

**BREAKING NEWS**

\$1.00

Since 1883

YOUR NUMBER ONE SOURCE FOR HEADLINES

# OPIOID CRISIS

25,000 DEATHS  
IN THE LAST

OPIOID MICRO TRAINING MODULE 4: UNDERSTANDING OPIOID  
USE, PREGNANCY, AND NEONATAL ABSTINENCE SYNDROME (NAS)

SOCIAL

day more than 90  
after

reassure  
community that patients  
become addicted to  
pain

understand  
deaths due to  
overdoses have ac  
underrep

This training is offered by the Florida Alcohol and Drug Abuse Association and JBS International. It is supported by funding from the Department of Children and Families, Office of Substance Abuse and Mental Health (Contract #LD987) as part of its Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis (O-STR) grant efforts.



## PURPOSE OF THE OPIOID STR GRANT

The grant aims to address the opioid crisis by:

- ✓ Increasing access to treatment;
- ✓ Reducing unmet treatment need; and,
- ✓ Reducing opioid overdose related deaths.

## MODULE 4 LEARNING OBJECTIVES

Participants will:

- Articulate at least two common barriers that prevent pregnant women who misuse opioids from seeking treatment.
- Name two U.S. Food and Drug Administration (FDA)-approved medications that are used as part of medication-assisted treatment and recovery (MAT-R) support for pregnant women who misuse opioids.
- List two actions to identify or help pregnant women with opioid use disorder (OUD) get treatment.



# **OP** OUD AND NEONATAL ABSTINENCE SYNDROME (NAS)



# OPIOID USE DISORDER

- OUD is a problematic pattern of opioid use leading to clinically significant impairment or distress.
- People with OUD typically experience a strong desire for opioids; experience inability to control or reduce use; continue use despite interference with major obligations or social functioning; use larger amounts over time; develop tolerance; spend a great deal of time to obtain and use opioids; and undergo withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia (SAMHSA, 2015).

- We are experiencing an epidemic of opioid use and addiction in the US.
- Opioid medications taken by pregnant women also get into the baby's system. Shortly after birth, many of these babies experience temporary withdrawal symptoms such as fussiness or shaking. This is called neonatal abstinence syndrome (NAS).
- NAS occurs in 30%-80% of opioid pregnancies, and is an expected and treatable consequence of opioid exposure.



## NAS/NOWS

- NAS is a nonspecific term assigned to these types of symptoms in the newborn.
- The more specific term *neonatal opioid withdrawal syndrome* (NOWS) is becoming more widely used (it more accurately identifies the numbers of infants experiencing withdrawal from opioid exposure in utero).
- In reality, prenatally substance-exposed infants are typically exposed to multiple substances.
- Fetuses exposed to other substances such as tobacco, alcohol, prescription medications (e.g., benzodiazepines), and illicit substances may also exhibit signs of physiologic withdrawal from these substances after birth.



# NAS

- NAS symptoms are monitored in the hospital.
- About 50 percent of the time, NAS symptoms require special treatment that may include medications and longer stays in the hospital before infants can be discharged.
- These symptoms can be monitored and are easily managed in most hospitals, and there is no evidence of permanent effects.

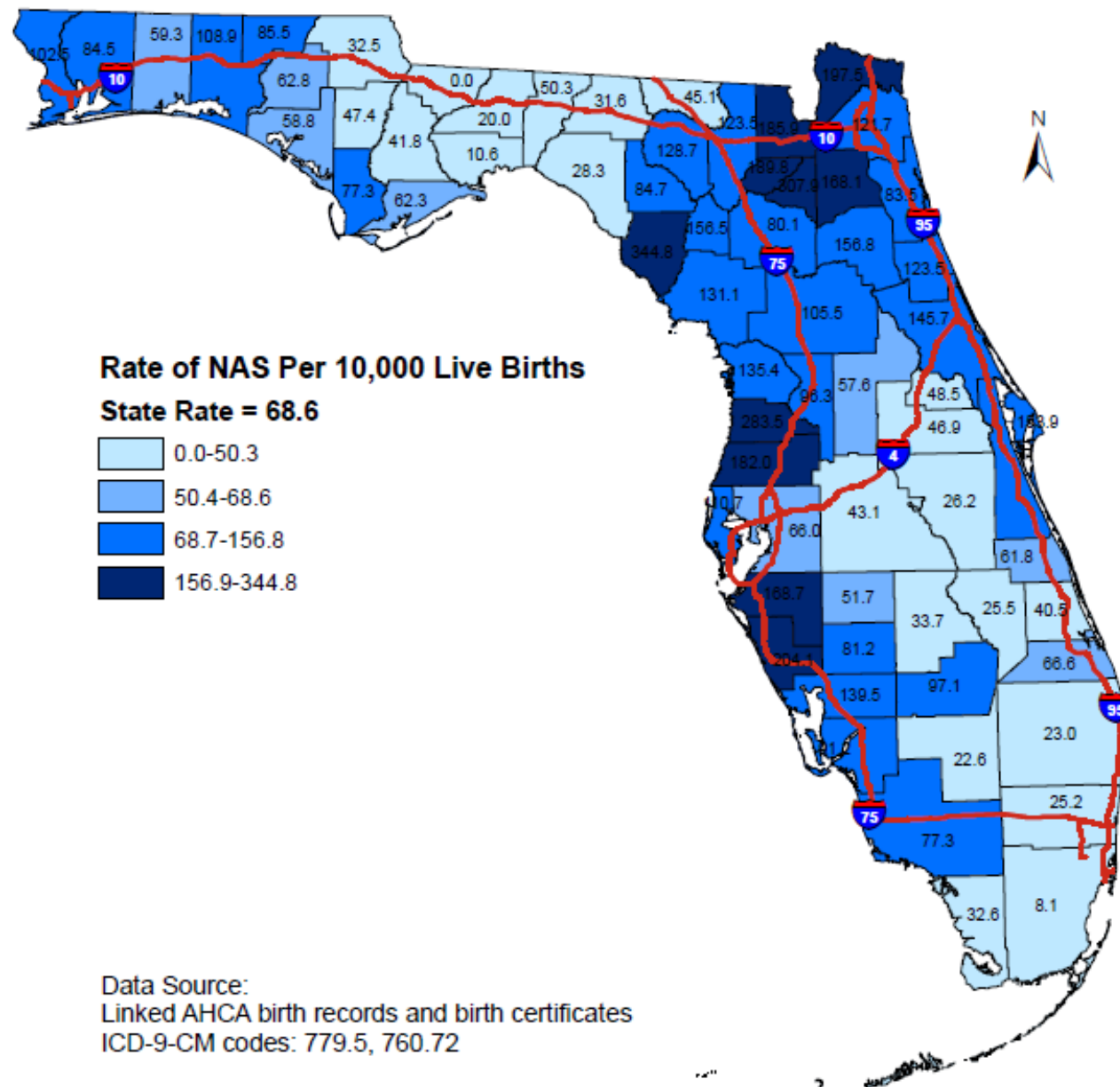


# PROMISING NONPHARMACOLOGICAL NAS TREATMENTS



- Rooming in
- Extended skin-to-skin contact with the mother
- Gentle handling
- Swaddling
- Pacifiers
- Quiet environments
- Supine positioning (infant sleeping on back)

The exact number of NAS cases is difficult to determine because of significant variability in hospital policies and practices for both diagnosing and reporting of NAS.



## NAS HOSPITAL STAYS: FL EXAMPLE

A retrospective chart review conducted at University of Florida Health in Gainesville, FL using data collected from January 1, 2012 to December 31, 2015 found:

- The average length of stay for newborns diagnosed with NAS who required only supportive measures was 4.6 days.
- The average length of stay for newborns diagnosed with NAS requiring medication was 14.4 days.



# **FACTORS CONTRIBUTING TO NAS**



# VAST PRESCRIPTION MISUSE: HOW DID WE GET HERE?



- The FDA approved OxyContin and other opioid pain meds in the mid-1990s (for short-term pain only).
- However, physicians quickly started prescribing the effective new pills for long-term or chronic pain management.
- When patients built up a tolerance and the pills stopped working, pain experts and drug company representatives instructed doctors to give higher doses.
- They assured doctors that the pills were safe and nonaddictive. **THEY WERE WRONG!!!!**

## OPIOID POLICY CHANGES CAN CONTRIBUTE TO HEROIN USE

Factors that contribute to an increase in counterfeit opioid medications and heroin use by pregnant women with opioid addiction include:

- The implementation of a prescription drug monitoring program
- The tightening of pain clinic regulations
- The designation of NAS as a mandatory reportable condition

## NAS INCREASE IS NOT SURPRISING...

- Women enrolled in treatment programs reported a significant increase in opioid use from 2% in 1992 to 28% in 2012, especially in the South.



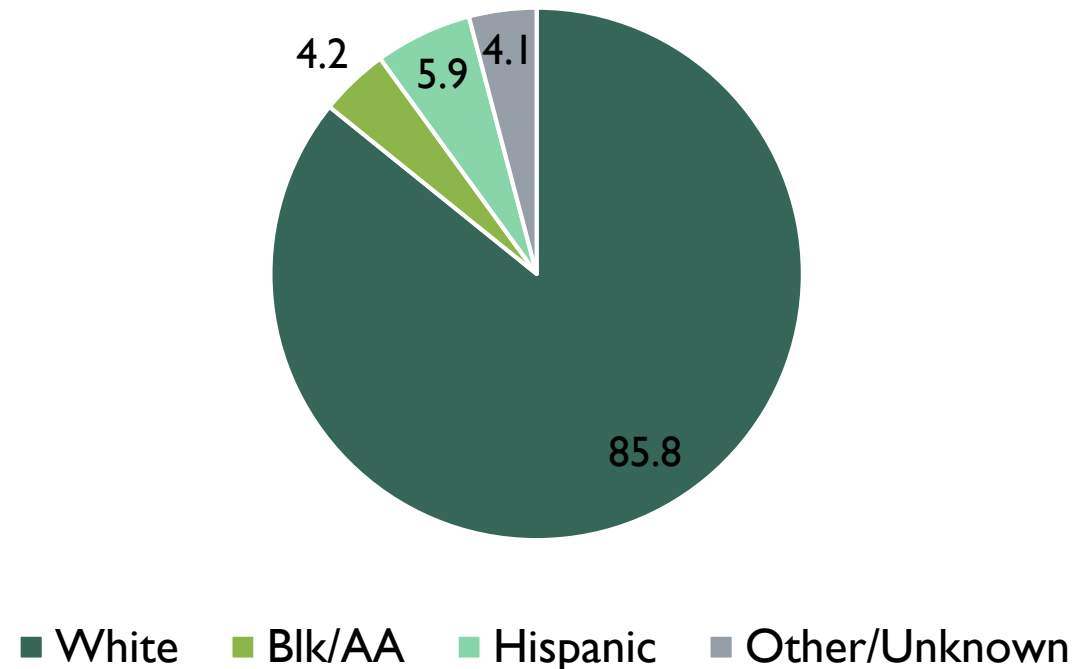


# CHARACTERISTICS OF 4,324 PREGNANT FLORIDA (FL) WOMEN WITH OPIOID USE

## Age ranges:

- 68% were 25-34
  - 19% were 18-24
  - 12% were 35-44
  - About 2% were 45+
- 
- 50.3% also had a mental health diagnosis
  - 44.6% also had a chronic physical condition

Opioid-Using Pregnant Women in FL by Race



# UNTREATED OPIOID ADDICTION IN PREGNANCY

- Untreated OUD during pregnancy has well-known, severe adverse consequences for the baby.
- Besides NAS, consequences may include stunted growth, preterm labor, fetal convulsions, and miscarriage.
- Indirect risks include maternal infections (e.g., HIV, hepatitis C), malnutrition, poor prenatal care, and dangers associated with drug seeking (e.g., violence, imprisonment).

## UNTREATED OUD

- Most pregnant women who misuse opioids also use other substances, and most of their children are raised in high-risk social environments.





# **COMMON BARRIERS AND SOLUTIONS TO ACCESSING MAT-R**



## IN A PERFECT WORLD, DETECTING PRENATAL DRUG USE WOULD BE SIMPLE:

- Every pregnant woman would get tested with an accurate tool, and both the mother and the newborn would receive appropriate treatment.
- Drug use would be recognized as a medical issue, and legal entanglements would not flow from positive toxicology results.
- Societal resources would be committed to strengthening family bonds and to the well-being of each family member.



## REALITY ... IN FL



- In a FL study, less than half of the pregnant women in substance use disorder (SUD) treatment reported that their SUD provider was in communication with their pregnancy doctor or staff.
- About one quarter reported receiving a referral for obstetrical care from their SUD treatment provider.

# COMMON TREATMENT BARRIERS

- Not knowing pregnancy status
- Shame associated with OUD during pregnancy and motherhood
- Fear of incarceration or losing custody
- Lack of insurance or funds
- Lack of transportation
- Lack of day care for other kids
- Coercive controlling partner
- Co-occurring mental illness
- Misinformation among healthcare professionals and systems that results in reluctance to provide care for such women
- These barriers can prevent women from receiving essential prenatal care or treatment for their OUD until they are close to delivery or in labor.



## NAS: WHAT CAN WE DO?

- Implementation of safe prescribing practices
- Encouragement of healthy behaviors
- Provision of appropriate information
- Identification and referral of individuals with SUD to addiction treatment professionals.





## NAS: WHAT CAN WE DO?

- Knowledge of a mother's drug use during pregnancy can facilitate diagnosis and intervention in a timely fashion to temper NAS effects.
- Testing should result in a medical “good,” not merely the capture and stigmatization of those with a disease.
- The “good” should pertain to both the child AND to the mother (as a dyad).



## SAMHSA SAYS ...

- Have a careful, empathetic, and non-judgmental interview with her that lets her know that all parents are asked the same questions about substance use.
- Have a SUD screening, and if needed, assessment, by a trained professional (assess for high-risk activities like injection drug use, domestic violence (DV), and trauma/other mental health issues).
- Implement a warm handoff to ensure that pregnant women with OUD receive counseling and education on: the medical and social consequences of pharmacotherapy for OUD; continued use of legal and illicit substances while pregnant; withdrawal from opioids while pregnant; and inherent risks to the mother and fetus if the mother returns to use.

## SAMHSA SAYS ...



- Pay attention to the woman's immediate needs (e.g., health, nutrition, safety/safe housing, transportation, and other stressors).
- Provide detailed information about opioid use (e.g., amount, route, duration, and MAT opioid meds) and other substances (including alcohol).
- Provide informed consent to speak with treatment provider (if in treatment) and other health professionals to ensure that safe MAT continues or is initiated (if appropriate), and ensure continued health and prenatal care.

## SAMHSA SAYS ...

- Pregnancy is a time of great potential for positive change.
- A pregnant woman with OUD not in treatment should be offered MAT consisting of pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions.



## SAMHSA SAYS ...

As soon as a pregnant woman is diagnosed with OUD they should be informed ...

- that treatment without any pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and the consequences such as risk of overdose.
- about the possibility of NAS and its diagnosis, management, and consequences.
- of the consequences that relate to NAS and unmonitored prenatal withdrawal.
- on ways to optimize the well-being of the fetus (e.g., tobacco cessation and early pediatric care after delivery and hospital discharge).
- of nonpharmacological interventions that should be provided to her infant to reduce NAS symptoms (including rooming-in).

# THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES (DCF) OFFICE OF CHILD WELFARE SAYS ...

## Chapter 1

### PLANS OF SAFE CARE FOR INFANTS AFFECTED BY PRE OR POST-NATAL SUBSTANCE USE

1-1. Purpose. This chapter provides guidelines for ensuring mothers, infants and family members receive the necessary supports to prevent the negative outcomes associated with pre-natal exposure or post-natal substance use. Appropriate intervention efforts include, but are not limited to, assistance with maternal entry or retention in substance abuse or mental health treatment, enhancement of child well-being, and development of family skills to facilitate healthier lifestyles.

- Follow DCF guidelines for ensuring that mothers, infants, and family members receive the necessary supports to prevent the negative outcomes associated with prenatal or postnatal opioid and other substance use.

# OPIOID MEDICATION COMPARISONS: PREGNANCY

Opioid Medications/ Associated Property	Methadone	Buprenorphine Subutex® ONLY
Research supports that it is safe for pregnancy	Effectively controls withdrawal symptoms and maternal and fetal functions (supported by many years of research)	Effectively controls withdrawal symptoms and stabilizes maternal and fetal functions (supported by fewer years of research)
Withdrawal/NAS	Safe to use during pregnancy. Withdrawal symptoms for the baby may be more severe than for buprenorphine, and hospital stays may be a bit longer	Withdrawal symptoms are milder for infants, less likely to require treatment with medications, and more likely to have shorter hospital stays
Breastfeeding	Research has deemed safe (outweighs non-breastfeeding risks)	Research has deemed safe (outweighs non-breastfeeding risks)- Discuss breastfeeding with Subutex and Naloxone w/physician*

Naltrexone and Suboxone are NOT currently deemed safe for pregnant women.

## SAMHSA SAYS ...

Healthcare professionals should tell pregnant women with OUD:

- The benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD
- To date, there is no evidence that buprenorphine and methadone causes an increase in birth defects or significant long-term neurodevelopmental impact
- Experts do not agree on whether intrauterine exposure to buprenorphine, buprenorphine/naloxone, or methadone results in lasting developmental or other problems for the infant
- Tobacco and alcohol exposure are known to be harmful to her and the fetus. Women should be provided with support to limit or preferably discontinue exposure to these substances.





## BENEFITS OF MEDICATION DURING PREGNANCY

- Stabilizes fetal levels of opioids
- Reduces likelihood of transmittal of infectious diseases to the baby
- Better prenatal care
- Better long-term health outcomes for the mother and baby.

# WITHDRAWAL AND DETOX NOT ADVISED

The American College of Obstetrics and Gynecology (ACOG), the American Society of Addiction Medicine (ASAM), SAMHSA, and the DCF Office of Substance Abuse and Mental Health recommend against medically supervised withdrawal or detoxification from heroin or opioids during pregnancy, due to the high relapse rate and the increased risk of fetal distress and death.



## SAMHSA SAYS ...

- Immediate and simultaneous discontinuation of all substances (e.g., alcohol, benzodiazepines, and opioids) may not be feasible or even safe, particularly during pregnancy because of the additional risk to the developing fetus (which may also be going through withdrawal unmonitored).



## SAMHSA SAYS ...

- Pharmacotherapy, combined with behavioral interventions, helps people who misuse opioids avoid experiencing withdrawal symptoms or overwhelming cravings when the opioid misuse is stopped.
- By blocking cyclic withdrawal symptoms associated with the misuse of short-acting opioids, methadone or buprenorphine can provide a more stabilized intrauterine environment.
- By controlling the symptoms of OUD (e.g., withdrawal, cravings), the pregnant woman can regain control; reengage in important obligations and activities in her life; and rebuild a stable social environment for herself and her family.

## POSTPARTUM MAT-R

- A dose effective in pregnancy may be too high during the postpartum period.
- In the immediate postpartum period (while still in the hospital or shortly after discharge), complaints of drowsiness and sleeping for unusually long periods should prompt evaluation of the new mother's MAT medication dose.
- As over sedation may impact the mother's ability to parent, it is important that anyone working with the patient be alerted to signs of overmedication so dosage may be adjusted.

# EFFECTIVE TREATMENT FOR OPIOID ADDICTION: MAT-R



Medications combined with behavioral counseling:

- Decreases opioid use, deaths, criminal activity, and infectious disease transmission
- Increases social function and retention in treatment
- **IMPROVES CHILD PERMANENCY OUTCOMES.**



The need for timely recognition of and assistance for pregnant women who use opioids, other drugs, and alcohol has never been greater.





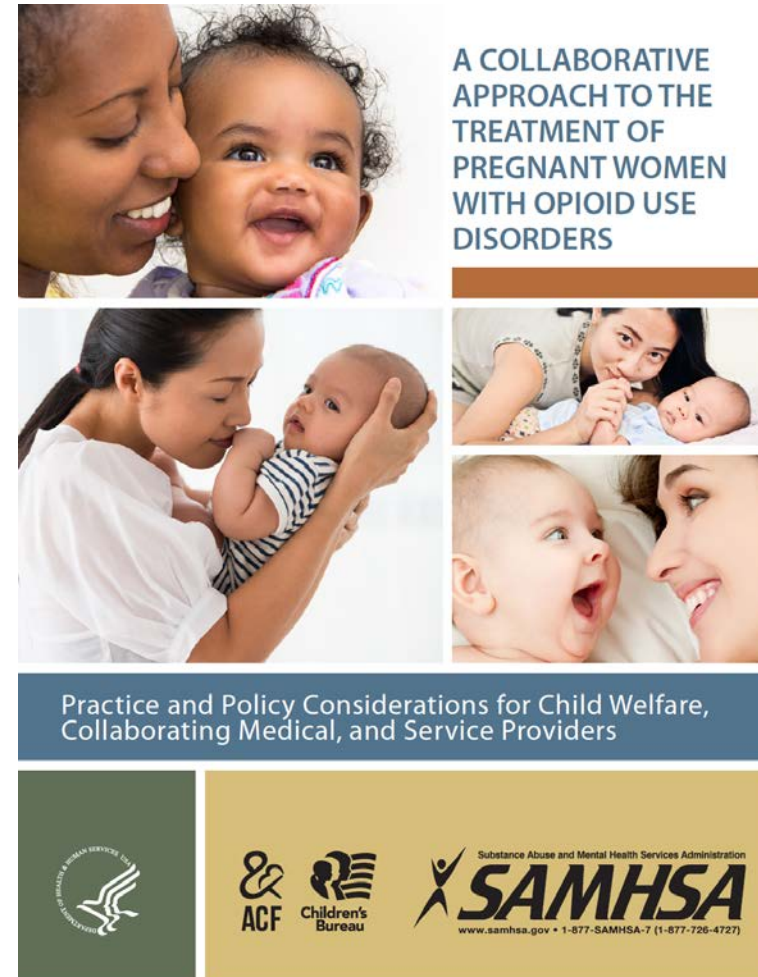
## A HELPFUL RESOURCE

<https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>



# A HELPFUL RESOURCE

- [https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)



## FOR QUESTIONS OR FOR ADDITIONAL INFORMATION

For additional opioid training modules:

- [FADAA.org](https://www.fadaa.org)

For additional information about Florida's opioid treatment options or other DCF opioid information, contact:

Walter Castle LCSW, MCAP

Opioid STR Project Director

Office of Substance Abuse and Mental Health

Florida Department of Children and Families

1317 Winewood Blvd., Bldg. 6, Room 250

Tallahassee, FL 32399

Office: (850) 717-4277

Email: [walter.castle@myflfamilies.com](mailto:walter.castle@myflfamilies.com)

# REFERENCES

Slide 6: <https://www.samhsa.gov/disorders/substance-use>

Slide 7: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>

Slide 8: Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Slide 9: <http://www.astho.org/prevention/nas-neonatal-abstinence-report/>

and <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>Slide

## REFERENCES

Slide 10 (multiple sources): <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

American Academy of Pediatrics, Section on Breastfeeding. (2012). Policy statement: Breastfeeding and the use of human milk. *Pediatrics*, 129(3), e827–e841. Retrieved from

**<http://pediatrics.aappublications.org/content/129/3/e827.full#content-block>**

Bagley, S. M., Wachman, E. M., Holland, E., & Brogly, S. B. (2014). Review of the assessment and management of neonatal abstinence syndrome. *Addiction Science & Clinical Practice*, 9(1), 19.

d'Apolito, K. (1999). Comparison of a rocking bed and standard bed for decreasing withdrawal symptoms in drug-exposed infants. *MCN, American Journal of Maternal Child Nursing*, 24(3), 138–144.

MacMullen, N. J., Dulski, L. A., & Blobaum, P. (2014, July–August). Evidence-based interventions for neonatal abstinence syndrome. *Pediatric Nursing*, 40(4), 165–72, 203. Retrieved from

**<https://www.pediatricnursing.net/ce/2016/article40051.pdf>**

## REFERENCES

Slide 10 cont.:Velez, M., & Jansson, L. M. (2008).The opioid dependent mother and newborn dyad: Nonpharmacologic care.*Journal of Addiction Medicine*, 2(3), 113–120. doi:10.1097/ADM.0b013e31817e6105;

World Health Organization. (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Geneva, Switzerland:WHO. Retrieved from [http://www.who.int/substance\\_abuse/publications/pregnancy\\_guidelines/en/](http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/)

Slide 11: Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018; p. 2. and 1. Patrick, Davis, Lehmann, & Cooper, 2015; 2.Villapiano, Winkelman, Kozhimannil, Davis, & Patrick, 2017; 3. Patrick, Davis, et al., 2015

Slide 12: Florida Health Neonatal Abstinence Syndrome Data Summary: Maternal Characteristics Among Live Births From 2011-2013. March 2015. [http://www.fbdr.org/pdf/NAS\\_FLDOH\\_2011\\_thru\\_2013.pdf](http://www.fbdr.org/pdf/NAS_FLDOH_2011_thru_2013.pdf)

# REFERENCES

Slide 13: <http://www.scientificojournals.org/pdf/jgo.1018.pdf>

Slide 15: <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/03/03/states-cdc-seek-limits-on-painkiller-prescribing>

Slide 16: <https://www.ncbi.nlm.nih.gov/pubmed/25151440> Martin, C. E., Longinaker, N., & Terplan, M. (2014). *Recent trends in treatment admissions for prescription opioid abuse during pregnancy*. Journal of Substance Abuse Treatment, 48(1), 37–42.

Slide 17: DCF FL pregnant women enrolled in managed medical assistance (MMA) plans claims data 7/1/14-12/31/16.

Slide 18: <http://www.scientificojournals.org/pdf/jgo.1018.pdf>

Slide 19: <https://www.drugabuse.gov/about-nida/noras-blog/2018/02/could-naltrexone-be-used-to-treat-pregnant-women-opioid-addiction>

Slide 22: 2016 by The American College of Obstetricians and Gynecologists. Published by Wolters Kluwer Health, Inc. All rights reserved. ISSN: 0029-7844/17VOL. 129, NO. 1, JANUARY 2017, pg. 164

## REFERENCES

Slide 23: DCF FL pregnant women enrolled in managed medical assistance (MMA) plans claims data 7/1/14-12/31/16.

Slide 24: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 26:

[https://journals.lww.com/greenjournal/Abstract/2017/01000/Neonatal\\_Abstinence\\_Syndrome\\_and\\_Ethical.21.aspx](https://journals.lww.com/greenjournal/Abstract/2017/01000/Neonatal_Abstinence_Syndrome_and_Ethical.21.aspx)

Slide 27: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 28: DCF DRAFT policy provided by Office of Child Welfare on 3.1.18

## REFERENCES

Slide 29: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf> Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 30: Ibid

Slide 31: Ibid

Slide 32: <https://archive.samhsa.gov/MAT-Decisions-in-Recovery/Default.aspx> and Substance Abuse and Mental Health Services Administration. Medications To Treat Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. HHS Publication No. (SMA) 18- 5063FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 33: <https://www.drugabuse.gov/about-nida/noras-blog/2018/02/could-naltrexone-be-used-to-treat-pregnant-women-opioid-addiction>

Slide 34: <http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf>



# REFERENCES

Slide 35: [https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)

Slide 36: Ibid

Slide 37: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 38: [https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)

Slide 39: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 40: Ibid

## REFERENCES

Slide 41: J Subst Abuse Treat. 2016 Dec;71:63-67. doi: 10.1016/j.jsat.2016.09.006. Epub 2016 Sep 17. Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System

Slide 42: <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Slide 43: Ibid