Perinatal Addiction & The Opioid Crisis – What We Have Learned So Far

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Faculty/Presenter Disclosure & Conflict of Interest

- **Presenters:** Kate Bodkin, Eric Cattoni, Kevin Desmarais
  - Employees of BC Women's Hospital and Sheway
- **Disclosures:**
  - We have not received any financial support for this presentation
  - We will be discussing prescribing Opioid Agonist Therapy (OAT) outside of currently recommended guidelines
  - Kevin is a clinical investigator in the pRESTO and OPTIMA studies, through the BCCSU

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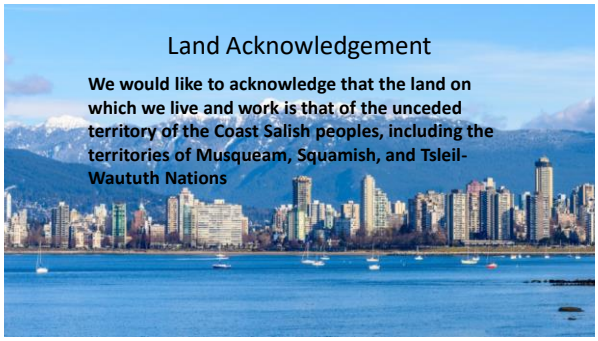

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Learning Objectives

1. Appreciate the value of the principles of harm reduction, woman-centred care, trauma informed care and cultural safety
2. Highlight the importance of having an integrated and seamless transition between community and hospital programs
3. Identify multidisciplinary professionals that can help to develop perinatal addictions programs
4. Recognize "rooming-in" of the mom and baby dyad as a national standard of care
5. Gain confidence in providing appropriate perinatal care to women with substance use disorder in your own community

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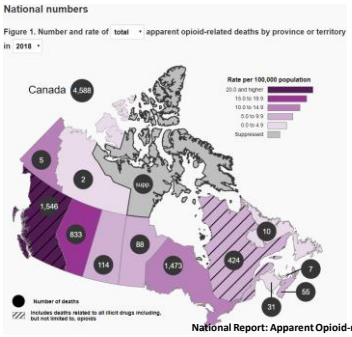

National Report: Apparent Opioid-related Deaths in Canada

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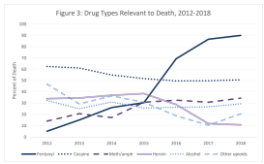
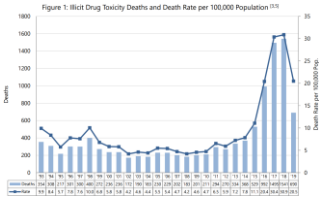


Comparison to Other Common Causes of Unnatural Deaths from 2010 to 2018:



BC Coroners Service – Illicit Drug Toxicity Deaths in BC Jan 1, 2009 - August 31, 2019

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Opiate use disorder in Pregnancy

- Obstetrical outcomes
  - Maternal death
  - Intrauterine growth restriction (IUGR)
  - Placental abruption
  - Oligohydramnios
  - Preterm labour
  - Premature rupture of membranes
  - Cesarean Delivery
- Fetal Outcomes
  - Miscarriage and stillbirth
  - Neonatal abstinence syndrome
  - Low birth weight

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Philosophies of Care

Equity-Oriented
Trauma-Informed
Woman-Centred
Cultural Safety
Harm Reduction

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"What (people) need is sensitive, intelligent social scaffolding to hold the pieces of their imagined future in place - while they reach towards it."

- Marc Lewis - The Biology of Desire

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FIR Square, BCWH

13-bed inpatient unit, for expecting or new mothers with substance use disorder

Physicians, Nurses, Pharmacist, Social Workers, Drug & Addictions Counselor, Art Therapist, Spiritual Counselor, Elder

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Continuum of Care

- **BC Women's Hospital**
  FIR Program (BCWH locating (604) 875-2161)
  Perinatal Addictions Service (BCWH locating or through RACE Line)
- **Community Medical Services**
  Sheway, Vancouver
  Maxxine Wright, Surrey
- **Housing/Treatment Programs**
  YWCA Crabtree, United Gospel Mission, Atira, Genesis, Karis (Kelowna), Ellendale (Surrey), Peardonville (Abbotsford), Heartwood

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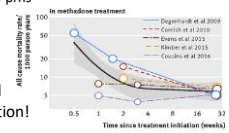
Our approach

- Establish rapport!
- Treatment mostly initiated by community partners
- For some patients, inpatient stabilization is needed
  - Allows for rapid aggressive titration with use of prns

Why admit?

- High rates of mortality during treatment initiation
- Pregnancy risk of acute opiate withdrawal
- Opportunity for interdisciplinary intervention!



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SOGC CLINICAL PRACTICE GUIDELINE

No. 349, October 2017 (replaces No. 256, April 2011)

No. 349-Substance Use in Pregnancy

4. Health care providers should employ a flexible and harm reduction approach to the care of pregnant women who use alcohol, tobacco, or drugs. Pregnant women at risk for problematic substance use should be offered brief interventions and referral to community resources for further psychosocial interventions (II-2B).

7. The standard of care for the management of opioid use disorders during pregnancy is opioid agonist treatment with methadone or buprenorphine. Other sustained-release opioid preparations are also an option if methadone or buprenorphine is not available (I-A).

8. Opioid detoxification should be reserved for selected women because of the high risk of relapse to opioids (II-2B).

14. Pregnant women on opioid agonist treatment should be encouraged to breastfeed regardless of the maternal dose, in the absence of an absolute contraindication (II-2B). Women with active substance use should be encouraged to discontinue alcohol or other drug use while breastfeeding, and the risks and benefits of breastfeeding versus breast milk exposure to substances should be discussed (II-2B).

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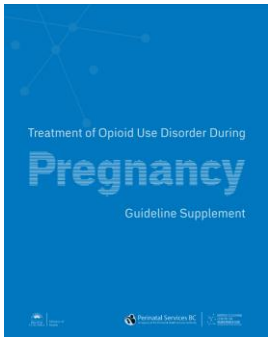

2. Withdrawal management alone is NOT recommended due to high rates of relapse and subsequently elevated risk of fatal and nonfatal overdose, infections, and negative pregnancy outcomes.

4. The type of OAT to be initiated should be selected based on patients' individual circumstances and with consideration of access and availability.
i.Methadone is traditionally recognized as the first-line option for OAT during pregnancy.
ii.Buprenorphine/naloxone is an alternative first-line medication for this population. Recent studies have found this medication to be as safe and effective as methadone and buprenorphine monotherapy during pregnancy.
iii.Slow-release oral morphine may be considered for patients who are not successfully retained in treatment with buprenorphine/naloxone or methadone.
iv.Injectable opioid agonist treatment (iOAT) has not been studied in the context of pregnancy. Caution should be exercised when prescribing iOAT for individuals who are pregnant or may become pregnant. This caution should be exercised with consideration of the potential harms of denying access to iOAT for a pregnant person who otherwise meets eligibility criteria.

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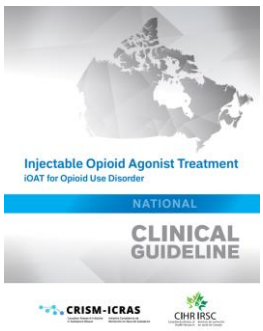

"However, the potential harms of initiating iOAT should be weighed against the considerable risk of morbidity and mortality associated with untreated opioid use disorder in the case of individuals with severe opioid use disorder who have been unable to stabilize with other options. Similarly, for individuals who are stable on iOAT prior to pregnancy, the likelihood of relapse to non-medical opioid use and associated harms should be carefully assessed when considering treatment de-intensification."

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BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Perinatal Addictions Service High-Dose HYDROmorphone Administration for Opioid-Use Disorder (Adult)
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DATE ____/____/____ (DD MM YYYY) TIME _____

WEIGHT: _____ kg HEIGHT: _____ cm ☐ ALLERGY CAUTION sheet reviewed

Status/Admit/Transfer/Discharge
- **Orders must be completed by a prescriber with injectable opioid agonist treatment (iOAT) clinical privileges**
- **Call the patient's community provider to discontinue any ongoing opioid prescriptions**
- **Refer to BC Women's Hospital High-Dose HYDROmorphone for Opioid Use Disorder Protocol**

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Rooming-In

- Decrease NAS/NOWS
- Decrease LOS
- Decrease need for morphine treatment
- Decrease NICU admission
- Increases successful breastfeeding
- Increases chance of mom and baby going home together
- Decreased system costs

"Rooming-in is recommended as the standard of care for opioid-exposed infants as it facilitates care for the mother-child dyad as one unit while alleviating neonatal opioid withdrawal symptoms. Assessment and treatment of neonatal opioid withdrawal symptoms should be conducted in rooming-in settings"
-Treatment of Opioid Use Disorder During Pregnancy, Guideline Supplement. Perinatal Services BC, BCCSU BC Ministry of Health

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Managing infants born to mothers who have used opioids during pregnancy

Posted: May 11 2018 | **Updated:** Oct 3 2019

Principal author(s)

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Abstract

The incidence of infant opioid withdrawal has grown rapidly in many countries, including Canada, in the last decade, presenting significant health and early brain development concerns. Increased prenatal exposure to opioids reflects rising prescription opioid use as well as the presence of both illegal opiates and opioid-substitution therapies. Infants are at high risk for experiencing symptoms of abstinence or withdrawal that may require assessment and treatment. This practice point focuses specifically on the effect(s) of opioid withdrawal and current management strategies in the care of infants born to mothers with opioid dependency.

Keywords: *Discharge planning; Management; NAS; NPI; Treatment strategies*

"Strategies to support keeping mothers and infants together and breastfeeding are essential. Providing nonpharmacological interventions, such as skin-to-skin contact, developmental positioning, comfort measures, minimizing environmental stimuli, ensuring adequate nutrition and providing pharmacological treatment when indicated, are key components of a comprehensive plan."

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Parenting and drug use

- There is no duty to report to the ministry on a pregnant women (and it violates doctor-pt confidentiality)
- BC government ended birth alerts as of Sept 2019

"*Used in hospitals for decades in B.C. and in other provinces and territories, these alerts are issued, without the consent of the expectant parents, where there is a potential safety risk to infants at birth. . .We know that birth alerts have been primarily issued for marginalized women and, disproportionately, Indigenous women.*"

**We offer and encourage early, voluntary referrals in order to facilitate planning

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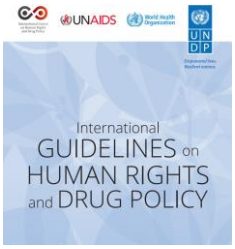
"Ensure that a parent's drug use or dependency is never the sole justification for removing a child from parental care or for preventing reunification. Efforts should be directed primarily towards enabling the child to remain in or return to the care of their parents, including by assisting drug dependent parents in carrying out their childcare responsibilities."



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DISCUSSION

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Co-Sleeping

- Sedating medications (OAT) and substance use increase risk of adverse outcomes
- Safe sleep planning essential

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Breastfeeding

- Safe and protective!!
- OAT not a contraindication
  - iOAT?
- Drug use not an absolute contraindication
- HCV not a contraindication
- HIV IS a contraindication
  - Make sure to check recent serologies

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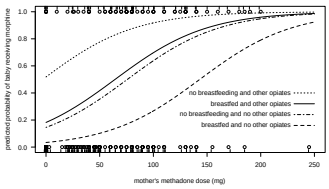
Effects of breastfeeding on NAS/NOWS morphine requirements



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Consider joining

- Perinatal Substance Use Google Group (Rebecca Coish) https://groups.google.com/forum/#!forum/perinatal-substance-use

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