Impact of Opiate Abuse and Addiction on Families / Child Welfare / Pregnancy

Ted Parran Jr. MD FACP
Isabel and Carter Wang Professor and Chair in Medical Education
CWRU School of Medicine
Cleveland, Ohio
tvp@case.edu

Substance Abuse or At Risk Use

- Planned use to intoxication/disinhibition
- Rare adverse consequences
- Use remains within peer group norms
- “Willful misconduct”

Chemical Dependence: UCR

- The **intermittent** **inconsistent** **repetitive** ***loss of control*** over the use of euphoria producing drug (EPD), resulting in ***repetitive adverse consequences***.
- EPD's:
  - ***Opioids***
  - Stimulants (including nicotine)
  - Sedative-hypnotics
  - Cannabinoids
  - Other

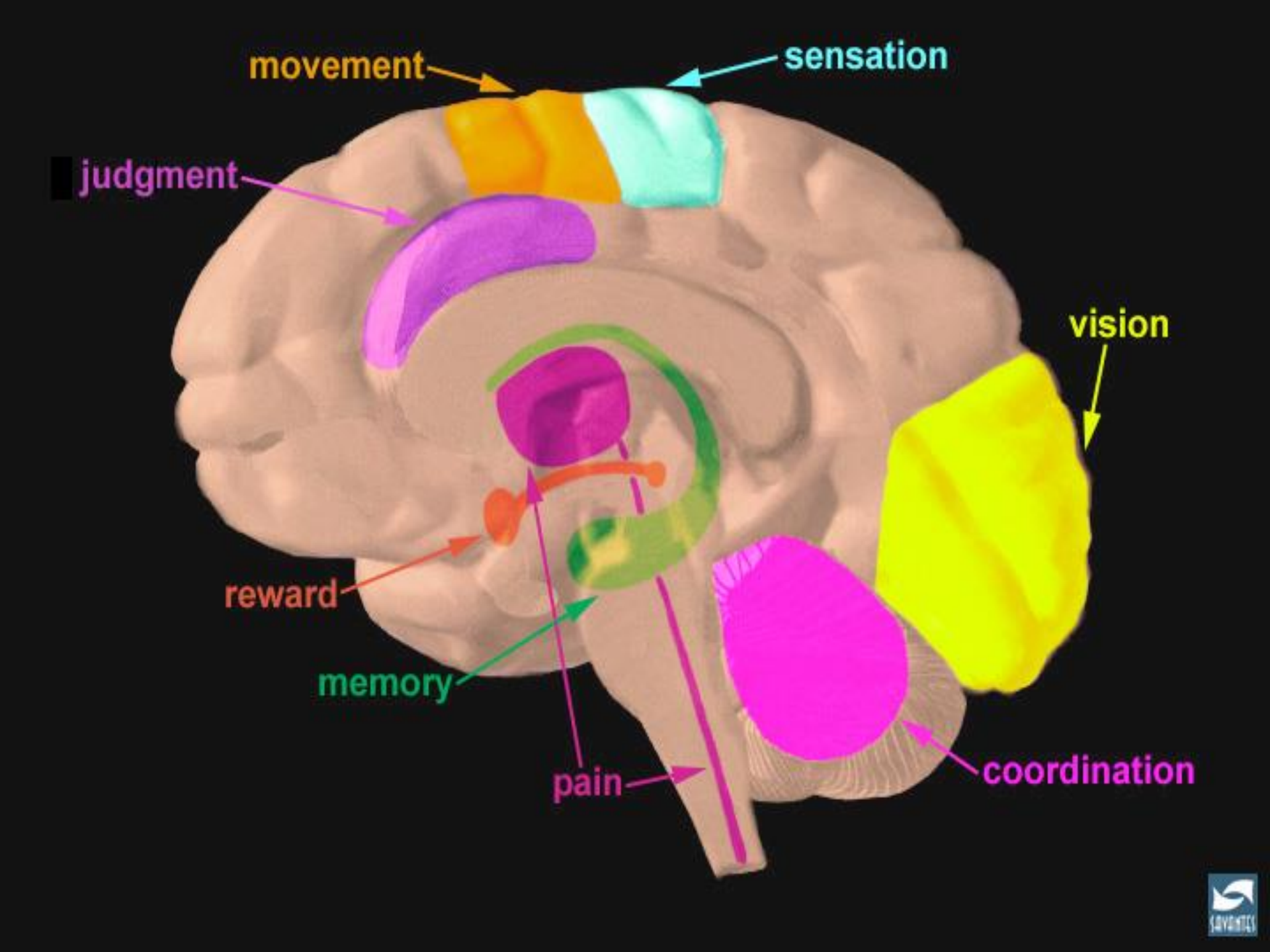
Recognizing Addiction

- DSM-5 Criteria for Substance Use Disorder[1]
  - Tolerance
  - Withdrawal
  - Taken more/longer than intended
  - Desire/unsuccessful efforts to quit use
  - Great deal of time taken by activities involved in use
  - Use despite knowledge of problems associated with use
  - Important activities given up because of use
  - Recurrent use resulting in a failure to fulfill important role obligations
  - Recurrent use resulting in physically hazardous behavior (eg, driving)
  - Continued use despite recurrent social problems associated with use
  - Craving for the substance

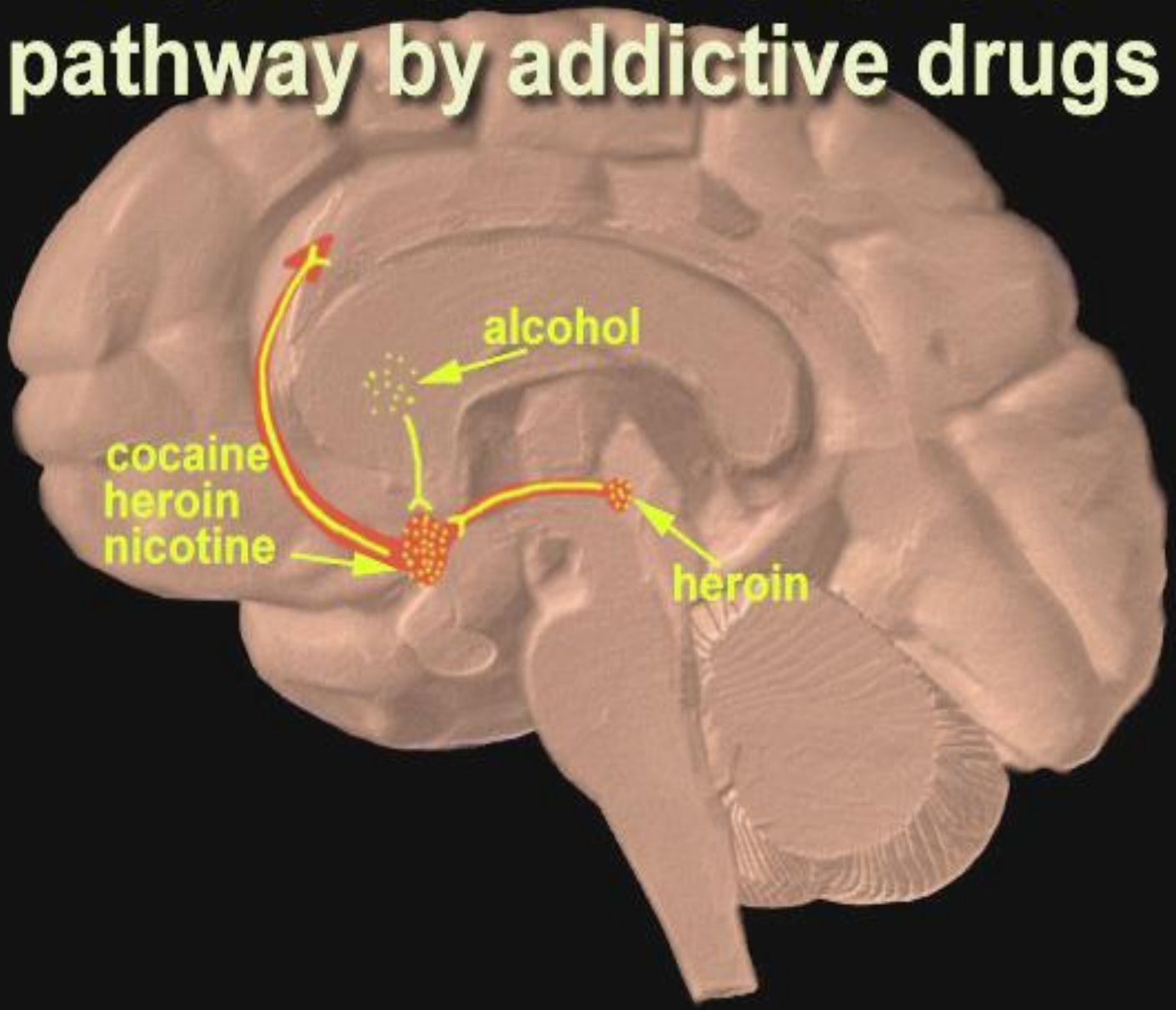
≥ 2 items → Dx

≥ 6 items → severe case

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition*. Arlington,VA: American Psychiatric Publishing(2013).


movement
sensation
judgment
vision
reward
memory
pain
coordination

Activation of the reward pathway by addictive drugs



Addiction as a Familial Disorder

- Aristotle- “drunken women bring forth children like themselves”
- Plutarch- “one drunk begets another”
- Every study since the late 1800’s shows higher rates of addiction in relatives of alcoholics.
- 3 to 4 times higher rate in first degree relatives.

From Familial to Genetic "genes vs. environment"

- What is the relative importance of genetic influences **(nature)** compared to environmental and family influences **(nurture)**?
  - Adoption studies = **genes matter**
  - Twin studies = **environment matters**

- 50-60% genetic, 20% environment, 20% ???

Chemical Dependence: prevalence

- 13.5% lifetime prevalence
- **Lower in older / same in younger women**
- 15–18% primary care outpatient
- 25% primary care inpatient
- 40% trauma inpatient
- 40–70% psychiatric inpatient
- **25% of couples bearing children (1/4)**
- **10-15% tox positive in OB private office / public clinic**

Chemical Dependence: risk factors

- (–) Family history = 0.3 – 3% risk
- (+) One parent = 20% risk
- (+) Two parents = 30% risk

- ***NOT***
  - ***WOMEN < MEN (IF BORN AFTER 1950)***
  - ***WEALTHY < POOR***
  - ***WHITE < "MINORITIES"***

Chemical Dependence: Natural History (It's a Brain Disease)

- Brain function number 3: Behavior Control
- Diseases of the brain that effect Behavior Control Centers:
  - Addiction, Schizophrenia, Bipolar
- Sns/Sx of the **biologic** disease of addiction:
  - Behavioral, Behavioral, Behavioral …
- Not a psychological disease

Addiction v. Axis III: natural history

- Increased dysfunction and disability in the following domains:

	ADDICTION		**AXIS III**
1.	**Self image***	v.	Physical
2.	**Interpersonal***	v.	Work
3.	**Social***	v.	Financial
4.	**Financial***	v.	Social
5.	**Legal** *	v.	(nothing)
6.	**Work**	v.	Interpersonal
7.	**Physical**	v.	Self image

***** = *very problematic in pregnancy / child raising***

Addiction morbidity and mortality: the unspeakable toll

- Tobacco addiction kills 33%, maims 33%.
- Other addictions-
  - ***divorce, *domestic violence, *child abuse, *child neglect** (**very** common with opioids)
  - ***suicide, *trauma**
  - productivity, disability
  - medical complications

  *very problematic in pregnancy/child rearing

Treating Addictions as chronic illnesses- the challenge

- Study the natural history
- Implement screening strategies (CRAFFT / AUDIT-C)
- Practice presenting the diagnosis (SOAPE)
- Assess patient's readiness for change
- Negotiate treatment plans
- Develop comfort with pharmacotherapy
- Strategies for long-term monitoring

CRAFFT

C **Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?**

R **Do you ever use alcohol or drugs to RELAX, feel better about yourself?**

A **Do you ever use alcohol or drugs while you are by yourself ALONE?**

F **Do you ever FORGET things you did while using alcohol or drugs?**

F **Do your FAMILY or FRIENDS ever tell you that you should CUT down on your drinking or drug use?**

T **Have you ever gotten into TROUBLE while you were using alcohol or drugs?**

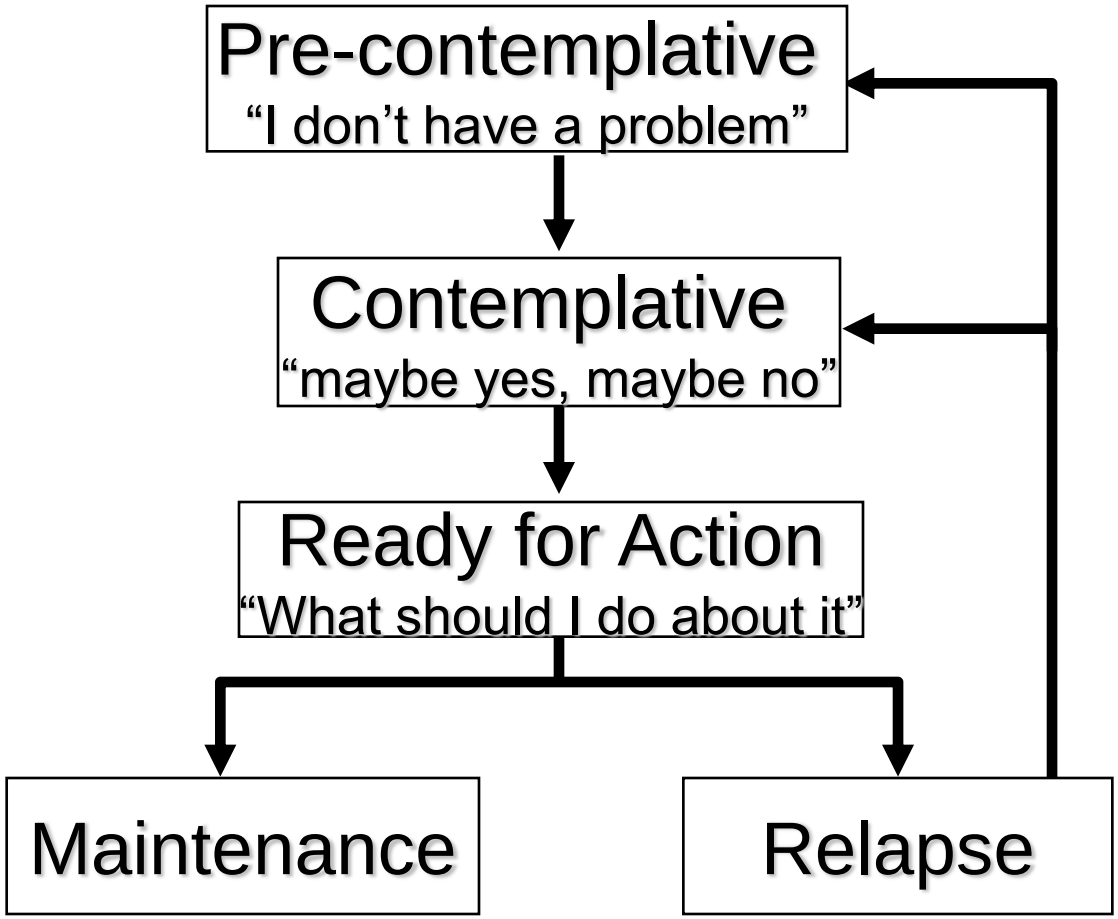
Score: 2 or more yes answers indicate a problem for follow-up.

(Knight et al., 1999)

Presenting the Diagnosis: the Brief Intervention (cont.)

- "Pearls to use" - **SOAPE**
  - **S**upport ("I want to work with you")
  - **O**ptimism ("you can and will get better")
  - **A**bsolution ("it is not your fault for having the illness, just your responsibility to manage it")
  - **P**lan (depends on the patient readiness for change)
  - **E**xplanatory model ("this can be hard to hear, what are your thoughts about your substance use?")

Presenting the Diagnosis
Assessing Readiness



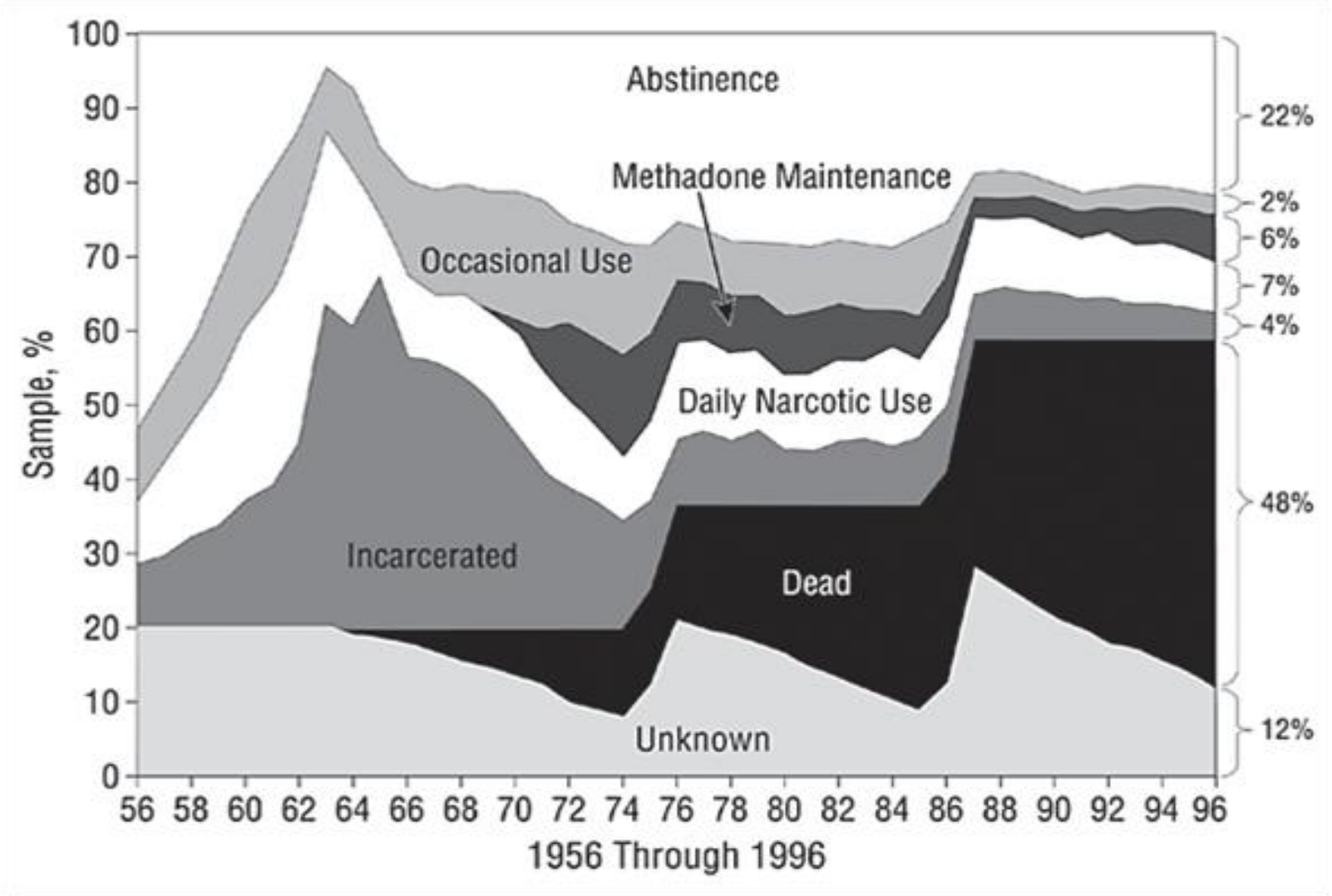
Motivational interviewing in a nut shell

- Pre-contemplative: maintain the relationship, encourage change, ?mobilize consequences
- Contemplative: educate … educate … educate
- Preparation / Action: behavioral change, monitor … support … monitor … support … monitor … support … …

Opioid Addiction: Specifics

Natural HX of Opioid Addiction:

40 year longitudinal experience



The Natural History of Opioid Addiction

- High mortality rate
- High incarceration rate
- High relapse rate

BUT ALSO …

- More than 50% eventual “sobriety” rate (if you include stable OMT with abstinent as “sober”)

SO THE GOAL IS …

- Keep them alive, increase sobriety and decrease relapse!

MAT (medication assisted treatment)

- Why Do It? (re: the patient)
  - It decreases relapse
  - It decreases re-incarceration
  - It decreases death rates
  - … SO IT IMPROVES LIVES
- Why Do It? (re: the provider)
  - IF MAT does all of the above … then it makes dealing with patients / families easier / more efficient / more effective (***AND*** more enjoyable).

MAT: 2 Approaches

- Harm Reduction:
  - Pharmacotherapy first ??? Addiction TX second
  - E.g. historical methadone maintenance experience
  - E.g. “stand alone Suboxone”
- Adjunct to or Addition to Treatment:
  - Treatment first
  - Then add in MAT to try to improve outcomes
  - E.g. Intensive Outpatient Counseling & 12 step meeting attendance … plus MAT
- For the Child Protective Services clients … *AVOID* HARM REDUCTION MODEL … *REQUIRE* ADJUNCT TO TX MODEL

MAT with opioid dependence: What Are The Medications???

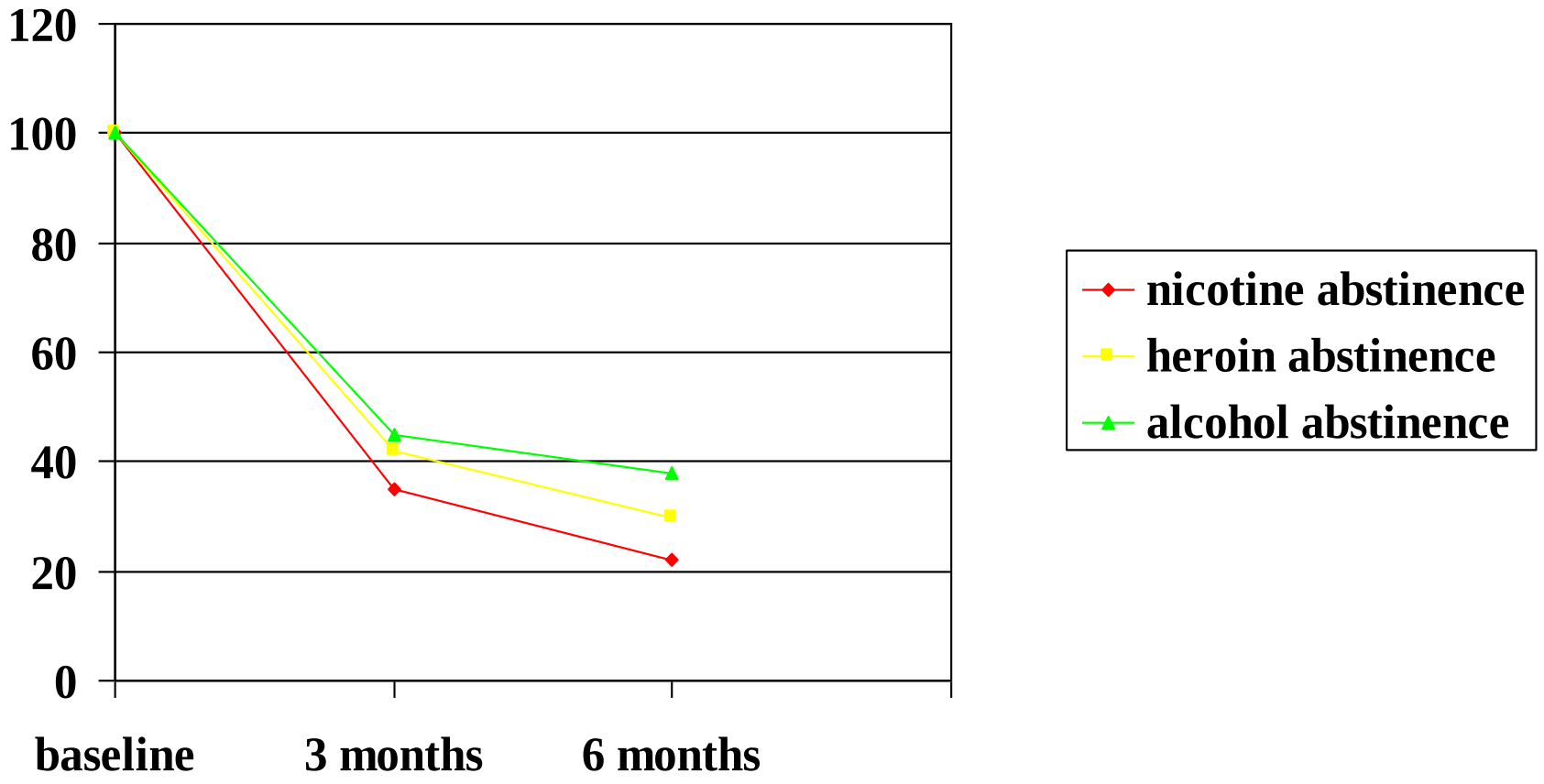
- **Methadone:** "opioid maintenance TX"
  - ONLY if part of a Methadone Treatment Program
- **Buprenorphine:** "opioid maintenance TX"
  - **Not** harm reduction (as above)
- **Naltrexone:** "opioid blocker treatment"
  - Pills (naltrexone) or Shots (Vivitrol)

- OUTCOMES? … *SIMILAR! (**if** done well)*

MAT maintenance: outcome data

- Opiate maintenance therapy (methadone OR buprenorphine) on balance results in improvement in every domain of life function … especially if combined with good treatment:
  - **family**
  - **health**
  - **legal**
  - **employment**
  - **financial**

Relapse rates



Opioid maintenance data

- Duration of therapy -
  - When should people get off?
  - Longer = better.
  - > 1.5 years better than < 1.5 years.
- Need for comprehensive longitudinal gradual approach.
- Need ultimate goal of abstinence.
- *Methadone OR Subutex in pregnancy*.

Opiate maintenance - methadone

- What's a “GOOD” methadone program?
  - Release of information for all health care / social service / legal providers … with frequent contact
  - Tox screening monthly or more often – results avail.
  - Counseling
  - Open TX Plan … harm reduction **OR** abstinence
  - The treatment goal should be CLEAR (and shared)
  - Dose =/**<** 120mg/d
  - Discourage other controlled RX drugs (benzos etc.)
  - Increasing intensity of treatment over time if non-adherent (problem urines due to still using)

Opiate maintenance - buprenorphine

- What's a “GOOD” buprenorphine program?
  - Release of information for all health care / social service / legal providers … with frequent contact
  - Tox screening / Counseling / OARRS required
  - Dose =/**<** 16mg/d … ***most*** patients on 4-12mg/d
  - Requires ***combined*** bup-naloxone product mostly
  - NO other controlled RX drugs (benzos etc.)
  - Increasing intensity of treatment over time if non-adherent (problem urines due to still using)
  - Accepts insurance payments for visits

Monitoring Opioid Dependent Pts.

- Constant awareness of client's level of participation in Tx. Prog. (releases!!!!!!!!!!)
- Ask Tx. Prog. about patient's OARRS result / tox screen result / continued use of MAT.
- Obtain patient and collateral report of sobriety and ***full*** adherence with the treatment plan.
- 12 Step Monitoring – DO IT!
  - Ask client AND sponsor: how often / which meetings / what "step" working on … PLUS signed slips.
- ***ANY*** slip in adherence = increased relapse risk!!!!

In conclusion …

- Addictive disease is prevalent in men and women of child rearing age.
- Onset late adolescence / young adulthood
- Peak activity during the “child bearing” years
- Addiction = loss of control … in many ways
- Symptoms are behavioral & disastrous
- General Addiction – Child Welfare Risks
- Opioid Addiction:
  - Some specific risks (child neglect, overdoses)
  - Some specific TX options (TX plus MAT)