

Maximizing Outcomes for Pregnant Women on Medication Assisted Therapy

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Methadone

- A synthetic, long-acting, rigorously tested narcotic medication used for the treatment of narcotic withdrawal and dependence
- Maintenance treatment in the U.S. - 1960's
- Opioid "agonist" – acts in a way that is similar to morphine and other narcotic medications
- Is a treatment not a cure

Why Methadone Maintenance (MMTP)?

- No physical cravings, no withdrawal
- "Blocks" the effects of street opiates
- Promotes physical and emotional health
- Raises overall quality of life
- IVDU relapse rate increase significantly
 - off 3 months 14%
 - off 6 months 57%
 - off 9 months 72%

Goals of MMTP During Pregnancy

- Improve mother's attendance at high risk clinic
- Improve mother's nutritional status
- Prevents maternal drug level fluctuations
- Enhance the mother's ability to prepare for birth
- Promote drug and alcohol free environment
- Reduce incidents of violence
- Reduce risk of HIV and Hepatitis C
- Reduce obstetrical complications

Methadone and Pregnancy

- Gold standard of treatment for opioid dependent mothers since the 1960's
- General principle and philosophy:
"Despite possible complications and public policy controversy, methadone maintenance during pregnancy is still the treatment of choice for opioid dependent women. The course results in better fetal outcomes and helps stem the tide of HIV infection in mothers and their children."
Journal of Psychoactive Drugs
26:155-161, 1994

Buprenorphine

- High affinity for the Mu Opioid Receptor
- Competes with other opioids and blocks their effects
- Displaces heroin or other opiates from receptors
- Slow dissociation from Mu Opioid Receptor
- Prolonged therapeutic effect
- "Ceiling effect" – poor drug for intoxication purposes

Buprenorphine

- Safer in an overdose
- Formulated with Naloxone
- Naloxone is poorly absorbed if taken orally
- Naloxone blocks opiate effects if injected
- Not approved by FDA for use in pregnancy

Limited Indications for Use

- Potential benefits must outweigh the risks
- Conceive already on buprenorphine
- Opioid addicted but cannot tolerate methadone
- Poor program compliance or MAT not available
- Documented informed consent
- Limit use to Subutex

Subutex and Pregnancy

- As safe as methadone
- Easier to administer
- Less potential for abuse/ overdose
- Neonatal Abstinence Syndrome is shorter and less severe
- NAS – lower prevalence

Medically Supervised Withdrawal

- Never during the 1st or 3rd trimester
- Consultation with Medical Director of MMTP
- High relapse rate to street opioids
- Why?
 - * refuse to be on MMTP
 - * no transportation to clinic
 - * financial reasons
 - * Buprenorphine?

Methadone and Breastfeeding

- Absolutely!!!!
- Mothers should be *encouraged* to breastfeed
 - *HIV, other drug use – exception
 - *HCV, ok to breastfeed
- Excretion to breast milk is minimal to 180mg qd
- Immunologic and bonding benefits
- Reduce NAS?
- AAP considers methadone compatible with breastfeeding at *any* maternal dose

Methadone and Neonatal Abstinence Syndrome

- Complex and poorly understood disorder
- Syndrome itself is widely variable
- Many confounding variables:
 - * Maternal and fetal factors
 - * Illicit and licit drug use
- Hospital scale – See handout

- 48 and 94% of neonates exposed to NAS
- Not all neonates need medication to treat NAS, all need to be evaluated
- Can be mild to severe
- Can begin after birth, average onset 72hrs
- Other drugs play a part in NAS, methadone has consistently shown to NOT affect NAS
- NICU stay – variable
- Rhythmic feeding, sleep cycles, weight gain = discharge

NAS Treatment

- Supportive care
- Decrease sensory stimulation
- Medication increases hospital stay
- Optimal treatment has not been established
- Other conditions can mimic NAS, need complete blood work and comprehensive neurological consultation if indicated

Outcomes for Neonate

- Increased birth weight
- Increased head circumference
- Prolonged gestation
- Improved growth

Outcomes for Infants

- Findings show there are no significant differences between infants born methadone-affected and those born with no exposure (see handout)
- Research on developmental sequelae associated with in-utero methadone exposure has found that infants through age 2 function well within developmental range (e.g., Kaltenbach and Finnegan 1986)

Perinatal Task Force

- Clinical Director
- Director of Women and Family Services
- Methadone Counselor
- RN
- Outreach Case manager
- Coordinator of Help Me Grow
- Intake Counselor/Nurse

Women's Recovery Program

- Outreach (Homeless Shelters, High Risk Clinics, CPS, Courts, etc)
- Women's Recovery Support Meetings (open to all women)
- Engage in treatment
- Schedule intake and assessment
- Assign level of care

Women's Recovery Program

- Treatment (OP, IOP, Residential)
- Case Management (Resources, Referrals)
- Collaboration (Medical providers, CPS, Courts, etc)
- Education
- Birth Plan
- Parenting

Issues

- Stigma
- Motherhood
- Depression (Pregnancy or Post Partum)
- Child Protective Services
- Other children
- Time in hospital
- Trauma
- Relationships

Primary Counselor

- Manage case
- Help develop a plan
- Address substance abuse issues
- Address mental health or collaborate with mental health provider
- Address trauma and make plans to reduce impact
- Maintain contact with other care providers

Case Management

- Assess for needs (see handout)
- Resources (see handout)
- Referrals (food, housing, etc.)
- Support
- Collaborate

Outcomes for 2010

- Tracked over 78 women
- 52 pregnant women delivered
- 4 miscarried
- 24 on medication assisted treatment
- 21 on methadone 19 babies methadone affected
- 2 with illegal drugs

Outcomes

- 3 subutex
- 24 drug free babies
- Others either moved, dropped out, aborted, etc

Summary

Women on Medication Assisted Therapy can have Healthy Babies with the proper care, intervention and support.

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