NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Substance Use Disorders
Opioid Use Disorder
Progressive Case Conference
Facilitator's Guide

Contributors
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Learning Objectives
1. Describe the epidemiology, risk factors for, and consequences of opioid use disorders (OUD) in pregnancy
2. Discuss validated screening tools for substance use in pregnancy
3. Explain evidence-based treatment options for OUD in pregnancy

Required Pre-Reading
Opioid Use Disorder Self-Study

Optional Supplemental Reading
References for this module can be found in the Opioid Use Disorder Self-Study

Case Presentation
Ms. M is a 32-year-old G3P1011 presenting for an initial prenatal visit at an estimated gestational age of 27 weeks based on a certain last menses. She reports that the pregnancy was unplanned, and that she had originally considered a termination. However, she did not have the money for a termination, and as time went on, she felt more accepting of the pregnancy. She states that aside from nausea and constipation, she hasn't had any concerning symptoms during the pregnancy. While the RN is doing her medication reconciliation for her prenatal chart, she notices that the patient has on her medical chart past-year prescriptions for tramadol, oxycodone, and naproxen. She acknowledges taking non-prescribed buprenorphine periodically in order to manage opioid cravings.

1. What are non-judgmental ways to discuss substance use during pregnancy?
   - Ask in a confidential setting
   - Ask universally
   - Listen with empathy and respect
   - Discuss addiction as a chronic disease
   - Avoid stigmatizing words such as "abuse," "addict," "rehab," "relapse," or "dirty" or "clean" (in reference to drug screens). Try instead more value neutral words like "substance use disorder," "substance misuse," "risky use," "addiction," "individual with substance use disorder," "treatment," "recovery," "recurrence of use," "positive" drug screen results, etc.
   - Use motivational interviewing techniques when discussing substance use and making treatment plans

2. What are the differences between opioid use, opioid misuse, and opioid use disorder?
   - Opioid use: Refers simply to the act of taking an opioid. For example, a patient with sickle cell disorder may require the use of opioids during her pregnancy for a pain crisis.
   - Opioid misuse: Denotes that the opioid is being used in a problematic manner but does not rise to the level of a diagnosed disease. Misuse includes using medications without a prescription or using medications not as prescribed (eg, higher doses, longer duration, for conditions different than the original prescribed condition). For example, a pregnant patient complains to her mother that she is

having excruciating back pain in pregnancy. In response, the mother gives the patient an old tablet of Percocet she had left over from a wisdom tooth extraction, and the patient takes the Percocet over the next few days.

- Opioid use disorder: Per the DSM-5, defined as at least 2 of the following symptoms over a 12 month period.

Table. DSM-5 Diagnostic Criteria for Opioid Use Disorder[a]

1. Opioids are taken in larger amounts or duration than intended
2. Persistent desire/unsuccessful efforts to cut down or control opioid use
3. A great deal of time is spent obtaining, using, or recovering from the effects of opioids
4. Craving
5. Recurrent use of opioid results in failure to fulfill major role obligations at work, school, or home
6. Continued use despite social/interpersonal substance-related problems
7. Important social, occupational, or recreational activities are given up or reduced because of substance use
8. Recurrent use in hazardous situations
9. Continued use despite knowledge of having a persistent or recurrent opioid-related physical or psychological problem that is likely caused or exacerbated by opioid use
10. Tolerance[b]
11. Withdrawal[b]

Severity: Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: ≥ 6 symptoms

[a] The information above is only an overview of the criteria used. Consult the DSM-5 before making a diagnosis.
[b] Note: This criterion is not considered to be met for patients taking opioids solely under appropriate medical supervision
Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Association; 2013:541.

- It is also helpful to keep in mind the ASAM's definition of addiction:

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

After exploration, Ms. M's clinical history is consistent with an opioid use disorder. She acknowledges that she should enter treatment, but is worried about her boyfriend and her family finding out about her addiction. She wants to know what safeguards you have for protecting her confidentiality. She is willing to explore options for treatment "as long as I don't get my baby taken away from me."

3. What should you tell her regarding confidentiality?
   - Let her know that her health care is confidential and that you will not share information about her care with her boyfriend or family without her permission
   - It is important to be aware of state rules in your jurisdiction regarding mandated reporting of substance use during pregnancy or at birth and to be transparent about these so women know what to expect at delivery (www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy)
   - Share that being stable in recovery prior to her baby's birth will give her the best preparation to parent her child and that being actively engaged in treatment is generally seen as a strength by child protection if they become involved.

Reassured by your guarantees of confidentiality, Ms. M states she is interested in buprenorphine treatment for her opioid use disorder. “My girlfriend told me that if I get treatment, I won’t be on opioids anymore, and the baby won’t go into withdrawal.”

4. What kind of treatment is recommended for perinatal OUD?
    - Elicit that comprehensive, integrated treatment including medication for opioid use disorder, psychosocial interventions, support for social determinants of health needs, and treatment of co-occurring mental health conditions is recommended in pregnancy
    - Programs that offer integrated prenatal care and SUD treatment show promise in terms of improving outcomes.
    - Opioid agonist treatments (methadone, buprenorphine, buprenorphine/naloxone) are currently recommended for pregnant women with OUD and are associated with improved outcomes compared to women with OUD who are not treated
    - Women may require increased doses or increased dosing frequency of methadone or buprenorphine during pregnancy
    - Naltrexone has limited but growing reproductive safety data at this time, and is not considered standard of care in pregnancy. Naltrexone could be considered for a woman who strongly prefers this option or who has responded well to naltrexone in the past and who is comfortable with the limited reproductive safety data available
    - Medically supervised withdrawal/detox is not recommended for OUD in pregnancy due to the risk of relapse to opioid use as well as theoretical concerns about the risks associated with withdrawal symptoms
    - Patient education should be provided regarding treatment options; a shared decision-making process may be helpful

5. What should you tell her about her baby’s risk for withdrawal if she is taking methadone or buprenorphine?
    - Neonates exposed to methadone or buprenorphine during pregnancy are at risk for neonatal opioid withdrawal syndrome (NOWS) but have improved outcomes compared to infants exposed to untreated OUD
    - NOWS is a constellation of withdrawal signs in the neonate including central nervous system dysfunction (e.g., seizures, exaggerated moro reflex, increased muscle tone, irritability), gastrointestinal dysfunction (e.g., vomiting, diarrhea, poor weight gain/feeding), and respiratory dysfunction.
    - NOWS can be managed with both pharmacologic (medications such as morphine) and non-pharmacologic interventions (calm, quiet environment, skin to skin contact, breastfeeding, etc.)
    - Opioid exposed newborns generally need to be monitored for at least 4-5 days after birth for the development of NOWS
    - Requirements for pharmacologic treatment vary from 10% to greater than 50% of opioid exposed newborns

Ms. M is back for a prenatal appointment 6 weeks after you last saw her. She is now 35 weeks along. She missed an appointment in the interim, and missed an appointment for her buprenorphine refill. She used heroin during that time to prevent withdrawal. Her last ultrasound showed an appropriately grown fetus without any anatomical abnormalities. Her prenatal labs show that she is positive for Hepatitis C. She feels stressed that she used heroin, and is worried about getting her child taken away from her. She has increased her smoking in the past few days.

In addition, Ms. M endorses increasing relationship problems after her boyfriend found out about her OUD treatment – “He thinks I should be able to kick this on my own, and thinks I’m selfish for exposing his baby to an unsafe medication.” She is upset that he is pulling away from her, and has been yelling at her more frequently.

6. What would be the most appropriate next steps? How might you reduce her risk for opioid overdose?
    - Be sure she has access to naloxone (either provide a prescription or dispense in clinic if available). Naloxone can and should be used in the case of opioid overdose in pregnancy.
    - Ensure she has adequate support in her treatment program. Ask her to sign a release of information for her treatment provider in order to coordinate care.
    - Offer support with her relationship concerns—be aware of local intimate partner violence resources

You connect Ms. M with a delivery doula since it's no longer a guarantee that her boyfriend will be there to support her during delivery. At 38 weeks, Ms. M wants to talk about scheduling an induction so her sister can make plans to watch her other child. She's worried about being judged by the staff on Labor & Delivery, and equally worried about how she'll manage her pain if she ends up getting a Cesarean section.

7. How can you assist this patient in meeting her goals for labor, delivery, and the postpartum period?
    - The post-natal period is highly demanding and challenging for every parent. Women with Substance Use Disorders (SUDs) may have additional challenges that can make this time even more stressful including lack of social support, unstable housing, financial difficulties, psychiatric comorbidities, history of early childhood or past trauma, and/or current interpersonal violence. Further, in many states, Medicaid insurance will terminate during the postpartum period rendering women without additional insurance unable to access ongoing SUD treatment. Stressful life events are one of the greatest risk factors for relapse to substance use among women putting the mother-infant dyad at risk for separation. These potential stressors are apparent during pregnancy and should prompt the implementation of a supportive, dyadic-centered treatment plan prior to delivery and can include the following:
    - Pharmacotherapy including methadone, buprenorphine or buprenorphine/naloxone should not be stopped prior to delivery, nor should the dose of these medications be reduced prior to delivery. Women can receive epidural or spinal anesthesia for birth and can also be treated with short acting opioids such as hydromorphone after delivery if they require additional pain medication
    - Women should consider visiting the hospital where they will deliver to meet the staff and learn about how they will monitor and, if appropriate, treat NOWS. It is also important to know the hospital's drug testing procedures or potential for consultation with the Department of Child and Family Services at the time of delivery.
    - The postpartum period is a high-risk time for relapse and overdose as well as loss to follow-up. Providers should ensure close follow-up in the postpartum period.

Ms. M is now 6 weeks postpartum and returns to see you for a postpartum visit. She reports that her delivery went well and that her baby did not require any medication treatment for NOWS, although it was hard for her to stay with the baby in the hospital for 4 days since she has another young child. She had a vaginal birth and did not require an opioid pain medication. The hospital made a report to child protection after her baby was born due to her heroin use in the third trimester. She was initially upset about this and anxious that her children would be removed, but after investigation, child protection made a safety plan with her and have helped her obtain childcare for her older child. She is currently staying with her sister, which she identifies as a safe and supportive environment. She is not currently seeing her baby's father regularly and is unsure if she will get back together with him. She is breastfeeding her baby and attending treatment visits regularly at her buprenorphine program. She hopes to return to work in a few months and is on a waiting list for supportive housing. She plans to get treatment for her hepatitis C when she is finished breastfeeding.