Objectives

• Review neurological underpinnings of addiction
• Describe approaches to screening + diagnostic criteria for SUD, SBIRT, and motivational interviewing
• Focus on OUD given opioid crisis:
  • MOUD pharmacology
  • MOUD efficacy
  • Post-natal consideration: NOWS, breastfeeding, etc
• Outline components of the AAP “Recovery-Friendly” Practice

Substance Use Disorder (DSM-5)

A problematic pattern of substance use leading to clinically significant impairment or distress
- Tolerance (need more of the substance to get same effect)
- Withdrawal
- Cravings or strong desire to use
- Often taken in larger amounts or over a longer period than intended
- Inability to cut down or control use despite desire to do so
- Considerable time spent using/obtaining/recovering from use
- Important activities given up/reduced
- Failure to fulfill role obligations
- Recurrent use despite persistent, related social or interpersonal problems
- Recurrent use in physically hazardous situations
- Continued use despite knowledge of negative consequences
Physical Dependence vs Substance Use Disorder

What is Addiction?
Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry (ASAM)

Neurobiological underpinnings of Addiction

1. Binge & intoxication
2. Withdrawal & negative affect
3. Preoccupation & anticipation

Decreases in Striatal Dopamine Release Occur with Chronic Cocaine Use
Brain Changes: Decrease in Dopamine Receptors Persists in Recovery

1. Binge & intoxication
2. Withdrawal & negative affect
3. Preoccupation & anticipation

Why address parental addiction in pediatric practice?

Screening

Evidence-based Screening Tools
Motivational Interviewing

“a collaborative goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance.” (Miller and Rollnick)

Cultivating an Atmosphere of Acceptance

- Asking Permission
- Give the option of not answering
- Address confidentiality concerns up front
- Normalizing
- Transparency

The Language of Change

- Focus on ambivalence and change
- Most people who need to make a change are ambivalent.
- When they talk about change they have a mix of two kinds of talk.
  - Change talk – arguments for change
  - Sustain Talk – arguments for not changing
Tips for Using Motivational Interviewing

Core Skills

• Be respectful and curious
• Avoid the “fixing” or “righting reflex”
• Avoid arguing – roll with resistance
  • Use reflections
    • Straight reflection
    • Double sided
  • Develop discrepancy (plant seeds)

Recovery-friendly Pediatric Care

• Patient- & Family-centered medical home model
• 8 touchpoints in the first post-partum year

Components:

• Strength-based, Family-centered
• Stigma Reduction
• Dyadic Approach
• Community Collaboration

Recovery-friendly Pediatric Care: Strength-based, Family-centered

• Prioritize building a therapeutic alliance and continuity of care
• Open, nonjudgmental communication
• Build parental confidence by celebrating small (and large!) victories & milestones
• Highlight parent’s strengths; praise parenting skills
• Work with families to establish health and recovery goals.

Recovery-friendly Pediatric Care: Stigma Reduction

• Provide staff education and training about SUD as a chronic medical condition
• Practice trauma-informed care
• Use non-stigmatizing language
Recovery-friendly Pediatric Care: Dyadic Approach

- Encourage parents to care for their own well-being
- Maternal screenings and referrals (e.g., Edinburgh Postnatal Depression Scale, SEEK PQ-R, etc.)
- Basic familiarity with addiction treatment and local landscape
- Pediatric subspecialist for referrals as indicated (pediatric ID, DBP, etc.); enhanced developmental surveillance; Early intervention
- Parenting supports (e.g., peer recovery, lactation support, home visiting program referrals)

Plan of Safe Care (POSC)

- States required to create & implement policies to support birth parents and infants exposed to substances prenatally, including POSC — an individualized plan for birthing parent & their infant
- Emerges from federal legislation (Child Abuse and Prevention Treatment Act [CAPTA] Comprehensive Addiction and Recovery Act [CARA])
  - “The CAPTA specifically states that a POSC is not a definitive finding of child abuse and neglect”
  - “However, states retain ultimate legal authority to define substance use during pregnancy as a form of abuse/neglect”

Substance Use During Pregnancy | Guttmacher Institute → resource on state laws

Association of State Child Abuse Policies and Mandated Reporting Policies With Prenatal and Postpartum Care Among Women Who Engaged in Substance Use During Pregnancy

CONCLUSIONS AND RELEVANCE: The results indicate that state child abuse policies and mandated reporting policies are associated with reduced receipt of prenatal and postpartum care among women who engage in substance use during pregnancy.
Legal Landscape: Children Exposed to Parental Substance Use

• Civil and criminal laws vary by state and by drug-related activity
  
  State Statutes Search - Child Welfare Information Gateway

• Know and follow your state laws
• Be mindful of bias and disproportionality; take steps to mitigate implicit bias
• Not all episodes of substance use (or misuse) are child maltreatment, neglect, or abuse
• Relapse is part of recovery
• When a CPS report is required, be transparent and direct with family re: mandated reporting, outline supports available

Parental Health Screening

Review & support POSC components pertinent to birth parent
• Post-partum visits
• BP check
• Contraceptive management
• PPD/PPA screening
• IPV screening
• Parental fatigue
• Conversation re: sleep, feeding, supports, & NOWS management, if pertinent
• Methadone or buprenorphine dosing considerations
• Opportunity to discuss safe sleep plan

Peripartum Opioid Overdoses

MOUD Impact on Peripartum Opioid Overdoses

Postnatal considerations for baby

<table>
<thead>
<tr>
<th>NOWS</th>
<th>HIV</th>
<th>HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysregulation of neuromodulation</td>
<td>If positive: specialized antiretroviral regimen and monitoring</td>
<td>May be vertically transmitted</td>
</tr>
<tr>
<td>May have hyperphagia, impacting sleep/wake cycle</td>
<td></td>
<td>HCV RNA test at 2-6 months</td>
</tr>
<tr>
<td>Nonpharmacologic tx: skin to skin, swaddling, quiet environment, etc</td>
<td></td>
<td>HCV Ab rfrx to RNA at 18 months</td>
</tr>
</tbody>
</table>

Breastfeeding Considerations

<table>
<thead>
<tr>
<th>Breastfeeding implications</th>
<th>Buprenorphine</th>
<th>Methadone</th>
<th>Vivitrol (naltrexone)</th>
<th>Hepatitis C</th>
<th>HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraged</td>
<td>Encouraged</td>
<td>Scant data</td>
<td>Encouraged; abstain if nipples cracked/bleeding</td>
<td>Historically advised exclusive formula feeding; shift to shared decision making; exclusive breastfeeding-mixed feeding</td>
<td></td>
</tr>
</tbody>
</table>
Recovery-friendly Pediatric Care: Community Collaboration

- POSC implementation
- Supporting parent in connecting to addiction medicine services, including MOUD, therapy, mutual help (peer support) groups
- Multiparty consents to facilitate multi-D team communication (eg Early Intervention monitoring, home visiting service)
- Community-based resource mapping/referrals/warm hand-offs: transportation, nutrition (SNAP, WIC), professional development, supplies (safe sleep, car seats)

Medication for Opioid Use Disorder (MOUD)

**Maintenance**
- Full agonist: methadone
- Partial agonist: buprenorphine (+/- naloxone)
- Antagonist: naltrexone

**Withdrawal management/ “detox”**
- "Comfort meds" +/- some opioid agonist agent with rapid taper

**Methadone**

- Prevents/treats withdrawal symptoms
- Blocks euphoric effect of opioids
- Reduces illicit opioid use
- Risk of overdose
- Long half-life → once a day dosing
- Highly regulated: OTP setting

**Buprenorphine Basics**

- Partial agonist at mu opioid receptor
  - Partial agonism → clinically desirable
  - Lower physical dependence
  - Lower abuse potential
  - Greater safety profile
  - Ceiling effect at higher doses
  - Very high affinity at mu receptor: will displace morphine, methadone, other full agonists
  - Low intrinsic activity at mu receptor → agonist effects reach a max DO NOT increase linearly with increasing doses
Treatment Retention:
Bup-assisted Detox vs. Maintenance

Kakko, Lancet 2003

Days
Treatment Retention:
Bup-assisted Detox vs. Maintenance

Maintenance: 75% Abstinent at 1 year
N=15/20

Detox: 0% Abstinent at 1 year
N=20

- Decreases cravings and drug use → benefit to pregnant person and fetus (stabilized intrauterine environment)
  - Detox during pregnancy is discouraged
- Decreases prematurity and low birth weight

MOUD during Pregnancy

Reduction of Overdose Risk with MOUD During Pregnancy

Duration of MOUD during pregnancy, wk

0 0.2 0.4 0.6 0.8 1.0
Adjusted relative risk of nonfatal overdose (95% CI)

- 97% risk reduction
- 92% risk reduction
- 82% risk reduction
- 57% risk reduction
A few pearls re: discussing treatment with parents

- MOUD regulatory environment → treatment setting
- Stigma & desire to “detox”
- Experiencing cravings?
- Identified triggers?
  - Changing “people, places and things”
- Mutual help meetings
  - NA, AA: home groups, sponsor, working the steps; sometimes look down on medication; AlAnon and NarAnon for family members
  - Secular alternatives: SMART recovery, Lifeling, Women For Sobriety (WFS)
- Relapse as part of recovery
- Relapse prevention plan

• SUD is a challenging, but treatable, chronic medical condition, and recovery is possible!
• Supporting family members on the path to recovery is an important intervention for the health of the child
• Pediatric healthcare professionals can expand skills and attitudes they already have to create a Recovery-Friendly practice environment

Thank you!

Questions?
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Some Resources

- Parent Infant Dyad Community Resource Mapping (aap.org)
- Handout #1_Recovery-Friendly Pediatric Care (aap.org)
- Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants (samhsa.gov)
- A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders (hhs.gov)
- AAP Policies Related to Substance Use
- Course: Recovery-Friendly Care for Families Affected by Opioid Use Disorder (aap.org)