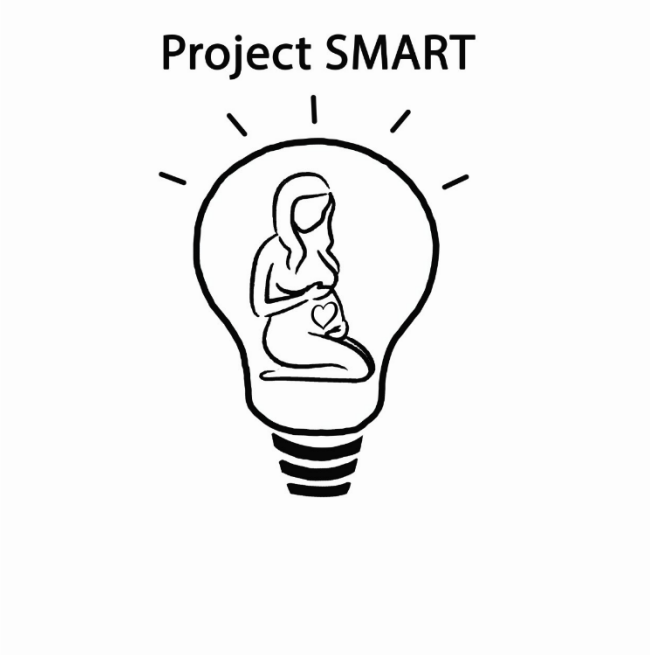
Support Models for Addiction Related Treatment (SMART) Trial of Opioid Use Disorder in Pregnant Women



Improving Treatment of Pregnant Women All Around

Clinical Resource Manual

Disclaimer.
These resources have been compiled from multiple sources to aid clinicians in caring for women with Opioid Use Disorder in the perinatal period. These were compiled to provide general information and guidance to clinicians. The recommendations contained do not indicate anexclusive course of action and should be adapted to different clinical contexts.

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Screening and Brief Intervention for Substance Use in Pregnancy

All women should be screened for substance use at the first prenatal visit using a screening tool; e.g., the Modified NIDA Quick Screen (Modified NIDA) *(see SUD2).*

If **positive screen** on Modified NIDA, had aberrant urine test, or clinical suspicion *(see SUD2)*, woman is **at risk**

If **negative** screen, then woman is lower risk

Brief Assessment

1. "What substances have you been using in the past 3 months? During this pregnancy?"
2. "How much of each substance have you been using at a time?"
3. "How frequently are you using them?"
4. "How does this affect your life (job, home life, self-care, health, emotions)?"
5. "Are you being treated for an SUD? Have you had prior treatment?"

Educate

1. Provide brief education about recommendations to not use alcohol, tobacco, cannabis, illicit opioids, or other drugs.
2. Encourage the patient to ask for help in the future, as needed.

Stratify into risk group

High Risk

Current: Opioid use or binge pattern/heavy use of any substance(s) or relapse of any SUD

Moderate Risk

Current: Low-level use of non-opioid substances, engaged in MAT, or other SUD treatment
History: High use in past and/or past treatment for SUD

Low Risk

Current: No use
History: Low-level use prior to learning of pregnancy

Brief Intervention

1. "How ready are you to quit now?" Ask the patient to rate this motivation on a scale from 1-10.
2. "How confident are you that you can stop?" Ask the patient to rate their confidence on a scale from 1-10.
3. "Why did you rate that way?"
4. "How can we increase this score?"

Create Treatment and Monitoring Plan

1. Refer to or provide medication treatment for opioid/alcohol use (see *SUD4*)
2. Recommend non-pharmacological treatment (see *SUD3*)
3. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check MassPAT at each visit
4. Identify who will coordinate Plan of Safe Care (see *SUD3*)
5. Call MCPAP for Moms with questions

Is the patient currently misusing any substance?

Yes

Brief Intervention

1. "How ready are you to quit now?" Ask the patient to rate this motivation on a scale from 1-10.
2. "How confident are you that you can stop?" Ask the patient to rate their confidence on a scale from 1-10.
3. "Why did you rate that way?"
4. "How can we increase this score?"

Is there an active need for a referral to treatment?

Yes

Monitor and Refer to Treatment

1. Counsel on MAT in pregnancy (see *SUD4*) and non-pharmacological treatment (see *SUD3*)
2. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check MassPAT at each visit
3. If already in treatment, contact SUD provider
4. Identify who will coordinate Plan of Safe Care (see *SUD3*)
5. Call MCPAP for Moms with questions

No

Monitor

1. Repeat Modified NIDA and Brief Assessment at least once per trimester
2. Urine testing at least once per trimester
3. Check MassPAT at each visit
4. If already in treatment, contact SUD provider
5. Identify who will coordinate Plan of Safe Care (see *SUD3*)
6. Call MCPAP for Moms with questions

No

For all women with any opioid use or on MAT for OUD, discuss:

- Overdose prevention (see *SUD6*)
- MAT during pregnancy/postpartum (see *SUD4*)
- Neonatal Opioid Withdrawal Syndrome (NOWS) - a.k.a. Neonatal Abstinence Syndrome (NAS)
- Pain management (see *SUD5*)
- Plan of Safe Care and DCF reporting (see *SUD3*)

MAT: medication for addiction treatment
SUD: substance use disorder
OUD: opioid use disorder
MassPAT: Massachusetts Prescription Awareness Tool

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272) ***www.mcpapformoms.org***

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Authors: Mittal L., Suzuki J., Moore Simas T., Ziedonis D., Callaghan K., Straus J., Rosadini S., Byatt N.

Assessment of Substance Use in Pregnancy

Modified NIDA Quick Screen (Modified NIDA)

Ask: "In the past three months, how often have you used:"

Alcohol (four or more drinks a day)	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Tobacco products	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Prescriptions drugs not used as prescribed or any marijuana	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Illegal drugs	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily

Any answer other than "never" is a positive screen and should prompt follow-up questions to further characterize which substance(s) are being used, the amount, and the time course (see *SUD1*).

Adapted from the NIDA Quick Screen

Behaviors that may warrant clinical suspicion for a substance use disorder (SUD)

Gather more history	Monitor closely	Intervene
• Dose escalation • Very focused on controlled substances • Substantial effort/time/resources spent on obtaining controlled substances • Requests early refills of controlled substances • Evidence of tolerance • History of withdrawal	• Loses prescriptions for controlled substances • Requesting specific agent, route, frequency • Purchasing illicit drugs • Taking diverted opioids (taking others' prescriptions) • Multiple providers prescribing controlled substances • Mood or personality changes • Emotional lability	• Clinical signs of intoxication (confused, sedated or hyperactive, rapid or slurred speech) • Withdrawal • Evidence of tampering with IV or hoarding pills while inpatient • Crushing/injecting/snorting pills • Seeing drug use paraphernalia (e.g., syringes or pipes) • Physical signs of injection, stigmata of chronic alcohol use, intranasal irritation

Interpretation of Urine Drug Tests

Urine drug tests are useful for monitoring high-risk women and preferred over universal screening because they can:

- Detect undisclosed substances
- Help identify risk for neonatal withdrawal
- Help with risk assessment for medical complications (withdrawal, management of hypertension)
- Confirm use of prescribed medications

Discussion of urine drug tests results with patients should focus on promoting safety and not be punitive in nature.

Approximate Detection Times in Urine

Drugs	*Duration of Detection in Urine*
Buprenorphine	*1-6 days*
Methadone	*Up to 14 days*
Cannabinoids	*Up to 60 days (in chronic users)*
Cocaine	*1-3 days*
Heroin	*1-3 days*
Benzodiazepines	*Up to 21 days*

Urine drug tests have limitations because:

- They only reflect recent use, and detection times vary.
- Drug levels may vary widely depending on fluid intake, time elapsed since use, or individual variation.
- Providers need to know the characteristics of tests used within their institution because different assays may be used by different labs.
- They do not capture all illicit use (e.g., synthetic cannabinoids (K2/Spice), synthetic opioids (fentanyl, carfentanil), hallucinogens (LSD)).
- Patients can tamper with their urine specimen.
- The opioid urine assay tests primarily for heroin, morphine, and codeine and **does not** test for synthetic opioids like oxycodone, fentanyl, methadone, and buprenorphine, which each have their own urine test.

If the urine drug test is inconsistent with the patient's report, order confirmatory testing (e.g., Gas Chromatography/Mass Spectrometry – a.k.a. GC/MS).

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Treatment Options for Perinatal Substance Use Disorder (SUD)

How to Find Treatment and Resources	
Bureau of Substance Abuse Services (BSAS) Helpline: Helps patient/provider determine treatment needs	1-800-327-5050 www.helplinema.org
Institute for Health and Recovery Resource Locator: Community resource locator by zip code	www.healthrecovery.org/resource-search
The Journey Project: Website for pregnant and parenting women with substance use disorders	www.journeyrecoveryproject.com

Plan of Safe Care (POSC)

The Plan of Safe Care is a document created jointly by a pregnant or parenting woman and her providers. This document helps a women and her team determine services or supports they may find useful to record and organize the patient's engagement in care.

- All women with a history of SUD should have a POSC coordinated.
- The POSC is intended to enhance collaboration and coordination of care.
- SUD treatment providers licensed by the MA BSAS are required to create a POSC and communicate about the POSC with other providers.
- POSC can be initiated at any time to facilitate the patient's engagement in care.
- POSC can be used to identify additional resources that may be helpful.
- DCF will ask if a POSC exists at the time any report is made.

A suggested template can be found at http://www.healthrecovery.org/safecare/.

Psychosocial Treatments

Peer Support	Professionally led	Residential
• Alcoholics Anonymous: www.aa.org • Narcotics Anonymous: www.na.org • SMART recovery: www.smartrecovery.org	• Cognitive Behavioral Therapy • Motivation enhancement • Mindfulness-based treatments • Couples/family • Group counseling	• Inpatient rehabilitation • 28-day programs/"rehab" • Long-term residential • Sober living • Therapeutic community
Patients can self-refer to any of the above options	Call MCPAP for Moms for assistance with referrals	

Treatment Settings for Substance Use Disorders

Level of Care	Services Offered	Additional Notes/Perinatal Options
Outpatient	Counseling	• Individual or group • Facilitated by social workers or mental health/drug and alcohol counselors
	Medication management	• Methadone needs to be administered by a federally licensed facility. • Buprenorphine can only be prescribed by a waivered provider. • Naltrexone, acamprosate, disulfiram, or medications for smoking cessation can be prescribed by any provider *(see SUD4, SUD5).*
Intensive Outpatient	Group and Individual Counseling +/- medication	• Can be used for direct admission or as a step-down from a higher level of care • Can vary in length and frequency of sessions • Examples include: Intensive Outpatient program (IOP), Structured Outpatient Addiction Program (SOAP), and Partial Hospital Program (PHP)
Acute Treatment Services (a.k.a. "Detox")	Medically Supervised Withdrawal (Inpatient)	• Indicated for physiological dependence on alcohol or benzodiazepines • Difficult to access during pregnancy • Tapering opioids is not recommended during pregnancy.
Short-Term Residential (under 30 days)	Step-down and non-pharmacologic "detox"	• Examples include Clinical Stabilization Services (CSS) and Transitional support Services (TSS) or "holding." • Some treat co-morbid psychiatric and substance use disorder (dual-diagnosis) and include: Individual, group, family therapy, case management, and linkage to aftercare, and medication. • Some programs admit pregnant women and coordinate with prenatal care providers.
Long-term Residential (over 30 days)	Structured group living with supervision and treatment provided by addiction professionals	• Examples include 4-6 month recovery homes or "halfway houses" and specialized residential programs for women, families, and youth. • Many programs assist with employment, parenting skills, and retaining/regaining custody of children. • Some have enhanced services for pregnant/post-partum women and their infants, which include the coordination of perinatal/pediatric care. • Individual, group therapy, case management
Involuntary Commitment/ Section 35 (up to 90 days)	Court-ordered treatment for medically supervised withdrawal and step-down services	• Family/providers can petition the local court with evidence that the patient is a danger to self/others due to substance use. • The patient is brought before the judge, who decides if commitment is warranted.

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Choosing a Medication for the Treatment of Opioid Use Disorder (OUD)

Medication for addiction treatment (MAT) with methadone or buprenorphine is the first line for treatment of OUD during pregnancy. It is important to limit the use of benzodiazepines and other sedating medications to decrease overdose risk.

Is the patient already on a medication for the treatment of opioid use disorder?

YES

Avoid changing medication during pregnancy

- Continue medications that the patient is stable on and optimize the dose.
- The patient may require dose increase as pregnancy advances and dose decrease at 2-4 weeks postpartum.
- If withdrawal symptoms emerge in the third trimester, you may need to increase total daily dose or frequency.

NO

Considerations for initiating medication

- Which medications are readily available?
- Which treatment setting can the patient get to?
- Which medication has the patient done well with before?
- What does the patient prefer?
- For all medication choices, make sure to consider implications for pain management *(see SUD5)* and neonatal withdrawal risk.

First-Line Treatments

	Mechanism	Pros	Cons	Special Considerations in Pregnancy	Lactation
Methadone	Full agonist at the Mu opioid receptor	Administered in structured setting with daily observed treatment Often includes multidisciplinary treatment such as groups and counseling	Must be prescribed through a federally licensed clinic, and clinics are not easy to access Daily observed dosing is not compatible with some work/childcare schedules. Can be sedating at higher doses	Risk of QTc prolongation Rapid metabolism in the third trimester may require dose increase and change from daily to twice daily doses. Pregnant women are eligible for expedited access to a methadone clinic. Multiple drug-drug interactions (e.g., many antiretrovirals, rifampin, phenytoin)	Translactal passage: 1-6 % of the maternal weight adjusted dose Low infant exposure should not preclude breastfeeding. Breastfeeding is encouraged in substance-exposed newborns unless there is active substance use or risk of infection.
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial agonist at Mu opioid receptor High-affinity receptor binding	Office-based treatment; can get a prescription at variable intervals Not usually sedating Low risk for overdose	Must be prescribed by a waivered provider Can complicate pain management in labor (see *SUD5*)	Patient must be in mild withdrawal prior to initiation treatment May require dose increase in third trimester Buprenorphine without naloxone (Subutex) is preferred if available; less-severe neonatal opioid withdrawal	Translactal passage: 1-20 % of the maternal weight adjusted dose (only absorbed sublingually and not orally) Breastfeeding is encouraged in substance-exposed newborns unless active substance use or risk of infection.

Treatments with Less Evidence for Use in Pregnancy

Gradual taper with medication (a.k.a. "detox")	Naltrexone
• Can be done using taper of methadone or buprenorphine • Emerging data for safety in pregnancy but still not standard treatment • High risk of relapse	• Reversible binding of opioid receptor antagonist with efficacy for alcohol and opioid use • Available as oral, daily medication (Revia), and IM monthly injection (Vivitrol) • Very limited and emerging data in pregnancy • Can complicate pain management • Requires 7-10 days of abstinence from all opioids prior to starting naltrexone

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Management of Pain During and After Delivery

Pregnant women with opioid use disorder (OUD) must be reassured that their pain during and after delivery can and will be treated. For women on medication for addiction treatment (MAT), it is important to support continued treatment of pain, because adequate pain control is essential for their health and well-being.

Addressing Pain in Patients with OUD

Special considerations for patients on medication treatment for OUD

- Medications used for treatment of OUD are not sufficient alone for pain control.
- Maintenance doses of MAT should be continued throughout labor and delivery.
- When using buprenorphine and methadone during pregnancy:
  - Increase total daily dose
  - Increase frequency of administration to 2-4x per day
- Additional opioids may be needed if non-opioid treatments are insufficient.

Buprenorphine

- Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
- If using additional opioids for pain, the patient may require higher doses due to the buprenorphine-blocking effect (high-affinity).

Methadone

- Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
- Confirm the dose with the provider, and notify the provider of all pain medications given.
- Baseline dose is not sufficient for analgesia.
- Pain relief can be achieved with additional doses of methadone; split dose three times per day.
- If the patient is NPO, methadone can be given by IV, IM, or SC (if IM or SC, give half the dose divided 2-4 times per day).

Naltrexone

- Blocks the analgesic effects of opioids:
  - Oral naltrexone blocks analgesia for 72 hours after last dose.
  - IM (depot) blocks analgesia for 14-25 days
- For acute pain management favor regional and non-opioid options.

Optimize non-opioid medication options

- Acetaminophen
- NSAIDs (e.g., ibuprofen, ketorolac)
- Ketamine, if available
- Neuraxial or regional blocks

Optimize non-medication treatment options

- Mindfulness
- Meditation
- Hypnosis
- Massage
- Heat/Ice
- Cognitive Behavioral Therapy (CBT)
- Physical therapy/light exercise
- Biofeedback
- Acupuncture

Opioids can be used if the above strategies do not work (*see SUD6 regarding safe opioid prescribing*).

Managing Medication for Addiction Treatment (MAT) during the Perioperative/Postpartum Period

The dose of buprenorphine or methadone may need to be increased throughout the pregnancy.

- Due to metabolic changes during pregnancy it is common to have to increase the frequency of methadone and buprenorphine dosing; this can be continued post-delivery while pain management is challenging.
- Metabolism gradually returns to the pre-pregnancy state in the 2-4 weeks postpartum, so dosing needs to be decreased to pre-pregnancy dosing, and pain and sedation levels should be monitored.

Prior to delivery, collaborate with anesthesia colleagues to plan intrapartum pain management.

- Use a regional analgesia if possible (epidural or spinal, regional blocks if appropriate).
- Maximize non-opioid pain relief (avoid NSAIDs prior to delivery).
- Pain must be treated adequately to enable mobility for newborn care and breastfeeding.

Continue methadone and buprenorphine during labor and cesarean or vaginal delivery.

- Do not stop MAT at the time of delivery because it puts women at increased risk for relapse, and restarting MAT in the postpartum period is challenging.

Continuation of MAT in Postpartum period

- Avoid discontinuation of MAT in 6-12 months to minimize risk of relapse/overdose during this high-risk time.

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Opioid Overdose Prevention

Opioid overdose is a leading cause of preventable maternal mortality in Massachusetts. Opioid use disorder (OUD) greatly increases the risk of death by overdose up to 12 months postpartum.

Safe Opioid Prescribing

Ensure the patient and caregivers have access to naloxone.	Prescribe a short duration of narcotic medication (3-7 days).
Use short-acting/immediate-release opioids at the lowest effective dose.	Discuss safe storage and disposal of opioid medication to limit risk for diversion and overdose.
Perform urine drug monitoring for patients taking opioids (confirm use of prescribed medication, and check whether the person is taking other illicit agents).	Engage the patient in an agreement for close monitoring.
Check the Massachusetts Prescription Awareness Tool (MassPAT): All licensed prescribers in Massachusetts have access to MassPAT - https://massachusetts.pmpaware.net/login.	

Risk Factors for Opioid Overdose

- Combining use of opioids with other drugs (e.g., benzodiazepines or alcohol)
- A recent period without any opioid use – high risk of this with postpartum relapse because of the loss of opioid tolerance
- Contamination of illicit drugs with other active substances (e.g., heroin is often contaminated with fentanyl)
- Medical risks for respiratory depression (e.g., history of respiratory disease/infection, on other sedating medications)
- Previous overdose(s)
- Using alone

Naloxone (Narcan)

Naloxone is an opioid antagonist that reverses the effects of opioid intoxication.	
The goal of administering naloxone is to restore respiration and prevent death related to opioid overdose.	
Naloxone is most commonly administered intra-nasally.	
Prescribe naloxone to all patients at risk for overdose.	
Teach patients and friends/family supports how to administer nasal naloxone.	

How to Identify an Overdose	Steps to Manage an Overdose	Recovery Position
• Pinpoint pupils • Decrease/absent breathing • Unresponsiveness to loud voice or sternal rub • Body goes limp • Heart rate slows or stops • May have a blue color to skin or nails Counsel patients and their supports about how to identify an overdose.	**1.** Call 911 and stay until EMS arrives. **2.** Remove the kit from packaging (two sprays per kit). **3.** Hold nasal spray with your thumb on the bottom of the plunger and two fingers on either side of the nozzle. **4.** Insert the tip of the nozzle into either nostril until your fingers touch the bottom of the person's nose. **5.** Press the plunger firmly to deliver the first dose. **6.** Remove nasal spray. **7.** Wait 3 minutes; if there is no response, administer the second dose in the alternate nostril. **8.** Place the patient in the recovery position. Advise the person not to place the victim in an ice or water bath, induce vomiting, or try to wake by slapping/hitting.	
The Massachusetts Good Samaritan Law protects people from prosecution for drug possession if seeking help for an overdose.		

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272) ***www.mcpapformoms.org***

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Massachusetts Child Psychiatry Access Program
MCPAP For Moms

Summary of Impact and Management of Substance Use during the Perinatal Period

SUD7

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
Opioids			
Fetal effects: Opioids do not cause structural fetal abnormalities. However, opioid use during pregnancy is associated with intrauterine growth restriction, fetal demise, meconium leakage/aspiration, and preterm labor. **Neonatal effects:** Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS), hypotonia, respiratory depression at delivery **Maternal effects:** Postpartum hemorrhage, risk of maternal overdose (mortality increases first year postpartum)	**Symptoms:** Sedation, euphoria, decreased respiration **Management:** Naloxone (Narcan), monitoring respiratory status	**Symptoms:** Nausea, vomiting, diarrhea, abdominal muscle pain, leg cramping, rhinorrhea, lacrimation, recklessness, sweating, anxiety, hot and cold flashes, tachycardia, and yawning **Management**: Initiate agonist therapy to decrease risk for relapse. There is mixed data regarding the negative impact of maternal opioid withdrawal.	Pharmacologic treatment is the first line to decrease relapse risk. **Methadone** can only be obtained through a federally licensed clinic. **Buprenorphine (Suboxone, Subutex)** must be prescribed by a waivered provider. Psychosocial treatments like peer supports, counseling, and sober living should be offered concurrently.
Alcohol			
Fetal effects: Spontaneous abortion, pre-term labor, stillbirth, intrauterine growth restriction **Neonatal effects:** Fetal Alcohol Spectrum Disorder (FASD) and other developmental/behavioral problems, intoxication, withdrawal, Sudden Infant Death Syndrome (SIDS) **Maternal effects:** Hepatic/pancreatic toxicity, physiologic dependence, risks of injuries/falls	**Symptoms:** Disinhibition, sedation, slowed reaction time, vomiting, loss of coordination, sedation/loss of consciousness **Management:** IV fluids (supplement with multi-vitamin thiamine and folate), prevention of physical injury	**Symptoms:** Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, and seizures **Management:** Benzodiazepine taper. Lorazepam (Ativan) is preferred over other benzodiazepines. If the patient is using benzodiazepines, manage the taper with same medication being used. There is limited data regarding the impact of withdrawal on pregnancy. The setting for withdrawal management is individually determined based on obstetric status, gestational age, and medical and psychiatric comorbidity.	**Naltrexone:** Emerging data suggests low risk of adverse birth outcomes. **Disulfiram (Antabuse):** Not recommended for use in pregnancy due to risk of fetal malformation and severe reaction with ETOH use **Acamprosate (Campral):** No human pregnancy data Psychosocial treatments such as peer supports, counseling, or sober living should be offered concurrently.
Benzodiazepines			
Fetal effects: Not teratogenic, can slow fetal movement **Neonatal effects:** Preterm birth, low birth weight, low apgar, withdrawal syndrome, admission to NICU **Maternal effects:** Physiologic dependence, worsening of depression and anxiety, cognitive decline	**Symptoms:** Anxiolysis, euphoria, amnesia, disinhibition and symptoms similar to alcohol intoxication **Management:** Flumazenil can be used to reverse acute overdose, though it is associated with increased risk of seizure, and there is no human pregnancy or lactation data.	**Symptoms:** Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, and seizures **Management:** Benzodiazepine taper. Lorazepam (Ativan) is preferred, but may also use the same agent patient is dependent on. If using benzodiazepines, manage the taper with the same medication being used. There is limited data regarding the impact of alcohol or benzodiazepine withdrawal on pregnancy. The setting for withdrawal management is individually determined based on obstetric status, gestational age, and medical and psychiatric comorbidity.	The primary goal is to manage underlying symptoms and psychiatric comorbidity. Psychosocial treatments such as peer supports, counseling, or sober living should be offered concurrently.

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Summary of Impact and Management of Substance Use during the Perinatal Period (cont'd) SUD8

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
Cannabis			
Fetal effects: There is increased risk for psychiatric and substance use disorders in offspring. There are similar risks associated with smoking tobacco. Lipophilic (e.g., stores in fetal brain and body fat) **Neonatal effects:** Associated with deficits in visual processing, executive function, attention, academic achievement **In lactation:** Levels of cannabinoids in breastmilk can exceed maternal serum levels, and exposure via breastmilk is associated with lethargy, slowed motor development, and increased risk of Sudden Infant Death Syndrome (SIDS). **Maternal effects:** Risks are associated with smoking, exacerbation of depression, anxiety or psychosis; heavy use could trigger hyperemesis syndrome .	**Symptoms:** Euphoria, anxiety or paranoia, impaired judgement, conjunctival injection **Management:** Supportive care	**Symptoms:** Irritability, anxiety, sleep difficulty, change in appetite, mood changes, abdominal pain, shakiness, tremors, headache, and diaphoresis **Management:** Generally presents within 2-3 days of cessation of use and can last 2-3 weeks. Symptomatic and supportive care.	Women should be advised to abstain during pregnancy/breastfeeding. Given the dose response for some risks, like growth restriction, even cutting down may be beneficial. Assess for mental health or comorbid condition. There is no FDA-approved pharmacotherapy for cannabis use disorder. Psychosocial treatments are indicated.
Cocaine, Amphetamines, and Other Stimulants			
Fetal effects: Intrauterine growth restriction, placental abruption, increased risk for still birth **Neonatal effects:** Transient hypertonia, irritability, hyperreflexia. Vasoconstriction can increase the risk of necrotizing enterocolitis. There is mixed data on neurodevelopmental impact. **Maternal effects:** Hypertension and coronary vasospasm, pregnancy loss	**Symptoms:** Euphoria, agitation, hyperactivity, anxiety, disorientation, confusion, and psychosis Risk for placental abruption with binge use **Management:** If severe, manage agitation with benzodiazepines or antipsychotic. Acute intoxication can confound assessment of vital signs and management of labor. ***Avoid beta blockers.***	**Symptoms:** Sedation/somnolence, dysphoria, vivid dreams **Management:** Supportive care: symptomatic treatment for physical symptoms, otherwise does not require pharmacologic treatment	Anti-craving agents such as topiramate, tiagabine, and modafinil are used in non-perinatal patients, however have not been well studied in pregnancy and lactation. Psychosocial treatments are the primary evidence-based treatment – peer supports, counseling, and sober living.
Tobacco			
Fetal effects: Smoking is associated with spontaneous abortion and intrauterine growth restriction. Nicotine is associated with miscarriage and stillbirth. **Neonatal effects:** Preterm birth, low birth weight, SIDS, persistent pulmonary hypertension of the newborn **Maternal effects:** Increased risk of deep vein thrombosis, pulmonary embolism, stroke, respiratory illness	**Symptoms:** Acute use can result in increased heart rate, blood pressure, and GI activity. **Management:** Supportive care is generally sufficient.	**Symptoms:** Cessation has been associated with cravings, anxiety, insomnia, and irritability. **Management:** Nicotine replacement can help with acute withdrawal, with the goal of eventual, gradual taper.	Quitting is the goal, but cutting down has benefits. Nicotine replacement should be used with a goal of cessation, not for ongoing and/or concurrent use. **E-cigarettes:** not well studied in pregnancy **Bupropion:** minimally effective **Varenicline:** effective, but limited pregnancy data Quitworks offers free phone counseling.

Authors: Mittal L., Suzuki J., Moore Simas T., Ziedonis D., Callaghan K., Straus J., Rosadini S., Byatt N.

Language of Addiction. Why Words Matter.

Many people who are unfamiliar with Substance Use Disorder (SUD), may find themselves unintentionally using **words** that **perpetuate** negative **stigmas**. These words shape the opinions of others, **reinforce** longstanding **stereotypes**, and have been found to adversely **affect** quality of care and **treatment outcomes**. They may also deter help-seeking among those with substance use disorders **and** their **families.**

Remember, people are more than their health problems. Substance Use Disorder does not describe what a person is, but rather describes what a person has.

REPLACE	USE
Addict, Abuser, Junkie, User	Person with a Substance Use Disorder
Clean sample, Dirty drug test	Negative test, Positive test
Staying Clean	Maintaining Recovery, Substance-Free
Habit or Drug Habit	Substance Use Disorder, Substance Use
Opioid Replacement or Methadone Maintenance	Treatment, Medication-Assisted Treatment, Medication
Binge Drinking	Heavy Alcohol Use
Suffering from/a victim of a mental illness	Experiencing/being treated for/a diagnosis/history of mental illness

DSM-5 CHECKLIST OF DIAGNOSTIC CRITERIA: OPIOID USE DISORDER

Patient Name: _____ **Provider Name:** _____

Date: _____ **Provider Signature:** _____

Opioid Use Disorder is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

Diagnostic Criteria	Meets Criterion?	Additional/Supporting Information
1. Opioids are often taken in larger amounts or over a longer period than was intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.		
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.		
4. Craving, or a strong desire or urge to use opioids.		
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.		
6. Continued opioid use, despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.		
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.		
8. Recurrent opioid use in situations in which it is physically hazardous.		
9. Continued opioid use, despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.		
10. Tolerance,* as defined by *either* of the following:		
A. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.		
B. A markedly diminished effect with continued use of the same amount of an opioid.		

Diagnostic Criteria	Meets Criterion?	Additional/Supporting Information
11. Withdrawal,* as manifested by *either* of the following:		
A. The characteristic opioid withdrawal syndrome.		
B. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.		

***Note:** This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Specify if:

In early remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion 4, "Craving, or a strong desire or urge to use opioids," may be met).

In sustained remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion 4, "Craving, or a strong desire or urge to use opioids," may be met).

On maintenance therapy: This additional specifier is used if the individual is taking a prescribed agonist medication, such as methadone or buprenorphine, and none of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone. In a controlled environment: This additional specifier is used if the individual is in an environment where access to opioids is restricted.

Current severity:

☐ *Mild:* Presence of 2–3 symptoms. **Code as: F11.10 (ICD-10)**

☐ *Moderate:* Presence of 4–5 symptoms. **Code as: F11.20 (ICD-10)**

☐ *Severe:* Presence of 6 or more symptoms. **Code as: F11.20 (ICD-10)**

After completion, scan this form into the patient's record. Make a copy for the patient.

Agreement for Treatment with Buprenorphine/Naloxone

☐ Yes	☐ No	**I understand that buprenorphine/naloxone is a medication to treat opiate addiction (for example: heroin, prescription opiates such as oxycodone, hydrocodone, methadone). Buprenorphine/naloxone contains the opiate narcotic analgesic medication, buprenorphine, and the opiate antagonist drug, naloxone, in a 4 to1 (buprenorphine to naloxone) ratio. The naloxone is present in the tablet to prevent diversion to injected abuse of this medication. Injection of buprenorphine/naloxone by a person who is addicted to opiates will produce severe opiate withdrawal.**
☐ Yes	☐ No	**1.** I agree to keep appointments and let staff know if I will be unable to show up as scheduled
☐ Yes	☐ No	**2.** I agree to report my history and my symptoms honestly to my physician, nurses, and counselors involved in my care. I also agree to inform staff of all other physicians and dentists who I am seeing; of all prescription and non-prescription drugs I am taking; of any alcohol or street drugs I have recently been using; and whether I have become pregnant or have developed hepatitis.
☐ Yes	☐ No	**3.** I agree to cooperate with witnessed urine drug testing whenever requested by medical staff, to confirm if I have been using any alcohol, prescription drugs, or street drugs.
☐ Yes	☐ No	**4.** I have been informed that buprenorphine is a narcotic analgesic, and thus it can produce a "high"; I know that taking buprenorphine/naloxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking buprenorphine/naloxone after a period of regular use, I could experience symptoms of opiate withdrawal. I also understand that combining buprenorphine/naloxone with benzodiazepine (sedative or tranquilizer) medications (including but not limited to Valium, Klonopin, Ativan, Xanax, Librium, Serax) has been associated with severe adverse events and even death. I also understand that I should not drink alcohol with buprenorphine/naloxone since it could possibly interact with buprenorphine/naloxone to produce medical adverse events such as reduced breathing or impaired thinking. I agree not to use benzodiazepine medications or to drink alcohol while taking buprenorphine/naloxone and I understand that my doctor may end my treatment with buprenorphine if I violate this term of the treatment agreement.
☐ Yes	☐ No	**5.** I have been informed that buprenorphine/naloxone is to be placed under the tongue for it to dissolve and be absorbed, and that it should never be injected. I have been informed that injecting buprenorphine/naloxone after taking buprenorphine/naloxone or any other opiate regularly could lead to sudden and severe opiate withdrawal.
☐ Yes	☐ No	**6.** I have been informed that buprenorphine/naloxone is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to get high by using it or who want to sell it for profit, may be motivated to steal my take-home prescription supplies of buprenorphine/naloxone.

☐ Yes	☐ No	**7.** I have a means to store take-home prescription supplies of buprenorphine/naloxone safely, where it cannot be taken accidentally by children or pets, or stolen by unauthorized users. 1 agree that if my buprenorphine/naloxone pills are swallowed by anyone besides me, 1 will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or hospital for treatment.
☐ Yes	☐ No	**8.** I agree that if my doctor recommends that my home supplies of buprenorphine/naloxone should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.
☐ Yes	☐ No	**9.** I will be careful with my take-home prescription supplies of buprenorphine/naloxone, and agree that I have been informed that if I report that my supplies have been lost or stolen, that my doctors will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opiate withdrawal. Also, I agree that if there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.
☐ Yes	☐ No	**10.** I agree to bring my bottle of Buprenorphine/naloxone in with me for every appointment with my doctor so that remaining supplies can be counted.
☐ Yes	☐ No	**11.** I agree to take my Buprenorphine/naloxone as prescribed, to not skip doses, and that I will not adjust the dose without talking with my doctor about this so that changes in orders can be properly communicated by to my pharmacy.
☐ Yes	☐ No	**12.** I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Buprenorphine/naloxone, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side-effect of taking it.
☐ Yes	☐ No	**13.** I agree that I will arrange transportation to and from the treatment facility during my first days of taking Buprenorphine/naloxone so that I do not have to drive myself to and from the clinic or hospital
☐ Yes	☐ No	**14.** I want to be in recovery from addiction to all drugs, and I have been informed that any active addiction to other drugs besides heroin and other opiates must be treated by counseling and other methods. I have been informed that buprenorphine, as found in Buprenorphine/naloxone, is a treatment designed to treat opiate dependence, not addiction to other classes of drugs.
☐ Yes	☐ No	**15.** I agree that medication management of addiction with buprenorphine, as found in Buprenorphine/naloxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling while being treated with Buprenorphine/naloxone.
☐ Yes	☐ No	**16.** I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are also pursuing recovery.
☐ Yes	☐ No	**17.** I agree to participate in a regular program of peer/self-help while being treated with Buprenorphine/naloxone. -
☐ Yes	☐ No	**18.** I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment
☐ Yes	☐ No	**19.** I agree that a network of support, and communication among persons in that network, is an important part of my recovery. I will be asked for my authorization, to allow telephone, email, or face-to-face contact, as appropriate, between my treatment team, and outside parties, including physicians, therapists, probation and parole officers, and other parties, when the staff has decided that open communication about my case, on my behalf, is necessary.

☐ Yes	☐ No	**20.** I agree that I will be open and honest with my counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred -before a drug test result shows it.
☐ Yes	☐ No	**21.** I have been given a copy of clinic procedures, including hours of operation, the clinic phone number, and responsibilities to me as a recipient of addiction treatment services, including buprenorphine treatment with Buprenorphine/naloxone.

Patient Signature:_____ Date:_____

Staff Signature/Title:_____ Date:_____

PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Clinical Opiate Withdrawal Scale (COWS)

For Buprenorphine/naloxone induction: Enter score at time zero, 1-2 h after first dose, and at additional times that buprenorphine/naloxone is give over the induction period.

	Date/Time:	Date/Time:	Date/Time:
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting/lying for one minute.* **0** pulse rate 80 or below **1** pulse rate 81-100 **2** pulse rate 101-120 **4** pulse rate greater than 120			
Sweating: *Over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills of flushing 1 one subjective report of chills or flushing **2** flushed or observable moistness on face **3** beads of sweat on brow or face **4** sweat streaming off face			
Restlessness: *Observation during assessment.* **0** able to sit still **1** report difficulty sitting still, but is able to do so **3** frequent shifting or extraneous movements of legs/arms **5** unable to sit still for more than a few seconds			
Pupil Size: **0** pupils pinned or normal size for room light **1** pupils possibly larger than normal for room light **2** pupils moderately dilated **5** pupils so dilated that only rim of the iris is visible			
Bone or Joint Aches; *If patient was having pains previously, only the additional component attributed to opiate withdrawal is scored.* **0** not present **1** mild diffuse discomfort **2** patient reports severe diffuse aching of joints/muscles **4** patient is rubbing joints or muscles and is unable to sit still because of discomfort			
Runny Nose or Tearing: *Not accounted for by cold symptoms or allergies.* **0** not present **1** nasal stuffiness or unusually moist eyes **2** nose running or tearing **4** nose constantly running or tears streaming down cheeks			
GI Upset: *Over last ½ hour* **0** no GI symptoms **1** stomach cramps **2** nausea or loose stools **3** vomiting or diarrhea **5** multiple episodes of diarrhea or vomiting			
Tremor: *Observation of outstretched hands* **0** no tremor **1** tremor can be felt, but not observed **2** slight tremor observable **4** gross tremor or muscle twitching			
Yawning: *Observation during assessment* **0** no yawning **1** yawning once or twice during assessment **2** yawning three or more times during assessment **4** yawning several times/minute			
Anxiety or Irritability **0** none **1** patient reports increasing irritability or anxiousness **2** patient obviously irritable, anxious **4** patient so irritable or anxious that participation in the assessment is difficult			
Gooseflesh skin **0** skin is smooth **3** piloerection of skin can be felt or hairs standing up on arms **5** prominent piloerection			
Total			
Observer Initials			
Blood Pressure/Pulse			
Dose of Buprenorphine/Naloxone Given			

Note: Given first dose when COWS score >
7 SCORE: 5-12 = Mild
13-24 = Moderate
25-36 = Moderately Severe
More than 36 = Severe Withdrawal

Buprenorphine Maintenance Treatment

Physician/Office Information

Management at Follow-up Appointments

Frequency of Follow-up Appointments

Follow-up appointments should occur at least monthly. More frequent follow-up appointments may be necessary early in treatment, or if the patient is experiencing difficulty in treatment.

Activities at Follow-up Appointments

The activities at follow-up appointments are focused on evaluating the adequacy of treatment and danger for relapse. They should include:

- urine testing for drugs of abuse and alcohol
- prescription of buprenorphine medication
- an interim history of any new medical (including psychiatric) problems or social stressors
- self-report of drug and alcohol use
- pill counts, including reserve tablets (this should not be at each visit, but should be used as a check of adherence; e.g.: once every few months)

Dangerous Behavior, Relapse and Relapse Prevention

The following behavior "red flags" should be addressed with the patient as soon as they are noticed:

- missing appointments
- running out of medication too soon
- taking medication off schedule
- not responding to phone calls
- refusing urine or breath testing
- neglecting to mention new medication or outside treatment (including ED visits)
- appearing intoxicated or disorganized in person or on the phone
- frequent or urgent inappropriate phone calls
- neglecting to mention change in address, job or home situation
- inappropriate outbursts of anger
- lost or stolen medication
- frequent physical injuries or auto accidents
- non-payment of visit bills
- changes in patient's usual pattern of behavior

These changes should be brought to the patient's attention, and he or she should be supported in a making appropriate response to them. Additional or higher level of care (for example: referral to methadone maintenance) or monitoring may be indicated.

Example Notes and Epic Smart phrases for OUD in Pregnancy

By Katherine Callaghan, MD

MAT Counseling:

Today NAME was oriented to clinic as a safe place to discuss her SUD and recovery as well as receive pregnancy care. We reviewed our policies such as urine toxicology each visit and random witnessed urine toxicology. We reviewed options of treatment of opioid dependence. In particular we discussed the recommendation for MAT which has been shown to decrease relapse rates and increase compliance with prenatal care. We also discussed the risks of withdrawal in pregnancy including poor growth, preterm labor and stillbirth. We discussed that NAS is a risk of therapy with buprenorphine, but this is a temporary condition with little evidence of long-term effect. Smoking cessation is one way to reduce the risk of NAS and I encouraged her to quit by third trimester. A consult will be placed at 35 weeks with NICU to give her more information. We discussed that the risk of NAS is dose independent and that many people in pregnancy need to have doses increased. She agreed to be open and honest about symptoms and have medications adjusted accordingly.

ROS:

Doing well on current dose of methadone/buprenorphine. COWS today = 0. Denies lapse or relapse. No cravings /temptations. Last utox negative excepting prescribed substances. Will f/u utox today.

Problem list:

To Do:

-

#Opioid Dependence

- Last use: _____
- Inpatient stay: _____
- Number of overdoses: _____
- Longest recovery time: _____
- Previous prescriber: _____

#Current treatment

- Current Rx: _____
- Last Rx: _____
- Narcan: _____
- Prior Auth: _____
- Groups: _____

- POSC: _____
- NAS consult (35wk): _____
- EFW (35wk): _____
- Antenatal Testing: _____
- Delivery Plan: _____
- Pregnancy Goal: _____
- Breastfeeding: _____

#Problem

-

#Problem

-

History
- **OBHx**: _____
- **GYN**: _____
- **PMH**: _____
- **PSYCH**: _____
Meds: _____
Counselor: _____
Psychiatrist: _____
- **PSH**: _____
- **Meds**: _____
- **ALL**: _____
- **SocHx**: _____
- **FH**: _____

Routine:
- Dating: _____
- Initial labs: HIV __, RPR __, hepC __, hbsag __, Rubella __, Varicella __, GCC __, UCX __, CBC __, T&S __
- PAP: _____
- Genetic: _____
- Anatomic Survey (18-21wks): _____
- 28wk labs: _____
- Rhogam: _____
- TDap: _____
- Flu: _____
- GBS: _____
- PPBC: _____

UTox Hx:
- 00/00: _____

NSH Hx:
- 00/00: _____

Billing and Scheduling Tips

By Melissa Sherman, MD, FACOG, FASAM

Codes frequently used:

O99.320 Drug use complicating pregnancy.
O99.310 Alcohol use affecting pregnancy
O99.320, F11.10 Heroin use affecting pregnancy

O.09.70 Supervision of high risk pregnancy due to social problems
O.09.899 Supervision of other high risk pregnancy
O.09.90 Supervision of high risk pregnancy

O99.320 , F11.20 Pregnancy complicated by suboxone maintenance, antepartum
O99.320, F11.20 Methadone maintenance treatment affecting pregnancy, antepartum

F11.99 Opioid use disorder
F11.10 Mild abuse
F11.11 Mild abuse in early remission, +/- maintenance therapy
F11.21 Moderate/severe in early remission, +/- maintenance therapy

Z51.81, Z79.899 Encounter for monitoring maintenance therapy (Suboxone, Naltrexone)

NOTES:

- For all insurances, once you pass 13 visits in pregnancy you can bill for the additional visits. We have been paid for these as long as a substance use code is the first code.

- Alternatively you can bill outside the global for a separate E&M code using the F codes if your visit is primarily substance use. The note has to have the elements of an E&M note with history, ROS, etc.

Scheduling Tips:

- Scheduling in the office can also be a challenge for this population. Public payers/lateness due to life and transportation/no shows are all challenges.
- In my practice I have a held block for these patients on Tuesdays from 9:20-2. Only I can authorize booking into this block.
- If it is not full by the Friday before I will open up appts for general booking.
- This time coincides when our social worker/peer moms are holding therapeutic groups on campus.
- I give all clients 20-minute appointments.
- I also anticipate weekly "walk ins" as sometimes clients are sent over from group if there is an acute issue.
- We did a lot of training with staff to reduce barriers - if a program patient walks in the front desk will tell me right away and we figure out how to accommodate them; same with phone calls. This model has worked fairly well in limiting the chaos to one day a week. Flexibility on that day is key.

INPATIENT INITIATION OF MEDICATION ASSISTED TREATMENT (MAT) OF OPIOID USE DISORDERS

Background: This protocol was developed to assist providers in starting pregnant patients on Medication Assisted Treatment (MAT) for Opioid Use Disorders. It is a work in progress and may vary from patient to patient but is meant to serve as a guideline in how to begin treatment. Treatment for substance use / abuse is not limited to Medication Assisted Treatment and MAT alone is not sufficient treatment, but is one portion of a treatment plan.

In counseling patients, risks and benefits of all treatment options should be reviewed. In short, abstinence or detox ("going cold turkey") is NOT recommended in the pregnant population, both because of an increased risk of miscarriage or IUFD, but also because of a high relapse rate.

Methadone is the gold standard for MAT, both because more long-term studies have been conducted on both mothers & babies exposed to this medication and because of a lower relapse rate (compared to buprenorphine.)

Buprenorphine is an acceptable alternative, but requires high patient motivation and can only be prescribed by physicians waivered to do so.

NAS (neonatal abstinence syndrome) is a risk with any pregnant patient exposed to opiates, including those treated with methadone or buprenorphine. Patients choosing treatment with MAT should be made aware of this risk as well.

PRE-ADMISSION:

Identified as Outpatient / In Community →Phone screen or Outpatient meeting for:

- History / Assessment
- Viability u/s and prenatal labs
- Utox + bup screen
- Discussion of options including methadone and buprenorphine
- Review of process & patient responsibilities
- Plan for future admission (if patient safe / able to return)
- If planning for future admission, counsel patient to arrive in mild withdrawal (~6h after short-acting opioids, ~12h after long acting)
- Alert nursing managers to possible admission

Identified inpatient / In ER:

- MFM resident to eval as above
- Decide if able to return or admission / MAT needed immediately

ON ADMISSION:

- ☐ HR resident to see, admit
- ☐ Review Inpatient Treatment Agreement with patient & have her sign
- ☐ Patient belongings search (confiscate drugs, inhalants, weapons)
- ☐ Labs (any prenatals not already obtained, plus AST/ALT, Hep C, HIV)
- ☐ EKG* See below for guidelines
- ☐ Utox / Bup screen
- ☐ Doptone or strip (after 24 wks)
- ☐ MMT or Bup tx per protocol (see attached)
- ☐ Place Social Work consult, determine discharge plan (inpatient vs outpatient)
- ☐ Place Psych / MCPAP consult if needed immediately
- ☐ Call or Page MomsDoCare for referral for Peer Support Services. Page at: 508-387-3811 or 7082. Can also text page with patient name, location or email Carol.Zappulla@umassmemorial.org. Patients will be seen within 12 hours.

PRIOR TO DISCHARGE

- ☐ Plan for 24-36 hour stay
- ☐ Treatment plan & follow-up in place (both Obstetrics follow-up plan and MAT follow-up plan)
- ☐ EKG (if methadone)
- ☐ Strip (if NST plan to do prior to dosing)
- ☐ Bup only: Rx w/1-3d supply depending when follow-up scheduled

<u>EKG: Concern is primarily QT prolongation→ Torsades with METHADONE</u>

- Under 450 = normal
- 450-500 = elevated requiring follow up and careful monitoring – call Jeff Baxter / Spectrum for guidance before initiating or continuing methadone
- Over 500 = potentially too dangerous to continue on methadone– call Jeff Baxter / Spectrum (call 508-854-3320-> #3 to speak with nursing who will contact Dr. Baxter) for guidance before initiating or continuing methadone
- The Qtc elevation is likely dose related, so if it is elevated at the time of admission while not on methadone, or if patients are on other meds that prolong the QT, it could worsen as patients increase the dose to stabilize.

MMT Protocol

Start COWS q2 until:

- COWS >8, dose with 20mg methadone
- Continue COWS q2h
    - If COWS >6 two hours after first dose, give additional 10mg methadone, continue q2h COWS. Can re-dose until max of 40mg/in 24h reached.
    - If COWS >6 and max of 40mg/in 24h has been given, treat breakthrough symptoms with PRN dosing (see below)
    - When COWS <6, continue COWS q4h when pt awake (document respiratory rate q4 when asleep)
- D/C COWS when <6 x24h on stable dosage
- Methadone takes 3-4 days to reach steady state

Monitor FHT x1h after first dosage (if viable), or while COWS >6

If vomited: replacement doses only if emesis witnessed/observed

- <15 min after dosing: replace 50% of dose
- 15-30 min after dose: replace 25% of dose
- >30 min after dose: replacement not needed

PRN ORDERS:

Hydroxizine 50mg PO q8h PRN anxiety or insomnia

Dicylomine 20mg PO q8h PRN abdominal cramping

Tylenol 650mg PO q6h prn pain

Loperamide 4mg PO x1 for loose BM (then 2mg each loose BM after that to max of 16mg/24h)

Zofran 4mg PO q8 PRN nausea

Pantoprazole 40mg PO daily for reflux

Naloxone 0.4mg IM q3 min to max of 1.2mg PRN respiratory depression

Nicotrol inhaler: inhale with continuous puffing over 20 minutes, 1 cartridge every 2 hrs prn nicotine craving

Buprenorphine Protocol

Start COWS q2 until:

- COWS >8, dose with 4mg
    - Obs pt place under tongue
    - No PO x 10 min
    - After 10 min obs that pill dissolved or have pt swallow residue
- COWS 1h after first dose to eval for precipitated withdrawal
    - If 1h COWS>12, assume precipitated withdrawal
    - Alert H.O.
    - Start clonidine 0.1mg PO q4h for s/sx withdrawal (hold if systolic BP<90)
    - Continue PRN orders
- Otherwise, continue COWS q2 until COWS <6
- Treat COWS>6 with additional 2mg bup until COWS <6 or max of 8mg/24h reached
    - If COWS>8 and 8mg/24h reached, treat breakthrough sx with PRN dosing (see below)
    - Alert H.O
- When COWS<6, continue COWS q4 while awake
- When COWS<6 x24 h, d/c COWS

Monitor FHT x1h after first dosage (if viable), or while COWS >6

If vomited:

- <10 min: give 2mg or half current dose
- >10 min: fully absorbed. No reason to repeat dose.

<u>PRN ORDERS</u>:

Hydroxizine 50mg PO q8h PRN anxiety or insomnia

Dicylomine 20mg PO q8h PRN abdominal cramping

Tylenol 650mg PO q6h prn pain

Loperamide 4mg PO x1 for loose BM (then 2mg each loose BM after that to max of 16mg/24h)

Zofran 4mg PO q8 PRN nausea

Pantoprazole 40mg PO daily for reflux

Naloxone 0.4mg IM q3 min to max of 1.2mg PRN respiratory depression

Nicotrol inhaler: inhale with continuous puffing over 20 minutes, 1 cartridge every 2 hrs prn nicotine craving

Anesthesia Protocol

-Katherine Callaghan

PODx: Consult anesthesia for TAP block
Toradol 30mg IV x1 in OR, then 15mg IV q6h x48 hours Percocet 10mg/650 PO q4h ATC x24h (not PRN) Oxycodone 5mg PO q2h BTP:

- 1 tab for pain 4-6/10
- 2tab for pain 7-10/10

POD1:
Percocet 5mg/325 PO q4h PRN pain

- 1 tab for pain 4-6/10
- 2tab for pain 7-10/10

Oxycodone 5mg PO q2h
BTP:
- 1 tab for pain 4-6/10
- 2tab for pain 7-10/10

POD2-discharge:
Percocet 5mg/325 PO q4h PRN pain

- 1 tab for pain 4-6/10
- 2tab for pain 7-10/10

*Motrin 800 PO q8h ATC

*D/c home with 0 tabs of Percocet (no rx) - 20 tabs depending on in-hospital use F/u in 3-5 days to assess pain

*Highly individualized to the patient

CAPTA Notification FAQ

- **What is CAPTA, CARA and the corresponding CT State specific CAPTA legislation?**

The Child Abuse Prevention and Treatment Act (CAPTA) was originally enacted in 1974 and reauthorized in 2010 to include a policy requiring states to implement a notification process to DCF when a baby is born who has been prenatally exposed to substances.

The Comprehensive Addiction and Recovery Act (CARA) was signed into federal law in 2016, with the aim to address the problem of opioid addiction in the United States and offered amendments to CAPTA.

Specifically included in the CAPTA/CARA requirements are:

- States are to develop policies and procedures for the notification to child protective services of the birth of an infant affected by prenatal drug or alcohol exposure
- Work with stakeholders to ensure the development of a Plan of Safe Care for infants who are prenatally exposed
- Develop a process for referrals to screening and early intervention services
- Healthcare providers involved in the delivery of care of an infant born substance exposed must notify child protective services. A plan of safe care is to be developed for these infants and their families.
- The requirements are intended to provide the needed services and supports for infants with prenatal exposure, their mothers with substance use disorders and their families to ensure a comprehensive response to the effects of prenatal exposure.
- Congress stated that these reports to CPS, on their own, are not grounds to substantiate child abuse or neglect.
- The establishment of a Plan of Safe Care to address the needs of both the infant and parent(s),
- Amending the legislation to include the needs of infants born with and identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

CT state legislation requires:

- The DCF Commissioner, in consultation with other departments, agencies, or entities concerned with the health and well-being of children, to develop guidelines for the safe care of newborns with Substance Exposure.
- The creation of written Plans of Safe Care, which must be developed between the providers and mothers of the newborns.
- A provider involved in the delivery or care of a newborn who, in the provider's estimation, is exposed to substances in utero or exhibits physical, neurological, or behavioral symptoms consistent with prenatal substance exposure, associated withdrawal symptoms, or fetal alcohol spectrum disorder must notify DCF of these conditions in the newborn.

- **How does this federal and state legislation impact current practice in Connecticut?**

Effective March 15, 2019, birthing hospitals, will be required to notify DCF when an infant with prenatal substance exposure is born or presents with suspicions of abuse or neglect, through an online portal. This portal will guide the reporter through a variety of questions to determine if the matter is a CAPTA Notification or requires a referral to the Department of Children and Families (DCF 136). If it is a referral of abuse and neglect, this will be accomplished online through this same portal, with a call to the DCF Careline no longer required.

- **What is the difference between a report and notification?**

A DCF report or referral, sometimes called a "136", is made when mandated reporters or anyone has concerns about the safety of a child. DCF staff determine if the information meets the statutory definitions of abuse or neglect.

A CAPTA notification to DCF would occur when a newborn has been prenatally exposed to substances but there are no concerns about safety or well-being. This notification does not contain any personally identifying information.

If the prenatal exposure was a result of maternal substance misuse, the reporter would be directed to the DCF 136 path through the online portal. Substance misuse is defined as the use of non-prescribed substances or overuse of prescribed substances by an individual.

- **How is CT defining infants born substance exposed for the purposes of the CAPTA notification:**

1. A newborn exposed in utero to: methadone, buprenorphine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication.

2. Newborn with withdrawal symptoms

3. Diagnosed with Fetal Alcohol Syndrome

- **What specific substances are included and excluded in the notification?**

CAPTA notification applies to mothers who are prescribed and take medications during their pregnancy that are clinically indicated but may result in withdrawal symptoms in the newborn. This includes: Methadone, Buprenorphine, Prescription Opioids, and Prescription Benzodiazepines.

Also required for notification are exposure to alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication.

Federal legislation requires the notification of the presence of Fetal Alcohol Spectrum Disorder, however it is recognized that determination of this at the time of birth is extremely rare.

While tobacco use may have adverse impact during pregnancy it is not included in this notification.

Psychotropic medications are not included in the notification requirement.

Whether or not the concerns of substance exposure meet the threshold for investigation of abuse and neglect concerns by DCF will be determined by the questions answered in the online portal.

- **What about marijuana use and medical marijuana?**

Any in utero exposure to marijuana constitutes meeting the requirement to submit a notification through the CAPTA online portal.

Non-prescribed Marijuana is an illegal substance in Connecticut, so its use, by definition of this legislation and CT state statutes, makes it a substance of misuse.

Whether or not the concerns of substance exposure meet the threshold for investigation of abuse and neglect concerns by DCF will be determined by the questions answered in the online portal.

- **What information is provided during the notification?**

There is not personally identifying information obtained during a notification. The following data is required:

- Name of hospital and staff making the notification
- Zip Code of family,
- Race/Ethnicity of child and mother,
- Mother's age
- Substance that caused withdrawal symptoms
- Verification or development of plan of safe care provided by birthing hospital
- Services identified/referred in the plan of safe care

- **Is there a time frame for when the notification must be made?**

Yes, the notification must be made by the birthing hospital as soon after the birthing event as possible and before discharge. Mandated Reporter requirements include notification to the Department of Children and Families within 12 hours of learning of suspicions of abuse or neglect. Notification is accomplished by accessing and completing the online portal, which will provide confirmation upon a successful submission.

- **What is the process for making the CAPTA Notification?**

DCF will provide an online notification portal for all infants identified at time of birth with substance exposure or concerns of abuse/neglect. This online notification process will ask for identifying information from the person completing the submission, notification data (described above), and additional questions regarding substance misuse and concerns for abuse or neglect. If there are concerns that warrant a referral to DCF in addition to the notification, additional questions will be asked that include identifying information on mother and infant that will be completed in this same online portal.

The person submitting the information will obtain an immediate response that the notification was submitted. In the circumstances when the submission is a Careline referral, the Reporter will complete the Mandated Reporter requirements for reporting and will be notified, as is done presently, of the status of this referral.

- **What is a Plan of Safe Care (POSC)?**

A Plan of Safe Care is a document that provides a roadmap of what supports are and should be in place to support mother, baby and family. It is important to note that this is "mom's plan" and she chooses the lead professional to collaborate. All POSC must have an identified lead provider. The plan should also value the role of the father of the child and/or mother's partner. It is imperative that we encourage natural family supports, especially through fatherhood engagement, to assist in the successful implementation of the Plan of Safe Care. Their shared investment in the health of mother and child are invaluable sources of lifelong support.

The POSC must be:

- Verified with the POSC developer by the birthing hospital at time of birth and notification. Possible collaborators on Mom's POSC may include: pregnancy care providers; pain specialists; Medication Assisted Treatment providers; OB-GYNs/Pediatricians; maternal postpartum providers (visiting nurse, Birth to 3, home visitors); Substance Use Treatment or other Behavioral Health providers, birthing hospital staff.
- A plan that meets the needs of mom, infant, and family

Possible components to include in a POSC should be based on the individual and unique needs of mom, baby, and family. Examples to consider include:

Behavioral health counseling	Child Care
Medication Assisted Treatment	Birth to 3
Community support	Pediatric Care
Housing	Parenting
Financial Support	Safe Sleep Plan

It is recognized that while some of these services may already be in place at the time of verification other identified supports may be referred to following delivery.

- **How does the POSC get verified at the time of the birthing event?**

There are three options for verification:

- Mother may come into the hospital with a POSC. With a Release of Information, hospital staff can call and confirm with the lead POSC provider.
- If mother does not have a POSC, hospital staff can work with mother (and additional provider) to establish a POSC before discharge and inclusive of their discharge plan.

- If a POSC cannot be verified at the time of submission, the online portal will direct the notification to the DCF 136 referral track.

- **How are multiple births handled?**

When there are multiple births, each infant requires a separate and unique notification and/or mandated report.

- **If a birth occurs in Connecticut and mom and baby reside out of state, how should this be handled?**

Notifications are to be made in the State where the birth occurs. Concerns regarding child safety are to be made to the Child Protection Agency where the child resides.

- **How was this process designed?**

DCF recognizes that while the notification process is federally mandated to rest with the state child protection agency, a comprehensive system response is necessary and appropriate to achieve the intended spirit of the legislation: to ensure that mom, newborn and have the supports they need for a successful start. To that end, DCF has been working in collaboration with key stakeholders including: Department of Mental Health and Addiction Services, Department of Social Services, Department of Public Health, CT Hospital Association, Office of Early Childhood, CT Chapter of American Association of Pediatrics, CT Chapter of ACOG, Community providers, and other key stakeholders including mothers with the lived experience.

- **How can I get more information regarding this?**

DCF will be offering training materials in the form of an online webinar, in person trainings upon request, and FAQ documents. A link is also under development where these documents and additional information will be found.

Please direct any specific questions to:

Mary Painter, LCSW, LADC
Director of the Office of Intimate Partner Violence & Substance Use Treatment & Recovery
Department of Children and Families
Mary.painter@ct.gov

Plan of Safe Care

- Client is currently admitted into our long term, residential, Women and Children's, Substance Use Treatment Program.
- Our Women and Children's program provides clients with a minimum of **20-hours of substance use disorder treatment weekly**,
- Group and individual interventions include but are not limited to: Relapse Prevention, Co-Occurring Disorders, Parenting in Recovery, Anger Management/Domestic Violence, Family and Natural Supports Relations, Vocational, Discharge Planning, Trauma education, individually and/or in Group setting.
- This Plan of Safe Care provides a current picture of client's engagement in her recovery process, as of today's Date: _____

Client Name: _____ Date of Admission:_____
Client Cell/Phone: _____ Date of Birth:_____

Program: _____ Program Case Manager: _____
Address: _____
Phone: _____

Pregnancy Due Date: _____ OB/GYN Physician/Office: _____
Plans to Breastfeed? Yes☐ No☐ Plans for post-Partum contraception? Yes☐ No☐
If so, explain: _____

DCF Involved? Yes☐ No☐ If so, DCF Region: _____
If so, DCF Social Worker Name: _____ Phone: _____
Post-Discharge Plan for Mom and Baby? _____

Name of Child/ren currently in client's care: Name: _____ Age: _____
Name: _____ Age: _____
Medical/Medications:
Medication Assisted Treatment*? Yes☐ No☐ If so, Medication/Dose: _____
Prescriber Name/Agency Name: _____
Address: _____Phone: _____
Client's Drug of Choice: _____
Client:
Used Substances during pregnancy? Yes☐ No☐ Last Date of Substance Use: _____
Treated with opioids for chronic pain, during pregnancy*? Yes☐ No☐
Treated with benzodiazepines, during pregnancy*? Yes☐ No☐

Mental Health Diagnoses: _____

List of Client's Current Medications:	Dose/Frequency	Prescriber

Emergency Contact:
Name: _____ Relationship: _____
Address: _____ Phone: _____

Client/Family current Strength and Goals:

_____
_____
_____
_____

Check box (es) for all applicable services and new referrals for infant and mother/caregiver and N/A, if not applicable:

	Discussed	***Active***	***Pending/ Referred***	**Organization/Program**
Prenatal Care				
Medication Assisted Treatment				
Mental Health Treatment				
Substance Use Treatment				
Safe Sleep				
12 STEP/Recovery Groups				
Recovery Supports (Sponsor, Network, CCAR, ABH,				
Childcare				
Home visiting				
WIC				
Birth to Three/Early Childhood				
Housing Assistance				
Financial Assistance/Employment/DSS				
Parenting Groups				
Faith Based Supports				
Other				

If my baby is to remain in hospital for continued monitoring after birth, I plan to coordinate with my Case Manager and program staff to make arrangement with hospital staff, in efforts to assist with my baby's care and continue to meet my program expectations. Client initials: _____

Client Signature: _____Date: _____

Case Manager Signature: _____ Date: _____

Supervisor Signature: _____Date: _____

CHILDBIRTH, BREASTFEEDING AND INFANT CARE:

Methadone and Buprenorphine

Are you pregnant, taking methadone or buprenorphine, and want to know how this may affect your delivery, ability to breastfeed, or your newborn?

Or are you a pregnant woman using heroin or prescription opioids and considering treatment with methadone or buprenorphine?

HOW SHOULD I PREPARE FOR DELIVERY?

- Choosing a doctor and hospital with experience in methadone and buprenorphine during labor and delivery can be helpful.
- Select a doctor for your baby *(a pediatrician or family physician)* and meet before delivery to talk about the care of your baby.
- Find out whether you can tour the nursery before your baby is born to learn about how the nursery cares for opioid exposed infants.

WHAT ABOUT PAIN RELIEF DURING AND AFTER DELIVERY?

- Your usual daily methadone or buprenorphine dose will not treat pain.
- Discuss pain control for childbirth and after delivery with your physician during prenatal care.
- Meet with the anesthesia doctor to discuss your labor and delivery pain. This meeting can happen before labor or early in labor.
- If you are having a planned cesarean delivery or have one after labor, discuss postoperative pain.
- The doctors on Labor and Delivery MUST know that you are taking methadone or buprenorphine so that you are not given labor pain medications such as Stadol and Nubain which can cause withdrawal in women taking methadone or buprenorphine.

WHAT ABOUT CHILD PROTECTIVE SERVICES?

- Many babies and mothers get tested for drugs and alcohol at delivery -- this might include methadone and buprenorphine
- Having a positive drug test, even if it's for prescribed medications, may mean that social workers or a child protection agency will want to talk to you and your family.
- A child services worker may come to your home to see how safe the environment is for your baby.
- Please talk to your doctor and other health care providers about the child protection laws in your state.

HOW DOES OPIOID WITHDRAWAL AFFECT THE BABY AFTER DELIVERY?

- After delivery, the baby no longer receives nutrients and medications such as buprenorphine and methadone from the mother's bloodstream. Your baby may develop withdrawal – called Neonatal Abstinence Syndrome (NAS).
- Not all babies born to moms on methadone or buprenorphine develop NAS.
- Each baby shows withdrawal differently. The following are some of the most common signs in opioid exposed babies:

Tremors or shakes	*Crying*	*Frequent yawning*
Poor feeding/sucking	*Sleep problems*	*Stuffy nose*
Fever	*Sneezing*	*Tight muscles*
Vomiting	*Diarrhea*	*Loose stool (poop)*

- These signs may happen from birth to 7 days after delivery and can last days, weeks, or months.
- Your baby may need medication to treat these symptoms and make the baby feel better. The baby's dose will then be decreased over time, until the symptoms have stopped.
- Your baby may be watched for four or five days in the hospital to see if medication will be needed.
- If a baby has NAS, it does not mean that he or she will have long-term problems.

CAN I BREASTFEED IF I AM TAKING BUPRENORPHINE OR METHADONE?

- Breastfeeding is usually encouraged for women who are taking methadone or buprenorphine, except in some cases.
- Breastfeeding is not safe for women those with HIV, taking certain medicines that are not safe in breastfeeding, or who are actively using street drugs.
- Only very small amounts of methadone and buprenorphine get into the baby's blood and may help lessen the symptoms of NAS.

HOW WILL HAVING A NEWBORN AFFECT MY RECOVERY?

- The weeks and months after the baby is born can be a stressful time for women in recovery. Be sure to continue counseling, and use parenting support programs.
- Do not make a decision to stop your opioid medication too quickly or too soon because this increases the risk of relapse.
- It is important to discuss decisions about your medication with your doctors and your counselors. *For further information, please see brochure Pregnancy and Methadone and Buprenorphine.*

PREGNANCY:

Methadone and Buprenorphine

Some women are surprised to learn they got pregnant while using heroin, Oxycontin, Percocet or other pain medications that can be misused (known as opioid drugs). You, along with family and friends, may worry about your drug use and if it could affect your baby.

Some women may want to "detox" as a way to stop using heroin or pain medicines. Unfortunately, studies have shown that 8 out of 10 women return to drug use by a month after "detox." Therefore, most doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.

HOW SAFE IS IT TO TAKE METHADONE OR BUPRENORPHINE (SUBUTEX®) DURING PREGNANCY?

- In the right doses, both methadone and buprenorphine stop withdrawal, reduce craving, and block effects of other opioids.
- Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
- Based on many years of research studies, neither medicine has been associated with birth defects.
- Babies born to women who are addicted to heroin or prescription opioids can have temporary withdrawal or abstinence symptoms in the baby (Neonatal Abstinence Syndrome or NAS). These withdrawal symptoms (NAS) also can occur in babies whose mothers take methadone or buprenorphine
- Talk with your doctor about the benefits versus the risks of medication treatment along with the risks of not taking medication treatment.

IS METHADONE OR BUPRENORPHINE A BETTER MEDICATION FOR ME IN PREGNANCY?

- A pregnant woman and her doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
- If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

HOW CAN I GET STARTED ON METHADONE OR BUPRENORPHINE?

- Depending where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
- Methadone may only be given out by specialized clinics while buprenorphine may also be available from your primary care physician or obstetrician if they have received special training.
- Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

WHAT IS THE BEST DOSE OF METHADONE OR BUPRENORPHINE DURING AND AFTER PREGNANCY?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

- The "right" dose will prevent withdrawal symptoms without making you too tired.
- The right dose depends on how your body processes the medications.
- In pregnancy, you process these medications more quickly, especially in the last several months and this affects what dose you need.
- The dose of methadone usually needs to increase with pregnancy – especially in the third trimester and you may need to take methadone more than once a day.
- There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.
- The dose does not seem to determine how much NAS a baby will have.
- After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause sedation. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. *For further information, please see brochure Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine.*

Information for Family Members of Patients who Have Been Prescribed Buprenorphine/Naloxone

Opioids & Addiction

- Opioids are narcotics – medications used to treat pain (e.g., Codeine, Oxycontin, Vicodin). Opioids are in the same family as fentanyl, morphine, and heroin. Buprenorphine and methadone are also opioids.
- Addiction – Everyday use of substances, in this case opioids.
- It is a long-life disease that impacts brain chemistry over extended periods of time. It is **NOT** a problem with willpower.
- To suppress withdrawal symptoms, patients are recommended to take Buprenorphine/Naloxone.

Buprenorphine/Naloxone

- It is a long acting opioid medication proven to help improve Opioid Use Disorder (OUD).
- Because it is long acting it is not "just substituting" one drug or addiction for another.
- Medication can be a tablet that is swallowed or a film that dissolves under the tongue.
- When medication is dissolving the patient is unable to continue regular activities (e.g., talking, answering phone).
- Medication must be stored separately from other vitamins to eliminate confusion to house hold members.
- If medication is accidentally taken by a member of the household or a pet, seek medical attention immediately.

How to Support Someone Who is Using Medicated Assisted Treatment (MAT)

- Understand that medications are not a "cure". OUD needs to be treated EVERY day like any other disease.
- The best way to help and support the patient is to encourage regular medical care, which is necessary to continue MAT.
- Encourage the patient not to skip doses or forget to visit doctor and take medication daily.
- Missing DR appointments may increase chances of withdrawal, which is uncomfortable and leads to relapse.

Other Supports for Individuals Who receive MAT

- Specialty medical care on top of regular check ins.
- Counseling – family attending counseling can be helpful.
- Meetings – daily or weekly meetings with providers or support groups.

How will MAT affect you and your family?

- Life can change once someone seeks treatment for an opioid use disorder. Be patient – it will take time to adjust for both you and your family member.
- The tendency to abuse substance is genetic.
- It is important to encourage family members to be aware of symptoms of addiction and substances that are highly addictive.
- Integrating counseling and support for family will improve well-being.

Be patient. Take care. Seek support.

Adapted from the Providers' clinical Support System for Medication Assisted Treatment (PCSS) information sheet for families by the Project SMART team

Treating Opioid Use Disorder During Pregnancy

Getting the help and support you need from your healthcare professionals

Introduction

Opioid use disorder (OUD) is a treatable disease. When OUD is managed with medicines and counseling, you *can* have a healthy pregnancy and a healthy baby. However, during pregnancy, adjustments to your OUD treatment plan and medicines may be needed.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know about OUD treatment during pregnancy, as well as the Do's and Don'ts for making sure you receive the best treatment possible.

Things to know

- Methadone and buprenorphine are the safest medicines to manage OUD during your pregnancy. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- If you have used opioids, methadone and buprenorphine medicines can help you stop.
- Many pregnant women with OUD worry about neonatal abstinence syndrome (NAS), a group of withdrawal signs that may occur in babies exposed to opioids and other substances before birth. NAS *can* be diagnosed and treated.
- You may need medicine other than those for OUD to treat pain during or after delivery. Other options, such as an epidural and/or a short-acting opioid, can be used to keep you comfortable.
- All hospitals must report to state child welfare agencies when a mother who is using substances gives birth. This report is used to make sure that a safe care plan is in place to deal with both your and your baby's well-being. It is not used to remove your baby from your care. Participating in OUD treatment before and after the birth of your baby shows your commitment to providing a safe, nurturing environment for your baby.

Treatment vs. Withdrawal

Some pregnant women with OUD consider completely withdrawing from using opioids, but seeking treatment is always the most helpful course of action. Withdrawal may make you more likely to start using drugs again and even experience overdoses.

If you are not currently in treatment, talk with your healthcare professionals about treatment medicines and behavioral counseling. If you need to find a provider, visit this website: www.samhsa.gov/find-help.

Do

Do ask about the risks and benefits of taking one of the medicines for OUD during pregnancy.

Do talk to your healthcare professionals about your OUD treatment medicine dose if you are experiencing cravings or withdrawal symptoms.

Do ask your healthcare professionals about counseling and recovery support services.

Do make sure your treatment plan includes steps to treat other medical or behavioral health problems such as depression or anxiety.

Do request that your medical chart includes several ways to address your pain during and right after delivery.

Do ask your healthcare professionals to help you make and keep follow-up visits and to talk to each other on a regular basis.

Don't

Don't consider changing your OUD medicine unless you are taking naltrexone, which has not been studied in pregnancy. Changing your OUD medicine may increase your risk of returning to substance use.

Don't use alcohol or any medicines that might make you sleepy, especially benzodiazepines, when taking OUD medicines.

Don't let your OUD go untreated because you want to prevent your baby from experiencing NAS. Treatment medicines can be used safely during pregnancy and dosing changes will not change the risk or severity of NAS for your baby.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy

Creating a treatment plan requires your healthcare professionals to talk to you about the risks and benefits of different medicines and then together select the one that's best for you. You and your healthcare professionals will also discuss other medical conditions or behavioral health problems that could affect your treatment. Your healthcare professionals will help you decide how best to involve your family and friends in your recovery. They can also suggest support groups to join and other services that can help you throughout your recovery.

Remember: The **benefits** of taking methadone or buprenorphine during pregnancy far outweigh the risks of not treating your OUD. You and your healthcare professionals can **work together** to adjust your treatment plan to achieve success.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

_____

_____

_____

_____

Next Appointment Date: _____ Time: _____ Location: _____

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
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HHS Publication No. SMA-18-5071FS2

SAMHSA
Substance Abuse and Mental Health Services Administration

Treating Babies Who Were Exposed to Opioids Before Birth

Support for a new beginning

Introduction

Many pregnant women with an opioid use disorder (OUD) worry about harmful effects of opioids to the fetus. Neonatal abstinence syndrome (NAS) is a group of withdrawal signs that may occur in a newborn who has been exposed to opioids and other substances. NAS signs may include high-pitched and excessive crying, seizures, feeding difficulties, and poor sleeping. **NAS is a treatable condition**.

The actions you take or don't take play a vital role in your baby's well-being. Below are some important things to know about what to expect if your baby needs special care after birth, as well as the Do's and Don'ts for understanding and responding to your baby's needs.

Things to know

- A baby born to a mother who used opioids or took OUD medicine during pregnancy is typically observed in the hospital by a medical provider for 4–7 days for any physical signs of NAS. A care plan is created for your baby right away if signs of NAS are noted.
- Some babies with NAS may need medicines such as liquid oral morphine or liquid oral methadone in addition to non-medicine care supports.
- Other parts of treatment in hospitals include rooming-in and putting the baby's crib near your bed. You can also give this type of care to your baby through skin-to-skin contact, gentle handling, swaddling, using pacifiers, breastfeeding, and spending quiet time together.
- Your baby will be able to leave the hospital when he/she is successfully feeding and has been monitored for at least 24 hours after no longer needing medicine (if it is used). Some hospitals may also provide medicine for your baby in an outpatient clinic after he/she has been discharged from the hospital.
- Breastfeeding has many benefits for your baby. Breastfeeding can decrease signs of NAS and reduce your baby's need for medicine and hospitalization. Sometimes, breastfeeding is not recommended, so talk with your healthcare professionals to find out what's right for you and your baby.

Medicine Dose and NAS

If you are taking medicine for your OUD, reducing your dose will NOT help your unborn baby, but it might put your baby at risk. Changing or reducing your OUD medicine while pregnant is not a good idea because it can increase your risk for a return to substance use and might increase the chances of having your baby too early or having a miscarriage. The goal for your OUD medicine dose is to minimize withdrawal and to reduce the chances of going back to substance use.

Do

Do gain the skills and knowledge to understand and respond to your baby's needs. Your baby may need extra contact and cuddling to reduce NAS signs.

Do continue breastfeeding as long as possible when recommended.

Do ask for support so you feel prepared and comfortable with breastfeeding.

Don't

Don't change your medicine or dose of medicine without talking to your healthcare professionals.

Don't be afraid to mention any cravings or urges to use opioids to your healthcare professionals and seek the help you need.

What to expect when you meet with healthcare professionals about OUD treatment after birth

Before you leave the hospital, your healthcare professionals should describe the signs of NAS and provide you with contact information of someone who can help you if you have concerns. They will make sure that you know how to soothe your baby (for example, dimming lights, softly playing white noise, skin-to-skin contact, using a pacifier, and swaddling). They will also explain that the safest sleeping and napping position for a baby is on the back and will show you how to place your baby in the Safe to Sleep position (http://bit.ly/NIHSafeSleep). This position, and having babies sleep in their own space with nothing in the sleep area, reduces the risk of sudden infant death syndrome. You should also expect to have follow-up plans that include home visits and early pediatric follow-up visits (within 5 days of leaving the hospital).

Remember: Before leaving the hospital, make sure you **receive information** on caring for your baby if there are special needs as well as names and contact information of others who can give you additional support.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

_____

_____

_____

_____

_____

Next Appointment Date: _____ Time: _____ Location: _____

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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HHS Publication No. SMA-18-5071FS3

SAMHSA
Substance Abuse and Mental Health Services Administration

Opioid Use Disorder and Pregnancy

Taking helpful steps for a healthy pregnancy

Introduction

If you have an opioid use disorder (OUD) and are pregnant, you can take helpful steps now to ensure you have a healthy pregnancy and a healthy baby. During pregnancy, OUD should be treated with medicines, counseling, and recovery support. Good prenatal care is also very important. Ongoing contact between the healthcare professionals treating your OUD and those supporting your pregnancy is very important.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know, about OUD and pregnancy, as well as the Do's and Don'ts for making sure you have a healthy pregnancy and a healthy baby.

Things to know

- OUD is a treatable illness like diabetes or high blood pressure.
- You should not try to stop opioid use on your own. Suddenly stopping the use of opioids can lead to withdrawal for you and your baby. You may be more likely to start using drugs again and even experience overdoses.
- For pregnant women, OUD is best treated with the medicines called methadone or buprenorphine along with counseling and recovery support services. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- Tobacco, alcohol, and benzodiazepines may harm your baby, so make sure your treatment includes steps to stop using these substances.
- Depression and anxiety are common in women with OUD, and new mothers may also experience depression and anxiety after giving birth. Your healthcare professionals should check for these conditions regularly and, if you have them, help you get treatment for them.
- Mothers with OUD are at risk for hepatitis and HIV. Your healthcare professionals should do regular lab tests to make sure you are not infected and, if you are infected, provide treatment.
- Babies exposed to opioids and other substances before birth may develop neonatal abstinence syndrome (NAS) after birth. NAS is a group of withdrawal signs. Babies need to be watched for NAS in the hospital and may need treatment for a little while to help them sleep and eat.

About OUD

People with OUD typically feel a **strong craving for opioids** and find it hard to cut back or stop using them. Over time, many people **build up a tolerance** to opioids and need larger amounts. They also spend more time looking for and using opioids and less time on everyday tasks and relationships. Those who suddenly reduce or stop opioid use may suffer **withdrawal symptoms** such as nausea or vomiting, muscle aches, diarrhea, fever, and trouble sleeping.

If you are concerned about your opioid use or have any of these symptoms, please check with your **healthcare professionals** about treatment or tapering or find a provider at this website: www.samhsa.gov/find-help.

Do

Do talk with your healthcare professionals about the right treatment plan for you.

Do begin good prenatal care and continue it throughout your pregnancy. These two websites give helpful information on planning for your pregnancy: http://bit.ly/ACOGprenatal and http://bit.ly/CDCprenatal.

Do stop tobacco and alcohol use. Call your state's Tobacco Quit Line at 800-QUIT-NOW (800-784-8669).

Do talk to your healthcare professionals before starting or stopping any medicines.

Do get tested for hepatitis B and C and for HIV.

Do ask your healthcare professionals to talk to each other on a regular basis.

Don't

Don't hide your substance use or pregnancy from healthcare professionals.

Don't attempt to stop using opioids or other substances on your own.

Don't let fear or feeling embarrassed keep you from getting the care and help you need.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy

The healthcare professionals who are treating your OUD and providing your prenatal care need a complete picture of your overall health. Together, they will make sure you are tested for hepatitis B and C and for HIV. They will ask you about any symptoms of depression or other feelings. You should be ready to answer questions about all substances you have used. They need this information to plan the best possible treatment for you and to help you prepare for your baby. These issues may be hard to talk about, but do the best you can to answer their questions completely and honestly. Expect them to treat you with respect and to answer any questions you may have.

Remember: Pregnancy is a time for you to feel **engaged** and **supported**. Work with your healthcare professionals to gain a better understanding of what you need for a healthy future for you and your baby.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Next Appointment Date: _____ Time: _____ Location: _____

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
HHS Publication No. SMA-18-5071FS1

SAMHSA
Substance Abuse and Mental Health Services Administration

Good Care for You and Your Baby While Receiving Opioid Use Disorder Treatment

Steps for healthy growth and development

Introduction

If you have an opioid use disorder (OUD), receiving the right medicine along with counseling and recovery support services is important at all stages in your life. From pregnancy to delivery to caring for your baby, addressing your OUD and taking care of yourself is a continuous process. You will be better able to protect and care for your baby with a focus on creating and updating your treatment plan and getting the support you need. In all situations, your commitment to treatment and recovery will go a long way.

After your pregnancy, the actions you take or don't take matter. Below are some important things to know about OUD and caring for your baby, as well as the Do's and Don'ts for creating a healthy environment for your family.

Things to know

- Birth control is important to prevent pregnancies you do not want as well as to ensure proper space between pregnancies. Talk to your healthcare professionals about the full range of birth control options, including long-acting reversible contraception and the best birth control options while you are breastfeeding.
- Breastfeeding is healthy for you and your baby, so you should continue breastfeeding as long as possible. The amount of OUD medicine that passes into breast milk is extremely small. Talk with your healthcare professionals to find out what's best for you and your baby.
- You may need additional treatment and support to help with your recovery. It is important to seek help early!

  1. To find a treatment provider in your area, visit this website: www.samhsa.gov/find-help.

  2. Join a support group: LifeRing (https://lifering.org); Mothers on Methadone (www.methadonesupport.org/Pregnancy.html); Narcotics Anonymous (www.na.org/); Secular Organizations for Sobriety (SOS; www.sossobriety.org/); SMART Recovery (www.smartrecovery.org/); Young People in Recovery (www.youngpeopleinrecovery.org/).

Medicine Dose

Now is a good time to ask your OUD treatment professionals to check your medicine dose. An effective dose during pregnancy may be too high or too low once your baby is born. It is normal to feel tired and stressed, but if these feelings are causing you to have cravings or urges to use opioids again, tell your healthcare professionals.

Do

Do schedule a follow-up visit with your healthcare professionals as soon as possible after you leave the hospital.

Do talk to your healthcare professionals before starting or stopping any medicines.

Do talk to your healthcare professionals about birth control and family planning.

Do continue breastfeeding for as long as possible and ask for support if you need it.

Don't

Don't change the type of OUD medicine right after delivery.

Don't hesitate to ask for help when you are feeling stressed or depressed.

Don't be afraid to tell your healthcare professionals that you are having cravings or urges for opioids.

What to expect when you meet with healthcare professionals about OUD treatment while caring for your baby

If your medicine is no longer working and you feel sleepy or are tempted to start using again, your healthcare professionals can help. Be honest about any cravings or urges you may have to use opioids. The stress that comes with being a new mother may increase these urges.

Your healthcare professionals can offer counseling and other support services. But before they do, they need to know if you have other medical and mental health problems. They will test you for these conditions before you leave the hospital and at your follow-up visits to make sure you get the treatment you need. They will continue to recommend support services that allow you and your baby to receive the high-quality health care that you need.

Your healthcare professionals will work with you to create a birth control plan. Together, you will discuss if you want to have another child, how many children you would like to have, and how you would like to space out the births of your children. At this time, they will check in on how you are doing with breastfeeding and make sure you have the support you need.

Remember: The longer you follow your OUD treatment plan, the better your chances are of **staying in recovery** and strong for your baby. **Counseling** and **support services** are important to keep you and your baby safe and healthy at home.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Next Appointment Date: _____ Time: _____ Location: _____

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HHS Publication No. SMA-18-5071FS4

SAMHSA
Substance Abuse and Mental Health Services Administration

JOURNEY guides

Neonatal Abstinence Syndrome (NAS) Guide

WHAT IS NEONATAL ABSTINENCE SYNDROME?

Neonatal Abstinence Syndrome (NAS) looks similar to medicine or drug withdrawal in adults. It can happen when a baby is born and suddenly cut off from the medicines or drugs in the mother's body. It is actually the way a baby heals from dependence on drugs or medications. It looks uncomfortable, and it can be painful to watch, but it is *temporary: most babies recover completely from NAS by the time they are six months old*.

Within one to five days, a baby may start to show signs of NAS. The time it takes for signs to show can depend on how much and what kind of medicine or drug the baby's mother took and for how long. It also can depend on whether or not the baby's mother used also other kinds of substances, such as alcohol, nicotine or tobacco, additional medicines, or drugs.

It's important to remember that a lower dose of methadone or buprenorphine does not mean a lower chance of NAS.

The chance a baby will show symptoms of withdrawal from opiates has more to do with genetics, metabolism, and whether other substances, such as nicotine or alcohol, were also used. Not all babies show signs of NAS, but all women who use substances during pregnancy should prepare to care for a baby with signs of NAS.

WHAT ARE THE SIGNS OF NAS?

- Tremors or shakes
- Poor feeding/sucking
- Fever
- Vomiting
- Crying
- Sleep problems
- Sneezing
- Diarrhea
- Frequent yawning
- Stuffy nose
- Tight muscles
- Loose stool (poop)

The good news is that NAS is treatable! The best way to help a baby with NAS recover quickly is for the mother or another caregiver to be with the baby as much as possible during their first week of life.

Human touch is the most important medicine for NAS.

JOURNEY guides

THE MOST IMPORTANT TREATMENTS FOR NAS ARE THINGS YOU CAN DO:

- Make your baby comfortable by setting up a routine, letting few people visit, talking softly, keeping the room quiet and dim. Turn off the TV or radio, turn your phone down or off, and turn down the lights.
- Make soothing sounds to your baby, they already know the sound of your voice.
- Let your baby sleep as long as needed and without being woken up suddenly.
- Hold your baby's skin against your skin.
- Try breastfeeding or suckling.
- Make feeding time quiet and calm, and burp your baby often.
- Learn to spot your baby's "I am upset" signs, whether he or she is yawning, sneezing, shaking, crying, or frowning. Also learn the signs that say your baby is happy, hungry, or relaxed.
- When your baby is upset, stop what you are doing, hold your baby skin-to-skin or gently swaddle him or her in a blanket on your chest. Let your baby calm down before trying anything new, or gently sway or rock your baby.
- Gently and slowly introduce new things to your baby one at a time.
- As your baby becomes calmer for longer periods of time, start checking to see if he or she might like to have the blanket wrapped more loosely or taken off sometimes.
- As you do this work of caring for your baby, check to make sure they are **Eating**, **Sleeping**, and can be **Consoled** or calmed when they are fussy. As they learn how to do these three things, they will begin to heal from NAS, and be on their way to normal, healthy development.

JOURNEY guides

EATING

Breastfeeding is often the healthiest food for a baby. There are some things to consider:

- Infants need to eat every one and one-half or two hours
- Always hold babies while they are eating
- In order to learn when your baby is hungry, pay quiet attention to your baby: learn their cues and practice meeting their needs.
- Routines are good for babies, so try to get on a feeding schedule.

SLEEPING

Safe sleep is important for a new baby's safety. A baby should always be put to sleep on their backs, without blanket, toys, or pillows, and in their own crib.

A new baby only needs one more layer than you're wearing to be comfortable.

A baby should be put down when they are drowsy, and lights and sounds should be kept very low. A bedtime routine, like a song or story, can help a baby fall asleep.

BEING CONSOLED

Crying is part of life for all new babies. It is important for parents to be very patient with crying, because that is how a new baby can tell you what they need.

Check to see if the baby needs a diaper change, is hungry or tired, or if there is too much light, sound, or commotion in the room. If the crying doesn't seem normal, or if you're getting upset, call your baby's doctor or nurse, or ask right away for help.

YOUR SPACE: *(write information, thoughts, ideas, or hopes for you and your baby here)*

For substance abuse treatment 24/7 call the Access Line
1-800-563-4086

(this includes detox, and prescription opioids and heroin addiction treatment)

METHADONE PROGRAMS

REGION ONE

Liberation Programs Inc

115-125 Main Street
Stamford CT 06901
(203)356-1980

Regional Network of Programs

2 Research Drive
Stratford CT 06615
(203)386-8802

Liberation - Bridgeport Clinic

399 Mill Hill Avenue
Bridgeport CT 06610
(888)822-2270

Kinsella Treatment Center

1438 Park Avenue
Bridgeport CT 06604
(203)335-2173

REGION TWO

APT Foundation Inc.

495 Congress Avenue
New Haven CT 06519
(203)781-4740

Multicultural Ambulatory Addict Services (MAAS)

426 East Street
New Haven CT 06511
(203)495-7710

APT - Orchard Hills

540 Ella T Grasso Boulevard
New Haven CT 06519
(203)781-4695

South Central Rehabilitation Center (SCRC)

232 Cedar Street
New Haven CT 06519
(203)503-3000

REGION THREE

Root Center For Advanced Recovery

931 Bank Street
New London CT 06320
(860)447-2233

Root Center- Willimantic Clinic

54-56 Boston Post Road
Willimantic CT 06226
(860)456-7990

Root Center - Norwich Clinic

772 West Thames Street
Norwich CT 06360
(860)886-0446

Root Center - Doctor's Clinic

345 Main Street
Hartford CT 06106
(860)525-2181

Root Center - New Britain Clinic

70 Whiting Street
New Britain CT 06051
(860)827-3313

Root Center - Henderson-Johnson Clinic

12-14 Weston Street
Hartford CT 06106
(860)525-9376

Root Center - Bristol Clinic

1098 Farmington Avenue
Bristol CT 06010
(860)589-6433

Connecticut Counseling Centers, Inc.

4 Midland Road
Waterbury CT 06705
(203)755-8874

INPATIENT TREATMENT FACILITIES

Greater Bridgeport Community Mental Health Center

1635 Central Avenue
Bridgeport CT 06610
(203)551-7400

Connecticut Valley Hospital

P.O. Box 351
Middletown, CT 06457
(860)252-5000

Connecticut Mental Health Center

34 Park Street
New Haven CT 06519
(203)974-7300

Blue Hills Hospital

500 Vine Street
Hartford CT 06112
(860)293-6400

OUTPATIENT/INTENSIVE OUTPATIENT (IOP) AND RELAPSE PREVENTION PROGRAMS

New Haven
Substance Abuse Treatment Unit
1 Long Wharf Drive
(804)939-5214

MCCA

Bridgeport

140 John Street 06604
Tel. 203-450-9944

Derby

100 Elizabeth Street 06418
Tel. 203-446-2252

New Milford

50 Bridge Street
Tel. 860-355-7312

Waterbury

34 Murray Street
203-597-0643

RUSHFORD (locations around CT- part of Hartford Healthcare)

Medication Assisted Treatment Close to Home (MATCH™)
855-825-4026

Programs for Pregnant Women/New Moms offered through Medicaid/Husky

Community Health Network of Connecticut, Inc.
Colleen Combs,RN 1-800-859-9889 ext.4103
speak to the nurse anytime about your pregnancy and your child after birth. Will also do house visits

Wellmore, Nurturing Families Network Program
https://wellmore.org/
203-935-5667
Locations around CT

Family Care Visiting Nurse and Home Health Care Agency, LLC
Michelle Macchio 203-566-0884
They come weekly to your house. They take the baby's blood pressure, temperature, check his heart, weight, growth, etc.
Speak to you about his eating and sleeping habits.

Carolyn's Place Pregnancy Care Center
Ellen Cavallo, Client Director
www.carolynsplace.net
Childbirth and parenting classes offered ("earn while you learn"). After taking classes women are eligible for gifts for newborn babies

Birth to Three (Programs for newborns & toddlers)
www.birth23.org
1-800-505-7000

WIC (Women Infants & Children)
https://portal.ct.gov/dph/WIC/WIC
The Special Supplemental Nutrition Program for Women, Infants and Children, better known as the WIC Program, provides supplemental foods, health care referrals, nutrition education, and breastfeeding promotion and support to low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.