Mother & Baby Substance Exposure Toolkit

Best Practice No. 35

A part of the California Medication Assisted Treatment Expansion Project

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ADDICTION

Educate patients and families about opioid use disorder

Best Practice No. 35

Outpatient, Labor and Delivery, Nursery/NICU, and Education

Overview

Addiction is a chronic, relapsing condition. Pregnancy can motivate women to discontinue drug use, but abrupt discontinuation of opioids during pregnancy can have deleterious effects for both the mother and fetus. Patients and their families may not be aware that medication assisted treatment (MAT) is the standard of care for opioid use disorder (OUD) during pregnancy and may adopt risky strategies such as abrupt and complete cessation of opioids without realizing the risk to their pregnancy and to their recovery.

Why we are recommending this best practice

Patients need to be educated on different types of opioids to understand how they will affect their body. Understanding different types of opioids opens the discussion about withdrawal symptoms, warning signs to look for, and when to obtain medical help for withdrawal. Patients and their families need to fully understand the nature of addiction, the potential impact of continued opioid use during pregnancy, the recommended treatment for OUD during pregnancy and beyond, the need to address potential or co-occurring mental health conditions, the members of the treatment team involved in their comprehensive care, and the aim of partnering with them every step of the way.

Strategies for Implementation

- **Educate the patient on the definition of opioid use disorder (OUD).** Patients should be informed that OUD is defined as a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences.

- **Assess and educate the patient for potential causes of opioid use disorder, including but not limited to:**
  - Chronic pain
  - History of trauma
  - Opioid misuse

- **Assess the patient for co-occurring mental health conditions.** A preliminary assessment conducted on intake should be followed by a second assessment once patient's OUD is stabilized on MAT or another course of OUD treatment. For many women with OUD, what appears at first to be significant mental illness may resolve or lessen significantly once the OUD is addressed. Validated screening tools include GAD-7, MDQ, PHQ-9, ACE, and the Edinburgh Postnatal Depression Scale (See the **Resources** for more tools). Assess patients for:

- Depression
- History of trauma
- PTSD
- Anxiety
- Other psychiatric disorders such as bipolar, schizophrenia, and personality disorders

- **Educate the patient on the different types of opioids.** For short-acting opioids, such as heroin, withdrawal symptoms can occur 4-6 hours after ingestion, can peak at 1-3 days, and gradually subside over 5-7 days. For long-acting opioids, such as methadone or buprenorphine, withdrawal symptoms occur 24-36 hours after ingestion and may last days to several weeks.

- **Withdrawal Symptoms:**
  - Generalized pain
  - Muscle pain
  - Nausea
  - Vomiting
  - Diarrhea
  - Sweating
  - Rhinorrhea
  - Tearing and dilated pupils
  - Tremors
  - Restlessness and anxiety

- **Educate patients on why treatment during pregnancy is important and what it involves:**
  - Better outcomes for the patient and her newborn.
  - Abrupt cessation of opioids, and withdrawal, is harmful to the fetus.
  - Planning for safe care.
  - Connecting mother and newborn to resources to help them after discharge.
  - Helping the mother receive treatment that will help her and that is recommended for her and her newborn.

- **Develop an OUD management plan with the patient and her family:**
  - Review dose and appropriateness of current opioid use, and limit opioid prescribing for post-partum pain as detailed in **Best Practice #14.**
  - Discuss risks and benefits of opioid use, review treatment goals, review neonatal abstinence syndrome (NAS).
  - Take a thorough history and review the prescription drug monitoring program.
  - Ensure adequate resources for psychosocial support, substance abuse treatment programs, and locally available resources.
  - If appropriate and resources are available, discuss the potential for outpatient buprenorphine induction (refer to **Best Practice #10**).
  - Discuss harm reduction. Have resources available to discuss the use of naloxone, safe injection sites, needle exchange clinics and safe needle handling. See

Resources below for an infographic from the CDC regarding the cleaning of syringes.
- Discuss dangers of abrupt cessation of opioids.

- **Educate patient and family on use of naloxone (Narcan):**
  - Naloxone is used, along with other emergency medical treatment, to reverse the life-threatening effects of a known or suspected opioid overdose. Naloxone is in a class of medications called opioid antagonists. It works by blocking the effects of opioids to relieve dangerous symptoms caused by high levels of opioids in the blood. Naloxone will not reverse the effects of non-opioid drugs.
  - Naloxone comes as a liquid solution that can be sprayed into the nose, or as a liquid in a vial that can be injected into muscle. It is usually given as needed to treat opioid overdoses.
  - Keep the nasal spray available at all times to use in case of an opioid overdose. Be aware of the expiration date on the medication and replace it when this date passes. Some harm reduction kits include two doses of naloxone. Explain how the patient can continue to access naloxone so that it is always available.
  - Symptoms of an opioid overdose include excessive sleepiness, not awakening when spoken to in a loud voice or when the middle of the chest is rubbed firmly, shallow or stopped breathing, or small pupils (black circles in the center of the eyes). If someone sees a person experiencing these symptoms, he or she should give the first naloxone dose and then call 911 immediately. After giving the naloxone nasal spray, someone should stay with the patient and watch closely until emergency medical help arrives.
  - A **"Guide for Patients and Caregivers"** is available to print in pamphlet format. See the Resources section of this Best Practice.
  - Fentanyl: Whether taken knowingly or as a contaminant with other drugs, fentanyl's increased potency relative to other opioids may require the administration of greater doses of naloxone per overdose event.
  - Call 911 for any suspected overdose event.

Kayla

The midwife at one of Kayla's prenatal visits reassures her that no baby is born an addict. She educates her about how prenatal exposures to medications can lead to temporary withdrawal within newborns and that for opioid-exposed newborns there is an evidence-based treatment for NAS called Eat Sleep Console that makes her mothering and ability to console her baby the most important part of her newborn's treatment. Kayla seems relieved after the midwife shares this with her.

The midwife than speaks with her about how substance use is a chronic disease, similar to diabetes or hypertension, and like any other long-term process, it requires a wide-ranging treatment plan to ensure good health outcomes for her and her baby. She shares that the medication buprenorphine prevents relapse, decreases cravings and even helps some of the chronic pain. The midwife also suggests other mind-body techniques to help with chronic pain and substance use, such as counseling, physical therapy, and other manual therapies to decrease her pain and desire for pain pills. Kayla has relaxed more and is even starting to smile and make more eye contact with the midwife. She wants to know how long she'll have to be on a medicine like buprenorphine or methadone. The midwife tells her that although the medical literature indicates that Medication Assisted Treatment (MAT) is effective and the best treatment for OUD during pregnancy and postpartum, the optimal duration of treatment with MAT is unknown. Just as with other effective medications for chronic conditions, like insulin or blood pressure medicine, MAT is not usually prescribed with an expected end date. The midwife reassures her that breastfeeding is safe with either of these medication options and is in fact strongly encouraged to help diminish the symptoms associated with NAS. Lastly, she points out to Kayla that the clinic has a Seeking Safety group and she may want to attend to learn more about trauma and panic disorders.

Resources

1. A Guide for patients and caregivers regarding overdose and naloxone administration.
2. CDC infographic on cleaning syringes.
3. MBSEI Resource Library.

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Carrie Griffin

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Dr. Carrie Griffin is a family medicine physician who specializes in maternal, child and reproductive health and practices in Humboldt County. She completed her residency at Maine Dartmouth Family Medicine Residency and fellowship at the University of New Mexico. Perinatal substance use is her clinical area of interest and expertise; she currently serves as a mentor for CMQCC's Mother Baby Substance Exposure initiative and the Humboldt RISE project, a community initiative to promote screening and case management services for women with substance use disorders in pregnancy.

Lorena Watson

FNP

Lorena Watson is a Family Nurse Practioner. Her focus is rural health and providing compassionate patient-centered care in Lake County, CA. She coordinates and provides care for mothers with OUD through pregnancy and postpartum. Before becoming an FNP, Lorena was a labor and delivery nurse for 16 years.