



SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
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INTEGRATED CARE NEWS

Periodic Updates and Information for the Sandhills Center Provider Network

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Overcoming opioid abuse during pregnancy is one of Sandhills Center's priorities

OVERVIEW OF OPIOID USE IN PREGNANCY

Opioid use and abuse -- in both urban and rural areas -- is an epidemic in the United States. According to the National Survey of Drug Use and Health, 4.8 percent of urban U.S. residents over age 12 used opioids non-medically in the past year, which is slightly more than the 4.4 percent in rural areas. However, rural users often face special challenges that make it more difficult for them to access treatment.

Opioid use in pregnancy is in a special category of this epidemic, and is of serious importance, as it affects the mother, child and community. It is estimated that opioid use during pregnancy affects about 5 percent of pregnant women in the United States. Opioid abuse in pregnancy is defined as illicit use of heroin or misuse of legal opioids prescribed for pain. It is associated with an increased risk of adverse outcomes to both the fetus and the mother.

The shorter-acting opioids, such as illicit heroin, have more drastic effects on the fetus as the shifting blood levels cause repetitive withdrawal symptoms in both mother and fetus. The fetus feels withdrawal symptoms. This increases the risk of miscarriage. Short-acting opiates cause fluctuations in the opiate levels -- ranging from very high during mother's intoxication to low levels a few hours later -- as the drug wears off and withdrawal symptoms start appearing. These fluctuations are very dangerous to the developing fetus.

Heroin is the most rapidly-acting opioid, has a short half-life, and users have to take multiple doses per day to maintain the drug effect, and therefore is highly addictive.

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Prescribed opioids that may be misused include Oxycodone, Hydrocodone, Methadone, Codeine, Meperidine (Demerol), Propoxyphene (Tramadol), Morphine, Fentanyl, among similar compounds. These products -- as well as heroin -- may be injected, smoked, nasally inhaled or swallowed. All of these products have the potential for overdose, physical dependence and addiction.

Injecting these products also carries potential risks for local infection, abscess formation, HIV, Hepatitis C, as well as Septicemia, Endocarditis, Osteomyelitis and Respiratory Arrest. This last condition is most serious as these products slow down and depress respiration, resulting in respiratory arrest and death if the patient is not rescued in time.

Early identification of women who are using opioids is important to Sandhills Center in order to improve maternal and infant outcomes. Before prescribing opioids for pain-related conditions, it is essential that prescribers ensure that a woman is not pregnant nor plans to get pregnant. Alternatives for pain medications are available. If opioids must be dispensed, prescribers should start with the smallest dose and shortest course possible.

Women of childbearing age may be taking opioids in a variety of circumstances, including prescription for pain, management of opioid dependence, and misuse of prescriptions (using someone else's medication and/or using heroin or other illegal opioids).

They may have physical dependence or experience physical withdrawal symptoms if abruptly discontinued, or they may have opioid use disorder/addiction and use opioids to get high and/or for perceived pain, stress, anxiety, depression or other conditions.

Pregnant patients on opioid therapy for chronic pain management or medication-assisted treatment for dependence should not be advised to discontinue treatment due to the high risk for relapse and pregnancy complications associated with withdrawal.

If taking opioids illegally, she should be referred to an opioid treatment program (Methadone or Buprenorphine), or to a physician who has Drug Enforcement Administration (DEA) approval to prescribe Buprenorphine.

GUIDANCE FOR PROVIDERS' MANAGEMENT OF SUBSTANCE USE IN PREGNANCY

- Use a universal screening tool with patients during the initial prenatal visit and throughout the pregnancy.
- Gather additional information to assess patients' risks for problems with drugs and alcohol; review medications; and ask about prescription medications, as well as non-prescription medications.
- Refer to the North Carolina Controlled Substance Reporting System (CSRS), a controlled substance prescription reporting system that allows registered dispensers and prescribing practitioners to review patients' controlled substances prescription histories on the web -- www.ncdhhs.gov/divisions/mhddsas/csrs.
- Record all relevant information in the medical record.
- Provide clear, accurate information to all patients about possible side effects of all common substances on the fetus.
- For patients no longer using controlled substances, provide continuing support.
- For patients who stopped using since learning of the pregnancy, support non-use.
- For patients currently using opioids, assess the patients' perceptions of their problems and readiness to change; discuss referral options for substance abuse treatment; focus on strategies to reduce risk; and regularly reassess patients' readiness to change.
- Make referrals for those patients who have tried to stop without success, those who are not confident of their ability to stop without help, and those who are not willing to stop but are willing to meet with a behavioral health provider for an assessment.
- All referrals must contain the patients' signed release/consent forms.
- If the patient already is receiving substance abuse treatment, contact the provider to coordinate care and maintain this contact throughout the treatment period.

References: Medscape Psychiatry & Mental Health; and excerpts from CCNC Pregnancy Medical Home Care, Pathways Management of Substance Use in Pregnancy.