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# We can do better: An argument for improved care of the opioid addicted mother-infant dyad

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## **Abstract**

As the number of addicted maternal-infant dyads increases, so does the need for nursing to expand its understanding of the addiction process and the evidence-based interventions that best serve mothers and infants. Nursing attitudes toward the opioid-addicted mother and infant dyad are influenced by knowledge deficits and communication difficulties. Care required encompasses medical, legal, social, and economic perspectives. Professionals and society at large have disagreements regarding whether to approach the phenomenon from a punitive or supportive strategy. Facilities to care for the mother-infant dyad with addiction are limited. Increasing knowledge has great potential for active understanding and ability to impact these vulnerable patients. Policies must be carefully considered and nuanced. Opportunities for research are myriad. Nurses are well positioned to intervene and create positive outcomes for mother-infant dyads experiencing opioid addiction.

## **Introduction**

Drug use in the United States (US), including among pregnant women, is rising: 4.4% of pregnant women use illicit drugs, with a much higher rate in women aged 15 to 25 years. Approximately 180,000 infants annually are born with neonatal abstinence syndrome (NAS) (Caitlin, 2012), which can directly affect infant development. Many of these infants require prolonged hospitalizations, and multifaceted inter-professional skills are required to guide them and their mothers through the period of withdrawal.

The American Congress of Obstetricians and Gynecologists (ACOG) states that there are multifactorial reasons for drug use, which is a biologic and behavioral problem with genetic components (ACOG, 2014). Substance abuse affects more people who are living in poverty, who have experienced abuse or trauma, and who are unemployed or have mental illness. This means that a large percentage of women who deliver opiate-exposed infants are uninsured or on Medicaid. By one estimate Medicaid will pay one trillion dollars for substance abuse over the next twenty years (Coleman & Miller, 2006). This translates into problems for families, healthcare systems, legal systems, and society.

Caring for patients with NAS requires empathy, knowledge, and curiosity. It demands experience and stamina, which can be corrupted and exhausted. Research indicates that nurses feel unprepared to care for these families (Fraser, Barnes, Biggs, & Kain, 2007; Maguire, Webb, Passmore, & Cline, 2012). Due to increased numbers of opiate-exposed mother-infant dyads, the stress and challenge of caring for vulnerable families is only increasing. The nurse, mother, and infant are in a continual feedback loop with the actions of each affecting the reactions of the other (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Nursing needs to expand its knowledge and understanding of the addiction process and the evidence-based interventions that best serve mothers and infants.

## **Background**

Hill (2013) defines addiction as a “chronic, relapsing disease that is characterized by compulsive drug seeking and use, despite harmful consequences” (p. 183). Addiction is a disease of both brain and behavior, and science has yet to understand the various reasons why people use drugs or how drugs affect the brain to compel addiction (Hill, 2013). This lack of understanding creates a chasm into which fall many well-intentioned ideas that have no basis in fact.

Nurses may be conflicted by the need to advocate for these vulnerable, sick infants whose issues stem directly from maternal actions. They are frequently not trained in addiction behaviors and the experiences of those with addiction (Fraser et al., 2007; Maguire et al., 2012). This may impede the nurse-mother relationship and in turn accentuate negative feelings held by the mother. Hill (2013) notes that lack of a trusting relationship can mean a mother is four times less likely to receive adequate preventive and ongoing health care. This may include how to bond with her infant. If a nurse can impart “competence and confidence” in the mother by focusing on what she can do for her infant, she may give the mother the needed boost to care for herself and seek or stay in treatment (Hill, 2013).

Without the ability to understand and empathize with the opioid-addicted mother, nurses may find themselves frustrated and unintentionally contributing to the failure of successful maternal-infant bonding (Fraser et al., 2007). The nurse who lacks an understanding of what the mother experiences may reinforce negative behavior such as non-visitation on the part of the mother (Cleveland & Gill, 2013; Cleveland & Bonugli, 2014). Attitudes of the nurse toward the mother, and the ability or inability of the nurse to communicate with the mother, impact care of the mother and infant (Cleveland & Bonugli, 2014). Additionally, a paucity of maternal education by the nurse on the topic of infant cues and signs of withdrawal exhibited by the infant may perpetuate maternal actions that exacerbate infant distress (Velez & Jansson, 2008).

## **Current Trends**

There is a growing movement nationally to enact punitive approaches to the opioid-addicted mother. This may be driven not by evidence but by a perceived need to

intervene in the abuse cycle. Nurses are increasingly raising their voices against the mother, advocating for foster care (Bauer & Diedrik, 2014) or legal ramifications for the mother (B. Hall-Long, personal communication, July 21, 2014). These ideas seem born of frustration rather than evidence. Evidence suggests that mothers and infants kept together have improved outcomes (Isemann, Meinzen-Derr, & Akinbi, 2011; Saiki, Lee, Hannam, & Greenough, 2010). Studies have also pointed out that mandatory reporting systems create fear of incarceration and fear of removal of the infant from parental care, or require entry into the social service system. Nurses who advocate for foster care or legal ramifications may not be aware of the lack of evidence to support this position and that they are in conflict with many nursing organizations (ANA, 2011; AWHONN, 2015).

### **Legal Perspective**

Mandatory reporting of opiate-exposed infants can be used as a proxy for local prevalence of maternal opioid use. It may lead to interventions by law enforcement or social services. Legislative action toward maternal opiate use is variable between states, and is creating disparities in care and intervention (Guttmacher Institute, 2015; Young et al., 2009). Some state policies regarding testing and reporting of mothers and infants with opiate exposure are more punitive, focusing primarily on the safety of the child, whereas others are more preventative and consider the health and well-being of the pregnant woman and her newborn. Testing and reporting policies can vary even within states (National Abandoned Infants Assistance Resource Center, 2012). Mandatory reporting, therefore, exposes women and infants to very disparate outcomes, depending on where they live and how local and state laws are interpreted and enforced.

A recent report from the Guttmacher Institute (2015) gives a national perspective of state laws. Eighteen states consider substance use in pregnancy child abuse and three consider it grounds for civil commitment. Fifteen states require healthcare workers to report suspected abuse to the state, and four mandate testing of pregnant women (Guttmacher Institute, 2015). A myriad of other laws exist in counties and municipalities, and definitions of suspected substance abuse, as well as who is mandated to report and when, are not consistent or clear. The potential negative effects that may occur as a result of the legal actions taken against prenatal drug abusers are many. These negative effects may include, but are not limited to, avoidance of prenatal care, constitutional infringements, discrimination, poor prison conditions, and ineffectiveness of punitive measures (Coleman & Miller, 2006).

The punitive approach is aimed at cost reduction and social well-being. Nationally, costs of all infant drug exposure total between \$71 million and \$113 million per year, but in particular treatment for opiate exposure is extremely costly (National Abandoned Infants Assistance Resource Center, 2012). However, legal action has many negative unintended consequences. ACOG (2014) states, "policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus" and that "seeking obstetric-gynecologic care should not expose a woman to criminal or civil

penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.” ACOG also points out that it cannot be assumed that a pregnant woman who does not receive treatment does not want it, as availability of substance abuse treatment for pregnant women is limited (ACOG, 2014; Guttmacher Institute, 2015).

### **Professional Response**

Many health professional organizations instruct their members that their duty is to a woman and her baby rather than to law enforcement. This may place healthcare workers at odds with state and local ordinances. The American Nurses Association (ANA) states that the threat of prosecution undermines nurse efforts to assist women seeking care and that nurses should align themselves with social services rather than law enforcement to help women and infants (ANA, 2011). The National Perinatal Association opposes criminal prosecution of women who abuse substances while pregnant, as there is no evidence that this helps the mother or infant (Advocates for Pregnant Women, 2011; National Perinatal Association, 2013). The American Society of Addiction Medicine (ASAM) supports treatment rather than criminalization as incarceration may hurt the health of the mother and fetus, and may not address efforts toward long-term recovery (ASAM, 2011). Most recently in January of 2015 the Association of Womens’ Health, Obstetric, and Neonatal Nurses (AWHONN) released a position statement that, while endorsing a nurses’ responsibility to follow the law, opposes incarceration or punitive legal action against women due to substance abuse in pregnancy. Additionally they affirmed nurses’ role in supporting mandatory screening in all pregnant women for the purpose of providing referrals and treatment to support healthy outcomes (AWHONN, 2015).

### **Working Together**

Some have advocated for combined punitive and supportive approaches. The national extent of maternal opioid abuse and resulting NAS is not clear, and it is variable around the country. Programs aimed at quantifying NAS as a diagnosis, looking at trends in geographic areas and in differing populations, are needed. Young et al. (2009) concluded we may be missing an opportunity to increase the impact of policy on the issue of substance use in pregnancy, and that solutions require public and private entities to work together to address how we serve families. Additionally there is opportunity for partnerships to identify where differences exist in policy goals versus implementation of local laws (Young et al., 2009).

De-identified mandatory reporting of infants exposed to opiates can provide data to drive interventions and has the potential to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Programs such as this are underway in Tennessee and Florida, the results of which are eagerly awaited (ASTHO, 2014; CDC, 2015; Bondi, 2014; Tennessee, 2015). Screening and reporting should be viewed as part of a larger issue of policy and practice interventions for individuals and families. Which mechanism to use for screening, where to collect and house

the data, and how the data is used are all questions that need to be addressed. This issue requires a clear definition of terms, consistent implementation, and availability of treatment interventions, which are currently sparse. According to the Guttmacher Institute (2015) only 19 states have drug treatment facilities targeted to pregnant women, and only 11 provide these women with priority access. Four states do prohibit publicly funded programs from discriminating against pregnant women (Guttmacher Institute, 2015).

### **Family Response**

Hogan (2007) provides another distinct point of view in researching how opioid-addicted parents view themselves, and how to best intervene. This study looked at various factors affecting the parenting ability of opioid addicts. Parents perceived themselves to have difficulty being emotionally available and responsive. Additionally, they were often separated from their children by incarceration, hospitalization, or drug seeking behaviors. The implication of this study is that “support should be targeted at families as systems, rather than at drug users as individuals. It should focus on ensuring continuity, not only of instrumental caregiving, but also of emotional caregiving to children” (Hogan, 2007, p. 17). Clearly all interventions attempted will need a systematic population health focus. As stated earlier, nurses need to understand how their actions are perceived, and what nursing modalities improve infant outcomes. Nurses’ attitudes and actions toward an opioid-exposed mother may interfere with the mother’s self-worth and ability to care for and bond with her baby (Cleveland & Gill, 2013; Davis & Yonkers, 2012; Fraser et al., 2007). Society has much work to do, and nurses who encounter these situations daily are well positioned to intervene and create positive outcomes for mother-infant dyads experiencing opioid addiction.

### **Nursing Challenges**

Nurses need education regarding substance abuse and different ways to nurse that can mitigate challenges and decrease stress. Problems addressed should include how nurses are trained regarding NAS, what leads mothers to abuse opiates, and the psychosocial effects of the disease on the infant and his caregivers. They also need evidence-based strategies that are shown to aid mother and infant through the crucial early withdrawal and bonding moments. Velez and Janssen (2008) give a succinct, clear message about the care of our vulnerable infants when they describe the interactions between the nurse, the mother, and the infant experiencing NAS. They describe how dysregulated infants require stable responsive caregivers and how the infants’ behavior can alter caregiver behavior. These authors also note that signs displayed by the infant, and the modification of the signs with concomitant recovery, depend on the ability of the caregiver to interpret these signs and provide appropriate individualized care (Velez & Janssen, 2008). Many things affect the mother’s ability to interpret these signs and provide this care to her infant; therefore it is incumbent upon the nurse to “assess and interpret the infant’s behaviors, determine how the mother understands and responds, and tailor interventions” to help the mother have confidence in her ability to care for her infant (Velez & Janssen, 2008, p. 119) thereby creating successful mother-infant bonds.



Increased perception of support from nursing staff results in decreased likelihood of depressive symptoms among opioid-exposed mothers (Davis & Yonkers, 2012). Also, there is increasing information that keeping the opioid-exposed mother-infant dyad together in the same room and breastfeeding leads to shorter hospital stays and increased bonding (Isemann et al., 2011; Saiki et al., 2010). Non-pharmacologic intervention and complementary therapies are used in neonates, but they have not been widely studied and while they have anecdotal success, they do not have proven efficacy (Sublett, 2013). The literature around approaches to pharmacologic and non-pharmacologic maternal and infant therapies as well as optimal feeding and differences in gestational age response is inconsistent (Isemann et al., 2011). The research possibilities abound. Validating and implementing potential interventions may go a long way toward allowing for increased understanding on the part of nurses and increased success of the mother-infant dyad.

## Conclusion

While the number of substance-abusing mothers is increasing, so is the understanding of the addiction and withdrawal process and how we as professionals might best intervene. While current trends may encourage punitive responses to these mothers, the evidence is mounting that treatment and support are better options for families affected by substance abuse. Professional organizations are unanimous in calling for this approach. De-identified mandatory reporting of infants exposed to opiates may provide data to drive interventions and therefore has the potential to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Screening and reporting can be viewed as part of a larger issue of policy and practice interventions for individuals, families, and communities. Inter-professional cooperation can aid with mutual goal setting for affected mothers and children. Non-punitive policy solutions may include drug diversion courts, priority for pregnant women in treatment centers, and treatments designed specifically for women. There is a need to educate nurses, legislators, and society in general about the addiction disease process, to address issues upstream such as reasons that lead to opiate abuse, and to clarify the role of legislation and health care providers in the fight against opiate abuse. Educated nurses are well positioned to research, advocate, intervene, and create positive outcomes for mother-infant dyads experiencing opioid addiction.

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