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Care for Opiate Dependent Women and Their Infants

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National Crisis

By now, most Americans are aware of the devastating opioid epidemic in America. Drug overdose deaths have continued to increase in the United States among men and women, all races, and all age groups, and opiates were involved in two-thirds of drug overdose deaths in 2017 (Hedegaar, Miniño, & Warner, 2018). The increasing death toll from opiate abuse has created a crisis for child welfare, as the number of children entering care jumped nearly 7% to almost 429,000 between 2013 and 2015 (US Department of Health and Human Services Administration on Children and Families), and children in care whose parents have not died from an overdose but do actively use/abuse substances have worse outcomes than other children in foster care (Lloyd & Akin, 2014) and take longer to reunify (Brook, McDonald, Gregoire, Press, & Hindman, 2010).

As more resources are poured into treating the opioid epidemic, which largely relies on Medication Assisted Treatment (MAT; e.g., methadone and buprenorphine), psychologists find themselves increasingly called upon to be familiar with addiction medicine as well as behavioral interventions for this population. Child psychologists practicing in hospital settings, particularly those working in NICU or nursery wards, can play a pivotal role at the intersection of child welfare and medicine. The goal of this article is to (a) familiarize the reader with best practices for pregnant and postpartum women with opiate use disorders; (b) educate psychologists about the medical management of these women and their prenatally exposed infants; and (c) make recommendations for the on-going integrated care of the opiate-dependent/opiate-exposed mother-infant dyad.

Pregnancy

Learning of a pregnancy can be a life-changing moment for many women, and is sometimes enough to motivate opiate-dependent women to begin treatment for their substance abuse. In our experience, many women will transition to Medication Assisted Treatment (MAT) after learning of their pregnancy with the assistance of their physician. Methadone and buprenorphine prevent the body from entering withdrawal while preventing the euphoria associated with opiate intoxication. MAT is the most clinically accepted treatment protocol for opioid addiction during pregnancy, as withdrawal and detoxification protocols risk a higher drop out and relapse rate (Brook et al., 2010).

Despite a history of opiate use/abuse early in their pregnancy, some women may still feel anxious about initiating MAT with a synthetic opiate (as opposed to pursuing complete detoxification) for fear that synthetic opiates will harm the developing fetus. In fact, there is no correlation between monitored synthetic opioids use and birth defects or the severity of withdrawal for the infant after birth (Jones, Jansson, O’Grady, & Kaltenbach, 2013; Jones, Dengler, Garrison, O’Grady, Seashore, Horton, Andringa, Jansson, & Thorp, 2014).

Although there is no correlation between the amount of maternal opioids used and the severity of withdrawal for the infant after birth, there are other risks to illicit opiate use during pregnancy, such as placental abruption, preterm labor (Almario, Seligman, Dysart, Berghella, & Baxter, 2009; Cleary, Donnelly, Strawbridge, Gallagher, Fahey, White, & Murphy, 2011), abnormal heart patterns, low birth weight, and small head circumference (Hulse, Milne, English, & Holman, 1997; Madden, Chappel, Zuspan, Gumpel, Mejia, & Davis, 1977). For these reasons, MAT is most effective when combined with comprehensive obstetrical care and behavioral intervention to support maternal efforts toward harm reduction.

Perinatal

In the period shortly following delivery, infants with prenatal opiate exposure are at risk for Neonatal Abstinence Syndrome (NAS), a complex disorder that involves the central and autonomic nervous systems as well as the gastrointestinal system, and is commonly called “withdrawal.” Symptoms of NAS include irritability, fever, diarrhea, vomiting, poor feeding, sleep disturbance, seizures and excessive sneezing. The incidence of NAS is variable, but current

consensus is that NAS occurs in about 50% of infants with buprenorphine and/or methadone exposure (Klaman, Isaacs, Leopold, Perpich, Hayashi, Vender, Compopiano, & Jones, 2017).

The immediate goal following delivery of opiate-exposed infants is to optimize their growth and development while averting or minimizing negative outcomes, such as discomfort and seizures, through conservative measures and pharmacology. The onset of NAS is typically within 24 to 72 hours, but can develop as many as 4 to 5 days after delivery, which has led to the recommendation that all opiate exposed infants remain in the hospital for 5 to 7 days post-delivery for observation (Hudak & Tan, 2012).

Conservative Measures for NAS. Conservative treatment measures should be initiated in all opioid exposed infants, which include the 5 Ss (swaddling, shushing, swaying, stomach, sucking), and minimizing sensory input (e.g., dimming the lights; Abrahams, MacKay-Dunn, Nevmerjitskaia, MacRae, Payne, & Hodgson, 2010).

Breastfeeding has been shown to reduce the frequency and severity of NAS and results in shorter hospital stays (Wachman, Hayes, Brown, Paul, Harvey-Wilkes, Terrin, Huggins, Aranda, & Davis, 2013). It is possible that the very low amounts of opioids in the breastmilk may help decrease the severity of NAS (Malpas & Darlow, 1999). It has also been suggested that the very act of breastfeeding mitigates the severity of withdrawal (WHO, 2014), possibly due to the skin to skin contact and subsequent bonding with the mother. Therefore, it is recommended that mothers who are stable on opioid replacement therapy be encouraged to breastfeed.

Psychologists and physicians must be ready to advocate on behalf of the mother if the child is in

care and the court is uninformed about the safety of breastfeeding while the mother is maintained on MAT.

Pharmacology for NAS. MAT can be initiated with infants that are exhibiting severe symptoms of NAS. Currently there is no standardized protocol for dosing or weaning. Morphine and methadone are the two most commonly used medications, with morphine being more common than methadone. Morphine is initiated in the hospital and the infant must remain hospitalized until the weaning is complete. Methadone is initiated in the hospital, but the infant may be discharged home as the medication is weaned. The choice of medication is institution dependent and no studies have shown either medication to be more efficacious. (Kocherlakota, 2014.)

Long-Term Dyadic Care

Postpartum Mood Disorder Screening. Once the infant is no longer showing signs of NAS and/or has been successfully weaned from any medication (methadone, morphine), s/he should be seen by the pediatrician at a slightly higher frequency than low-risk infants during the initial 6-month period. During these primary care pediatric visits, it is imperative that physicians and/or psychologists assess for postpartum depression and/or anxiety *at every visit*. Opiate dependent women are at significantly higher risk for having a coexisting mental disorder such as depression, anxiety, bipolar, posttraumatic stress, or personality disorders (Feske, Tarter, Kirisci, & Pilkonis, 2006; Peles, Schreiber, Naumovsky, & Adelson, 2007; Tuten, Heil, O'Grady, Fitzsimons, Chisolm, & Jones, 2009). Not only does this increased frequency of contact allow for better monitoring of the infant and the mother, it also helps establish a stronger connection

between the mother and the primary care provider/psychologist, which is essential for on-going assessment of substance use/relapse.

Advocacy. When opiate-exposed infants are placed in care, courts often are not aware of the longer-term neurological sequelae that may occur during the early months of infancy, such as increased irritability and tremors. These neurological symptoms should not be confused with NAS, as they are longer-term consequences of prenatal substance exposure and do not represent a withdrawal syndrome. Psychologists working with this population should be prepared to advocate for alterations in the court-ordered visitation plan if it is likely to cause increased stress for the infant (i.e., visits in noisy, brightly-lit, and crowded places).

Developmental Monitoring. Contrary to popular conjecture, prenatally opiate exposed children typically have average general intelligence (Cubas & Field, 1993; Hans, 1989; Rosen & Johnson, 1985), and although they do score lower on executive functioning tasks than children without any exposure, both groups (opiate exposed and non-exposed) had mean scores in the Average range (Konjnenberg & Elinder, 2015). In general, opiate exposed children can be thought of as higher risk than non-exposed children, but similar to other high-risk populations, such as premature delivery. In our clinic, we typically conduct developmental screening at 1, 3, 6, 9, and 12 months, and developmental testing whenever concerns arise.

Parenting Interventions. Many women who retain custody of their infant while on MAT for opiate addiction are first-time parents or custodial parents for the first time, and likely need support and psychoeducation about infant and child development, appropriate disciplinary

practices, and attachment. Promising practices have been developed that are brief enough for a primary care setting (e.g., PC-CARE; Timmer, Hawk, Forte, Boys, & Urquiza, 2018), and additional consideration should be given to the role of attachment and the unique way opiate use can influence attachment, bonding, and parenting style throughout the lifespan (Mirick & Steenrod, 2016).

Conclusion

The opiate epidemic has affected hundreds of thousands of children, not least of which are the infants born to opiate-dependent mothers. With support from psychologists in the primary care setting, these infants and their caregivers—whether biological, kin, or foster—can move through the vulnerable perinatal period to develop secure attachments and increase the likelihood of remaining on a typical developmental trajectory. Women on opiate agonist therapies, such as methadone or buprenorphine, need not feel ashamed or guilty, and can be empowered to maintain their stability as they step into the parenting role.

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1. Be a graduate student within one year completion (before or after) of a Master's or Doctorate degree from an accredited California educational program;
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3. Submit one or two letters of recommendation from faculty members or academic readers who are familiar with your research;
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