# The Opioid Epidemic: The Landscape of Comprehensive Care for Women with Opioid Use Disorder and Their Children

Hendrée E. Jones

# Disclosures

- Dr. Jones has no conflicts of interests or disclosures relevant to the content of this presentation.

# FDA Context

- Methadone and buprenorphine have historically been labeled by the US Food and Drug Administration (FDA) as Category C for use in pregnancy for the treatment of maternal opioid dependence: *"Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks"*
- As of May 2016, the FDA requires methadone and buprenorphine safety labeling to include information regarding the risk of neonatal opioid withdrawal syndrome (NOWS)

# FDA Context: Part 2

- Pregnant women with opioid use disorders (OUDs) can be effectively treated with methadone or buprenorphine. However, labeling states it should be used only if the potential benefit justifies the potential risk to the fetus

- Pregnant women with opioid use disorders can be effectively treated with methadone or buprenorphine.  Both these medications should not be considered “off-label” use in the treatment of pregnant patients with opioid use disorder (Jones et al., *Am J Obstet Gynecol,* 2014).

# Objectives

- At the conclusion of this activity participants should be able to:
  - Identify at lest three historical and current factors that help explain the current opioid epidemic for women
  - Identify at least three new SAMHSA recommendations to care for pregnant women and their children touched by opioid use disorder
  - Identify at least three factors that drive Neonatal Abstinence Syndrome outcomes
  - Identify at least three elements that are common themes among Model Programs

# Historical Context: Opioid Use and Women

Main Eras of Opioid Use in the USA

1800s: 66–75% of people using opioids were women

1940-50s: New York saw large increase in teenage opioid use

1969-70's: Opioid use by Vietnam veterans

1996-now: Pain as the 5th vital sign and pain medication access

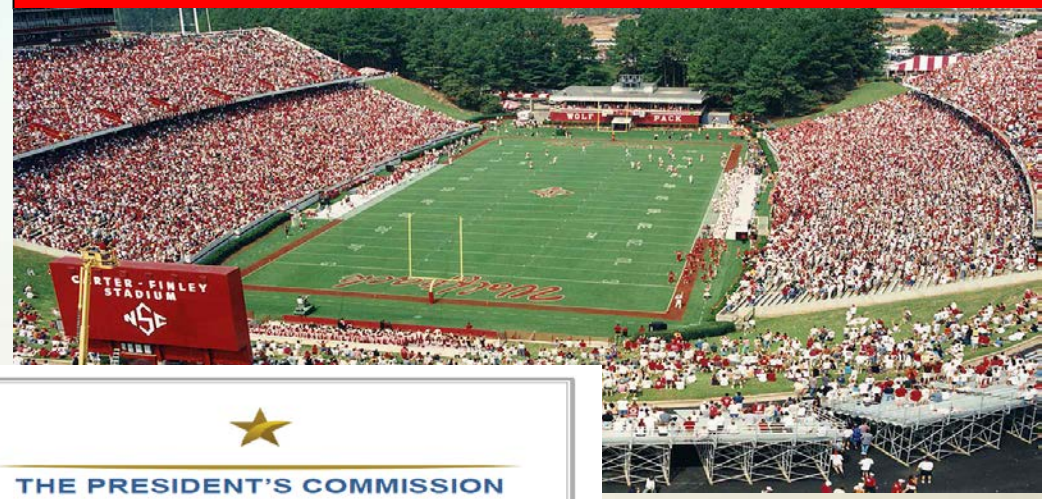
http://usslave.blogspot.com.br/2012/02/opiate-addiction-and-cocaine-use-in.html; https://pixabay.com/en/vintage-retro-ladies-photo-paper-1303815/

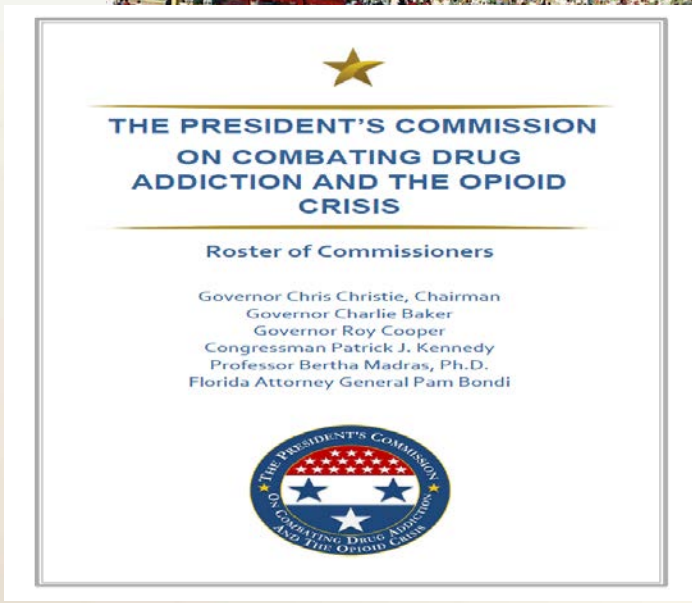
Courtwright D. *J Southern History* 1983; Kandall S *Substance and shadow*, 1996.
Earle, *Medical Standards*, 1888
The Incidental Economist 2014 https://pointsadhsblog.files.wordpress.com/2012/03/08-0620hair20salon20loc20nywt20226b.jpg

# Recent History: Opioid Use in the USA

- **80's** – Reports state few receiving narcotic painkillers develop addiction
- **90's** – Purdue Pharma Develops Oxycontin
- **1996** – The Joint Commission "Pain - the 5th Vital Sign"
- **2003** – Tripling of 18-25 year olds misusing opioid pain relievers; DEA and FDA task forces to reduce internet opioid sales
- **2007** – George Brothers open first pain clinic in FL. American Pain prescribed almost 20 million pills over two years
- **2009-now** – Drug overdose surpass motor vehicles as the leading cause of injury death

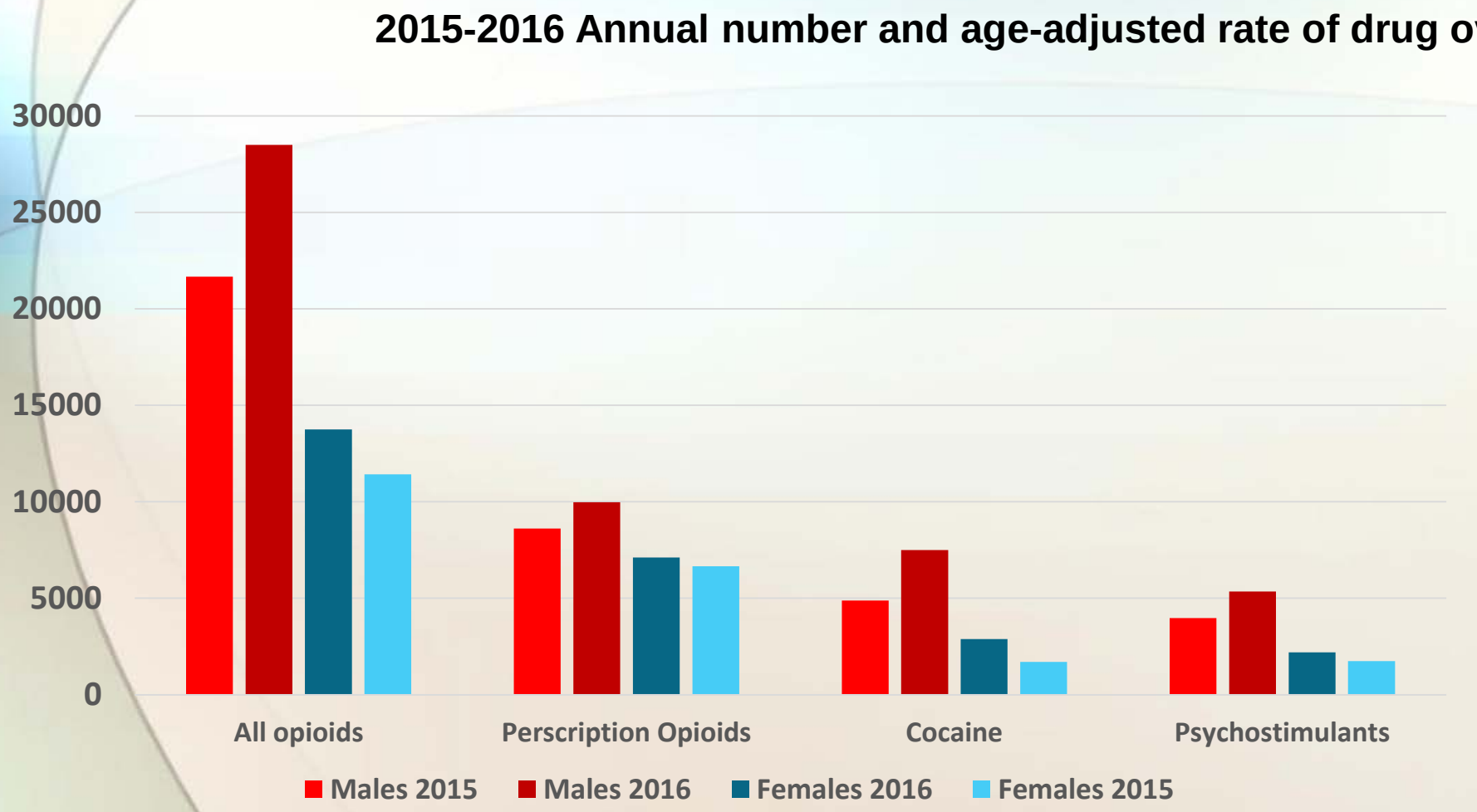
**"Our people are dying. More than 175 lives lost every day. If a terrorist organization was killing 175 Americans a day on American soil, what would we do to stop them?"**




Frakt, A. *NY Times* 12/22/14; CDC *Morbidity and Mortality Weekly Report* (*MMWR*) 1/1/16

# Current Context of Opioid Misuse in the USA for Women




From 1999 to 2017, the death rate from drug overdose among women aged 30–64 years increased by 260%.

Drug overdose deaths involving antidepressants, benzodiazepines, cocaine, heroin, prescription opioids, and synthetic opioids all increased.

Seth P, et al. MMWR Morb Mortal Wkly Rep 2018;67:349–358.

VanHouten JP, Rudd RA, Ballesteros MF, Mack KA. Drug Overdose Deaths Among Women Aged 30–64 Years — United States, 1999–2017. MMWR Morb Mortal Wkly Rep 2019;68:1–5.

# Gender and Development of Addiction

- Healthcare professionals tend to miss signs of addiction in women
  - Especially in older women and younger girls

- ADVISe Study: RCT SBIRT implementation into primary care:
  - 640,000 adult patients
  - Women less likely to be screened (OR=0.78)
  - Among those screened, women less likely to receive BI/RT (OR=0.60)

Simoni-Wastila L. *J Womens Health Gend Based Med*. 2000 Apr;9(3):289-97.
casacolumbia.org/articlefiles/380-Formative_Years_Pathways_to_Substance_Abuse.pdf
who.int/mental_health/prevention/genderwomen/en/

# Current Context: Opioid Use and Women

**Compared to men, women are more likely to:**

- **report chronic pain**
- **be prescribed prescription pain relievers**
- **be given higher doses**
- **use them for longer time periods than men**
- **have a shorted duration between opioid use initiation and seeking help for an opioid use disorder**
- **Less likely to receive naloxone for an overdose**

*Specific risks for the misuse of prescription opioid medication among women include: experience of violence and trauma, being a native minority, adolescent, young, older, pregnant, a sexual minority, and being a transwoman*

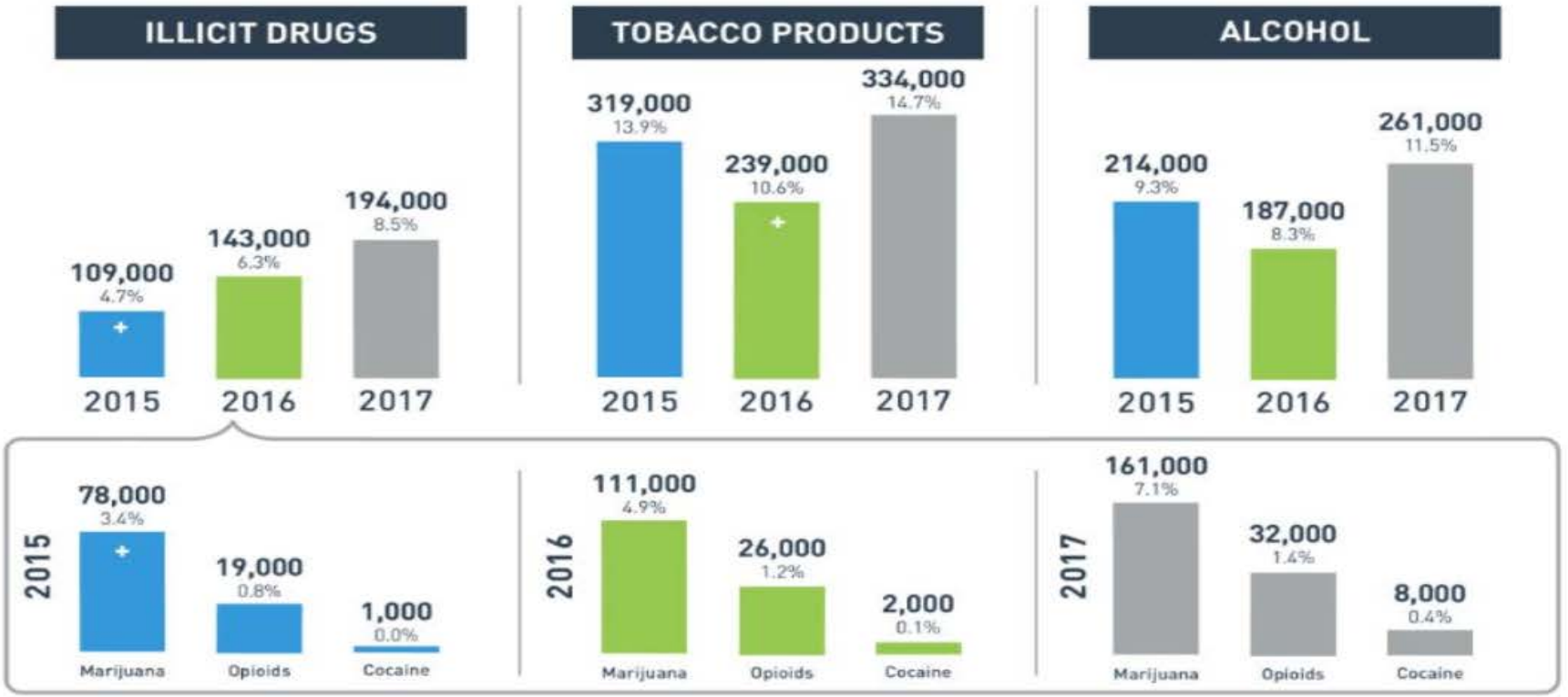
http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/

Sumner SA et al., *Prehosp Emerg Care*. 2016
Hemsing N, et al. *Pain Res Manag*. 2016; Khan SS et al., *Drug and Alcohol Dependence* 2013;
Randall C et al., *J Stud Alcohol*. 1999

# Current Context of Substance Use during Pregnancy

## Substance Use in Past Month Among Pregnant Women

PAST MONTH, 2015 - 2017, 15 - 44




Special analysis of the 2017 NSDUH Report.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

SAMHSA
Substance Abuse and Mental Health

# History: Defining Neonatal Abstinence Syndrome (NAS)

**Results when a pregnant woman regularly uses opioids (e.g., heroin, oxycodone) during pregnancy**

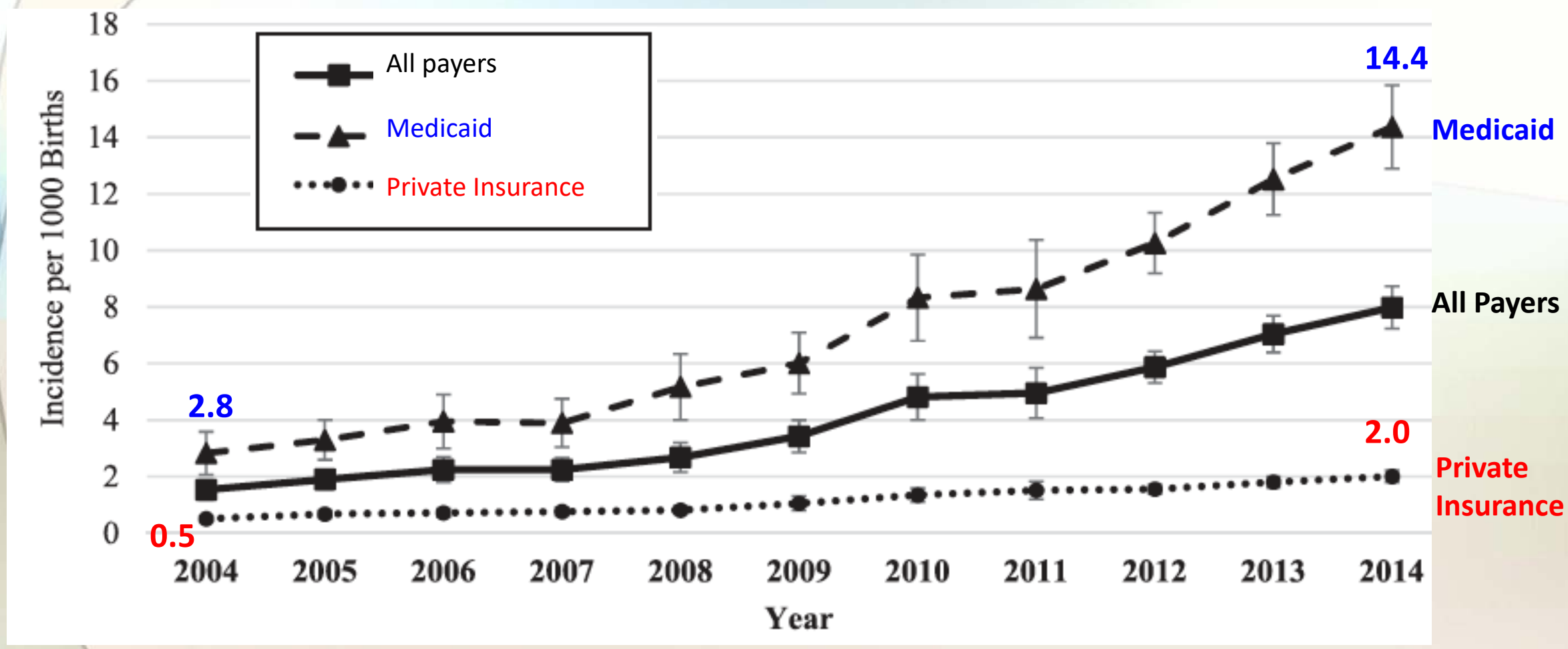
**NAS defined by alterations in the:**

- ***Central nervous system***
  - **high-pitched crying, irritability**
  - **exaggerated reflexes, tremors and tight muscles**
  - **sleep disturbances**
- ***Autonomic nervous system***
  - **sweating, fever, yawning, and sneezing**
- ***Gastrointestinal distress***
  - **poor feeding, vomiting and loose stools**
- ***Signs of respiratory distress***
  - **nasal congestion and rapid breathing**

- **NAS is *not* Fetal Alcohol Syndrome (FAS) only FAS has confirmed long term physical, cognitive and behavioral effects**
- **NAS is treatable**
- **NAS and its treatment are not known to have long-term effects; interactions between the caregiver and child can impact resiliency/risk with potential long-term effects in some cases.**

Finnegan et al., *Addict Dis,* 1975; Desmond & Wilson, *Addict Dis,* 1975; Jones & Fielder, *Preventive Medicine,* 2015.

# Current Context: Opioids, Pregnancy, and NAS




Winkelman et al. Incidence and cost of neonatal abstinence syndrome among infants with Medicaid: 2004-2014. Pediatrics. 2018 Apr;141(4).

# NAS is Not Addiction

- Newborns can’t be “born addicted”
- NAS is withdrawal – due to physical dependence
- Physical dependence is not addiction
- Addiction is brain illness whose visible signs are behaviors
- Newborn do not have the life duration or experience to meet the addiction definition

Jones & Fielder, *Preventive Medicine,* 2015.

# NAS: Various Substances

STATE-OF-THE-ART REVIEW ARTICLE

## Neonatal Abstinence Syndrome

AUTHOR: Prabhakar Kocherlakota, MD

*Pediatrics* 2014;134:e547–e561

**TABLE 1** Onset, Duration, and Frequency of NAS Caused by Various Substances

| Drug | Onset, h | Frequency, % | Duration, d |
|---|---|---|---|
| Opioids | | | |
| Heroin | 24–48 | 40–80[27] | 8–10 |
| Methadone | 48–72 | 13–94[37] | Up to 30 or more |
| Buprenorphine | 36–60 | 22–67[46,48] | Up to 28 or more |
| Prescription opioid medications | 36–72 | 5–20[56,60] | 10–30 |
| Nonopioids | | | |
| SSRIs | 24–48 | 20–30[64] | 2–6 |
| TCAs | 24–48 | 20–50[64] | 2–6 |
| Methamphetamines | 24 | 2–49[101] | 7–10 |
| Inhalants | 24–48 | 48[70] | 2–7 |

# Salient Maternal Categories Related to NAS

1. Women using opioid analgesics for medical condition who do not have a substance use disorder

2. Women using opioid analgesics for medical condition and who also have a substance use disorder

3. Women receiving pharmacotherapy for the treatment of an opioid use disorder

4. Women with an (unrecognized) untreated opioid use disorder

(Thank you Mishka Terplan and Borrowed from National Center on Substance Abuse and Child Welfare)

# NAS: Factors

**Other factors that contribute to severity of NAS in neonates exposed to opioid agonists in utero:**

- **Genetics**
- **Other Substances**
  - **Tobacco use**
  - **Benzodiazepines**
  - **SSRIs**
- **Birth weight**
- **Hospital Protocols**
  - **Presence of a protocol**
  - **Rural vs. urban**
  - **NICU setting**
  - **The NAS assessment choice**
  - **NAS medication choice**
  - **Initiation and weaning protocols**
  - **Not breastfeeding**
  - **Separating mother and baby**

**MOTHER NAS Predictors**

**Receipt of NAS treatment for infants was predicted by:**

- **Higher infant birthweight**
- **Greater maternal nicotine use**

**Total medication dose needed to treat NAS was predicted by:**

- **Maternal use of SSRIs**
- **Greater nicotine use**
- **Fewer days of study medication received**

**Methadone or buprenorphine dose is not consistently related to NAS severity**

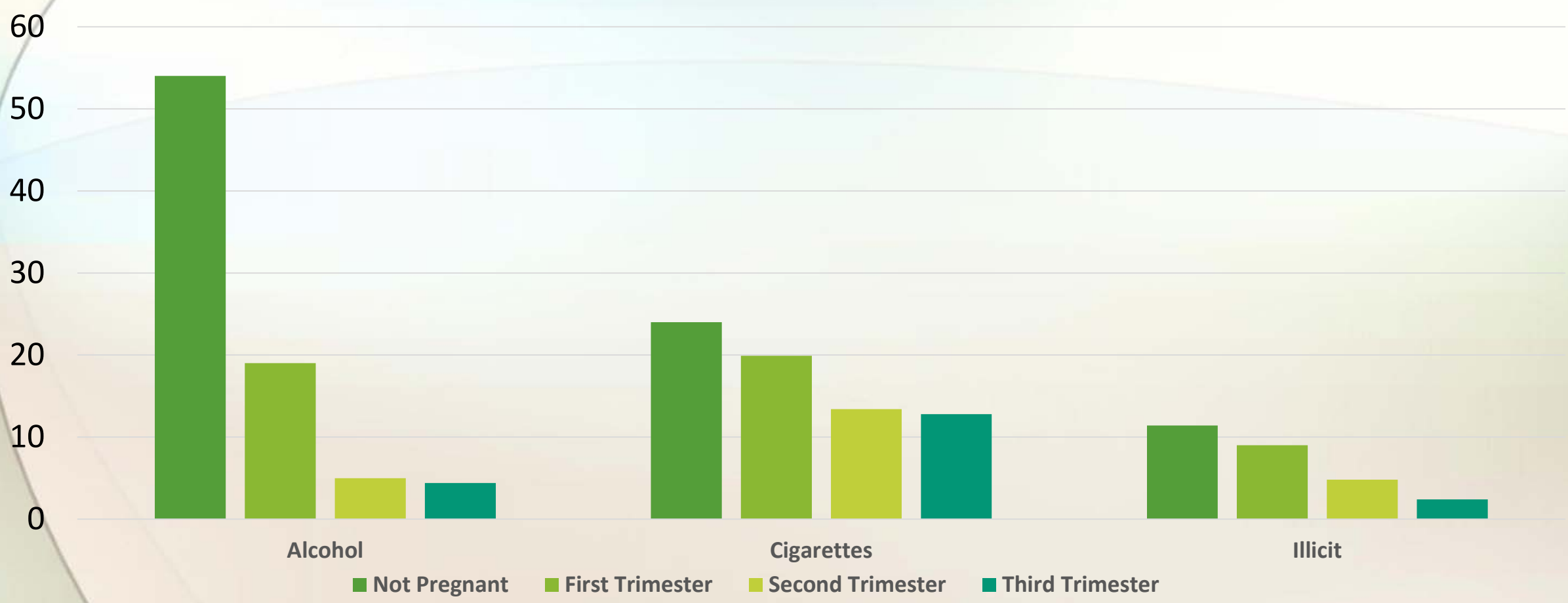
Kaltenbach et al., *Addiction*, 2012 Jansson and Velez, *Curr Opin Pediatrics*, 2012

# NAS Assessment and Treatment: New Assessment

- **N=50 consecutive opioid-exposed infants managed on the inpatient unit**
- **All infants had FNASS scores recorded every 2 to 6 hours but were managed by using the Eat, Sleep, Console (ESC) assessment approach.**
- **Breastfed or take >1 ounce from a bottle per feed, to sleep undisturbed for >1 hour, and consoled if crying within 10 minutes**
- **Actual treatment decisions made by using the ESC approach were compared with predicted treatment decisions based on recorded FNASS scores.**
- **ESC approach, 6 infants (12%) were treated with morphine compared with 31 infants (62%) predicted to be treated with morphine by using the FNASS approach ($P < .001$).**
- **There were no readmissions or adverse events reported.**

Grossman MR et al., Hosp Pediatr.2018 Jan;8(1):1-6.

# What Happens When Women Who Use Drugs Get Pregnant?




National Survey Drug Use and Health 2013/2014 Past Month Use Data

All pregnant women are motivated to maximize their health and that of their developing baby

Those who can't quit or cut back – likely have a substance use disorder

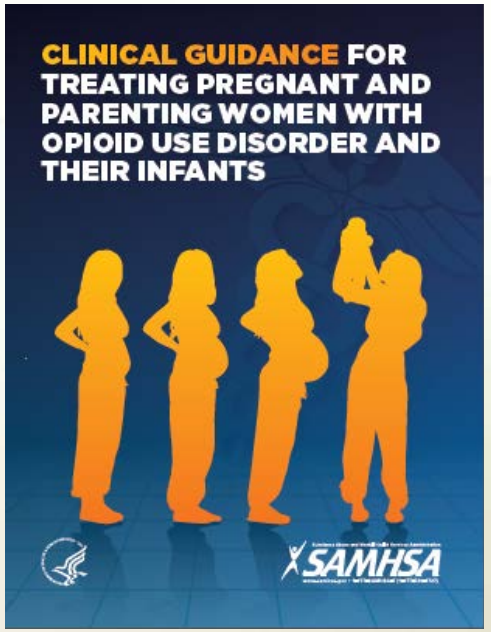
Continued use in pregnancy is pathognomonic for addiction

Addiction: A Brain-Centered Condition Whose Symptoms are Behaviors

Salient Feature: Continued use in spite of adverse consequences

# SAMHSA Clinical Guide Recommendations

- Medication assisted withdrawal is not recommended during pregnancy
- Buprenorphine and methadone are the safest medications for managing OUD during pregnancy
- Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended
- Breastfeeding is recommended for women on buprenorphine and methadone
- Neonatal abstinence syndrome (NAS) should not be treated with dilute tincture of opium




The *Clinical Guide* consists of 16 factsheets that are organized into 3 sections: Prenatal Care (Factsheets #1–8); Infant Care (Factsheets #9–13); and Maternal Postnatal Care (Factsheets #14–16).

# SAMHSA's Guidance: Medically Supervised Withdrawal is *Not* Recommended

- Pharmacotherapy is the recommended standard of care
- Pharmacotherapy helps pregnant women with OUD avoid a return to substance use, which has the potential for overdose or death
  - A decision to withdraw from pharmacotherapy should be made with great care on a case-by-case basis.
  - A pregnant woman receiving treatment for OUD may decide to move forward with medically supervised withdrawal if
    - It can be conducted in a controlled setting.
    - The benefits to her outweigh the risks.

Pregnant patients should be advised that withdrawal during pregnancy increases the risk of relapse without fetal or maternal benefit.

# ACOG Guidance: Treating Women for Opioid Use Disorders during Pregnancy

- Universal screening starting at the first prenatal visit and using a validated verbal screening tool, which is preferable to urine testing
- If a woman screens positive, the guidelines recommend a brief intervention and referral to treatment.
- Medication-assisted treatment remains the preferred treatment
- Relapse is associated with serious risks, such as transmission of infectious agents, accidental overdose as a result of decreased tolerance, lack of prenatal care, and obstetric complications
- Medically supervised withdrawal may be considered in women who do not accept treatment with an opioid agonist or when treatment is unavailable. In that case, a physician experienced in treating perinatal addiction should supervise care, with informed consent of the woman
- Multidisciplinary long-term follow-up should include medical, developmental, and social support

Opioid Use and Opioid Use Disorder in Pregnancy. Committee on Obstetric Practice. American Society of Addiction Medicine (ASAM). American College of Obstetricians and Gynecologists (ACOG) Committee Opinion. Number 711, August 2017
*(Replaces Committee Opinion Number 524, May 2012)*

# ACOG Guidance: Screening Differs from Testing

**All screens and tests for the mother require informed consent and neither diagnose a Substance Use Disorder**

| | Screening with an Instrument | Maternal Urine Testing |
|---|---|---|
| **Purpose** | To detect possible illness indicators | To establish presence/absence of a recent substance use |
| **Test method** | Simple, quick, acceptable to patients and staff | May take days for results and must be GC/MS or other confirmed test |
| **Positive result threshold** | Generally chosen towards high sensitivity not to miss potential disease | Chosen towards high specificity (true negatives). More weight given to accuracy and precision |
| **Cost** | Cheap, benefits should justify the costs since large numbers of people will need to be screened to identify a small number of potential cases | Higher costs associated with test ; cost may be justified to establish specific result |

Adapted from: https://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding

# When We Ask: What is our Response?

- **Urine drug testing is not sufficient for a diagnosis of substance use/use disorder (ACOG 2017)**
  - Short detection window
  - Might not capture binge or intermittent use
  - Rarely detects alcohol
  - Doesn't capture prescription opioids (without confirmation testing)

- **Essential component of SUD treatment**

- **Ethical issues:**
- **Robinson v. California (1962)** - Addiction is an illness, and that criminalizing it is a violation of the 8th Amendment, prohibiting cruel and unusual punishment

- **Ferguson v. City of Charleston (2001)** - Drug-testing pregnant women without their knowledge or consent constituted unlawful search and seizure in violation of the 4th Amendment

# Possible Implications of Punitive Measures

- No evidence supporting punitive responses decrease drug use in pregnancy
- Unnecessary stressful child welfare involvement
- Loss of parental rights
- Disruption of critical parent/infant bonding time—used as evidence-based treatment of Neonatal Opioid Withdrawal (NOW)
- Deters pregnant people from seeking healthcare and social support
- Long-term consequences of being convicted of a drug-related crime
  - Loss of financial aid
  - Housing restrictions
  - Employment challenges
- Fails to recognize the inadequacies in the healthcare system and other supportive services for pregnant people who use drugs

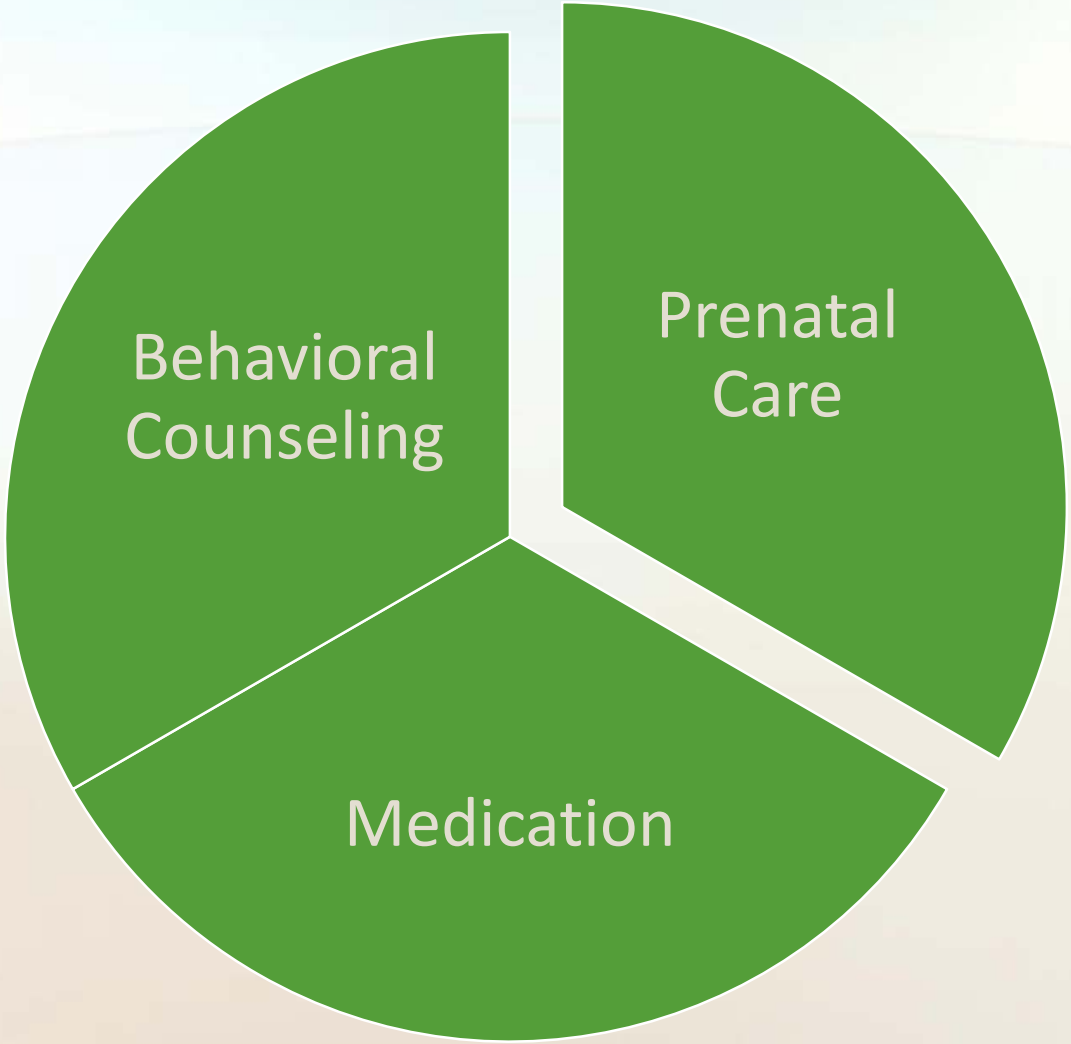
Patrick, S. W., & Schiff, D. M. (2017). A Public Health Response to Opioid Use in Pregnancy. Pediatrics, 139(3)

# Treatment Access and Effectiveness

- Capacity is inadequate
  - Only 15% of treatment centers offer specified services
  - Access is limited
  - For those in poverty, rural areas, uninsured, or insured through Medicaid
- Quality of treatment ranges dramatically
- Barriers in treatment for opioid use disorder
- Engagement in prenatal care is effective regardless of continued drug use

Patrick, S. W., & Schiff, D. M. (2017). A Public Health Response to Opioid Use in Pregnancy. Pediatrics, 139(3)

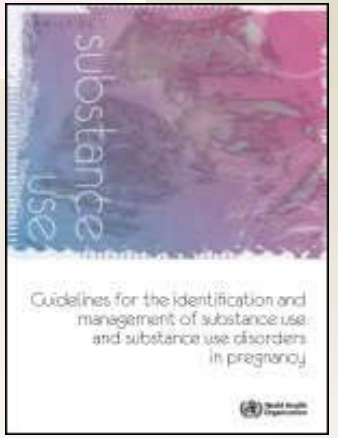
# During Pregnancy:
# Treatment Principle = Integration



# World Health Organization: 18 Recommendations in their Guidelines

| No. | Recommendation | Strength of recommendation |
|---|---|---|
| **Pharmacological treatment (maintenance and relapse prevention) for substance dependence in p** | | |
| 9 | Pharmacotherapy is not recommended for routine treatment of dependence on amphetamine-type stimulants, cannabis, cocaine, or volatile agents in pregnant patients. | Conditional |
| 10 | Given that the safety and efficacy of medications for the treatment of alcohol dependence has not been established in pregnancy, an individual risk-benefit analysis should be conducted for each woman. | Conditional |
| 11 | Pregnant patients with opioid dependence should be advised to continue or commence opioid maintenance therapy with either methadone or buprenorphine. | Strong |

http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/



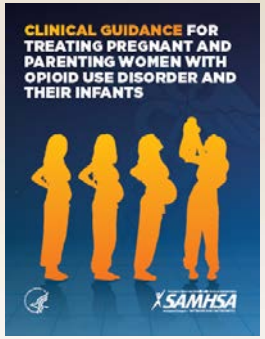
# World Health Organization, ACOG and ASAM: Medication Option Guidance

- Methadone
- Buprenorphine alone
- Buprenorphine + naloxone
- *Naltrexone*

# Methadone and Buprenorphine: Advantages

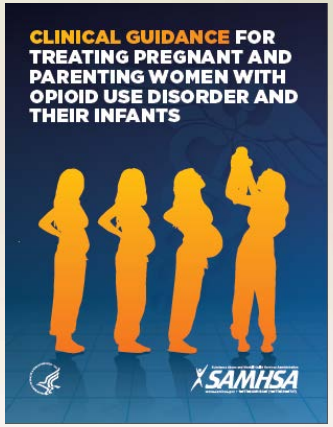
| | Methadone | Buprenorphine |
|---|---|---|
| **Advantages** | | |
| Reduces/eliminates cravings for opioid drugs | ● | ● |
| Prevents onset of withdrawal for 24 hours | ● | ● |
| Blocks the effects of other opioids | ● | ● |
| Promotes increased physical and emotional health | ● | ● |
| Higher treatment retention than other treatments | ● | |
| Lower risk of overdose<br>Fewer drug interactions<br>Office-based treatment delivery<br>Shorter NAS course | | ● |

Approximately 6 out of every 1,000 women presenting for delivery in the United States are treated with one of these agents.

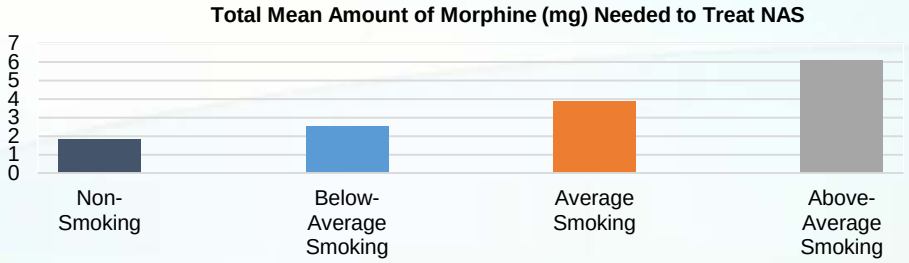


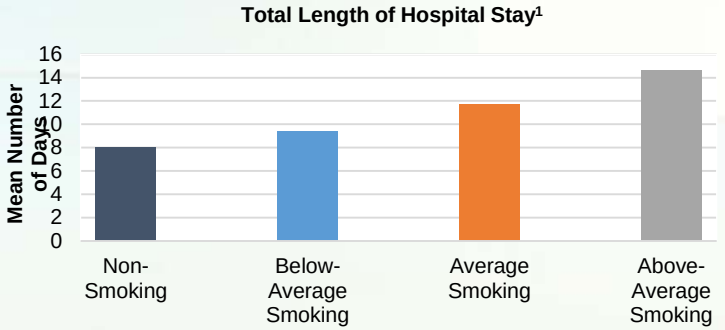
# Methadone and Buprenorphine: Disadvantages

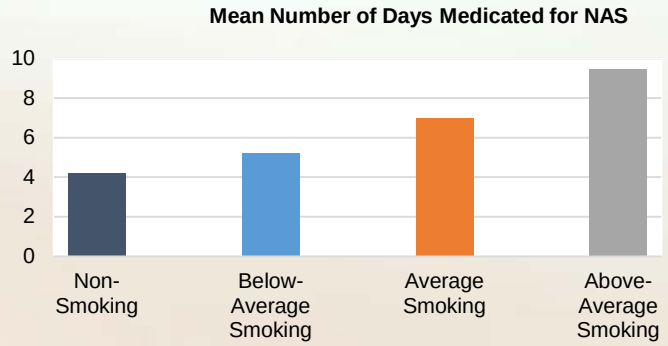
- Methadone Disadvantages
  - Achieving stable dose could take days to weeks
  - Increased risk of overdose
  - Usually requires daily visits to federally certified opioid treatment programs
  - Longer neonatal abstinence syndrome (NAS) duration than other treatments
- Buprenorphine Disadvantages
  - Limited efficacy in patients with high opioid debt
  - Demonstrated clinical withdrawal symptoms
  - Increased risk of diversion

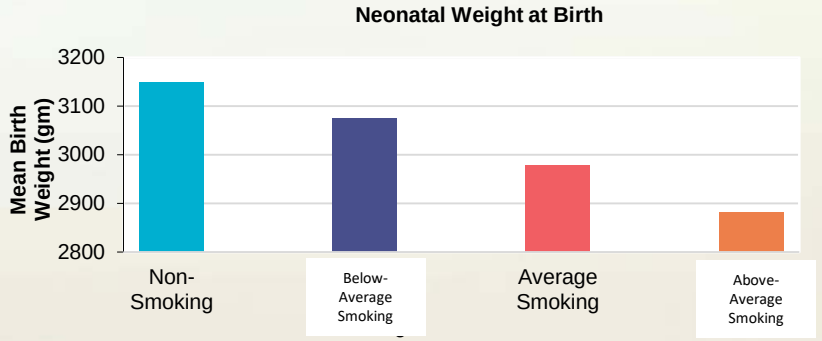


# Smoking and NAS



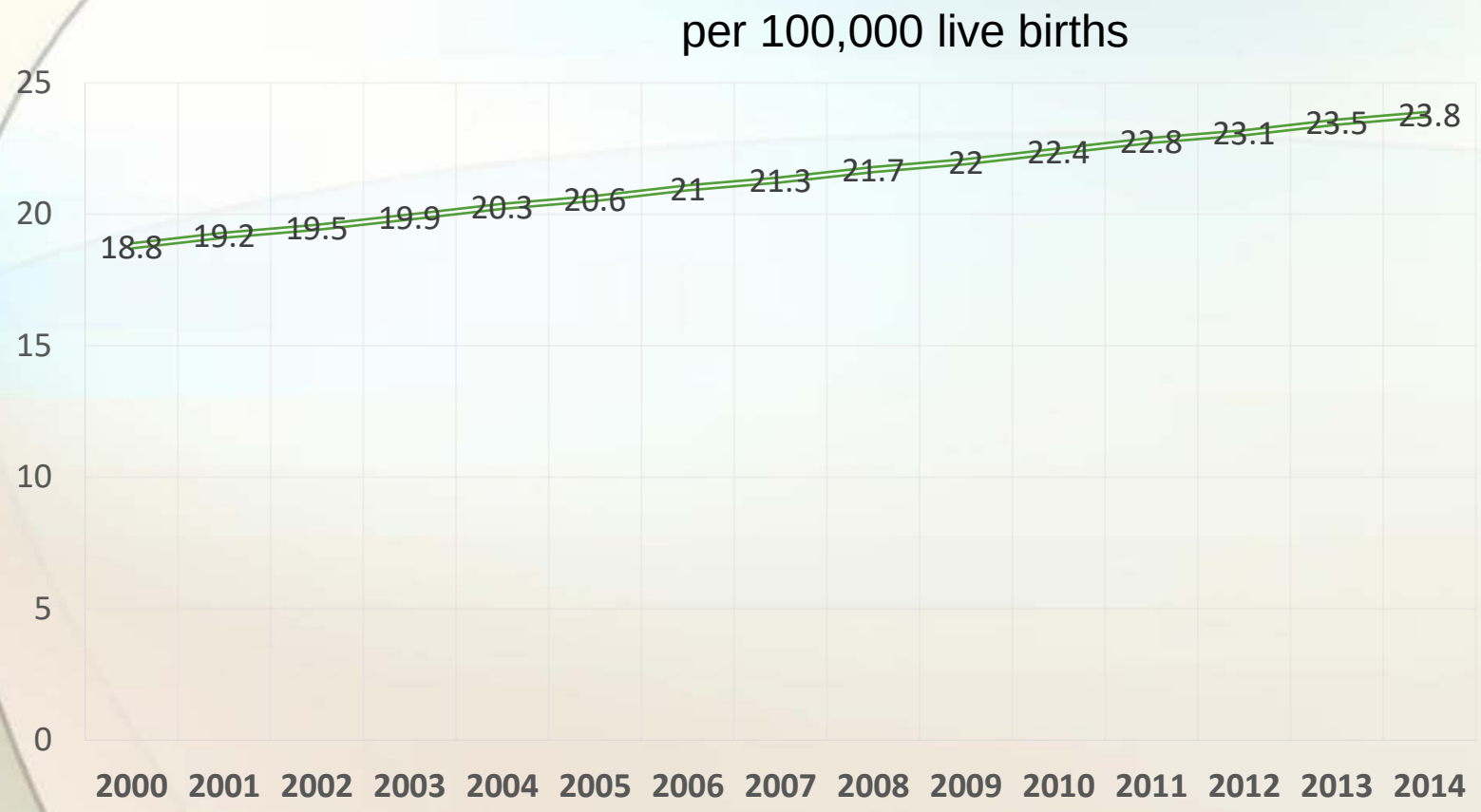

Ordinary least squares and Poisson regression analyses were used to test average daily number of cigarettes smoked in the past 30 days at α=0.05, adjusting for both Medication Condition and Site.
Below-average cigarette smoking was defined as 6 cigarettes/day (-1 *SD*), average cigarette smoking as 14 cigarettes/day (Mean), and above-average cigarette smoking as 21 cigarettes/day (+1 *SD*).

Jones HE, et al. *Drug Alcohol Depend.* 2013

# The 4th Trimester - Postpartum

- Critical Period
  - Newborn care, breastfeeding, maternal/infant bonding
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn
- Neglected Period
  - Care shifts away from frequent contact with PNC provider – to pediatrician
  - Care less “medical” (for mom) and shifts to other agencies (WIC)
  - Insurance and welfare realignment
  - SUD treatment provider(s) – care is constant

# Maternal Mortality is Increasing




*Excludes California and Texas California showed a declining trend, whereas Texas had a sudden increase in 2011-2012.

MacDorman MF et al *Ob/Gyn* 2016

## Possible Factors

**Drug use with homicide/suicide**

**Overdose**

**Medicaid coverage loss at 6 weeks postpartum**

**“Detox” during pregnancy to prevent NAS**

**Inadequate Access to drug treatment/MAT**

# Maternal Mortality Worse for Women Who Use Opioids

**Pregnancy-related discharges from 1998 to 2009 using the largest publicly available all-payer inpatient database in the United States.**

**Women who used opioids during pregnancy experienced higher rates of:**

- **depression**
- **anxiety**
- **chronic medical conditions**

**After adjusting for confounders, opioid use was associated with increased odds of:**

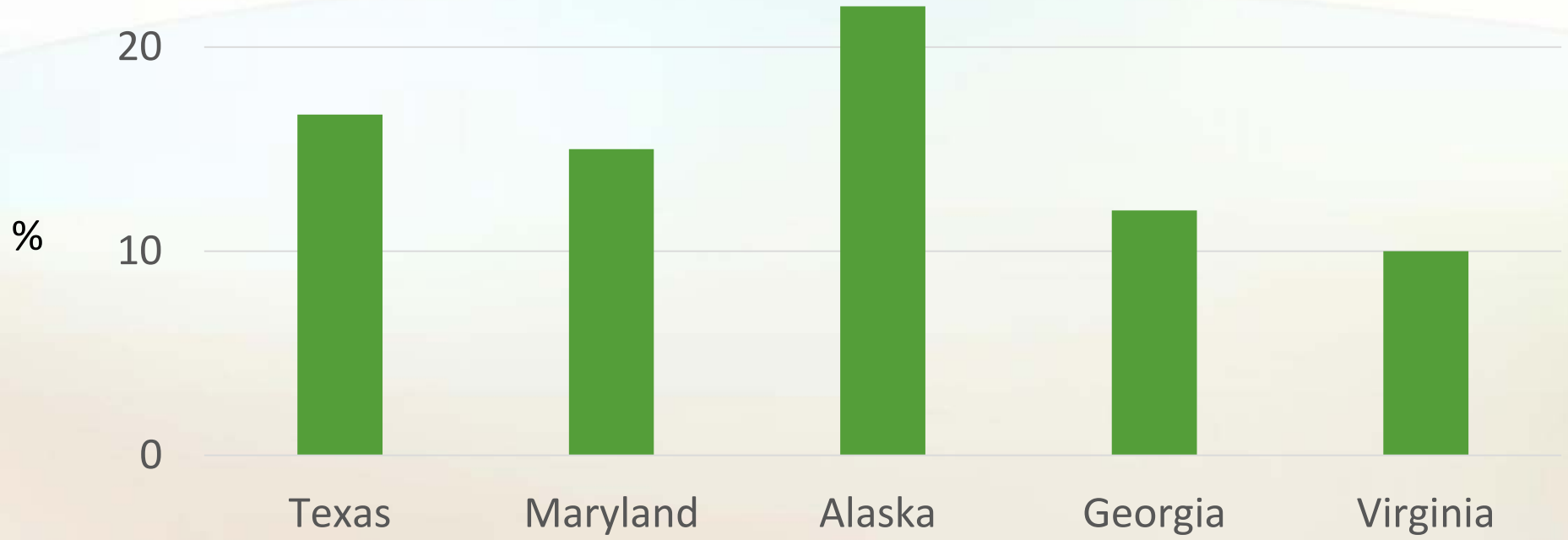
- **threatened preterm labor**
- **early onset delivery**
- **poor fetal growth**
- **stillbirth**

**Women using opioids were four times as likely to have a prolonged hospital stay and *were almost four times more likely to die before discharge.***

Whiteman VE **et al.,** J Pregnancy. 2014;2014:906723

# Percent of Pregnancy Associated Deaths Due to Drugs

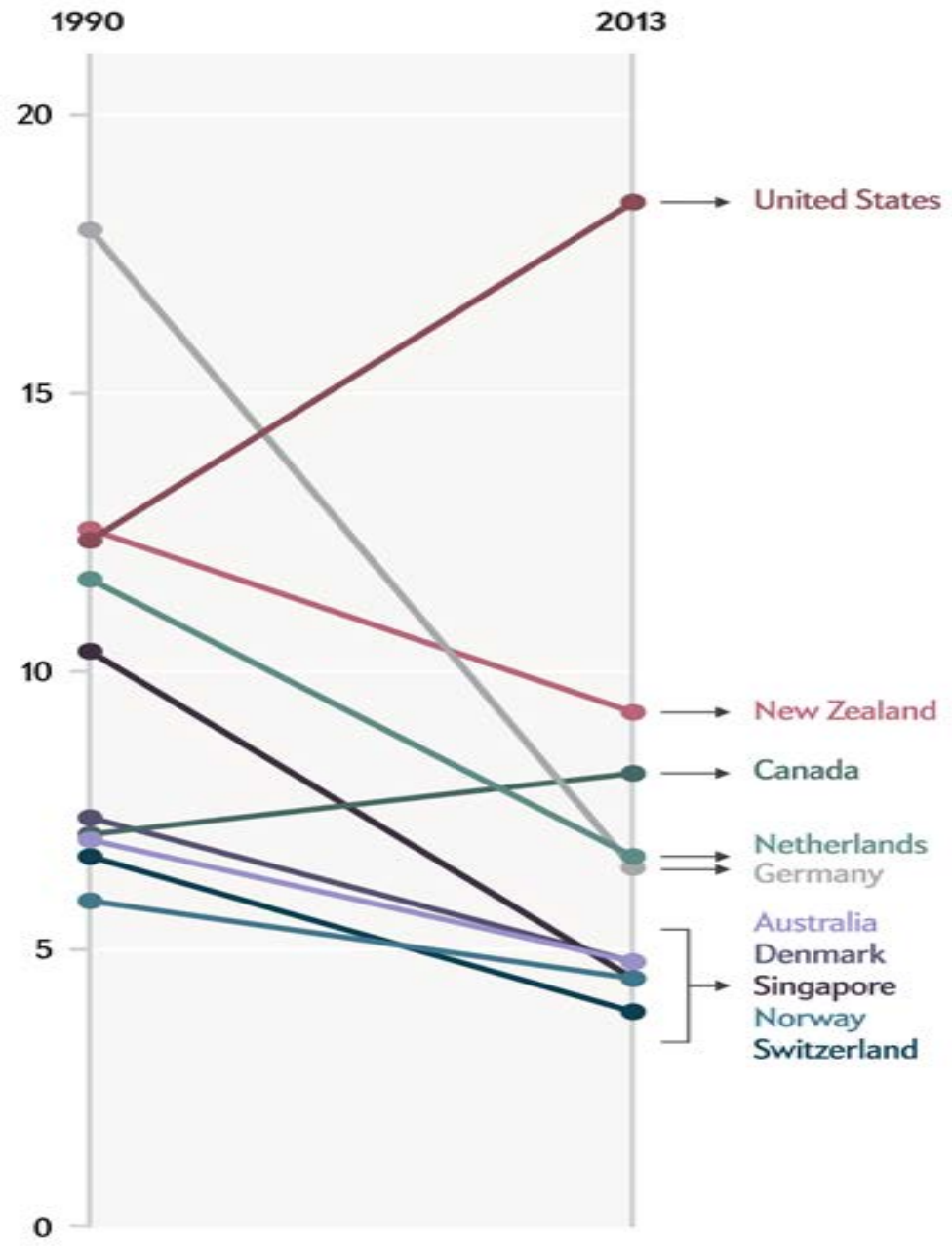
(thanks to Jennifer Bailit)




Role of Opioid Overdoses in Confirmed Maternal Deaths 2012-2015
MMR June 2015
Pregnancy Associated Mortality Alaska 2000-2011
Maryland Maternal Mortality review 2016

## Maternal Mortality Ratio (MMR) by Developed Country

Maternal deaths per 100,000 live births

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HEALTH

# Has Maternal Mortality Really Doubled in the U.S.?

Statistics have suggested a sharp increase in the number of American women dying as a complication of pregnancy since the late 1980s, but a closer look at the data hints that all is not as it seems

By Dina Fine Maron on June 8, 2015

## U.S. Maternal Mortality Ratio by Race in 2011

Maternal deaths per 100,000 live births


**Source:** Centers for Disease Control and Prevention

*Graphic by Tiffany Farrant-Gonzalez, for* **SCIENTIFIC AMERICAN**

# What are the Long Term Outcomes of Children Prenatally Exposed to Opioids?

Issues to consider when reading the literature

- Population of Interest definitions
- Comparison group? What kind?
- Prospective data collection in the perinatal period?
- Masked assessment?
- Include a substantial proportion of subjects exposed in utero other substance?
- Matching
- Statistical
- Inferential

“Addiction, illegality, prenatal toxicity and poor outcomes are linked in the public and professional mind. In reality, scientific evidence for prenatal toxicity and teratogenicity is equivocal for some drugs and stronger for others. Inaccurate public expectations of correspondence between illegality and toxicity lead to distortions in interpreting and applying scientific findings.”

Jones et al., in preparation; Zuckerman B, Frank DA, Mayes L. JAMA. 2002 Apr 17;287(15):1990-1

# MOTHER Child Outcomes 0-36 Months

*N*=96 children

- No pattern of differences in physical or behavioral development to support medication superiority
- No pattern of differences for infants treated for NAS v. infants who did not receive treatment for NAS
- No pattern  of differences when children were compared to norms on tests

Results indicate children born in the MOTHER study are following a path of normal development in terms of growth, cognitive and psychological development

Kaltenbach, K. et al., Drug and Alcohol Dependence 2018

# Are We Learning From Past Mistakes?

"Those who cannot remember the past are condemned to repeat it.“

Quote attributed to philosopher George Santayana

“Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity, scope, or kind from the sequelae of multiple other risk factors.

Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment.

Further replication is required of preliminary neurologic findings.”

Frank DA. et al., JAMA. 2001 Mar 28;285(12):1613-25.

# Understanding Attachment

- Securely-attached infants would develop a “secure base script” that explains how attachment-related events happen
  - for example: “When I am hurt, I go to my mother and receive comfort”
- Children with an insecure attachment and an Internal Working Model that says that the caregiver will be unavailable and/or rejecting when the child needs him/her may develop a chronic activation of the physiological stress-response system

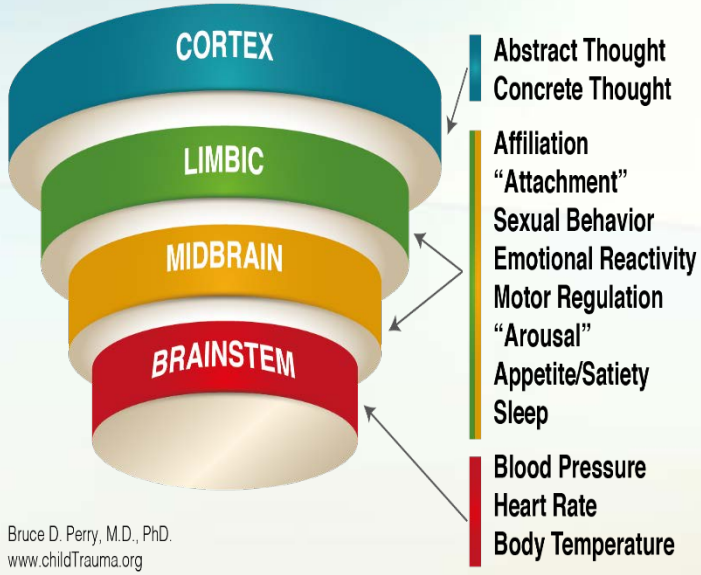
# Relationship: Non-secure Attachment and Substance Use

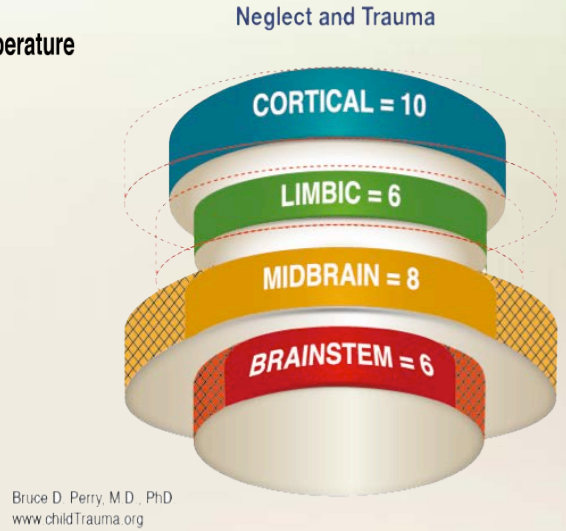
- **Having been abused as a child is an important risk factor for abuse of one's own children**
- **There is a high incidence of abuse during childhood among women in treatment for substance use disorders**
- **Maternal substance use disorder is one of the most common factors associated with child maltreatment**
- **Mothers who have substance use disorders have higher incidences of hostile attributions and inappropriate expectations of child behavior as well as repeated disruptions in their parenting behaviors**
- **These disruptions can create a negative effect on the parent–child relationship, as evidenced in the increased rates of insecure attachment in children who have parents with substance use disorders**

Suchman 2007

# Trauma and The Brain

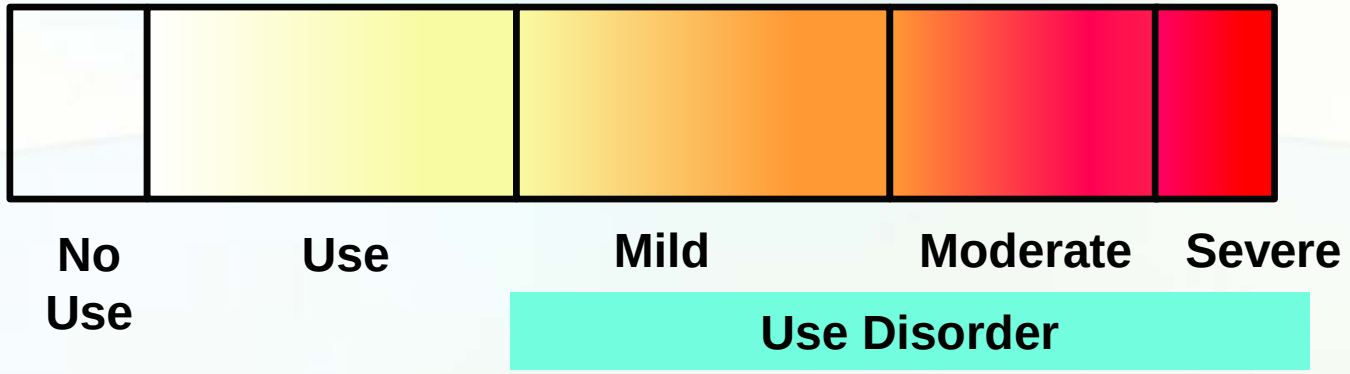
- The brain has a “bottom-up” organization
- Neurons and connections change in an activity-dependent fashion
- This "use-dependent" development
- The brain is most plastic (receptive to environmental input) in early childhood
- With trauma and neglect, the midbrain is overactive and grows in size while the limbic and cortical structures are stunted in growth




Perry B 2003

# Treatment Response Needs to Match the Severity of the Problems




**American Society of Addiction Medicine Placement Criteria**

| | |
|---|---|
| **LEVEL 0.5** | **Early Intervention** |
| **LEVEL I** | **Outpatient Treatment** |
| **LEVEL II** | **Intensive Outpatient/ Partial Hospitalization** |
| **LEVEL III** | **Residential/ Inpatient Treatment** |
| **LEVEL IV** | **Medically Managed Intensive Hospital/ Inpatient Treatment** |

# Model Programs Described in TIP 2: Pregnant, Substance-Using Women: Treatment Improvement Protocol (TIP) Series 2

The goal of the program - provide comprehensive services that are appropriate and sensitive to the needs of the target population -- services that will enable women to secure prenatal care and other support throughout pregnancy, to achieve a successful delivery, and to receive months of postpartum care.

Services will be provided by a multidisciplinary team of health professionals

All health care services will be provided in one setting

If the patient needs to undergo medical withdrawal or be hospitalized, referrals will be made to the appropriate programs.

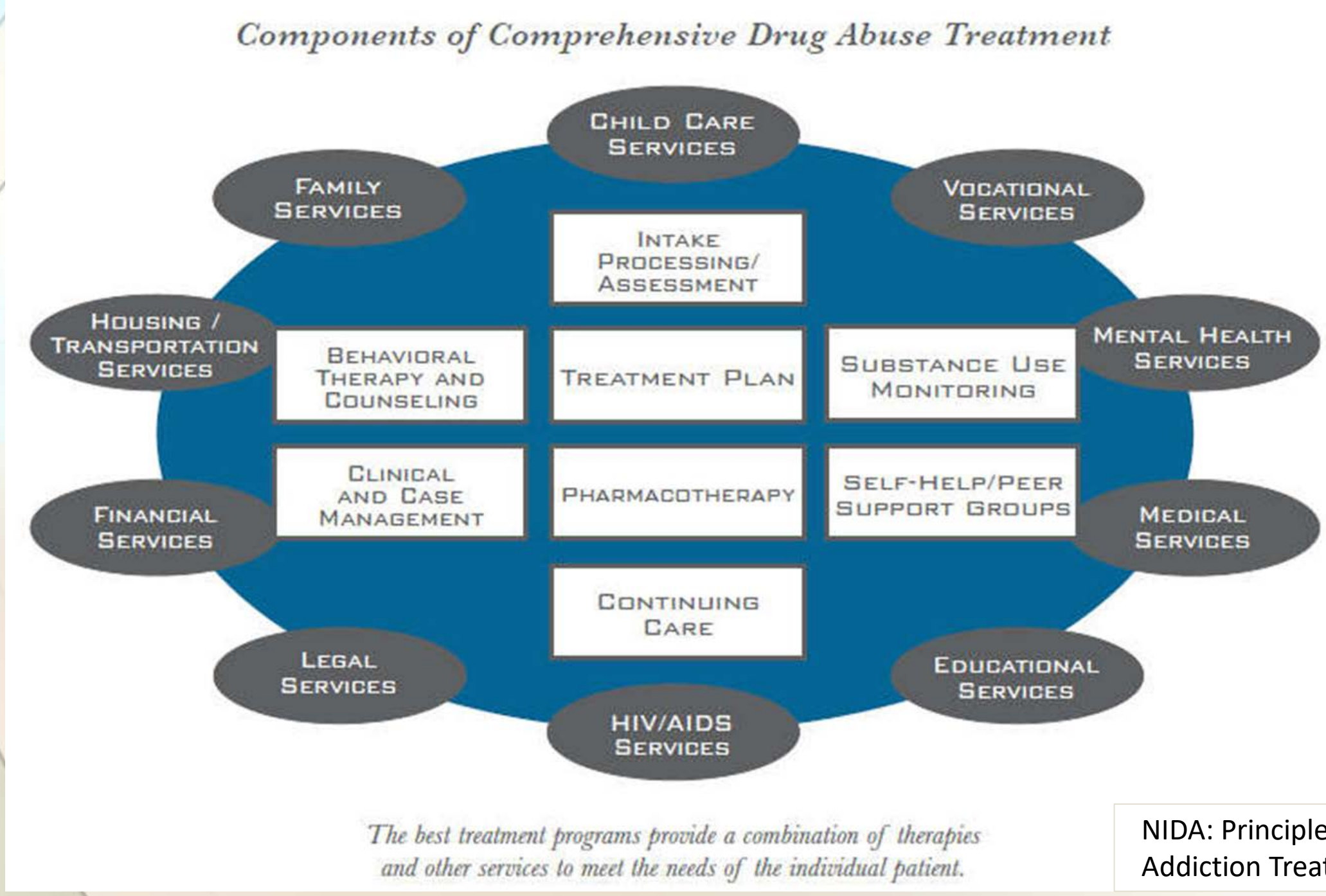
The model program will provide:

- outreach services
- laboratory workups
- obstetrical and gynecological physicals
- social work intervention
- appropriate follow-up services
- diagnosis, evaluation, and short-term clinical interventions, along with medical management

A case management model is used

The woman's transition into providing child care and parenting will be facilitated by a complete and thorough assessment of her needs and the development of a comprehensive treatment plan.

DHHS Publication No. (SMA) 95-3056, 1993




NIDA: Principles of Drug Addiction Treatment

# UNC Horizons: Care for Women and Children

Medication Assisted Treatment

Trauma and SUD Treatment

Residential and/or Outpatient Care

Childcare and Transportation

Medical Care OB/GYN Psychiatry

Vocational Rehabilitation Housing Legal aid

Parenting Education and Early Intervention

Unified Philosophy Informed by Social Learning, Relationship and Empowerment Theories

# LANGUAGE MATTERS:

## Using Affirmative Language to Inspire Hope and Advance Recovery

| Stigmatizing Language | Preferred Language |
|---|---|
| abuser | a person with or suffering from, a substance use disorder |
| addict | person with a substance use disorder |
| addicted infant | infant with neonatal abstinence syndrome (NAS) |
| addicted to [alcohol/drug] | has a [alcohol/drug] use disorder |
| alcoholic | person with an alcohol use disorder |
| clean | abstinent |
| clean screen | substance-free |
| co-dependency | term has not shown scientific merit |
| crack babies | substance-exposed infant |
| dirty | actively using |
| dirty screen | testing positive for substance use |
| drug abuser | person who uses drugs |
| drug habit | regular substance use |
| experimental user | person who is new to drug use |
| lapse / relapse / slip | resumed/experienced a recurrence |
| medication-assisted treatment (MAT) | medications for addiction treatment (MAT) |
| opioid replacement | medications for addiction treatment (MAT) |
| opioid replacement therapy (ORT) | medications for addiction treatment (MAT) |
| pregnant opiate addict | pregnant woman with an opioid use disorder |
| prescription drug abuse | non-medical use of a psychoactive substance |
| recreational or casual user | person who uses drugs for nonmedical reasons |
| reformed addict or alcoholic | person in recovery |
| relapse | reoccurrence of substance use or symptoms |
| slip | resumed or experienced a reoccurrence |
| substance abuse | substance use disorder |


Mid-America (HHS Region 7)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

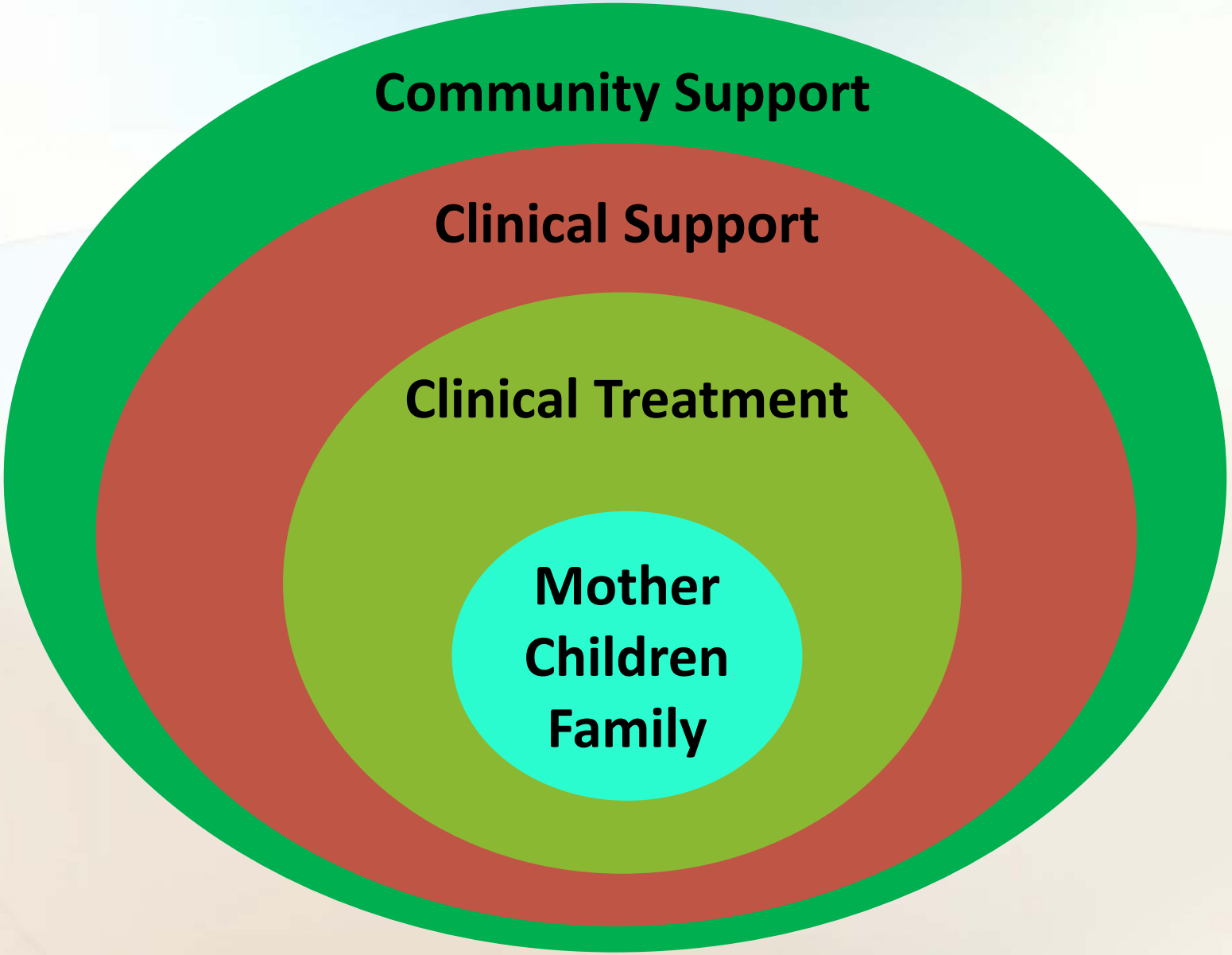
# Other Model Programs and Resources

**CHARM Collaborative**

**Dartmouth Hub and Spoke Model**

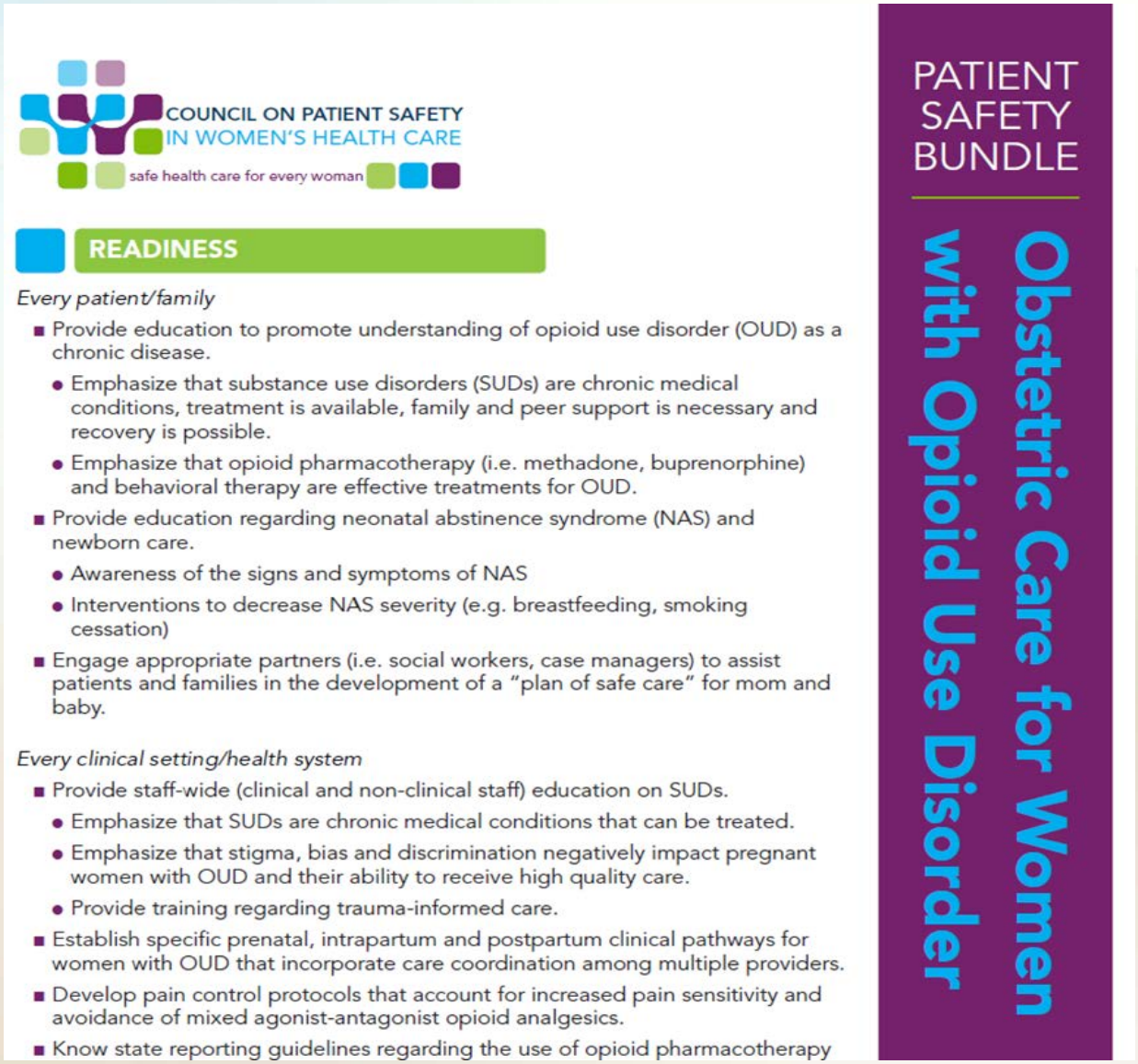
**SHIELDS for family Program**

# Recovery Oriented System of Care for Families



# Improving Maternal Health

- Treatment expansion
- Medicaid expansion (to one year post delivery for non-expansion states)
- Naloxone co-prescribing
- Contraception/Family Planning integration
- Uptake of AIM Maternal Safety Bundle(s)



COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Care for Women with Opioid Use Disorder

**READINESS**

*Every patient/family*

- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
  - Emphasize that substance use disorders (SUDs) are chronic medical conditions, treatment is available, family and peer support is necessary and recovery is possible.
  - Emphasize that opioid pharmacotherapy (i.e. methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
  - Awareness of the signs and symptoms of NAS
  - Interventions to decrease NAS severity (e.g. breastfeeding, smoking cessation)
- Engage appropriate partners (i.e. social workers, case managers) to assist patients and families in the development of a "plan of safe care" for mom and baby.

*Every clinical setting/health system*

- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
  - Emphasize that SUDs are chronic medical conditions that can be treated.
  - Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
  - Provide training regarding trauma-informed care.
- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy

# What You Can Do

## Individual Level

- Mothers, children and families need strength-based support
- Help tell stories of recovery and success
- Consider mother and child not mother vs. child
- Be familiar with toolkits from NC and SAMHSA

## Structural Level

- Access to whole health care
- Responsible prescribing by providers and training in substance use disorders and their treatments
- Create or engage in local networks to foster ROSCs that support families

# Summary

- Opioid use disorder is a concerning medical illness that has radiating effects on the life of the person and those around the person
- Those who have this illness deserve the most appropriate medical care – medication in only one part of a complete treatment approach
- Patients are best served by having choices in medication treatment options
- Structured, evidence-based behavioral treatment is needed to help support the mother, child and family
- Women who have opioid use disorders and their prenatally opioid exposed children are best served with a strength-based perspective

***See Klaman SL, Isaacs K, Leopold A, Perpich J, Hayashi S, Vender J, Campopiano M, Jones HE.J Addict Med. 2017 for a full list of unanswered research questions for mother, fetus, child and the mother-child dyad***

# To Treat Babies for Drug Withdrawal, Help Their Mothers, Too

**Rather than stigmatizing mothers with addiction, research suggests that a holistic approach to improving the lives of both mother and child is most effective.**

12.12.2018 / By Jocelyn Wiener