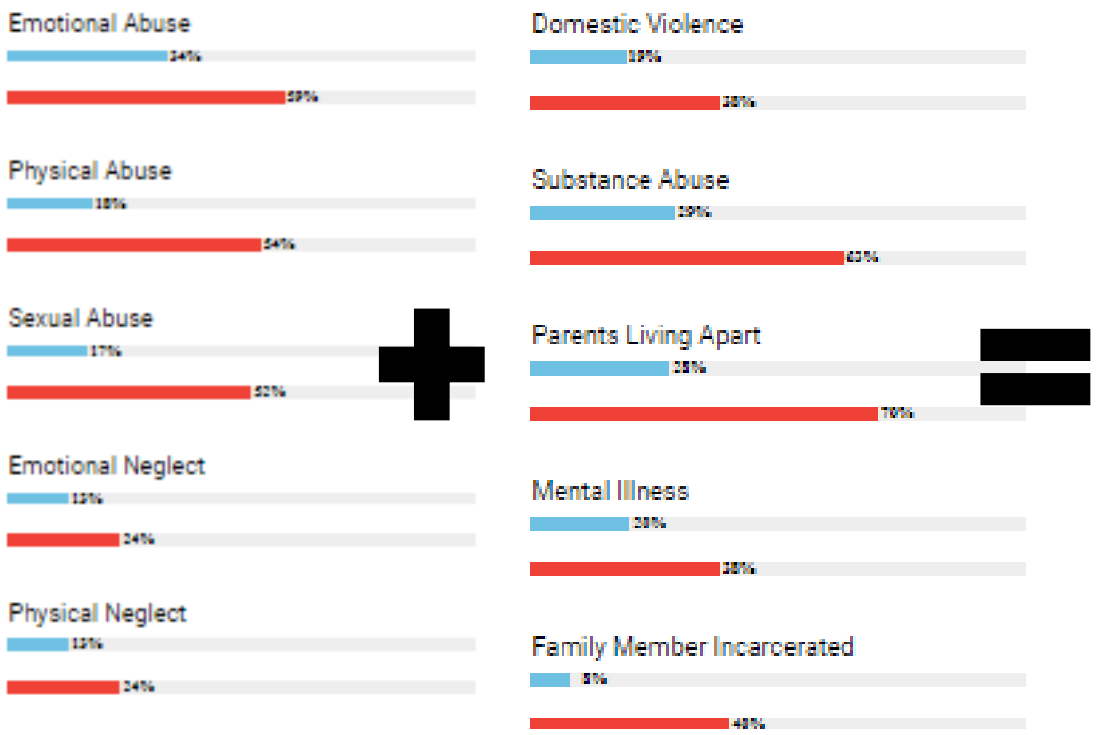
- Is she pregnant or not pregnant?
- What are her plans for the pregnancy?
  - Continuation of pregnancy? Yes, no and appropriate referrals
- Does the patient have SUD/OUD?
- Does the patient want treatment?
  - Starting treatment while someone is incarcerated results in better outcome than referral to treatment post-release
  - Continuing patients on treatment compared to withdrawing them results in better outcomes
- Basic health and wellness-sleep, nutrition, vitamins, reduced stress
- Access to healthcare for testing, perinatal care, and SUD care is critical
- Access to consultation with social work
  - There are often special programs available for pregnant women

Sources: Sufrin, et al. OUD incidence & treatment among incarcerated pregnant women in the US. Addiction: 115(11), 2057-65; Sheriff's Association & National Commission on Correctional Health Care. (2018) Jail-Based Medication Assisted Treatment: Promising Practice Guidelines and Resources For the Field. Clinical Guidance for treating pregnant & parenting women with OUD & their infants https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf. Kinlock, TW et al. A randomized controlled trial of methadone maintenance for prisoners: results at twelve-months post release. J Substance Abuse Treatment 2009; 37(3): 277-85. Rich J, et al. Methadone continuation versus force withdrawal on incarceration in a combined US prison and jail: a randomized open label trial. Lancet. 2015; 386: 350-359;

GENDER RESPONSIVE TRAUMA INFORMED CARE

Comparison of ACEs Categories among Women

General Population vs. **Incarcerated Population**



- Assume early trauma
- Women under correctional supervision are more likely to have experienced physical and sexual abuse than their male counterparts
- High rates of trauma in female clients with OUD
- While men outnumber women in the criminal justice system, this is changing, with the proportion of women in the system growing

Source: Messina and Burdon 2020, BRFSS data 2011-2014

Source: https://cjinvolvedwomen.org/wp-content/uploads/2016/06/Fact-Sheet.pdf

TRAUMA INFORMED CARE FOR INCARCERATED PREGNANT WOMEN

- It is important to recognize that many aspects of incarceration are not trauma informed, especially for pregnant women
  - Confinement
  - Stigma/negative judgement from custodial and other staff
  - Lack of privacy
  - Lack of choice on health care provider
  - Use of restraints on women
  - Loss of newborn to family or foster care

Maximize respect, dignity and choice when ever possible.

MEDICATION ASSISTED TREATMENT

TIME FOR A POLL…

POLL QUESTION

Which of the following statements is most accurate about MAT for pregnant persons?

A. Those on MAT prior to pregnancy should be titrated down to 4-8 mg/during pregnancy
B. Those on methadone or buprenorphine often require increased dosage and sometimes split dosing as the pregnancy progresses
C. After c-section they can usually be managed with slight increases in dosage of their MAT medication
D. Mothers on MOUD should never breast feed their infants
E. They should ideally be medically detoxed completely off MAT

MOUD DURING PREGNANCY

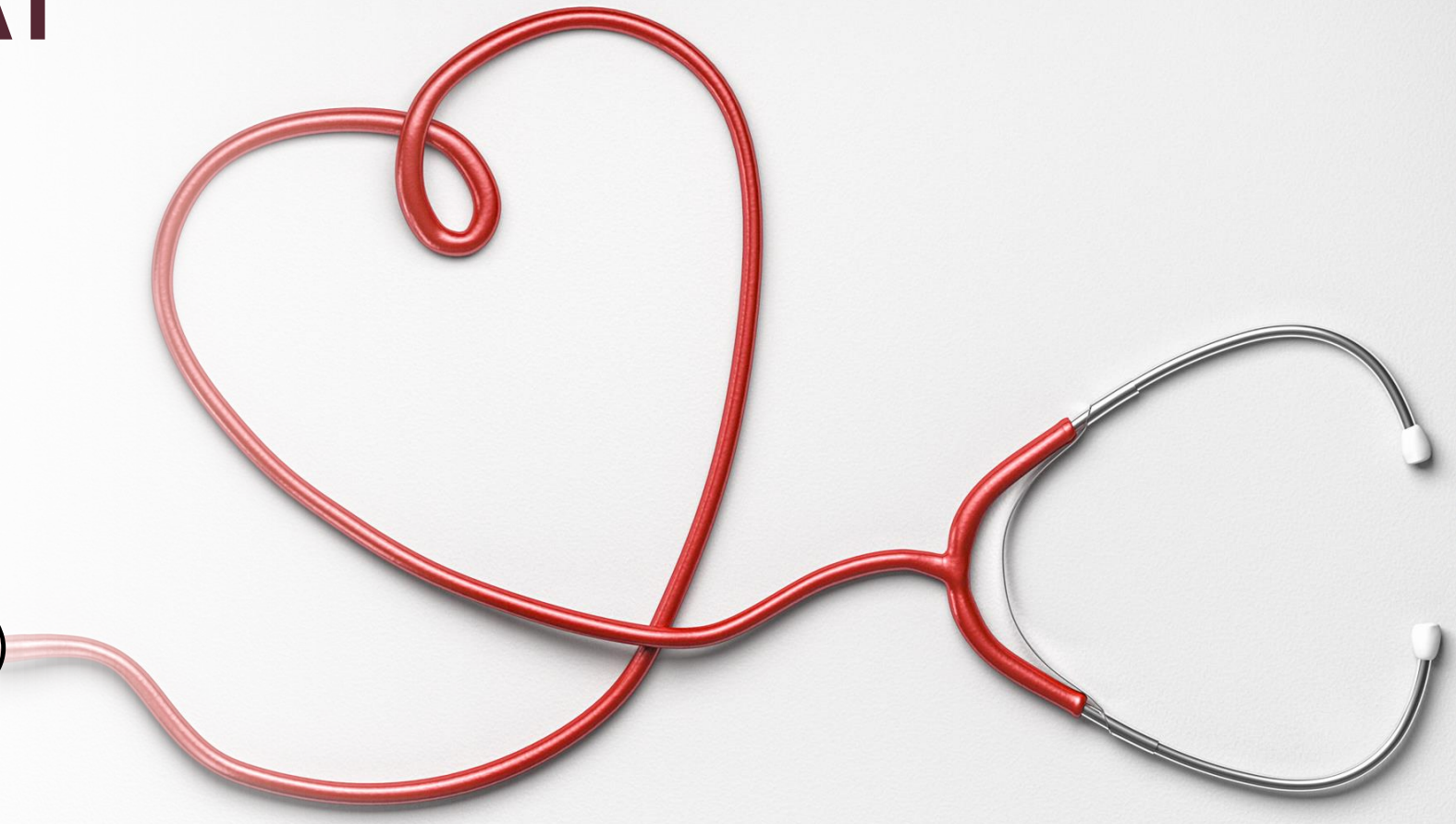
- Detoxification during pregnancy results in higher risk of relapse (59-90%), overdose, death
- Methadone and Buprenorphine are the standard of care
  - Safe for use during pregnancy
  - MAT tapering during pregnancy or immediate post-partum period is contraindicated
  - Doses may need to be adjusted upward during pregnancy
- MOUD is not replacement therapy
  - For persons with OUD it treats the dysregulation that defines OUD as a chronic disease
  - Pain management in the peripartum period for women with OUD or on MOUD should be coordinated with the medical team

MAT	OD Deaths	Retention in Treatment	Pregnancy Outcomes	NAS
Detox/ Withdrawal				
Methadone				
Buprenorphine (Mono)				
Buprenorphine /Naloxone				
Naltrexone				

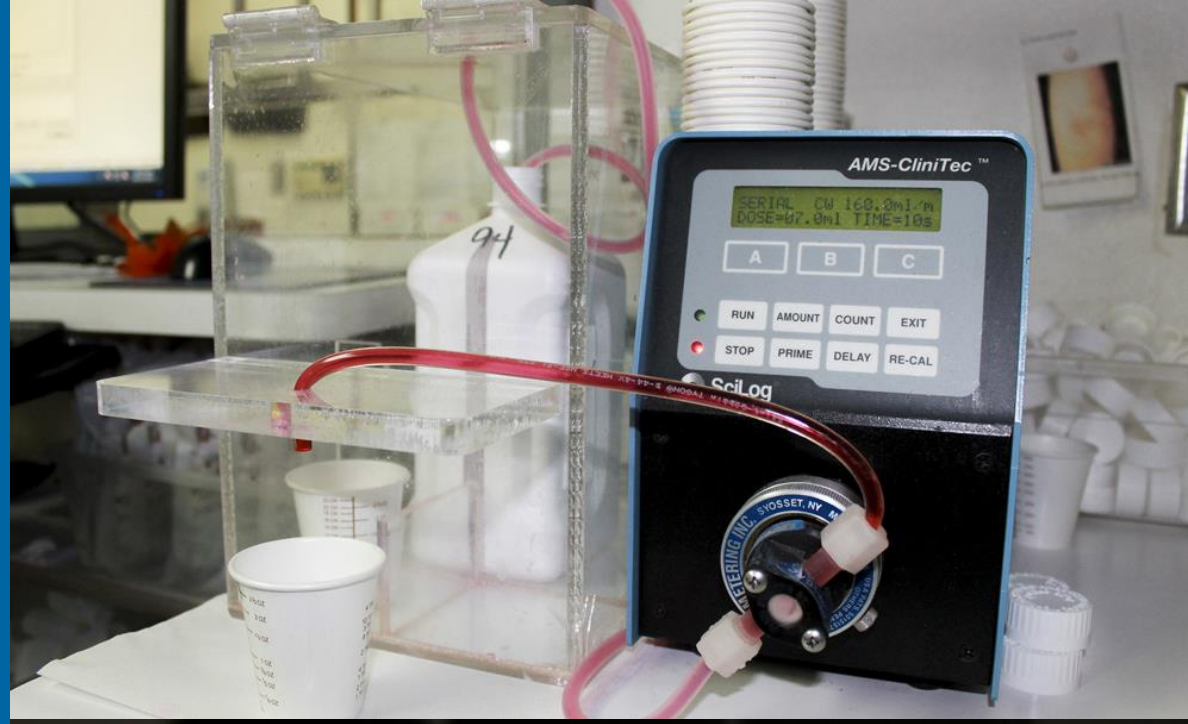
	Research indicates use is contraindicated and/or that risks of poor outcome outweigh benefits of use
	Research is insufficient to conclude that benefits outweigh risks or that benefits exceed those of other MATs
	Research indicates that benefits do outweigh risks or that benefits do exceed those of other MATs

BENEFITS OF MAT

- Reduced cravings
- Reduces illicit opioid use
- Reduced poor pregnancy outcomes (compared to use)
- Reduced overdose (pre- and post-partum)
- Reduces HIV & hepatitis risk behaviors (i.e., injection drug use)
- Reduces criminal behavior
- Increased treatment retention
- Safer and healthier communities



METHADONE



Source Methadone Dispenser: Tucson Sentinek.com, Jan. 20, 2015
Source Methadone Bottles: Shutterstock - 11.30.2018 : Six Methadone Bottles from mmtp clinic. by NYCstringer

METHADONE: WHAT AND FOR WHOM?

- Mu agonist without a "ceiling effect"
- Reaching a **therapeutic dose** takes time
  - <60 mg/d is not therapeutic
  - Typical dose 60-120 mg/d (if not pregnant)
  - **Increased frequency and daily dose** required during pregnancy
- Several significant drug-drug interactions
- Illegal to write prescription for methadone to treat OUD unless:
  - Covering a gap in treatment - 3 days are allowed
- Despite having the best outcomes, it has the highest level of **stigma**
- Difficult to get patients off after a few years of treatment

Patients with greater than a year of an OUD

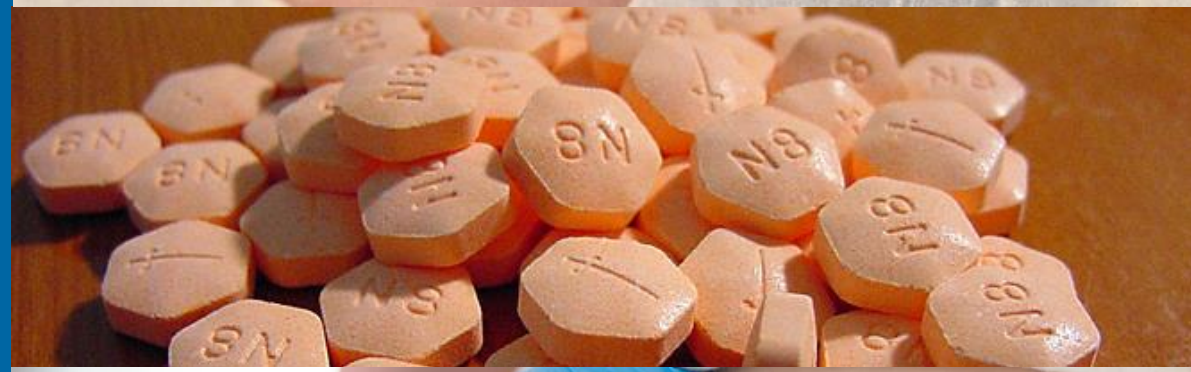
Patients who have been injecting opioids

Patients who have failed other MAT for OUD

Patients with a more severe OUD

Patients who have **transportation**

BUPRENORPHINE



Source Patch: https://nationaladdictionnews.files.wordpress.com/2017/02/suboxone-pic.jpg
Source Implant: Daily Hampshire Gazette, Oct. 17, 2017
Source Pills: Adam Fedorko, 2006 Erowid.org
Source Injection: Hope by the Sea, Dec. 5, 2017

BUPRENORPHINE: WHAT AND FOR WHOM?

- Partial Mu agonist with ceiling effect
  - Available alone or in combination w/naloxone
  - Doses >32 mg don't cause greater effect
  - Different formulations (SL and buccal pill/film, implant, injectable)
- Greater binding affinity than full agonists
  - Start buprenorphine when client in mild-moderate withdrawal (to avoid causing precipitated withdrawal)
  - Other opioids are not as effective when buprenorphine is present
- Many ways to do induction (protocols needed)
  - <8 mg/d is not therapeutic
  - **Typical does is 8-16 mg/d**
  - **Increased frequency and daily dose** required during pregnancy
- Fewer drug-drug interactions than methadone

Positive DSM 5 with a score of 2 or greater

Positive DAST (6 or greater) for opioids

Failed other forms of MAT

Can afford the medication

BUPRENORPHINE: GENERAL REGULATIONS

Approved in the 1981 for pain via an injectable form (XR - NOT FOR PREGNANT WOMEN)

Approved in 2002 for use in maintenance treatment for OUD

DEA X-Waiver updates: Federal Register 4/28/21

- To prescribe buprenorphine for OUD to ≤30 patients (at one time)
  - Requires only Notice of Intent to SAMHSA→ approves & notifies DEA
  - DEA issues X-waiver
  - Attestation of Training NOT required
- To prescribe to ≥30 (at one time)
  - Complete 8 hr (MD) or 24 hr (NP/PAs…) training
  - Apply, get approval for & receive X-waiver
  - Provide or refer for counseling & ancillary services

NALTREXONE

Source Packaging and Materials: The Fix, May 5, 2013
Source Bottle: James Leynse/Getty Images

NALTREXONE: WHAT AND FOR WHOM?

- Mu opioid antagonist with high, competitive binding affinity
- Does not treat withdrawal or underlying dopamine depletion
- Must be **opioid free x7 days before starting**
- **More widespread acceptance in criminal justice** and "abstinence-only" communities
- **Insufficient evidence to recommend during pregnancy at present**

Patients with a high degree of motivation (dopamine)

Patients with a history of OUD and AUD

Patients who had poor results with methadone or buprenorphine

Can be useful for occasional use or after discontinuation of methadone or buprenorphine

NALOXONE

❶ Pull the auto-injector from the outer case

❷ Pull firmly to remove the red safety guard (do not touch the black base)

Source Nasal Spray: AP Photo/Matt Rourke
Source Instructions: Public Source

NALOXONE OVERVIEW: OVERDOSE REVERSAL AGENT AS HARM REDUCTION

- Mu opioid antagonist used for opioid OD reversal
- Shorter half-life & more rapid onset of action than naltrexone
- High affinity, competitive binding & displaces full agonists
- Intranasal or intramuscular by bystander
- May require more than one dose
  - Opioids have longer half-life than naloxone
  - Fentanyl contamination may require higher dose for reversal
- CA Assembly Bill 2760- Naloxone prescribing
  - >90mg Morphine Milliequivalents
  - Opioids + benzodiazepines
  - Increased risk of OD: History of OD or SUD
- Available with prescription and through Naloxone Distribution Program

MAT DURING INTRAPARTUM PERIOD

- Maintenance opioid agonist + additional pain relief
  - Epidural or spinal anesthesia
  - Patients on MAT will require higher doses of analgesia, due to tolerance
  - Opioid agonist-antagonist should be avoided due to causing precipitated withdrawal

MAT ≠ analgesia

- 72hour rule
  - Despite Methadone for OUD require a special facility license
  - Despite Buprenorphine for OUD requiring special training and DEA license
  - Both can be given in a hospital without a special facility license or DEA license

Mascola, MA, et al. ACOG Committee Opinion 711. 2017.

MAT DURING POSTPARTUM PERIOD

- Post delivery, do NOT adjust dose immediately back to pre-pregnancy dose
- Titrate to signs and symptoms of sedation, particularly at peak dose (2h)
- Consider 3-4 times per day dosing to support pain control
- **MAT + additional pain treatment**
- Patients on MAT will require higher doses of analgesia, due to tolerance
  - Vaginal
    - Evidenced-base says women do not require opioids for normal vaginal delivery; acetaminophen and NSAIDs
  - C-section
    - Evidence-base says short course of opioids for women who are not on MAT
  - Injectable NSAIDs

Mascola, MA, et al. ACOG Committee Opinion 711. 2017.

POTENTIAL LONG AND SHORT-TERM EFFECTS OF PERINATAL OUD

CONSEQUENCES OF PERINATAL SUD

	Preterm Labor	Low Birthweight	Fetal demise	Cognitive or Developmental Effects	Other
Nicotine (tobacco)	X	X	X		Birth defects
Alcohol	X	X		X	Fetal Alcohol Spectrum Disorders (FASD)
Cannabis		X	X	X*	Mood/ behavioral disorders
Opioids	X	X		X*	Abruption, Neonatal Abstinence Syndrome (NAS)

SOURCE: See Perinatal Outcome References at end of this presentation

* For discussion today

Alcohol use during pregnancy can lead to lifelong effects.

Up to 1 in 20 US school children may have FASDs.

People with FASDs can experience a mix of the following problems:

Physical issues

- low birth weight and growth
- problems with heart, kidneys, and other organs
- damage to parts of the brain

Which leads to...

Behavioral and intellectual disabilities

- learning disabilities and low IQ
- hyperactivity
- difficulty with attention
- poor ability to communicate in social situations
- poor reasoning and judgment skills

These can lead to...

Lifelong issues with

- school and social skills
- living independently
- mental health
- substance use
- keeping a job
- trouble with the law

Drinking while pregnant costs the US $5.5 billion (2010).

SOURCES: CDC Vital Signs, February 2016. American Journal of Preventive Medicine, November 2015

FETAL ALCOHOL SPECTRUM DISORDER

- Fetal Alcohol Spectrum Disorder (FASD) encompasses a broad and complex range of neurobehavioral and physical effects
  - Fetal Alcohol Syndrome (FAS) and Partial Fetal Alcohol Syndrome (pFAS) – include presence of distinct facial and other physical dysmorphology (e.g., growth and brain anomalies)
- FASD in the absence of physical features
  - Alcohol-related Neurodevelopmental Disorder (ARND) – confirmed prenatal alcohol exposure plus neurobehavioral impairment
  - Alcohol-related Birth Defects (ARBD) – confirmed prenatal alcohol exposure plus ≥ 1 physical anomaly
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) – used with or without diagnosis of FAS and must include more than minimal prenatal alcohol exposure plus impaired:
  - Neurocognitive function
  - Self-regulation
  - Adaptive function - ≥2 impairments

LONG TERM EFFECTS OF OPIOIDS: A SUMMARY

Encourage critical appraisal of the literature

Four Developmental Domains

- Psychomotor development – best studies show no difference @18 and 36 mos (methadone vs. control)
- Cognitive and achievement
  - "Trends" but no significant difference in memory and cognition (2014 meta-analysis)
  - Australian (2017) and European studies (2015) demonstrate significant difference in IQ, academic performance to 8th grade or 8 years, respectively
- Language – no good data
- Socio-emotional - recent study demonstrates ↑risk of anxiety, emotional disturbance, autism; ADHD, conduct or adjustment disorder

Picture from Admin of Children and Families.

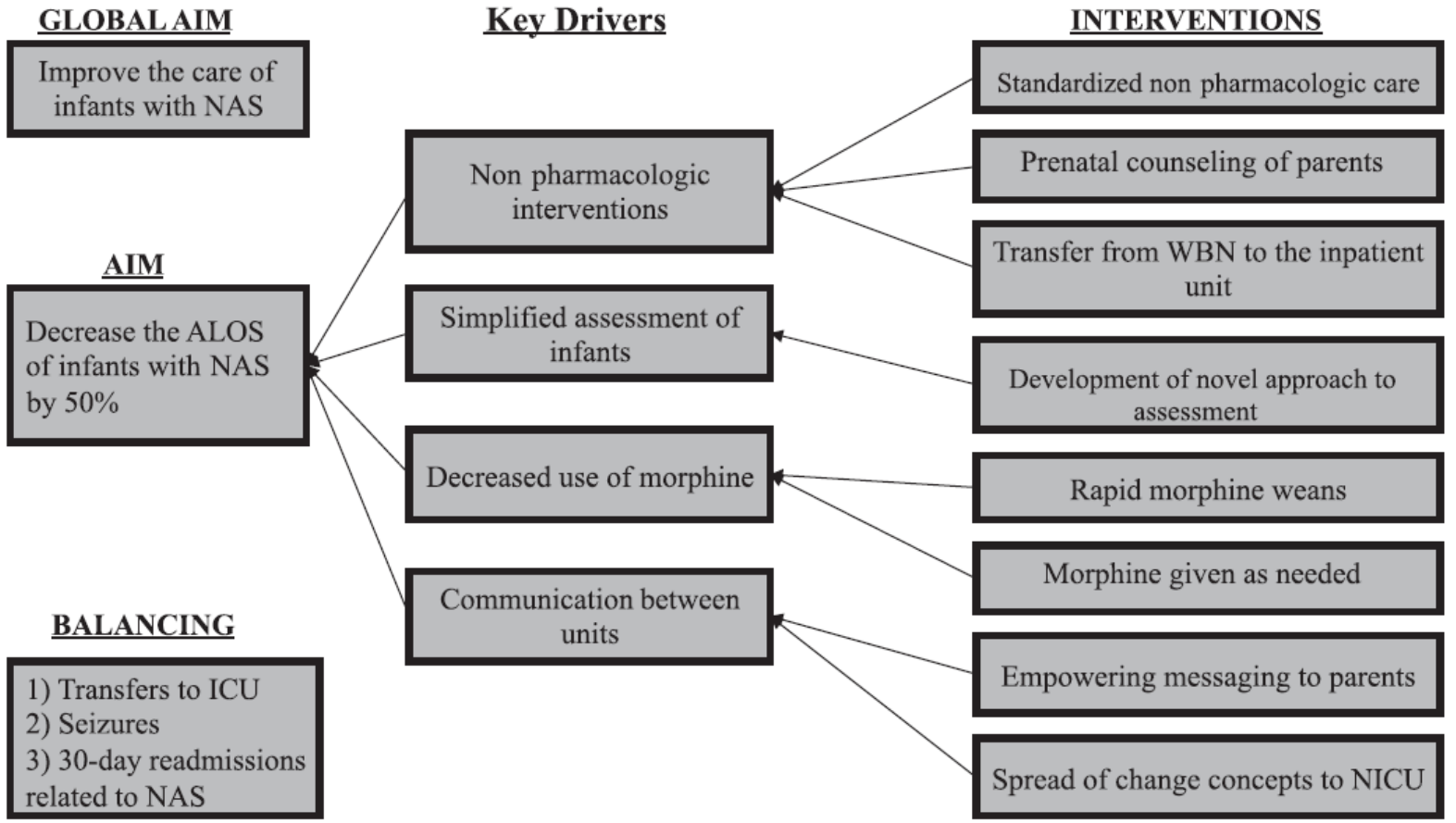
SHORT TERM EFFECTS OF OPIOID EXPOSURE:
THE SUMMARY

Picture from Bella Vista Health Center

- No effect on human fetal development or brain growth
- ↑Risk of preterm births, lower birthweight*: no long-term effect on growth
- NAS/Neonatal Withdrawal Syndrome (NWS) in 50-80% of exposed infants – dependence NOT addiction

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

Eat: ≥ 1 oz or full BF session
Sleep: ≥ 1 hour between feeds
Console: Cease crying within 10 min. of being consoled



Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

BREASTFEEDING AND PERINATAL SUD

HEALTH MANAGEMENT ASSOCIATES

DHCS

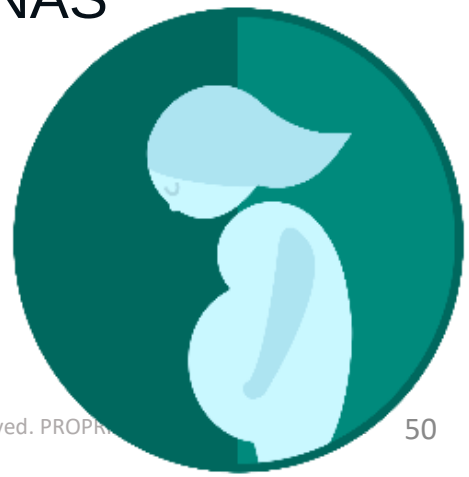
BENEFITS OF BREASTFEEDING: Mom's Second Greatest Gift

GENERAL BENEFITS

- Reduced respiratory infections and otitis media
- Reduced gastrointestinal infections
- Lowered risk of sudden infant death syndrome
- Protection against allergic disease
- Reduced risk of Celiac disease, inflammatory bowel disease
- Lower incidence of obesity, diabetes (types 1 and 2)
- Better neurodevelopmental outcomes

BENEFITS TO WOMEN AND IN PERINATAL SUD

- Reduced risk of breast and ovarian cancer
- Improved maternal-infant bonding
- Reduced risk of child abuse
- Breastfed infants less likely to require pharmacological intervention for NAS
- Reduced symptoms of NAS
- Shorter length of stay for NAS
- Shorter duration of pharmacologic treatment when needed for NAS



FACTORS RELEVANT TO BREASTFEEDING DECISIONS: SHARED MEDICAL DECISION-MAKING

Relevant Factors	Specific Conditions	
Medical Contraindications	**Mother** • Certain communicable diseases* • Some psychotropic medications	**Infant** • Genetic conditions affecting metabolism • Mechanical (e.g., neurologic, severe cleft lip and palate)
Maternal conditions: Expressed milk only (avoid close contact)	• *Communicable diseases spread through close contact (respiratory)	
Maternal Conditions: Pump and Dump	• *Communicable diseases spread through bloodborne contact	
Special situations: Tailored recommendations	• Women with SUD, NOT stable in treatment • Heavy alcohol consumption or AUD • Cannabis use (controversial)	

MAT is NOT a contraindication to breastfeeding

Women don't want to hurt their babies

SUPPORTIVE STRATEGIES FOR BREASTFEEDING FOR PERSONS WITH OUD/SUD

- Formulate prenatal care plan that addresses breastfeeding on MAT
- Education and training for PROFESSIONALS on breastfeeding
- Stigma abatement
  - Recognize biases among staff
  - Model and train
- Establish rational policies and procedures as a guide

- Communication and "informed consent"
  - Mothers should know contraindications and relative contraindications
  - Considerations for breastfeeding while on other psychotropic medications
  - Relapse and risky behaviors
- Trauma informed approaches

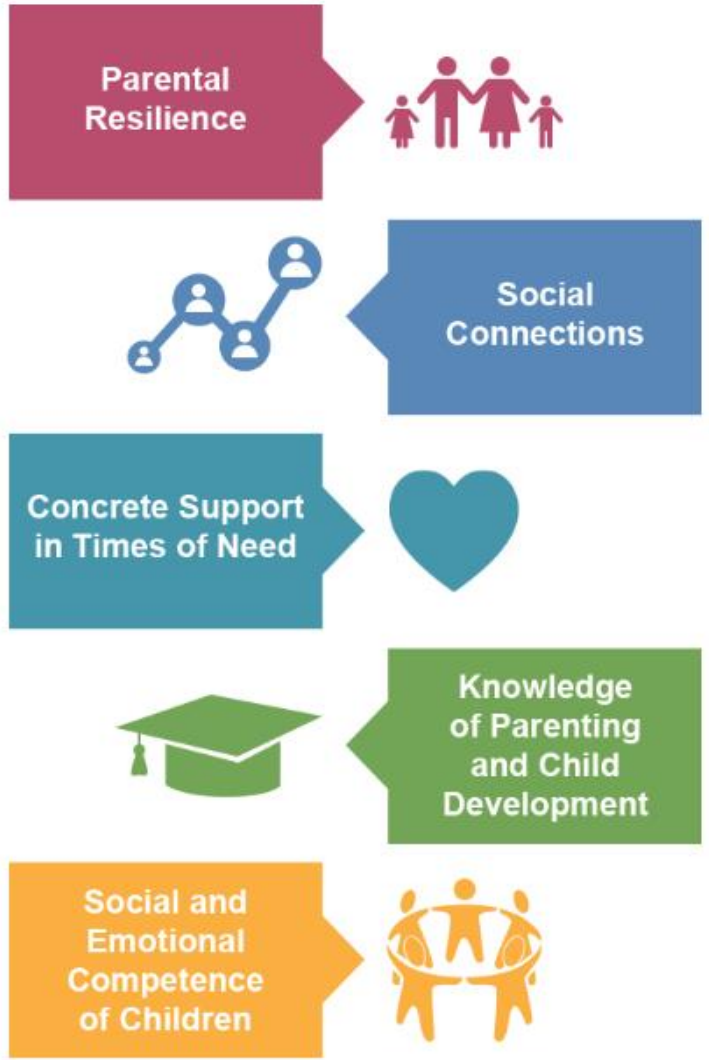
"Maternal substance abuse is not a categorical contraindication to breastfeeding. Adequately nourished narcotic dependent mothers … stable methadone or buprenorphine maintained women should be encouraged to breastfeed"… as long as there is no other contraindication to breastfeeding.

American Academy of Pediatrics & Academy of Breastfeeding Medicine

TRANSITION AND POST-DISCHARGE CARE: PLAN OF SAFE CARE

The ideal POSC addresses mom's and baby's needs, is multidisciplinary, shared and reinforced

- Find or build stable, experienced recovery program opportunities for pregnant persons
  - Address and support basic parenting and personal growth
  - Use trauma informed approaches
  - Provide skills development to address stigma and build confidence
- Ensure health services for post-partum persons
  - Postpartum and intrapartum care
  - Ongoing MOUD
  - Behavioral health services
- Medical and neuro-developmental monitoring for Baby
  - Monitoring for additional symptoms
  - Basic health care supervision for infants
  - Services and Supports for Baby and Family (IDEA, HRIF, etc.)
- Home Visiting and other supports →Protective Factors for Parenting



Picture from Children's Home Society, Concept from Center for the Study of Social Policy.

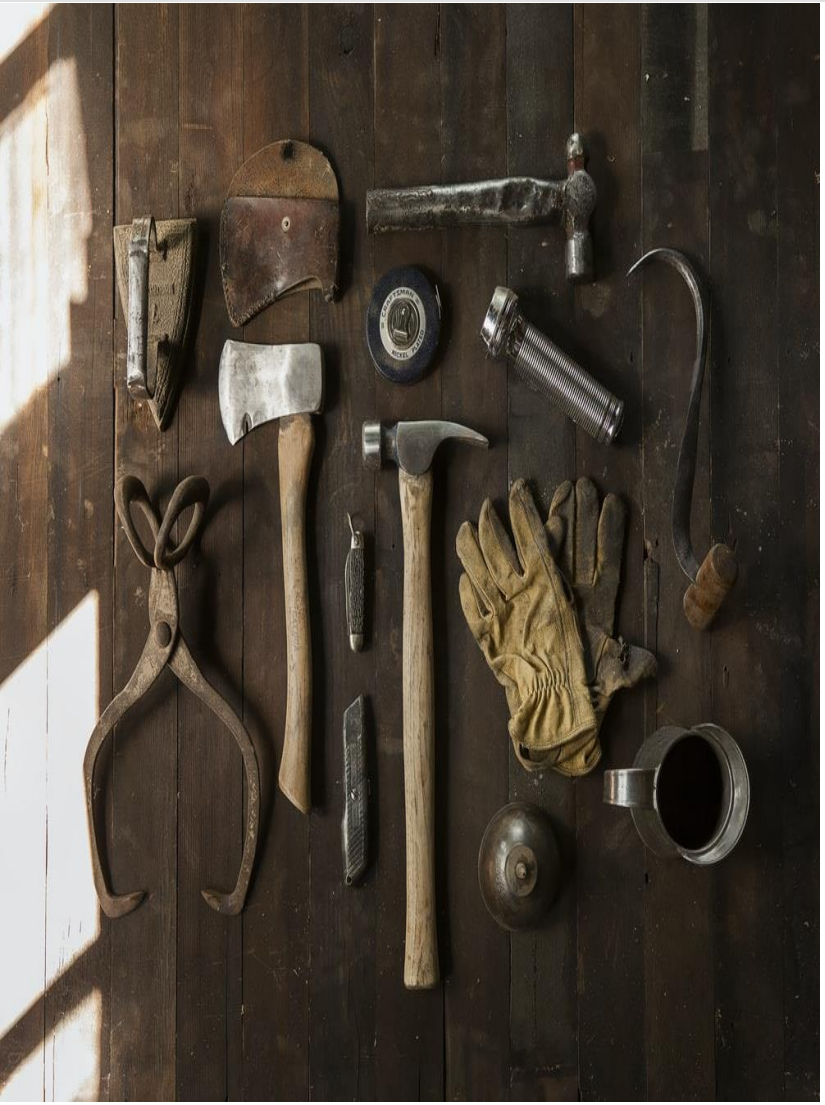
TIME FOR A POLL…

POLL QUESTION

Which of the following statements is most accurate about MAT for pregnant persons?

A. Those on MAT prior to pregnancy should be titrated down to 4-8 mg/during pregnancy
B. Those on methadone or buprenorphine often require increased dosage and sometimes split dosing as the pregnancy progresses
C. After c-section they can usually be managed with slight increases in dosage of their MAT medication
D. Mothers on MOUD should never breast feed their infants
E. They should ideally be medically detoxed completely off MAT

RESOURCES

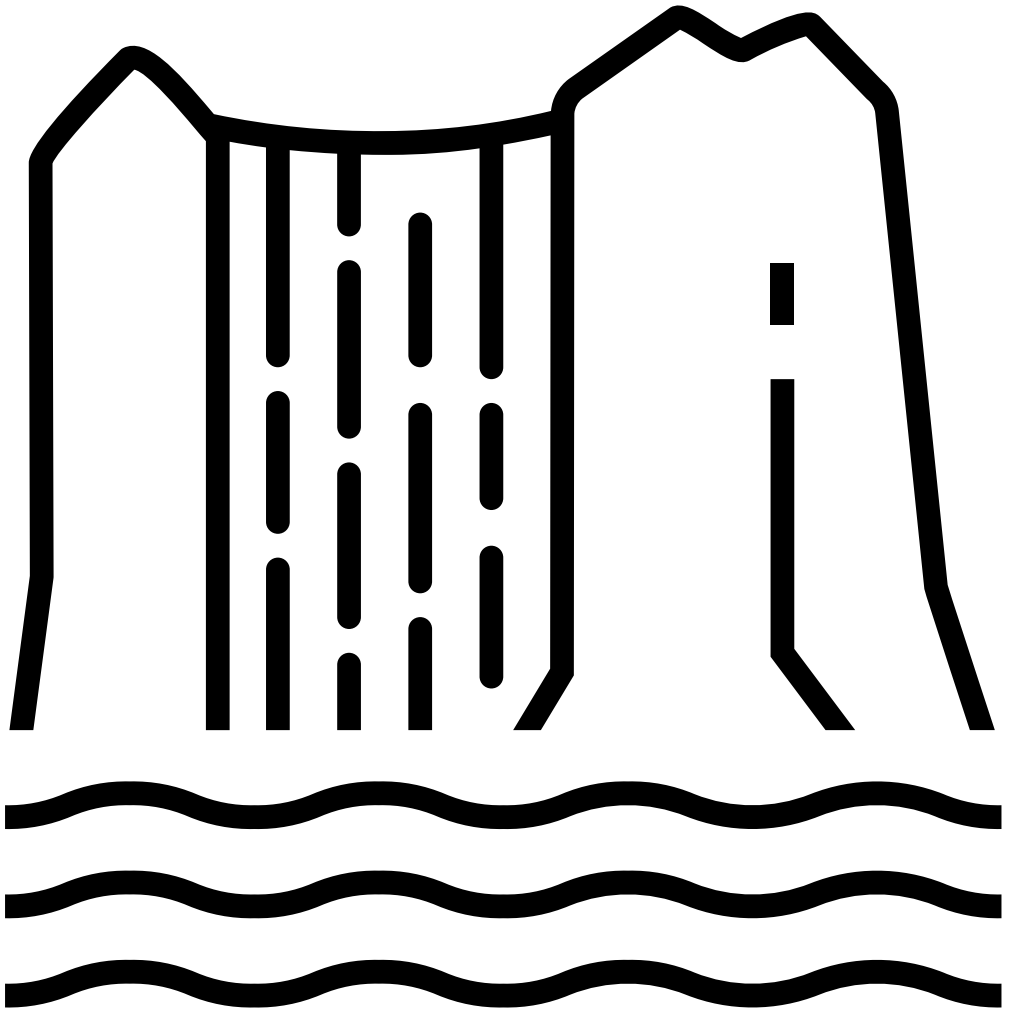


Picture from Unsplash.

- **NAS Toolkit** – 39 best practices, guidelines and protocols on perinatal SUD
  www.nastoolkit.org
  - *Breastfeeding: Best Practice 9*
  - *MAT during pregnancy: Best Practices 10, 11, 13*
  - *NAS: Best Practices 16-24*
  - *Outcomes of exposed infants: Best Practices 28-33*
  - *Neurobiology of SUD: Best Practice 7, 8, 10, 13, 14, 37*
- HMA's SUD Website: ***addictionfreeca.org***
- CA SUD Consultation line (USCF): https://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line/
- Line CA Bridge: **bridgetotreatment.org**
- CA DHCS: ***californiamat.org***
- SAMHSA: SAMHSA's National Helpline ***https://www.samhsa.gov/find-help/national-helpline***

KEY TAKEWAYS AND DISCUSSION

CHATTERFALL



What information do you need to better prepare you to care for pregnant/parenting persons with OUD/SUD and their affected children?

Type a brief sentence about how your thinking may have changed.

- Wait to press enter

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

MATinCountyCJ@healthmanagement.com or
CountyTouchpoints@healthmanagement.com

HEALTH MANAGEMENT ASSOCIATES

DHCS

POLLING QUESTIONS

1. Overall, today's webinar was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

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  - *There is an updated website for LactMed from what in listed in the Protocol – Drugs and Lactation Database (LactMed) can be accessed at https://www.ncbi.nlm.nih.gov/books/NBK501922/
- SAMHSA Has a compendium of recommendations and guidelines in their publication, "Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants," Factsheet #11 addresses breastfeeding. The publication can be accessed at
  - https://www.samhsa.gov/sites/default/files/topics/alcohol_tobacco_drugs/healthy_pregnancy_healthy_baby_flyer.pdf
- American Academy of Pediatrics Section on Breastfeeding Policy Statement on Breastfeeding and the Use of Human Milk, and the Transfer of Drugs and Other Therapeutics in Human Breast Milk and more
  - https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/AAP-Policy-on-Breastfeeding.aspx
- Association of Women's Health Obstetrical and Neonatal Nurses (AWHONN) Practice Brief #4
  - https://nwhjournal.org/article/S1751-4851(16)30207-0/abstract
- New York State Department of Health adopted a policy on breastfeeding that is very comprehensive and useful as a model. The policy and transmittal letter can be found at
  - https://www.health.ny.gov/diseases/aids/providers/testing/perinatal/docs/transmittal_letter.pdf
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ADDITIONAL RESOURCES

The Clearinghouses for Evidence-based Practices

- The California Evidence-based Clearinghouse for Child Welfare. https://www.cebc4cw.org/
- Title IV-E Prevention and Services Clearinghouse. https://preventionservices.abtsites.com/

Home Visiting

- Maternal Infant and Early Childhood Home Visiting. https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview
- California Home Visiting Program. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx
- Evidence-based Practices and Resource Center (formerly National Center for Evidence-based Practices). https://www.samhsa.gov/ebp-resource-center
- Child Welfare Information Gateway. Strengthen Families and Education to Prevent Maltreatment. https://www.childwelfare.gov/pubpdfs/parented.pdf