WOMEN & ADDICTION

Screening, Treatment, and Whole Person Care

ABOUT ASAM

ASAM, founded in 1954, is a professional medical society representing over 6,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

Course Description

ASAM's **Women and Addiction: *Screening, Treatment, and Whole Person Care*** pre-conference course will equip healthcare providers with the necessary tools to make a meaningful difference in the lives of women facing addiction. This interactive course will explore the complexities associated with women's health and addiction, instilling participants with the knowledge and skills needed to provide compassionate, effective, and equitable care to women with substance use disorders. Participants will discuss gender-specific issues, stigma, and unique challenges faced by women in relation to addiction. Participants will consider pharmacotherapy and treatment options appropriate during pregnancy and postpartum, and they will consider holistic care for women across the lifespan. This course will empower participants to support women in making informed decisions about their care and through their journey toward recovery.

Course Learning Objectives

1. Examine gender-specific issues and stigma associated substance use disorder to promote informed decisions and support women with addiction.
2. Apply motivational interviewing techniques specific to women's needs to evaluate and enhance their readiness to change.
3. Provide holistic care to women with substance use disorder across the lifespan, considering specific needs of women during adolescence, young adulthood, and adults in later life.
4. Recommend pharmacotherapy options for opioid, alcohol, and tobacco use disorders that are appropriate during pregnancy, and postpartum.
5. Provide compassionate care to women with substance use disorder that includes family planning, promotes trauma informed care, addresses mental health concerns, and encourages self-advocacy.

Today's Agenda

Topics to Discuss

- Providing Compassionate Care
- Adolescents
- Young Adulthood
- Adulthood – pregnancy and postpartum
- Adulthood – non-pregnancy
- Aging

Case-Based Learning

What is it?

We will follow a case-based learning approach where we will explore scenarios that resemble or typically are real-world examples. This approach is learner-centered and links theoretical knowledge to practice by giving opportunities for the application of knowledge.

Ground Rules

1. We use cases to give time to process new information – please participate!
2. Everyone's experiences differ; assume the best intentions.
3. Monitor your participation: Everyone is accountable.
4. If someone says something that is not your understanding of the evidence, ask questions and do so respectfully.

Use of the Word "Women"

- **Cis-gender women have specific biologic, social, and health differences.**
- **Recognition of importance of diversity, equity, and inclusion in research, clinical practice, and guidelines.**

PRESENTERS

Katrina Mark, MD, FASAM
Associate Professor, University of Maryland School of Medicine, Maryland; Medical Director of the University of Maryland Women's Health Center at Penn; Director of the Substance Use in Pregnancy and Parenting Outpatient Recovery and Treatment (SUPPORT) practice

Hendrée E. Jones, Ph.D., L.P.
Professor, Department of Obstetrics and Gynecology; Senior Advisor, UNC Horizons, School of Medicine, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina; Special Expert, SAMHSA

Teresa Crosby, MSW, CADC
Clinical Social Worker, Certified Alcohol & Drug Counselor

Jennifer Bello Kottenstette, MD MS, FASAM
Associate Professor, Department of Family & Community Medicine Saint Louis University School of Medicine; Board certified in Family Medicine and Addiction Medicine; Core Faculty, Addiction Medicine Fellowship

PRESENTERS

Barbara V. Parilla, MD, FACOG, FASAM
Professor, Obstetrics and Gynecology, University of Kentucky, College of Medicine; Director, UK HealthCare Perinatal Assistance and Treatment Home

Shona Ray-Griffith, MD
Associate Professor, Departments of Psychiatry and Obstetrics & Gynecology, University of Arkansas for Medical Sciences (UAMS); Outpatient Director, UAMS Women's Mental Health Program; Program Director, UAMS Addiction Medicine Fellowship Program

Vania Rudolf, MD, MPH, DFASAM
Medical Director, Addiction Recovery Services, Swedish Medical Center, Washington; President of the Washington Society of Addiction Medicine; Assistant professor at University of Washington, Seattle, WA

Jenny Lau, Guest Speaker
A mother and woman in recovery with 6 years of continuous recovery

Audience Poll

GETTING TO KNOW THE AUDIENCE!

Which of the following describes your involvement in the healthcare industry?

Audience Poll

GETTING TO KNOW THE AUDIENCE!

In which type of setting do you work?

Audience Poll

GETTING TO KNOW THE AUDIENCE!

03

How many years of experience do you have treating patients?

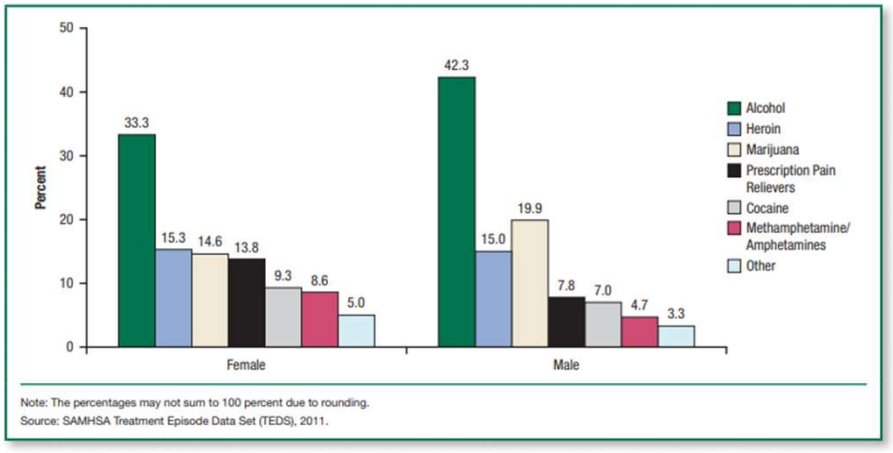
Gender Differences in Addiction Treatment

Katrina Mark, MD, FASAM
10 Minutes

Why Focus On Women?

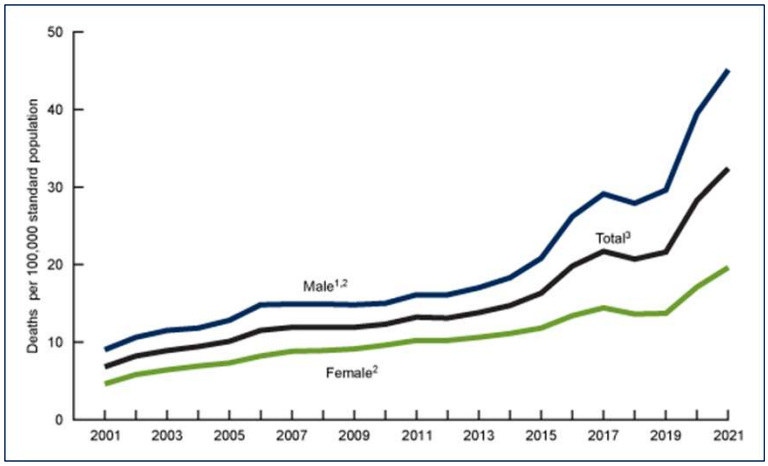
Primary Drug of Choice

Substance Abuse Treatment Admissions Aged 12 or Older, by Gender and Primary Substance, 2011



SOURCE:SAMHSA Treatment Episode Data Set (TEDS), 2011

Deaths from Drug Overdoses
Male vs. Female



SOURCE: CDC, 2022

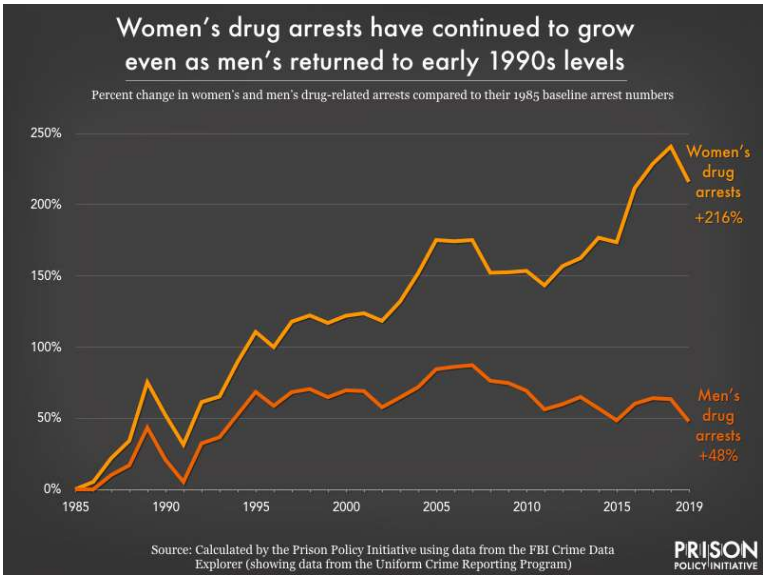
Why Focus On Women?

- Biologic and hormonal differences
- Differences in reasons for use
- Variations in patterns of use and susceptibility to use disorders.
- Differences in engagement in and efficacy of treatment

Women are Historically Underrepresented in Research and Guidelines

Drug Related Arrests

Male vs. Female



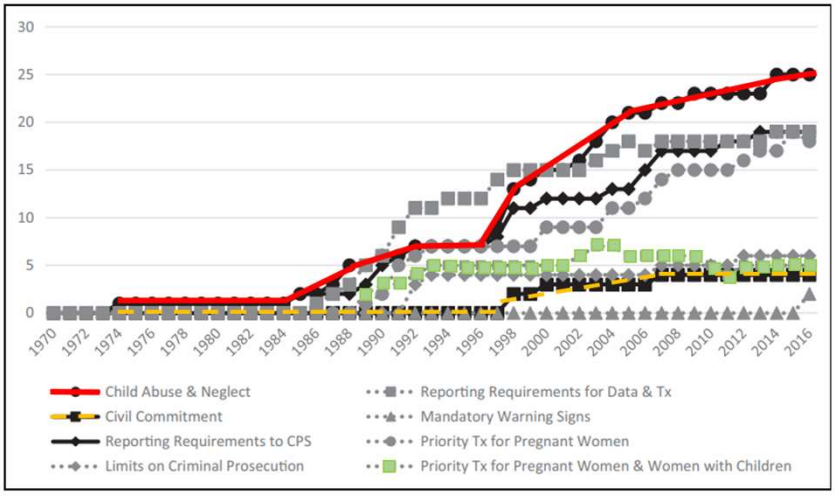
SOURCE: SOURCE: Herring, 2020

Women: Criminalizing Pregnancy

- 45 states have sought to prosecute pregnant people for exposing their fetus to drugs
- 18 states have laws that classify drug use during pregnancy as child abuse
- 3 states have laws allowing pregnant people to be involuntarily committed to treatment programs

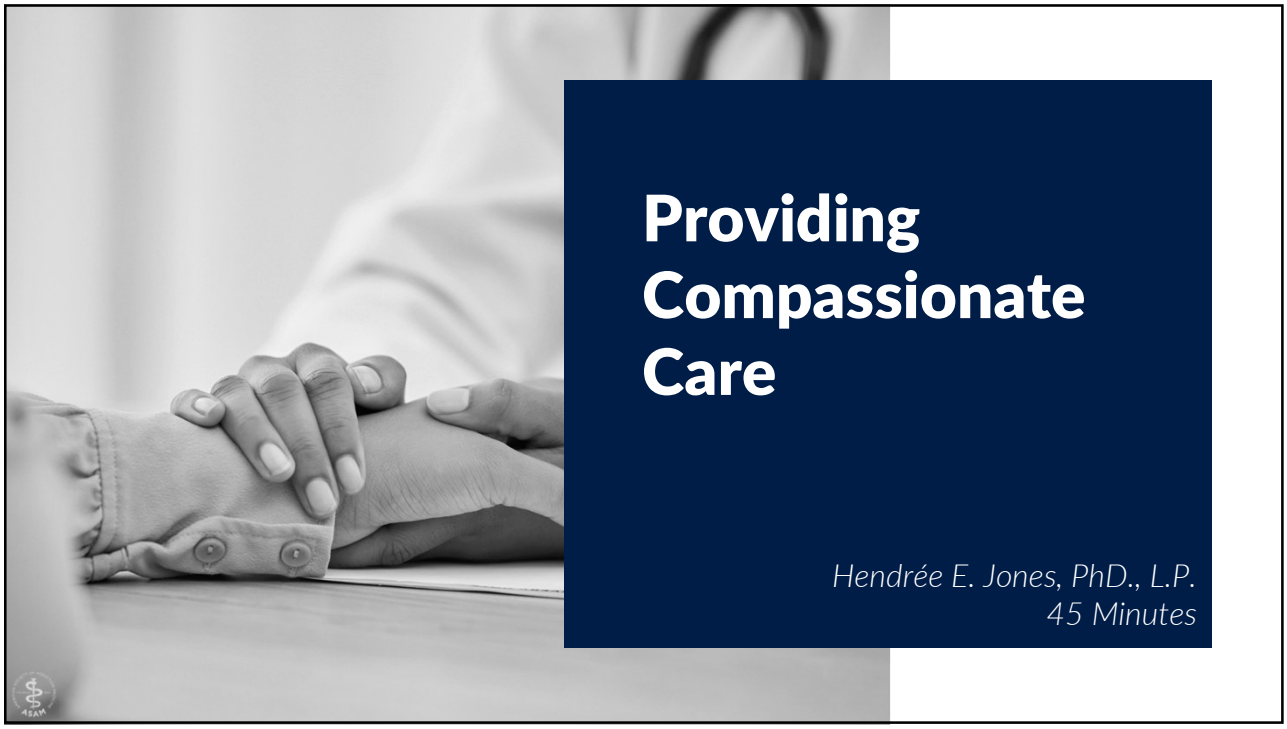
SOURCE: Miranda et al., 2015. How states handle drug use during pregnancy. ProPublica.

Trends in Punitive and Supportive Policies Related to Drug Use in Pregnancy



SOURCE: THOMAS, CONTEMPT DRUG PROGRAM 2018


You do the best you can until you know better. Then when you know better, you do better.
- Maya Angelou


Providing Compassionate Care
Hendrée E. Jones, PhD., L.P.
45 Minutes

Session 2
Learning Objectives

1. Explore the principles and foundational concepts of trauma-informed care, including the recognition of the prevalence and impact of trauma among individuals with substance use disorders, to facilitate a compassionate and empathetic approach to care delivery.
2. Develop practical skills and strategies for implementing trauma-informed practices within substance use disorder treatment settings.

Centering our Training with Living Experience and Wisdom

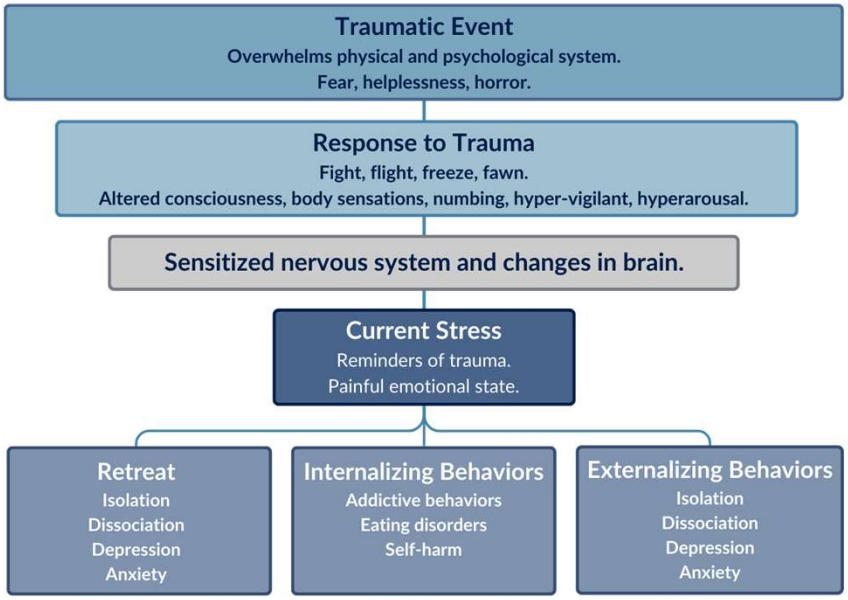
Compassionate Care in Action

Defining Trauma

> An event, series of **events**, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or threatening, and that has lasting adverse **effects** on the individual's functioning and physical, social, emotional, or spiritual well-being.
>
> *- SAMHSA, 2014*

= TRAUMA

Process of Trauma



The Brain Does Not Process Trauma As The Past

The brain doesn't file the memory of the event as being in the past.

- The result: You feel stressed and frightened even when you know you're safe.

The **brain** attaches details, like sights or smells, to that memory

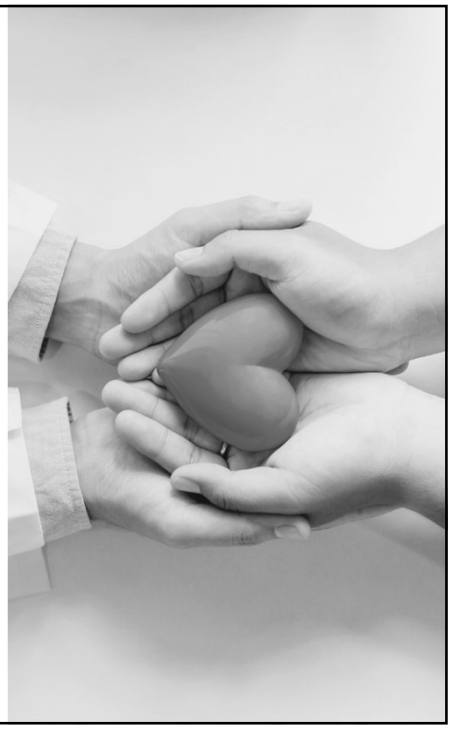
- These become triggers. They act like buttons that turn on your body's alarm system.

Females express their trauma in internalized and externalized ways.

What Does Safety Look Like For the Patient?

- Achieve reduction or freedom from substances.
- Self-care not self-harm.
- Trustworthy relationships.
- Gain control over overwhelming symptoms.
- Remove oneself from dangerous situations (such as domestic violence, unsafe sex).

Seeking Safety: Lisa Najavits



Ways To Create and Nurture Safety
What Providers Can Do

- Change the conversation from "*what is wrong with you*" to "*what happened to you*."
- Prepare women to be overwhelmed - normalize their emotions (treatment, CPS, incarceration is stressful).
- Have clear process for handling conflict.
- Be true to your word and avoid surprises.
- Recognize when trauma is shown through behaviors.
- Recognize self-protection from judgment, shame, and traumatic childhood.
- Notice and acknowledge the strengths and positives.

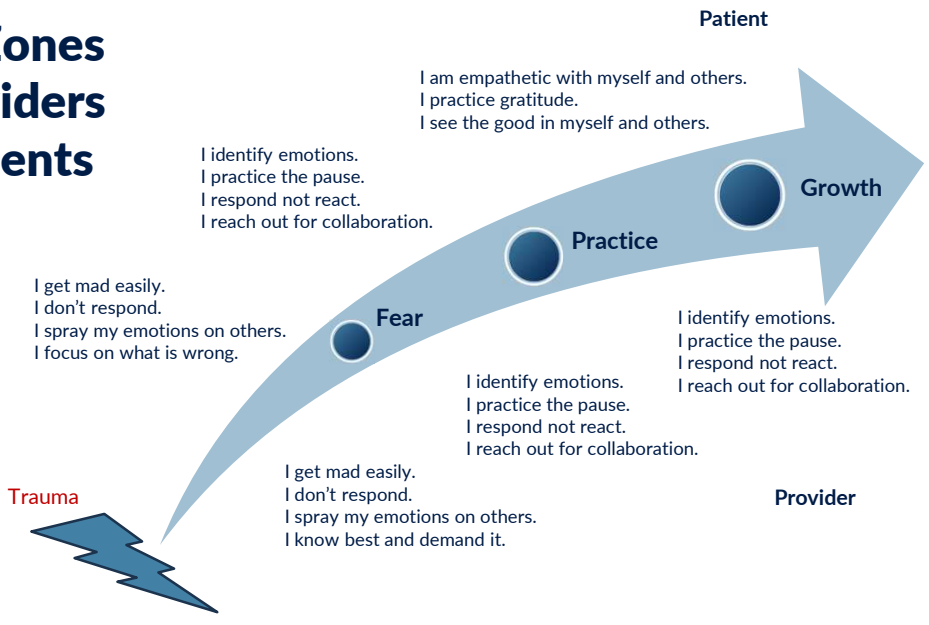
Provider magic wand: courage and kindness!

- Reflect on your role as a healer and what you bring to the interaction

Trauma Responsive Care In Action

Stop – Pause – Visualize	When you feel triggered by a patient - stop and breathe in for a count of 4 and out for a count of 4. "See" your patient asking for help or attention to meet their needs.
Cultivate	Cultivate genuine compassion. Extend empathy toward the birthing parent. Appreciate their life situation. Validate and respect feelings.
Ask	Ask for permission, pay attention, and be inquisitive. Ask open questions to effectively engage in a therapeutic conversation.
Offer	Offer reflective listening. Listen carefully to understand (not to respond).
Speak	Speak respectfully – soft voice, kind and welcoming approach. Find a common goal, give choices, set limits, use humor, positively re-direct, and encourage.

Safety Zones for Providers and Patients



Recovery Language for Women/Families

Instead of…	Use…	Because…
• Pregnant opiate addict • Addict • User	• Pregnant women with an OUD. • Person with substance use disorder. • Person with OUD or person with opioid addiction (when substance in use is opioids).	• Person-first language helps to focus on the person and not their disorder. While they may have history of substance use, it is not their only identity.
• Clean	**For toxicology screen results:** • Testing negative • Drug free **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not Currently or actively using drugs	• Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical condition. • It is important to set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.
• Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person actively using substances	• Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions. • Such terminology may decrease patients' sense of hope and self-efficiency for change.

SOURCE: drugabuse.gov

The Essence is Connection

Clinical work is an intimate human encounter and connects us with those who chose to come and tell us their problems.

- Close your eyes and envision a recent patient and look at the patient's feet – what is on their feet?
- At each patient encounter, notice their feet covering.
- This allows you to take an imaginary step into their shoes.

Building Connection

- **Prepare with intention:** Familiarize yourself with the patient you are about to meet; create a ritual to focus your attention before a visit.
- **Listen intently and completely**: Sit down, lean forward and position yourself to listen; don't interrupt; your patient is your most valuable source of information.
- **Agree on what matters most**: Find out what your patient cares about and incorporate these priorities into the visit agenda.
- **Connect with the patient's story**: Consider the circumstances that influence your patient's health; acknowledge your patient's efforts, and celebrate successes.
- **Explore emotional cues**: Tune in, notice, name and validate your patient's emotions to become a trusted partner.

SOURCE: DOI: 10.1001/jama.2019.19003

7 Ways To Build Rapport With Patients

1
MAINTAIN EYE CONTACT

2
SHOW EMPATHY

3
OPEN COMMUNICATION

4
MAKE IT PERSONAL

5
ACTIVE LISTENING

6
PRACTICE MIRRORING

7
KEEP YOUR WORD

Ready, Set and.... Demonstrate Compassion

Ask	• For permission
Listen	• For what is said • For what is not said
Reflect	• What you heard
Provide Options	• Everyone likes to feel in control.
Thank	• Affirm • Leave room for more conversation next visit.

Defining Ambivalence

- Simultaneous and contradictory attitudes or feelings towards an object, person or action.
- Continual fluctuation between one thing and its opposite.
- Uncertainty in which way to go.

Recognizing Ambivalence in Words

"I want to go to treatment, but I don't want to call right now"

"I am on the fence about treatment"

"I want to stop using but I am worried my partner won't support me"

Recognizing Ambivalence in Actions

- Hesitation in answering questions or completing forms
- Avoidance of completing recommended actions
- No-shows, cancellations and re-schedules

Provider Focus

- Patient autonomy
- Freedom in decision making
- The patient has the answer
- How do you create space for patients?
- Ask open ended questions

Provider Actions

- Listen with openness and curiosity.
- Gather information on patients journey to her own decision-making.
- Use the story method.
- Use the Certainty Scale.

On a scale of 1 to 10 how would you rate your answer to the statement “going to treatment is the best decision for me now” (1=not at all to 10 =100% certain).

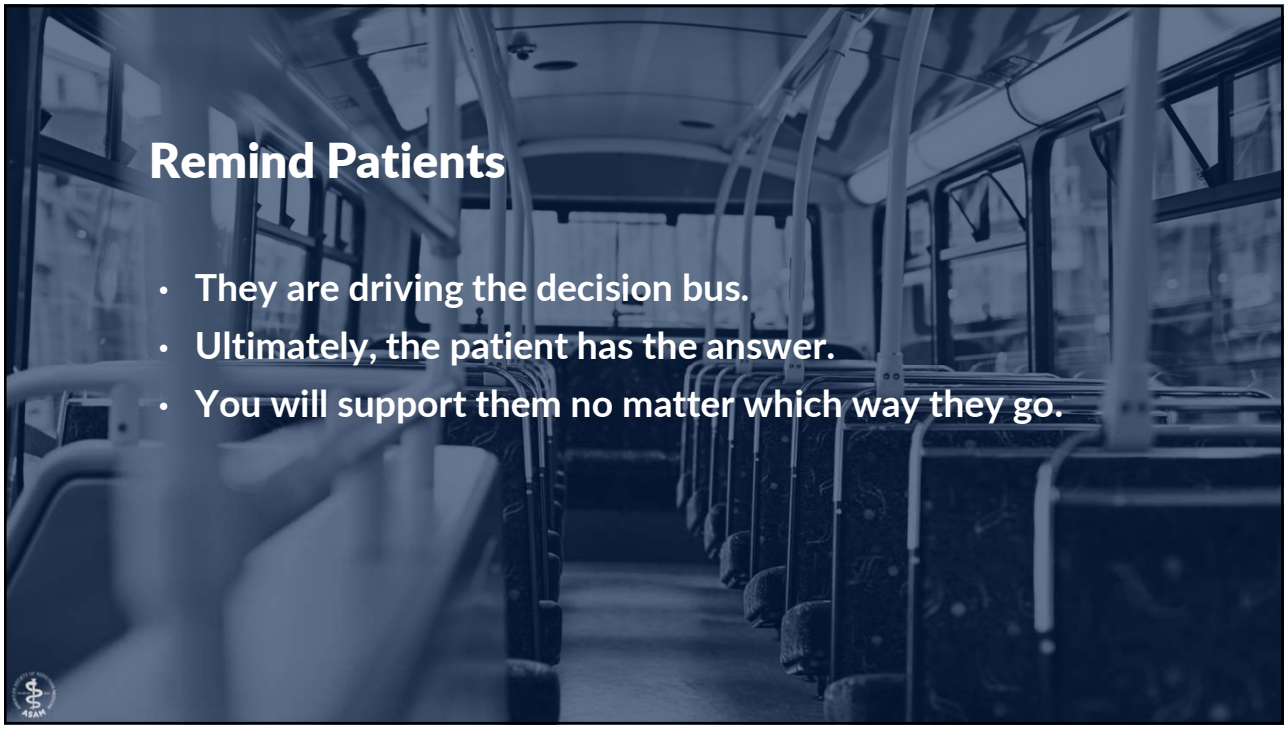
Provider Actions

- **Avoid binary framing.**
- **Ask about the good as well as the not-so-good.**
- **Listen for "stuckness."**
- **There are things getting in the way with treatment.**
- **Exercise in asking "what if" feelings and beliefs of self and others.**

Provider Actions

- Listen for possibilities.
- Listen for things that are drawing the patient toward treatment.
- What happens if we entertain the possibility?
- Does anything change?

It is essential to bring the circumstance to light so that its role as an obstacle, no matter how unfair or unjust it is, can be recognized and acknowledged.



- Decision assessment tools allow patients and providers to understand the struggle better.
- Patients make decisions no matter how small.
- Uphold their autonomy even in case of low freedom.

Key Takeaways

Your patient is the expert on their own life, and the decision they make is not about you.

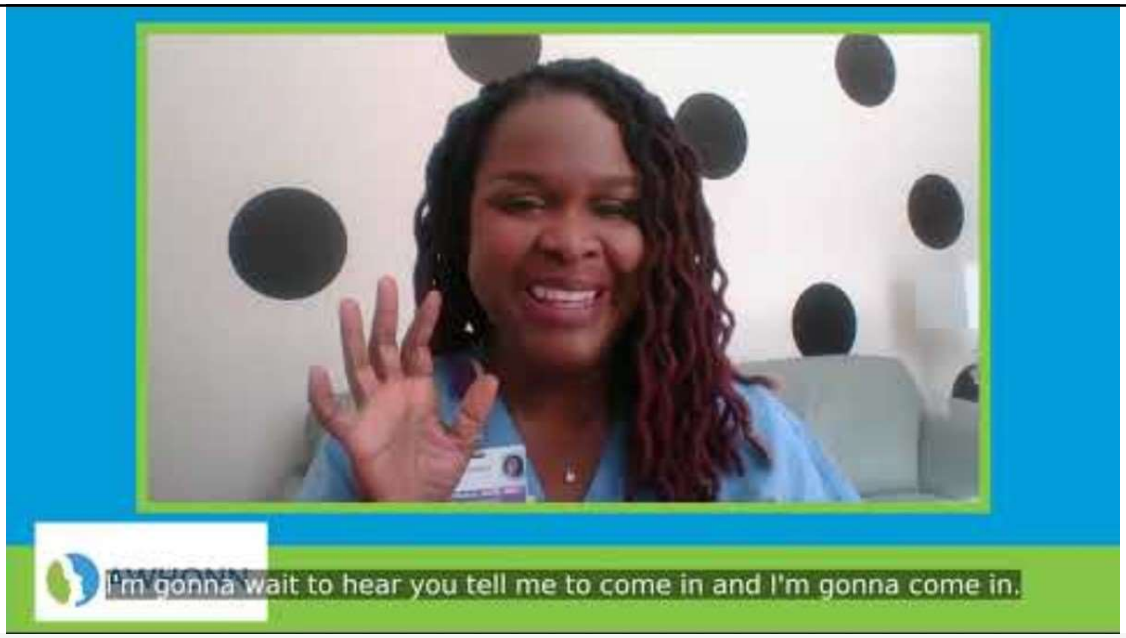
Remain neutral and remind yourself that the patient has the answer.

Seek understanding of the patient's experience of different barriers and facilitators to resolution.

Do not try to produce an "answer" or a "score" when using the tools. Simply view them as techniques that allow the patient to think out loud and engage in conscious reflection.

Recognize that the patient is doing the best they can do at the present moment, given their life circumstances.

Validate, normalize, and practice loving-kindness to show that you will support the patient regardless of their decision



Let's Watch Compassionate Rapport in Action

Activity 1

Creating Your Compassion Toolbox

Often our discomfort with someone or some situation comes from not knowing how to react to it.

Completing this toolbox will increase your ability to respond in more compassionate ways to the patients you serve and those around you.

Task

1. Take a few minutes to fill out the worksheet.
2. We will invite a few volunteers to share aspects of their completed worksheet with the audience.

Share:

7 minutes

Knowledge Check

Patient-centered care includes all of the following except:

A. Respect for patient's values, preferences and expressed needs
B. Reminding patients of what is wrong and needs to be fixed
C. Coordination and integration of care
D. Transition and continuity

ADOLESCENTS

Trends, Risk Factors, and Special Considerations

Teresa Crosby, MSW, CADC
Katrina Mark, MD, FASAM
20 Minutes

Session 3
Learning Objectives

1. Explore the factors contributing to the development and progression of substance use.
2. Recognize the interconnectedness between trauma, intimate partner violence (IPV), and substance use.
3. Identify the factors contributing to risky sexual behavior among individuals who use substances.

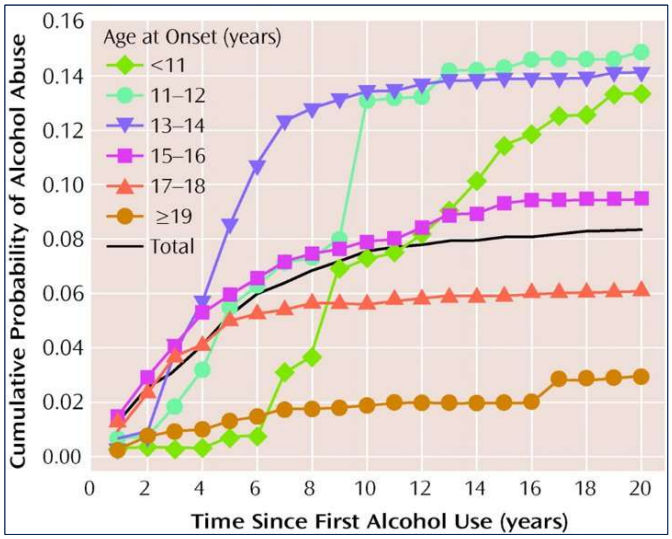
National Youth Risk Behavior Survey

29% of high school students use alcohol, marijuana or opioids.

34% of those use multiple substances.

Age of Onset and Probability of Use

- The earlier the age of onset of use, the more likely to develop a use disorder

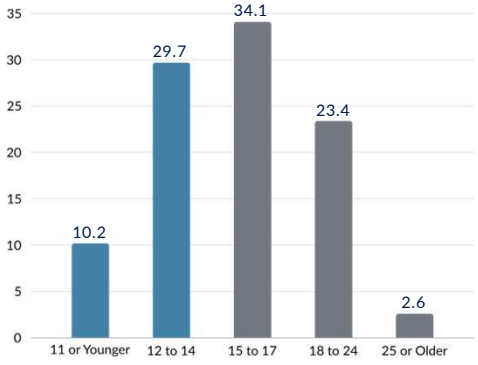


SOURCE: 10.1176/appi.ajp.157.5.745

Substance Use Disorders: A Pediatric Disease

- Majority reported initiating alcohol or drug use at the age of 17 or younger.
- 39.9% reported initiating substance use age 14 or younger.
- There is critical importance for prevention *and* treatment initiatives aimed at children and youths.

Age of Substance Use Initiation Among Those Admitted to Treatment 18-30 Years Old



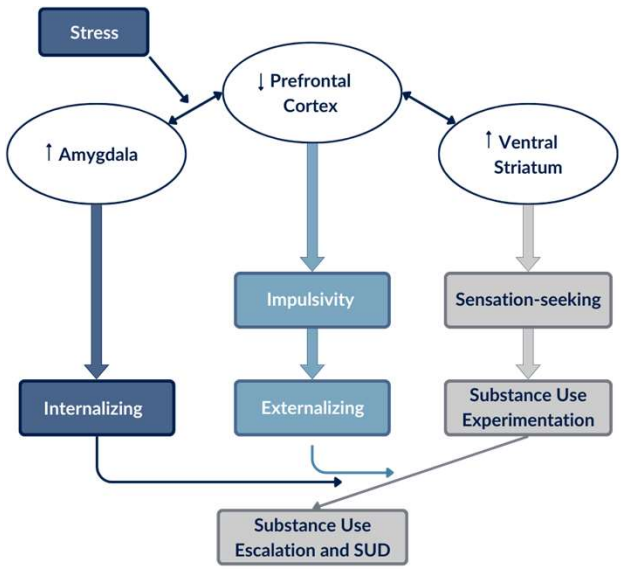
SOURCE: DOI: _____

Current and Lifetime Use of all Drugs

2021

Behavior/Substance	Male	Female
Current Use		
Alcohol	18.8	26.8
Marijuana	13.6	17.8
Binge Drinking	9.0	12.2
Prescription Opioid Use	4.0	8.0
Lifetime Use		
Alcohol	42.0	53.2
Marijuana	24.8	30.9
Inhalants	6.8	9.4
Ecstasy	2.9	2.7
Cocaine	2.6	2.2
Methamphetamine	1.9	1.4
Heroin	1.6	0.8
Injection Drug Use	1.7	0.9
Synthetic Marijuana	5.8	7.1
Prescription Opioid Use	9.5	14.8

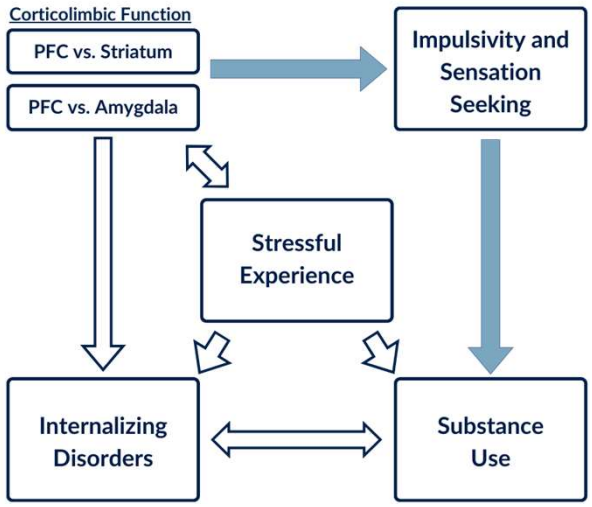
SOURCE: CDC MMWR 2021



- Adolescents have developed a dopaminergic pathway without the control of a prefrontal cortex.
- Girls' prefrontal cortex develops earlier than boys.
- Girls have greater amygdala response to negative experiences.
- Result is that girls are typically more risk averse than boys.

SOURCE and Image Adaptation: DOI: 10.1016/j.cobeha.2018.01.020

Neurological Differences in Adolescent Vulnerability to Developing SUD



SOURCE and Image Adaptation: DOI: 10.1016/j.bbr.2015.04.008

Confidentiality in Adolescents

- Parental involvement in healthcare should not be mandated.
- HIPAA allows for control of health information and decisions by parents with the exception of treatment for reproductive health, mental health, and substance use.
- State laws supersede HIPAA exceptions and vary state by state.
- Providers should be aware of their state's laws on:
  - Parental notification
  - Parental consent
  - Need for minor consent (can parent consent to treatment without child consent)

SOURCE: DOI: 10.1001/jama.1997.03550120089044; 0.1001/virtualmentor.2005.7.3.pfor1-0503; NDAA Minor Consent to Medical Treatment Laws, 2013

Confidentiality in Adolescents

- Adolescents are more likely to disclose sensitive information if they are given assurance of confidentiality by a healthcare provider.
- Girls are more likely than boys to avoid healthcare due to concern regarding confidentiality.
- Limitations of confidentiality should always be outlined by provider.

SOURCE: DOI: 10.1016/s1054-139x(98)00146-3; 10.1001/jama.1997.03550120089044

Risk Factors, Associated Behaviors, and Treatment Considerations

Association with Eating Disorders

- **Youth with eating disorders are more likely to develop AUD.**
  - Purging is most associated with development of AUD.
  - 10% of patients developed AUD in a prospective study.

- **Dieting was predictive of later substance use in girls**
  - In a prospective study of young women with eating disorder, 17% developed SUD.

SOURCE: DOI: 10.1002/eat.20178; 10.1016/j.cpr.2006.04.001; 10.1016/j.eatbeh.2021.101515

Risky Sexual Behavior

Youth who engage in non-medical use of prescription drugs have higher rates of:

- Being currently sexually active
- Having more than four lifetime partners
- Drinking alcohol or using drugs before sex
- Not using a condom at last sexual intercourse

SOURCE: DOI: 10.1542/peds.2015-2480

Childhood Trauma

- Female victims of childhood sexual trauma are five times more likely to engage in heavy drug use and polysubstance use.

- Boys are more likely to engaged in externalizing behavior such as physical aggression.

- Girls of alcoholic fathers are more likely to misuse substances.

SOURCE: Homel, Subs Use Misuse, 2019, 2012; Shin, DAD 2010

Targeting Female Youth

Alcohol advertisements target female youth.

- Girls aged 12 – 20 are **exposed to higher rates of advertising** than those 21 and over.

- Exposure to **advertising to girls increased by 216% in girls** and only 46% for boys.

- Exposure to advertisements is **directly associated** with early age of onset of drinking.

SOURCE: DOI: 10.1001/archpedi.158.7.629; 10.15288/jsads.2020.s19.113

Validated Screeners: S2BI and BSTAD

- Screening should be done annually by pediatricians using a validated screener starting at age 12.

Screening to Brief Intervention (S2BI)

IN THE PAST YEAR, HOW MANY TIMES HAVE YOU USED:

Tobacco?
- Never
- Once or twice
- Monthly
- Weekly or more

Alcohol?
- Never
- Once or twice
- Monthly
- Weekly or more

Marijuana?
- Never
- Once or twice
- Monthly
- Weekly or more

***STOP** if answers to all previous questions are "never." Otherwise, continue with questions on the right.*

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
- Never
- Once or twice
- Monthly
- Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?
- Never
- Once or twice
- Monthly
- Weekly or more

Inhalants (such as nitrous oxide)?
- Never
- Once or twice
- Monthly
- Weekly or more

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?
- Never
- Once or twice
- Monthly
- Weekly or more

Boston Childrens Hospital, 2015

Brief Screener for Tobacco, Alcohol, and other Drugs

FRIENDS' USE

Do you have friends who
smoked cigarettes or used other tobacco products in the past year? ☐ No ☐ Yes

Do you have friends who
drank beer, wine, or any drink containing alcohol in the past year? ☐ No ☐ Yes

Do you have friends who in the past year:
- smilfed or "huffed" anything;
- took illegal drugs like marijuana (weed, blunts), cocaine, etc;
- took prescription medications that were not prescribed for them; or
- took prescription or over-the-counter medications and took more than they were supposed to take?

☐ No ☐ Yes

PERSONAL USE

In the past year, have you
smoked cigarettes or used other tobacco products? ☐ No ☐ Yes

In the past year, have you
had more than a few sips of beer, wine, or any drink containing alcohol? ☐ No ☐ Yes

In the past year, have you:
- smilfed or "huffed" anything;
- takes illegal drugs like marijuana (weed, blunts), cocaine, etc;
- taken prescription medications that were not prescribed for you; or
- taken prescription or over-the-counter medications and took more than you were supposed to take?

☐ No ☐ Yes

[IF DRUGS ARE ENDORSED IN THE PERSONAL USE QUESTION, ASK THE FOLLOWING:]

Which of the following substances have you used in the past year? (check all that apply)
- ☐ Marijuana or Hashish
- ☐ Cocaine or crack
- ☐ Heroin
- ☐ Amphetamines or methamphetamine (nonpharmaceutical)
- ☐ Hallucinogens (eg, Mushrooms, LSD)
- ☐ Inhalants

Which of the following medications have you used in the past year that were not prescribed for you or which you took more of than you were supposed to take? (check all that apply)
- ☐ Prescription pain relievers (eg, morphine, percocet, vicodin, oxycontin, dilaudid, methadone, buprenorphine)
- ☐ Prescription sedatives (eg, Valium, Xanax, Klonopin, Ativan)
- ☐ Prescription stimulants (eg, Adderall, Ritalin)
- ☐ Over-the-Counter Medications (eg, Nyquil, Benadryl, cough medicine, sleeping pills)

[FOR EACH SUBSTANCE WHERE USE WAS ENDORSED, ASK:]

In the past 30 days, on how many days have you…
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐☐ days

In the past 90 days, on how many days have you…
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐☐ days

In the past year, on how many days have you…
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]? ☐☐☐ days

DOI: 10.1542/peds.2013-2346

Treatment for Adolescents

- Brief intervention, motivational interviewing and motivational enhancement therapy are the most common methods of treatment.
- Mixed reviews on benefit of feedback.
- Girls respond more strongly to motive-tailored interventions.

SOURCE: DOI: 10.1016/j.addbeh.2012.07.001 ; 10.1016/j.pmedr.2015.12.009

Gender Specific Risk Factors/Motivation

- Girls more likely to use drugs for weight loss.
- Girls with lower self-esteem are more likely to use drugs.
- Relationship factors effect girls more than boys
  - Familial and peer norms
  - Familial discipline and supervision
  - Parental bonding

SOURCE: DOI: 10.1081/ja-120024240

Gender Specific Prevention

Web-based Intervention

- Focuses on:
  - self-esteem/efficacy
  - goal setting
  - body-image
  - perceived stress
  - anxiety/depression
  - coping skills
  - drug refusal
- After three years of follow-up, girls in the intervention group had less drug use themselves and less peer drug use.

SOURCE: DOI: 10.1016/j.addbeh.2019.01.010

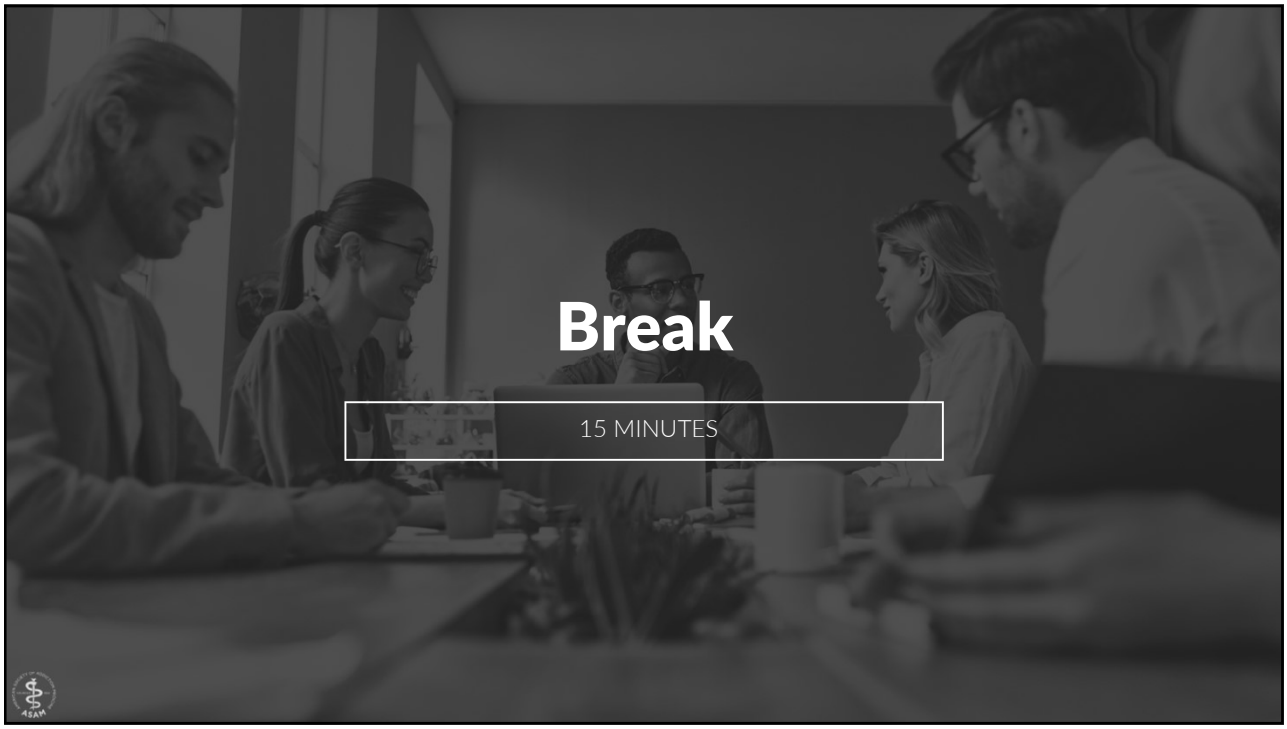
Key Takeaways

- Begin screening by age 12 for substance use with validated screeners.
- Screen adolescent girls with a history of abuse and/or eating disorders for substance use.
- Discuss safe sexual practices.
- When they exist, provide gender-specific treatment options.
- Consider gender differences in research and development/ testing/implementation of interventions.

Knowledge Check

A 15-year-old female presents to your office for a well child check. Which of the following substance use screeners is validated for use in adolescents?

A. BSTAD
B. DAST-10
C. NIDA-Quick Assessment
D. ORT-OUD



YOUNG ADULTHOOD

Sexual and Reproductive Wellness

Jennifer Bello Kottenstette, MD, MS, FASAM
40 Minutes

Session 4
Learning Objectives

1. Articulate why it is important to incorporate sexual and reproductive health screening, referral, and service delivery into the settings where women with substance use seek care.
2. Provide comprehensive counseling on reproductive goals, pre-pregnancy health, and contraception options to individuals of reproductive age who use drugs.
3. Implement harm reduction strategies and interventions tailored to the needs of individuals who use drugs, including transmission of infectious diseases and other adverse consequences associated with risky sexual behaviors and drug use.

Comprehensive Sexual and Reproductive Health Care

Why?

- People seeking addiction treatment may want to become pregnant now or in the future.
- People who want to become pregnant may have a substance use disorder.

Opportunities to Improve Care:

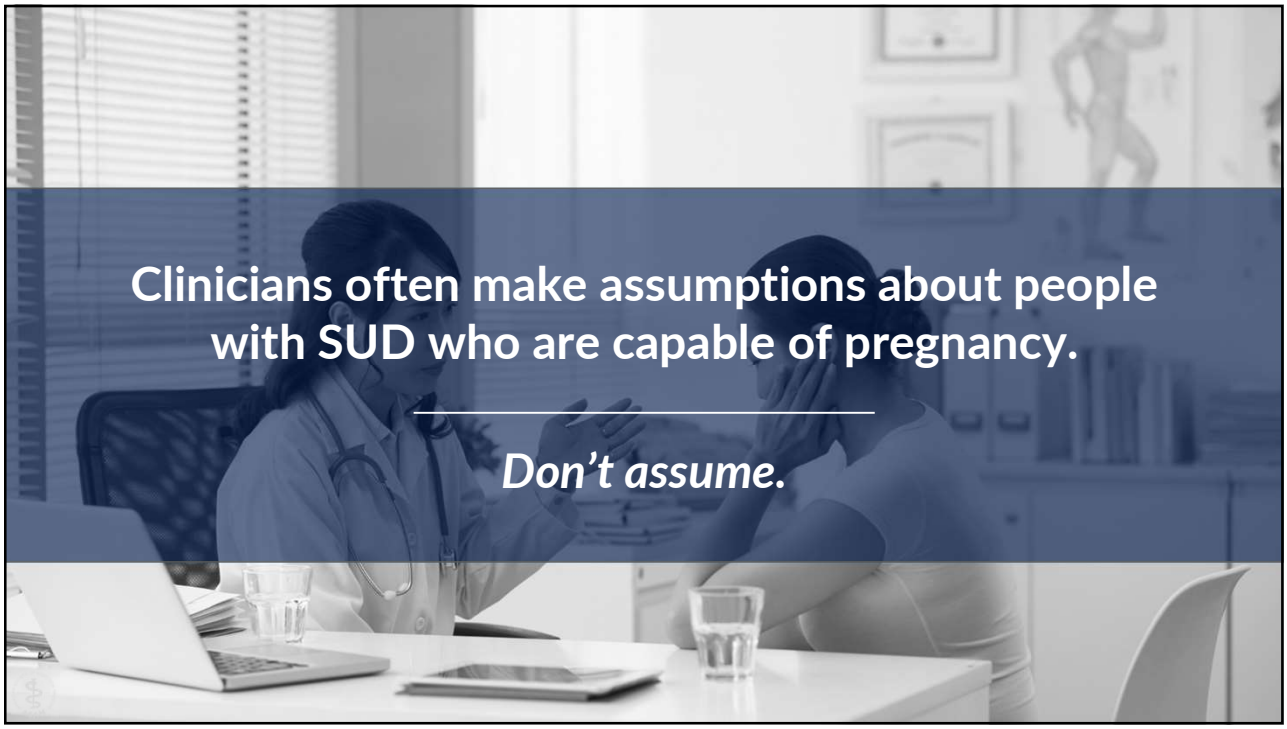
- Overcome stigma.
- Need for reproductive justice.
- Non-judgement.
- Focus on women's overall health rather than using a pregnancy prevention model.

SOURCE: Urban Institute, Health Policy Center, 2022.

Family Planning

- Preconception
- Contraception
- Abortion

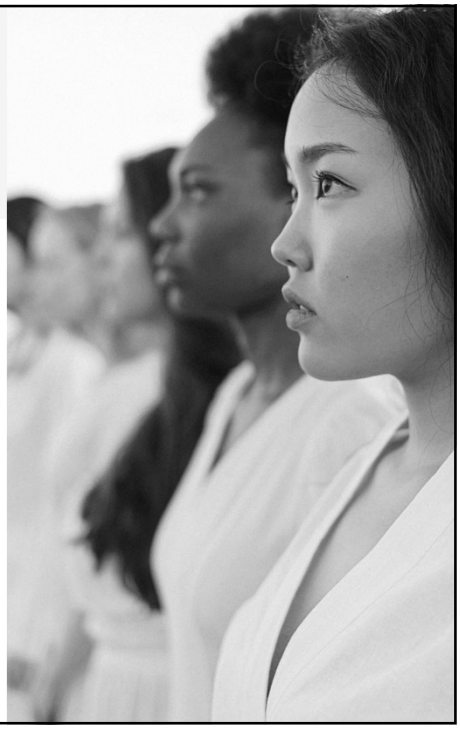
Preconception


Clinicians often make assumptions about people with SUD who are capable of pregnancy.
Don't assume.


What if I want to become pregnant? What if I want to have a baby?
They didn't ask me.
Let me tell you about effective birth control methods...

Unique Reproductive Health Needs of People in Treatment for SUD

- Competing social and general health needs.
- History of domestic violence.
- Transactional sex.
- Sexual trauma.
- Risks of experiencing unplanned pregnancy during the sensitive treatment and recovery periods.



SOURCE: Urban Institute, Health Policy Center, 2022

Preconception Health Care

2006 Recommendations from the CDC

- Evidence-based risk screening, health promotion, and interventions that will enable people to enter pregnancy in optimal health.
- Reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children.
- Reduce the disparities in adverse pregnancy outcomes.

SOURCE: PMID: 16617292

Every time a woman interfaces with the healthcare system is an opportunity to address preconception health/ pre-pregnancy wellness.

Challenges and Current State:

Substance use is a behavior that can impact pregnancy outcomes:

- Pre-pregnancy interventions have the potential to make a large public health impact by addressing substance use behaviors **before** pregnancy.
- Preconception interventions we know work **target alcohol and tobacco use**.
  - They are largely focused on using motivational interviewing techniques.
  - Less is known about how interventions will work in the pre-pregnancy period for people who use illicit substances and multiple substances.

SOURCE: DOI: 10.1037/tps0000242; 10.1016/j.addbeh.2020.106393; PMID: 32200197

Challenges and Current State

Lack of preconception services provided to women in general:

- Using nationally representative electronic health record data, **only 5.7% of women** with a delivery received preconception services in the year prior to pregnancy.

- **9.6% of women** with SUD with a delivery received preconception services in the year prior to pregnancy.

SOURCE: DOI: 10.1016/j.drugalcdep.2021.109194

Screening for Infections

- Part of comprehensive sexual and reproductive healthcare.

- People with SUD are at increased risk for infections:
  - Injection drug use
  - Unprotected sex
  - Transactional sex

Infection Risk in People with SUD

- Over half of women with OUD seeking treatment reported having ever tested positive for a sexually-transmitted infection.
- People who inject drugs account for about 1 in 10 HIV diagnoses in the United States.
- The hepatitis C virus disproportionately affects people who inject drugs, and the rising opioid epidemic has paralleled a rise in hepatitis C virus infection.
- Rates of STIs range from 5 to 60 times higher among sex workers than the general population, and many people do not know their HIV status.

SOURCE: DOI: 10.1097/AOG.0000000000003666 ; 10.1016/S2214-109X(17)30375-3 ; 10.1377/hlthaff.2018.05232 ; Injection Drug Use, CDC ; iQSolutions

Screening for Infections

- Screening is recommended by the USPSTF.

***Persons who engage in commercial sex work, exchange sex for drugs, and have carceral involvement are at increased risk for infections**

- Grade A for HIV and Syphilis
  - High certainty that the net benefit is substantial.
- Grade B for gonorrhea, chlamydia, and Hepatitis C.
  - High certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

SOURCE: DOI: 10.1001/jama.2019.6587; 10.1001/jama.2022.16887; 10.1001/jama.2021.14081; Chou et. al., 2020.

Intimate Partner Violence (IPV)

Abuse or aggression that occurs in romantic relationships:

- Includes current and former spouses and dating partners
- Physical and sexual violence, reproductive coercion, stalking, psychological aggression, abuser control of drug supply
- Financial violence
- Varies in severity and frequency
- Connected to other forms of violence
- Related to serious health issues and economic consequences

SOURCE: CDC, Violence Prevention

Intimate Partner Violence

- **Relationship between IPV and substance misuse is bi-directional:**
  - Substance misuse is common among people exposed to IPV.
  - There is high risk of developing SUD, and at greater symptom severity.
  - Brain injury, mental health diagnoses, and substance use can increase re-victimization.

- **Has significant impact on women's substance use behaviors:**
  - Physical IPV may be due to partner's substance use.
  - Emotional abuse can prevent engagement in recovery.
  - Financial abuse prevents independence from partner.
  - Substance use may be to cope with IPV

SOURCE: DOI: 10.3389/fpsyg.2022.1028375; 10.1080/08897077.2019.1671296

Intimate Partner Violence

- Integrated treatments to address MOUD and PTSD among women with IPV are lacking.
  - Studies are underway to evaluate behavioral interventions for women who experience IPV and PTSD.

Promoting Retention in Opioid Treatment among Women Experiencing Intimate Partner Violence: A Novel Stepped Care Model Targeting PTSD

Project Number	Contact PI/Project Leader	Awardee Organization
1R61DA059895-01	SULLIVAN, TAMI POther PIs	YALE UNIVERSITY

USPSTF Screening Recommendations for IPV

Clinicians should screen all women of reproductive age for IPV and provide or refer women who screen positive for ongoing support services.

Risk factors that increase risk of IPV:

- Exposure to violence as a child
- Unemployment
- Young age
- Substance misuse
- Relationship difficulties
- Economic hardships

SOURCE: DOI: 10.1001/jama.2018.14741

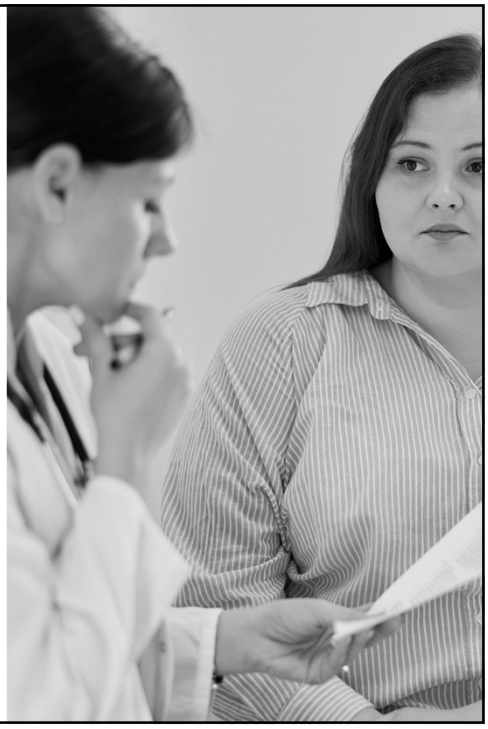
Unique Challenges to Sexual and Reproductive Health Service Delivery

- Lack of interest in discussing reproductive health
  - Loss of custody of prior children
  - Poor outcomes in prior pregnancies
- Perceived infertility
  - Etiology: Chronic OUD
- Lack of provider knowledge
- Lack of reimbursement
- Lack of patient demand for services
- Healthcare system delivers care in silos
- Synergistic barriers:
  - Structural – criminalization, costs, accessibility
  - Interpersonal – higher rates of IPV
  - Individual – reduce reproductive autonomy

SOURCE: DOI: 10.1016/j.josat.2023.209052

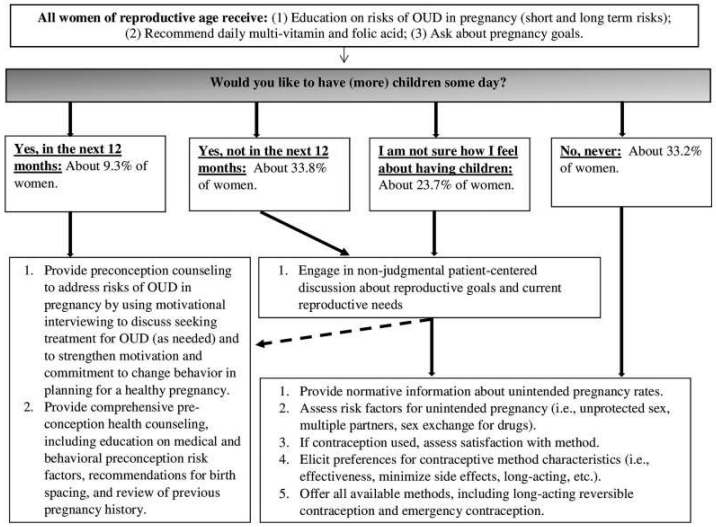
Potential Solutions

- Co-located services
- Screen treatment seeking people capable of pregnancy for reproductive wishes/service needs to guide counseling and referral



SOURCE: DOI: 10.1016/j.josat.2023.209052

Algorithm Describing Reproductive Goals Assessment and Recommended Health Services for Women with OUD Using a Patient-Centered Approach.



Note. Adapted from Bello et al., 2013, Chuang et al., 2011, and Power to Decide, 2019.

Screening for Pregnancy Intention

SOURCE: powertodecide.org; DOI: 10.1007/s10995-019-02754-z; 10.1007/s11606-020-06506-6

Ambivalence About Pregnancy Wishes

Acceptance

- Use motivational interviewing techniques to explore both sides of the ambivalence.
  - What are some good things about getting pregnant right now?
  - What are some not so good things about getting pregnant right now?

- Consider approaches to counseling that acknowledges pregnancy wishes:
  - Enter pregnancy healthy – consider goals for parenthood and family
  - How can your healthcare provider help you achieve your goals?

Contraception

Contraception

- People with SUD are less likely to use contraception and more likely to use less effective methods.

  - Only half of women with SUD reported using contraception.
    - Condoms were the most common form.
    - 7-17% of participants were using a non-barrier method (OCPs or LARCs).

- What do we mean when we describe unmet contraceptive need among people with SUD?

SOURCE: DOI: 10.1016/j.ypmed.2015.04.008; 10.1016/j.contraception.2022.09.129

Method Effectiveness

- Women with OUD report considering LARC acceptable, but lifetime use has been reported to range from only 5-12%.
  - Reasons:
    - Limited knowledge and access.
    - Other unexplored factors that may influence contraceptive method decision making.
- **Barriers** to contraceptive uptake include patient misconceptions or knowledge gaps about reproductive health and family planning, cost, IPV, fear of criminalization, difficulty accessing care, comorbid health conditions, and healthcare provider misconceptions or practice limitations.
  - **Greatest barriers** of LARC uptake were fears of complications and inaccurate information from family, friends, and acquaintances.

SOURCE: DOI: 10.1186/s40834-018-0056-y; 10.1002/jcph.1772; 10.1097/Jpn.0000000000000401

Provider Perceptions

- Provider's perception of patient **instability** and barriers to contraceptive access and use led them to:
  - Use patient-centered communication.
  - Highlight the benefits of LARC when they perceived a LARC method would help clients overcome barriers.
  - Postpone contraceptive discussions.
- When patients are **stable** in long-term recovery, they may be more likely to discuss short-acting contraceptive methods.
- Timing: acute needs versus long-term recovery
  - Realistic locations

SOURCE: DOI: 10.1016/j.whi.2021.11.010; 10.1097/ADM.0000000000001049

Overcoming Barriers

- Contraception decision aids.
  - SAFE: Sex and Female Empowerment to support women in OUD treatment through contraception decision process using social cognitive theory.

- Where can women receive contraceptive services?
  - Co-located care.
  - Referral – know community providers.

SOURCE: DOI: 10.1016/j.drugalcdep.2021.108634; 10.1007/BF02287320; 10.3389/fpsyt.2022.910389; 10.1080/09540261.2021.1904845

Abortion

Abortion

- **Reasons for abortion among women in treatment for OUD:**
  - Among women surveyed in Michigan, reasons for prior abortion included financial, timing, and partner-related concerns, in addition to concerns about the effects of their drug use on the pregnancy.
- **International landscape:**
  - In a 2012 study in Australia, women in OTPs had higher rates of termination compared with national data.
  - From 2000-2014 in a Czech Republic national database study, women with illicit SUD had higher abortion rates than women with alcohol and sedative and hypnotic use.

SOURCE: DOI: 10.1037/adb0000959 ; 10.1016/j.drugalcdep.2020.107933

Clinician Ethical Duty vs. Fear of Legal Consequences

- Dobbs v. Jackson Women's Health Organization case, 2022
- While the legal consequences of providing abortion counseling in states with abortion bans are low, many providers do not make referrals or provide resources about abortion options.
  - One year after the Roe v. Wade was reversed, in states that ban abortion, 78% of OB/Gyns surveyed don't make out-of-state referrals and 30% don't inform patients about online resources.
- For free legal advice for providers:
  - Contact Abortion Defense Network: https://abortiondefensenetwork.org/

SOURCE: DOI: 10.1056/NEJMms2306439; Frederiksen et. al., A National Survey of OBGYNs' Experience After Dobbs, 2023

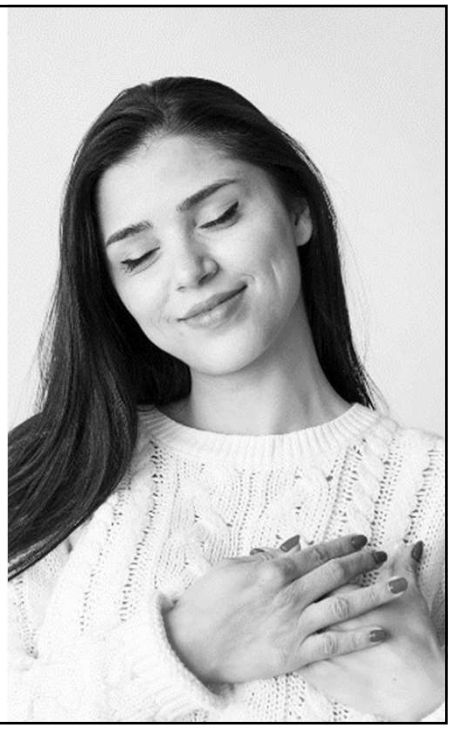
Uncertain Legal Consequences for Providers

- There are low odds of being charged with a crime and even lower odds of successful prosecution:
  - Advising a patient about abortion in a state where it is legal cannot lead to provider being an accomplice.
  - When providing all options counseling, it is difficult to establish that the provider intended for the person to commit a crime.
- You have a First Amendment right to share relevant medical information with patients.
- Counseling about out-of-state abortion options is required by HHS as part of Title X funding.
- Sharing abortion information is consistent with ethical obligations, and in most instances does not violate any law.

SOURCE: DOI: 10.1056/NEJMms2306439

Self-Advocacy

- Providers are advocates for their patients.
- Empower patients to advocate for themselves.
- Start with understanding sexual and reproductive health rights.

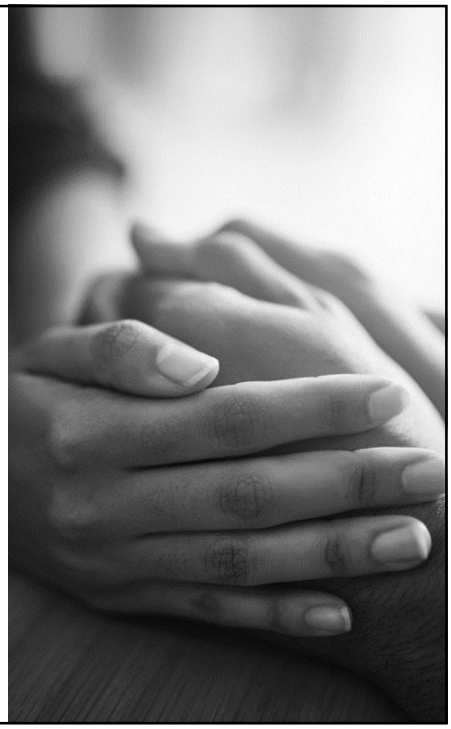


Motivational Interviewing

- How can you use this technique when interacting with people capable of pregnancy who are not yet pregnant?
- Patients select their own goal for change.
- Focus on change talk.
- Consider these questions:
  - Where do you see yourself in 5 years?
  - What are your thoughts on having a family?
  - What does a healthy family look like to you?
  - What kind of parent do you want to be (current versus future children)?
  - Self-confidence/advocacy – what are the barriers? How can they be overcome?

Harm Reduction

- Policies, programs, and practices aimed at minimizing negative health, social, and legal impacts associated with drug use, drug policies, and drug laws
- Due to the association between substance use and high-risk sexual behaviors, harm reduction approaches are important measures to improve sexual and reproductive health in at-risk populations.
- Use harm reduction approaches that maintain patient autonomy in all encounters related to sexual and reproductive health.



Key Takeaways

- A person's sexual and reproductive health beliefs, wishes, and behaviors may be influenced by their experience with substance use.
- Providers should consider that having a family may be an important part of their patient's goals, regardless of their substance use history or prior pregnancy outcomes.
- Using a non-judgmental approach is necessary to meet women where they are and empower patients to achieve their goals for their family.

Knowledge Check

Which one of the following is an advantage of using a comprehensive sexual and reproductive health approach to patient care with women who use substances?

A. This approach helps women meet an unmet contraceptive need.

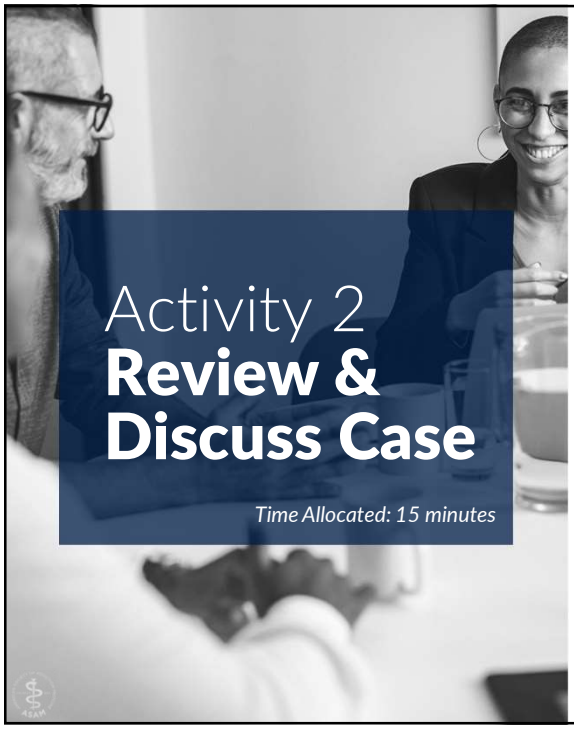
B. This approach creates a space of non-judgment where patients can express their reproductive goals.

C. This approach is only used when a woman wants to become pregnant in the next year.

D. This approach increases the uptake of the most effective contraceptive methods for women who use substances.

Case Exercise

15 Minutes



Activity 2
Review & Discuss Case

Time Allocated: 15 minutes

Task
Small Group Discussion

Review *(7 minutes)*
1. Review the case details in your course handout.
2. As you review, place yourself in the shoes of the provider.
3. Review and discuss your case as a group.

Share *(8 minutes)*
1. Discuss as a large group your key findings.
2. Address questions related to the case scenarios.

Case Information

- A 29 y/o ciswoman who identifies as a woman (she/her) presents for outpatient treatment for polysubstance use.
  - Urine pregnancy test: Negative
  - Urine drug screen: + Fentanyl, methamphetamines, amphetamines, THC
- She is interested in starting buprenorphine/naloxone.
- She last used fentanyl 24 hours ago, and last used meth this morning.
- She has 2 children not in her custody due to substance use.
- She is sexually active with a new romantic partner and says, "he takes care of me."

Case 1

1. **How can you, the provider, engage the patient in a conversation about sexual and reproductive health that supports reproductive autonomy?**

   a. You screen for her reproductive goals.
   - You: "Would you like to become pregnant in the next 12 months?"
   - The Patient: "I'm ok either way."

   - You: "Are you currently using any methods to avoid or delay pregnancy?"
   - The Patient: "My partner takes care of me."

Case 1

2. **If the patient expressed ambivalence about pregnancy, how would you address this with her?**
   a. Explore ambivalence using motivational interviewing techniques.
   b. Get more information about method of avoiding pregnancy.
   - *After non-judgmental discussion using MI techniques, she decides she would like to get pregnant with her partner when she is stable on buprenorphine/naloxone.*
     - *She has two children who she no longer has custody of.*
     - *One of her motivations to enter treatment is to regain custody.*
     - *She has a new partner, and they want to have a child together.*
   - *The patient has been using withdrawal for the past two years and has not conceived.*

Case 1

3. **After discussion, the patient tells you she wants to have a baby with her new partner when she is stable on suboxone but is not sure if she can get pregnant. How would you counsel the patient about her fertility? How would you counsel her on OUD treatment options?**
   a. You provide preconception counseling.
      - You discuss treatment for SUD to improve chances of entering pregnancy healthy when she is ready.
        - You discuss starting buprenorphine/naloxone and safety in pregnancy.
        - You identify and address any other risk factors that could impact a pregnancy, including STI risk.

   b. You refer for additional services if needed.

Case 1

a. You educate the patient on opioids and fertility.
   - You inform her that chronic opioid use can suppress sex hormones and lower the chance of conception.
   - You inform her that the impact of buprenorphine/naloxone (partial opioid agonist) on the ability to conceive is not well known.

b. You ask if she would like to discuss birth control method options to use while waiting to become pregnant.
   - She does not want to talk about birth control methods, stating her partner will take care of her.

Case 1

a. You review with her that condoms are the only way to prevent STIs during sexual intercourse and acknowledge her risk of STIs is low based on her reported history.
   - She states she is monogamous with her partner who does not use substances.
   - She denies transactional sex.

b. You offer her STI testing.

c. You then start buprenorphine/naloxone stabilization.

d. You continue to ask about sexual and reproductive health behaviors and goals at her future visits and address any new needs as they arise.

ADULTHOOD

Opioid Use Disorder in Pregnancy

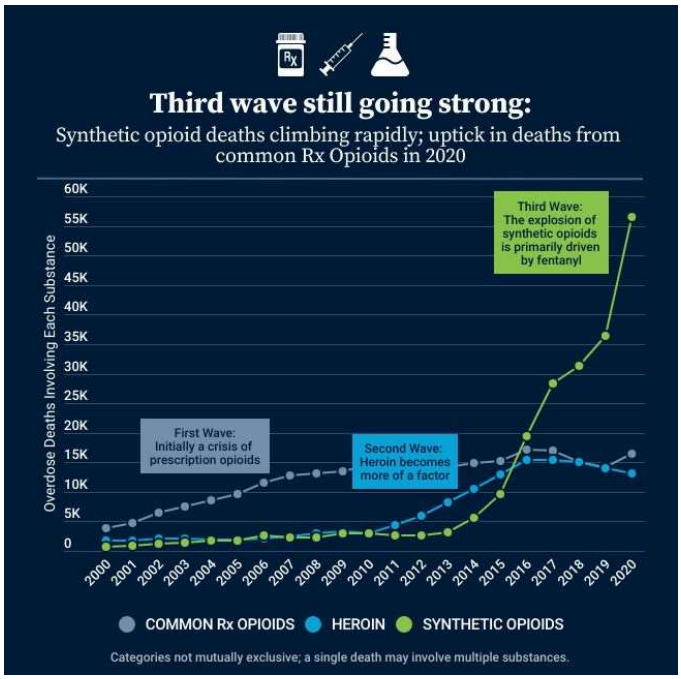
Barbara V. Parilla, MD, FACOG, FASAM
Hendrée E. Jones, PhD., L.P.
50 Minutes

Session 5
Learning Objectives

1. Analyze current public health trends related to opioid use disorder (OUD) during pregnancy.
2. Evaluate the impact of OUD on maternal and fetal health outcomes.
3. Explore evidence-based guidelines and recommendations for the screening, diagnosis, and management of OUD during pregnancy.
4. Evaluate and assess the pharmacological differences in pregnancy and options for treatment of OUD.
5. Develop strategies for assessing and addressing the safety and stability of pregnant individuals with OUD.
6. Define neonatal opioid withdrawal syndrome (NOWS), including its clinical presentation, risk factors, and diagnostic criteria, to facilitate early identification and intervention.

Trends of Opioid Use Disorder in Pregnancy

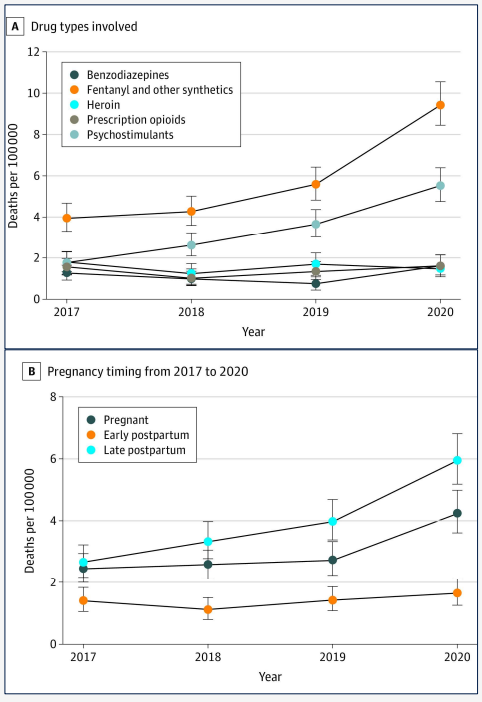
Synthetic Opioids



SOURCE: NIHCM Foundation

Pregnancy-Associated Drug Overdose Mortality

- Among pregnant and postpartum persons, drug overdose mortality increased approximately 81% from 2017 to 2020.
- Increases in drug overdose mortality were most pronounced in 2020, coinciding with the onset of the COVID-19 pandemic.
- Drug overdose deaths are now the leading cause of maternal mortality in many states.

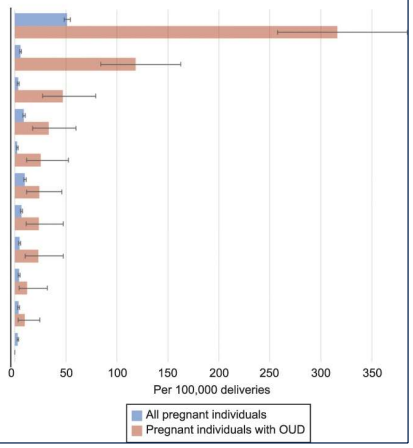


SOURCE: DOI: 10.1001/jama.2022.17045

Postpartum Opioid-Related Mortality in Patients With Public Insurance

Distribution of causes of death and cumulative incidence per 100,000 deliveries of specific causes of death by 1 year postpartum.

Cause of death	All pregnant individuals (n=4,972,061)	All pregnant individuals with OUD (n=48,902)
All deaths	51.1 (48.3, 54.1)	316 (258, 385)
Opioid overdose	5.4 (4.5, 6.4)	118 (84, 163)
Other drug and alcohol related	3.1 (2.5, 4.0)	47 (27, 79)
Other injuries	8.9 (7.8, 10.3)	33 (18, 60)
Suicide	2.4 (1.8, 3.1)	26 (12, 52)
Pregnancy and delivery	9.6 (8.6, 10.8)	24 (12, 46)
Other diseases	6.3 (5.3, 7.4)	24 (11, 47)
Circulatory	4.6 (3.8, 5.6)	23 (10, 47)
Unknown cause	4.1 (3.4, 5.0)	12 (4, 32)
Homicide	3.6 (2.9, 4.5)	9 (3, 24)
Cancer	3.0 (2.3, 3.8)	0



SOURCE: DOI: 10.1097/AOG.0000000000005115

Pregnancy and Stigma

- Stigma and punitive policies increase overdose risk by making it harder to access life-saving treatment and resources.
- Twenty-five states and Washington DC consider substance use during pregnancy to be child abuse.
- Crippling fear that their babies will be taken away also keep some pregnant people from seeking prenatal care.
- Fewer than 1 in 4 individuals with OUD receive treatment in any given month of pregnancy.

IMAGE: Linda Leshay, 2014

SOURCE: DOI: 10.1097/ADM.0000000000001241; 10.1001/jamainternmed.2023.6977; 10.1097/AOG.0000000000002235

Untreated Opioid Use Disorder and Its Risks in Pregnancy

- As a class have no proven teratogenicity.*
- Majority of risk related to the cyclic effects of withdrawal.
- Acute opioid withdrawal carries increased risk of miscarriage, placental abruption, preterm birth, and stillbirth.
- Exposure to criminal activity and incarceration.
- Increased risks of hepatitis C, HIV, bacterial infections, STDs from risky behaviors.

IMAGE: Linda Leshay, 2014

*SOURCE: DOI: 10.1186/s12884-022-04733-9

Medically Supervised Withdrawal

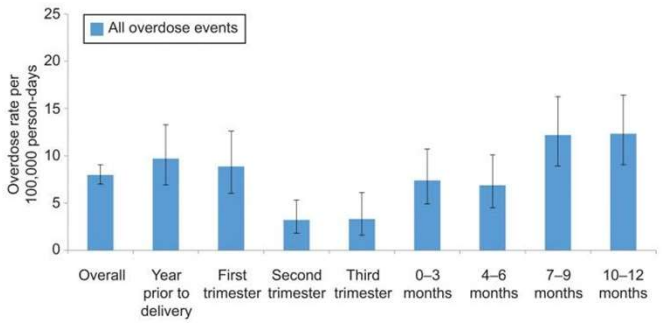
- Addiction is a chronic disease.
- Withdrawal is an acute treatment.
- Return to use rates are as high as 90%.
- Overdose deaths increase dramatically after periods of abstinence.

Consider patient preferences.

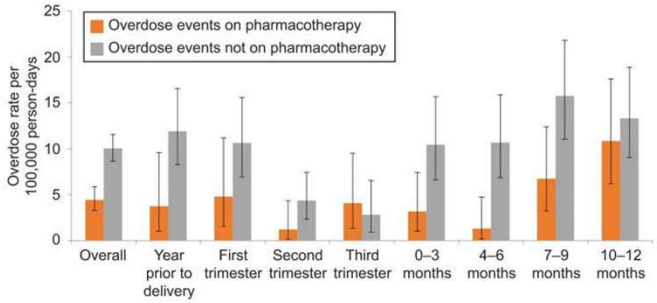
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Opioid overdose rates among pregnant and parenting women with evidence of opioid use disorder in year prior to delivery (n=4,154). All overdose events (A), stratified by receipt of pharmacotherapy during month of overdose event (B). Error bars represents 95% CIs. First trimester defined at 0–12 weeks of gestation, second trimester defined as 13–28 weeks of gestation, and third trimester defined as ≥29 weeks of gestation.

SOURCE: DOI: 10.1097/AOG.0000000000002734



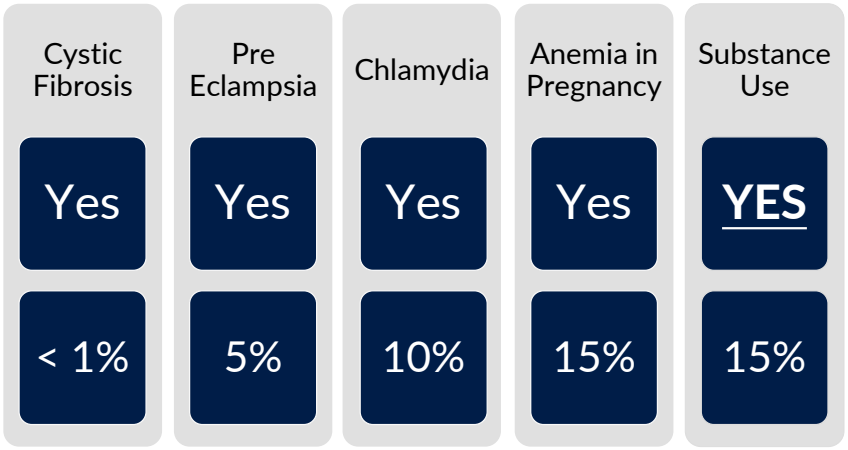
A



B

Screening for Opioid Use Disorders in Pregnancy

Are You Screening for Opioids?



In 2016, **15%** of women had used illicit substances in the past year.

SOURCE: Center for Behavioral Health Statistics and Quality.(2017). 2016 National Survey on Drug Use and Health: Detailed Tables, SAMHSA

SBIRT

Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.

Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

- Need universal screening of all women of childbearing age
- Screening tools-5Ps, NIDA quick screen
- Conversation, not just the tool
- Not urine drug testing to screen

SOURCE: SAMHSA, Clinical Practice, SBIRT

Patient Perceptions of Three Substance Use Screening Tools for Use During Pregnancy

- 493 cognitive interviews were completed with a diverse sample of pregnant women presenting to two obstetrics practices in Baltimore, MD, from January 2017 to January 2018.
- Participants reported they preferred the 4P's Plus (43.4%) vs. the NIDA Quick Screen (32.5%) vs. the SURP-P (24.1%).
- They felt that the 4P's Plus was both comprehensive and concise.
- They also suggested that when screening is confidential, includes questions about a patient's background, and administered by a non-judgmental provider, pregnant people may be more likely to answer honestly.

SOURCE: DOI: 10.1007/s10995-022-03442-1

Urine Drug Testing

- Limited utility in making an SUD diagnosis
- No information on the frequency or intensity of use
- **May discourage pregnant people from seeking and engaging in care**
- May have value for patient monitoring in SUD treatment programs
- **Permission should be obtained**

Drug	Duration of Detectability in Urine	Drugs Causing False-positive Preliminary Urine Screens
Amphetamines	2 to 3 days	Ephedrine, pseudoephedrine, phenylephrine, selegiline, chlorpromazine, trazadone, bupropion, desipramine, amantadine, ranitidine
Cocaine	2 to 3 days	Topical anesthetics containing cocaine
Marijuana	1 to 7 days (light use); 1 month with chronic moderate to heavy use	Ibuprofen, naproxen, dronabinol, efavirenz, hemp seed oil
Opiates	1 to 3 days	Rifampin, fluoroquinolones, poppy seeds, quinine in tonic water
Phencyclidine	7 to 14 days	Ketamine, dextromethorphan

SOURCE: Adapted from: Tests for drugs of abuse. *Med Lett Drugs Ther.* 2002;44(1137):71-73.

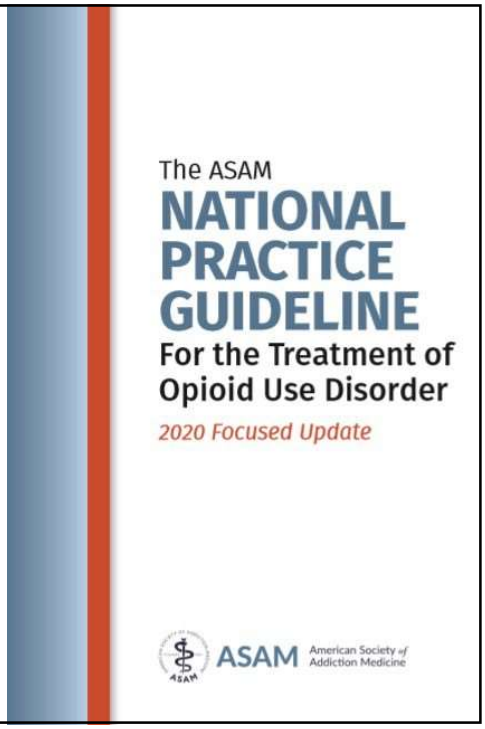
Medication Options

New and Major Revisions

A medical examination and psychosocial **assessment** are recommended when evaluating pregnant women for opioid use disorder. **Completion** of all assessments **should not delay or preclude** initiating pharmacotherapy for opioid use disorder.

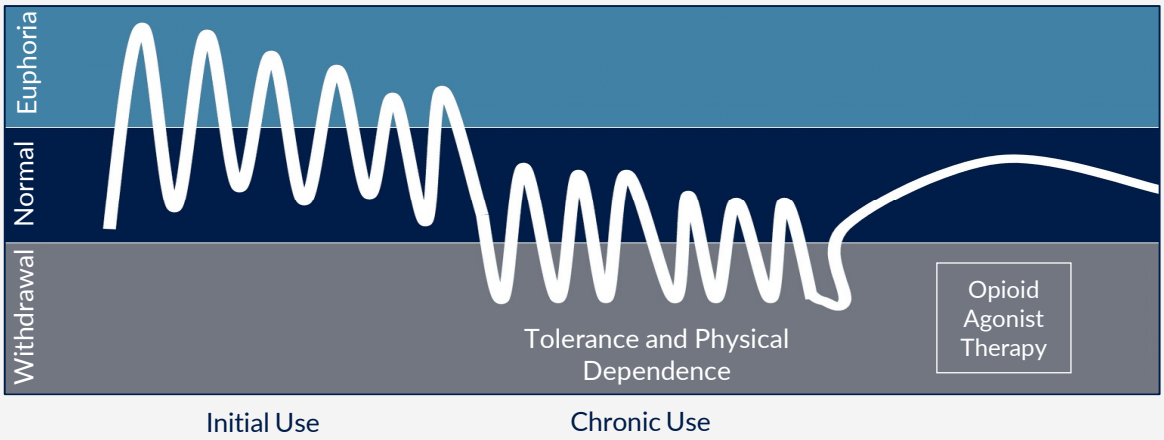
If not completed before initiating treatment, assessments should be completed as soon as possible thereafter.

Rationale:
Since patients with opioid use disorder are at risk for significant harm – including overdose and overdose death – a delay in completion of each assessment should not delay treatment.



Medications for Opioid Use Disorder (MOUD)

Methadone and Buprenorphine



Adapted From Dole et al., 1996. DOI: 10.1001/archinte.1966.00290160004002

Pregnancy: Benefits of MOUD

Maternal Benefits

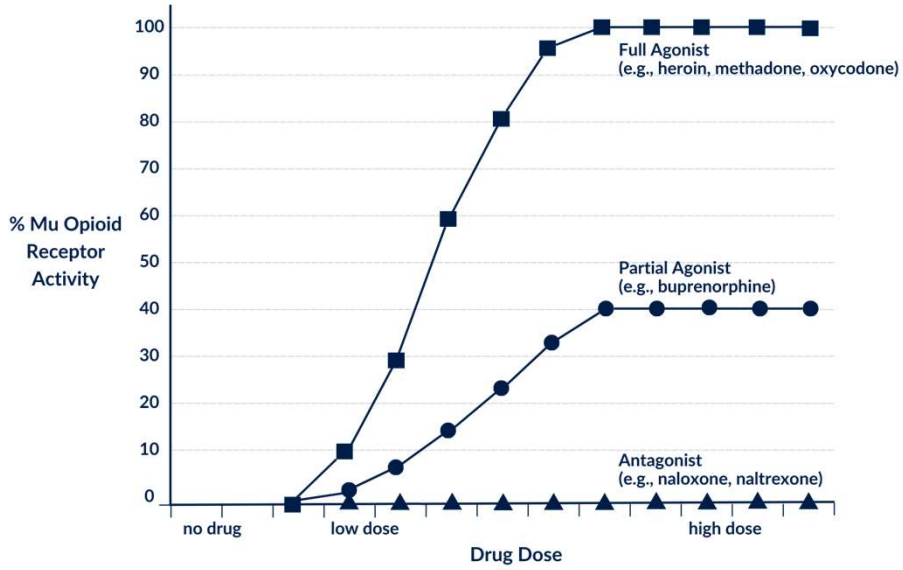
- 70% reduction in overdose related deaths
- Decrease in risk of HIV, HBV, HCV
- Increased engagement in prenatal care and treatment

Fetal Benefits

- Reduces fluctuations in maternal opioid levels, thus reducing fetal stress*
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

SOURCE: 10.1097/ADM.0000000000000308; *10.1016/0002-9378(75)90613-4

Opioid Agonists and Antagonists

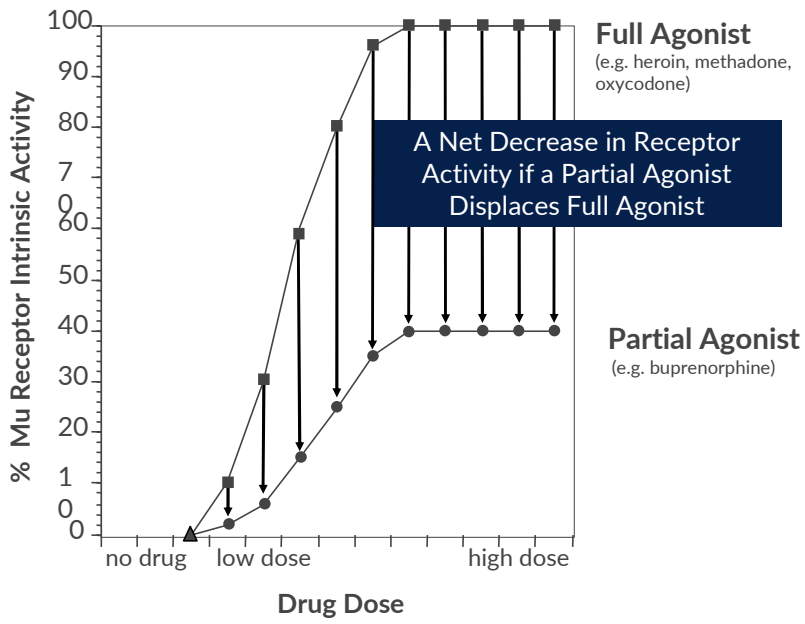


Precipitated Withdrawal

Buprenorphine is a Partial Agonist

Buprenorphine will precipitate withdrawal when it displaces full agonist off the Mu receptors.

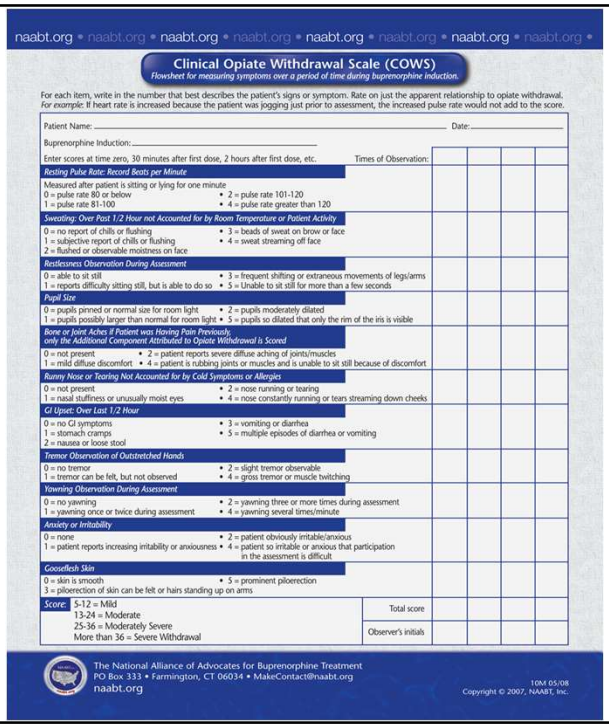
HIGH AFFINITY = SLOW DISSOCIATION



Buprenorphine
Standard Dosing

- Buprenorphine initiated when there are objective signs of opioid withdrawal (COWS > 10-12).
- Start with a dose of 2 to 4 mg.
- Dosages may be increased in increments of 2 to 8 mg.
- Hospitalize in 3rd trimester.
- Can give oxycodone or additional buprenorphine for precipitated withdrawal.
- Adjuvant/supportive medications: Tylenol, Hydroxyzine, Loperamide, Ondansetron, Cyclobenzaprine, Clonidine

SOURCE: DOI: 10.1080/02791072.2003.10400007



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Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. *For example:* If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc. Times of Observation: | | | | |

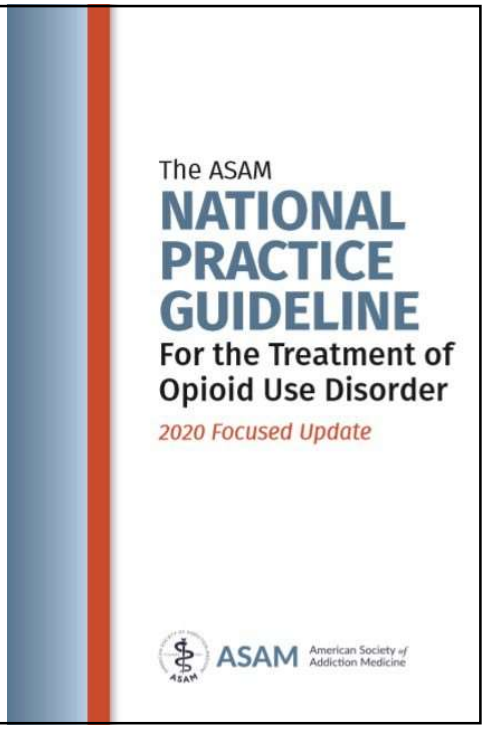
Resting Pulse Rate: Record Beats per Minute				
Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below • 2 = pulse rate 101-120 1 = pulse rate 81-100 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity				
0 = no report of chills or flushing • 3 = beads of sweat on brow or face 1 = subjective report of chills or flushing • 4 = sweat streaming off face 2 = flushed or observable moistness on face				
Restlessness Observation During Assessment				
0 = able to sit still • 3 = frequent shifting or extraneous movements of legs/arms 1 = reports difficulty sitting still, but is able to do so • 5 = Unable to sit still for more than a few seconds				
Pupil Size				
0 = pupils pinned or normal size for room light • 2 = pupils moderately dilated 1 = pupils possibly larger than normal for room light • 5 = pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches: If Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored				
0 = not present • 2 = patient reports severe diffuse aching of joints/muscles 1 = mild diffuse discomfort • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies				
0 = not present • 2 = nose running or tearing 1 = nasal stuffiness or unusually moist eyes • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour				
0 = no GI symptoms • 3 = vomiting or diarrhea 1 = stomach cramps • 5 = multiple episodes of diarrhea or vomiting 2 = nausea or loose stool				
Tremor Observation of Outstretched Hands				
0 = no tremor • 2 = slight tremor observable 1 = tremor can be felt, but not observed • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment				
0 = no yawning • 2 = yawning three or more times during assessment 1 = yawning once or twice during assessment • 4 = yawning several times/minute				
Anxiety or Irritability				
0 = none • 2 = patient obviously irritable/anxious 1 = patient reports increasing irritability or anxiousness • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin				
0 = skin is smooth • 5 = prominent piloerection 3 = piloerection of skin can be felt or hairs standing up on arms				
Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal	Total score			
	Observer's initials			

The National Alliance of Advocates for Buprenorphine Treatment
PO Box 333 • Farmington, CT 06034 • MakeContact@naabt.org
naabt.org

10M 05/08

Buprenorphine

- In pregnancy, buprenorphine (Subutex) initially favored over buprenorphine/naloxone (Suboxone) combination.
- Lack of data combination product, concerns naloxone may produce maternal & fetal hormonal changes.
- **The combination buprenorphine/naloxone product is frequently used in pregnancy and is considered safe and effective.** Naloxone is minimally absorbed when these medications are taken as prescribed.



Fentanyl and Norfentanyl Elimination

Fast onset and high potency

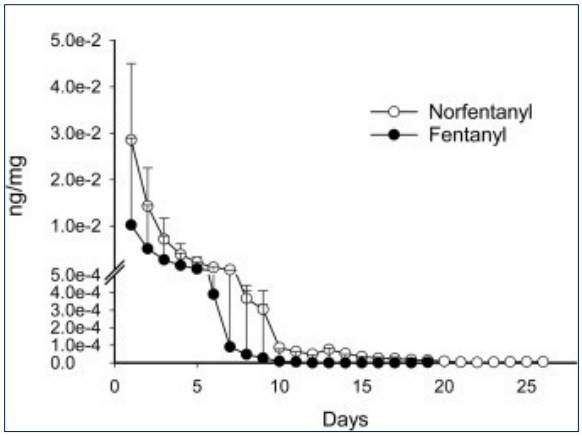
- Fentanyl rapidly crosses the blood-brain barrier.
- 50-100X more potent than morphine

Short action

- Fentanyl levels rapidly decline due to redistribution to body fat

Sequestration leads to fentanyl accumulation.

- Chronic use causes accumulation in adipose tissue.
- Unknown changes to withdrawal course



SOURCE: DOI: 10.1097/ADM.0000000000001185

Buprenorphine Low Dose Initiation (Microdosing)

- Patients are instructed to take their usual amounts of opiates on days 1-6.
- Stop all opiates on day 7, and take your total dose of buprenorphine 12 mg in the am.
- Take an additional 4 mg of buprenorphine for a total dose of 16 mg on Day 7.

Day	Total dose
1	0.25 mg
2	0.5 mg
3	1 mg
4	2 mg
5	4 mg
6	8 mg
7	12 mg

SOURCE: DOI: 10.1186/s13722-020-0177-x; 10.1055/a-2250-6419

ASAM Clinical Considerations

Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids

	Fastest		Slowest
Initiation Strategy	**High-dose Buprenorphine (macrodosing)**	**Standard**	**Low-dose Buprenorphine with Opioid Continuation (microdosing)**
Possible advantages	• Quick stabilization • Bridge access barriers to ongoing buprenorphine	• Most common and well-described technique	• Opioid abstinence not initially required
Need for opioid withdrawal?	Yes	Yes	No
Premedicate with adjuvant medications?	Consider	Yes	Yes
Initial starting dose* (buprenorphine SL formulation)	8–16+ mg	2-8 mg	0.25 mg–1 mg
Duration of initiation until stabilization	≤2 h	1–3 days	3–10 d (may be longer in certain situations)
Need for opioid continuation	No	No	Yes
Full agonist opioid continuation dose	None	None	Examples: Methadone 30 mg PO daily or Hydromorphone 4 mg PO every 4 hr or Self-directed illicit/nonprescribed opioid use
Care coordination required	Moderate	Moderate	High

Adjuvant medications include clonidine, hydroxyzine, acetaminophen, and NSAIDs
*This refers to the initial dose only. The total daily dose on day 1 and subsequent days is likely more than this initial dose.

SOURCE: Journal of Addiction Medicine. July 28, 2023

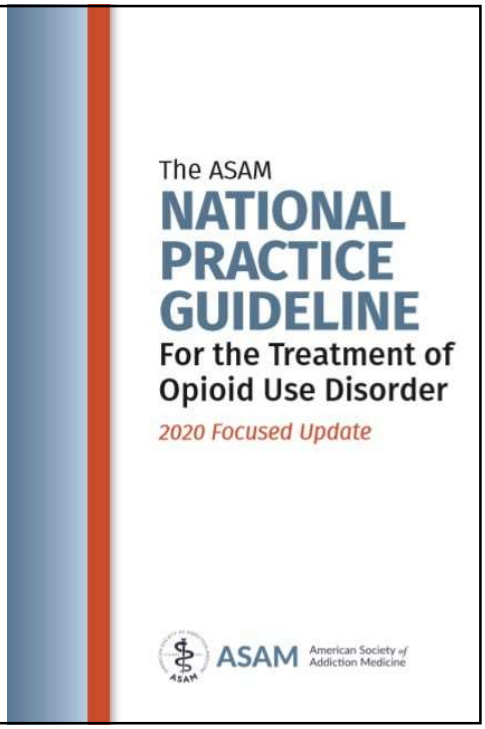
Methadone Major Revision

Methadone should be initiated at a dose range of 10 to 30 mg. Incremental doses of 5 to 10 mg is recommended every 3 to 6 hours, as needed, to treat withdrawal symptoms, to a maximum first day dose of 30 to 40 mg.

After initiation, clinicians should increase the methadone dose by **no more than 10 mg approximately every 5 days.** The goal is to maintain the lowest dose that controls withdrawal symptoms and minimizes the desire to use additional opioids.

Transitioning from buprenorphine to methadone does not pose a risk of precipitated withdrawal.

Long QT syndrome and Ondansetron



MOTHER Study

Randomized Trial of Methadone vs. Buprenorphine

Primary Outcome: NAS

- Similar prevalence of treatment for NAS
- Less neonatal abstinence severity and treatment (Bup)
- Shorter neonatal LOS (Bup)
- Bigger HC

Table 2. Primary and Secondary Outcomes in the Methadone and Buprenorphine Groups.*

Outcome	Methadone (N=73)	Buprenorphine (N=58)	Odds Ratio (95% CI)	P Value
Primary outcomes				
Treated for NAS — no. (%)	41 (57)	27 (47)	0.7 (0.2–1.8)	0.26
NAS peak score	12.8±0.6	11.0±0.6		0.04
Total amount of morphine for NAS — mg	10.4±2.6	1.1±0.7		<0.0091†
Duration of infant's hospital stay — days	17.5±1.5	10.0±1.2		<0.0091†
Infant's head circumference — cm	33.0±0.3	33.8±0.3		0.03
Secondary neonatal outcomes				
Duration of treatment for NAS — days	9.9±1.6	4.1±1.0		<0.003125†
Weight at birth — g	2878.5±66.3	3093.7±72.6		0.03
Length at birth — cm	47.8±0.5	49.8±0.5		0.005
Preterm, <37 wk — no. (%)	14 (19)	4 (7)	0.3 (0.1–2.0)	0.07
Gestational age at delivery — wk	37.9±0.3	39.1±0.3		0.007
Apgar score				
1 min	8.0±0.2	8.1±0.2		0.87
5 min	9.0±0.1	9.0±0.1		0.69

SOURCE: DOI: 10.1056/NEJMoa1005359

MOTHER Study

Randomized Trial of Methadone vs. Buprenorphine

Secondary Outcomes

- Bigger neonates (Bup)
- No difference preterm birth
- Longer gestational age (Bup)

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5 min	9.0±0.1	9.0±0.1		0.69

SOURCE: DOI: 10.1056/NEJMoa1005359

MOTHER Study

Randomized Trial of Methadone vs. Buprenorphine

Secondary Measures: Maternal Outcomes

- Fewer medical/ delivery complications (Bup)
- Increased % of women randomized to buprenorphine did not complete the study

Table 2. Primary and Secondary Outcomes in the Methadone and Buprenorphine Groups.*

Outcome	Methadone (N=73)	Buprenorphine (N=58)	Odds Ratio (95% CI)	P Value
Secondary maternal outcomes				
Cesarean section — no. (%)	27 (37)	17 (29)	0.6 (0.2–2.0)	0.23
Maternal weight gain — kg	8.6±1.0	8.3±0.9		0.80
Abnormal fetal presentation during delivery — no. (%)	10 (14)	3 (5)	0.3 (0.0–2.4)	0.09
Analgesia during delivery — no. (%)	60 (82)	49 (85)	1.1 (0.3–4.8)	0.85
Positive drug screen at delivery — no. (%)	11 (15)	5 (9)	0.5 (0.1–2.7)	0.27
Medical complications at delivery — no. (%)	37 (51)	18 (31)	0.5 (0.2–0.9)	0.03
Did not complete study — no. (%)	16 (18)	28 (33)	2.6 (1.3–5.6)	0.02
Amount of voucher money earned for drug-negative tests — U.S. $	1,570.00±121.72	1,391.39±123.59		0.31
No. of prenatal obstetrical visits	8.8±0.5	8.7±0.4		0.86

SOURCE: DOI: 10.1056/NEJMoa1005359

The NEW ENGLAND JOURNAL of MEDICINE

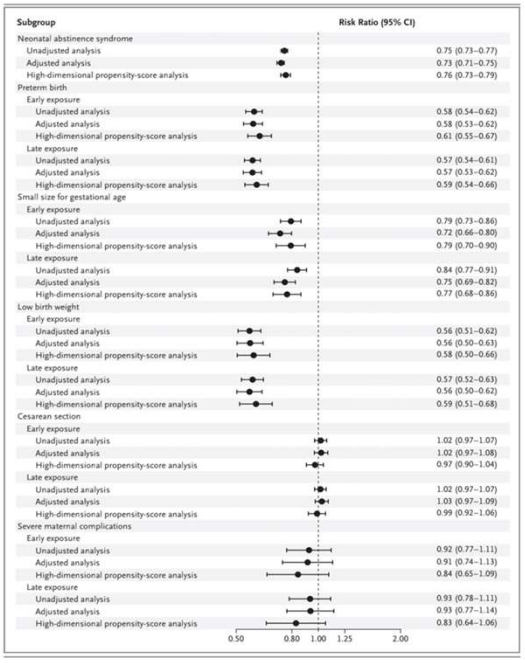
ORIGINAL ARTICLE

Buprenorphine versus Methadone for Opioid Use Disorder in Pregnancy

E.A. Suarez, K.F. Huybrechts, L. Straub, S. Hernández-Díaz, H.E. Jones, H.S. Connery, J.M. Davis, K.J. Gray, B. Lester, M. Terplan, H. Mogun, and B.T. Bateman

SOURCE: DOI: 10.1056/NEJMoa2203318

Buprenorphine vs. Methadone for Opioid Use Disorder in Pregnancy



Pharmacological Differences in Pregnancy

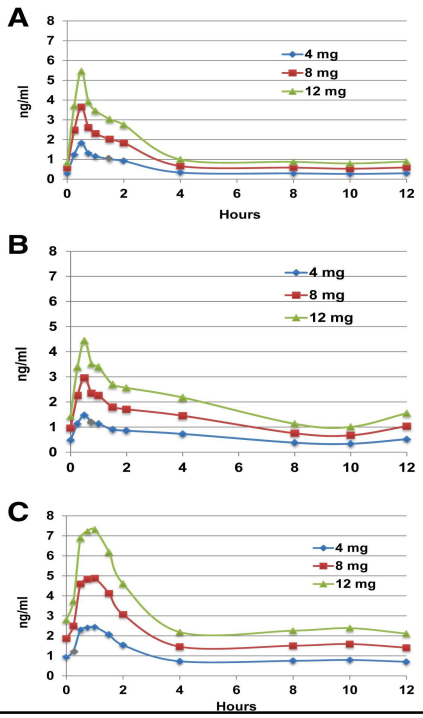
Median Buprenorphine Concentrations in Pregnancy

Median buprenorphine concentrations according to dose in second (A) and third trimesters (B) and postpartum period (C) after sublingual dose of 4, 8, or 12 mg BID. All subjects were at steady state.

Volume of distribution and metabolism increases

Can expose mother and fetus to episodic withdrawal

Split dosing in pregnancy



SOURCE: DOI: 10.1016/j.ajog.2017.06.029

Maternal Dose and NOWS Severity

No correlation between maternal opioid maintenance therapy dose and the duration or severity of NOWS.

Women should be encouraged to report any symptoms of withdrawal through her pregnancy without fear a dose increase will affect her baby's hospital stay or need for NOWS treatment.

Tobacco use is strongly associated with NOWS and NOWS severity.

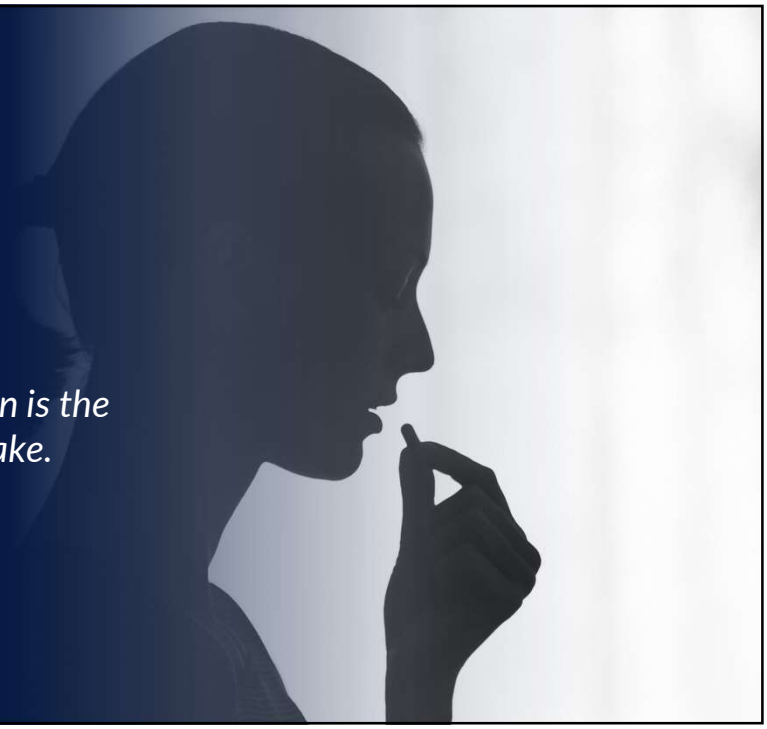
SOURCE: DOI: 10.1067/S0002-9378(03)00520-9; 10.1038/jp.2010.66; 10.1056/NEJMoa1005359; 10.1111/j.1360-0443.2010.03120.x; 10.1016/j.ajog.2005.03.072; 10.1097/ADM.0000000000000099; 10.1016/j.ajog.2009.04.013

Summary of Outcomes

Summary of Outcomes MEANING IS UNCLEAR	FAVORS Methadone	EQUIVALENT	FAVORS Buprenorphine
Maternal			
Treatment efficacy	Failed treatment in past	X	Reasonable first line therapy
Access to treatment			X
Retention	X		
Does not require withdrawal for initiation	X		
Treatment automatically coordinated	X		
Maternal medical complications			X
Neonatal			
Long-term outcome data		X*	
Birthweight			X
Gestational age			X
% requiring NAS treatment		X	
Severity of NAS symptoms			X
Duration of NAS treatment			X

Methadone and Buprenorphine

The best medication option is the one that the patient will take.



Emerging Treatments

Long-acting Injectable Buprenorphine

- Clinical studies demonstrated LAI-B medications:
  - Suppression of opioid withdrawal
  - Suppression of illicit opioid use
- Similar side effect profile as SL buprenorphine with the addition of injection site reactions (typically mild)
- **Potential to enhance access to care across the entire continuum of healthcare services** (difficult transitions; ER, leaving hospital, jail, unstable living situations, transportation, addiction to injections)
- Pregnant women and newborns ?? Better outcomes from steady state. NIDA clinical trial underway- weekly during pregnancy

DOI:10.1001/jamainternmed.2018.1052

Differences Between Sublocade® and Brixadi®

Both are long-acting subcutaneous (SC) (under the skin) buprenorphine injections that may be used for the maintenance treatment of opioid misuse disorder in adults.

Sublocade®

- Approved on November 30, 2017
- Monthly injection NMP 278 & 833 mg

Brixadi®

- Approved on May 23, 2023
- Weekly ethanol 16-61 mg (1 drink 14 g)

Subcutaneous Monthly Sublocade® Injection Transition Doses for Patients Whose Disease Symptoms Are Controlled

BUP-Sublingual Transition Doses	Sublocade Injection #1	Sublocade Injection #2	Maintenance Dose
8-18 mg/day	300 mg (1.5 mL)	100 mg (0.5 mL)	100 mg
20-24 mg/day	300 mg	300 mg	100 mg
If new- after 7 day Lead of ≥8 mg daily	300 mg	300 mg	100 mg
	Brixadi (Weekly)	**Brixadi (Monthly)**	
BUP-Sublingual	**Brixadi Weekly (rotate sites)**	**Brixadi Monthly**	
≤ 6 mg	8 mg	–	
8 - 10 mg	16 mg	64 mg	
12 - 16 mg	24 mg	96 mg	
18 - 24 mg	32 mg	128 mg	
If new to buprenorphine	Use arms only after 4 weekly doses. Can initiate on day 1 after a 4mg SL dose, then 16 mg same day without option of additional 8 mg if needed.		

SOURCE DOI: 10.14740/jcgo919

Naltrexone for OUD

- Non-selective opioid receptor antagonist that in therapeutic doses blocks the euphoric effects of opioids
- Used in non-pregnant patients with OUD in effort to maintain abstinence
- Approved injectable LA more effective than placebo in maintaining abstinence.
- **Naltrexone has been shown to be as effective as buprenorphine against opioid craving and retention**.
- Limited experience in pregnancy, but initial reports favorable*
- For women already on prior to pregnancy-continuation vs. risk of relapse with discontinuation

IMAGE: S Abbas Shobeiri, MD

SOURCE: DOI: 10.1111/j.1360-0443.2012.03811.x;
*DOI:10.1016/j.ajog.2019.07.037; DOI: 10.1097/AOG.0000000000005510

Requirements
Naltrexone for OUD

- No need for pain relief
- Abstain from all opiates for 3-10 days (short acting/long acting opiates)
- Two negative UDS for opiates 7 days apart
- Start naltrexone 50 mg orally daily.
- Consider Vivatrol® (naltrexone 380 mg) monthly IM injections if ≤32 weeks of gestation.
- At 36 weeks switch to daily oral naltrexone 50 mg to minimize pain control issues peripartum.
- If delivery occurs less than 4 weeks from Vivatrol® injection, rely on non-opiate pain control with NSAIDs (including Ketorolac), Tylenol, and peripheral nerve blocks. Consider gabapentin as a rescue analgesic for select patients with severe post-CD pain.

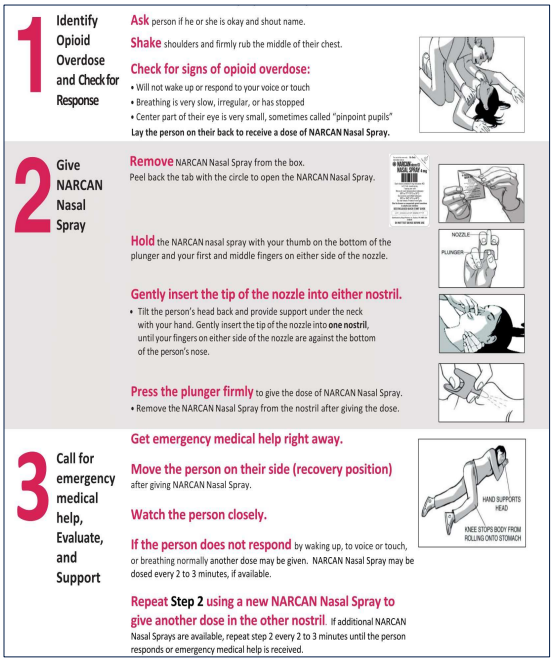
SOURCE: DOI: 10.1001/jamapsychiatry.2017.3206; 10.1016/S0140-6736(17)32812-X

Safety and Stabilization

Treatment of Overdose Narcan Nasal Spray

- Intranasal naloxone significantly increases the odds of surviving opioid overdose (OR = 8.6, 95% CI, 3.9 – 13.3).
- Communities that trained more than 100 people/100,000 in the use of intranasal naloxone had a 46% reduction in opioid death rates.
- Reports of fentanyl overdoses requiring multiple doses of naloxone
- These cases may represent opioid overdoses involving other respiratory depressants not reversed by naloxone.

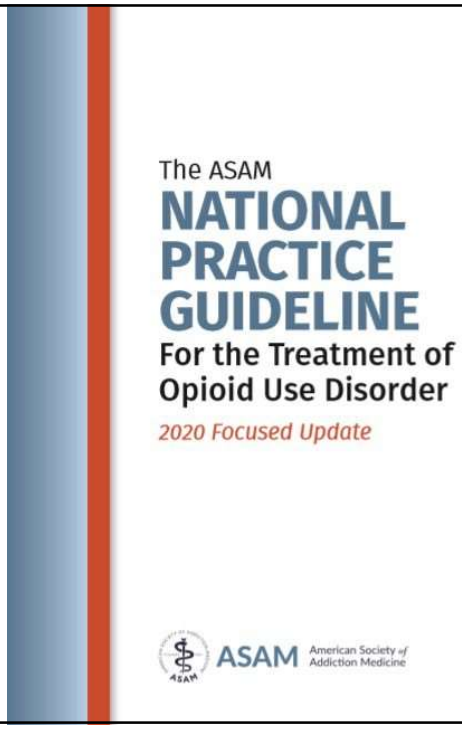
SOURCE: DOI: 10.1001/jama.2023.23248



Treatment of Overdose

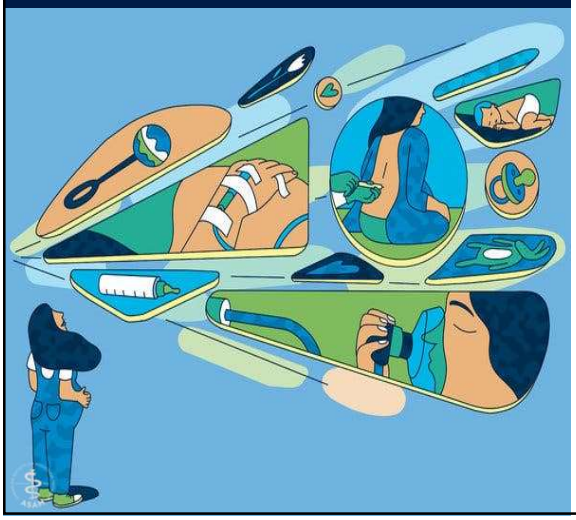
Summary of Recommendations:
Naloxone for the Treatment of Opioid Overdose

1. **MAJOR REVISION:** Naloxone should be administered in the event of a suspected opioid overdose.
2. **MINOR REVISION: Naloxone may be administered to pregnant women in cases of overdose to save the mother's life.**
3. **MINOR REVISION:** Patients who are being treated for opioid use disorder (as well as people with a history of opioid use disorder leaving incarceration) and their family members/significant others should be given naloxone kits or prescriptions for naloxone. Patients and family members/significant others should be trained in the use of naloxone in overdose.
4. The Guideline Committee, based on consensus opinion, recommends that first responders such as emergency medical services personnel, police officers, and firefighters be trained in and authorized to carry and administer naloxone.



Pain Management

Pain Management
Intrapartum



- Maintain on daily dose medication (buprenorphine, methadone, opioid).
  - Prevent withdrawal/baseline requirement.
  - Additional opioid agonists can be added as needed for pain relief.
- Neuraxial anesthesia (epidural or CSE) as soon as desired
- Avoid partial agonists (nalbuphine or butorphanol) as may precipitate withdrawal.

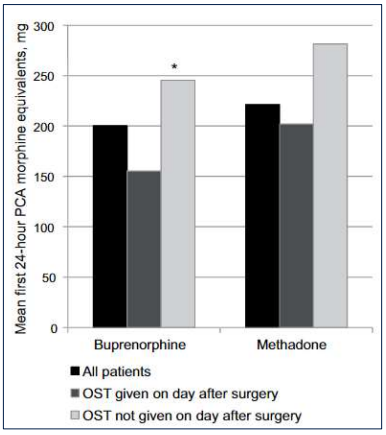
SOURCE: DOI: 10.1097/ADM.0000000000000339

Pain Relief and Opioid Requirements in the First 24 Hours After Surgery in Patients Taking Buprenorphine and Methadone

Myth: buprenorphine products will block full opioid agonist pain medications (oxycodone, morphine, etc.).

Truth: People whose MOUD was discontinued required higher doses of morphine PCA postoperatively.

Recommendation: Continue MOUD and add appropriate pain medications.



Comparison of PCA opioid requirements in buprenorphine and methadone opioid substitution therapy patients. *The mean PCA morphine equivalent dose was significantly higher (P=0.02) in patients who did not receive buprenorphine the first day after surgery compared with those who did. PCA = patient-controlled analgesia, OST = opioid substitution therapy.

SOURCE: DOI: 10.1177/0310057X1304100212

Pain Management
Postpartum

- Multimodal
  - Scheduled Tylenol, NSAIDS
  - Consider epidural morphine or hydromorphone prior to catheter removal (significant laceration repair or complicated delivery).
- Additional opioids prn, not ordered routinely.
- Split daily buprenorphine or methadone.
  - Half-life for pain much shorter than for withdrawal.

SOURCE: DOI: 10.1097/ADM.0000000000000339

Neonatal Opioid Withdrawal Syndrome (NOWS)

Neonatal Opioid Withdrawal Syndrome (NOWS)

- A risk for all opioid exposed babies
- Dose independent
- Dysfunction of the autonomic nervous system, GI tract and respiratory system
- Occurs in 30-80% of infants with intrauterine exposure to opioid maintenance therapy
- Onset: majority present within 72 hours after delivery
- Duration: Several days to weeks (prolonged if exposed in-utero to more than one substance associated with NOWS)

IMAGE: S Abbas Shobeiri, MD

SOURCE: DOI: 10.1016/j.pcl.2018.12.006, 10.1097/ADM.0000000000000099

NOWS Management

Non-Pharmacologic Approaches

- Quiet dimly lit room, handled gently, swaddling, pacifier, gentle rocking
- Rooming In by keeping mother and baby together - reduction in NAS length of stay and cost
- Non-insertive acupuncture
- Breastfeeding is recommended, as it sooths agitated infants

Pharmacotherapy

- Oral morphine is preferred first-line medication

SOURCE: 10.1186/1940-0640-9-19

Eat, Sleep, Console Approach or Usual Care for Neonatal Opioid Withdrawal

- Cluster-randomized, controlled trial at 26 U.S. hospitals, infants with neonatal opioid withdrawal syndrome who had been born at ≥36 weeks' gestation
- Hospitals transitioned from usual care that used the Finnegan tool to the Eat, Sleep, Console approach.
- The primary outcome was the time from birth until medical readiness for discharge.
- Safety outcomes included in-hospital safety, unscheduled health care visits, and nonaccidental trauma or death first 3 months.

SOURCE: DOI: 10.1056/NEJMoa2214470

Primary, Secondary, and Safety Outcomes

Outcome	Unadjusted Analysis (95% CI)*		Adjusted Analysis (95% CI)†			
	Usual Care	Eat, Sleep, Console	Usual Care	**Eat, Sleep, Console**	**Absolute Difference**	Estimated Effect
Primary outcome						
Mean time until medical readiness for discharge — days‡	15.3 (13.3 to 17.3)	8.0 (7.0 to 9.0)	14.9 (13.1 to 16.7)	8.2 (7.2 to 9.2)	6.7 (4.7 to 8.8)	Rate ratio, 0.55 (0.46 to 0.65)
Secondary outcomes						
Mean length of hospital stay — days§	13.9 (12.5 to 15.3)	7.8 (7.0 to 8.5)	14.0 (12.7 to 15.3)	7.8 (7.1 to 8.5)	6.2 (4.6 to 7.7)	Rate ratio, 0.56 (0.49 to 0.64)
Percent who received pharmacologic therapy§	53.6 (45.9 to 61.3)	19.2 (14.0 to 24.4)	52.0 (45.4 to 58.7)	19.5 (14.9 to 24.2)	32.5 (25.9 to 39.0)	Relative risk, 0.38 (0.30 to 0.47)
Mean time until initiation of opioid replacement — hr¶	53.0 (49.1 to 56.8)	71.4 (61.5 to 81.3)	53.0 (48.7 to 57.3)	76.0 (63.0 to 89.0)	23.0 (8.1 to 37.9)	Rate ratio, 1.43 (1.16 to 1.77)
Percent who received adjuvant therapy‖	21.6 (9.3 to 33.9)	15.6 (5.8 to 25.3)	19.4 (8.5 to 30.4)	15.7 (5.5 to 25.8)	3.7 (−9.8 to 17.3)	Relative risk, 0.81 (0.37 to 1.76)
Total opioid dose before discharge — mg/kg¶	6.9 (4.7 to 9.1)	5.2 (3.2 to 7.2)	7.5 (5.0 to 10.1)	5.3 (3.2 to 7.4)	2.3 (−0.4 to 4.9)	Rate ratio, 0.70 (0.46 to 1.06)
Maximum percentage weight loss — %§	7.5 (7.1 to 7.9)	8.0 (7.5 to 8.4)	7.6 (7.2 to 8.0)	8.0 (7.5 to 8.4)	0.4 (−0.3 to 1.0)	NA**
Feeding type at discharge — %††						
Exclusive maternal breast milk	6.6 (2.8 to 10.4)	13.9 (7.7 to 20.1)	6.3 (2.7 to 9.8)	12.1 (7.2 to 17.1)	5.9 (−0.4 to 12.1)	Relative risk, 1.94 (0.94 to 3.99)
Combination of formula and maternal breast milk	25.6 (18.4 to 32.9)	32.1 (23.6 to 40.5)	26.5 (18.7 to 34.2)	31.3 (23.6 to 39.0)	4.8 (−8.3 to 17.9)	Relative risk, 1.18 (0.75 to 1.87)
Exclusive formula	69.9 (61.4 to 78.4)	58.2 (50.6 to 65.8)	68.3 (62.2 to 74.4)	60.0 (53.2 to 66.8)	8.2 (−1.9 to 18.4)	Relative risk, 0.88 (0.75 to 1.03)
Any direct breast-feeding at discharge (%)††	19.1 (15.2 to 22.9)	35.3 (24.5 to 46.2)	19.5 (15.3 to 23.7)	32.7 (23.2 to 42.2)	13.2 (2.1 to 24.2)	Relative risk, 1.68 (1.13 to 2.48)

Safety outcome

Descriptive Summary of Safety Measures

Variable	Usual Care (N=702)	Eat, Sleep, Console Care Approach (N=603)
	number of patients (percent)	
Inpatient outcome		
Composite safety outcome†	1 (<1)	2 (<1)
Seizures	1 (<1)	0
Accidental trauma	0	2 (<1)
Outcome at 3 mo		
Composite safety outcome‡	113 (16)	86 (14)
Acute or urgent care visit	40 (6)	13 (2)
Emergency department visit	66 (9)	47 (8)
Hospitalization§	24 (3)	35 (6)
Composite critical safety outcome	5 (1)	1 (<1)
Nonaccidental trauma	4 (1)	1 (<1)
Death	2 (<1)	0

Composite Safety Outcome **16.1** (95% CI, 11.6-20.5) v **15.8** (95% CI, 12.3-19.2)

Resources

SAMHSA Advisory
Substance Abuse and Mental Health Services Administration

Evidence-Based, Whole Person Care of Pregnant People Who Have Opioid Use Disorder

SOURCE: Samhsa.gov
Publication ID: PEP23-02-01-002
Publication Date: May 2023

Key Takeaways

- OUD is a chronic illness with life-saving treatment available.
- Pregnancy is a window of opportunity to engage individuals in MOUD.
  - Start as soon as possible, continue post-partum (warm hand-off)
- Linking pregnant persons to MOUD / Recovery Services:
  - Reduces overdose deaths
  - Improves pregnancy outcomes
  - Increases # people who can parent their baby

Knowledge Check

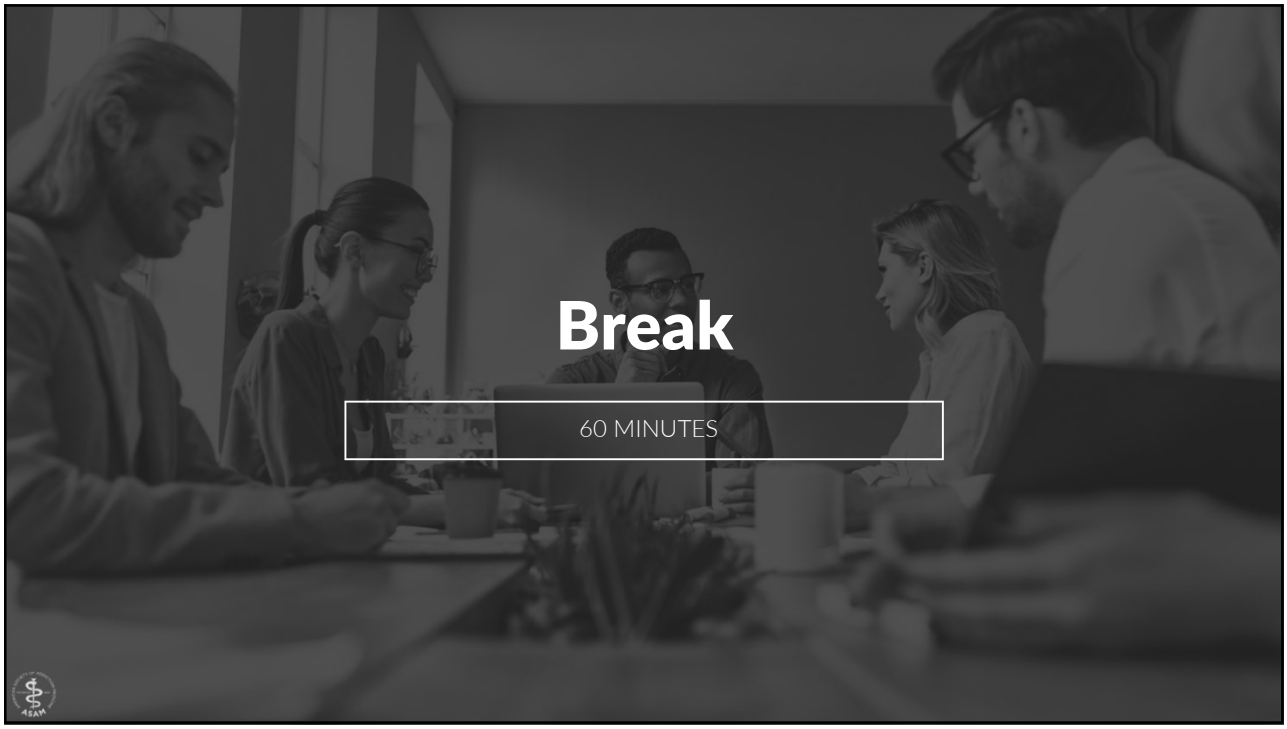
A 32-year-old at 28 weeks' gestation presents for follow-up for her opioid use disorder which is managed on buprenorphine-naloxone 16-4 mg SL daily which she takes in the morning. She states her nausea and vomiting of pregnancy has returned and is worse in the evening. She requests a prescription for Zofran which worked well for her in early pregnancy. What is the best response and course of action?

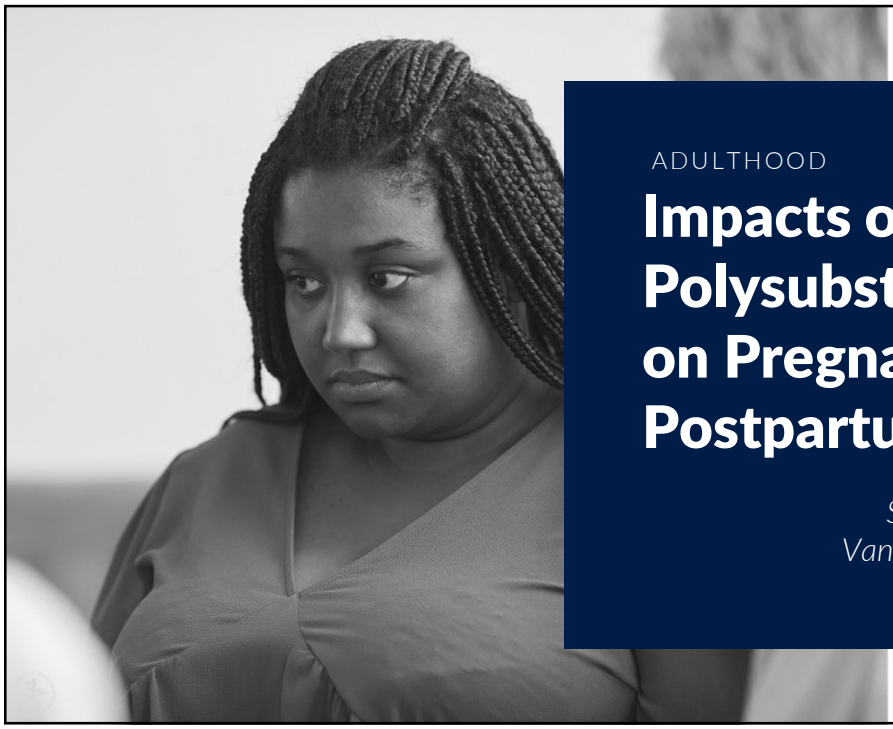
A. Prescribe Zofran as hyperemesis of pregnancy can return in the third trimester.

B. Ask about cravings and additional symptoms. Recommend split dosing, ie buprenorphine-naloxone 8-2 mg bid.

C. Increase her morning dose of buprenorphine-naloxone.

D. Discuss the importance of hydration and supportive care as this is most likely gastroenteritis.





ADULTHOOD

Impacts of Polysubstance Use on Pregnancy and Postpartum Care

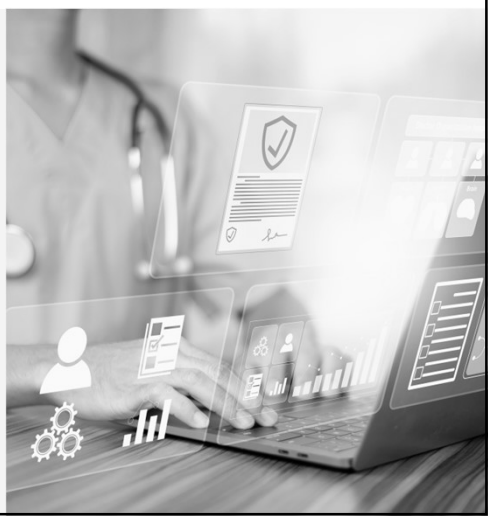
Shona Ray-Griffith, MD
Vania P. Rudolf, MD, MPH, DFASAM
50 Minutes

Session 6
Learning Objectives

1. Explore the unique challenges and considerations in providing postpartum care to patients with an SUD.
2. Identify evidence-based interventions and treatment modalities for addressing the physical, emotional, and social needs of postpartum patients with an SUD.
3. Explore communication strategies for facilitating smooth transitions of care between healthcare providers.

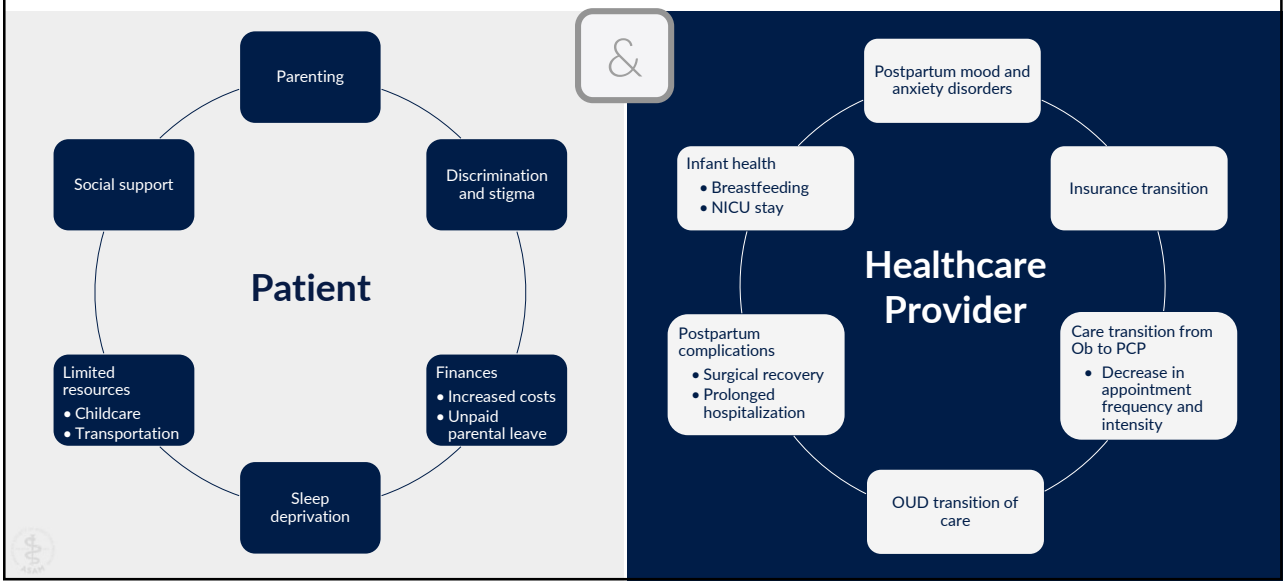
Best Practices

- Communication in patient handoff
- Risk of return to use
- Maintaining medications
- Continuation of care/transfer/discharge



Postpartum Timeline of Care: Labor & Delivery

Postpartum Period Factors to Consider



Timeline: Labor & Delivery

Labor & Delivery

Acute Postpartum Period
0-6 weeks postpartum

Extended Postpartum Period
6 weeks – 1 year postpartum

Outpatient SUD to Inpatient Pediatrician
- Breastfeeding
- Neonatal opioid withdrawal syndrome

Outpatient SUD to Inpatient OB Providers
- Continuation of medications
- Pain management
- Breastfeeding

Psychosocial Factors
- Discrimination & stigma
- Social support
- Postpartum complications
  - Surgery recovery
  - Prolonged hospitalization
- Infant health
  - NICU stay
  - Medical conditions

Risk of Return to Use in Postpartum Period

- Postpartum treatment discontinuation among birthing parents with OUD is high.
  - Methadone discontinuation before 6 months postpartum was 56%.[1]
  - Buprenorphine discontinuation at 12 weeks postpartum was 27%.[2]
  - Buprenorphine discontinuation at 6 months postpartum was 20.1%.[3]
  - Buprenorphine discontinuation at 12 months postpartum was 29.1%.[3]
- Factors associated with treatment continuation include:
  - Early access to medication & antidepressant prescription during pregnancy[3]
  - Breastfeeding[2]

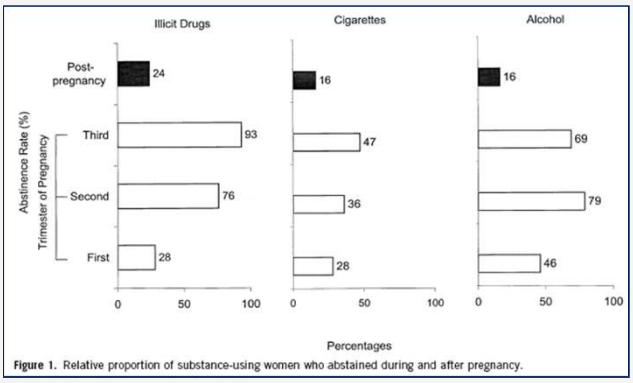
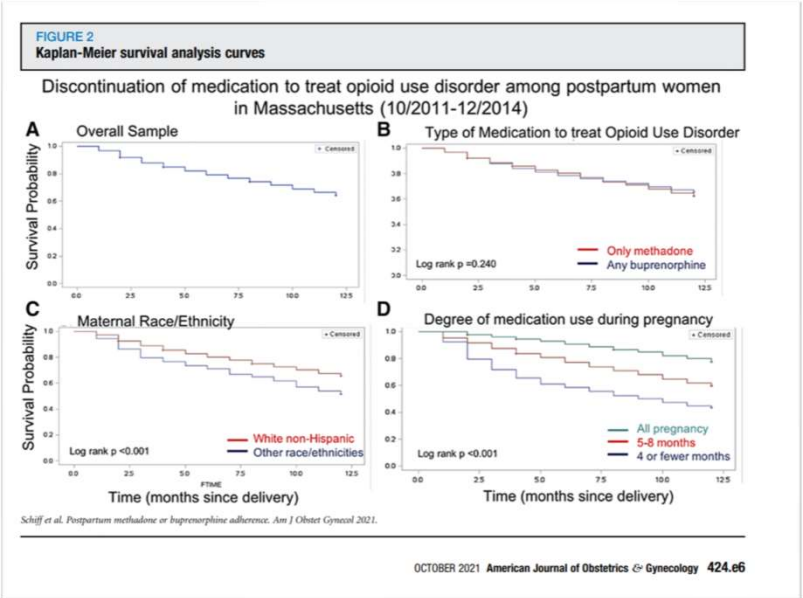


Figure 1. Relative proportion of substance-using women who abstained during and after pregnancy.

SOURCE: DOI: 10.1016/j.drugalcdep.2015.02.012[1]; 10.1111/ajad.13084[2]; 10.1016/j.jsat.2017.12.001[3]

Kaplan-Meier Survival Analysis Curves



SOURCE: DOI: 10.1016/j.ajog.2021.04.210

Risk of Return to Use

- Postpartum use of opioids is also associated with increased rates of overdose and overdose death.
  - Drug overdoses and suicide are the leading causes of maternal mortality.[1,2]
  - Recent review of Maternal Mortality Review Committees[3]:
    - Total maternal deaths from drug overdose ranged from 10.5-51.4% with a mean of 29.1%.
    - Accidental overdoses were relatively common (n=603, 31.3%).
- What to do?
  - Naloxone co-prescribing and overdose awareness education.
  - Increase frequency of visits in postpartum period.

SOURCE: DOI: 0.1016/j.ajog.2019.05.045[1] ; 10.1097/AOG.0000000000001695[2]; 10.1007/s00737-023-01334-z[3]

Proper Communication in Patient Handoff

Acute Postpartum Period
0-6 weeks postpartum

Outpatient SUD to Outpatient OB provider
- Medication adjustments
- Breastfeeding
- Postpartum complications

Medication Maintenance Postpartum

- **Goal:** Adequate dosing to stop use and block cravings.
- **Management:** Management of dose should be individualized and based on patient's symptoms.

Adjustments: Adequate dosing to stop use and block cravings:

Pregnancy

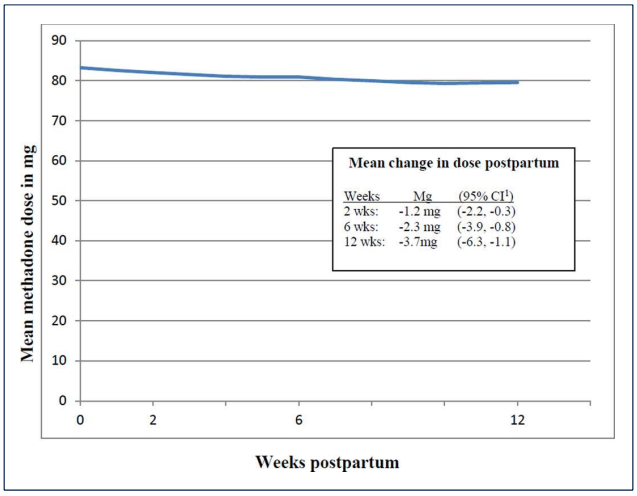
- Split dosing due to accelerated metabolic clearance in pregnancy
- Use of buprenorphine monoproduct

Postpartum

- Transition to once daily dosing
- Transition tonaloxone dual product

Postpartum Methadone Dosing

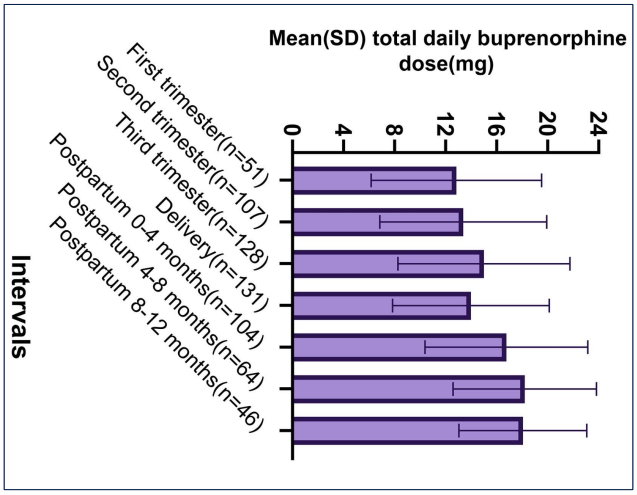
- Dose decreases were rare in first 12 weeks postpartum.
- Oversedation events were rare.



SOURCE: DOI: 10.1016/j.jsat.2014.04.004

Postpartum Buprenorphine Dosing

- Other factor: Transition monoproduct to dual product



SOURCE: DOI: 10.1007/s40501-020-00221-z

Breastfeeding

Breastfeeding

- American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for approximately six months after birth, as well as continued breastfeeding for two years or beyond.
- Medical contraindications to breastfeeding are rare.
  - Marijuana use while breastfeeding is discouraged secondary to insufficient data.
  - Alcohol: Avoid binge drinking. Occasional, limited ingestion may be acceptable (i.e., 1-2 drinks daily).
  - Tobacco use is tolerated under certain circumstances.

SOURCE: DOI: 10.1542/peds.2022-057988

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Policy Statement: Breastfeeding and the Use of Human Milk

Joan Younger Meek, MD, MS, RD, FAAP, FABM, IBCLC,* Lawrence Noble, MD, FAAP, FABM, IBCLC,[b,c] and the Section on Breastfeeding

abstract

Breastfeeding and human milk are the normative standards for infant feeding and nutrition. The short- and long-term medical and neurodevelopmental advantages of breastfeeding make breastfeeding, or the provision of human milk, a public health imperative. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for approximately 6 months after birth. Furthermore, the AAP supports continued breastfeeding, along with appropriate complementary foods introduced at about 6 months, as long as mutually desired by mother and child for 2 years or beyond. These recommendations are consistent with those of the World Health Organization (WHO). Medical contraindications to breastfeeding are rare. The AAP recommends that birth hospitals or centers implement maternity care practices shown to improve breastfeeding initiation, duration, and exclusivity. The Centers for Disease Control and Prevention (CDC) and The Joint Commission monitor breastfeeding practices in US hospitals. Pediatricians play a critical role in hospitals, their practices, and communities as advocates of breastfeeding and, thus, need to be trained about the benefits of breastfeeding for mothers and children and in managing breastfeeding.

Since the publication of the previous policy statement of the American Academy of Pediatrics on breastfeeding and the use of human milk, research and systematic reviews have continued to reinforce the conclusion that breastfeeding and human milk are the normative standards for infant feeding and nutrition.[1] More than 80% of women initiate breastfeeding in the United States, and both federal and state laws protect a woman's right to breastfeed as well as the right to breastfeed in public and to continue breastfeeding or to express milk in the workplace.[2] With most women choosing to breastfeed, breastfeeding has been established as the cultural norm in the United States. Furthermore, breastfeeding, or the provision of human milk,

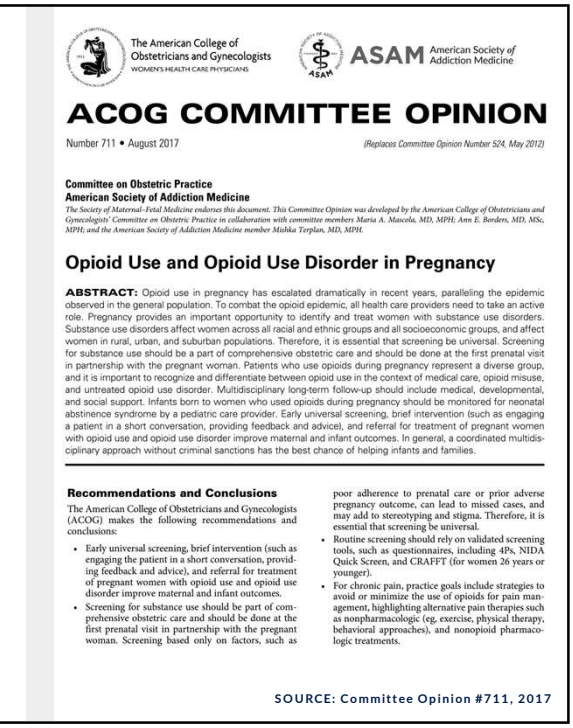
PEDIATRICS Volume 150, number 1, July 2022:e2022057988

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Breastfeeding

- Human milk levels and infant serum levels of buprenorphine and methadone are low.
- Breastfeeding is encouraged by the Academy of Breastfeeding Medicine & American Academy of Pediatrics.
- American College of Obstetrics & Gynecology:

  "Breastfeeding should be encouraged in women who are stable on opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as HIV infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse."
- Recommendations are irrespective of dose.



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017 (Replaces Committee Opinion Number 524, May 2012)

Committee on Obstetric Practice
American Society of Addiction Medicine

The Society of Maternal-Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

Opioid Use and Opioid Use Disorder in Pregnancy

ABSTRACT: Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. To combat the opioid epidemic, all health care providers need to take an active role. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, it is essential that screening be universal. Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care, opioid misuse, and untreated opioid use disorder. Multidisciplinary long-term follow-up should include medical, developmental, and social support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome by a pediatric care provider. Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.

SOURCE: Committee Opinion #711, 2017

Decision to Breastfeed

Societal pressure to breastfeed:

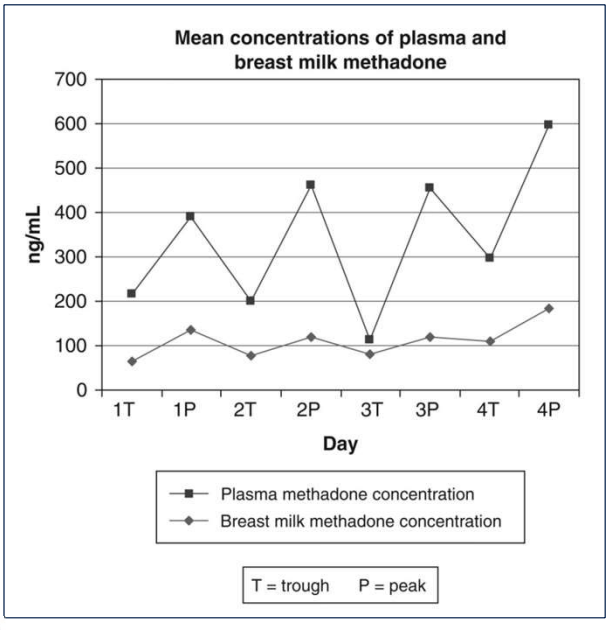
- Medical community (e.g., Baby friendly hospital initiative)
- Media
- Family and/or friends

Decision to breastfeed should be made an on individual basis.

- Balance the infant's needs with the mother's well-being.
- Mothers often face external shame and internal guilt over the decision.
- Consider the mother's mental health and need for sleep.

Support choices around infant feeding nonjudgmentally.

- Clinician's role is to enhance problems solving and flexibility about breastfeeding.
  - Role of supplementing with formula
  - Lactation support



- Methadone concentrations were small:
  - Doses ingested ranged from 0.006mg - 0.084mg per day.
- Concentration was not related to maternal dose.

SOURCE: DOI: 10.1177/0890334407300336

Breastmilk

	Methadone	Buprenorphine	Buprenorphine-Naloxone	Naltrexone
Dr. Hale's Lactation Risk Category	L2/Significant Data - Compatible	L2/Probably-Compatible	L3/No Data-Probably Compatible	L1/Limited Data-Compatible
Relative Infant Dose	1.9-6.5%	0.09% - 2.52%	0.13% - 2.52%	1.4%
Lactmed	Acceptable	Acceptable. No information available about naloxone.		Limited data. If maternally required, no reason to discontinue breastfeeding.

SOURCE: DOI: 10.3390/ijerph17020568

Hale, T. W., & Krutsch, K. (2023). *Hale's medications & mothers' milk, 2023: A Manual of Lactational Pharmacology* (20th ed.)

Postpartum Depression

What is Postpartum Depression?

- Most common postpartum complication of childbirth
- Suicide & drug overdoses are leading causes of maternal mortality in the United States.[1,2]
- Postpartum depression is associated with adverse outcomes on mom and infant:
  - Impaired maternal-infant bonding
  - Impaired infant emotional development
  - Use of substances
  - Decreased breastfeeding success

SOURCE: DOI: 0.1016/j.ajog.2019.05.045[1] ; 10.1097/AOG.0000000000001695[2]

Screening for Postpartum Depression

The American Psychiatric Association recommends screening pregnant individuals at three time points:

- Early pregnancy
- Late pregnancy
- Postpartum period

Screening should be completed using patient history and a standardized, validated tool:

- Patient Health Questionnaire (PHQ-9)
- Edinburg Postnatal Depression Scale (EPDQ)
- Postpartum Depression Screening Scale (PDSS)

Individuals who screen positive should be clinically evaluated.

SOURCE: DOI: 10.1097/AOG.0000000000002927

Postpartum Depression Differential

	Incidence	Time Period	Clinical Features
Postpartum Blues	50-70%	Brief period (less than 7 days) occurring within two weeks following delivery	• Transient - requires no intervention • Evidence of increased risk for depression later in the postpartum period
Postpartum Depression	12-16%	Onset postpartum or worsening of previous symptoms within first 12 months after delivery	• Typically presents within 1 month after delivery • Other common signs: Below prepregnancy weight quickly, not able to sleep despite feeling exhausted, psychomotor agitation, believe they are a bad mother but no evidence of this, difficulty making decisions for themselves or baby, ANXIETY, increased physical discomfort
Postpartum Psychosis	1-2 per 1000	Typically, acute onset within the first 4 weeks postpartum	• Can be a depressed episode, hypomanic episode, manic episode, or mixed episode • Psychotic symptoms are also common. • Medical Emergency

SOURCE: UAMS IDHI High-Risk Pregnancy Program. (2023). *Depression (Antepartum and Postpartum)* https://angelsguidelines.com

Treatment of Postpartum Depression

- For **mild postpartum depression** = **psychotherapy**
- For **moderate to severe postpartum depression** = **consider pharmacological treatment**
  - Medication choice should be driven by costs, affordability, accessibility, and whether or not the mother is breastfeeding.
  - Two FDA-approved medications for postpartum depression:
    1. **Brexanalone**
       - 60-hour IV infusion
       - REMS certification required
    2. **Zuranalone**

Treatment of Postpartum Depression

Medication	Lactation Data		Dosing Strategies	Comments
	Data	Hale's LRC RID		
SSRIs				
Citalopram	++	L2 RID: 3.56-5.37%	Start 10mg X 2-4 days, then increase to 20mg daily Range 10-40mg/day	
Escitalopram	++	L2 RID: 5.2-7.9%	Start 5mg X 2-4 days, then increase to 10mg daily Range 10-30mg/day	
Fluoxetine	+++	L2 RID: 1.6-14.6%	Start 10mg X 4 days, then increase to 20mg daily Range 10-60mg/day	
Sertraline	++++	L2 RID: 0.4-2.2%	Start 25mg X 4 days, then increase to 50mg daily Range 25-200mg/day	
SNRIs				
Duloxetine	+	L3 RID: 0.12-1.12%	Start 30mg X 4 days, then increase to 60mg daily Range 30-90mg/day	
Venlafaxine	++	L2 RID: 6.8-8.1%	Start 75mg/day X 4 days, then increase to 150mg daily Range 150mg-450mg/day	May increase blood pressure
Other				
Buproprion	+	L3 RID: 0.11-1.99%	Start 150mg XL Range: 150-450mg/daily	Reducing tobacco use Weight loss
Nortriptyline	++	L2 RID: 1.7-3.36%	Start 10mg at night, then increase 10mg every 4 days to target dose of 30mg nightly Range: 30-100mg po nightly	May help with insomnia, headaches, and neuropathic pain

SOURCE: DOI: 10.3390/ijerph17020568; Hale, T. W., & Krutsch, K. (2023). *Hale's medications & mothers' milk, 2023: A Manual of Lactational Pharmacology* (20th ed.)

Zuranolone

- FDA approved in Summer 2023
- **Indication:** Severe MDD onset during third trimester or less than 4 weeks postpartum
- **Dose:** 50mg/day po QHS X 14 days
- **Side effects:** sedation
- No published data in pregnancy or breastfeeding

Zuranolone for the Treatment of Postpartum Depression

Kristina M. Deligiannidis, M.D., Samantha Meltzer-Brody, M.D., M.P.H., Bassem Maximos, M.D., E. Quinn Peeper, M.D., Marlene Freeman, M.D., Robert Lasser, M.D., M.B.A., Amy Bullock, Ph.D., Mona Kotecha, M.D., Sigui Li, M.S., Fiona Forrestal, M.Sc., Nilanjana Rana, M.B.B.S., Manny Garcia, M.D., Bridgette Leclair, Pharm.D., James Doherty, Ph.D.

Objective: Postpartum depression (PPD) is a common perinatal complication with adverse maternal and infant outcomes. This study investigated the efficacy and safety of zuranolone, a positive allosteric modulator of synaptic and extrasynaptic $GABA_A$ receptors and neuroactive steroid, as an oral, once-daily, 14-day treatment course for patients with severe PPD.

Methods: In this double-blind phase 3 trial, women with severe PPD were randomized in a 1:1 ratio to receive zuranolone 50 mg/day or placebo for 14 days. The primary endpoint was change from baseline in total score on the 17-item Hamilton Depression Rating Scale (HAM-D) at day 15; key secondary endpoints were change from baseline in HAM-D score at days 3, 28, and 45 and change from baseline in Clinical Global Impressions severity (CGI-S) score at day 15. Adverse events were monitored.

Results: Among 196 patients randomized (zuranolone, N=98; placebo, N=98), 170 (86.7%) completed the 45-day study. Treatment with zuranolone compared with placebo resulted in statistically significant improvement in depressive symptoms at day 15 (least squares mean [LSM] change from baseline in HAM-D score, −15.6 vs. −11.6; LSM difference, −4.0; 95% CI=−6.3, −1.7); significant improvement in depressive symptoms was also reported at days 3, 28, and 45. CGI-S score at day 15 significantly improved with zuranolone compared with placebo. The most common adverse events (≥10%) with zuranolone were somnolence, dizziness, and sedation. No loss of consciousness, withdrawal symptoms, or increased suicidal ideation or behavior were observed.

Conclusions: In this trial, zuranolone demonstrated significant improvements in depressive symptoms and was generally well tolerated, supporting the potential of zuranolone as a novel, rapid-acting oral treatment for PPD.

Am J Psychiatry 2023; 180:668–675; doi: 10.1176/appi.ajp.20220785

Postpartum depression (PPD) is a common perinatal condition affecting approximately 17.2% of women during pregnancy or following parturition globally (1). Major or minor depressive episodes in the postpartum period are frequently underdiagnosed and untreated (2–4), and many women experience PPD with elevated anxiety (5). Moreover, the risk of developing PPD is twofold in women with a family history of psychiatric disorders (6). Adverse maternal and infant outcomes associated with PPD include reduced breastfeeding initiation rates, poor maternal and infant bonding, and increased infant behavioral, emotional, and cognitive impairment (3, 7, 8). Women with severe PPD may experience suicidal ideation, and maternal death from suicide comprises approximately 20% of all postpartum deaths (3, 9). Current treatment options often include standard-of-care antidepressants; however, achieving response to treatment can take up to 12 weeks (10, 11). Given the deleterious effects of untreated PPD, identification of rapid and effective treatment options is critical.

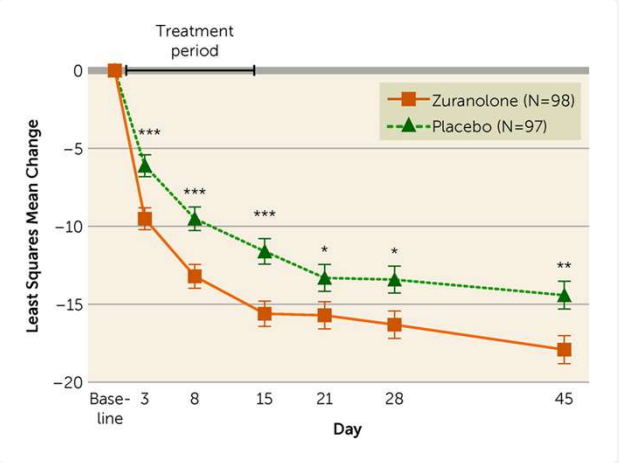
Allopregnanolone, an endogenous, potent positive allosteric modulator of synaptic and extrasynaptic γ-aminobutyric acid type A ($GABA_A$) receptors and neuroactive steroid, may play an important role in PPD (2, 3, 12). Maladaptation to peripartum fluctuations in reproductive hormone concentrations during the perinatal period may be associated with PPD (13, 14), with levels of allopregnanolone—a metabolite of progesterone—increasing during pregnancy, reaching peak concentrations in the third trimester, and then decreasing abruptly following childbirth (13, 14). In a functional MRI study investigating resting-state functional connectivity and allopregnanolone levels in women with or without PPD, those with PPD had greater resting-state functional connectivity between an area of the dorsomedial prefrontal cortex and the rest of the default mode network compared with healthy postpartum women (15). These alterations in functional connectivity in women with PPD were correlated positively with both allopregnanolone levels and with more severe depression scores compared with healthy postpartum women, suggesting a connection between neuroactive steroid levels, network connectivity, and symptom severity in PPD (15). In preclinical studies, mice deficient in the $GABA_A$ receptor

See related features: **Editorial** *by Dr. Pine (p. 631) and* **Video** *by Dr. Pine (online)*

SOURCE: DOI: 10.1176/appi.ajp.20220785

Zuranolone

- Positive allosteric modulator of synaptic and extra synaptic GABAa receptors and neuroactive steroid.
  - Allopregnanolone is endogenous allosteric modulator of GABAa & metabolite of progesterone.
  - **Theory:** PPD results from maladaptation from abrupt decline in allopregnanolone postpartum.



SOURCE: DOI: 10.1001/jamapsychiatry.2021.1559

Treatment Duration

- There is no data to support optimal treatment duration in postpartum depression.
- A duration 6-8 weeks of treatment is required for a complete antidepressant trial.
  - Dose increases are often needed if patient only has a partial response.
- Standard treatment of depression is 10 to 12 months.

SOURCE: DOI: https://doi.org/10.4103%2F0019-5545.196973

Timeline: Other Psychosocial Factors

Acute Postpartum Period
0-6 weeks postpartum

- Sleep deprivation
- Finances
  - Unpaid leave
- Limited resources
  - Childcare
  - Transportation
- Social support
  - Focus on baby and not mom
- Infant health
- Child welfare

Sleep Deprivation

- Nearly universal among new parents
  - Secondary to physiological changes postpartum and need to care for newborn baby
- Most important modifiable risk factor for postpartum psychiatric disorders
- Consequents for parents with SUD:
  - Trigger to use substances or misuse of buprenorphine
  - Increased risk for postpartum depression and anxiety disorders
  - Emotional dysregulation
  - Interpersonal problems

SOURCE: DOI: 10.1097/AOG.0000000000004657

Sleep Deprivation: Provider's Role

- Educate about the safety of sleep medications.
- Educate about non-pharmacological treatment options, such as massage, exercise, or behavioral modifications.
- Discuss self-care with patients.
  - "Putting your own oxygen mask on first."
- Engage social support to assist with postpartum sleep plan.
  - Best if done prior to delivery.

Best Practices in the Care of Postpartum Patients

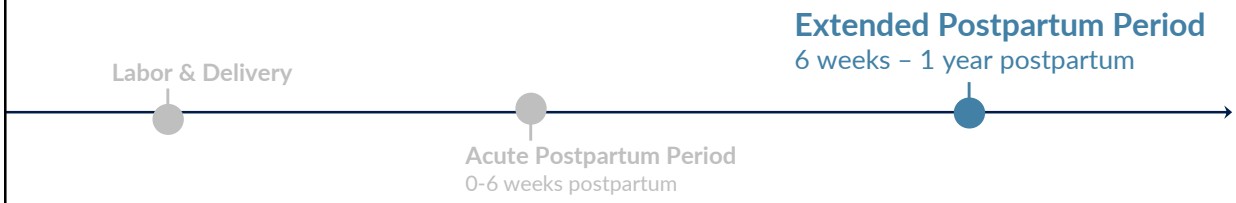
Social Support

- Engagement with social workers, case managers, peer support specialists, and peer support groups to provide social support and address psychosocial stressors (e.g., Childcare, Transportation, Financial)

Child Welfare

- Providers need knowledge of state-specific, civil child-welfare statues to counsel patients appropriately
- Advocacy for de-legalization of harmful statutes and expansion of treatment services

Timeline: Other Psychosocial Factors



Ob Provider to PCP

- Frequency and intensity of appts

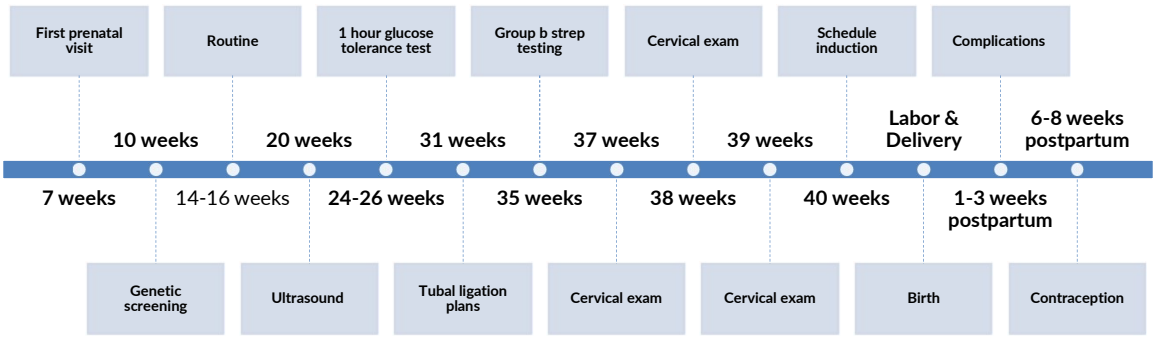
Psychosocial Factors

- Parenting
- Childcare
- Finances
- Postpartum mood disorder

Pregnant SUD provider to postpartum SUD provider

- Medication management
- Insurance
- Childcare
- Frequency of appts

Transition of Care from Ob to PCP
Pregnancy Timeline of Visits



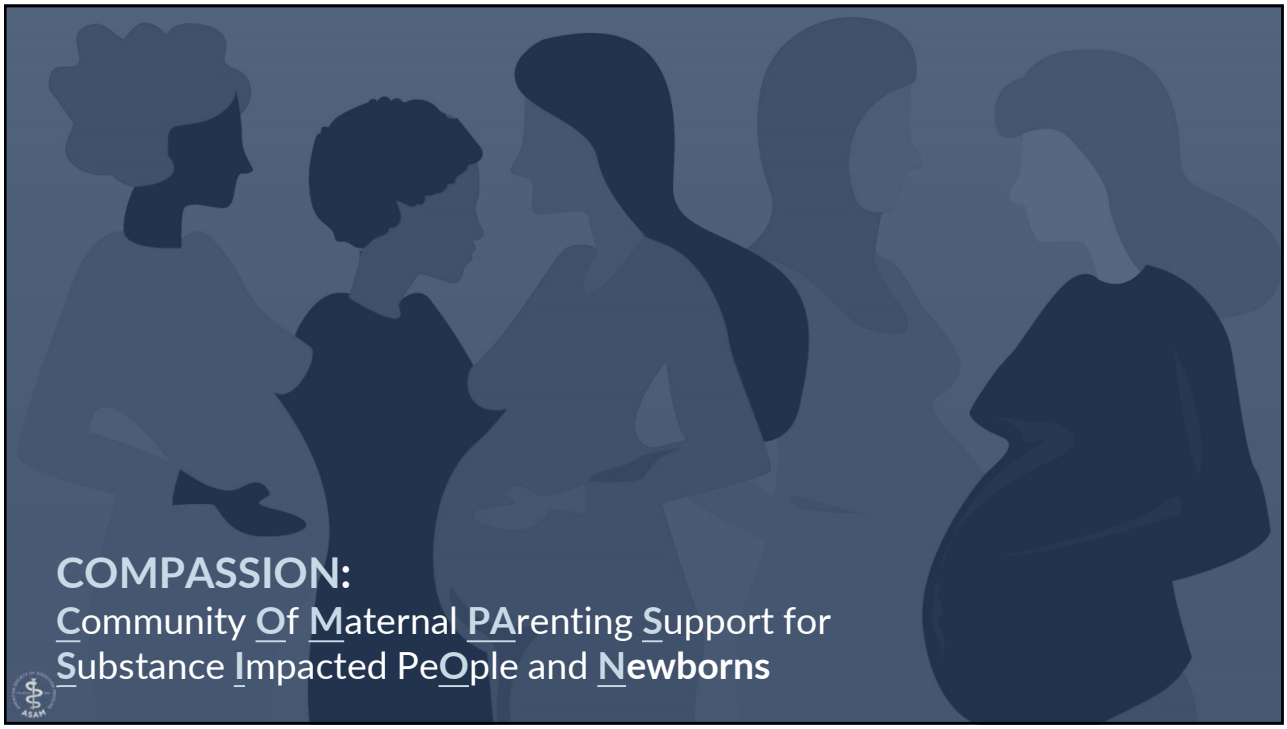
Insurance Transition

Medications should be continued throughout the postpartum period.

- Plan for postpartum discharge/transfers.
- Proper referral/recommendation.

Medication Coverage Policy

- Know insurance coverage in pregnant patients based on their geographical location and potential uninsured status.
- Plan for affordable care for uninsured patients, including scheduled taper of medication.



COMPASSION

Culture of Nonjudgment and Acceptance

COMPASSION: Community Of Maternal PArenting Support for Substance Impacted PeOple and Newborns

- ***Access***: "No door", "no barrier" service, access for ALL!
- ***Equity/diversity***: Inclusive, and empowering care for all patients (all recovery phases, cultures/races, all backgrounds).
- ***Equality:*** Birth is an essential time and a special new beginning for every birthing parent, indifferent of life circumstances/recovery stages.
- ***Recovery:*** Lifelong journey; foster safe, peaceful, and compassionate environment to strengthen each recovery path without marginalizing people on stability.

Pregnancy is an opportune time for improving maternal and fetal health. Delivery is an essential time to support the birthing parent, newborn, and family unit!

Value-based pathway, reimbursed as part of SUPP, HCA

COMPASSION

Culture of Nonjudgment and Acceptance

COMPASSION: Community Of Maternal PArenting Support for Substance Impacted PeOple and Newborns

5-day extended postpartum floor stay for birthing parents, babies, and family.

- Our COMPASSION model promotes trauma-informed and respectful comprehensive care that is patient-centered and tailored to whole person/family support.
- We foster "zero separation" to encourage birthing parent, newborn, and family unit bonding through respect, compassion, self-sufficiency, and empowerment.
- Birthing parent, newborn and family love is the medicine, keeping the unit together.
- Postpartum floor setting to normalize care/decrease trauma (not pediatric or NICU).

COMPASSION

Culture of Nonjudgment and Acceptance

5S summary: Sobriety, Safe home, Sober support, Self-sufficiency, Set for success

Sobriety: access and freedom of choice, harm reduction and trauma-responsive healing:

- Positive, warm, and non-judgmental service and trauma-informed approach
- A smooth transition of care for birthing parents who admit to the hospital
- Education and timely evaluation of SUD, medication stabilization/withdrawal management, continuation – offering choices to meet people where they are
- Education on importance of tobacco, marijuana, and vaping cessation and treatment
- Ongoing daily patient-centered rounds, including medication dose adjustment and wellness (parent, family, newborn, doula, MD, RN, SW)
- Pain management, integrative modalities, and doula support
- Mental health, aromatherapy, and psychosocial support
- Focus on trauma history, DV, and psychiatry
- Lactation, nutrition, wellbeing support, and mindfulness
- Culture of nonjudgment and acceptance to empower birthing parents to feel safe and comfortable with the treatment choices they make

COMPASSION

Culture of Nonjudgment and Acceptance

5S summary: Sobriety, Safe home, Sober support, Self- sufficiency, Set for Success

Safe home environment/housing:

- Help parents and families to find strategies and resources to match any needs necessary to optimize safe home environment for the birthing person, baby, and the family unit.
- Support birthing people with Trauma, DV, IPV with shelter, and safe discharge coordination.

Sober support:

- Make an effort to connect the birthing parent with their significant other, family members, and any peer support necessary to optimize their hospital stay and ongoing recovery.
- Loved ones play a critical role in the birthing parent's recovery and are a tremendous source of comfort and strength.
- Offer harm-reduction and doula support.

COMPASSION

Culture of Nonjudgment and Acceptance

Self-sufficiency: Commitment to offer a whole-person treatment to all birthing parents to empower them with knowledge, tools, and confidence for them to meet the needs of their baby and family.

- Opportunity to boost self-sufficiency and to discuss ways for birthing people to practice good nutrition, hydration, ambulation, and hygiene.
- Promote bonding for parent, baby, father/partner, and the whole family unit.
- Ways to support nursing, breastfeeding/chestfeeding/lactation support, and family planning - lactation, OT, nutrition consult, BM 72hr post last use.
- Compassionate birth control counseling to help with allowing the birthing parent's body to rest post-delivery (recognize that short inter-pregnancy intervals are associated with low birthweight and prematurity); offer education on long-acting reversable contraception (LARC) and offer it immediately postdelivery if desired.
- Wellness support and resources for relaxation, mindfulness, DBT, aromatherapy, stress reduction, and self-efficacy.
- Education on wellbeing and recovery across the lifespan, with a focus on relapse prevention and coping skills.

COMPASSION

Culture of Nonjudgment and Acceptance

Set for success – offering information, support and resources while setting healthy expectations

- Focus on harm-reduction, gratitude, and empowerment:

  "Thank you for coming to our program! We are looking forward to supporting your needs to help you feel successful in your recovery journey and parenting."

- Social work, counseling, and medical teams are available to offer help/support:
  - "We are grateful for you being part of our team, and we appreciate the opportunity to learn from you how to navigate future steps for your real-life situation." (including family support, discharge coordination and safe home transition)
  - "We kindly request your permission to allow all staff to provide daily care." (doctors, nurses, counselors, support person, doula, SW, etc.)
  - "Can I ask for your permission to discuss SW and hospital policy expectations?"
  - "We appreciate your willingness to guide us in learning how to best support you in ways that feel comfortable for you!"

As a provider, have courage and be kind!

Washington State Pilot: N=44 Characteristics

Variable	Methadone (n=24)	Buprenorphine (n=20)
Age	30	31
Ethnicity/race%		
Asian Hispanic	8 12	10 15
Black	4	5
White	68	50
American Indian	8	20
Education: <11th grade%	50	50
Unhoused%	30	30

Washington State Pilot: N=44 Maternal Outcomes

Variable	Methadone (n=24)	Buprenorphine (n=20)
Dose range	30mg BID-> 150mg BID (95mg BID)	4mg BID->8mg QID (20mg QD)
Illicit substance use at delivery%	25	30
Gestational Age at delivery (weeks.days)	38	38.5
Mode of delivery% Vaginal C-section	 62 38	 45 55
Breastfeeding%	88	75
Discharge with baby% D/c to home with baby Treatment with baby	 74 25 1 AMA (after CPS referral)	 70 30
Average Length of Stay (maternal, days)	5	5

Washington State Pilot: N=44 Neonatal Outcomes

Variable	Methadone (n=24)	Buprenorphine (n=20)
NOWS% None Treated with morphine 1 time **NICU/NOWS%** (scheduled morphine)	 88 8 4	 75 15 10
Mean Length of Stay (days) Average Length of Stay (days) **Warm hand-off%**	**5** 8.2 5 (80%) 18 (16%) peds/feeding 30 (4%) NICU/NOWS 100	**5** 8.2 5 (80%) 10 (10%) CPS hold 32 (10%) NICU/NOWS 100

COMPASSION

A focus on equity/ equality for the birthing parent, infant, and family unit

Birthing parents on MOUD, n=44	Birthing parents on Methadone BID, n=24	Birthing parents on Buprenorphine, n=20
MOUD Dose	30mg BID – 150mg BID (mean 95mg BID)	4mg BID – 8mg QID (mean 20mg qd)
Mode of delivery, GA	15 SVE (63%), 9 CS (37%), mean GA 38w0d	10 SVE (50%), 10 CS (50%), mean GA 38w5d
Breastfeeding	88%	75%
NOWS	21 (88%) no NOWS 2 (8%) morphine x1 1 (4%) NICU/NOWS	15 (75%) no NOWS 3 (15%) morphine x1 2 (10%) NICU/NOWS
ALOS – birthing parent	5 days, 100% MOUD, warm-hand-off, OD, f/u	5 days, 100% MOUD, warm-hand-off, OD, f/u
ALOS – newborn	Mean 5 days Average 8.2 days: 19 (80%), 5 days 2 (16%), 18 days peds/feeding 1 (4%), 30 days NICU	Mean 5 days Average 8.2 days 16 (80%), 5 days 2 (10%), 10 days placement 2 (10%), 32 days NICU
Warm hand-off, MOUD+Narcan+f/u care	100%	100%

COMPASSION

A focus on equity/equality for the birthing parent, infant, and family unit

Child Welfare Outcomes:

Methadone-exposed newborns

- Plan of Safety Care/POSC: 12 (50%)
- Child Protective Services/CPS, FTDM: 12 (50%)
- Parent discharge with newborn: 23 (99%): 17 (74%) home, 6 (25%) residential/PPW

Buprenorphine exposed newborns

- Plan of Safety Care/POSC: 10 (50%)
- Child Protective Services/CPS, FTDM: 10 (50%)
- Parent discharge with newborn: 20 (100%): 14 (70%) home, 6 (30%) residential/PPW

NICU – COMPASSION/Newborn LOS Timeline

Year	Number of Moms	Average NICU LOS
2018	3	18 days
2019	20	13 days
2020	80	10 days
2021	90	3.2 days COMPASSION
2022	67	5 days COMPASSION 9.1 days ESC

Perinatal/postpartum Stabilization for Fentanyl Use Disorder

- Education on OUD, whole person and patient-centered care, shared-decision making
- Education on available MOUD, Methadone and Buprenorphine
- Empower "voice and choice" for pharmacotherapy and formulation-> stabilization, safety, OD education
- Warm hand-off and care coordination
- Longitudinal follow up during pregnancy, postpartum and across the lifespan
- Celebrating our moms/people and meeting them where they are with kindness, respect and compassion

Peer-to-Peer Support Line:

- 1833-YesWeCan: 1833-937-9326

Together, we can make a difference!

Fentanyl Pharmacokinetics

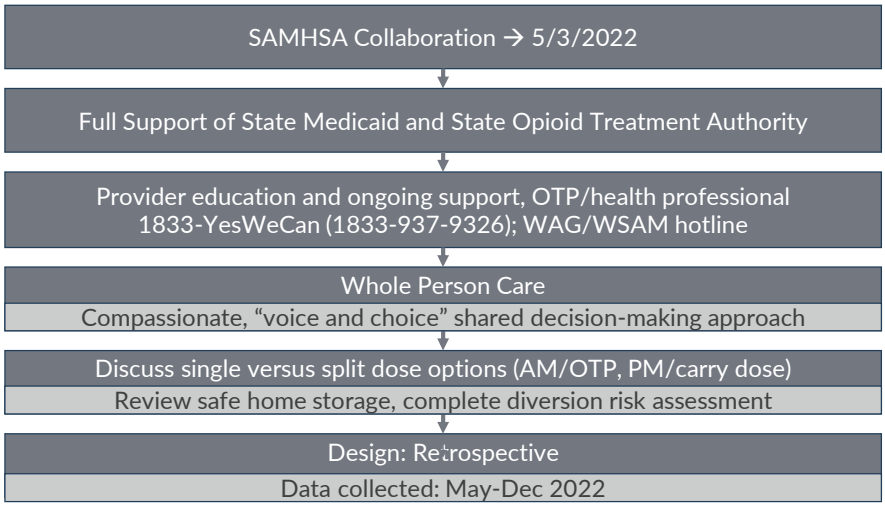
- Pharmacokinetic data mostly from anesthesia literature
- Limited data on chronic use
- Highly Lipophilic
  - Chronic exposure leads to a “drug reservoir” in adipose tissue which slowly leaches out over time
  - Variable half life
- Single Day Administration
  - Half-life:
    - IV: 1.5 – 6 hrs
    - IN: 1.5 – 7 hrs
  - Renal Clearance: 1-4 days
- Chronic non-prescribed administration (N=12)
  - Renal Clearance:
    - Fentanyl 7.3 (4.9) days (range 4-19)

SOURCE: DOI: 10.1016/j.drugalcdep.2020.108147; 10.2165/00003088-198308050-00004; 10.1007/s40262-012-0016-7

MOUD in Perinatal and Parenting People

- Education on OUD, whole person and patient-centered care, shared-decision making
- Education on available MOUD, Methadone and Buprenorphine
- Empower “voice and choice” for pharmacotherapy and formulation-> stabilization, safety, OD education/prevention
- Warm hand-off and care coordination
- Longitudinal follow up during pregnancy, postpartum and across the lifespan
- Celebrating our moms/people and meeting them where they are with kindness, respect and compassion

Washington State: Standardize Methadone Split Dose For Perinatal and Parenting People



Order Set: Methadone Split Dose Initiation

Perinatal/Parenting People

Offer whole person care, education on OUD, pharmacotherapy MOUD and shared-decision making → choice for split methadone dose to any person interested to initiate.

Methadone split dose stabilization protocol:

- Day#1: 30mg x1 + 10mg Q4H prn
- Day#2: 20mg Q12H + 10mg Q4H prn
- Day#3: 30mg Q12H + 10mg Q4H prn
- Day#4: 40mg Q12H + 10mg Q4H prn
- Day#5: 50mg Q12H + 10mg Q4H prn

Ancillary Medications to bridge intensity of Fentanyl withdrawal symptoms:

- Tizanidine 2-4 mg Q6h x 24-48hr
- Hydroxyzine 50 mg Q6h x 24-48hr
- Gabapentin 300 mg Q6h x 24-48hr
- Dicyclomine 20 mg Q6h x 24-48hr

72hr Dispensing of Methadone & Split Dose for Perinatal/Parenting People

The "72-hour rule," to initiate/dispense methadone for OUD in the hospital/ED (8/8/23)

- "The 72hr rule allows practitioners to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)."
  - https://www.federalregister.gov/documents/2023/08/08/2023-16892/dispensing-of-narcotic-drugs-to-relieve-acute-withdrawal-symptoms-of-opioid-use-disorder#

SOURCE: (DEA) CFR Title 21 1306.07

WA ARS Pilot: Standardize 72hr Dispensing of Split Methadone Dose For Pregnant and Postpartum People

Admit and stabilize on Methadone BID, offer choices for shared-decision making, discharge coordination and warn hand-off, (Methadone 72hr, OTP intake, OB/PCP f/u)

↓

Day prior to discharge: confirm patient's choice, BID dose, OTP intake/provider hand-off, connect with pharmacy for Methadone 72hr dispensing

↓

Day of discharge: Rounding, place take-home order, pick up from pharmacy, dispense directly to patient, document in EPIC/MAR, hand Narcan kit/AVS OD prevention, OTP, OB/PCP, telehealth f/u 24-48hr

↓

Methadone liquid, labeled/dispensed in 6 syringes with safety caps, packed in a safely locked medication bag

Daily telehealth follow up to support ongoing care, safe home dispensing, complete diversion risk

↓

Methadone liquid dispensed in 6 syringes with safety caps, packed in a locked medication bag

Daily telehealth follow up to support ongoing care, safe home dispensing, complete diversion risk

↓

Whole Person Care/patient's voice

"It was a very thoughtful, considerate, practical and life changing experience!"

“It went really well!”

25 y.o. year old G2P0010 at 22w4d by 7wk US, admits for fentanyl use disorder. MOUD with Methadone at OTP, 15-20 tabs per day on top, smoked; unable to stop use.

- Admits to Addiction Recovery Services, Swedish Medical Center for Methadone stabilization, “I want to quit the blues, I want to be healthy for myself and for my baby”
- During the admission, stabilized on MOUD with methadone 130 mg BID
- Counseling on option for methadone 72hr dispensing and education on ongoing MOUD, OD prevention and Narcan kit.
- Choice to receive 72hr Methadone dispensed in syringes and packed in a safely locked medication storage bag.
- OTP intake and Q12H doses coordinated with OTP provider
- Patient was offered the opportunity to have a telehealth follow up visit at the Bridge ARS clinic x 24-48 hrs., medically-shared group zoom visit, support and COMPASSION

“It was a very thoughtful, considerate, practical and life changing experience!”

72hr Methadone pathway, patient’s voice:

- “The last time I used Fentanyl was the day I came to the ARS program.”
- “I am grateful to be able to say that I am on a stable dose, taking Methadone twice daily helps me and my unborn son feel healthy.”
- “Being able to receive Methadone for 3 days allowed me to come home with a plan set up to give me the peace of mind to be with my family, to receive calls from my doctor and to go to my Methadone clinic to continue care. It went really well: the safety caps, the locked bag, the labels on every syringe, the Narcan kit, the support, all very clear and it helped me feel safe.”
- “I have a much better chance to have a healthy baby now that I have been able to kick off fentanyl.”

Buprenorphine Initiation

Low Dose Initiation

- Strategy for initiation
- goal to titrate to therapeutic dose
- More medically accurate

Microdose

- Pharmacology term for subtherapeutic doses
- Lay media/ literature: hallucinogen microdosing

> *Low-dose buprenorphine initiation is increasingly necessary and is the most accurate and appropriate term to describe the overlapping initiation of buprenorphine with full agonist opioids.*
>
> *- Weimer and Fiellin, 2022*

SOURCE: DOI: 10.1111/add.15799

Buprenorphine Low Dose Initiation

Inpatient Setting

Offer a choice for bup formulation based on system availability:

- Buprenorphine liquid/Belbuca film
  - 0.075 mg SL Q4h x2
  - 0.15 mg SL Q4h x2
  - 0.3 mg SL Q4h x2
  - 0.6 mg SL Q4h x2 (0.6 mg dose at least 24 hours from last fentanyl use)
- Start Buprenorphine SL 2mg tablets/buprenorphine/naloxone 2/0.5mg film – give first dose after patient has received 4-8hrs of scheduled non-opioid meds
  - 0.25-0.5 SL Q4h x2
  - 1 mg SL Q4h x2
  - 2 mg SL Q4h x2
  - 4 mg SL Q4h x 2
  - 8 mg SL TID-QID ongoing
- Encourage 8 mg TID/QID rather than BID for those using fentanyl, new recommendation for higher doses
- Offer choice of buprenorphine mono vs buprenorphine/naloxone formulation
- Whole person care – encourage nutrition, hydration, self care

Buprenorphine Low Dose Initiation
Inpatient Setting

- Upon admission, start scheduled ancillary medications x 96 hrs until achieved target bup dose-> schedule prn x 48-72hr, then taper off
  - Tizanidine 2-4 mg Q4-6h
  - Hydroxyzine 50 mg Q4-6h
  - Gabapentin 300 mg Q4-6h
  - Dicyclomine 20 mg Q4-6h
- Offer Full Agonist Opioids:
  - Hydromorphone 2-4 mg Q4h PRN COWS > 7 (if Fentanyl <15tabs/0.5g powder)
  - Hydromorphone 4-8 mg Q4h PRN COWS > 7 (if Fentanyl >15tabs/0.5g powder)
- Methamphetamine withdrawal: Mirtazapine 15 mg QHS
- TUD: NRT – Nicotine patch, nicotine gum

Call Peer to Peer Support Line if you have questions:

- 1833-YesWeCan: 1833-937-9326

Rapid Low Dose Buprenorphine Initiation

Variable	Dosing	Total Daily Dose	Hydromorphone	Scheduled Adjunctive Medications
Day 1 (0-24 hrs)	Last fentanyl use PTA Buprenex SL Liquid 0.075 mg Q4hx2 = 0.15 mg 0.15 mg Q4hx2 = 0.3 mg 0.3 mg Q4hx2 = 0.6 mg	1.05 mg SL liquid	2-4 mg Q4H prn COWS >7	**Start** **Tizanidine 2mg Q4H** **Hydroxyzine 50mg Q4H** **Gabapentin 300mg Q4H** **Dicyclomine 10mg Q4H** **Mirtazapine 15mg HS** **NRT**
Day 2 (24-24 hrs)	0.6 mg Q4hx2 = 1.2 mg 1 mg Q4hx2 = 2 mg 2mg Q4hx2 = 4 mg	1.2 mg SL liquid 6mg SL tablet	2-4 mg Q4H prn COWS >7	
Day 3 (48-72 hrs)	4 mg Q4hx2 = 8 mg 8 mg Q4hx2 = 8 mg	16 mg SL tablet	2-4 mg Q4H prn COWS >7	
Day 4 (72-96 hrs)	8 mg TID = 24 mg	24-32 mg SL tablet	2-4 mg Q4H prn COWS >7	
Day 5	8 mg TID-QID, discharge	Transition to pt's choice of bup formulation		Discontinue

Buprenorphine Low Dose Initiation
Outpatient Setting

New patient visit → team approach, safe plan:

- Trauma-informed and non-judgmental patient-centered care
- First person language
- Provide education on OUD, MOUD (formulations)
- Overdose education/Narcan
- Mental health support, PHQ2
- Patient's voice and choice, meeting people where they are
- Sober/peer support to help with initiation
- Safe home environment
- Daily phone/office check-in – "You got this, we are here and available to help/support"
- Compassionate, trauma-informed care to appreciate patient's strengths, foster welcoming, equitable and stigma-free caring

Buprenorphine Low Dose Initiation
Outpatient Setting

- Buprenorphine SL 2mg tablets vs buprenorphine/naloxone SL film 2/0.5mg
  - 0.5 mg SL Q4-6H x2 -> 6hrs post last use
  - 1 mg SL Q4-6h x2
  - 2 mg SL Q4-6h x 2
  - 4 mg SL Q4-6h x 2
  - 8 mg SL TID/QID ongoing
- Scheduled ancillary medications until 24 hrs + on 8 mg SL TID
  - Tizanidine 2-4 mg Q6h
  - Hydroxyzine 50 mg Q6h
  - Gabapentin 300 mg Q6h
  - Mirtazapine 15 mg QHS
  - Dicyclomine 20 mg Q6h
- Continue ancillary medications prn for 3-5 days
- Compassionate, trauma-informed care to appreciate patient's strengths, foster welcoming, equitable and stigma-free caring

Social Work Care Coordination

Role/Responsibilities, Communication Strategies

- Psychosocial (day after labor).
  - Discuss role of Inpatient SW. Ask a parent if they were told SW would be stopping by.
  - There to complete a safety assessment to determine if there is a need for CPS involvement or POSC.
  - Focus on the positive.
  - Ask what their plans are and discuss the options to determine if plans are realistic.
  - Be transparent about possible next steps.
- MSW is present at the FTDM.
- **Speaking to parents:** Have confidence. Listen to what they are saying!

COMPASSION SUPPORTIVE GROUP MODEL

Our aim: to provide a flexible and sustainable model of supportive group care that is healing, compassionate, and beneficial to moms, families, and providers.

Parenting

- Sleep deprivation
- Limited social support
- Lack of role models for parenting
- Inadequate coping skills needed for high stress of parenting
- Stigma associated with OUD is a barrier for birthing parents seeking support for parenting

Parental Skills Training and Education

- Recognition and support for birthing parents with infant health concerns (e.g., abnormal sleeping patterns, feeding difficulties, difficult to soothe), including NICU hospitalization

Take Home Points for Health Equity Growth Opportunities

COMPASSION model - foster "no door," whole-person care that is trauma-informed, compassionate, racially equitable and evidence-based

Meeting needs of vulnerable and disadvantaged people

Community effort

Birthing parent/woman empowerment

Together we can make a difference - Yes, We Can!

Key Takeaways

- Optimize care in the postpartum period to minimize risk of return to use and maternal morbidity and mortality.
- Screen for postpartum depression and if needed, treat or refer to treatment.

Knowledge Check

35-year-old patient at 34 weeks gestation presents for follow-up of opioid use disorder managed on buprenorphine-naloxone 8-2mg SL TID. Her past medical history is positive for methamphetamine use disorder in remission. She has no acute complaints. She asks, "Is it safe to breastfeed on this medication?" Which of the following is the best response?

A. No, because buprenorphine is transmitted at high levels into the breastmilk.

B. No, because you have a history of opioid and methamphetamine use.

C. Yes, because you are stable without active use or other contraindications.

D. Yes, because your dose of buprenorphine is low.

Q&A

15 Minutes

ADULTHOOD

Risk Factors and Treatment Considerations

Katrina Mark, MD, FASAM
45 Minutes

Session 7
Learning Objectives

1. Explore the biological, psychological, and sociocultural factors that contribute to gender-specific vulnerabilities to substance use disorders.
2. Identify the specific health risks associated with the use of tobacco, alcohol, and prescription medications, including both short-term and long-term consequences.
3. Identify common gender-specific barriers to treatment for individuals with substance use disorders.

Historical Context

19th Century

- Women were prescribed opium for "female troubles."
- "Women were more prone to opium addiction because of their more nervous organization and tendency to hysterical and chronic disease." (Becker 2016).

19th Century
Opium

Historical Context

20th Century

- Tranquilizers and sedatives were more frequently prescribed for mood disorders.
- Most commonly prescribed to affluent white women.

19th Century
Opium

20th Century
Tranquilizers

Historical Context

20th Century

- During the same time, drugs such as amphetamines and nicotine were marketed to women for weight loss.

19th Century
Opium

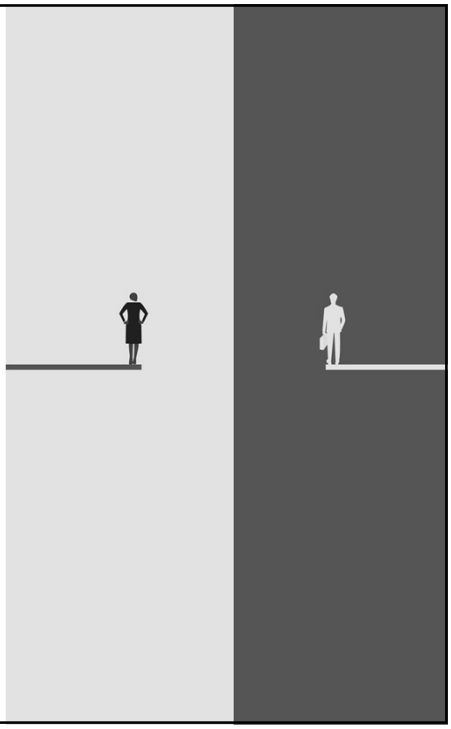
20th Century
Weight Loss
Supplementation

20th Century
Tranquilizers

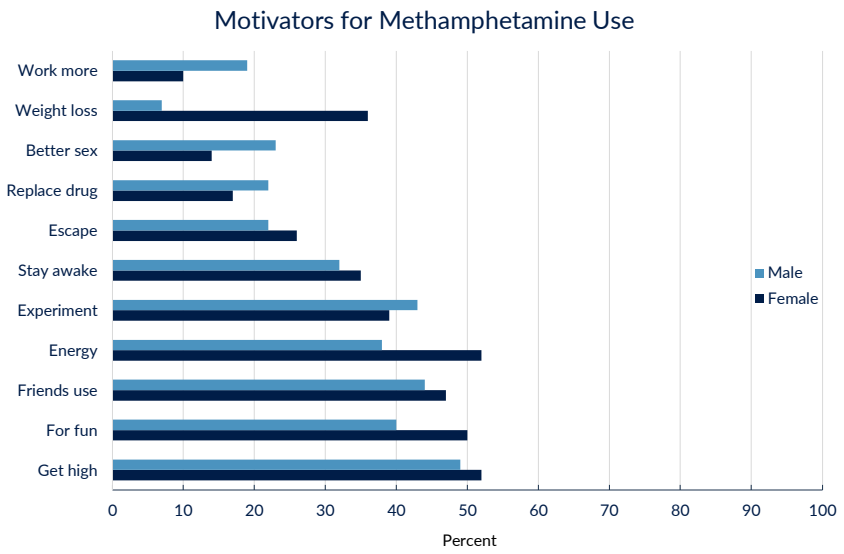
Reasons for Use

Men are more likely to report using for sensation-seeking.

Women are more likely to report using to cope with negative emotions and/or for more "medical" reasons.



Reasons For Use



SOURCE AND CHART ADAPTATION: DOI: 10.1016/S0306-4603(03)00082-0

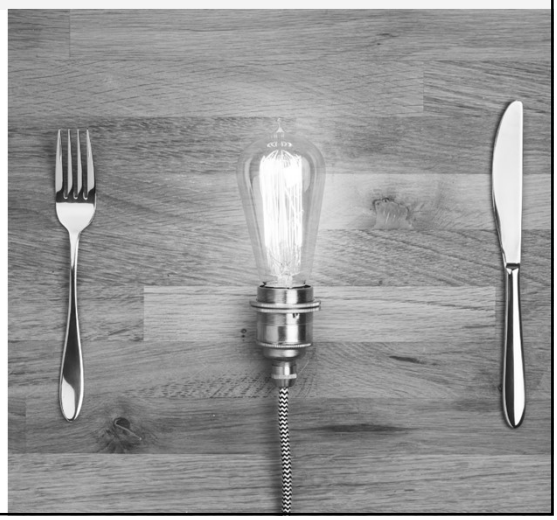
Reasons For Use

	Alcohol Use Reasons						Marijuana Use Reasons			
	Linear Age Trend		Male Gender		Binge Drinking (Age 18)		Linear Age Trend		Male Gender	
	Est(SE)	p	Est(SE)	p	Est(SE)	p	Est(SE)	p	Est(SE)	p
Social/Recreational										
Experiment	--	--	--	--	--	--	−0.44(.01)	.000	−0.06(.05)	.217
Get High	−0.10(.01)	.000	0.11(.03)	.001	0.93(.03)	.000	0.07(.01)	.000	0.09(.05)	.058
Good Time	−0.08(.01)	.000	0.09(.03)	.008	0.59(.04)	.000	−0.10(.01)	.000	0.21(.04)	.000
Fit In	−0.22(.01)	.000	0.43(.06)	.000	−0.15(.06)	.013	−0.19(.02)	.000	0.15(.07)	.036
Bored	−0.27(.01)	.000	0.22(.04)	.000	0.60(.04)	.000	−0.16(.01)	.000	0.15(.05)	.004
Coping Negative Affect										
Relax	0.22(.01)	.000	0.01(.03)	.707	0.52(.03)	.000	0.16(.01)	.000	−0.01(.04)	.873
Get Away	−0.13(.01)	.000	−0.19(.04)	.000	0.54(.04)	.000	−0.11(.02)	.000	−0.14(.05)	.011
Anger/Frustration	−0.15(.01)	.000	−0.14(.04)	.001	0.64(.04)	.000	−0.11(.02)	.000	−0.12(.06)	.049

SOURCE: DOI: 10.1037/a0022445

Food for Thought...

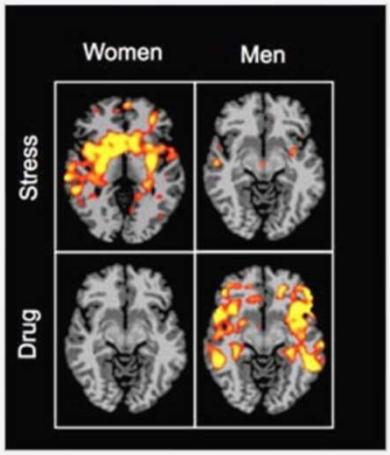
Are women using only to cope with negative emotions?

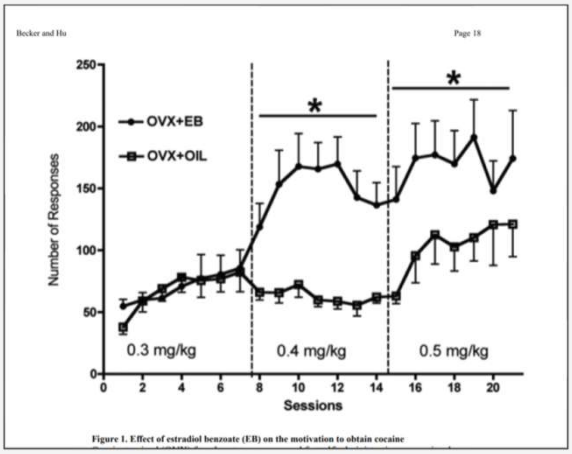


Food for Thought...

Or does the societal view of women as "caretakers" make it less acceptable to use for what are perceived to be more self-serving purposes?

Women: Biologic Differences

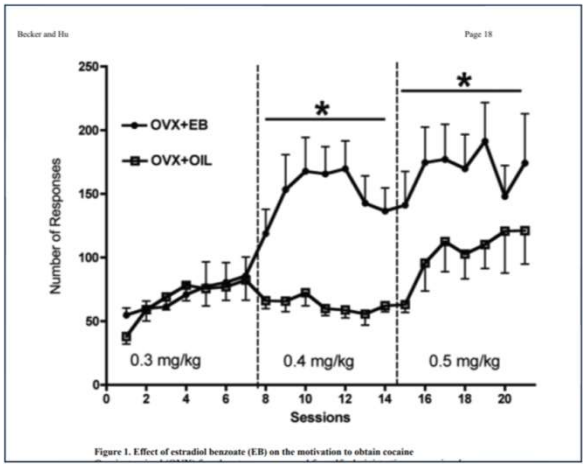




SOURCE: DOI: 10.1016/j.yfrne.2007.07.003

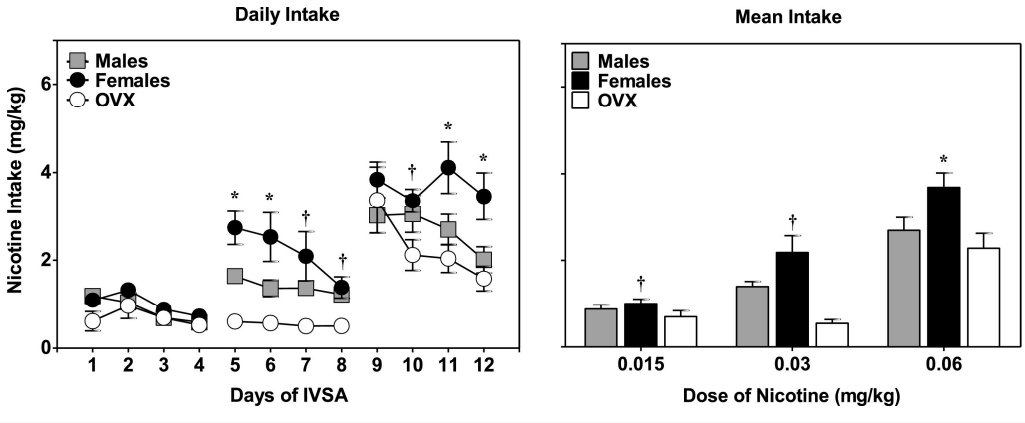
Animal Models

- Female rats self-administer cocaine at a faster rate than males.
- Estradiol treatment results in a linear increase in drug administration.
- Administration of Tamoxifen decreases cocaine administration.



SOURCE: DOI: 10.1016/j.yfrne.2007.07.003

Animal Models

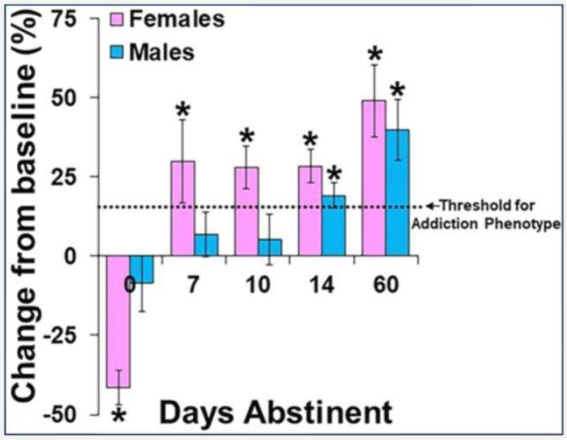


SOURCE: DOI: 10.1016/j.bbr.2016.04.004

Note: The same relationship can be seen in nicotine administration by female rats.

Animal Models

- Female rats show higher motivation to obtain cocaine after forced abstinence



SOURCE: DOI: 10.1124/pharmrev.121.000361

Human Studies

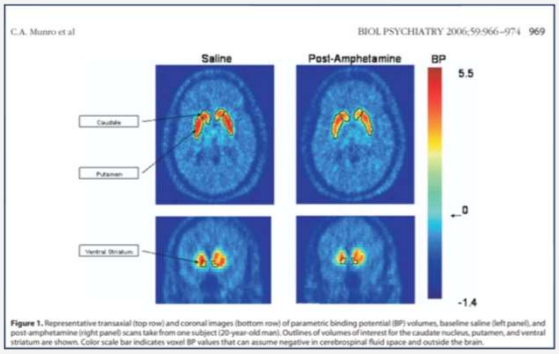


Figure 1. Representative transaxial (top row) and coronal images (bottom row) of parametric binding potential (BP) volumes, baseline saline (left panel), and post-amphetamine (right panel) scans take from one subject (20-year-old man). Outlines of volumes of interest for the caudate nucleus, putamen, and ventral striatum are shown. Color scale bar indicates voxel BP values that can assume negative in cerebrospinal fluid space and outside the brain.

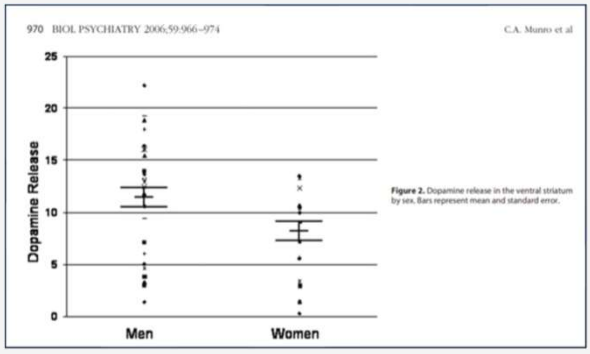
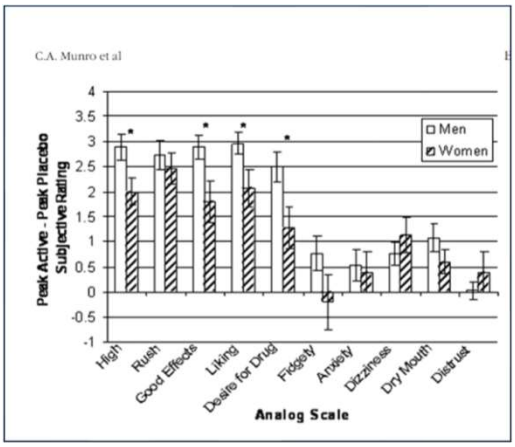


Figure 2. Dopamine release in the ventral striatum by sex. Bars represent mean and standard error.

SOURCE: DOI: 10.1016/j.biopsych.2006.01.008

Human Studies

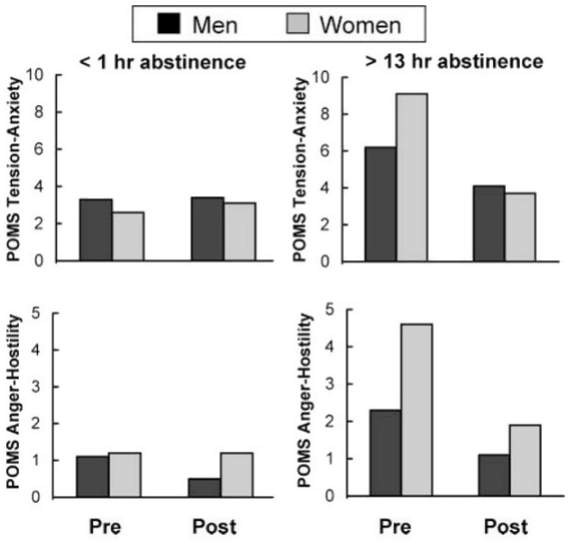
- There are also differences between men and women with subjective effects of drug intake.
- Similar findings were identified in studies of nicotine and cannabis.



SOURCE: DOI: 10.1016/j.biopsych.2006.01.008

Human Studies
Gender Differences in Smoking Cessation

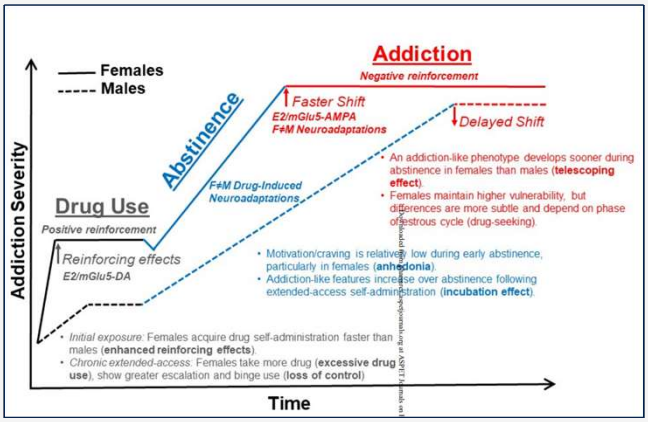
- Women report more intense withdrawal symptoms
- Women have greater cue-induced cravings



SOURCE: DOI: 10.1093/ijnp/pyab015; 10.1080/14622200802412929

Telescoping

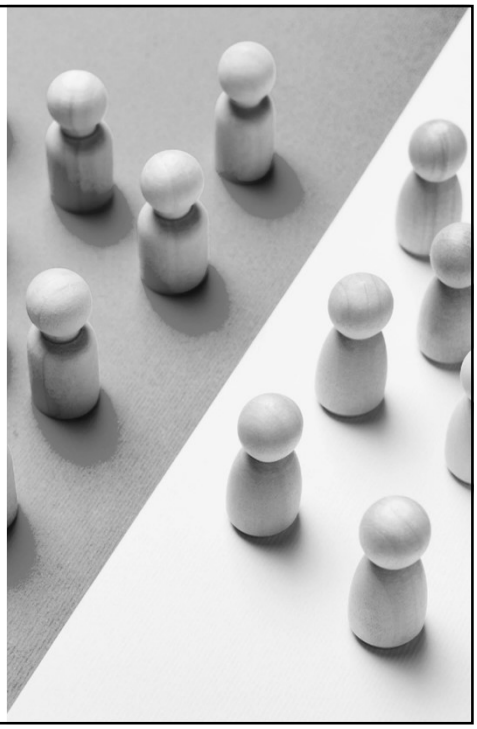
The concept that women are less likely to develop use disorders, but those that do often progress more rapidly.



SOURCE: DOI:10.1124/pharmrev.121.000361.

Telescoping or Gender Bias?

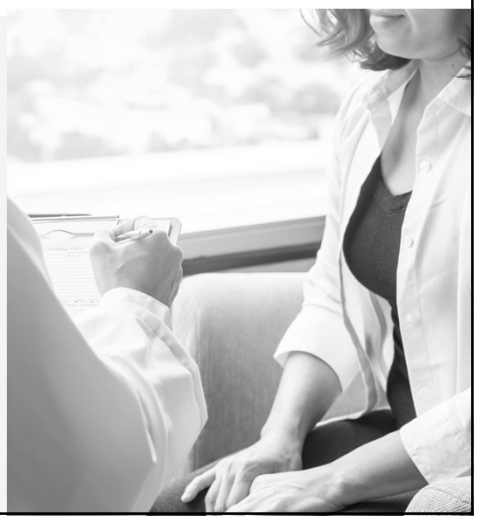
- Assumes a reference of male as the "typical"
- Assumes that women progress through stages in same order as men
- Women have different motivations for treatment



SOURCE: DOI: 10.1080/10826084.2017.1385079

Health Consequences: Tobacco

- Women have worse health consequences from use (specifically alcohol and tobacco).
- Women have greater increase in risk of coronary vascular disease and MI from smoking
- Long-term smoking increases risk of breast and ovarian cancer.



SOURCE: DOI: 10.1016/j.ogc.2014.02.001

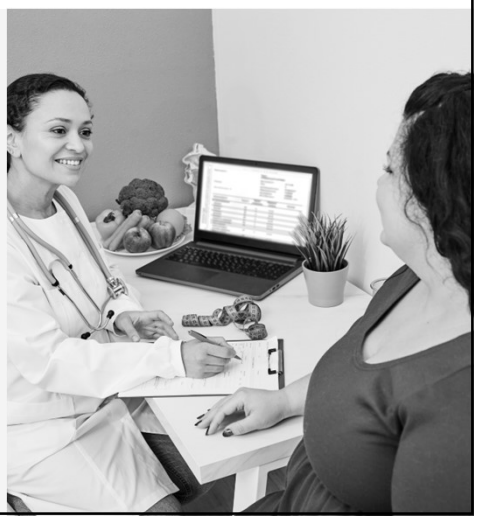
Alcohol: Health Consequences

- Women feel effects of alcohol with lower levels.
- Women experience memory loss more often.
- Women with AUD perform worse on cognitive testing than men with AUD.
- There is a higher likelihood of cardiovascular and liver disease.
- Liver disease more rapidly progresses to fibrosis, which is more persistent.

SOURCE: DOI: 10.35946/arcr.v40.2.01

Screeners

- Women may be more sensitive to mode/environment of screening.
- Some screeners for AUD and SUD are less sensitive for women:
  - CAGE score of 1 rather than 2 proposed for women
  - AUDIT need to modify to use 4 drinks rather than 6 as positive



SOURCE: SMA15-4426

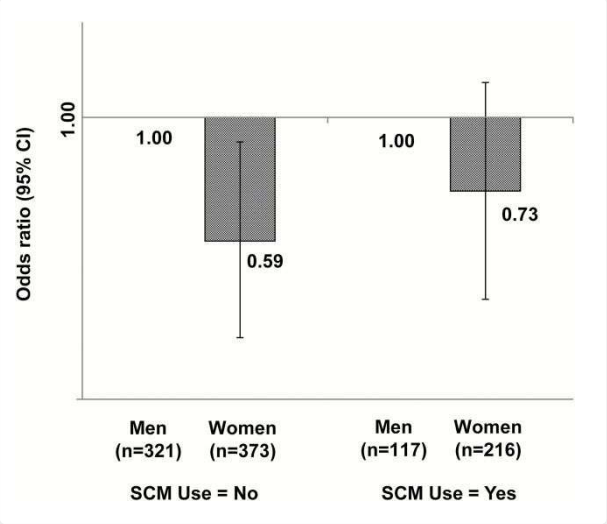
Smoking: Gender Differences

- Stated desire to quit is the same among men and women.
- Women are less likely to successfully quit with each attempt.
- Women who quit are less likely to stay abstinent.

SOURCE: DOI: 10.1093/ntr/ntu212

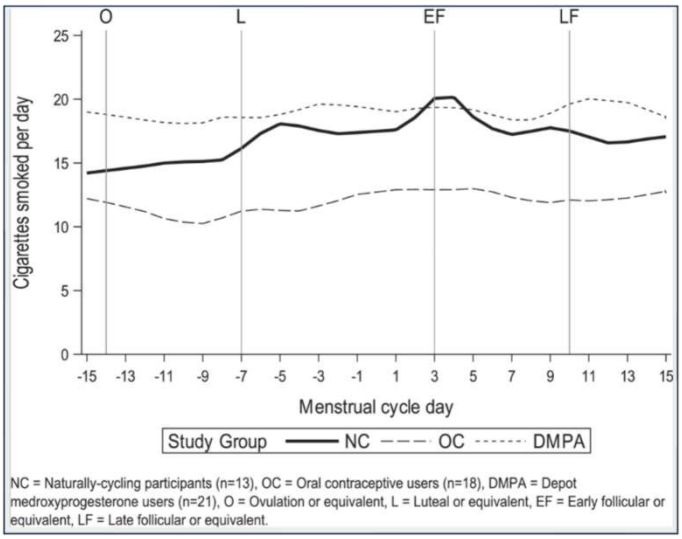
Smoking Cessation

- Women are 41% less likely to be successful in quit attempts without medication.
- Similar success when medication used (pooled all medications)



SOURCE: DOI: 10.1093/ntr/ntu212

Smoking and Menstrual Phase

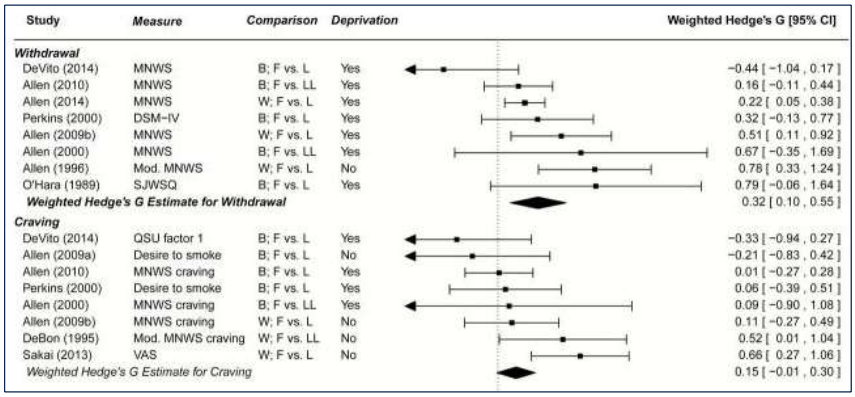


NC = Naturally-cycling participants (n=13), OC = Oral contraceptive users (n=18), DMPA = Depot medroxyprogesterone users (n=21), O = Ovulation or equivalent, L = Luteal or equivalent, EF = Early follicular or equivalent, LF = Late follicular or equivalent.

SOURCE: DOI: 10.1016/j.dadr.2023.100145

Smoking and Menstrual Phase

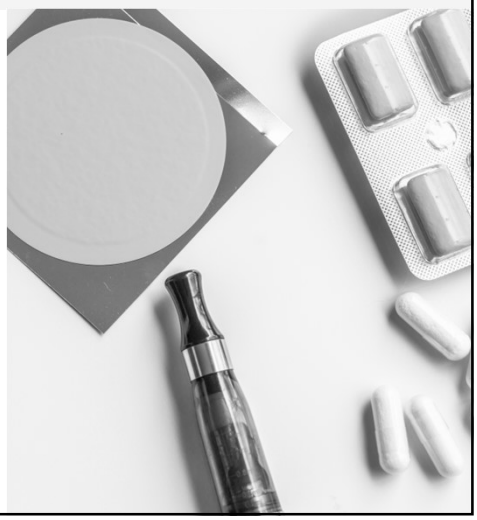
- Metanalysis of smoking cessation and menstrual cycle
- Craving and withdrawal symptoms were greater in the luteal phase.



SOURCE: DOI: 10.1093/ntr/ntu249

Smoking: Different Treatments

- Nicotine replacement (NRT) has shown less success in women than in men.
- Meta-analysis of 14 placebo-controlled studies found:
  - OR for quitting 2.2 in men vs. 1.6 in women
  - Interaction considering men:women 1.4



SOURCE: DOI: 10.1007/s00213-005-0103-7

Smoking: Different Treatments

Meta-analysis including 12 RCTs of bupropion vs placebo

Effect Name	Citation	Zyban Abstinent	Placebo Abstinent	Effect	Lower	Upper	PValue
Men	Ahluwalia et al, 2002	23 / 88	9 / 92	3.263	1.414	7.530	.004
Men	Collins et al, 2004	69 / 120	53 / 120	1.710	1.026	2.850	.039
Men	Dale et al, 2001	39 / 77	14 / 62	3.519	1.672	7.407	.001
Men	George et al, 2002	4 / 6	1 / 8	14.000	.944	207.597	.036
Men	Gonzales et al, 2001	41 / 117	5 / 101	10.358	3.903	27.488	.000
Men	Gonzales et al, 2002	55 / 98	50 / 112	1.585	.919	2.738	.097
Men	Hall et al, 2002	11 / 41	6 / 41	2.139	.706	6.476	.173
Men	Hurt et al, 2003	0 / 44	0 / 42	.955	.019	49.226	.982
Men	Selby et al, 2001	11 / 63	6 / 70	2.256	.782	6.512	.125
Men	Smith et al, 2003	65 / 118	25 / 66	2.011	1.087	3.722	.025
Men	Tashkin et al, 2001	34 / 112	22 / 110	1.744	.941	3.231	.076
Men	Tonstad et al, 2003	102 / 232	49 / 247	3.170	2.112	4.759	.000
Men (12)		**454 / 1116**	**240 / 1071**	**2.525**	**1.875**	**3.401**	**.000**
Women	Ahluwalia et al, 2002	40 / 212	32 / 208	1.279	.768	2.130	.344
Women	Collins et al, 2004	81 / 157	43 / 157	2.826	1.766	4.521	.000
Women	Dale et al, 2001	30 / 79	15 / 91	3.102	1.516	6.349	.002
Women	George et al, 2002	4 / 10	1 / 8	4.667	.404	53.950	.196
Women	Gonzales et al, 2001	20 / 109	5 / 123	4.362	1.690	11.365	.001
Women	Gonzales et al, 2002	64 / 118	42 / 100	1.637	.956	2.801	.072
Women	Hall et al, 2002	7 / 32	4 / 32	1.960	.512	7.496	.320
Women	Hurt et al, 2003	1 / 52	1 / 56	1.078	.066	17.697	.958
Women	Selby et al, 2001	13 / 72	5 / 69	2.820	.948	8.392	.055
Women	Smith et al, 2003	76 / 126	27 / 94	3.772	2.129	6.682	.000
Women	Tashkin et al, 2001	23 / 92	10 / 90	2.667	1.187	5.990	.015
Women	Tonstad et al, 2003	33 / 81	12 / 66	3.094	1.437	6.659	.003
Women (12)		**392 / 1140**	**198 / 1094**	**2.468**	**1.820**	**3.174**	**.000**
Combined (24)		**846 / 2256**	**438 / 2165**	**2.487**	**2.061**	**3.001**	**.000**

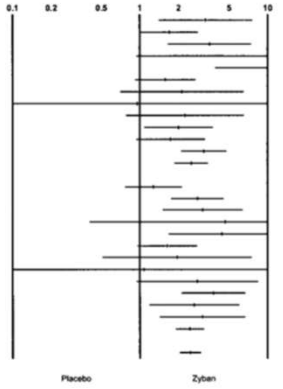
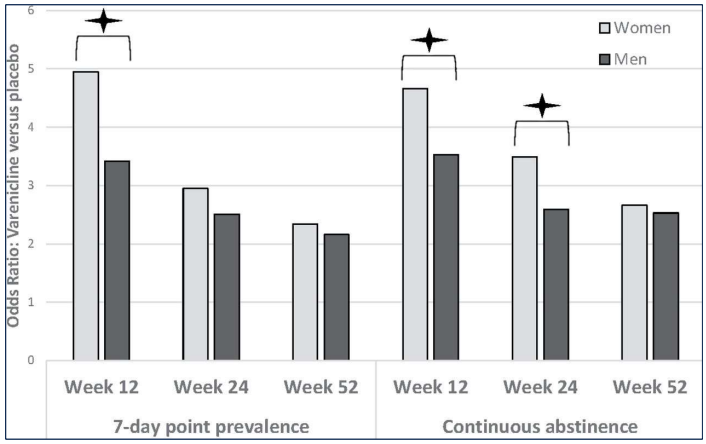


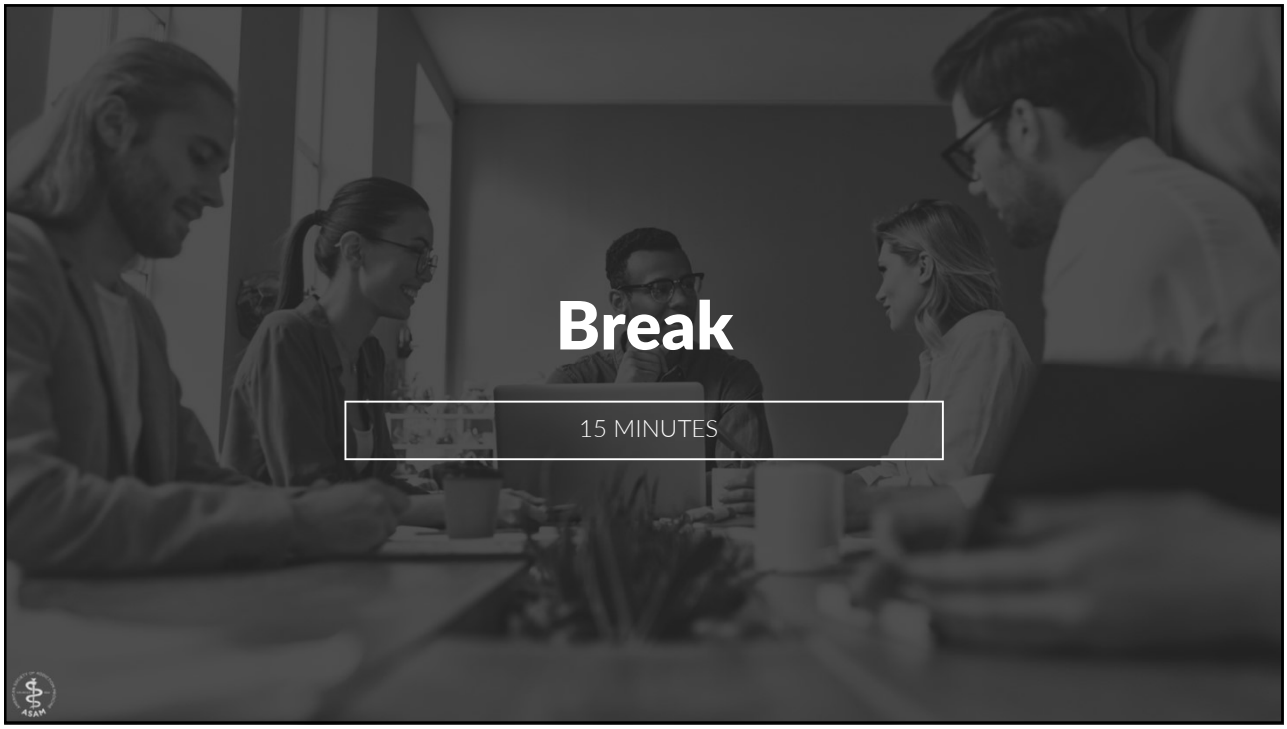
Figure 1 Forest plot of the effects (adjusted ORs) of treatment on cessation outcomes, grouped by gender

SOURCE: DOI: 10.1111/j.1360-0443.2004.00845.x

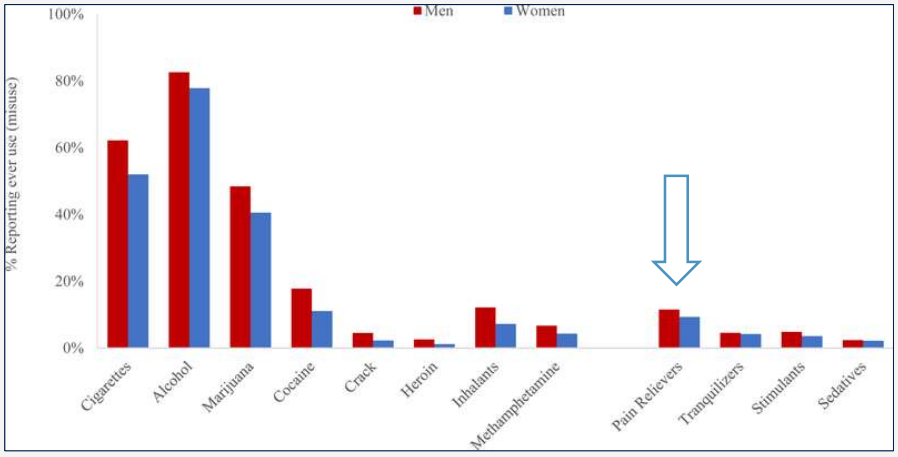
Varenicline for Smoking Cessation



SOURCE: DOI: 10.1093/ntr/ntv207



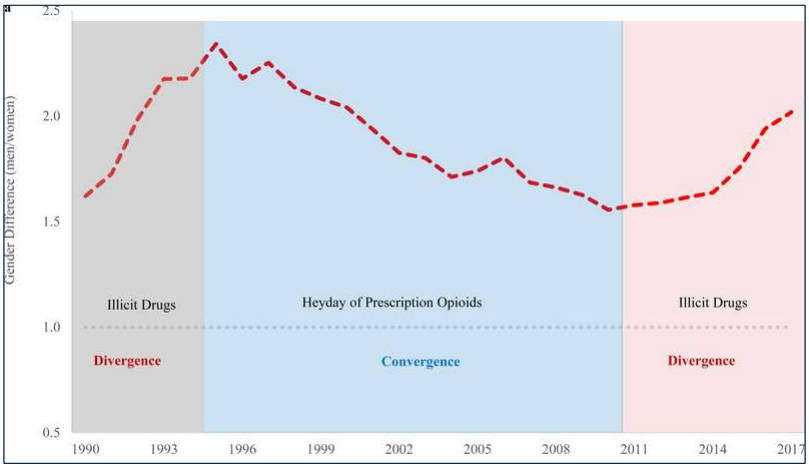
Drug of Choice: Gender Differences



SOURCE: DOI: 10.1111/padr.12336

Overdose Deaths

- As the landscape of opioid use has changed, so has the ratio of overdose deaths between men and women.



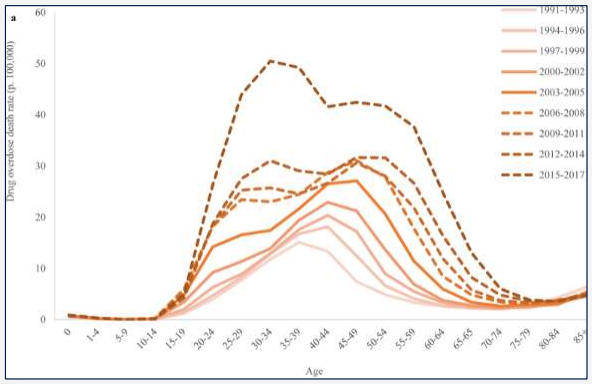
SOURCE: DOI: 10.1111/padr.12336

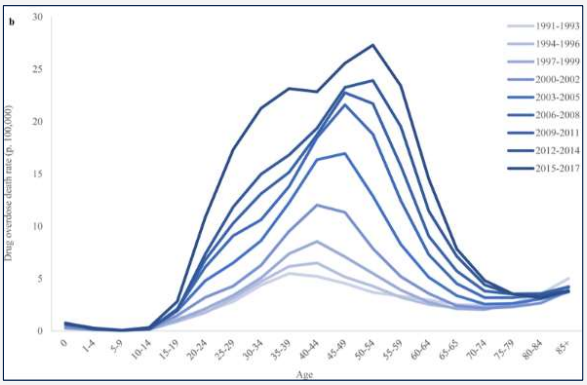
Overdose Deaths: Age

Men

VS

Women





SOURCE: DOI: 10.1111/padr.12336

Sexual Health

Transactional Sex

Definitions (*varied*)

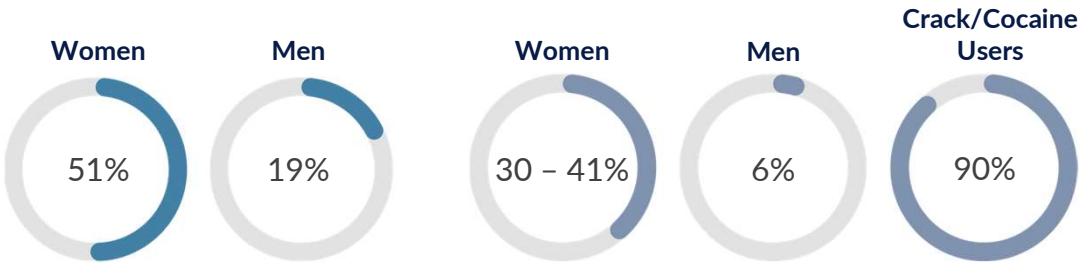
Transactional sex: informal, noncommercial exchange of sex for goods or services

- Love, trust and/or a romantic relationship often present
- May present as the threat to withhold support, housing, money ect.

Commercial sex work: formalized and commercialized negotiation of sex in exchange for payment

SOURCE: DOI: 10.1016/j.drugalcdep.2016.03.006
DOI:10.1080/26410397.2023.2210859

Transactional Sex



SOURCE: DOI: 10.1016/j.drugalcdep.2016.03.006

Risky Sexual Behavior

- Risk of condomless sex was increased among women who engaged in all types of transactional/commercial sex:
  - **Commercial sex work:** OR 2.15
  - **Transactional sex for drugs or money:** OR 1.98
  - **Transactional sex for goods or services:** OR 1.55

All types of exchange sex were risk factors for STIs, sexual and physical violence, and psychological distress.

SOURCE: DOI: 10.1007/s10508-023-02663-x

Transactional Sex and Drug Use

- Increased incidence of risky sexual behavior, STI acquisition, psychological distress, injection drug use and heavy drug use.
- Same treatment outcomes in SUD treatment.
- SUD treatment decreases transactional sex engagement:
  - 89% reduction in a prospective study following women 9 months after engagement in SUD treatment

SOURCE: DOI: 10.1016/j.drugalcdep.2016.03.006

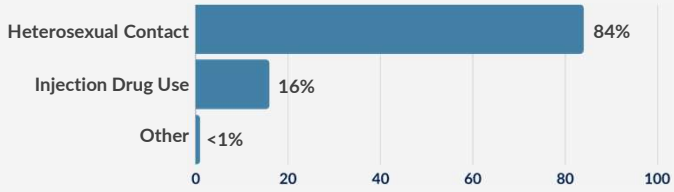
Other Sexual Health Considerations

- Abnormal menses including amenorrhea
  - Lack of awareness of fertility
  - Unclear menopausal transition
- Vaginal dryness
  - Dyspareunia
  - May increase STI acquisition
  - Treated with vaginal estrogen

SOURCE: DOI: 10.1111/j.1360-0443.2005.01091.x

Pre-Exposure Prophylaxis (PrEP)

New diagnosis of HIV in women in 2019



Reminder that PrEP is not just for people who inject drugs

SOURCE: CDC, HIV and Women: HIV Diagnoses

Is PrEP right for me?

PrEP can help protect you if you don't have HIV and any of the following apply to you:

You have had **anal or vaginal sex in the past 6 months** and you:

- have a sexual partner with HIV (especially if the partner has an unknown or detachable viral load),
- have not consistently used a condom, or
- have been diagnosed with a sexually transmitted disease in the past 6 months.

You **inject drugs** and you:

- have an injection partner with HIV, or
- share needles, syringes, or other drug injection equipment (for example, cookers).

You have been **prescribed PEP (pos-exposure prophylaxis)** and you:

- report continued risk behavior, or
- have used multiple courses of PEP.

You may choose to take PrEP, even if the behaviors listed above don't apply to you. Talk to your healthcare provider.

SOURCE: CDC.gov

Treatment

Engagement/Access to Care

- Less than 20% of women receive treatment.
- Women are less likely to engage in treatment than men.
- Once in treatment, women have similar outcomes.

SOURCE: DOI: 10.1016/j.cpr.2017.10.012

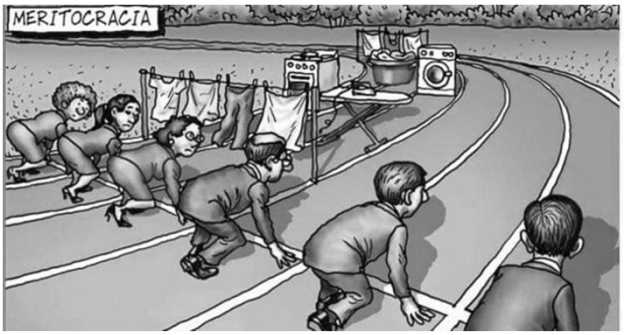
Barriers to Treatment

- Women are viewed by society as caretakers.
- Substance Use Disorder is historically viewed as a male problem.
- Intersectional stigma:
  - Not "proper" women
  - Also not proper "addicts"

SOURCE: DOI: 10.3390/jpm13060965

Engagement/Access to Care

- In treatment, women show greater growth in strengths than men.
- Males have greater reduction of **barriers to recovery** during treatment.



SOURCE: DOI: 10.1186/s13011-022-00444-8

Barriers to Treatment

- Women are more likely to live with their children, which may present barriers to care.
- Fear of loss of custody is a negative motivator to engage.
- Women are more likely to have dual diagnosis.
- Women are more likely to have been victims of abuse, which may prevent them from seeking gender-mixed care.

SOURCE: SMA15-4426
DOI: 10.3390/jpm13060965

Partner Use

- Women are more likely to have a partner who also has SUD or a "dual problem couple."
- When women are in "discordant couples," the rate of IPV is higher.
- Concordant-use couples may make it more challenging for women to seek care (lack of support, caring for a partner).

SOURCE: DOI: 10.1016/j.jsat.2018.06.004

Suggestions for Improvement

Gender-specific treatment options

- Many women report feeling safer, more supported, and able to communicate effectively in women-only groups.
- Studies show non-inferiority; some show benefit, but insufficient information on whether it would make more women engage in treatment.
- Honoring patient preference improves outcomes.

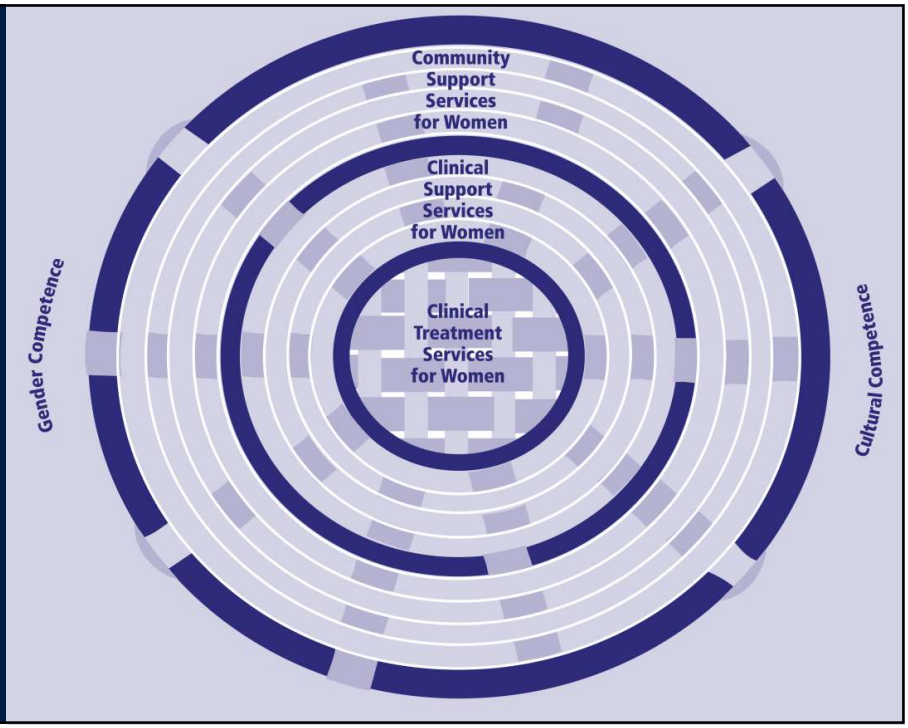
SOURCE: DOI: 10.1016/j.drugalcdep.2014.06.035
DOI: 10.35946/arcr.v40.2.08

Suggestions for Improvement

- In treatment, women show greater growth in strengths than men.
  - Other evidence-based interventions
  - Providing childcare
  - Acknowledging unique needs of women
  - Strength-based approach to counseling
  - Trauma-informed care
  - Treatment of co-occurring mental health disorders
- Including non-pregnant women in research and considering physiologic and psychosocial differences.

SOURCE: DOI: 10.1016/j.drugalcdep.2014.06.035
DOI: 10.35946/arcr.v40.2.08

Interrelated Elements in the Comprehensive Treatment Model



SOURCE: SAMHSA TIP 51

Note to Clinicians

For a woman entering treatment, the tendency to focus on problems or stressors other than her substance abuse is quite normal. Women are socialized to assume more caregiver roles and to focus attention on others. Even if she has not appropriately cared for others (such as her children) during her addiction, it does not mean that she will not see this as an important issue immediately upon entering a detoxification or treatment program. The clinician needs to appreciate this gender difference; instead of assuming that the client's worries and her tendency to be other-focused is a detriment or an issue of resistance to treatment, use the client's concerns as a means of motivation throughout treatment.

SAHMSA

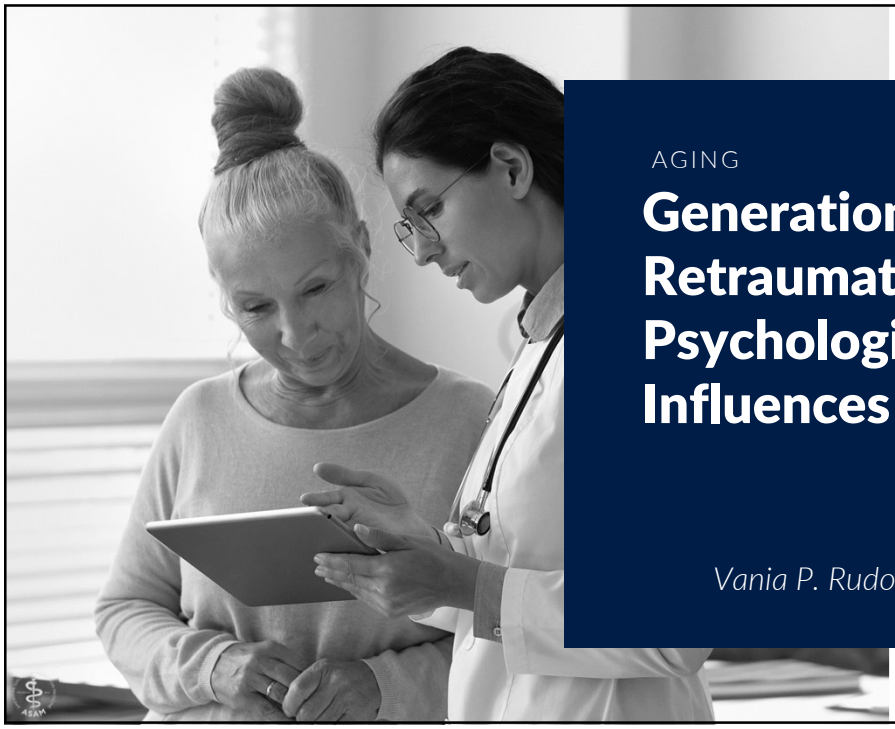
Key Takeaways

- Recognize and consider gender-specific motivations for substance use.
- Acknowledge that women may experience physiological effects of drug use differently and may be more susceptible to certain health risks.
- Consider gender specific barriers to treatment and engagement in care.

Knowledge Check

Which of the following treatments for tobacco cessation has been shown to be more effective in women than in men?

A. Nicotine replacement therapy (NRT)
B. Bupropion
C. Vaping
D. Varenicline



AGING

Generational Trauma, Retraumatization, and Psychological Influences

Vania P. Rudolf, MD, MPH, DFASAM
30 Minutes

Session 8
Learning Objectives

1. Explore advantages and challenges of paying attention to women's aging bodies in recovery from substance use.
2. Establish and maintain healthy social connection and relationships.
3. Describe an innovative model of compassionate and trauma-informed telehealth services to support equitable, inclusive, and empowering care for women across the lifespan.
4. Appreciate the voices of aging women across the lifespan.

As a Woman's Body Ages – Appreciate and Celebrate

- More patience
- Wisdom
- Resilience

- Ability to draw on past experiences
- Confidence

- Life experience, ACES, endurance
- Loved ones, children, grandchildren

- Pursue passions
- Relationships, friendship
- Less anxiety: "I got this"
- Less self-conscious

- Mental Health/Wellness
- Senior discounts
- Retirement
- Self-love, self-compassion

Demographics on Substance Use in Aging People

Current Trends

- Older adults tend to prefer alcohol over illicit drugs
- Misuse of prescription drugs is more common than "recreational" use

Two Main Groups of People with Alcohol Use/"Drinkers" in Later Life

- Drank throughout their lives; now at higher risk for having health-related issues
- Started drinking later in life as a "reaction" to stress, loss, health problem, COVID; tend to be easier to treat

Recent evidence:

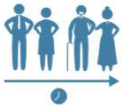
- Illicit drug use is on the rise in older adults.
- Substance use disorder (SUD) in > 50-year-olds will more than double by 2020.

Prescription drugs with potential for misuse:

- Used to treat anxiety, sleep disturbances, insomnia, pain.
- Benzodiazepines, hypnotics, opioid analgesics, skeletal muscle relaxants.

SOURCE: DOI: 10.4088/PCC.11r01320

Aging People



Silver Pandemic: Rapidly increasing number of older adults.

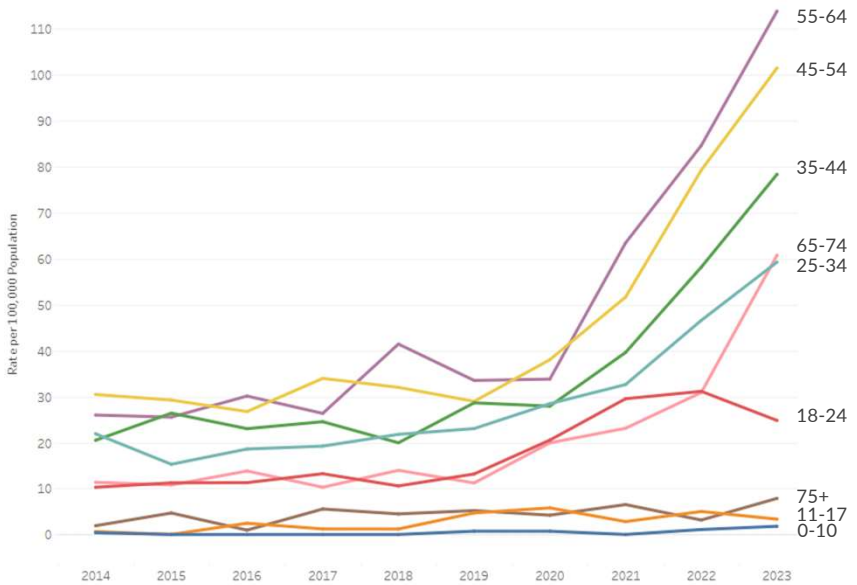
- Individuals ≥ 65 increased by 10M between 2004 and 2014 to > 46.2M
- In 2015, 1 of 7 Americans was an older adult
- Those who reach age 65 have an average life expectancy of 19.3 years
- Older women outnumber older men in the U.S.
- The proportion of the population that is female increases with age.
- In 2014, women accounted for 56% of the population ages 65 and older and for 66% of the population ages 85 and older.

SOURCE: DOI: 10.2105/AJPH.2008.149534;
Substance Abuse in Aging and Elderly Adults. Psychiatric Times, 2012

As Woman's Body Ages

- The reproductive lifecycle distinguishes woman's bodily experiences from men.
- Women who use drugs can experience amenorrhea (the absence or cessation of menses in women of reproductive age).
- Limited evidence suggests that older women who use drugs may be at risk of earlier onset of menopause than those in the general population.
- Issues related to the menopause can be complicated by methadone treatment; hot flashes resemble symptoms of opiate or methadone withdrawal.
- Women with drug using histories experiencing increased levels of physical discomfort, insomnia, irritability, anxiety, and depression during their menopausal transition may be at higher risk of return to use.
- Midlife can be a critical time to manage both chronic conditions and mental health conditions.
- The social marginalization of women who use drugs in older woman risks inhibiting wider medical and sociological interest; focus on pain, discomfort and other bodily sensations.

Disparities in Overdose Deaths



Screening Tools for Alcohol and Drug Use in Ageing People

- Steady growth is based on the Baby Boomer generation aging.
- Creates changes our country has never experienced before!
- Note that the number of older adults will more than double from rates in 2000 by 2040, which is less than 25 years away.

- *Consider living arrangements in the context of loss/change and risks.*

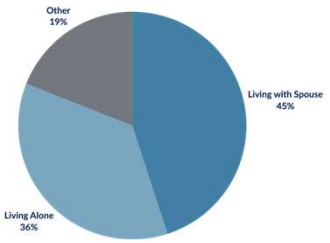
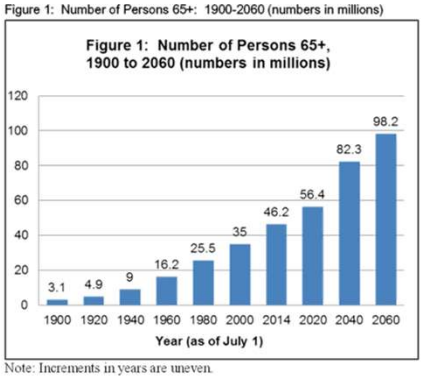


Figure 1: Number of Persons 65+: 1900-2060 (numbers in millions)



Note: Increments in years are uneven.

SOURCE: U.S. Census Bureau, Population Estimates and Projections

Prevalence and Alcohol Use in Ageing People

17% Overall prevalence in ageing people.

- Primary Care Outpatients:
  - 12% women, 15% men

- Prevalence of Alcohol Misuse/Abuse (NIAAA):
  - 2.5 million older adults
  - 21% of hospitalized adults > 40
- Community Elderly
  - Heavy Alcohol Use: 3-25%
  - Alcohol Misuse/Abuse: 2-9.6%

Prevalence and Alcohol Use in Ageing People

Reasons it is often underreported:

- Trauma, shame, guilt
- Symptoms mistaken for other comorbidities: dementia, depression, etc.
- Older adults tend to hide substance and alcohol use.
- Loved ones and relatives: poor awareness, may be ashamed (hide it).

Alcohol use, measurement is important:

One drink:


12 oz
Beer


4-6 oz
Glass of Wine


1 ½ oz
Distilled Spirit

Heavy use:


>2/day
Men


>1/day
Women

Prevalence and Substance Use in Ageing People

- People 65 and older consume more prescribed and OTC medications than any other age group.
- Illicit drug problems rare in people without prior substance history.

Opioids:

- Misuse or use disorder rare unless past history of addiction.
- Chronic pain is directly related to illicit opioid/Fentanyl use.

Benzodiazepines/Hypnotics:

- Chronic use: 1.8%
- Women > Men
- 17-23% of all prescriptions for older adults
- Chronic use >4 months not recommended

Risk Factors for Alcohol and Substance Use in Ageing People

"Risky Use" in older people combined with age-related health problems

- **Universal age-related changes** (e.g., metabolism, sensory) increase risks.
- **Medical problems** in late life.
- **Medications** (treat health-related problems interact with alcohol/drugs).
- **Loss/stress** → precipitate/contribute to use.

Community, Residence Changes

- **Marital status**
  - Approximately 2/3 of men and 1/5 of women are married.
  - Roughly 1/3 of women and a smaller segment of men are widowed.
- **Living arrangements**
  - Approximately 1/3 live alone.
  - Around1/5 of women ≥ 75 years old live alone.
  - Stress; relocation AND isolation

Considerations and Communication Around Alcohol and Substance Use in Ageing People

Ways to help with generational trauma, meet people where they are:

- Listen, be gentle and offer respect, validation, empathy, curiosity
- Safety, comfort and presence 500%
- Engage in an open conversation; collateral Information
- Talk to loved ones and others to confirm story
- Ask for permission to ask questions and to support

Social and health-related distress "treated" with alcohol:

- Fear of disability, death, role changes, uncertainty
- Depression, anxiety
- Isolation, boredom

Screening for Alcohol Use in Ageing People

Risks: Medications

- *Older adults take many medications to treat health problems.*
- Meds interact with alcohol and create risks
- **Many adverse outcomes:**
  - **Common**: Nausea and vomiting, headaches, drowsiness, fainting, loss of coordination, confusion (and later increase fall risk)
  - **More severe**: Internal bleeding, heart problems, difficulty breathing
  - **Negative impact** on prescription medications action (less/more potent)

Common examples: Alcohol plus…

- Aspirin or NSAIDS = Bleeding, GI stomach
- Acetaminophen = Liver damage
- Cold/allergy meds = Drowsiness, impaired coordination
  (fall risk increases)
- Hypnotics, analgesics, anxiolytics = Sleepiness, poor coordination, difficulty breathing, tachycardia, memory impairment
- Hypertension, diabetes, ulcers, gout, heart failure meds

SOURCE: NIH; Administration on Aging

Screening for Alcohol Use in Ageing People

Risks: Loss and Social Stress

- **High levels of stress** are critical to consider!
  - **Retirement**
  - **Loneliness/social isolation**
  - **Loss/Widowhood:** Death of a spouse, close friend, even a pet.
  - **Stress related to:** hormonal influences on cognitive health; a particular emphasis on the menopausal transition; sex and gender-related demographic disparities in older age; economic implications of sex and gender at older age.
- **Health-related changes**
  - Hip fracture: social changes
    - Unable to drive to shop, care for home, participate in leisure activities.
    - Diseases and conditions that are unique to or more common in women, such as osteoporosis, breast and ovarian cancer
- **Disabilities**: Pain, depression, fear related to loss of abilities, impending death.
- **Sleep disturbances**: Typical/universal sleep pattern changes “treated” with alcohol.

SOURCE: NIH; Administration on Aging

Screening for Alcohol Use in Ageing People

Risks: Universal Aging Changes

- Changes that occur in everyone/ everywhere (aka "normal" aging changes, not disease).
- Over time, affects cells in every major organ.
  - Shift in muscle-to-fat ratio (sarcopenia)
  - Metabolic slowing
  - Sensory decline/changes: Visual (presbyopia), hearing (presbycusis)
  - Cardiovascular: Slower heart rate, cardiomyopathy, atherosclerosis
  - Many others!

Risks: Chronic Illness in Late Life

- Disease-related problems have more impact than universal changes!
  - **Nervous system**: Dementia, delirium, depression, Parkinson's, many others.
  - **Cardiovascular**: Hypertension, arteriosclerosis, coronary heart disease, arrhythmias, heart failure.
  - **Musculoskeletal**: Osteoporosis, falls, fractures, arthritis, degenerative joint disease.

SOURCE: DOI: 10.2105/AJPH.2008.149534;
Substance Abuse in Aging and Elderly Adults. Psychiatric Times, 2012

Screening for Alcohol Use in Ageing People

Risks: New Onset Illness in Late Life

- New onset **psychiatric problems** are associated with substance use risks, with estimated prevalence between 21% and 66%.
  - Cognitive disorders → 10% – 15%
  - Anxiety disorders → 10% – 15%
  - Depression* → 25%

Brief Intervention and Treatment for Elders

- Problems leading to referrals for BI:
  - Alcohol use (9.7%)
  - Illicit drug use (1.14%)
  - Depression (64.3%); significant correlation between alcohol and depression

Depression and drinking is the most common comorbid problem in late life!

SOURCE: DOI: 10.2105/AJPH.2008.149534;
Substance Abuse in Aging and Elderly Adults. Psychiatric Times, 2012

Screening for Alcohol Use in Ageing People

Alcohol

CAGE: 5% prevalence

- **C**: Have you ever felt the need to Cut Down?
- **A**: Have you ever been Annoyed at criticism of your drinking?
- **G**: Have you ever felt Guilty about your drinking?
- **E**: Have you ever had a morning Eye-opener to get going?

AUDIT: 18% prevalence

Alcohol Use Disorders Identification Test
Developed by the World Health Organization
Clinician-administered and self-report version.

- Ten questions
- First three questions deal with quantity and frequency of use
- Geriatric primary care outpatients
- Maximum in last year
- Other drugs
- Use despite consequences

SOURCE: DOI: 10.2105/AJPH.2008.149534;
Substance Abuse in Aging and Elderly Adults. Psychiatric Times, 2012

Screening Tools for Alcohol and Drug Use in Ageing People

ASSIST:

Alcohol, Smoking, and Substance Involvement Screening Test

- Eight item questionnaire.
- Obtains information from patients about lifetime use of substances.
- Current substances use associated problems over the last 3 months.
- Can identify a range of problems associated with substance use:
  - acute intoxication
  - regular use
  - dependent or 'high risk' use
  - injecting behavior

SBIRT:

Screening, Brief Intervention, and Referral to Treatment

An evidence-based practice that targets "risky" substance use

- **Screening**: Two-step screening for quickly assessing use of alcohol, illicit drugs, and prescription drug use, misuse, and abuse
- **Brief Intervention (BI):** Brief motivational and awareness-raising intervention given to risky or problematic substance users
- **Referral to Treatment**: Referrals to specialty care for patients with substance use disorders

SOURCE: DOI: 10.2105/AJPH.2008.149534;
Substance Abuse in Aging and Elderly Adults. Psychiatric Times, 2012

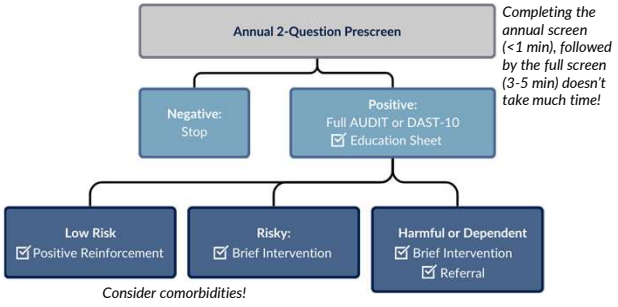
SBIRT+ and Whole Person Caring

- Screening: first step of the SBIRT process → determines the severity and risk level of the patient's substance use.
- Determine if a brief intervention or referral to treatment is a necessary.
- Provider engagement to meet people where they are and their needs is essential**!**

SBIRT+ and Whole Person Caring

Adaptations tailored to older women:

- Use lower drinking "threshold" for screening.
- Screen "as needed" based on observed changes.
- Consider late life problems when applying BI:
  - Problems/issues at "baseline"
  - Root causes of substance use/related distress
  - Involvement of community services
  - Follow-ups by PCP or community service



Completing the annual screen (<1 min), followed by the full screen (3-5 min) doesn't take much time!

SBIRT+ and Whole Person Caring

Brief Intervention (BI):

- Like adults:
  - Based on motivational interviewing skills
  - 5- to 15-minute semi-structured discussion
  - Aim: Awareness and risk reduction

BI Tailored to Older Adults:

Drug use is mostly misuse, still a focus!

  - Opioids (oxycodone, hydrocodone, fentanyl, methadone, buprenorphine).
  - Benzodiazepines (lorazepam, alprazolam, diazepam).
  - Stimulants (amphetamine, dextroamphetamine, methylphenidate, cocaine).
  - Sleep aids (zolpidem, zaleplon, eszopiclone).
- Possible stigma of mental health or substance use referrals.
- Greater need for PCP "treatment" -> BH integration/counseling.

SBIRT+ and Whole Person Caring

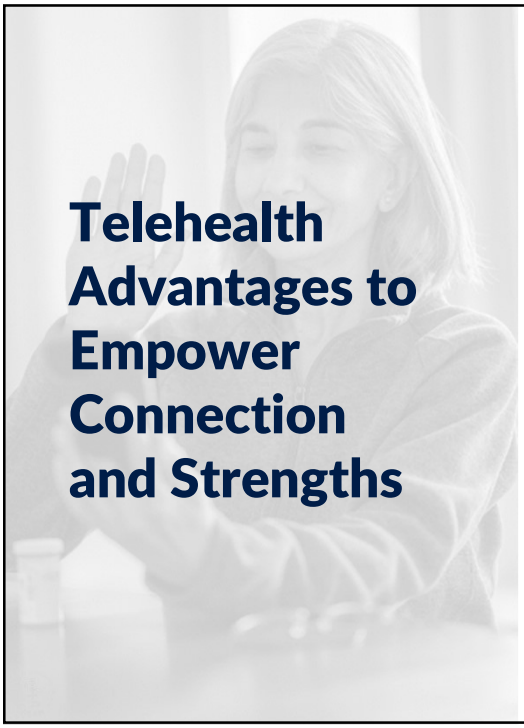
BI Tailored to Older Adults: *Consider…*

- Health, meds, loss and stress as antecedents
- Depression as causal or contributing factor
- Community/social resources [presence/lack]
- Importance of follow-up discussions
- Possible involvement of significant others
  - Support, encourage decreased substance use
  - Address causal/contributing psychosocial factors
- Education as an intervention
  - Fact sheets, other printed information
  - Discussion of risks/benefits

The Intersection of Drug Use and Ageing in Women

- Exploration of mid-life and older women's bodily experiences of transitioning from long-term substance use into recovery.
- Focus on the intersection between drug use, recovery, ageing, gender, and the body.
- Women's personal sense of power in relation to current and future health status.
- Challenges in terms of ageing in recovery and transitioning through the reproductive life cycle, and the somatic effects of trauma on women's recovery.
- Deeper understanding of their experiences of drug-free and ageing bodies.

SOURCE: DOI: 10.1037/hum0000295; 10.1080/1533256X.2020.1748975



Telehealth Advantages to Empower Connection and Strengths

Telehealth eliminates the transportation challenges that can prevent patients from attending counseling sessions.

Focus:
- Age-specific treatment setting, population of ageing women and pace

Focus on:
- Wellness, mental health support, depression
- Restoration of self-esteem and social supports
- Asking for permission, sharing with vulnerability
- Staff experienced with elders
- Links and hybrid resources with services for ageing and elder women

Building and reconnecting
- Building resilience
- Developing a positive mindset
- Promoting healing, self-love and self – compassion
- Be mindful of your thoughts and emotions
- Practice self-care, forgive yourself
- Focus on your strengths
- Practice mindfulness and gratitude

Telehealth Tailored to Factors Related to Increased Trauma and Substance Use in Ageing Women

Curriculum focused on:

- Changing societal norms
- Increase awareness re: access to prescription medications
- Emphasis on isolation due to ageing and loneliness when older
- Mental health focus/Anxiety re: COVID pandemic/natural disasters
- Trauma and sensitivity to body changes, and medical problems (mental health, wellness and chronic pain management)
- Lifestyle and life transitions: significant life events (career changes, retirement, loss of a spouse and/or friends), relationships (professional, personal)
- Vulnerability and emotional distress re: woman's role as a nurturer for family members/children
- Social factors: social isolation, lack of family/peer support can be overwhelming
- Disparities: poverty, homelessness, financial instability, trauma from abuse, DV

Telehealth to Focus on The Intersection of Drug Use and Ageing in Women

Highlights: Mental health and bodies in recovery → well-being, vulnerability and healthy relationships

- Ageing in recovery - changing woman's outlook as they get older; acknowledging potential damage to their health from past drug use → taking steps to improve their health in the present
- Ageing into the (peri) menopause - a natural bodily transition that requires medical and/or social support and understanding in the present
- Women's personal sense of power in relation to current and future health
- Challenges in terms of ageing in recovery and transitioning through the reproductive life cycle, and the somatic effects of trauma on women's recovery
- Deeper understanding of their experiences of drug-free and ageing bodies

"Alone we can do so little; together we can do so much."
- Helen Keller

Trauma as Felt, Embodied and Conquered by Women

- Physical or psychological trauma
- The trauma experienced throughout their lives, is still carried within their bodies → avoiding re-traumatization
- Women's personal sense of power in relation to current and future health status
- Post-traumatic stress disorder (PTSD) is embodied and carried on in the body long after the trauma has stopped; *Read: Body Keeps the Score, by Van der Kolk*
- 'Relationship actions' such as disconnecting or limiting contact with recovery-endangering people whilst adding recovery-supportive individuals to help maintain recovery

SOURCE:DOI: 10.1080/1533256X.2020.1748975; 10.1016/j.jsat.2020.108215; 10.1017/S1041610216001800; 10.1016/j.cobeha.2016.09.007

Telehealth Advantages to Empower Connection and Strengths with Ageing and Across the Lifespan

Group Medically-Shared Visits for Women of All Ages

The care is non-judgmental and focused on you!

We are grateful for the opportunity to provide this service to you and the community.

"Alone we can do so little; together we can do so much."
- Helen Keller

VIRTUAL BRIDGE
Group Medically-Shared Visits

Access: no wrong door service, flexibility

- *Appointment scheduled with patient's input; reminders via email and MyChart*

Equity/diversity: inclusive, and empowering care for all patients (all cultures, all backgrounds, any setting)

Equality

- *Group facilitated by a medical provider, fellows and learners are welcome*
- *Compassionate and trauma informed approach*
- *Everyone is invited to offer "voice" and participate, focus on peer support*

Recovery

- *Peer recovery skills, treatment engagement, relapse prevention, accountability, mindfulness, resilience, compassion*

VIRTUAL BRIDGE
Group Medically-Shared Visits

Model implemented April 2021

- Appointment scheduled with patient's input; reminders via email and MyChart

Group visit categories for ageing women:

- Chronic pain on buprenorphine
- Moms with SUD on buprenorphine
- Women with OUD
- Women with AUD
- Co-occurring ED and OUD

Advocacy and re-imbursement by HCA (99212, 99213, MAT – enhanced Medicaid pay for MOUD)

Metrics: PHQ2, No show, OD prevention, MAT and Narcan prescriptions, Patient survey (qualitative and quantitative evaluation)

Medically-Shared Group Visits Format

- Introductions and Check-Ins
- Reflection, EI and sharing
- Recovery focused topics: *relapse prevention, life/recovery skills, accountability, honesty, empowerment, kindness, self-resilience, growth mindset, humility, recovery journey*
- Self-resiliency focus topic: *self-empowerment, trauma response, stress reduction (DBT, mindfulness, ACT), coping skills, healthy boundaries*
- Wellness and mental health focused on ageing
- Mindfulness, DBT
- Gratitude
- Closure, check out, individual 1:1, refills, care coordination

Lessons Learned

- Women appreciate choice in modality of visit
- Flexibility and inclusiveness, whole person care in all group settings improve treatment engagement and retention
- Non-judgmental and harm reduction focused atmosphere promotes disclosure, openness
- De-centralizing UDS results as solitary outcome of treatment = more patient-centered and goal directed assessment
- Strong focus on recovery, wellness, mental health, OD prevention is highly valued by patients
- Patient's "voice and choice" for follow up improved patient satisfaction and decreases no shows
- Group visits, video, meet q3wk~monthly

Growth mindset:

- BH/Addiction, Primary care, any specialty – expand services for women across the lifespan
- Wider geographic catchment for patients in rural areas

Lessons Learned

- Women love the zoom format: “leaving with food for thought,” “liberating and educational,” “filling a niche for people,” “I can be real, everybody is so encouraging and understanding, no one is judgmental.”
- Learners love the opportunity to appreciate the connection, belonging to ageing community, peer support and interaction.

Data:

- 18 months Apr 2021- Oct 2022: 104 groups, 779 patients
- 22 months Jan 2022- Oct 2023: 158 groups, 806 patients

Metrics:

- PHQ2 < 0.5
- No show < 1%
- OD prevention (100%), OD 0%
- MAT and Narcan prescriptions (100%)
- Patient survey (qualitative and quantitative evaluation)

VOICES OF WOMEN IN RECOVERY

Voices of Women in Recovery

Chronic Pain on Buprenorphine Group; Mean Age: 48

- "I like hearing about others dealing with their issues and problems. It helps me realize that my issues and problems are not the end."
- "I love this group. It's a safe place to find support and connect with others around recovery."
- "The flexibility of the Zoom platform as a meeting space is a huge benefit."
- "I find the information sharing, tool learning and acceptance I feel from Dr. Rudolf and the people in the group very helpful."
- "I appreciate the time we spend honoring one another and spreading positive support."
- "There is something that is just magical about working through recovery hand in hand with other women who understand me."
- "It is flexible, meets me where I am, confidential and safe ."
- "This group provides a sense of family. No matter your situation, everyone is understanding, compassionate, and supportive."
- "I appreciate the open, nonjudgmental and safe haven dynamic the group employs and really love the family aspect every mom has and extends to every other mom participating."

Voices of Women in Recovery

OUD Group, Mean Age: 52

- "This meeting is an anchor and something solid I look up to."
- "I like the focus, it is a good outlet for me, and it is important for me to learn about recovery techniques, podcasts and skills that are helpful with my recovery."
- "The Swedish zoom meeting has been a positive experience to do a personal inventory."
- "I like the sense of community and safe space to share about what's going on in my recovery; it's a place I learn new coping skills."
- "I love the camaraderie of the group, the sharing, the honesty that everyone practices; we have a warm and caring group. It allows me to express my good times and my bad times, to talk to people who are not my family, who are like me. It is nice to have the common ground to share with other people in recovery."
- "I like the element of accountability; I am not alone and learning techniques from each other."
- "It is a great asset; it reminds me why I am sober. It helps me not being isolated during COVID."

Voices of Women in Recovery

Mom's Group, Mean Age: 31

- "The group means a lot to me, having a group of peers to connect with even though our journeys are all different. To have a safe space that we can all connect on, takes away the fear and pressure; knowing that I am not going to be judged and that I can connect my journey with others. To have the sense of community, of having peers I can share my journey with, it is truly humbling and inspiring."
- "After listening to the group, I feel like my day is going to go well. I like the support and is it a true camaraderie."
- "One of the only outlets I have that makes me feel like I am heard and understood."
- "It is inspiring to attend and to connect with other people while listening to their stories and strengths."
- "I like the convenience about it, and that I can do it from home or work; hearing the different stories we all talk about, why we are here and talking about the medicine that keeps me healthy helps me knowing that I am doing well. It's great to know that I have other people who have the same issues and that the Suboxone helps with addiction and with my pain."
- "I feel a sense of comfort and energized; it is a safe space to get coping support from a group of peers who understand the recovery."
- "The group fills up the gas in an empty gas tank."

Voices of Women in Recovery

AUD Group, Mean Age: 55

- "It's a great day to be sober."
- "Staying clean and sober, looking for success!"
- "I look to the future, there is so much to look forward to."
- "I appreciate the more emotional sharing opposed to AA especially with other women."
- "I appreciate having an alternative to AA meetings and having a medical professional in the room/facilitating the meeting."
- "I like that there is a women's only group and a mixed group."
- "I like the consistency of the program, and how routinely the same group of people who show up so we can continue to get to know each other on more than just a surface level."

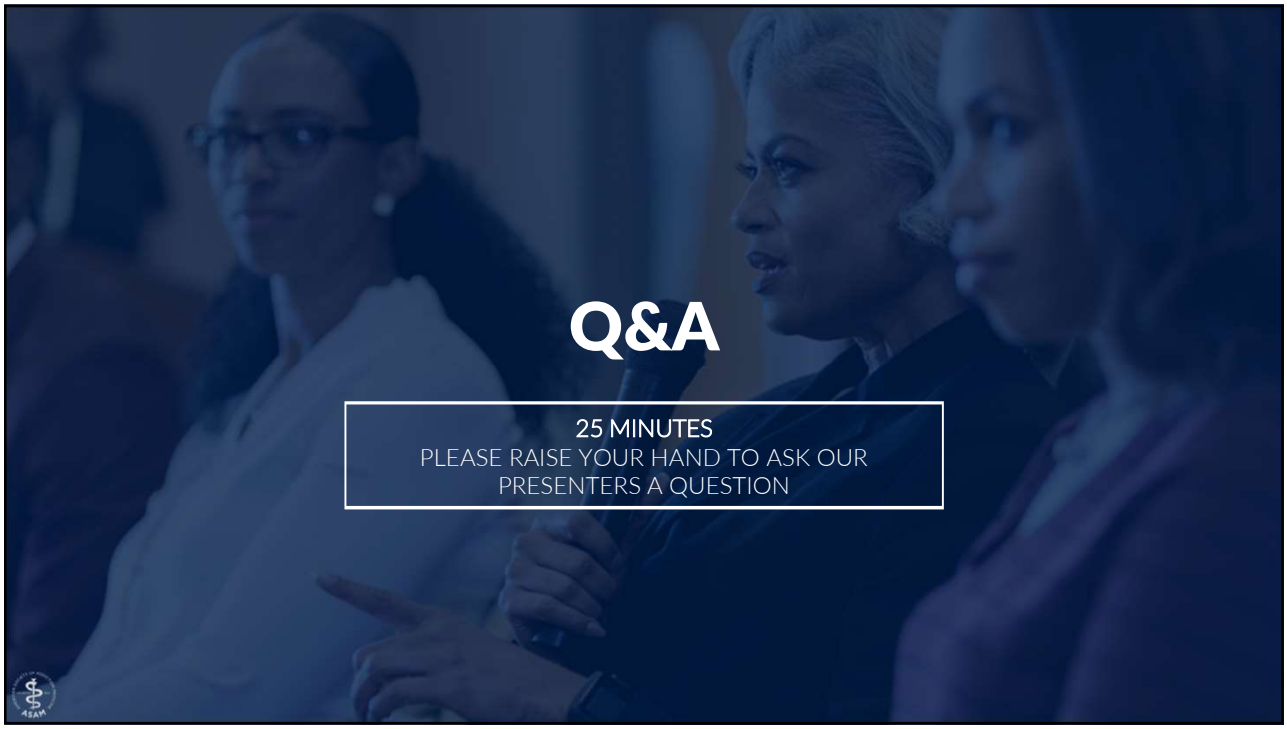
Key Takeaways

- Recognize that ageing women have unique life and medical circumstances that increase vulnerability and alcohol use.
- Acknowledge that women may experience trauma, shame, guilt and may be more susceptible to health risks related to alcohol and substance use.
- Consider screening, listening and genuine, regular follow up to engage and empower positive change.

Knowledge Check

What is the most common comorbid condition among adults later in life?

A. Anxiety disorder and alcohol use
B. Depression and alcohol use
C. Anxiety disorder and illicit drug use
D. Depression and prescription mediations



END OF SESSION

Women and Addiction: Screening, Treatment And Whole Person Care