Collaborative Approach to Serving Pregnant and Postpartum Women with Opioid Use Disorders and their Infants

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Disclosures

- **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**
- **As of May 2016, the FDA requires methadone and buprenorphine safety labeling to include information regarding the risk of neonatal opioid withdrawal syndrome (NOWS)**
- **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).**

Acknowledgements

- **Study patients and infants**

- **National Institute on Drug Abuse**
  - **R01 DAs: 015764, 015738, 017513, 015778, 018410, 018417, 015741, 15832**

- **Maternal Opioid Treatment: Human Experimental Research (MOTHER) Site PIs and investigative teams**

- **Investigative teams in Chapel Hill and Michigan**

Historical Context of Opioid Use and Women

Opioid use during pregnancy in the 1800s:

- 66–75% of opioid users were women
- Opium prescriptions to treat pain and uniquely female "issues"
- The southern United States had a larger per capita number of opioid users
- Early drug control legislation focused on immigrants and minorities and focus on white women being "lured into opium dens and corrupted"
- Media began to link and sensationalize drug use, women and sexuality in an effort to stimulate public outrage at drug use

http://usslave.blogspot.com.br/2012/02/opiate-addiction-and-cocaine-use-in.html

Courtwright D. *J Southern History* 1983; Kandall S *Substance and shadow*, 1996. Earle, *Medical Standards*, 1888

Defining NAS

Neonatal Abstinence Syndrome (NAS) often results when a pregnant woman 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 stuffiness and rapid breathing**

- **NAS is *not* Fetal Alcohol Syndrome (FAS)**
- **NAS is treatable**
- **NAS and 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.

Historical Context of Opioid Use and Women

Main Eras of Opioid Use in the USA

1800s: 66–75% of opioid users were women

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

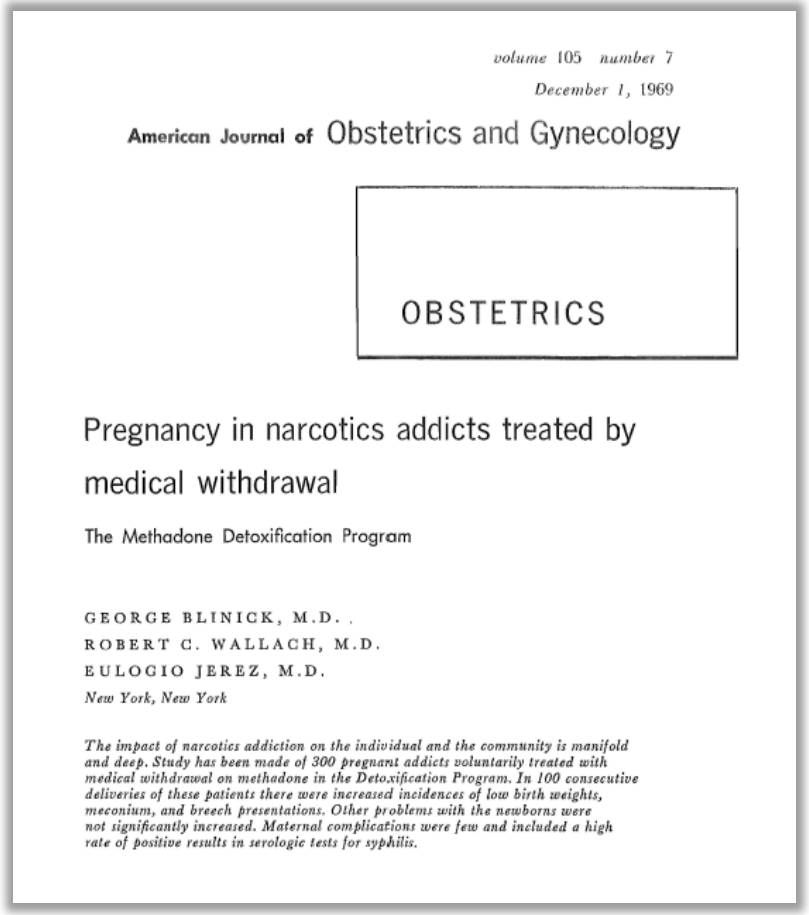
1969-70's: Opioid use by Vietnam veterans

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

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

Early Methadone and Pregnancy Literature



volume 105 number 7
December 1, 1969
American Journal of Obstetrics and Gynecology

OBSTETRICS

Pregnancy in narcotics addicts treated by medical withdrawal

The Methadone Detoxification Program

GEORGE BLINICK, M.D.
ROBERT C. WALLACH, M.D.
EULOGIO JEREZ, M.D.
New York, New York

The impact of narcotics addiction on the individual and the community is manifold and deep. Study has been made of 300 pregnant addicts voluntarily treated with medical withdrawal on methadone in the Detoxification Program. In 100 consecutive deliveries of these patients there were increased incidences of low birth weights, meconium, and breech presentations. Other problems with the newborns were not significantly increased. Maternal complications were few and included a high rate of positive results in serologic tests for syphilis.

Blinick G, et al., *Am J Obstet Gynecol.* 1969.

1973 FDA said all pregnant women on methadone should undergo a 21-day detoxification

Research shows that methadone:

- **Reduces maternal craving and repetitive episodes of fetal withdrawal**
- **When provided in the context of a comprehensive program, allows other behavior changes which decrease health risks to both mother and fetus**
- **Reduces the likelihood of complications with fetal development, labor, and delivery**

Zuspan. *Am J Obstet Gynecol.* 1975. et al., *Obstet Gynecol Clin North Am.* 1998.

Recent History: Opioid Use in the USA

80's
- Reports state few receiving narcotic painkillers develop addiction

90's
- Perdue Pharma Develops Oxycontin

1996
- American Pain Society "Pain - the 5th Vital Sign"

1998
- Federation of State Medical Boards: "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain"

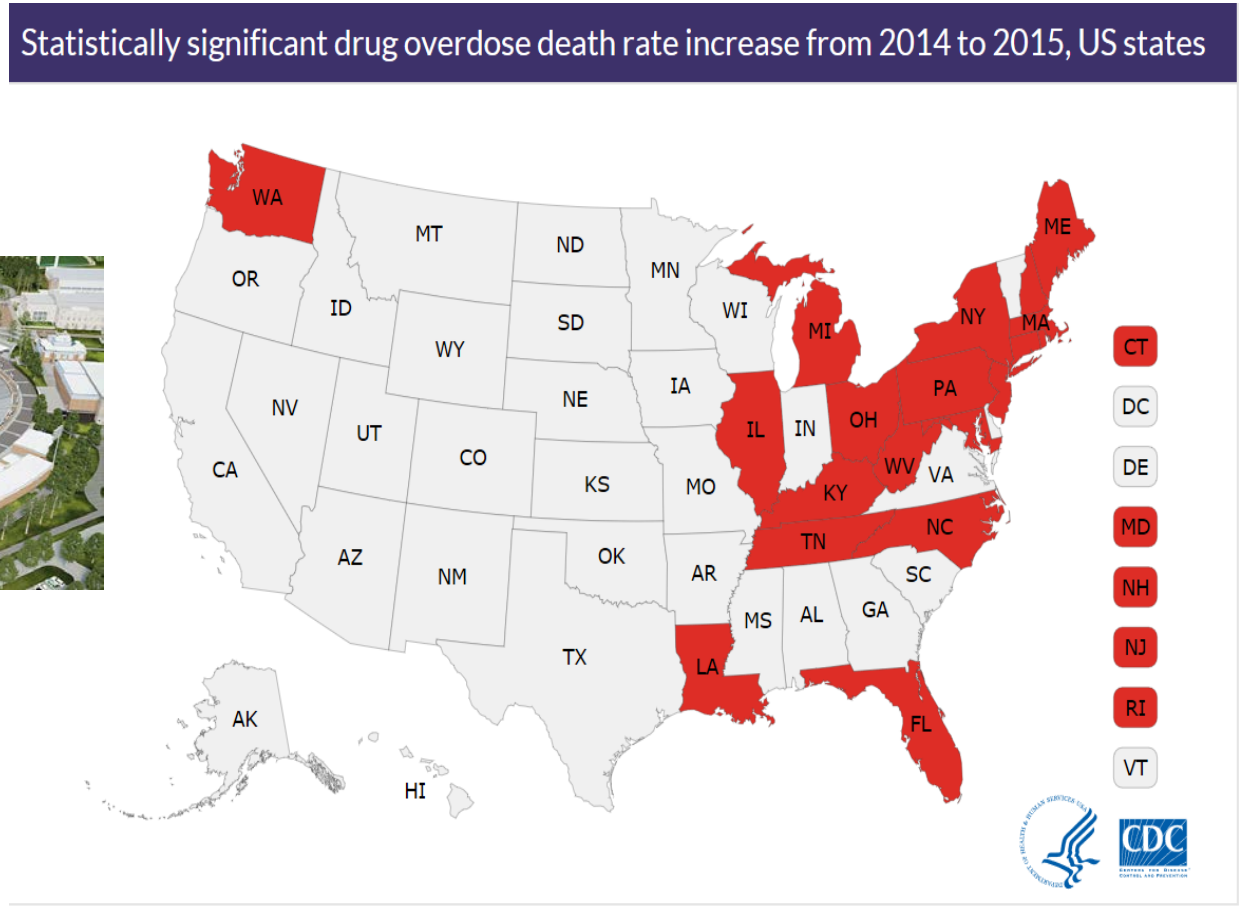
2003
- Tripling of 18-25 year olds abusing opioid pain relievers
- DEA and FDA task forces to reduce internet sales of opioids

2007
- George Brothers open first pain clinic in FL. American Pain prescribed almost 20 million pills over two years

2009-2015
- Drug overdose surpass motor vehicles as the leading cause of injury death

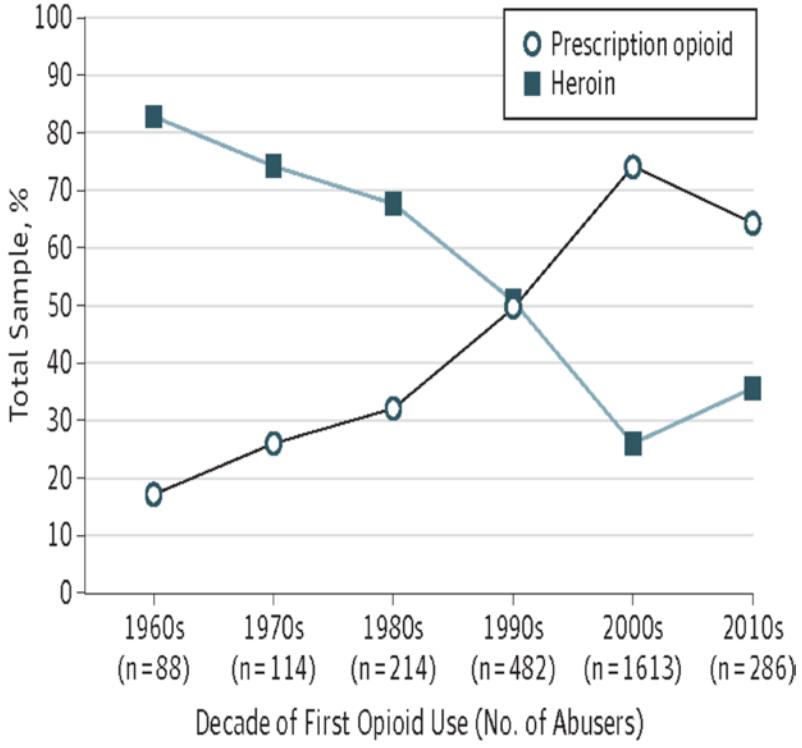
Frakt, A. NY Times 12/22/14; CDC Morbidity and Mortality Weekly Report (*MMWR*) 1/1/16

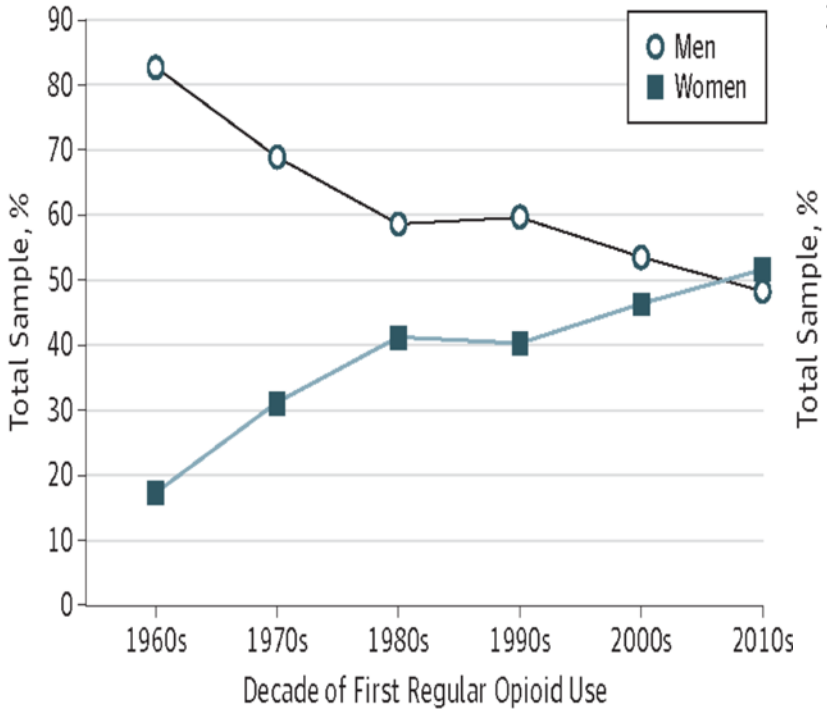
Current Context of Opioid Overdoses in the USA

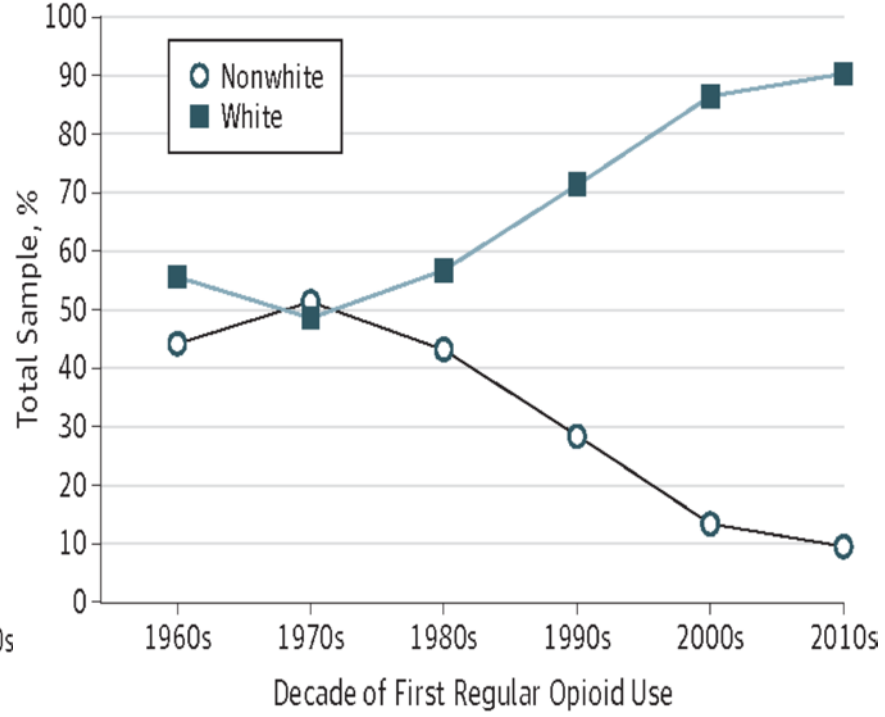


https://www.cdc.gov/drugoverdose/epidemic/index.html 9/2017

Current Context: The Changing Face of Those Taking Opioids







Cicero TJ et al., JAMA Psychiatry. 2014;71(7):821-826

Current Context: USA 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**

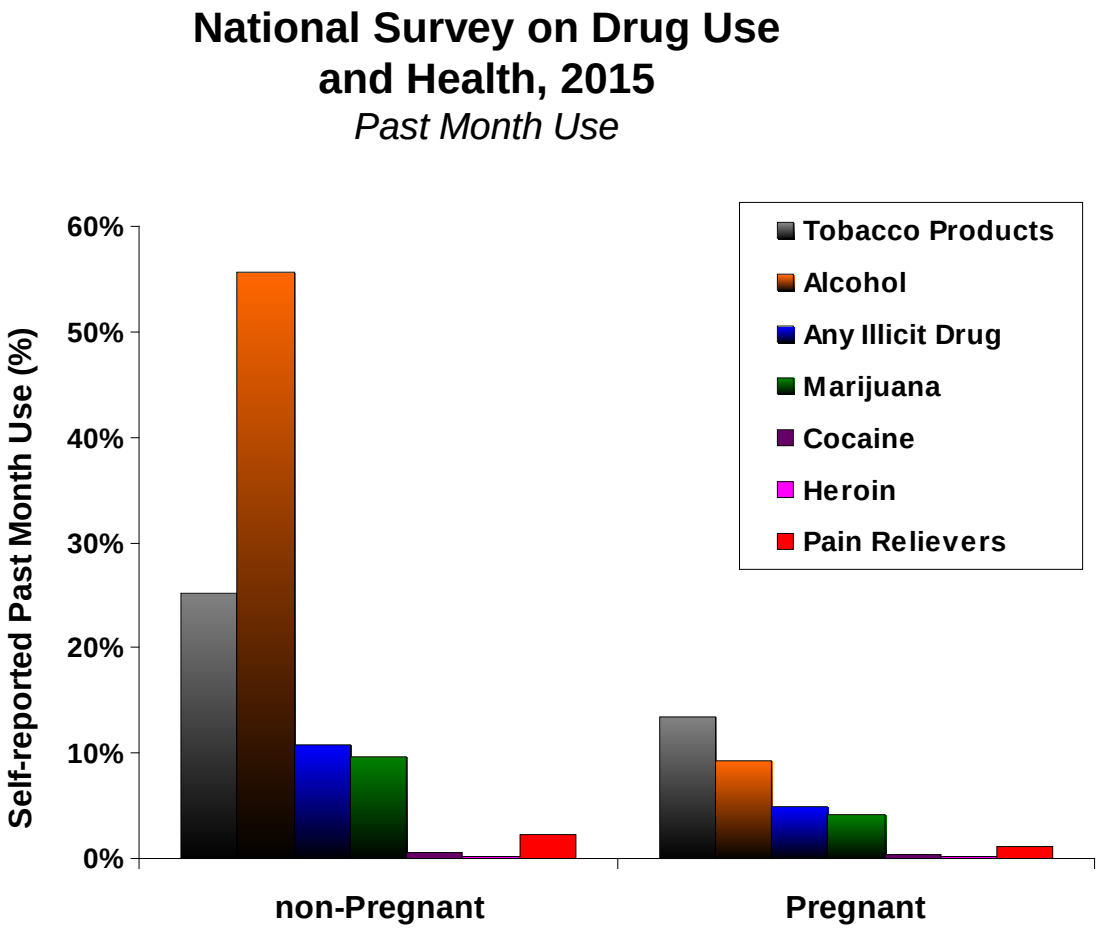
Specific risks for the misuse of prescription opioid medication among women include: experience of violence and trauma, being a native minority, adolescent, young, older, pregnant, a sexual minority, and being a transwoman

Sumner SA et al., Prehosp Emerg Care. 2016;20(2):220-5.

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

Hemsing N, et al. Pain Res Manag. 2016

Current Context of Substance Use during Pregnancy



- **The two most common drugs used by non-pregnant women have been alcohol and tobacco**
- **This same statement is true for pregnant women**

➥ ***Among pregnant women, approximately .2% used heroin, and 1.1% used pain relievers non-medically in the past month***

Tipping Point Data

Neonatal Abstinence Syndrome and Associated Health Care Expenditures
United States, 2000-2009

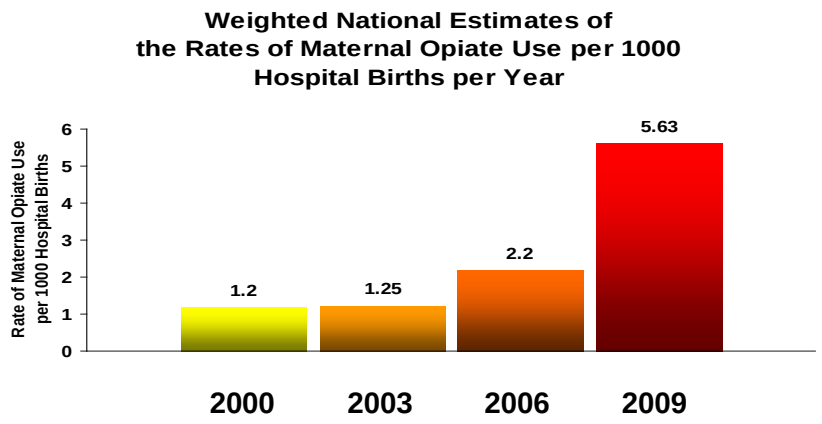
Stephen W. Patrick, MD, MPH, MS
Robert E. Schumacher, MD
Brian D. Benneyworth, MD, MS
Elizabeth E. Krans, MD, MS
Jennifer M. McAllister, MD
Matthew M. Davis, MD, MAPP

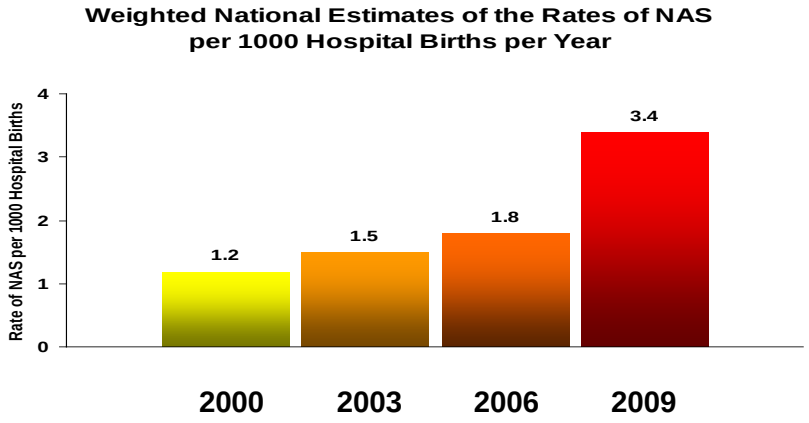
Context Neonatal abstinence syndrome (NAS) is a postnatal drug withc drome primarily caused by maternal opiate use. No national estimates ar for the incidence of maternal opiate use at the time of delivery or NAS.

Objectives To determine the national incidence of NAS and antepartur opiate use and to characterize trends in national health care expenditures with NAS between 2000 and 2009.

Design, Setting, and Patients A retrospective, serial, cross-sectional anal tionally representative sample of newborns with NAS. The Kids' Inpatient Dat

- **A retrospective, serial, cross-sectional analysis of a nationally representative sample of newborns with NAS.**
- **Clinical conditions were identified using ICD-9-CM diagnosis codes.**
- **NAS and maternal opiate use were described as an annual frequency per 1000 hospital births.**





in the United States – one infant every hour – suffers from neonatal abstinence syndrome (NAS)

Patrick et al. JAMA, 2012. Jones and Kaltenbach JAMA 2012

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**
- **Addiction is chronic disease – chronic illness can't be present at birth**

Jones & Fielder, *Preventive Medicine,* 2015.

Issues of Neonatal Withdrawal Diagnosis

Neonatal withdrawal symptoms from maternal use of drugs of addiction

- A constellation of signs and symptoms observable in a neonate that are consistent with maternal substance abuse or withdrawal while pregnant
- Fetal and neonatal addiction and withdrawal as a result of the mother's dependence on drugs during pregnancy. Withdrawal or abstinence symptoms develop shortly after birth. Symptoms exhibited are loud, high-pitched crying, sweating, yawning and gastrointestinal disturbances

Applicable To

- Drug withdrawal syndrome in infant of dependent mother
- Neonatal abstinence syndrome

Approximate Synonyms

- Neonatal drug withdrawal syndrome, maternal drug abuse
- Neonatal drug withdrawal syndrome, maternal drugs of abuse

NAS: Various Substances

STATE-OF-THE-ART REVIEW ARTICLE

Neonatal Abstinence Syndrome

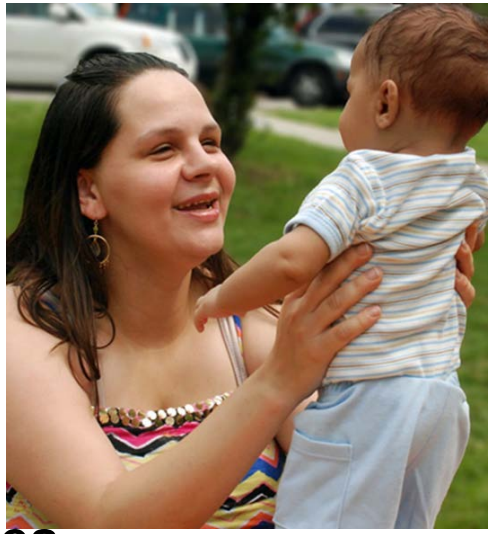
AUTHOR: Prabhakar Kocherlakota, MD
Pediatrics 2014;134:e547–e561

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

Pregnancy: A Unique Treatment Opportunity

- Mothers with substance use disorders have a mortality rate 8.4 times that of US women of similar age



- Pregnant women who use illicit substances may delay prenatal care and miss more healthcare visits than women who do not use substances
- Prenatal care may help to reduce the negative impact of illicit drug use on birth outcomes
- Lower prenatal care utilization may be due to a diverse set of barriers to seeking and obtaining care, including fear of child custody issues
- After childbirth, ongoing substance use disorders by caregivers and the dysfunctional home environment may create detrimental effects on children's psychological growth and development
- Maternal well-being has been recognized as a key determinant of the health of the next generation

Hser, Kagihara, Huang, Evans, & Messina, 2012; Funai et al., 2003 Staton et al., 2003 and Wagner et al., 1998; El-Mohandes et al., 2003; Roberts and Pies, 2011 and Schempf and Strobino, 2009; Chatterji and Markowitz, 2001, Clark et al., 2004, Conners et al., 2004 Hanson et al., 2006 and Linares et al., 2006

Specialized Care for Women Works

- **End-of-treatment outcomes between women-only and women receiving non-gender-specific treatment are mixed**
- **One-year post-treatment outcomes show that women treated in women only programs have better drug outcomes and some improved criminal justice outcomes**
- **Ten years post-treatment, 48.4% of the women had a successful outcome. More women-only than non-gender-specific treatment women had a successful outcome (50.0% *vs*. 46.6%, χ^2= .35) but this difference was not statistically significant**
- **Of women treated in women only programs:**
  - **63.6% had not used drugs**
  - **91.5% had not engaged in criminal justice activity**
  - **93.3% were alive**
- **Women only *vs*. mixed gender treatment increased the odds of successful outcome by 44%**
- **Women-only treatment was associated with fewer post-treatment arrests, which was associated with better outcomes**

Greenfield et al., 2010; Greenfield et al., 2007;Niv and Hser, 2007; Prendergast et al., 2011

Medication Assisted Treatment *v*. Medication-Assisted Withdrawal

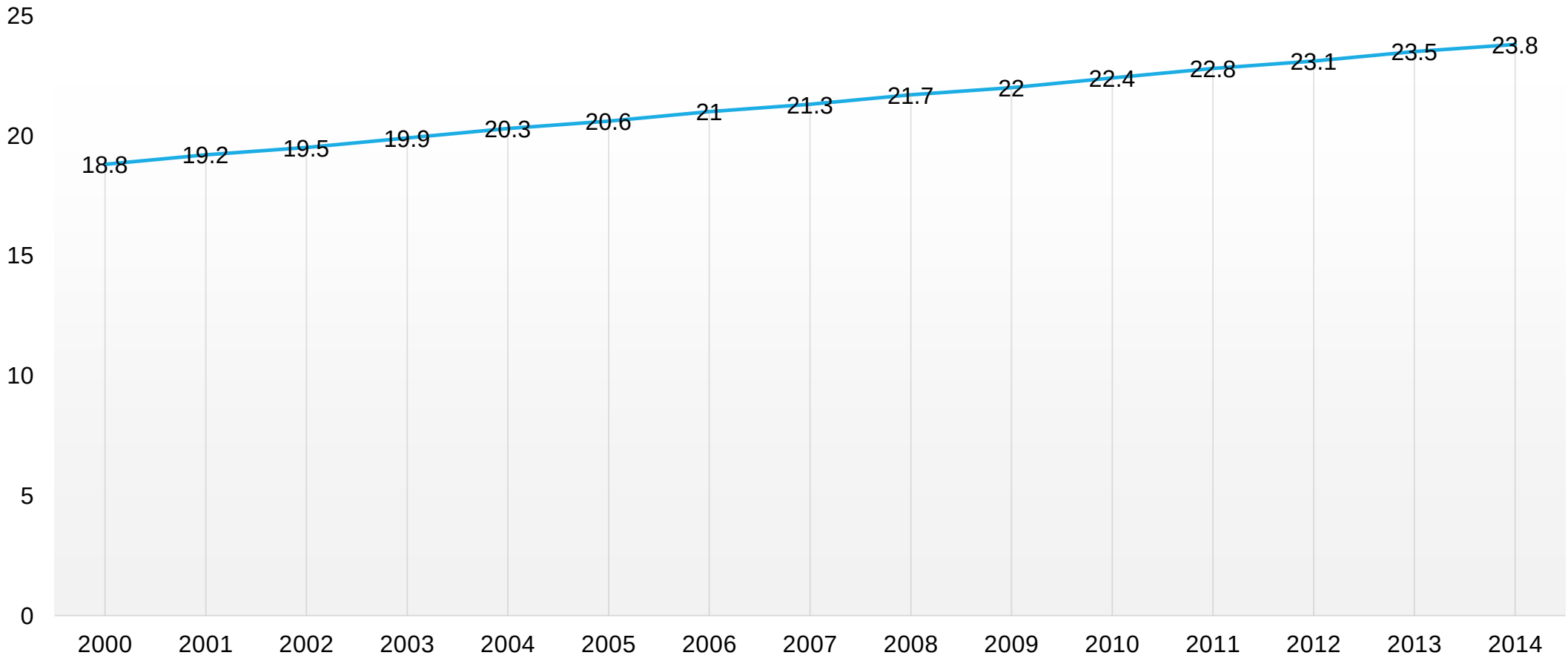
- **WHO 2014 Guidelines: "Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification. Opioid maintenance treatment in this context refers to either methadone maintenance treatment or buprenorphine maintenance treatment."**
- **Guidance regarding maintenance versus medication-assisted withdrawal has traditionally been based largely on good clinical judgment**
- **Medication followed by no medication treatment has frequently been found to be unsuccessful, with relatively high attrition and a rapid return to illicit opioid use**
- **Maintenance medication facilitates retention of patients and reduces substance use compared to no medication**
- **Biggest concern with opioid agonist medication during pregnancy is the potential for occurrence of neonatal abstinence syndrome (NAS) – a treatable condition**

Medically Assisted Withdrawal (Detoxification): Considering the Mother-Infant Dyad

- **Early reports associated withdrawal with maternal relapse and fetal demise**
- **Recent case series data do not support this association**
- **Relapse remains a significant clinical concern - rates ranging from 17% to 96% (average 48%)**
- **Current data do not support a reduction in NAS with medically assisted withdrawal relative to opioid agonist pharmacotherapy**
- **Medically assisted withdrawal increases the risk of maternal relapse and poor treatment engagement and does not improve newborn health**
- **Treatment of chronic maternal disease, including opioid agonist disorder, should be directed toward optimal long-term outcome**

Jones HE, Terplan M, Meyer M. *J Addict Med.* 2017

Maternal Mortality 2000-2014*

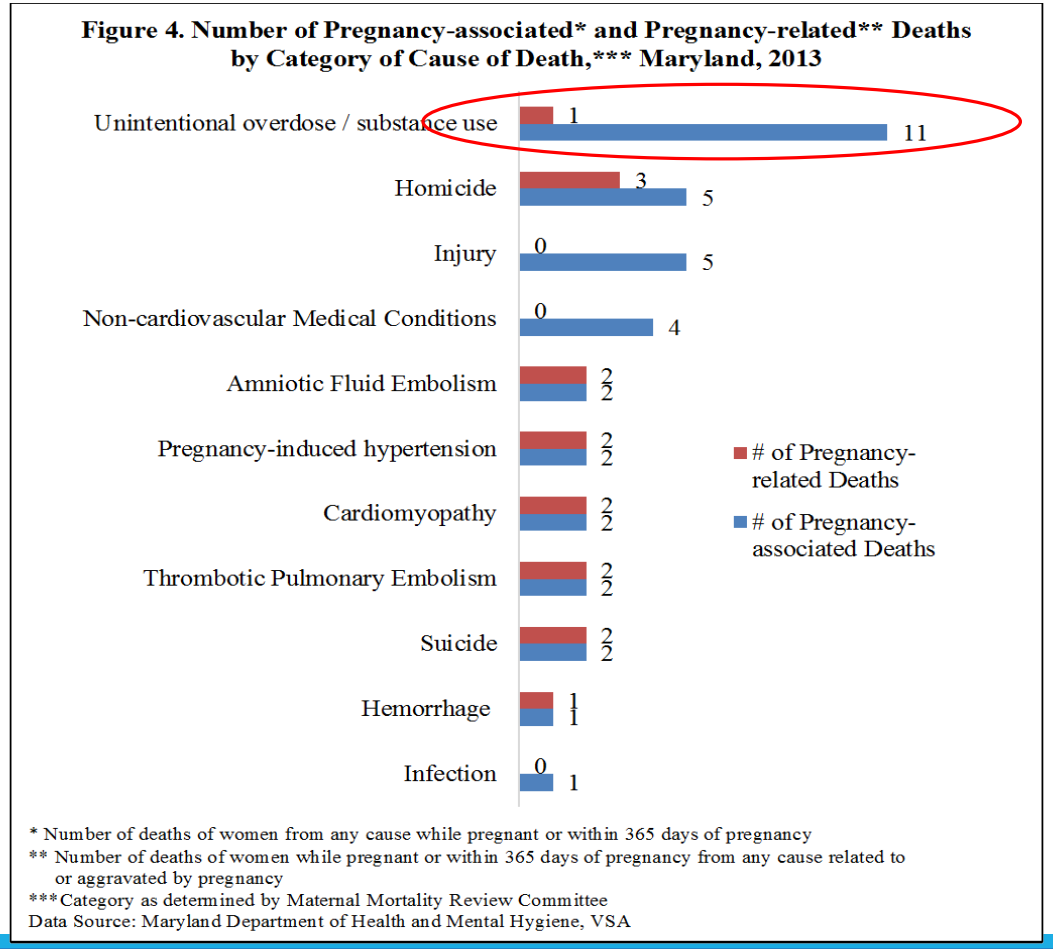


*Excludes California and Texas California showed a declining trend, whereas Texas had a sudden increase in 2011-2012.

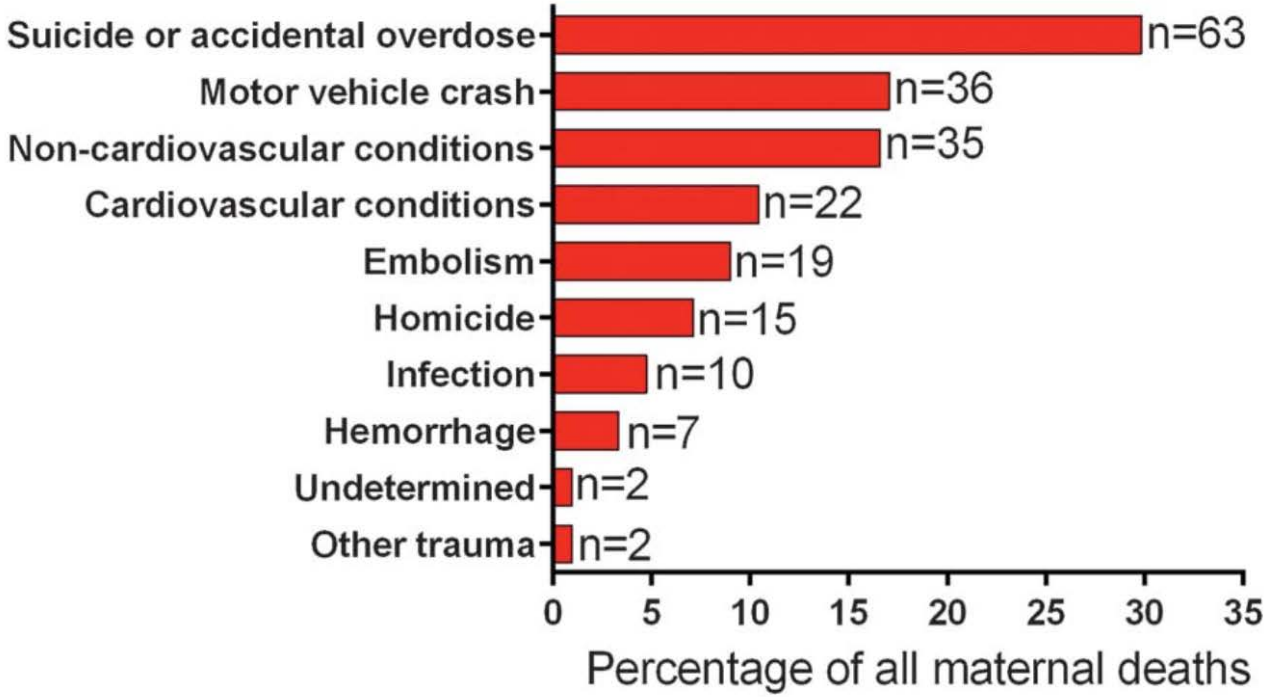
MacDorman et al Ob/Gyn 2016

Maternal Mortality: Opioids- A Factor

Maryland



Colorado



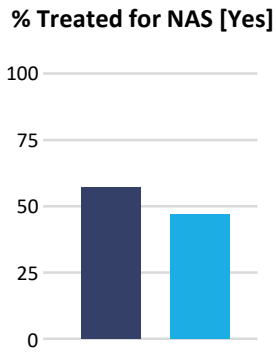
Metz et al., Obstet Gynecol. 2016

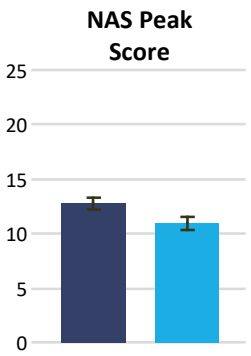
Medication Options

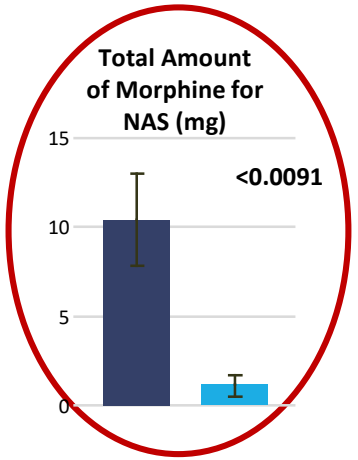
- **Methadone**
- **Buprenorphine alone**
- **Buprenorphine + naloxone**
- ***Naltrexone***

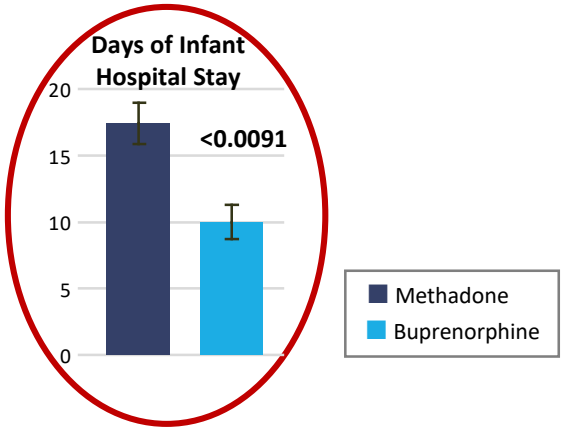
MOTHER: Buprenorphine *v*. Methadone

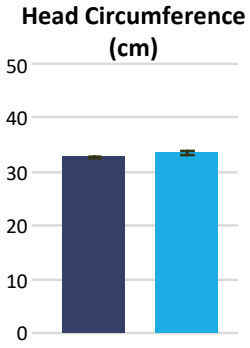
Primary Outcomes









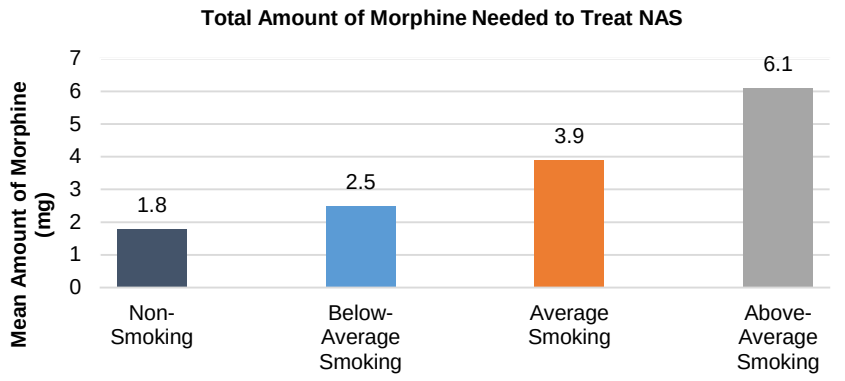


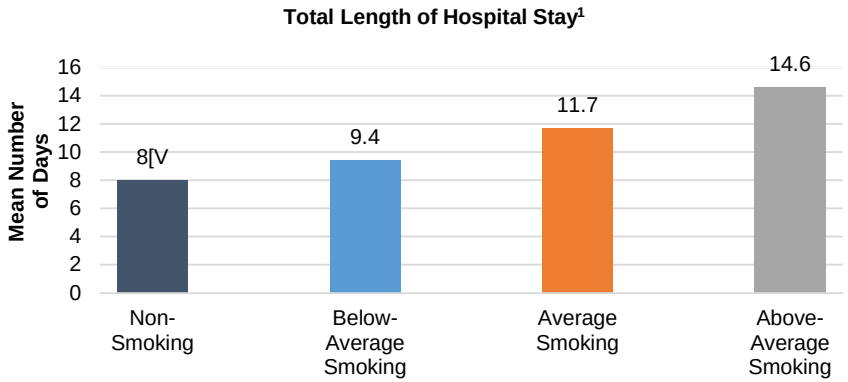
Notes: Significant results are encircled. Site was a blocking factor in all analyses. The O'Brien-Fleming α spending function resulted in α=0.0091 for the inferential tests of the Medication Condition effect for the 5 primary outcome measures at the conclusion of the trial.

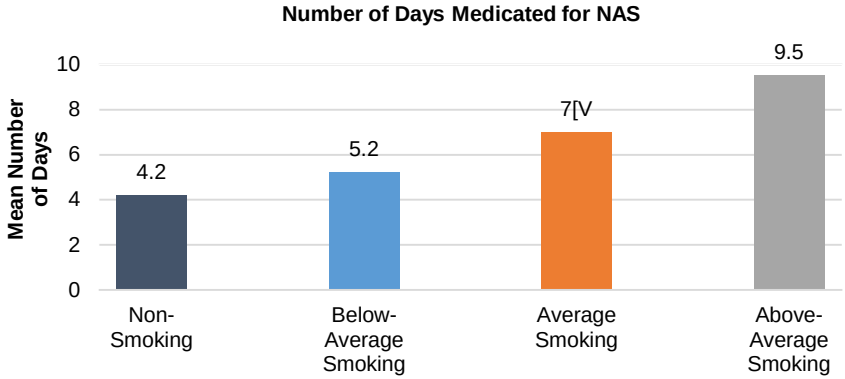
- **Compared with methadone-exposed neonates, buprenorphine-exposed neonates**
  - **Required 89% less morphine to treat NAS**
  - **Spent 43% less time in the hospital**
  - **Spent 58% less time in the hospital being medicated for NAS**
- **Both medications in the context of comprehensive care produced similar maternal treatment and delivery outcomes**

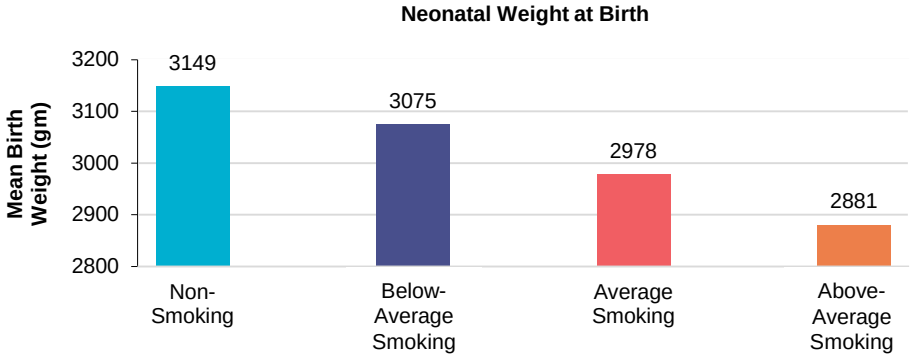
Jones HE, Kaltenbach K, Heil SH, et al. *N Engl J Med.* 2010;363(24):2320-2331.

MOTHER: 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;131(3):271-277.

MOTHER Child Outcomes up to 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**
- **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. The MOTHER study: what about the children? *Presented AAAP* 2015 (manuscript under review)

Retrospective Cohort Study of Methadone *v.* Buprenorphine: Newborn Outcomes

	Methadone (*n*=248)		Buprenorphine (*n*=361)		
Infant Characteristics	***n***	***M* (*SD*) or *n* (%)**	***n***	***M* (*SD*) or *n* (%)**	***p-Value***
Male	248	111 (45%)	361	177 (49%)	0.299
EGA at delivery (weeks)	248	38.2 (2.5)	361	39.2 (2.2)	<0.001
Preterm (EGA < 37 weeks)	248	43 (17%)	361	36 (10%)	<0.001
Birth weight (grams)	248	2899.7(583.1)	361	3143.3 (578.9)	<0.001
Standardized, z score	248	-0.59 (.93)	361	-0.46 (.98)	0.089
< 5th percentile	248	32 (13%)	361	40 (11%)	0.494
Head circumference (cm)	209	33.0 (2.0)	279	33.6 (2.1)	<0.001
Standardized, z score	209	-.50 (.80)	279	-0.46 (.98)	0.669
Treated for NAS	245	106 (42%)	358	82 (23%)	<0.001
Days of NAS treatment	106	133 ± 83	79	83 ± 60	<0.001
Length of stay, days (EGA ≥ 37 weeks)	205	5.6 (2.8)	325	4.2 (12.6)	0.107
Breast milk at discharge	247	156 (63%)	358	267 (75%)	0.003
Discharged to mother/family	248	237 (96%)	360	351 (98%)	0.189

EGA, estimated gestational age

Meyer MC, et al.,. *J Addict Med.* 2015;9(2):81-86.

Methadone *v*. Buprenorphine + Naloxone: UNC

Neonatal Outcomes *Primary outcomes*	Methadone (*n*=31)	Buprenorphine + Naloxone (*n*=31)	*p*-Value
Number Treated for NAS	16 (51.6%)	8 (25.1%)	0.01
Amount of Morphine (mg)	5.0 (3.3)	3.4 (1.2)	0.18
Duration of NAS treatment (days)	11.4 (3.4)	10.6 (3.1)	0.88
Peak NAS Score (range 1–25)	10.7 (3.7)	9.0 (4.4)	0.02

Results are given as number (%) or mean (SD)

Wiegand SL, Stringer EM, Stuebe AM, Jones H, Seashore C, Thorp J. *Obstet Gynecol.* 2015;125(2):363-368.

Methadone *v*. Buprenorphine + Naloxone: Ohio

Neonatal Outcomes	Methadone	Buprenorphine + Naloxone	*p*-Value
Number of infants	92	58	
Required NAS treatment, n (%)	74 (80)	37 (64)	0.03
Time to NAS onset (days) median (range)	2 (1–9)	2 (1–6)	ns
Cumulative methadone dose (mg)[a]	7 ± 5	5 ± 3	ns
Oral morphine equivalent (mg)[a,b]	28 ± 21	21 ± 14	ns
Total NAS treatment duration (days)[a]	38 ± 21	32 ± 21	ns
Required adjunctive phenobarbital, n (%)	5 (5)	4 (7)	ns
NAS-related hospital readmission, n (%)	0 (0)	1 (1)	ns

SD, standard deviation
[a]Mean ± SD
[b]1 mg methodone = 4 mg morphine sulfate

Gawronski KM, Prasad MR, Backes CR, Lehman KJ, Gardner DK, Cordero L. *SAGE Open Med.* 2014

Pain Management

- Medications that are full agonist opioids can effectively treat pain in patients stabilized on either methadone or buprenorphine.
- These results are consistent with data from non-pregnant surgery patients.
- The importance of uninterrupted methadone or buprenorphine treatment in these patients is critical.
- Each patient needs a pain management plan before delivery.

Jones et al., Am J Addict 2006

Breastfeeding

- Both methadone and buprenorphine are compatible with breastfeeding
- Concentration of either medication in breast milk is low
- Most recent guidelines: “the amounts of buprenorphine in human milk are small and unlikely to have negative effects on the developing infant”
- “The advantages of breast feeding prevail despite the risks of an infant opiate intoxication caused by methadone or buprenorphine.”

Image Credit: “Mother Is Breast Feeding For Her Baby” by Jomphong

Akinson et al., 1990; Marquet et al., 1997; Johnson, et al., 2001; Grimm et al., 2005; Lindemalm et al., 2009; Jansson et al., 2009; Müller et al., 2011; Reece-Stremtan, Marinelli and The Academy of Breastfeeding Medicine. Breastfeeding Medicine, 2015.

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**
  - 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:

- infant birthweight
- greater maternal nicotine use

Total medication dose needed to treat NAS was predicted by:

- Maternal use of SSRIs
- higher nicotine use
- fewer days of study medication received also predicted

Jansson and Velez, *Curr Opin Pediatrics*, 2012

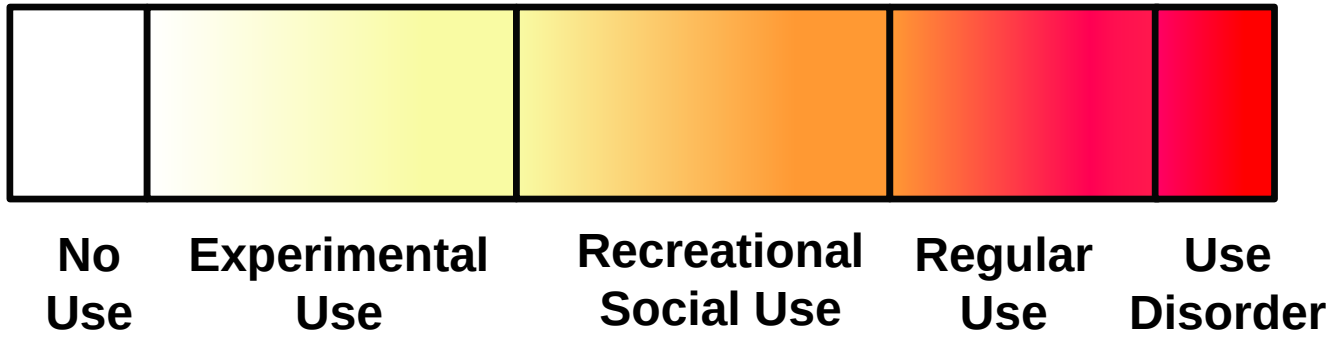
Kaltenbach et al., *Addiction*, 2012

A Urine Drug Test is Not …

- It is not a parenting test
- Toxicology tests for drugs are not sufficient for a diagnosis of a substance use disorder
- Having a substance use disorder is only one of many other factors in determining child safety

http://www.ezkeycup.com/iCup-Drug-Screen-8-p/i-dud-187-013.htm

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**

Mother–Fetal Dyad

- Both a pregnant woman and her developing fetus benefit when the mother is embedded in a supportive environment.

- However, a pregnant woman and her fetus are at risk when the mother is embedded in an unsafe setting of poverty or deprivation both economically and/or socially.

- Disregarding the interconnectedness of maternal and fetal health detracts from widely shared public health objectives, including safe pregnancies and healthy women, children, and families.

https://pixabay.com/en/speaker-child-pregnancy-baby-1305537/

Terplan et al., *Subst Abuse*. 2015 Sep 20;9(Suppl 2):1-4.

UNC Horizons: Model of 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

2016-2017 Treated 266 women

- 62% Primary OUD
- 24% reported TBI
- Age of first substance use started at 5 years old (mean 15 years old)
- Babies born at term and normal birth weight
- 77% employed at completion
- 100% CPS outcomes were positive at completion

Unified Philosophy Informed by Social Learning, Relationship and Empowerment Theories

Trauma-Informed Health Care Practices

- Before the appointment
- In the waiting room
- In the office or exam room
- After the appointment

The Power Of Words To Hurt Or Heal

Stigmatizing Words	Preferred Words
Addict, Abuser, Junkie	Person in active addiction, person with a substance misuse disorder, person experiencing an alcohol/drug problem, patient
User	person who misuses alcohol/ Drugs or person engaged in risky use of substances
Abuse	Misuse, harmful use, inappropriate use, hazardous use, problem use, risky use
Clean, Dirty	Negative, positive, substance-free
Habit or Drug Habit	Substance misuse disorder, alcohol and drug disorder, alcohol and drug disease, active addiction
Replacement or Substitution Therapy	Treatment, medication-assisted treatment, medication

The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L.White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04

Attitude Toward Medication?

1. Methadone/buprenorphine maintenance patients who continue to use illicit opiates should have their medication dose reduced.

2. Patients who ignore repeated warnings to stop using illicit opiates should be gradually withdrawn off methadone/ buprenorphine.

3. No limits should be set on the duration of methadone/ buprenorphine maintenance.

4. Methadone/buprenorphine should be gradually withdrawn once a maintenance patient has ceased using illicit opiates.

5. Methadone/buprenorphine services should be expanded so that all opioid dependent patients who want medication can receive it.

6. Methadone/buprenorphine maintenance patients who continue to abuse non-opioid drugs (e.g. benzodiazepines) should have their dose of methadone/buprenorphine reduced.

7. Abstinence from all opioids (including methadone/ buprenorphine) should be the principal goal of methadone maintenance.

8. Left to themselves, most methadone/buprenorphine patients would stay on methadone for life.

9. Maintenance patients should only be given enough methadone/buprenorphine to prevent the onset of withdrawals.

10. It is unethical to maintain individuals on methadone/ buprenorphine indefinitely.

11. The clinician's principal role is to prepare methadone/buprenorphine maintenance patients for drug-free living.

12. It is unethical to deny an individual methadone/ buprenorphine.

13. Confrontation is necessary in treating drug addiction.

14. Patients should remain in methadone/buprenorphine maintenance for at least three to four years.

Score 1 for each "yes" to question 1, 2, 4, 6, 7, 8, 9, 10, 11, and 13. Score 1 for each "no" to questions 3, 5, 12, and 14.

Adapted from Caplehorn et al., Drug Alc Dep, 1998

Staff Attitudes Toward Medication: Association With Early Treatment Discharge

- **Caplehorn and colleagues reported in 1998 that the Median Abstinence Orientation Scale was strongly related to patient time in treatment.**
- **A 1-unit increase in scores was related to a more than threefold risk of discharge.**
- **Estimates suggest than approximately 60% of patients would have left an abstinence-oriented program in the first year of treatment, while only approximately 20% would have left an indefinite maintenance program.**

Caplehorn et al., Drug Alc Dep, 1998

Patient Behavior- Sometimes Challenging

"I pressed this button over 3 seconds ago. What took you so long to get here?!"

"Usually, Stephanie, when a patient claims their pain is a 12 out of 1-10, and they demand pain killers, they're not on the phone, doing their nails and reading a magazine."

"Sorry, Mr. Barnes, but we have a strict rule about smoking in the hospital. So, you can stop hiding under the bed."

"She has a rude patient, so she put tape over her own mouth. She didn't want to say something she would regret."

Dealing With Anger and Frustration

ANGER

Results from an unmet need for

- **control**
- **information**
- **being listened to**
- **feeling safe**

- **Having to deal with issues when one feels underprepared or isolated**

Ways to Address it

- **Allow time and support to debrief**
- **Reflect on what the engagement may have taught them**
  - **What went right?**
  - **What could be done differently?**

Anger always involves framing behavior as 'wrong'—not-as-it-*should*-be.

https://www.nursingtimes.net/roles/mental-health-nurses/de-escalating-anger-a-new-model-for-practice/7009471.article

The LOWLINE Model

A tool to de-escalate conflict with patients

Listen

Offer

Wait

Look

Incline

Nod

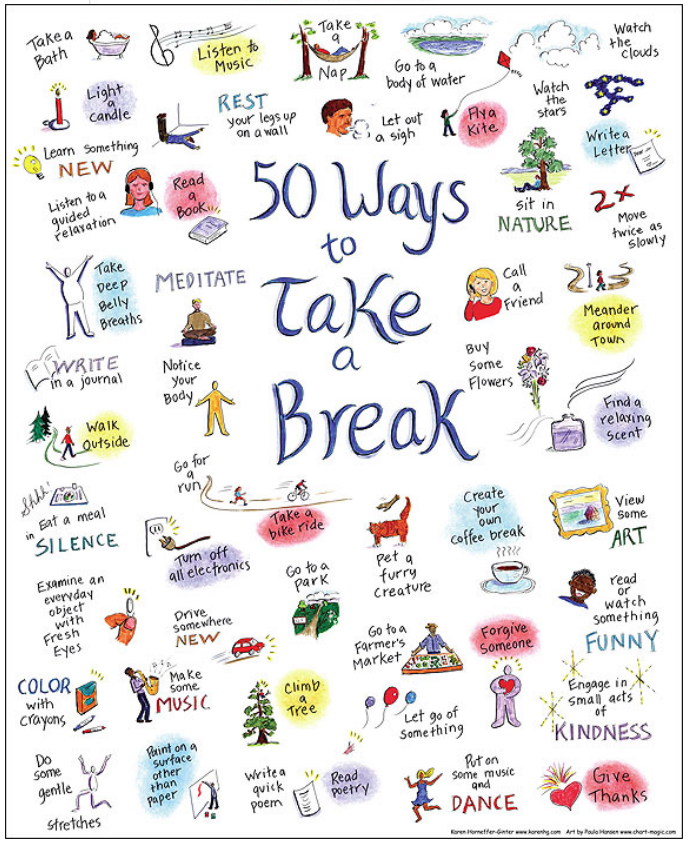
Express

Resolution of own feelings

- Having to deal with issues when one feels underprepared or isolated

Self-Care: The Anger Antidote

- Get some exercise
- Take a timeout
- Monitor every episode of anger
- Identify possible solutions
- HALT
- Don't hold a grudge
- Use humor to release tension
- Practice relaxation skills
- Know when to seek help



http://www.fullcupthirstyspirit.com/posters.php

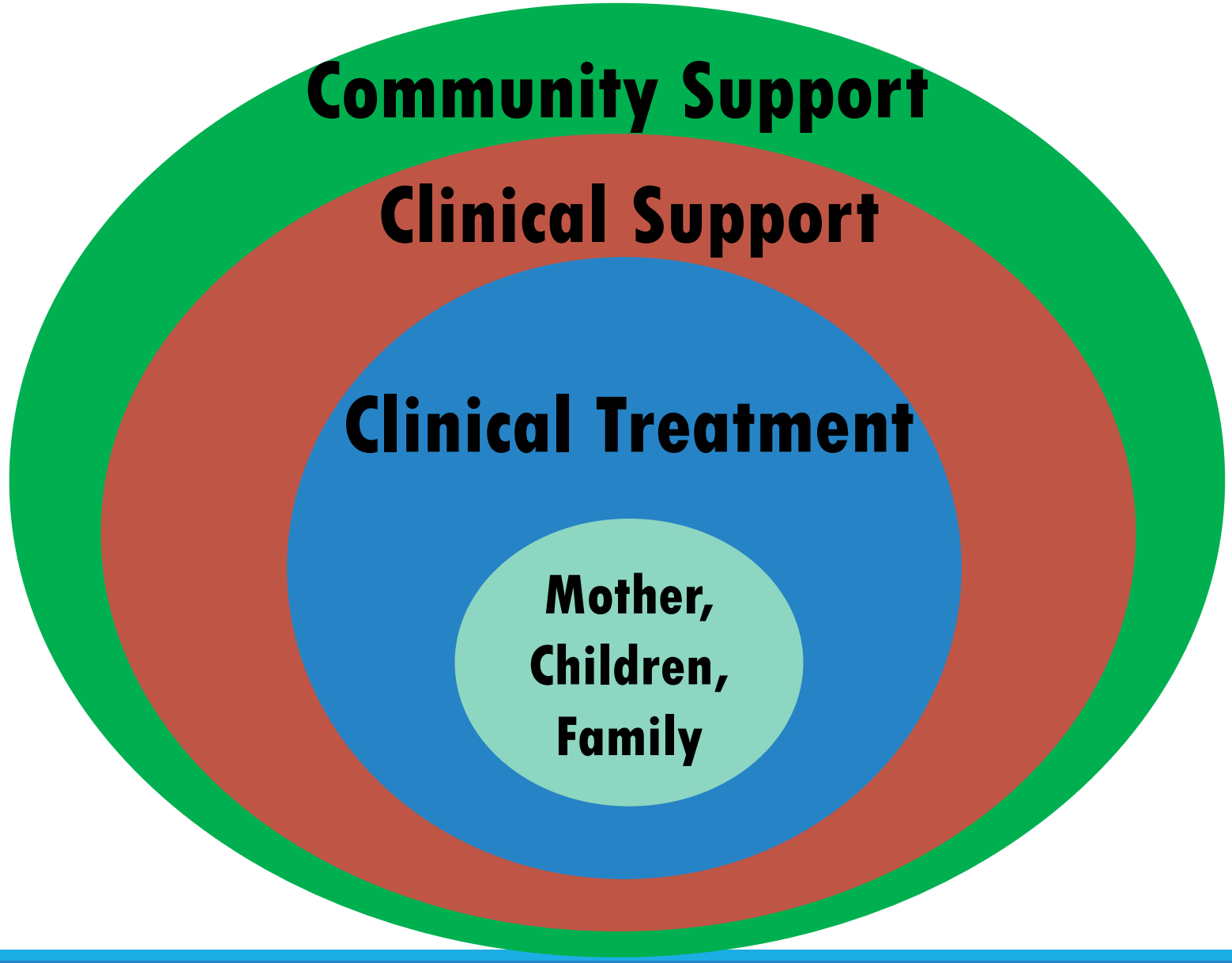
https://pixabay.com/en/be-being-presence-here-now-spirit-511557/

How To Increase Your Empathy

Practical tips to consider for increasing empathy:

- **Listen**
- **Don't interrupt people**
- **Tune in to non-verbal communication**
- **Practice the "93% rule"**
- **Use people's names**
- **Be fully present when you are with people**
- **Smile at people**
- **Take a personal interest in people**

ROSC for Families



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 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 while receiving evidence-based behavioral treatment**
- **Remember to "fill your own cup" before filling the cups of others**
- **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

UNC Horizons

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