Addressing Approaches to Maternal Opioid Use Disorder

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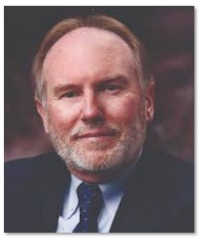

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It was a quiet September morning in our western Pennsylvania community hospital's Labor and Delivery Unit. With no one in labor, the stillness on the floor was broken only by a piercing cry from the nursery. Maya* lay in the nursery, showing that special beauty that only a newborn baby can demonstrate. However, her inconsolable crying resisted all efforts to comfort her. The only relief would occur when she was transferred to a tertiary care center in another state and started on a regimen of oral morphine. Yes, Maya had become the newest and youngest victim of America's opioid epidemic, but by no means the last.

Until the outbreak of the COVID-19 pandemic, the opioid epidemic was recognized as America's number one public health crisis, responsible for over 500,000 deaths in the prior 10 years. With the subsequent management of COVID-19, the opioid epidemic has again become a focus of media attention. In the interim, the pace of heartbreak resulting from the country's opioid epidemic has only accelerated. Over 100,000 U.S. drug overdose deaths were reported in 2021, with more than 80% due to opioids.[1] The crisis has traditionally been dominated by males, but women account for 33% of these deaths. From 2017 to 2020, overdose deaths in pregnancy and postpartum rose 81%, a number anticipated to climb as a result of COVID-19-imposed changes in access to care.[2] By comparison, the overdose death rate in non-pregnant females rose only 31%.[2] From 2010 to 2017, opioid diagnosis at delivery increased by 131%. When screened at delivery, 7% of women reported using opioids during pregnancy, primarily prescription opioids from physicians or obtained by diversion from others.[3]

But what of the babies who had no role in deciding to be exposed to opioids? Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS) are terms used to describe clinical withdrawal symptoms in newborn infants. While NOWS is specifically used to describe withdrawal symptoms from opioids only, these terms are often used interchangeably. For our discussion, we will utilize NAS. NAS occurs after delivery when a newborn who had been exposed to opioids in utero is suddenly cut off from the maternal supply. Within days, the infant may show signs of withdrawal: including high-pitched crying, irritability, and poor feeding and sleeping. The incidence of NAS has doubled in many states with West Virginia and Vermont seeing NAS in 1 of every 20 births. In Pennsylvania, NAS occurs in 11.7 of every 1000 births, compared to a national average of 6.8/1000 births.[4]

Not every infant born to an opioid-dependent mother will develop NAS, and there is no correlation between the opioid dose and the incidence of NAS. Mildly affected babies can be managed with supportive nursery care, quiet environments, breastfeeding, rooming in with mothers, and volunteer "cuddlers". It is only when these measures fail that opioid re-dosing and careful weaning are required. In Pennsylvania, mandatory reporting of NAS allows early intervention by social workers and PA Children's Services to coordinate discharge, as well as adequate home preparation and follow-up for infant safety.

What can the community do?

How can we, as a community, decrease the incidence of NAS? Making changes in our lives is never easy. Patients do not decide to develop a dependence on opioids, rather they often start by seeking treatment for pain, whether emotional or physical. No one should be deemed as a lesser person based on judgment errors or human weaknesses.

Foremost, all mothers must be screened for substance use early so that supportive measures can be implemented. A supportive social network and family structure are critical to a successful outcome. Reducing stigma and child abuse charges will help prevent mothers from pursuing early, quality medical care that will help the mother and protect the infant.

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an excellent tool to assist physicians in identifying and providing treatment for mothers with substance use disorder. This integrated approach has demonstrated success in identifying and providing treatment for Substance Use Disorders. More information on using SBIRT can be found at www.sbirt.pitt.edu.

We, as a community, must recognize that Medication Assisted Treatment (MAT) with Methadone or Buprenorphine is not just substituting one drug for another but is an evidence-based measure proven to decrease risks and promote safe pregnancy. Critically, continued care and support of mother and child are needed after birth. Three of the major risk factors for substance abuse include rural, white, and low socio-economic populations, which are prevalent in most areas of Pennsylvania.

What can the medical community do?

Physicians and other members of the medical team play a vital role in shaping community attitudes. We are recognized authority figures who can lead by example. In addition to setting the tone for addressing opioid issues within the community, there are several techniques that healthcare providers can utilize to engage patients who take opioids and are at risk for health concerns. Two effective techniques are motivational interviewing and initiating MAT with prescribed buprenorphine/naloxone. The treatment plan and the techniques used to address opioid use must be nonjudgmental and presented with empathy.

Motivational Interviewing (MI) is a conversational approach that can be used to support the patient. This approach encourages the patient to talk about their personal reasons and need for change. With a pregnant patient, the focus is on the health of both the baby and the mother. MI is a practical short-term tool that healthcare providers can utilize when faced with patients who need to change their behavior regarding opioid use.

In the MI process, it is vital to secure the patient's motivation for change and the patient's commitment to change. Encouraging the patient to openly express these two elements reinforces the action of the patient. The patient taking an active step toward change further develops the patient's impetus toward motivation for change.

There are four key principles to use in MI:

1. Engaging
2. Focusing
3. Evoking
4. Planning

While **engaging**, it is important to express empathy, use affirmations, support autonomy, and ask open-ended questions. The mnemonic OARS (Open-ended questions, Affirmations, Reflective listening, and Summaries) is useful in the engaging phase. Open-ended questions will invite the patient to provide information in their own words. Affirmations assist the client in building confidence and will lead in the positive direction of change. Reflective listening cultivates a trusting and collaborative relationship between the patient and the provider and ensures the patient will feel positive about the communication. The final step in this stage is summarizing the information that has been shared. This is a great place to correct any misperceptions and ask for additional information that the patient has not shared at this point. This first stage of engagement is crucial to the remaining stages of motivational interviewing.

The second stage, **focusing**, should examine the goals for change. This stage is often referred to as the "what" phase due to questions such as: what are the goals for change, and what type of change is the patient willing to commit to at this time?

The third stage is **evoking**. Evoking responds to the question of why. This is the stage that identifies the motivation for the changes the patient will be making.

The final stage of MI, the **planning** stage, is usually referred to as the how. This stage is where the patient and healthcare provider will work collaboratively to determine the next steps of

the change process: what skills are needed, what is the availability of outside support, and how can we remove barriers to the intended change?

Once the healthcare provider has completed the stages of MI, they may add the use of MAT with buprenorphine or Methadone to further support the patient's behavior change. With the recent passage of the 2022 bipartisan Mainstreaming Addiction Treatment (MAT) act, Congress has eliminated the requirement of obtaining an X Waiver before prescribing Buprenorphine, opening the capability of prescribing to a broader group of clinicians. If a provider prefers not to prescribe buprenorphine, cooperative management with a local MAT provider can support the patient with optimal care. Methadone can only be utilized for MAT through federally certified centers.

MI paired with the use of MAT may successfully reduce the number of infants that develop NAS. MI and SBIRT are services that can be reimbursed through Medicare, Medicaid, and some commercial insurances.

Conclusion

So, what happened to Maya? Her mother continued to follow up and do well herself. Maya, with the support of her social worker and her grandmother, developed into a bright and charming young girl. She is now in Pre-K and looking forward to kindergarten next September. With community support and physician leadership and advocacy, we can have even more happy endings. How will you and your practice make this happen?

**The person named has been altered to ensure confidentiality.*

References and Resources

1. Centers for Disease Control and Prevention. (2022, June 2). *Death Rate Maps & Graphs*. Centers for Disease Control and Prevention. Retrieved January 6, 2023, from https://www.cdc.gov/drugoverdose/deaths/index.html
2. Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. *JAMA.* 2022;328(21):2159–2161. doi:10.1001/jama.2022.17045
3. Centers for Disease Control and Prevention. (2022, November 28). *About opioid use during pregnancy*. Centers for Disease Control and Prevention. Retrieved January 6, 2023, from https://www.cdc.gov/pregnancy/opioids/basics.html#:~:text=In%20the%20most%20recent%20estimate,opioid%20pain%20relievers%20during%20pregnancy
4. *Pennsylvania Maternal Mortality Review: 2021 report*. Center for Innovative Research on Gender Health Equity. (n.d.). Retrieved January 6, 2023, from https://www.converge.pitt.edu/news/pennsylvania-maternal-mortality-review-2021-report

Motivational Interviewing Resources

- Motivational Interviewing website
- Quality Insights Motivational Interviewing Pocket Card
- Quality Insights Motivational Interviewing e-Course
- Colorado School of Public Health
- Florida State University Center for Prevention and Early Intervention Policy - Motivational Interviewing: Promoting Healthy Behaviors

Substance Use and Mental Health Services Administration (SAMHSA)

- SAMHSA Advisory: Using Motivational Interviewing in Substance Use Disorder Treatment
- SAMHSA Website: Empowering Change: Motivational Interviewing

SBIRT Resources

- Pittsburgh SBIRT (Screening, Brief Intervention and Referral to Treatment)
- SAMHSA SBIRT
- SAMHSA Coding for Screening and Brief Intervention Reimbursement
- 2020 Health Behavior Assessment and Intervention Billing and Coding Guide (American Psychological Association Services Inc.)
- SBIRT: Screening Brief Intervention & Referral to Treatment (YALE School of Medicine)
- SBIRT Services Booklet (Centers for Medicare & Medicaid Services)

Centers for Medicare & Medicaid Services (CMS)

- Behavioral Health Integration Services