POSITION STATEMENT

Prevention and Management of Opioid Misuse and Opioid Use Disorder among Women across the Lifespan

The National Association of Nurse Practitioners in Women’s Health (NPWH) supports the role of women’s health nurse practitioners (WHNPs) and other nurse practitioners (NPs) who provide healthcare for women across the lifespan in the provision of safe and effective treatment of pain. In certain cases, this treatment may include the prescription of opioid pain relievers (OPR). NPWH acknowledges that NPs must use evidence-based strategies to reduce harm from the misuse of OPR and to prevent the development of opioid use disorder (OUD). These strategies include screening for opioid use/misuse/abuse, educating patients about the risks associated with OPR misuse, and following evidence-based guidelines when prescribing OPR.1-3

Use of OPR in general should be reserved for acute pain resulting from severe injuries, medical conditions, or surgical procedures, and only when nonopioid alternatives are ineffective or contraindicated. When OPR are prescribed, it should be at the lowest necessary dose for the shortest duration (usually < 7 days).1 Although many NPs in primary care treat acute pain, the treatment of chronic pain is best achieved through a multimodal and multidisciplinary approach that includes a team member with expertise in pain management. This approach is particularly advantageous when chronic pain management includes OPR use.1,2 NPs should consider evidence-based nonpharmacologic therapies and nonopioid medications as first-line treatment for chronic pain. Primary care NPs with adequate training who prescribe OPR for chronic pain should follow evidence-based guidelines such as the one provided by the Centers for Disease Control and Prevention (CDC).1

Whether prescribing OPR for acute or chronic pain, NPs should use risk evaluation and mitigation strategies to reduce the potential for harm from misuse or abuse. These strategies include checking state prescription drug monitoring programs when available to assess a patient’s history of controlled substance use, avoiding concurrent prescription of benzodiazepines, and establishing realistic treatment goals with patients. Overdose mitigation includes consideration of co-prescribing the opioid antagonist naloxone when appropriate, along with education about its use to reverse respiratory depression from OPR overdose.1-3 In addition, NPs should educate patients for whom they provide OPR prescriptions to securely store OPR, not share OPR with family members or friends, and properly dispose of unused medications.3,4

For individuals with OUD, medication-assisted treatment (MAT) has proved clinically effective.5 MAT entails the use of medications along with counseling and behavioral therapies to treat OUD and to prevent opioid overdose. This recovery-oriented treatment approach has been shown to improve patient survival, increase retention in treatment, decrease drug-related criminal activity, increase patients’ ability to gain and maintain employment, and improve birth outcomes among pregnant women with OUD.5 The Comprehensive Addiction and Recovery Act (CARA) became public law on July 22, 2016.6 It has resulted in an increased number of healthcare providers who can provide MAT, although barriers remain in implementing treatment at federal, state, local, and individual practice levels.7-9 One section of CARA authorizes NPs who meet certain criteria, including participation in a mandatory 24-hour education program, to receive a Drug Enforcement
Administration (DEA) waiver to prescribe the opioid agonist buprenorphine as a crucial component of treatment for OUD. NPs who receive this education and waiver are able to work within their individual state prescribing laws to provide increased access to OUD treatment.

NPWH will provide leadership and collaborate with other organizations and agencies to deliver NP education, develop policies, and conduct and/or support research, all in a concerted effort to increase knowledge and provide resources for NPs to prevent and reduce harm from OPR misuse. NPWH will also actively monitor and engage in the process to continue the implementation of CARA, so that barriers can be reduced and all women in need can have access to treatment for OUD.

BACKGROUND

Pain can be acute or chronic in nature. Acute pain may be related to disease, injury, or recent surgery and typically diminishes with tissue healing. Chronic pain is defined as pain on most days or every day that lasts more than 3 months.\(^1,2\) It usually has neurologic, emotional, and behavioral components.\(^1,2\) High-impact chronic pain limits the ability to function in major life domains, including work, social, and self-care activities.\(^1,2\) An estimated 50 million adults in the United States have chronic pain, and an additional 19.6 million have high-impact chronic pain.\(^1,2\)

Efforts to improve pain management largely beginning in the 1990s and, despite the best intentions of clinicians, have had adverse effects. The number of prescriptions for OPR quadrupled between 1999 and 2010.\(^11,12\) The OPR prescribing rate has declined since 2012, likely because clinicians have become more cautious in prescribing practices. The rate persists at three times higher than that in 1999, however, and deaths from opioid misuse remain four times higher.\(^1,13,14\) Nearly 70% of the 67,367 drug overdose deaths in 2018 involved an opioid.\(^1,14\) The recent trend demonstrates a decrease in prescription OPR and heroin-involved deaths but an increase in synthetic (excluding methadone) opioid-involved death rates.\(^14\)

Lethal overdose is not the only risk associated with opioid misuse. The costs of healthcare, lost productivity, addiction treatment, and criminal justice system involvement from prescription OPR misuse have created a significant economic burden in the United States.\(^1,5\) Between 21% and 29% of individuals prescribed OPR for chronic pain misuse them, and approximately 10% develop an OUD. An estimated 5% of individuals who misuse prescription OPR transition to heroin.\(^1,5\)

The use of safer and more effective treatments for chronic pain could reduce the number of persons who develop OUD or experience an overdose or other adverse event related to opioid use. Studies have supported a range of effectiveness for nonpharmacologic approaches to chronic pain management that include behavioral, psychological, and physical-based therapies and nonopioid pharmacologic treatments such as acetaminophen, nonsteroidal anti-inflammatory drugs, and selected anticonvulsants and antidepressants. Use of multiple modalities is likely to be more effective than use of a single modality.\(^1-3\) Because of the complexities involved, the initiation of treatment and the ongoing care for patients with chronic pain are most safely and effectively directed by a multidisciplinary team that includes pain management specialists.\(^1-3\)

The OPR prescribing guideline of the CDC includes a recommendation for clinicians to offer or facilitate MAT for patients with OUD.\(^1\) With the implementation of CARA, appropriate training, and within state regulations, NPs as part of the treatment team are able to prescribe buprenorphine for MAT.\(^5\) In 2016, the same year that CARA was enacted, the maximum number of patients waivered physicians can treat concurrently was increased.\(^16\) Although access to MAT has improved with more available providers and individual physicians allowed to treat more patients, barriers remain. This is especially true in rural areas where more than one half (56.3%) of counties still lack a buprenorphine provider. Almost one third (29.8%) of rural Americans compared with 2.2% of urban Americans live in a county without a buprenorphine provider.\(^6\) Providers report barriers to either getting a DEA waiver or fully using it.\(^7,8\) The most common reported barriers from clinicians with DEA waivers include concerns about diversion or misuse of medication, lack of available mental health or psychosocial support services, insurance and reimbursement issues, and lack of confidence in ability to manage OUD.\(^7,8\)
IMPLICATIONS FOR WOMEN’S HEALTHCARE AND WHNP PRACTICE

Approximately 3.5 million women misused opioids in 2018, with 98% of this opioid misuse involving OPR. Women, relative to men, may progress from substance misuse including opioids to dependence at a more accelerated rate. Co-occurring substance misuse/SUD and mental disorders are common among women, with the mental disorder preceding the development of the SUD. SUDs are associated with an increased risk of suicide attempts among women. A high proportion of women with SUDs also have a history of trauma in childhood and within interpersonal relationships. Among women in substance abuse treatment, 55% to 99% report a history of sexual or physical abuse.

Nurse practitioners should ask adolescent and adult female patients about the use of prescription OPR and other medications for nonmedical reasons as part of routine alcohol and substance use screening. Validated screening tools are available to use with adolescents, pregnant women, and adults. NPs must be aware of and use strategies to reduce the stigma of OUD among both healthcare providers and patients to promote open communication. Early identification of opioid misuse/abuse allows NPs to provide evidence-based brief interventions. It also allows them to actively participate in MAT if they meet criteria for prescribing treatment medication and/or make referrals for additional services when needed.

The prevention and treatment of opioid misuse and OUD must take into consideration the diversity within the female population. Attention to the many intersections in women’s lives, including race, ethnicity, socioeconomic status, sexual orientation, gender identity, disability, and religion, is imperative to promote positive health outcomes. Age and reproductive status are other important factors to consider.

Adolescence—Opioid (OPR and heroin) misuse and OUD have declined in adolescents. In 2019, a reported 2.7% of adolescents (ages 12–17 years) misused OPRs and 0.3% misused heroin. A reported 0.4% of adolescents had an OUD in 2018. Even with these declines, attention to prevention, as well as early identification of opioid misuse and OUD in adolescents, remains critical. Treatment of pain with OPR in adolescent patients is associated with a greater risk for future opioid misuse. Close to 4,000 adolescents/young adults (ages 15–24 years) died from opioid overdoses in 2018.

NPs should ask adolescents about opioid use, including OPR, as part of routine alcohol and substance use screening. The NP should follow state and federal regulations regarding confidentiality when an adolescent needs OUD treatment. The combination of pharmacotherapy and behavioral therapy is associated with greater retention in care among adolescents with OUD compared with behavioral therapy alone. Buprenorphine has been approved by the US Food and Drug Administration for treatment of patients age 16 years and older, and naltrexone and methadone have been approved for patients age 18 years and older.

The reproductive years—Substance abuse, including abuse of opioids, is most prevalent during the reproductive years. OPR are prescribed for women in this age group more than any other group, male or female. NPs should assess pregnancy status, sexual activity, and contraceptive use before prescribing OPR to reproductive-age women. For women who are pregnant or could become pregnant while using OPR, NPs should discuss potential risks versus benefits, as well as alternative treatments. Uncertainty remains regarding the teratogenicity of opioids. Data from one systematic review suggest the potential for a small increased risk for birth defects (eg, neural tube defects, congenital heart defects) associated with maternal opioid use, while noting that most studies had methodologic and size limitations. When OPR are indicated for the treatment of acute pain in women who are pregnant, NPs should prescribe the lowest dose for the shortest duration of use just as is done for all patients in general. Care of pregnant women taking OPR for chronic pain should be multidisciplinary. WHNPs and other NPs who provide healthcare for pregnant and postpartum women are on the forefront in regard to identifying, supporting, and providing appropriate referrals and collaborative care for women with OUD.
Medication-assisted treatment that includes recovery support is important for pregnant women with OUD. Many pregnant women with OUD are late in seeking prenatal care and are erratic in attending appointments. Early, regular prenatal care is essential for women with OUD so that they can receive support and early treatment referrals to reduce their risks of harm and adverse pregnancy outcomes. Laws that require the reporting of substance abuse during pregnancy may deter women with OUD from seeking prenatal care. NPWH opposes policies that require reporting or criminalization of substance abuse during pregnancy and supports the repeal of existing laws with such mandates.

When a pregnant woman has OUD, collaboration with maternal-fetal medicine, addiction medicine, pediatrics, and anesthesia specialists in planning for intrapartum, early postpartum, and neonatal care is essential. A multimodal approach is needed for safe and effective pain management. Neonatal abstinence syndrome is an expected and treatable condition with continuous in utero opioid exposure whether opioid use is illicit, prescribed for maternal pain, or through MAT. A pregnant woman and her family should receive evidence-based information about neonatal abstinence syndrome and nonpharmacologic and pharmacologic interventions that can be used to reduce its severity.

Maternal mortality reports in several states have identified substance use as a major risk factor for pregnancy-associated deaths including through the first year postpartum. Data collected from 22 states and the District of Columbia indicate the percentage of pregnancy-related deaths involving opioids more than doubled between 2007 and 2016 (from 4% to 10%). The majority of these deaths in most states occurred during the postpartum period. Access to postpartum care, ongoing MAT as needed, and psychosocial support systems are essential for women with OUD. The postpartum period can be a time of increased vulnerability. Women with OUD are much more likely to relapse during the first year postpartum then during pregnancy.

Mothers receiving MAT—with the exception of those who are HIV positive or continuing to use illicit substances—should be encouraged to breastfeed. Breastfeeding, breast milk, and skin-to-skin contact support mother–infant bonding and may reduce the severity and duration of symptoms associated with neonatal abstinence syndrome. Methadone and buprenorphine are considered safe during breastfeeding. It is important to maintain open lines of communication for early identification of relapse. An isolated incident that is quickly back under control does not require breastfeeding to be discontinued. When necessary because of ongoing relapse, the mother should be provided with assistance to transition to bottle feeding with formula or donor milk.

Older age—Women age 50 years and older are generally at low risk for opioid misuse including OPR. However, specific concerns exist about the use of OPR among older women. WHNPs and other NPs who provide healthcare for older women should be cognizant of potential increased risks with OPR use related to reduced renal function and drug clearance, comorbidities, polypharmacy, and impaired cognition, as well as an increased risk for falls and fractures. Even though considered low risk, women older than age 50 years can experience OUD.

NPWH RECOMMENDATIONS

WHNPs and other NPs who provide healthcare for women should:

- Use evidence-based guidelines for management of acute and chronic pain.
- Use risk evaluation and mitigation strategies when prescribing OPR for acute or chronic pain.
- Assess pregnancy status, sexual activity, and contraceptive use, as well as discuss potential risks and benefits, before prescribing OPR to women who could become pregnant.
- Use a nonjudgmental, respectful approach when broaching the topic of substance use/abuse.
- Screen all adolescent and adult females at least annually—at well-woman visits, initial prenatal visits, and other visits when indicated—for substance use/abuse with a validated screening tool. Include questions concerning use of prescription drugs for nonmedical purposes.
- Provide an evidence-based brief intervention when substance abuse is identified and make referrals for additional services as needed. Know which services are available in the community.
NPWH will provide leadership and resources to ensure that:

- Continuing education (CE) programs are available for NPs to expand their knowledge about acute and chronic pain management.
- CE programs are available for NPs to expand their knowledge about opioid and other substance misuse/disorder screening, prevention, and treatment for women.
- NPs have access to training to be able to provide buprenorphine as part of MAT for OUD.
- Be aware of state reporting laws for substance abuse during pregnancy and advocate for retraction of legislation that exposes pregnant women with substance use disorders to criminal or civil penalties.
- Barriers to providing MAT are addressed to promote increased and safe access to OUD treatment.
- Policies and regulations regarding substance abuse during pregnancy do not expose pregnant women with substance use disorders to criminal or civil penalties.
- Research moves forward to advance knowledge in the area of best strategies for prevention and treatment of opioid and other substance misuse/disorders.

REFERENCES


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