

Peer Recovery Specialist Who Are Also Mothers: An Overview

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Peers Supporting Pregnant & Parenting Women with SUD



Pregnant and parenting women are a unique population disproportionately affected by SUD requiring tailored services instead of a one-size-fits-all approach to treatment and aftercare. Gender-specific treatment options operationalized with PRS who are also mothers in recovery can be the link and safety net needed to support this population through a trauma-informed lens utilizing a whole person-centered approach beyond symptom management as a specialty treatment and recovery collaborative model.

For many women with substance use disorder (SUD), pregnancy can be a pathway towards recovery and motherhood but for others, the issues experienced during this time are criminalized and stigmatized, limiting a person's ability to obtain treatment and wellness. Navigating the landscape as a mother with SUD presents a litany of challenges regarding prenatal care, specific treatment/recovery options, aftercare support, criminal justice rehabilitation practices, mandated reporting and postpartum behavioral health.

SAMHSA defines a Peer Recovery Specialist (PRS) as "A person who uses his or her lived experience of recovery from mental illness and/or substance use disorder, plus skills learned in formal training to deliver services in behavioral health settings to promote mind-body recovery and resilience." Gender specific SUD treatment collaboration models utilizing peer recovery specialist services are not well known or implemented universally for mothers in recovery. Nationally, only a handful of states are employing mothers in recovery who are also certified as PRS to combat this service gap, aiding prenatal and postpartum teams supporting

mothers affected by SUD. The need to enhance and build capacity around gender specific and culturally competent training standards to include subpopulation (such as mothers in recovery) options to support this unique intersection within the peer recovery scope of practice has shown to greatly impact participant outcomes, health disparities and community integration.

Evidence-Based Positive Maternal Health Outcomes Correlated with PRS Collaboration Models

<ul style="list-style-type: none">Increased use of perinatal health care	<ul style="list-style-type: none">Emotional support
<ul style="list-style-type: none">Provide service coordination before, during and/or after childbirth	<ul style="list-style-type: none">Decreasing isolation and depression symptoms
<ul style="list-style-type: none">Longer breastfeeding outcomes	<ul style="list-style-type: none">Adverse Childhood Experiences (ACEs) and Resiliency awareness
<ul style="list-style-type: none">Prevention of unplanned repeated pregnancies	<ul style="list-style-type: none">Reproductive health and contraception empowerment through self-determination
<ul style="list-style-type: none">Increased use of community resources by pregnant and parenting women	<ul style="list-style-type: none">Family unification and child removal prevention supports
<ul style="list-style-type: none">Sense of commitment and a positive effect on SUD treatment	<ul style="list-style-type: none">Promoting relapse prevention

Disparities Experienced by Pregnant and Parenting Women with SUD

Pregnant women with SUD face discrimination at an alarmingly higher rate than men when seeking substance use disorder treatment. Research indicates that women are disproportionately encouraged to discontinue medication assisted treatment (MAT) services while seeking prenatal and postpartum care. In many states, women lose Medicaid insurance coverage after the sixty-day postpartum period, accelerating additional risk factors for her and the baby during this critical time.

There are other disparities that also disproportionately impact women experiencing SUD. Women are one of the fastest growing demographic groups of the prison population, and sixty percent of women in prison are mothers to children under the age of 18. Roughly 150,000 pregnant women were admitted to jail in 2018. Twenty-six percent of the female prison population are incarcerated for drug convictions compared to thirteen percent of the male prison population. Women of color are ten times more likely to be reported to child welfare services for substance use compared to white women. The inhumane treatment women face while incarcerated compound issues of trauma and abuse along the continuum of the healthcare trajectory. In some jails and prisons, women are subjected to dangerous detox programs over a period of three days and upon delivery are shackled, furthering traumatization and damaging trust among service providers.

Cross Service Delivery Collaboration

Historically, service systems equipped to support mothers with SUD are fragmented and siloed. Mothers in recovery trained as PRS are an emerging non-clinical treatment collaboration model to support and motivate individuals facing unique challenges along their recovery journey. Several states have created safety nets within their continuum of healthcare by utilizing PRS when a pregnant person tests positive for illicit drugs and or MAT medication without a prescription within hospitals and primary care settings. For example, in Georgia PRS also support mothers whose babies have been placed in the newborn intensive care unit (NICU) due to substance exposure.

Peer-led, gender-specific recovery housing can be another intersection to support this population through drug court placement, reentry supports upon release and step-down transitional treatment options for pregnant and parenting women. Addressing social determinants of health for women and their families to achieve long-term recovery can be a crossroad for PRS collaboration models across the continuum of healthcare. Service system community collaboration among PRS assisting prenatal and postpartum women have been implemented at the following intersections nationally:

- ❖ Community behavioral health transitional postpartum support
- ❖ Emergency department overdose response teams
- ❖ Supporting mothers whose babies are born with Neonatal Abstinence Syndrome (NAS) & Fetal Alcohol Syndrome (FAS)
- ❖ Child Protective Services (CPS)/Child Welfare Services
- ❖ Early Childhood Education Interventions
- ❖ Doulas/Community Health Workers
- ❖ Mothers supporting mothers in MAT
- ❖ Consumer operated recovery housing
- ❖ Tribal/cultural community integration
- ❖ NICU Triage Team

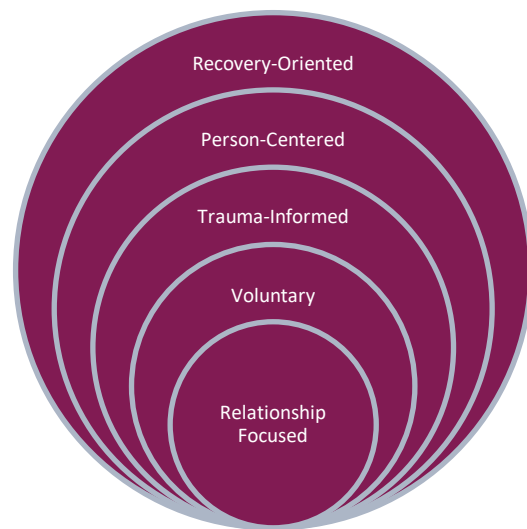
Peer Recovery Specialists who are also Mothers in Recovery

Research suggests a significant difference in participant outcomes between a trained PRS (who is also a mother in recovery) compared to women who are peers through lived experience with pregnancy and parenting but lack lived experience with substance use or mental health challenges. Illinois, for example, implemented a pilot program utilizing a dual certification programs for doulas and certified peer recovery specialists. Other states have attempted to replicate PRS by using social workers and community health workers to fill these roles **without** the ability to use lived experience as a core skill and modality, which is not concurrent with the evidence-based peer recovery model. Increasing the scope of practice for the PRS profession provides greater capacity to serve a larger demographic with more complex needs exacerbated by substance use and mental health challenges.

Training material for supporting prenatal and parenting people as a PRS within the scope of practice in Virginia (VA) does not currently exist. Other states like Oregon, Rhode Island, Massachusetts and Illinois have developed additional training components as supplemental material to coincide within their PRS training manual by offering additional subpopulation certification competencies (veterans, family support, and forensic PRS). Each subpopulation certification requires unique expertise and training components specifically tailored to these experiences as they coexist and compound with addiction and behavioral health challenges. For instance, Oregon has increased their training materials to focus on Trauma Informed Care as it relates to Adverse Childhood Experiences (ACEs), Early Childhood Interventions (EI), childhood attachment, Cardiopulmonary Resuscitation (CPR), home visiting protocols and mandating report standards.

Virginia Mom's in Recovery Programs at a Glance

As of June 2020, there are 638 certified PRS residing in the Commonwealth and 400 identified as female. However, it is unclear if these individuals also have lived experience with pregnancy and parenting. While surveying the landscape of gender-specific programs in VA targeting this population, the Project Link model was identified, utilizing intensive case management within a 16-week curriculum including ancillary peer supports services. Highlands Community Service Board was not one of the nine sites awarded Project Link funding, however they adapted and implemented their own community approach by hiring a PRS with lived experience with pregnancy and parenting. Their model relies on triaging services once the person is flagged at the hospital providing a warm-hand off to treatment and community services if interested. The peer is present for the SUD assessment completed by the case manager and can provide additional telephonic support prior to entering treatment. Having the peer embedded within multiple service entry points allow for cross lateral interventions and the relationship between the participant and peer to be strengthen and solidified. In addition to Community Service Boards (CSBs), for-profit treatment intensive outpatient programs (IOP's), recovery housing entities, Managed Care Organizations (MCOs), Federally Qualified Health Centers (FQHCs), and the criminal justice system are all entry points and healthcare continuums for pregnant and parenting women seeking SUD treatment and PRS collaboration models. However, PRS who are also mothers in recovery is an undeveloped and missing intersection in VA.



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