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WVU-Project SCOPE webinars-(Zoom)
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>> You can reach out to us in the CHAT, if you're having trouble doing so.

If you'd like to, you can use the raise your hand feature. If you have a question for the facilitator, you can also text, use the CHAT and text your questions or information there.

Again, information on the slide of how you can do that-- in your Zoom toolbar at the bottom of your screen.

We always love to see your faces. So we know who we're interacting with. If you want to turn on your videos so we can see you, that would be great. Please remember to leave your audio muted during the presentation, but feel free to unmute during the discussions and the Q&A sessions. We this whole session is for us to be engaged and asking questions and giving feedback. And using our case narratives to learn new skills and receive advice that could be added to our work and our everyday interaction with clients.

When sharing information about another person, we would like to talk about the individual privacy so not using first or last names, not identifying any family members, friends, or coworkers. Using always the identified examples.

So in the CHAT, now, please, if you would, add your first and last name; your organization, your email, and your Josh title. This will help to track attendance. So I'll leave that up there for a moment. And then, Melina, do you see anybody that's caught on the phone where we need to ask them identify directly?

>> I do not see anyone called in on the phone.

>> Okay.

>> Oh, wait, I do have one. There's a 340-4437-- 374-8043.

>> If you're calling in with that number, please unmute and introduce yourself? Okay, we'll check back if you're able to do so so we can identify the caller so we can give you credit for attendance. Unmute and let us know. Otherwise your information will be placed in the CHAT. Thank you.

>> Okay, so my name is Sue workman, is and I'm one of the SCOPE team members. We'll be facilitating today, Melina, is the assistant for today, helping us with the breakout rooms and the CHAT. We have additional facilitators for the breakout rooms today. So if Becky, Britney, Cassie, Susan, Leslie, is and Stacy, if you can raise your hand so people can-- or give a thumbs up on the screen so people can see who you are, that will be helpful.

I can stop sharing first--

>> Everyone could please mute their lines as well, that would be helpful. Thanks.

>> Okay, so what is an ECHO? It is an extension of community health outcomes. And we will be using an ECHO today. As an interprofessional practice network where education and/or health care professionals learn together. We will a didactic presentation and case presentation during these video conferences. This is session two of 12. We hope that you will learn best practices to support, get the individuals you serve by implementing realtime solutions, improving systems, and removing barriers to care.

So the heart of the ECHO modeling is a hub and spoke, knowledge sharing network led by teams and case space learnings and mentorship which is the key to the ECHO model.

So I'm going to stop screen sharing now and say, again, welcome to everybody that's here today. Today we're going to be talking about addiction and treatment. And I'm going to jump many right in and introduce our didactic and case presenters for today. They're going to do a tag team of the two presentations. And then after the case presentation, we'll be doing our breakout sections.

So lawyer why is an associate professor, social work section chief and addiction therapist in the department of behavioral medicine and psychiatry and department of neurosciences West Virginia University school medicine. She graduated with a masters in social work from Columbia university and currently holdings a licensure in an independent clinical social work under the West Virginia board of social license. She as over 25 years of clinical experience in the field of mental health and substance use disorders.

Amanda -- and department of neuroscience at WVU. She graduated with the masters of social work and has worked with children and families for over 20 years. So we're very excited to have them. And we're going to go ahead and turn it over to you Laura and Amanda. And again, if you have questions or need anything from us, feel free to use the CHAT.

>> Laura: Thank you. Sue. Welcome everybody. It's a very sunny day and my shades are not that effective. And I've tried to squirm around in my chair. The but I think this is the best I'm going to get. The let me share the screen and you'll be looking at the slides anyway.

So I was just looking a little bit at the audience and where you guys are from in different settings. This is kind of an overview of substance use disorders. And we're going to weave in information about stigma and treatment. Some of you guys may know some of this. To others this may be new material so may be a review or new depending on what you already know. Hope you will jump right in.

So the overview is just, we're going to look at substance use disorders as they have been defined. And they've been evolving over the last 20 years as we have much more in-depth information from MRI, brain scans, we understand how substance use disorders impact the brain much better than we did 30 years ago. We will use at the stigma of substance use disorders and treatment options and look at kind of an overview of prevalence in the state and in the United States.

So the definition from the American society of addiction medicine is that substance use disorders are treatable. But it's chronic medical condition. And it's really complex. And so we understand it impacts the brain, not only brain circuits but the genetics involved in brain development as well as brain chemistry and brain structure. And it's chronic disease that is treatable but not curable.

But we know that there are effective treatments that work. We also know the prevention is very effective. So early intervention with kids in middle school or even before are very useful interventions to consider.

So what happens with addiction is the primary neuro trans my tore involved is dopamine. And dopamine is really the pleasure neurotransmitter in our brains. There's a reward circuit in the brain. And when people use substances, really all substances whether it's nicotine, alcohol, opioids, it triggers a surge of dopamine in the brain. Some substances trigger more than others. The stimulants typically release the biggest surge of dopamine, that's why methamphetamine is addictive so quickly. But they all release dopamine in the brain. With repeated use, the brain adapts to the levels of dopamine in the brain and circulatory changes so the high levels no longer produce a euphoric effect. The other thing is depletes people's natural production of dopamine. So what you seize is the normal things that we enjoy in our lives whether it's like a good meal or, you know, watching our kids play sports or whatever it is, no longer produce dopamine that is perceived as reward because the brain doesn't register it. That's why when people hit early treatment, they often are pretty depressed early on in treatment because their brain is not producing dopamine, and they're used to relying on a substance to produce dopamine. That takes for the brain a little while to recover.

We're going to talk about opioid here since we have an opioid epidemic. It was getting better and now with COVID we see our overdose rates are back up. They have been down for the first time in 2018 and now they're back up. Opioids are a major problem in our society. And how they work on the brain is illustrated by this picture where the -- basically when you have opioids it produces a lot of dopamine in the brain. And normal dopamine stimulation in the brain does not overwhelm the brain.

And what happens in addiction, most people who use substances do not develop an addiction. So the rates again slightly different depending on the substance. But in general, 10 to 15% of people become addicted to it. It has to do with interplay intervene biology and genes and the environment. And the factors need to align to produce substance use disorder.

And they can be in the environment piece. So that can be what's happening at whole, community and peer influences. home. Kids who begin to initiate substance use that's a big factor. Administration in there, say for IV drug use the progression of substance use disorder is much quicker if someone is injecting versus if someone is taking an oral medication or drug.

And then how it affects the brain and that produces addiction.

So these biological factors which are genetics and epigenetics, we look at there's a trans generational transmission of substance use disorders. It's not just environmental factors but also genetic factors and then the psychological factors. So people who have mental health concerns are at higher risk for substance use in part because people are self-medicating just to try and function or feel not miserable so that they're not even looking to feel good. They're looking to not feel terrible.

And then environmental influences. What's happening in the home, family environment, are people using in the home or laissez faire about young children being exposed to substances. What's happening in school, too. Peers in the school environment as well as the community in general and access to activities in the community. Are there other things for kids to get engaged in after school? Whether that's church related activities or sports related activities or music or theater. Those things we know are protective for kids.

And so one of the biggest protective factors early on is early exposure. The earlier someone starts using a substance, puts them at greater risk of developing addiction. In the beginning, there is a choice. Often we debate this idea of is addiction "choice or disease? So early on in the progression, it's a choice. People as kids or as teenagers choose whether or not they use a substance. At some point the brain adapts and changes and it no longer becomes a choice. The prefrontal cortex, involved in choice is no longer functioning well. So that choice piece really no longer is a factor.

Parent al monitoring and support can make a difference as a preventor. Are parents paying attention? Are there consequences early on? There are no consequences, we know people are likely to continue using.

Negative consequences that would be. And other positive relationships.-- one of the resilience factors is having at least one positive adult in a child's life who is encouraging and validating of them. And neighborhood resources like I mentioned earlier, activities for kids to get involved in or even safe places to play outside would be considered a neighborhood resources. And youth and adolescence good grades and continue at this drug policies can be protective as well.

Prevention is important. In this country we don't put a lot of money into prevention even though we know it could be effective in all chronic diseases. The most important part of prevention with regard to substance use is laying that first onset of use because the brain is much more vulnerable when it's developing, say 12, 13, 14 years old than if

someone initiates use in their 20s. So targeted intervention to kids at risk, kids who have mental health issues or have experienced trauma. Because those are certainly risk factors.

And then strengthening protective factors like what's happening in the community resources and social engagement.

So I'm going to transition into talking about stigma. So I would characterize stigma as one of the primary barriers to individuals acknowledging they have a substance use disorder and seeking treatment. If we remove telling stigma from the picture, we would have more people coming forward and acknowledging the problem and seeking treatment.

Stigma can happen at the public level, at the institutional level, let's a even in hospital setting or it can't in the individual level itself. So we see people stigmatizing themselves and thinking of themselves as bad or unworthy because they have a substance use disorder. And this idea of label avoidance. People will not admit they have a disorder because the label is stigmatized.

The next slide breaks it out to the public and self-stigma label avoidance and differentiates between stereotypes and prejudices which are really thoughts and attitudes versus discrimination which is action. Action taken based on those thoughts and attitudes they're stigmatizing. These are very damaging. It can affect people's employment and people's ability to have a safe place to live as well as health care.

And then the idea that words matter not from a politically correct standpoint but from a shaping how we think about people with substance use disorder standpoint. And these are good words to think about so no longer referring to folks as addicts. But person with substance use disorder. We think of drug screens, not saying they're clean or dirty but positive or negative. The drug screen results-- and then person in recovery versus former addict or reformed addict.

And then even when we think about medication-assisted treatment, opioid replacement therapy is stigmatizing because it's trading one drug for another when people are taking a medication to treat a substance use disorder. We think of medications for addiction treatment. And we even-- I try to use the word substance use disorder versus addiction a little bit more as well.

And so I'm going to stop sharing my screen. And Amanda is going to take over with treatment.

>> Amanda: Hi, everybody. Let me find my screen.

Okay. Can everybody see that? I love seeing everybody's faces and backgrounds and visitors and workspaces. So thank you to everybody who has shared their space. I love seeing like little visitors and animal visitors. It makes me smile throughout my presentation.

I'm going to go over some pieces of treatment. This slide talks about-- I'm going to provide resources along with it. The NIDA, did this 13 principles of effective treatment. And this is a research based guide that is pretty informative and great. It lays everything out. It starts from talking about addiction as a brain disease and compares to other diseases such as hypertension and diabetes. And so really kind of gives you some educational pieces as well as pieces that you can educate others on. And so that's really helpful.

The 13 principles that it outlines are individualized treatment. Really looking at individuals as unique and tailoring to those unique individuals. I think sometimes when we are treating a certain population we can sometimes get into this like, monotony of the same type of person. The reality is they are not going through the same thing. Reviewing treatment often and regularly which is important. And needs to be done

especially when working in recovery because things change quickly and also talks about effective treatment of an individual therapy, group therapy, and medication management. All of that combination being the most effective treatment.

It talks about-- it was talking about-- it talks about co-occurring disorders. Unique pieces and treatments and adolescence and people who are pregnant. It addresses that. And greases screening tools and-- for infectious diseases such as hepatitis and HIV. These principles encompass a lot. The best part that it talks about too is recovery is long-term and it is a lifelong disease that-- and how to approach it in treatment. It's really helpful many. It utilizes and explores evidence-based treatment throughout this guide. And I love this diagram because it really shows how, you know, an individual is that core concept.

So you have the individual in the middle. And all of these systems around them. And so you know, oar treating that individual in recovery. You're doing their intake, assessment, treatment planning, substance use monitoring, you're looking at people, places and things. The support groups. You're looking at therapy, what kind of therapy they're getting and ensure they're getting the therapy they need and case management. They also have psychosocial issues around them. And they're important. Because sometimes they become stressors and that influence the core treatment piece. So it's really important to look at all of the factors.

I love this diagram because it givers you a perfect visual of that individual and everything else that can be impacting that individual as well.

So the American society of addiction medicine kind of puts out these different levels. And the levels help us identify how intense treatment should be. In when an individual is first often in recovery, they need intense treatment. It depends where they're at in their recovery and where their motivation for change it. Assessing and looking at that, being loo being at the needs and and if it needs to be intense or not. When they first enter treatment it needs to be intense. The longer they're in recovery, the less intense it becomes. Sometimes they start all over. It doesn't have to be this gradual step. Sometimes it be be a flow back and forth and, you know, in my experience in working with individuals in recovery, they're not always happy if they have to go to an intense level. However after talking to them about it and reviewing it, sometimes they look back and they're thankful that their recovery was intensified. They're not always happy but many of the times when they start to identify the need was there, they're thankful that we did that.

Sometimes we have to force that. Sometimes they're not able to see that because they almost relapse altogether. So when they relapse they relapse even in the thoughts. Their thoughts of what they need at that moment in time. Sometimes they go back to the old thoughts of map manipulating of getting out of a situation.

>> Treatment is categorized in three areas, pharmacological, behavioral and reduction.

Pharmacological is the MAT that's the medications for addiction treatment. And we know that this is most effective when coupled with counseling as well for substance use disorder. We flow for opioid use. It's standard. For MAT, the most common utilized is methadone and Buprenorphine. Methadone reduces cravings and withdrawal. The buprenorphine-- is partial. The Naltrexone on is the anti-agonist. It's a complete blocker. This gives you the idea, the methadone and the buprenorphine, the methotrexate is the blocker.

So this is in 2000, the drug addiction treatment act developed a waiver for eligible health care providers to take this eight hour course of education so that they're able to dispense buprenorphine. So this allowed treatment to be accessible. And the more

educated way, providing more education on dispensing because there were some providers that were dispensing that did not have all the education. They limited that. The this waiver allowed health care professionals, some of them to dills Pence but have the educational component.

We know that medication is best when coupled with behavioral health. Right? So the behavioral health component in treatment really addresses changing attitudes and actions related to substance abuse. When we're looking at that, we're looking at our motivational interviewing. That will help us identify where they're at, where they want to go, what their motivation is. And so we're identifying how to get them there. So maybe motivating them to get there, changing that attitude, looking at how their thoughts are and so when we talk about sometimes they need to understand where their thoughts are in the recovery process if we need to intensify. Sometimes we need CBT work, to identify their feelings where disproportions might be along the way for thinking a certain way for a long period of time. Not contingency management, some positive and rewarding piece so we can get healthy natural, dopamine release going on. The 12-step facilitation. Family therapy has been identified as one of the most effective, too, because it's not just one individual that goes through recovery. It's everybody involved.

So looking at the entire system.

There's also some harm reduction programs that have been put in place. And that's like the needle exchange rate because what the epidemic, that there's been an increase in infectious diseases. So some needle exchange many bras have been beneficial throughout.

When we're looking at resources, so the West Virginia substance use response plan through the DHHR and the Office of Drug Control Policy have this three year plan. It's interdisciplinary plan. And the link is below. If you get a chance, go ahead and jump many on there and look at that document. It really looks at this interdisciplinary approach of promoting prevention early on, right? So really addressing that within the schools and adolescences, accessing treatment. And treatment in general. It talks about concrete resources. So it talks about how important those protective factors are, the housing, child care, instrument. Transformation. Jobs. It looks 59 the concrete resources and how important education on substance use disorder is, is so we can reduce that stigma. So across the board, getting more so we can reduce more stigma. In this document we have all the recovery initiatives going in West Virginia. Some of them in there. Not all of them. There are great programs that are already involved. I always, you know, I talk with these workgroups of how we just need like this main database that can provide us with all of the information of all of the resources out there because there really are-- I find out about great things going on within the state that can help these families.

This is another great resource. So if you're looking at, you know, kind of tailoring different treatment and different areas, this behavioral health barometer from SAMHSA, if you have not explored their website, you should. They have great resources and downloads. Half of their stuff is free. If you go on there and download some of their workbooks and workgroups, tip she's, they have recovery books that have great group ideas and owe individual therapy ideas. I mean, be and it's all downloadable and free. So it's a great website to explore in general.

But this behavioral health barometer explores the percentage of substances that are used in each state. And it classifies it through gender, race, age. So you can really see specific percentages and tailor treatment around that or, you know, maybe service that you're trying to provide.

Then the key substance use in mental health indicator. This is also a great resource to identify by state the prevalence of substance use in your state, treatment and mental health indicators that come along with that. Very specific and laid out indicators. So it's really great.

And that's it. Let me stop sharing so Laura can pull up your case presentation.

Any questions about that so far? I don't know if we--

>> So we have a case presentation that we're going to share. So should we jump right into that? I can pull that up on my screen.

>> That's fine if you want to go ahead. Like if anybody has questions, Unreal mute. You can type it in the CHAT.

>> Okay. Let me share this.

we're going to go through a case presentation that hopefully illustrates some of the things we've talked about today. There you go. And then we're going to breakdown into smaller groups to discuss the case so that you guys can kind of think about how you might address the issues of the case. And then we'll come back together and discuss it as a group.

You want me to do the instructions, Sue?

>> Yeah, so Melina has assigned everybody to the breakout room so that will go automatically. And if you have any trouble, you can always come back to the main breakout room. And we can help you get moving from there.

>> So the case we're presenting today is loosely based on probably a couple of different cases. So as to not really be identified the and the names in the specific information has been shared. So it's not really representative of one person.

But of the folks we see and this is from our pregnancy clinic. Amanda and I both work in a medication-assisted treatment program for opioid use with pregnant women. And so the -- we have a program that is interdisciplinary. It is a centering model. So we combine OB care with our met indication assisted treatment care. So it's-- when we were in person, our nurse midwife would be on site and can actually work with the women who came in, is if they needed any particular OB care including like a quick exam or whatever their concerns were. Swelling in their feet. She could really do OB care for them right when they were coming in for their substance abuse treatment. It's nice integration of care and interdisciplinary model. We do our best on Zoom. We're not able to do that-- our nurse midwife is present in our groups and answer any OB related questions.

So this particular case is going to-- as we jump many into the case, think about any need for treatment of substance use disorder, factors impacting women with substance use disorders and especially pregnant women, are stigma and retention in treatment. And the real need to maintain abstinence especially during the duration of the pregnancy and after. A lot of times becoming pregnant can be a huge motivation for a woman to come into treatment. And then after she has the baby sometimes that motivation is not the same. And so retention is really important.

And then we also want to have positive neonatal outcomes. So thinking about how to facilitate those. In general when I think about the goals of treatment, retention and adherence is key. And usual little one of the objective ways we measure that is with urine drug screens and attendance at treatment for substance use disorders as well as those prenatal and post-natal visits. And then the neonatal health outcomes. We know that inter-uterine is a problem among women who use substances in addition to

nicotine. That could impact growth as well as all kinds of other pregnancy related problems like placenta eruption and preterm labor.

But again that barrier to treatment, when we talk to women about why didn't you come in sooner? Of course I don't phrase it that way because that will be stigmatizing. I'm wonder, what made you come in no you because it's great that you're here. The most of them say, I'm afraid of CPS involvement or I could not find a person to treat a pregnant person or, when I went in for treatment they treated me badly. The and I didn't go back. So those are some of the things we frequently hear.

And then logistics, too many rules and regulations where they can't get there because of no transportation and childcare. And stable housing, which in this particular case is absolutely a factor.

So this is a very cursory overview. And when we do case presentations, it's often more questions come up than get answered. So you can fill in the blanks because there are many blanks. But we're looking at a 44-year-old female with history of poly substance use, opioids being the primary substance being used. And she comes to the ED seeking treatment. She's in her third trimester. She hasn't had any prenatal care. She didn't realize she was pregnant until about a week ago. For women who are using substances, that's not that uncommon. A lot of times, women are not menstruating because they're not eating healthy and they're very skinny. And they're abusing substances and not menstruating. They don't realize they're pregnant and not paying attention to their body because they're using substances to numb for one reason or another.

So it's not usual for someone using heavily not to realize that they're pregnant. She has four other minor children, that are not in her custody. And her partner has also been admitted to the hospital with a serious infection requiring IV antibiotics that is not related to substance use disorder. They have currently lost their housing. So thinking about how that impacts a whole host of things relating to what interventions this woman may need.

And so for your small group discussion, go ahead and think about, how you would approach this case? What are the priorities? What would you could first? What strategies would you specifically use with a woman kind of obviously a little bit older, old inside for being pregnant. Presenting for substance use disorder treatment. And then what kinds of treatment do you think you would recommend for her. So thinking about those questions as you enter into your small breakout rooms.

>> Thank you, Laura. And feel free to unmute in the breakout rooms and have good discussion input. And Melina, be are we ready to separate up?

>>

>> Back breakout room back

>> Hi, everyone. I am Amy Burt. I'm an occupational therapist by trade. And I'm going to be your facilitator. I work for WVU in division of OT. So we're going to think about that case for a while, just things maybe to reiterate. We only have 15 minutes. You can see the count down clock on top of your screen. Mine is in the top right corner. Someone might get cut off in the end if you're having a good thought. And we can get bumped out of the room when they want us to come back, okay?

Would anyone want to be the reporter for when we go back to the main room to report out what our group has decided or collaborated on for the case? Any takers on that job?

That's okay. I can do it if not. All right. Maybe someone will change their mind once we get into it and start talking.

Okay. So I'll kind of bring that case back up just a quick overview because I know it goes fast when we're talking. 44-year-old female who is a substance use opioids are primary. This is her fifth pregnancy and has four other children who are not in her custody. She's in her third trimester and did not know it until recently. The patient's partner has been admitted to the hospital with various infection requiring IV antibiotics, reports its not substance use related but uncertain.

Being and then she currently has lost her housing. So they're homeless, living with someone else that is unclear. Does anybody have think questions about the case or any, you know, repeat anything?

Okay. So how would you approach this case from your professional perspective, from your experiences? Anybody like to share?

>> I think we need to figure out why she's homeless. Was it a financial issue? Was it a law issue? In if we can find out why she's homeless and we can figure out what we can do to if I cans that so that she's not homeless. And I will get her into a more stable environment.

>> What was the second thing you said? Financial or what--

>> Was there a legal issue? You know was there police involved? Were they kicked out? You know, because there's a lot of times that, if there's been trouble, the landlords will take steps to get them out.

>> Sure.

>> And it doesn't always have to be financial.

>> Right. Thank you. Different thought on that.

>> I don't know if you guys-- can you hear me?

>> Yes. The

>> The other question I have is, who else is her support? I know her significant other is currently in the hospital. But is there anybody else she considers, a family or-- [Off Mic].

>> Good. Yeah, who's giving her that support? Could be churching or shelter or a group that she attends. That's good. Who has some other thoughts about how much-- my kids just came moment from school.

>> Mommy.

>> [Speakers Overlapping]

>> Medical clearance and offer inpatient detox.

>> Sorry.

>> I would probably get her medical clearance and see if had he would be interested in any inpatient detox or ongoing treatment.

>> Okay.

>> Yeah. Along those same lines, I think I would like to talk to her about her history and find out what she's wanting to do if she's wanting to look at alternative treatments or if she plans to continue to use now that she knows where she is with her pregnancy. What does she want to do?

>> Thank you.

>> Also probably good to find out if she had been at one time established with an OB/GYN. She has four other children. So she's had them somewhere. So does she want to go ahead and get in and see that doctor and get established before the baby comes with the doctor, and get an appointment. Just trying to help her with that. Does she need transportation?

>> I'm taking notes if you're wondering why I'm pausing.

So those are really great ideas. Do we have why, see what support she has-- offer different options for treatment. You know, see what her preferences are and her goals. And then talk about other supports like transportation and a doctor, like OB/GYN.

With those ideas, what are strategies we can use as a team or you as her service provider to get her those things?

>> I think educating her on what those options are.

>> Okay.

>> Anybody have any other thoughts? I find this hard because, you know, it being her fourth child, you obviously know she's done this consistently. How are you going to be the person that gets her out of this rut she's in because she doesn't have custody of her other three children. So you can see that people have probably tried in her past. So what do you think is a good something that we can do?

>> Also, her other children were taken because of abuse and in egg by CPS. There might be an obligation to know that CPS is expecting if delivery is imminent for the well-being of the child.

>> Definitely. Has anybody ever encountered a patient-- similar to this?

>> Yes, I have had, this exact scenario and in this case, the mom had not been in an environment where she could -- could not keep those children. And her mother took them. But with the new baby she was in a little bit better situation. The and she did keep that baby. So I see looking at how are the circumstances different right now than they were in the past. Could possibly be the difference between her recovering this time.

>> Good.

>> Aren't there peer-- what are they called? Peer support coaches? Peer-- what's the word I'm looking for?

>> Yeah, I do some work with the homeless down at the friendship house. They're like peer mentors, peer support coaches. I don't remember the name either. The

>> They're support specialists.

>> I hear they're effective. Maybe she hasn't had something like that before as well as therapy or, you know--

>> Good. Yeah and I think that's a really important thing to think about because many times, when it comes from a professional who's never experienced that, that they experienced, you know, substance use maybe loss of partners, losing their kiddos, maybe poverty. We don't know much about this situation. so it's hard to get that trust. But those peer support specialists have been through it. And that's where they get that trust with the person that you've connected them with. It's the relationship they had and how they can really influence the decisions that they make or offer support when they're having good days, bad days, and need someone to talk to. Yeah, it's a really great thing.

>> It might be beneficial, too, to find out if these self-medicating and get her the proper treatment so she doesn't have to self-medicate.

>> The other thing, too, is the baby is pretty close to coming. Does she have clothing? Does she have any of the equipment that she's going to need? Car seat? There's so much stuff to get ready for a new baby. If she doesn't have any of that from the previous four, she's going to need all that stuff. Gabriel project or places can provide for all of that. Diapers, wipes.

>> Definitely. I think another question, too, that pops into my head with you talking, me written dah was, does she want the baby? You know if she didn't know she was pregnant until a week ago, that's kind of, like, hey-- what, four weeks, five weeks left.

>> Yeah, that's true.

>> That's what I think about. Is there any specific treatments that you could offer from your profession or experience? It could be maybe for a woman in her last trimester or could be post prenatal, like they kind of presented. That was one of the goals, improved post-natal outcomes. So what treatments that we as a team would offer in this situation? we're counting down. We only have three minutes just to check on time.

>> You might want to refer them to birth to three right from the start. Because right from the start can also work with her for the remainder of her pregnancy.

>> Good.

>> And then once the baby's born, birth to three just to make sure the baby's developmentally on target.

>> That's what I wrote look like as an ITM. I don't know if anybody else is an occupational therapist. Yeah, development actually had a case like this. She was on her seventh baby. We also worked on caregiving. Like I was working with mom how to learn how to take care of her baby. She didn't have custody of any of her children. I'm not sure when she lost custody of the older ones. But for-- she really wanted to keep the new baby. But we had to practice a lot on how to be a woman. You know, we talked about like signs the baby is giving her when she was hungry, is how it keep her safe. That's what I did as an OT in this situation. Development and caregiving. Anybody else have a thought from 23R your realm--

>> Maybe also handling stress or things that might come up just knowing when there's a baby what would be normal and having her understand what's coming.

>> Yeah, for sure. Yeah, because babies cry. When they're hungry, sad, hurt, when they're-- right? So yeah, that's good thing to think about.

Um, one more question in there. How about reducing stigma? You know, there is a lot going on in this case that is not just the substance use disorder. That's one of the stigmas. But there's other things, too, right? How could we help encourage this patient to want to receive care for that stigma? Last thought.

>> I think getting there with the resources for after the baby's there so she doesn't feel like she's going to lose this one. Like she has support, that she has what she needs to possibly keep it.

>> The things to succeed.

>> Yes.

>> Good. Anybody have a 15 second thought before we get bumped out of this room and go to the main room? Okay. Well, thanks for engaging with me. I appreciate it. See you on the other side with everybody together.

They didn't send us back many maybe we need to leave the room. Everybody

If you click there's a blue button in the bottom of your screen and says leave room. And you'll leave the breakout room.

>>

>>

>> Welcome back, everybody. I hope you had a good breakout session. I'm trying to get everybody back here. We'll wait a moment. And we'll start about having a little bit of a report out from some of the facilitators and the reporters from are the groups.

And Amanda, can you remind me, did you want to go over your outcomes first or do you want us to have some report outs?

>> I think we were going to go over outcomes first.

>>

>> I'll turn it back to you.

>> I'll go over some of ours first. This is some of what happened.

>> So the patient was admitted to our DDU diagnosis unit after being medically cleared and then transferred to the disorder group in the pregnancy center and programming. For those who don't know it's an interdisciplinary team approach. And it involves individual therapy, group therapy, OB sources. So we have a midwife. We have a behavioral medicine physician, therapist. We have our ACE liaison. Peer recovery coach, a case manager. And then we also incorporate other pieces. We have a pharmacist that's on hand for educational pieces. We have other educational pieces and services that come in and speak, dentistry.

We provide them with some great, like key pieces-- concrete resources like that as well as healthy snacks and teaching them nutrition and pregnancy prevention. It's all an income passed program. We are able to initiate prenatal care. She responded well to -- she was able to stay at the Rosenbaum house while her partner was in treatment, in completed treatment. And delivered a full term baby. 8 pounds one houses and able to breast feed.

However she's not able to retain custody of the baby due to unstable house and prior CPS issues, as a result she had to stop breast feeding. The baby end the up developing NAS symptoms and was traveled to the NICU, required several doses of Morphine but did not need a taper. Which was good. The infant was discharged 11 days later. Mother remained motivated to work towards reunification and remains abstinence and engaged in MOUD treatment. That's a big factor for relapse. So it's good. She's still motivated and engaged.

>> Thanks Amanda. So I'm going to look at our group here. Do you want to stop screen share for a minute, Amanda in thank you. Let's go to Susan and Britney's group. Did you have anything in your group to add to the outcomes Amanda mentioned?

>> We have Diane from our group to report out for us.

>> okay. We thought it would be important when she was, when we were thinking about how to approach was what was she looking for in treatment and had she had a history of treatment before. In patient or residential, someone mentioned sub U -- this isn't my field. Someone needs to explain this to me.

What are her goals? What are her intentions regarding her children? And then they need to think about housing and other support systems and p CPS and legal issues.

>> Great. Thanks, Diane. And Laura or Amanda do you want to add more about this sub U text to clarify for Diane?

>> So sub U text is a brand name that doesn't exist anymore. But the medication is buprenorphine. For pregnant women, sometimes they're prescribed buprenorphine. Which sub U text is buprenorphine or see box own which is it has, if you remember, early on when we were talking about the medication, the agonist versus partial versus antagonist. So the buprenorphine is that partial agonist. And naloxone is the full antagonist. Naloxone is only activated if someone tries to misuse the medication. So it actually passes through the gut if you take it by mouth but gets activated taken another way.

So actually, we prescribe the combination product in our clinic, many places for pregnant women just prescribe the buprenorphine. But both can be prescribed to pregnant women for opioid use disorders specifically.

>> Thank you, Laura. Becky, we'll go to your group. Anything from your group to add out to the discussion questions?

>> I think my favorite one was for question one was to praise her for getting help. She did come into the ED as soon as she found out she was pregnant. She didn't even given her past history with her kids being taken, you know, she didn't have custody. She knew that she was homeless. She knew what was going to come from that, the CPS would be involved. But she still chose to get help. So that probably needed to be step one was to prays her.

>> I love that.

>> Thank you. Amy, how about your group?

>> Yeah, um, so I think my group had a really good centered approach which is cool. Just some things that demonstrate that person centered approach like who is her support system. What are her goals? Does she have the things to care for the baby? Does she want this baby since it was a surprise that she just found out she was pregnant. And then like how are the circumstances different now than they were before with her other children?

And then the other thing was like to recommend a peer support specialist who understands the situation better and can build that comfort and connection. And then lastly make sure that she has the resources for her and her child to build success for both of them. So good person centered approach.

>> That's great. Thank you.

Cassie, we'll jump over to your group. Anything additional?

>> Two things that I thought really stood out from our group discussion. The first was being mindful of the patient having access to all these resources that we're providing. If they need support for literacy or if they need support to look at something on the internet. Make sure we're not giving resources they don't have access to. Another one is league at positions, the status of their driver's license, giving resources to legal aid if need food and a domestic violence screener. Those are the things that emerges from our discussion.

>> Thank you. And then I think we have one more group. Leslie, did you have a group?

>> I did. I'm sorry I was typing these reports. I think it's nice to hear across the groups. Our group also talked about the need to ask her in terms of the approach, really let her provide initial thoughts about what her biggest concerns which we heard from many groups. And that was great.

Identify musts. So obviously OB care, recovery coaches were mentioned, and the housing. Many people in our group talked about not only identifying and making that connection but starting it while she's in the ED to community service providers. And then there was a little discussion about how that might not be available. So the term crisis resource group was used or support group. And that may not be always there. So that might be a step that could go of giving the ED staff and team information on, okay, you have a patient there who is going to need follow-up community support. Who do you call? And go ahead and make that connection while they're in the hospital.

Team approach was mentioned. Depression screening, I didn't hear that prior. So that was listed. And anything that could be done if it can on the amenity side.

>> So Amanda and Laura, how do you think our groups did?

>> I think you guys did great. It's a great example of like how many heads are better than just one because, you know, this individual had so many needs and was struggling with a lot including her partner was very, very sick. And so she was very distressed about that.

That you know, just the holistic approach that you guys have laid out is fantastic. And just, we didn't include any outcomes. She did get connected to our ACE program here which has someone who helps with the case management services in terms of housing and also a peer recovery support specialist. She was linked up with that person. And she has taken full advantage of all of the services we have to offer which is, you know, to her credit. She was actually considering adoption initially and decided against that. I know that came up in some of the groups.

And just creating a space, a therapy space for her to talk through that I think is really important. And again the person centered approach that you guys mentioned would have allowed her to do that in you guys' plan.

One of the things we didn't do fast enough which I wish we had in retrospect, when you think of an individual who is homeless, typically they do not have their social security card, birth certificate and ID at the ready. In fact she had none of those. In order to pursue housing, you need to have those. And getting those things takes a long time. The I feel like we should have started that when she was in the hospital because we would have had some of those documents sooner. Perhaps she could have had housing at the time that she had the baby. But you know, hindsight is 2020. So just keeping in mind that that housing piece often can take so long to get in place. And there are so many steps for folks who don't have the documents they need to pursue that. But yeah, I know, I think you guys did an awesome job.

>> Yeah, I love the person centered approach. Everybody talking about meeting where she's at is important. Meeting individuals where they're at because sometimes we can clearly see where some of those needs are. And it can get overwhelming to some people because we see all of these places they need to help and need to go. Really identifying where their goals are and where they want to start. Sometimes they don't see it. Sometimes those motivational techniques could be beneficial because a lot of our patients in recovery are so transient. They're used to living with different people and kind of house surfing. So they don't even -- if they don't have previous children, this is their first pregnancy, sometimes they don't realize what they need. So meeting them where they're at. I love the little he is pieces because, by praising her when they first come in, they seem small, but they're huge. They make great impact.

One of the women in the group I said, feeding her when she comes in-- when they feed the girls they love it. Those things are huge. So they're like small changes that we can make a huge impact on.

>> Thank you both. Anybody have other comments or maybe questions about the didactic piece or case presentation or information you would like to share?

>> I have a question.

>> Okay.

>> I think I heard you say that she had to discontinue breast feeding. And then the baby developed NAS. And that seems so sad to me in so many ways. Was there a way to foresee that? Like here was a mom who it sounds like was trying to bond with her baby and you know, led to a lot of bad stuff. What happened?

>> so that was very sad for me, too. And of course I didn't find out about this until after the fact which is a little bit of a lapse in our communication. We have pretty good communication with our OB department. But that was done without consulting us.

And sometimes that can be a directive of child protective services. Which doesn't seem quite right to me either because regardless whether the child was going to remain in the mother's care, to me the benefits of breast feeding are very clear that until the child leaves the hospital, the child should be allowed to breast feed. So I was not

insulted on that end. And it's predictable. It is absolutely predictable. Even for babies who are -- babies who get removed to their mother, whether they have prenatal struggle struggling when me get removed from their mothers in their ability to self-regulate.

That was very unfortunate. The I'm very pleased to actually know that we have adopted a different kind of treatment with babies that are exhibiting some NAS symptoms. We don't put them on the 21 day regimen Morphine. They're experimenting with giving them small doses here and there. And it seems to give their nervous system a break. It kicks them and they can several regulate after that so they don't have to remain in the hospital for 21 days. It used to be between 14 and 21 days, but it could be longer depending on how the baby did.

So that at least was a good outcome. The baby did okay, given the separation and given the interruption of breast feeding. But yes, that's something that perhaps could have gone differently as well.

>> Thanks.

>> Just in regards to child protective services, you know, I'm just a CPS policy specialist. But just to let everyone know, when a child comes into custody of the department and goes to a placement, you have to take into consideration how close that placement is. There may be different factors here. But I absolutely agree there are a lot of information coming out about how breast feeding is appropriate and can be used. But if you look at disrupting the child's home environment and taking the child to the foster home, there comes into play how do you get the breast milk to the child? There are other factors that need to be taken into consideration. And you know, many years ago I was in the field and had an experience like that in a particular case. And it was not easy because the child was not locally placed. So it wasn't like we can pick up mom's breast milk and transport it or if the child is with a relative. There are variables that can be taken into consideration. But it is definitely something that is interesting and I can understand why everyone is concerned about that. But please take into consideration it would depend where the placement the is. And when the child comes into custody, there are many other factors. When you talk about a multidisciplinary team giving mom treatment where she has doctors and psychologists and peer recovery support specialists and case workers, there's a team like that when you involve child protective services that involves more than just a department and also involves CASA, the judges, attorneys, attorneys for the child, foster parents, the parents, attorneys. There were a lot of different players. And hopefully as this information starts to come out and people de-stigmatize a lot of things that surround a mother with a substance use disorder, hopefully we can make practice a little bit better across the state.

>> I'm a CPS worker. And my concern with continuing breast feeding specially if a drug affected infant is make sure the mom is staying not on substances. Because I would hate to-- mom's breast feeding. Let's give the milk to the baby and has a relapse. We'll shall exposing the child to more substances than they were already born with. I feel like you have to be very stringent on your screening process. How can you be 100% unless you screen them every day that the milk wouldn't have some sort of substance in it.

>> Typically substance is, not heavily transmitted into the breast milk either. Unless I'm incorrect. From my personal research with this topic, that has been what I have always read. But I'm also not a professional like many of the other individuals in here. But that's just what I have seen from my own research.

>> And just the paranatal partnership, West Virginia paranatal partnership has a beautiful training and presentation regarding stigma. I believe there is another one that

may be involved that may involve breast feeding during pregnancy or may have taken that somewhere else.

But it's enlightening to read those kinds of things. That's what this group is really about, I'm glad when everyone talked about stigma regarding substance use disorder. But there is a lot of information out there that's making its way into the social work realm that's more medical. Like being able to-- when it's appropriate for a mother with a substance use disorder in recovery to be able to breast feed. You know, and you have to-- I see a lot of people shaking their heads. You have to take into account, medical professionals' stands on when it's appropriate, too.

>> If I could say something. This is where I hear often in different seminars, webinars meetings I attend. This is where continuing education for all of us on a different agency pennings of different resources comes into play because, as a peer recovery specialist, I don't know all the avenues that go into when a child is removed from CPS. Where also you all as CPS workers know what's involved in our work. I think this is where cross education amongst the different agencies is very important and needs to happen more often.

>> Yeah, it's nice to see today a lot of different disciplines represented so we can have these conversations and understand, you know, the various systems at work on all sides of the issue. So thank you, guys for those contributions.

You know, in general breast feeding is not recommended if people are using other substances obviously. And I would say, it's more about the person' ability to sort of stay. Breast feeding is a lot of work for anybody who's done it. You have to be vigilant about, and clean up, pretty vigilant about the schedule and often happens every two to three hours. You know, it's a lot of work. So for folks who are actively using substances have really -- it's hard to manage that kind of schedule in addition to any negative effects that the breast milk might have on the baby if it contains other substances. This is actually while she was in the hospital, the breast feeding was happening. It was not being suggested that she pump and send it to the baby while she was still in the hospital.

But great issues that everybody brings up. So thank you for the discussion.

>> Yes, thank you, everybody. And we are trying to gather even additional resource that's we'll share with the follow-up email that you'll get. And if you have not already put your name and email in the CHAT for us to count your attendance and send you that information, please do so. We do give a follow-up email with the PowerPoint slides and the resources. And we'll give you information about how to complete the evaluation. And the evaluation will be needed if you want to get any type of CEU credits. I am just going to briefly screen share as we're wrapping up. I want to be able to let you know about our future sessions.

This was session two. So we'll be having session three on neonatal-- March 1. And sessions up to number 12 that end in September. Again this slide gives some information about how to get your credit for attendance. If you did not put your license number or STARS number in your registration form, you can email it to me. We will only provide CEUs for the live sessions. The recordings will be archived if someone wants to review them for learning purposes.

Again, the day before the next session, you should receive a log in email that will have the link. The and that will get you logged in you through the Zoom. If you don't get those, you can always contact me. And I'm happy to help you with that. There's a question about where to send the license number. You can send that to me. I can put my email in the CHAT for you.

>> [Speakers Overlapping]

>> And I realized we missed a question that was also in the CHAT because I just paid attention to the CHAT.

>> Go ahead.

>> Veronica brings up a good point when a child is removed from the custody of specifically their mother who has carried them to term for ten months.

You know, that's absolutely a trauma. And so we do provide support for that. So they have individual therapy. And this particular patient actually requested more regular individual therapy exactly for that.

>> We meet regularly with the OB services to discuss any women that might come on their radar or our radar that might need extra support. They absolutely share those needs with their permission and get involved with services.

>> I have a quick question. Is postpartum depression more prevalent among this population?

>> So depression and anxiety are more prevalent among individuals with substance use disorders. So that makes them at greater risk for postpartum. So yes. We do a great job screening for that except when patients don't show up for their six week visit. And so I mean, it's-- screened at the time of birth. If they're not showing up on their six week visit, it's a problem. We're very vigilant of changes in mood and symptoms in their treatment where they're coming to treatment inform are their MAT.

But yes. They are of greater risk.

>> And I think that's a nice piece of having the interdisciplinary approach because we can let OB know as well as us. Screen across the board. If they don't come to one of our visits we can screen them somewhere else. Especially if we know a lot of times. A lot of times they say they struggle with depression. And we talk about preparing for that. So yeah, it's really helpful.

>> Okay, we have one or two minutes. Any other last questions that anybody wants to raise? We will add some summary information on the slides that are archived on the impact site. So this will be there in case you want to reference those. You're back for a second time, we're so happy to have you. If you're here for the first time, we're happy to have you. We look forward to meeting with you all again. A huge thank you to Laura and Amanda for helping us today. I think it was just great information and very good discussion.

>> Thank you for having us. I loved the discussion.

>> Yeah, me, too.

>> Any time. okay, well, if there's no last minute questions or comments we look forward to seeing you in March. Have a great evening, and we'll talk to you later.

>> Bye, everyone.

>> Thank you.