



Original article

Initiation and Engagement with Methadone Treatment among Pregnant and Postpartum Women

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Article history: Received 2 November 2016; Received in revised form 11 May 2017; Accepted 11 May 2017

A B S T R A C T

Purpose: The purpose of this study was to explore perceptions of experiences and challenges with methadone maintenance treatment (MMT) and obstetrical care among pregnant and postpartum women enrolled in a methadone maintenance program.

Research Design: The study featured a grounded theory approach including two focus groups with pregnant and postpartum methadone users at a methadone maintenance clinic in Worcester, Massachusetts. Two research team members conducted and recorded focus groups, which took approximately 45 minutes to 1 hour. Grounded theory was used to guide data analysis and open coding, where transcripts were reviewed line by line to create code definitions as concepts emerged inductively from the data.

Results: Five emergent themes were derived from the data: 1) guilt, coupled with fear of negative outcomes for their infant, dictates women's MMT treatment decisions; 2) finding obstetricians with experience treating pregnant women using methadone can be a challenge; 3) methadone clinic physicians are instrumental in helping women find the right methadone dose during pregnancy; 4) some women had strong preferences for methadone over buprenorphine; and 5) women face substantial substance abuse treatment challenges after delivery.

Conclusions: Women experience substantial challenges engaging in MMT during the perinatal period. Additional challenges arise from finding obstetrical providers who have experience with MMT and are willing to care for pregnant women. This study may provide a starting point for future interventions seeking to improve care coordination between substance abuse treatment and prenatal care programs.

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Illicit opioid use among pregnant women has tripled in the past ten years, with 1.2% of all pregnant women reporting nonmedical use in 2012 ([Substance Abuse and Mental Health Services, 2013](#)). Data for pregnant women from the Substance Abuse and Mental Health Services Administration's Treatment Episodes Data Set suggests that the percentage of pregnant women in addiction treatment who reported opioid abuse

increased from 2% in 1992 to 38% in 2012 ([Martin, Longinaker & Terplan, 2015](#)).

Over the past decade, the incidence of neonatal abstinence syndrome (NAS) among hospital-born newborns increased from 1.20 to 3.39 per 1,000 live births per year ([Patrick et al., 2012](#)). Some infants exposed to opioids in utero may exhibit symptoms of NAS, including hyperirritability and dysfunction of the nervous system, gastrointestinal tract, and respiratory system ([Finnegan & Kaltenbach, 1992](#)). These symptoms can stem from appropriate use of prescribed medications as well as illicit use.

Methadone maintenance therapy (MMT) and buprenorphine are the leading evidence-based treatments recommended for opioid-dependent women during pregnancy. Several studies have compared methadone and buprenorphine treatment for pregnant women ([Jones et al., 2010](#); [Wiegand et al., 2015](#)). Methadone has been used for medication-assisted treatment in pregnancy since the 1970s, and is distributed through federally regulated clinics in which daily visits are usually required. Conversely,

Funding Statement: No funding for this study.

Conflict of Interest: No potential conflicts exist.

Disclaimer: The opinions expressed here are those of the authors and do not represent the official policy or position of the University of Massachusetts Medical School.

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buprenorphine, approved for opioid addiction treatment in 2002, is available by prescription and can be administered at home, has less overdose potential, fewer drug interactions, and generally results in a milder NAS (Johnson, Jones, & Fischer, 2003; Jones et al., 2012; Klaman et al., 2017). Because buprenorphine is available in an office-based setting, accessibility is greatly increased, especially for those living in rural areas where methadone clinics may not be located (Stein et al., 2015).

Pregnant women may experience unique challenges related to initiation and engagement with MMT, which reduces illicit opioid use, improves women's access to prenatal care, and improves neonatal outcomes (Keegan, Parva, Finnegan, Gerson & Belden, 2009; Bell & Harvey-Dodds, 2008; Jones et al., 2008). Pregnant women may be experiencing immediate psychosocial challenges (e.g., housing, money, child care, domestic violence, and physical and mental health) that may pose challenges related to MMT treatment initiation and engagement (Haskell, 2003; Davie-Gray, Moor, Spencer & Woodward, 2013; Dryden, Young, Hepburn & Mactier, 2009; Martin et al., 2009). Furthermore, the initiation of MMT requires significant changes in lifestyle, including daily medication visits, as well as clinic visits for drug screening and counseling (Holt, 2007), which may be an added burden to pregnant women struggling with competing psychosocial issues. MMT may also pose a challenge for pregnant women who may be experiencing withdrawal symptoms while titrating to an effective dose during pregnancy, while also managing both pregnancy and MMT side effects (Darke, Sims, McDonald & Wickes, 2000). During pregnancy, many women continue to use both licit and illicit drugs (Davie-Gray et al., 2013) and treatment attrition is common, with more than 60% of patients ending treatment within 12 months of initiation (Farré, Mas, Torrens, Moreno & Cami, 2002; Nosyk, Marsh, Sun, Schechter & Anis, 2010).

An additional challenge for pregnant women is finding obstetrical providers with experience caring for opioid-dependent pregnant women (Meyer & Phillips, 2015). Many women delay or avoid prenatal care for fear of being discovered or punished for their substance abuse (Roberts & Nuru-Jeter, 2010; Roberts & Piers, 2011; Stone, 2015). Few studies document the perspective of obstetrical providers in working with opioid-dependent pregnant women, but women's perspectives suggest that they experience stigma and discrimination from obstetrical providers unfamiliar with methadone treatment (Stone, 2015). Few programs coordinate opioid substitution and prenatal care, but recent studies suggest integrated opioid substitution and prenatal care programs increased use of opioid substitution therapy and decreased time to first prenatal care appointment for pregnant women in the study (Meyer & Phillips, 2015).

Despite existing literature, there is little information to describe the decisions women must make throughout the pregnancy and postpartum period related to methadone use, and how these decisions may change over the course of the pregnancy and during the postpartum period. Importantly, this paper describes how supportive medical and mental health services at one methadone clinic helped women to initiate and remain engaged in medication-assisted treatment during the pregnancy and postpartum periods.

Methods

Study Design

The study used a grounded theory approach (Corbin & Strauss, 2015), including two focus groups with pregnant and

postpartum methadone users at a methadone maintenance clinic in Worcester, Massachusetts. The focus groups were conducted during a regularly scheduled support group for pregnant and postpartum women. A grounded theory approach was used to create in-depth descriptions of participants' perceptions and experiences by identifying common themes through the words expressed by participants during the focus group. Grounded theory methods can be used to identify general themes without development of substantive theory as long as the researchers clearly state their intent (Corbin & Strauss, 2015).

Participants

Women were recruited from a pregnancy and postpartum support group within a large urban methadone maintenance clinic serving approximately 1,500 patients per day. For 1 month before the focus groups, the support group leaders reminded women that university researchers were going to attend the support group and conduct a focus group, and that women were welcome to not attend on the day of the focus groups if they did not feel comfortable being included. On the day of the focus groups, women were also given an opportunity to not participate if they did not feel comfortable doing so.

Women were considered eligible for the study if they were 18 years of age or older, currently pregnant or recently postpartum (within 12 months of delivery), on methadone treatment, and attending a pregnancy or postpartum support group at the clinic. Participants received a \$20 gift card for participation. The research protocol was approved by the Institutional Review Board at the University of Massachusetts Medical School.

Data Collection

Two research team members conducted the focus groups, and verbal consent was obtained before the focus groups. Both interviewers were experienced with qualitative data collection methodologies. Each focus group took approximately 45 minutes to 1 hour to complete. Focus group questions can be found in Table 1. Focus groups were audio-recorded, transcribed, and entered into Atlas.ti (Scientific Software Development, Berlin, Germany, 2014).

Data Analysis

Grounded theory was used to guide data analysis (Corbin & Strauss, 2015). Each transcript was read in its entirety to gain a sense of each woman's experience. Open coding was used, where the transcripts were reviewed line by line, creating code definitions as concepts emerged inductively from the data. Coders met to compare codes, resolve discrepancies, and review the code structure. The constant comparative method of qualitative analysis was used to compare coded segments of text to expand existing themes and identify new ones. Codes were refined until we reached a final coding structure. Descriptive statistics were used to describe the demographic characteristics of the participants, which were provided by clinic staff after the focus groups.

Results

Demographics of Participants

Overall, 14 women participated in the study; 5 women participated in the pregnancy focus group and 9 women participated in the postpartum focus group. Eighty percent of the

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