Educational Support Group for Pregnant and/or Parenting Women in an Opioid Dependence Treatment Program

A Manual for Implementation
Women’s Support Group Manual

Contents

Introduction

Part One – Starting an Educational Support Group in Your Medical Office

1. What is this group?
2. How is this different from other therapy and self-help groups?
3. How do I get my patients to attend?
4. What about patients with other addictions?
5. Who can run this group?
6. How can I incorporate this into my providers’ schedules?
7. How can I bill for this service?

Part Two – Choosing a Facilitator

1. What skills does someone need to be a group facilitator?
2. Trauma-informed Approach
3. What are the benefits of being a group facilitator?
4. What are the expectations of a group facilitator?

Part Three – The First Meeting

1. Where should I hold this meeting?
2. What to do at the first meeting
3. Getting the word out about your group

Part Four – Meeting Activities

1. Suggested discussion topics
2. How to facilitate discussions
3. Types of questions to ask
4. Additional tips for running groups

Part Five – Appendices

1. Appendix A: Sample Discussion Questions
2. Appendix B: Educational Videos
3. Appendix C: The Relational Model of Group Development
4. Appendix D: A Trauma-Informed Approach
Introduction

Over 90% of women who are drug-dependent are of child-bearing age\(^1\) resulting in increased hospital stays and higher incidence of treatment for Neonatal Abstinence Syndrome in babies born between 2004 and 2013.\(^2\) Among mothers in recovery, much of the literature suggests that there are deficits in parenting knowledge, specifically newborn care and feeding.\(^3\) Multidisciplinary interventions have been shown to be most beneficial in terms of providing patient care for mother and fetus.\(^4\) There is also significant literature demonstrating that mothers with a substance use disorder and their children can benefit from an attachment-style parenting intervention.\(^5\) The topic guide provided with this intervention was developed with input from female patients, past research studies, and information from the literature regarding this target population. The aim of this intervention is to support mothers during their recovery by providing medical information about the development of their child, parenting best practices, and emotional peer support.

Disclaimer

This group is meant to be in addition to regular medical treatment and medically-oriented substance abuse counseling by clinicians in a medical office setting for individuals in recovery. This is not meant to be a substitute for therapy or other addictions interventions. It is meant to be used for health education and risk reduction. We advise all participants to continue to follow the recommendations of their physicians and outside chemical dependency counselors while participating in this group.
Part One – Starting an Educational Support Group in Your Medical Office

1. What is this group?

The purpose of this group is to create a safe space for pregnant and/or parenting women in opioid dependence recovery to support and learn from each other. This group was originally created for women in an opioid dependence clinic who were prescribed buprenorphine. Some women were pregnant for the first time, while others had multiple children. The only criteria was motherhood (typically younger children), active status in treatment, and a willingness to share and learn from other women.

Groups for health education and risk reduction are meant to be facilitated by a professional member of the office staff. Topic guides and resources for groups have been provided to generate conversations regarding recovery, parenting, and more. It is the purpose of this group to help women create healthy, supportive relationships with other mothers in order to foster greater commitment to recovery and an increase in parenting skills and confidence.

2. How is this different from therapy and self-help groups?

The idea for these groups first developed from research which highlighted deficits in parenting knowledge among this population. With input from clinic patients, these groups then evolved into an educational support group which discussed topics related to recovery, domestic violence, Neonatal Abstinence Syndrome, and more.

This group is different from traditional group models in chemical dependency and inpatient treatment centers due to its emphasis on health education and mutual help and support, not therapy. Unlike therapeutic groups, the purpose of this group is to share personal experiences of motherhood and learn more about parenting and recovery from a trusted health professional. Since patients are not mandated to attend, an open dialogue can more easily be achieved among members.

This program is unique from self-help groups, such as Narcotics Anonymous, because of its specific emphasis on women and their experiences. This provides a safe space for members who may have experienced previous trauma from men and may not feel comfortable sharing in front of them. The fluid nature of this group also allows topics to be tailored to the interests of participants and current events in their lives. There are no added requirements for participants to complete the 12-steps or commit to a higher power. The groups simply exist as a space to share knowledge and grow with each other in recovery.
3. How do I get my patients to attend?

- **Scheduling is key:**
  - Schedule groups for the same day a patient’s prescription expires and at a time close to group time. For example, if group is held at 11:00am, schedule patients appointments with the doctor for 10:00am through 10:45am to ensure there is sufficient time for paperwork, urine samples, and seeing the provider.
  - Similarly, when prescribing, schedule prescriptions to expire the same day group is held. Our office found that patients are more likely to travel to the office if they need a prescription. This also decreases the amount of travel patients have to do if they can see the doctor and attend group the same day, thereby alleviating additional burdens of transportation and child care.
  - Other practice groups can schedule appointments for the same day as group and get women who attend group on the same visit schedule.
  - If the office schedule does not allow time for patients to be seen and attend group on the same day, schedule medical visits between group weeks. This may require patients to come to the office an extra day a month.

- **Allow mothers to bring children:**
  - Allow women to bring children to group. In many outpatient groups, mothers are not allowed to bring children, which places an additional hardship on mothers to find childcare and discourages many from attending.

- **Keep group size manageable:**
  - If the number of women attending becomes too many for the facilitator to handle, consider setting a maximum limit of participants or separate the group into two if possible. Having too many members in the group can prevent each participant from having adequate time to talk. Plus, too many members may also mean a large number of accompanying children, which can be distracting.

- **Keep attendance optional:**
  - Do not mandate that members must attend all groups. Requiring perfect attendance could set an unrealistic goal that might discourage women from participating.

- **Provide snacks or refreshments to encourage attendance**
4. What about patients with other addictions?

While this support group was only conducted with women who were prescribed buprenorphine for opioid dependence, many attendees had polysubstance abuse. Since many of these topics are general to any mother in recovery, expand the addictions criteria if you see fit.

5. Who can run this group?

Any office staff member who has the time, compassion, and empathy can run this group. However, in order to bill for services, groups must be run by a physician, nurse practitioner, physician assistant, or a registered nurse (RN). You may also want to have a group facilitator who is different than the patient’s regular provider in order to encourage a safe space for discussion.

6. How can I incorporate this into my providers’ schedules?

The minimal structure of this group is meant to allow for greater flexibility when incorporating groups into your existing office schedule. Our office found that many women could only attend group in the morning due to childcare needs in the afternoon. However, each office varies and we encourage you to discover a schedule that works with both your providers and patients.

7. How do I bill for this service?

Groups can be coded as a billable service in various ways depending on who is facilitating:

**Billing for Services.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>Bundled into standard E&amp;M codes</td>
</tr>
<tr>
<td>99078</td>
<td>Counseling and education provided by a physician to a group</td>
</tr>
<tr>
<td>99411 (30 minutes)</td>
<td>Physician:* preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)</td>
</tr>
<tr>
<td>99412 (60 minutes)</td>
<td>Physician:* preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)</td>
</tr>
<tr>
<td>98961 (2-4 patients)</td>
<td>Non-physician: education and training for patient self-management by a qualified, health care professional using a standardized curriculum</td>
</tr>
<tr>
<td>98962 (5-8 patients)</td>
<td>Non-physician: education and training for patient self-management by a qualified, health care professional using a standardized curriculum</td>
</tr>
</tbody>
</table>

* or other qualified health care professional
Part Two – Choosing a Facilitator

1. What skills does someone need to be a group facilitator?

Successful facilitators will be compassionate, nonjudgmental, and have strong listening skills. It is important for the facilitator to possess knowledge about matters related to addictions and pregnancy. It is also helpful if facilitators are versed in trauma-informed care. In order for groups to be successful, the facilitator must be able to lead group members in a discussion and be aware of triggers. Steering away from topics regarding past use and moving the conversation towards experience sharing and health education will create the most beneficial atmosphere. Someone who is able to gently lead a conversation, effectively manage group dynamics, reflect on what group members say, and abstain from giving nonmedical advice or therapy will be the most appropriate person to lead this type of group. Additionally, our office found through focus groups that a female facilitator is largely preferred over a male facilitator.

2. Trauma-informed Approach

Trauma can be an event or a response to a negative event, such as violence, abuse, or stigmatization. A trauma-informed approach is directly in line with the goal of these groups: to create a safe and gender responsive space to address the unique needs of women in recovery. A trauma-informed approach to care aims to create a safe environment that respects group members’ privacy and maximizes opportunities to make their own decisions. A facilitator can be trauma-informed by recognizing that trauma is widespread, comes in different forms, and group members may have experienced trauma at some point in their lives.

Part of a trauma informed approach is avoiding re-victimization and re-traumatization in the group setting. A facilitator’s familiarity with addiction and trauma triggers, sensitivity to the type of language used, and knowledge of the need for interconnectedness can better assist in the creation of a safe environment that creates opportunities for learning coping skills, a more comfortable environment for sharing, and a sense of empowerment. (See appendix D for further information on a trauma-informed approach.)

3. What are the benefits of being a group facilitator?

A group facilitator gets to know her patients in a unique and intimate way. Through witnessing their stories and experiences, a facilitator will learn more about patients’ condition and how to better treat their disease. Prior to conducting these groups, our office was unaware of the lack of knowledge among this population, the depth of shame they experienced, and the amount of structural stigma they encounter throughout their recovery. Being informed about these concerns adds to your
knowledge base as a medical professional and increases trust between you and your patients. Groups also offer another opportunity to interact with patients and educate them about their disease.

4. What are the expectations of a group facilitator?

- **Create a safe space**
  - The greatest responsibility of a group facilitator is to create a safe space for participants to share their experiences. Facilitators may also be responsible for mediating conflicts.

- **Prepare topics and materials**
  - Be prepared to introduce a topic for discussion.
  - Facilitators may use the prepared curriculum materials or prepare new materials as needed.
  - It is expected a group facilitator will spend time each week preparing for group sessions. Preparation may take 15 minutes to an hour or more depending on the topic, prior knowledge, and style of the facilitator. The facilitator is expected to prepare materials and set up any activities ahead of time. Preparation time requirements for the facilitator are approximately 5-10 hours per month.
  - Offer snacks or refreshments.
  - Provide toys or activities to entertain young children accompanying their mothers to group sessions.

- **Greet group members as they arrive**

- **Participate in the group process by guiding the conversation and providing information**
  - The facilitator should maintain a balanced discussion by preventing any one person from dominating the conversation and redirecting members who veer off topic.

- **Communicate and coordinate with office staff and providers**
  - Communicate with providers to align prescriptions with group dates
  - Communicate with office staff to coordinate the logistics of reserving a space and scheduling appointments around group dates and times
  - Maintain attendance records according to office policy
Part Three – The First Meeting

1. Where should the first meeting be held?

Meetings should be held somewhere participants can sit in a circle, facing one another. It may be helpful for everyone to be seated around a table, although this is not necessary. If there are no other patients in the office at the time of this group, you might find that the waiting room is the easiest place to have meetings. Otherwise, a break room, conference room, or other place that can fit a circle of 4-8 people and possibly some children would be ideal.

2. What to do at the first meeting?

- **Introductions**: At the first meeting, participants are trying to figure out their roles. Participants may be shy or uncomfortable until they get to know one another. At the first meeting, the facilitator should introduce herself and have all members introduce themselves as well. The facilitator may also ask why participants are interested in joining this group; to define the type of support they are looking for (i.e., advice, information, moral support, to be listened to, social outlet); and to share the number of children they have and their ages.

- **Review confidentiality**: It is important to explain the confidential aspect of the group. The facilitator should explain that group member identities and everything shared in group should remain confidential. Additionally, if the group facilitator is a mandated reporter, she should explain to group members this professional obligation to report suspected child abuse or maltreatment to the proper authorities, when there is reasonable cause to suspect child abuse or maltreatment, as well as group member threats to harm oneself or others.

- **Ground rules**: After introductions, take some time to set up ground rules with the input of group members. Examples of ground rules include:
  - Only one person speaks at a time
  - Refrain from side conversations
  - Everyone will have a chance to talk
  - Physical or verbal attacks will not be tolerated; member will be asked to leave group if this happens
  - Silence cell phones, unless expecting an important phone call
  - Keep members' identities and stories confidential; do not discuss other members' situations outside the group environment
o Group members should strive to be non-judgmental and accepting of others
o Punctuality

3. Getting the word out about your group

- Provider recommendation: Ask providers to notify eligible patients about the opportunity. In our office, any female patient who is pregnant and/or parenting children and in treatment for opioid dependence is welcome to attend. Since the group is most productive when participation is optional, we recommend providers do not mandate clients to attend.

- Flyers: Our office also found it helpful to post flyers about the group in the waiting room and in patient exam rooms.
Part Four – Meeting Activities

1. Suggested discussion topics

In speaking with the women at our clinic, there were many topics they were interested in learning more about. Many times in a group session, one topic would lead to another and the focus of the group might shift depending on the individual experiences and perspectives in the room.

Topic areas we identified include:

- Etiology of addiction and genetic risks
- Neonatal Abstinence Syndrome (NAS)
- Fetal Alcohol Syndrome
- Labor and delivery on buprenorphine
- Hepatitis C and pregnancy
- Breastfeeding
- Postpartum depression
- Contraception and family planning
- Sudden Infant Death Syndrome (SIDS)
- Stigma, shame, and guilt
- Parenting:
  - Positive discipline
  - Family mealtimes
  - How to handle difficult behavior
  - Co-parenting
  - Creating secure attachments with children
- Healthy relationships
- Stress management, coping, and self-care
- Balancing recovery, family, and multiple responsibilities
- Spirituality and recovery
- CPS and family court
- Drug court
- Custody issues

*Certain topics may be better suited for a doctor or nurse to convey (i.e., breastfeeding, family planning, etiology of addiction)

2. How to facilitate discussions

- Be an active listener
- Focus on what is being said, rather than trying to prepare a response
• Encourage the speaker to say more and paraphrase what they have said
• Show interest by making eye contact and nodding
• Ask other members what they think about what was shared
• Do not be afraid of silence; let group members fill in lulls in the conversation
• Give positive feedback
• Summarize the group at the end of the session
• Use prompts to move the conversation or prevent someone from monopolizing time,
  o “What you’re saying is very important and I don’t want to lose that point. Since we are running out of time, I will make sure we get to that next group.”
  o “Wow, you have a lot to offer the group and I’m so thankful you shared that with us! Let's move on to....”
• If a group member is in crisis, you may wish to allow her to share with the group before the discussion. However, make sure not all group time is spent on one person. Depending on the situation, you may offer to speak with her privately after group or provide referral resources for further help.

3. Types of questions to ask
• Avoid asking close-ended questions. Close-ended questions can typically be answered with a “yes” or “no” and do not open up the conversation for more dialogue.
  o Examples of close-ended questions: “Did you have a good day?” or “Do you know what Neonatal Abstinence Syndrome is?”
• Ask open-ended questions: Ask group members to talk about what they know about a topic to encourage more discussion and prevent the session from becoming a lecture about a health topic. As the conversation unfolds and gaps in knowledge become apparent, the facilitator can jump in with health information. To ensure that the group stays interactive, ask group members what they think about this new information.
  o Instead of asking “Do you know anything about Neonatal Abstinence Syndrome?” ask “Can you tell me what you know about Neonatal Abstinence Syndrome?”

4. Additional tips for running groups
• Invite an older woman who is in successful recovery to share her story with the group. (For example, we invited a guest speaker who shared her personal experience regarding trauma, unhealthy relationships, addiction, recovery, and hope with the group.)
• Aim for a mixture of pregnant and parenting women in the group in order to have diversity of experience.

• Keep group members consistent to encourage relationship-building and trust.

• Keep group numbers to 4-7 participants; anymore can restrict time available for everyone to talk.

• Spend the majority of group time allowing women to discuss their experiences. Interject when appropriate to provide supplemental medical information.

• Because children can be distracting, provide age appropriate entertainment for children accompanying their mothers to group: an iPad or DVD player with an hour long cartoon or movie; coloring books; play-doh; toys; etc.
Part 5 - Appendices

Appendix A: Sample Discussion Questions

1. What are some of the things that come to you naturally as a parent? What areas have you needed to reach out for advice or help?

2. How can you manage pain through delivery? What happens if you need to have a C-Section?

3. How can you advocate for yourself and your baby while in the hospital? What should you do if staff tells you information that is different than what your doctor told you?

4. What is Neonatal Abstinence Syndrome? How is the baby monitored and treated? What can you do to decrease the severity of the baby’s symptoms?

5. What can you tell me about the guidelines for breastfeeding while on buprenorphine? What are ways you can advocate about your right to breastfeed while on buprenorphine?

6. Can anyone describe the relationship between breastfeeding and Neonatal Abstinence Syndrome?

7. When do you think is the right time to introduce solid foods? How should you respond if your baby or child starts choking?

8. What do meal times look like in your house? Does anyone have tips on how to make meals more organized and less chaotic?

9. What are some ways babies communicate their needs? How do you know when your child needs something?

10. How would you describe separation anxiety? When does it happen and how do you help a child cope?

11. How do you manage a temper tantrum? Describe a time when you handled a tantrum by being sensitive to your child’s needs.

12. For women who have children already, share some experiences on how to continue nurturing a close relationship with older children. How do you set aside time to spend with them?

13. How often should you hold a baby? How often should you hold a small child? Do you think you can spoil a baby or child by holding them too much?

14. In what ways do you show affection to your child? How does your child ask for affection or how do you see him behave when he wants your affection?

15. What are things you could do to increase bonding and affection between you and your child using nurturing touch?
16. For women who have children already, tell us about the progression of your babies’ sleep schedules. When were they sleeping through the night? How many times did you have to get up to feed them?

17. What do you know about co-sleeping and bed-sharing? What about “back to sleep” and “tummy time?”

18. How can one create a safe environment for babies to sleep? Does anyone know the pediatrician recommended guidelines for sleep?

19. For women who have children already, how did you create a bedtime schedule for your children? What was effective? What was not as effective?

20. Can anyone describe an appropriate amount of supervision for a child? How does this change when the child gets older?

21. Does anyone have experience losing custody of children or had other prolonged periods of separation from children? How did you handle it?

22. What are some ways to reconnect with children after a separation? What has worked for other people?

23. Can anyone explain the difference between positive and negative discipline?

24. Is anyone familiar with the dangers of physical punishment and how they can affect a child?

25. If a child is being difficult and not listening to instruction, what is one creative way you have used to deal with this behavior?

26. Has anyone heard of using prevention, distraction, and substitution in disciplining a child? How do you think you might be able to incorporate these techniques? How do you think your child would respond?

27. On a scale from 1-10, how difficult do you find your child’s behavior to manage on a day-to-day basis? Is it manageable at this level? Where would their behavior need to be in order for you to find it manageable?

28. What do you think you have done that has been the most important for your children? How can you tell?

29. How do you help yourself deal with the pressures of raising children? How do you usually solve family problems? Who does what?

30. What time of the day or part of the daily routine seems tough in your family? What can you do to make this less stressful?
Appendix B: Educational Videos

1. Opiate Addiction: A New Medication  
2. Wait 21  
   https://www.youtube.com/watch?v=-6GMwAsdCOI
3. Journeys of Hope: Mommies and Babies Overcoming NAS  
   https://www.youtube.com/watch?v=__EVg05zCDM
4. NAS Soothing Techniques for Mommies and Babies  
   https://www.youtube.com/watch?v=7IFLrd8zudo
5. Subutex and Pregnancy, Dr. Steven Ferguson  
   https://youtu.be/Z3XYMdbWdhk
6. Talking to Kids About Addiction  
   https://www.youtube.com/watch?v=YH4Sz-1SGcE
7. Attachment Parenting  
   https://www.youtube.com/watch?v=eSlyRZm45ms
8. Positive Discipline  
   https://www.youtube.com/watch?v=4tBbL7VcNh0
9. Three Keys To Successful Co-parenting  
   https://youtu.be/9H8l9W9AkZq
10. Why Shame is Lethal, Brené Brown  
    http://huff.to/17bJoNp
11. Guided Meditation  
    https://www.youtube.com/watch?v=X7iBnp8T6nY
12. Drugs and Connection, In a Nutshell  
    https://youtu.be/ao8L-0nSYzg
13. Transcending Addiction and Redefining Recovery  
    https://www.youtube.com/watch?v=gzpTWaXshfM
14. Healthy Pregnancy, Healthy Baby: Alcohol and Pregnancy  
    https://youtu.be/W58S6VE6kgY?list=PL7EF68D0B439E073F
15. Medications and Pregnancy  
    https://www.youtube.com/watch?v=lYN1W1k4t1k&list=PL_XXfDtFe5UVJgszOUkTC2DKD1hiPPfXv&index=19
16. Prescription Medicine Before and During Pregnancy  
    https://www.youtube.com/watch?v=hBl9xmba0rs
17. Smoking, Alcohol, and Drugs  
    https://www.youtube.com/watch?v=JOvTo546YVU&index=56&list=PL7EF68D0B439E073F
18. How a Baby Develops During Pregnancy  
    https://youtu.be/h82l8r84_Yg
Appendix C: The Relational Model of Group Development

The Relational Model of group development was developed by Linda Yael Schiller to explain developmental stages in women only groups (1995). This model incorporates feminist scholarship to explain stages of development.

1. Pre-Affiliation

Similar to other theories of group development, the Relational Model begins with pre-affiliation. In this stage, group dynamics are beginning to form. Members of the group are concerned with more practical tasks such as planning and organizing and group emotions begin to emerge.

2. Establishing a Relational Base

At this stage in group development, women begin to form bonds and establish safety within the group. They may discover similar perspectives or life experiences that help them to build intimacy with group members. The group facilitator can help members at this stage by working to create a safe space within which members can connect with one another.

3. Mutuality and Interpersonal Empathy

This stage allows for the development of empathy and the appreciation of differences among group members. Since members have taken time to bond over similar experiences, they are now able to continue their relationships with each other despite any differences that may arise. At this stage, the facilitator can foster empathy by sharing when she was touched by something that happened during group.

4. Challenge and Change

At this stage, conflict begins to become more prevalent. Women have developed empathic connections to one another and feel safe enough to confront members. During this stage, the facilitator should help members navigate conflict while trying to maintain bonds. The facilitator should encourage women to explore conflicts.

5. Termination

In the final stage of group development, members may evaluate the results of the group. The process of separation begins and group cohesion decreases. Many times, members will have a celebration to mark the end of their group.
Appendix D: A Trauma-Informed Approach

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):\textsuperscript{10,11}

Trauma-informed interventions recognize:
- The trauma survivor’s need to be respected, informed, connected, and hopeful regarding recovery
- The interrelation between trauma and symptoms of trauma
- The need to work in a collaborative way with survivors, family and friends, and other agencies to empower survivors

Six key principles of a trauma-informed approach:
- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, historical, and gender issues

Trauma-informed programs, organizations, and systems:
- Realize the widespread impact of trauma and understand potential paths for recovery
- Recognize the signs and symptoms of trauma in clients, families, staff, and others involved in the system
- Respond by integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization

[See \url{https://www.samhsa.gov/nctic/trauma-interventions#Addiction and Trauma Recovery Integration Model} for examples of trauma-specific interventions.]

Common triggers for re-traumatization:\textsuperscript{12}
- Feeling a lack of control
- Experiencing unexpected change
- Feeling threatened or attacked
- Feeling vulnerable or frightened
- Feeling shame
Acknowledgment

This study was supported in part by the SUNY Buffalo State Institute for Community Health Promotion Collaborative Research Initiative.

References