Mindful Continuing Education

Treating Pregnant and Parenting Women with Opioid Use Disorder

Epidemiology

1. Neonatal abstinence syndrome (NAS), a group of physiologic and neurobehavioral signs of withdrawal that may occur in a newborn who was exposed to psychotropic substances in utero, develops among 50 to 80 percent of opioid-exposed infants.

A. True
B. False

Barriers to Treatment

2. According to the authors, barriers to treatment for pregnant and parenting women with opioid use disorder (OUD) include each of the following EXCEPT:

A. Legal consequences with statutes that sanction pregnant women with OUD
B. Shame associated with OUD during pregnancy and motherhood
C. Lower quality of services for pregnant and parenting women with OUD and mistrust of the healthcare system
D. Misinformation among healthcare professionals and systems that results in reluctance to provide care for such women

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Definition of Terms

3. Withdrawal symptoms that occur after stopping or reducing opioid use include negative mood, nausea or vomiting, diarrhea, fever, and:

A. Sweating and headache
B. Mild anxiety and dizziness
C. Fatigue and trouble concentrating
D. Insomnia and muscle aches

Section 1: Prenatal Screenings and Assessments-Clinical Action Steps

4. When interviewing a pregnant woman with OUD who is presenting for care, a detailed history should be obtained, including illicit and licit substance use before and during pregnancy, current exposure to interpersonal violence, and behavioral health history such as anxiety, depression, or trauma.

A. True
B. False

Other Evidence/Considerations

5. Since it is widely believed that people with OUD cannot successfully stop smoking or using other substances while they discontinue opioid use, addressing all the used addictive substances at once is not recommended.

A. True
B. False

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6. Women with OUD are at higher risk for HIV/AIDS and viral hepatitis infection than women who do not use substances, so screening for HIV/AIDS and hepatitis B and C should be standard at any initial assessment, regardless of the stage of pregnancy.

A. True
B. False

Initiating Pharmacotherapy for Opioid Use Disorder- Clinical Action Steps

7. Although experts don’t agree on whether intrauterine exposure to buprenorphine, buprenorphine/naloxone, or methadone results in lasting developmental or other problems for the infant, a woman receiving either buprenorphine or methadone should be informed that:

A. Low birth weight is likely with buprenorphine or methadone use
B. The benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD
C. Extended use of buprenorphine or methadone may cause future reduced fertility
D. All of the above

Patient Education

8. Treatment plans for pregnant woman with OUD should be:

A. Individualized

B. Evidence-based and comprehensive
C. Based on practiced protocols
D. Focused on psychological, medical, and psychosocial needs

Exhibit FS #2.1: Decision Considerations When Selecting an Opioid Agonist Medication for a Pregnant Woman

9. Patients who are new to treatment and resistant to methadone use should be given naltrexone, as it is easy to transfer from naltrexone to methadone later if necessary.

A. True
B. False

Changing Pharmacotherapy During Pregnancy-Maintaining Patient Stability Is Paramount

10. Which of the following in NOT a correct statement about managing opioid cravings or withdrawal among pregnant women?

A. A pregnant woman who is experiencing cravings or withdrawal should have the effectiveness of her pharmacotherapy dose evaluated, and the dose possibly adjusted
B. Changing from one opioid agonist to another is rarely, if ever, warranted on the basis of cravings or unrelieved withdrawal alone
C. Cravings will not likely occur if an OUD is well managed
D. Women who experience cravings despite optimal pharmacotherapy should receive additional behavioral interventions to address new or aggravated stressors

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11. Pregnant women with OUD, with or without a history of pharmacotherapy for OUD, should be advised that medically supervised withdrawal from opioids is associated with high rates of return to substance use and is not the recommended course of treatment.

A. True
B. False

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12. Since neonatal abstinence syndrome (NAS) expression and severity are correlated with maternal pharmacotherapy doses, women may be advised to change or reduce their medication in hopes of reducing the risk or severity of NAS in their infants.

A. True
B. False

Managing Pharmacotherapy Over the Course of Pregnancy-Clinical Action Steps

13. A pregnant woman will likely need periodic adjustments to the dose of her pharmacotherapy in response to the physiological changes of pregnancy and:

A. To manage side effects
B. To prevent reemergence of withdrawal symptoms
C. To enhance long-term recovery
D. None of the above

Other Evidence and Considerations

14. A pregnant woman using pharmacotherapy for OUD should also have access to and be encouraged to talk with a behavioral health professional, as counseling can:

A. Encourage and motivate women to continue with treatment
B. Enhance coping skills
C. Reduce the risk of a return to substance use
D. All of the above

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15. Recovery, which requires more than pharmacotherapy, is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

A. True
B. False

Pregnant Women with Opioid Use Disorder and Comorbid Behavioral Health Disorders

16. While expectant mothers receiving treatment with buprenorphine or methadone who use benzodiazepines should reduce their use if possible, they should not work toward the goal of being benzodiazepine free until after delivery because of the risk of heightened anxiety.

A. True
B. False

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17. Discrimination and bias against people who live with serious mental illness or OUD are widespread, and this may compound the reluctance and fear that pregnant women with OUD or

severe mental illness often experience when deciding whether to seek help for these disorders.

A. True
B. False

Addressing Polysubstance Use During Pregnancy- Return to Opioid Use During Pregnancy

18. Returning to substance use is a common occurrence with OUD, especially early in treatment when the medication dose is still being stabilized, and it should be viewed as:

A. An expected setback that is part of the process
B. An opportunity to discover how to better understand and control triggers
C. An indication of the need to reassess the patient and adjust the treatment plan
D. A sign that support and resources need to be increased

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19. Return to substance use is often the result of an interaction of physiological and environmental factors, and is best seen as a dynamic process in which external and internal factors impact the patient's:

A. Strengths and vulnerabilities
B. Decisions and actions
C. Thought processes and judgment
D. Determination and perseverance

Polysubstance Use Concerns for Pregnant Women and Infants

20. Evidence-based treatments can be offered to pregnant women with substance use disorder, and motivational interviewing and contingency management, with a focus on the mother-infant dyad and integration with child protective services and the court, have been recently added to the list of possible approaches.

A. True
B. False

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21. While new research is expected on both maternal cannabis smoking and ingestion of tetrahydrocannabinol, existing evidence shows that maternal cannabis smoking:

A. Increases the baby's heart rate
B. Induces low birth weight in the infants
C. Increases the baby's risk of developing respiratory problems
D. Lower's the amount of oxygen available to the growing baby

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Planning Prior to Labor and Delivery- Patient Education on NAS

22. Infant withdrawal from opioids usually begins a few days after the baby is born but may begin as late as 4 to 6 weeks after birth.

A. True
B. False

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23. Infant-related variables that can affect the infant's NAS course include genetics, gestational age, and:

A. Inadequate nutrition
B. Prenatal care
C. Birth weight
D. Gender

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24. When appropriate, any amount of breastfeeding, however brief, can decrease NAS severity, reduce the infant's need for pharmacological treatment, and decrease the length of pharmacological therapy and hospitalization.

A. True
B. False

Peripartum Pain Relief

25. Each of the following is an accurate statement about pain relief during her labor, delivery, and postpartum period for women with opioid use disorder EXCEPT:

A. During labor and delivery, patients with long-term opioid use are likely to require higher doses of opioid agonist medication than women who have not experienced long-term opioid use
B. During labor and delivery, the mother should be maintained on her current dose of opioid agonist therapy for OUD
C. Nalbuphine and butorphanol are reasonable options for acute pain management during labor and delivery for patients with OUD
D. Pregnant women on pharmacotherapy do not need to be transitioned from their maintenance medication before a planned cesarean section since labor and operative pain can be managed while pharmacotherapy is still being administered

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Section II-Infant Care-Screening and Assessment for Neonatal Abstinence Syndrome

26. The best approach for creating a long-term plan for the infant's safety and the recovery of a mother with OUD is to focus on maternal drug screens and drug exposure at the time of delivery.

A. True
B. False

Management of Neonatal Abstinence Syndrome (NAS)

27. Beginning at birth, all infants with NAS should receive nonpharmacologic care, and the substance-exposed mother–infant dyad should consist of:

A. A thorough understanding of the newborn's functioning with the goals of implementing comforting techniques and environmental modifications and promoting the infant's self-regulation and interactive capabilities
B. A thorough understanding of the mother's strengths and challenges to promote her self-regulation, confidence as a parent, and ability to respond contingently to and communicate with her infant
C. Attention to the dyadic communication patterns and behaviors and the environment that may need modifications to support the infant's physiologic organization and regulation and to encourage the mother to respond sensitively to the infant's needs
D. All of the above

Breastfeeding Considerations for Infants at Risk for Neonatal Abstinence Syndrome

28. Although a stable mother being treated for OUD with pharmacotherapy is encouraged to breastfeed her infant, careful consideration is needed for women who present to prenatal care and/or SUD treatment during or after the second trimester, women who return to illicit substance use/licit substance misuse, and women who attained abstinence only in an inpatient setting.

A. True
B. False

Infant Discharge Planning-Clinical Action Steps

29. The discharge plan for infants treated for NAS should include home visitation and early intervention services, such as including a home nursing consult, a social work consult, referrals to healthcare professionals who are knowledgeable about NAS and accessible, and parenting support that is:

A. Attachment-based

B. Nurturing
C. Positive and structured
D. Instinctive and emotive

Caregiver Education and Home Environment

30. A small study following prenatally opioid-exposed children for 5 years concluded that a parent– healthcare professional relationship established in pregnancy and continued during the postpartum period facilitated a long-lasting relationship with childhood professionals and reduced court-ordered placements and reports of developmental disorders.

A. True
B. False

Early Intervention Strategies and Development Assessments

31. After controlling for confounding factors, such as maternal psychological distress and instability in the home environment, infants born to mothers who received methadone or buprenorphine during pregnancy were found as toddlers to have slightly more significant problems with developmental tasks than children of mothers without SUD.

A. True
B. False

Section III: Maternal Postnatal Care- Adjusting Pharmacotherapy Dose Postpartum

32. In the immediate postpartum period, evaluation of the new mother's dose of agonist therapy should be prompted if there are complaints of drowsiness and:

A. Dizziness
B. Nausea
C. Somnolence
D. Headache

Pharmacotherapy Changes

33. When a new mother who is stable on methadone or buprenorphine requests a switch to naltrexone, she should be made aware that the risk of return to substance use is high in this case,

and that a change should not be made without a compelling reason.

A. True
B. False

Maternal Discharge Planning

34. In order to help those seeking recovery from SUDs avoid triggers that can lead to return to substance use, Substance Abuse and Mental Health Services Administration encourages the use of peer counselors or:

A. Support specialists
B. Rehabilitation educators
C. Spiritual mentors
D. Recovery coaches

Maternal Return to Substance Use

35. A comprehensive wellness model is recommended to enable healthcare professionals to work across disciplines and specialties and to provide services as needed to reduce maternal stress and risk of return to substance use.

A. True
B. False

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36. Privacy requirements are higher with issues of SUD than with other conditions, so it is especially important to obtain signed informed consent agreements tailored to SUD issues to facilitate sharing of information among healthcare professionals.

A. True
B. False

Conclusion

37. One essential strategy that is critical to success in caring for parenting women with OUD is offering non-coercive contraceptive counseling and the option to leave the hospital with a prescription for contraception, contraceptive supplies, or a contraception plan.

A. True
B. False

Exhibit C.1: Getting Started and Staying Engaged With Treatment for Pregnant and Parenting Women With OUD

38. Which of the following is NOT one of the advanced steps recommended by the authors when implementing treatment for pregnant and parenting women with OUD in a clinical setting?

A. Developing multidisciplinary protocols for the identifying, referring, and prioritizing pregnant and parenting women for treatment and a mechanism for communication on treatment compliance, sharing of urine testing results, and other procedures
B. Building a team with knowledge in treating pregnant and parenting women and preparing for the transition of care after delivery
C. Educating and encouraging staff to commit to a strengths-based, extensive, and authentic practice for pregnant women in treatment
D. Ensuring the patient has a primary care provider and pediatrician, and developing a long-term treatment and recovery program

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39. In order to build community partnerships for treating pregnant and parenting women with OUD, relationships with an experienced referral center can be developed and regular calls with other care providers in the community to informally discuss cases and share expertise can be initiated.

A. True
B. False

Appendix B: Glossary and Acronyms

40. Peer support specialists are individuals in recovery who have skills with mental illness, trauma, and/or substance use disorder that they learned in formal training, and they are distinguished from members of mutual-help groups because they are paid professionals rather than volunteers.

A. True
B. False

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