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The Role of Case Management in Providing Care to Pregnant and Parenting Women with Substance Use Disorders

Women frequently come into treatment with intense case management needs, and it has been our experience that without support for addressing psychosocial needs it is difficult for our patients to get their lives back on track. At the same time, it is important for the treatment team to not become overwhelmed or sidetracked by trying to address all case management needs at once.

Our model includes a "Resource Specialist", whose role is specifically to address case management needs of women in the program. Not all clinics will have the luxury of hiring staff specifically for this role, and it is also possible for other members of the team to provide case management support. This could be a nurse, a recovery coach, a behavioral health clinician or even the midwife or MAT provider. However, if the person providing case management support also has another role on the treatment team, it makes sense to schedule specific times to address case management needs with the patient, and specific times to address other needs. In this way the role of providing perinatal and addiction treatment does not get neglected by the pressure to solve enormous and often intractable psychosocial problems.

This is an important point. Knowing how to ask for help in an effective way is often not a well-developed skill with this population. It is a common scenario that a woman will spend her entire prenatal visit discussing her depression with her midwife, then talk to her therapist about her concerns about her pregnancy and ask her psychiatrist for help finding housing. Being clear about what issue is going to be addressed in a given session, and redirecting the patient to the appropriate person for help with her problems, is a crucial part of providing effective treatment.

Typical case management concerns for this population include homelessness or insecure housing, lack of insurance, difficulty accessing needed benefits such as cash assistance or food stamps, unmet healthcare needs (particularly dental health), lack of transportation, unresolved legal problems, child custody dilemmas, lack of child care, unemployment or underemployment, interrupted education, food insecurity and difficulty maintaining communication with necessary supports (no cell phone or running out of cell phone minutes, no internet access, mailing address, etc.). It is not uncommon for a patient to present to care with every single one of these unmet case management needs, and the treatment team needs to resist the understandable reaction of becoming overwhelmed or panicked.

It is important to remind ourselves that our patients' problems didn't develop in a single day and they cannot be solved in a single day. Homelessness and insecure housing is clearly the most destabilizing issue that any family will face, and also one of the most difficult issues to resolve. In the meantime,

women can be provided with support for addressing other needs. Hunger can often be ameliorated the same day, especially if a program is able to support on on-site food shelf. At our program we have been fortunate to partner with our local food pantry to provide on-site access to fresh food and canned goods, but most agencies can probably support a box with peanut butter, soup and tuna fish available for patients in need.

Co-located care is at the heart of this model. A highly effective case management strategy is to bring representatives from other agencies into the clinic so that women can sign up for needed services at the same time as they are receiving their prenatal care and addiction treatment. For example, a representative from WIC can sign moms up for care after group treatment. Having an advocate from the local domestic violence prevention agency come to the clinic to present information about healthy relationships and having her remain available afterwards to meet with women individually is an excellent way to introduce patients to this critical resource.

When addressing case management needs, we must consider patient autonomy and respect for the complex situations that can interfere with a woman's ability to access supportive services. For example, a woman may choose not to apply for benefits because DHHS requires that she name her children's father in the application, and this in turn may have financial or legal ramifications for her partner. She may be at risk of emotional or physical abuse if she were to go against his wishes. We may be perplexed by a woman's choice to live in her car rather than accept the opportunity to get an apartment, but PTSD symptoms might interfere with a woman's ability to tolerate living in an apartment complex.

While it is extremely helpful to do a full psychosocial needs assessment when a woman first comes into treatment, it is important to respect a woman's right to address any case management issues at her own pace and in her own way. Gentle encouragement to try new approaches to solving problems, support for overcoming barriers to accessing services, and using motivational interviewing techniques to help women resolve ambivalence about making changes are three ways to help our patients move towards a stable lifestyle that will support long term sobriety.