OPIOID 101:
WHAT EVERY FOSTER PARENT AND KINSHIP FAMILY NEEDS TO KNOW ABOUT OPIOID USE

APRIL 30, 2019
LEARNING OBJECTIVES

- Identify a common pathway that can lead a parent to use opioids in ways that potentially contribute to child maltreatment.
- Discuss the many effects of caregiver opioid use on children.
- Listen to stories and engage in discussion with Florida foster and adoptive parents to learn firsthand about the unique challenges of caring for the children of the opioid epidemic.
- Describe effective treatment and recovery responses to address parental opioid use.
A COMMON PATHWAY TO OPIOID USE

- Pain Management
“Developing a relationship with the foster child’s bio parent humanizes them. It helps my level of compassion to know where they came from, where they have been, and why they made the decisions they made.” Florida foster parent quote
The U.S. Food and Drug Administration (FDA) approved OxyContin and other opioid pain meds in the mid-1990s (for short-term pain only).

However, physicians quickly started prescribing the effective new pills for long-term/chronic pain management.

When patients built up a tolerance (about every 4 to 8 weeks) and the pills stopped working, pain experts and drug company representatives instructed doctors to give higher doses.

They assured doctors that the pills were safe and non-addictive. THEY WERE WRONG!!!!!
Other factors led to the opioid crisis facing us today, including:

- Pressure to fully relieve pain and measure it as the “fifth vital sign,” promoted by the American Pain Society and adopted by the Veterans Administration and the Joint Commission on Accreditation of Healthcare Organizations;

- Inclusion of pain control as part of patient satisfaction scores that could affect provider and hospital reimbursement;

- Inadequate healthcare professional education on treatment of pain and addiction; and

- Diversion of prescription opioids by distributors, pharmacies, prescribers, and patients.
FLORIDA’S PROGRESS

- FL is reducing the number of and access to opioid prescriptions according to, and in part because of, the state’s Prescription Drug Monitoring Program (PDMP).

- The FL Department of Children and Families (DCF) is contracting with physician peer prescriber mentors, Florida Alliance for Healthy Communities, and Area Health Education Centers (AHECs) to provide education and training on pain management, alternatives, prevention and treatment of opioid use disorder.
COMMON PRESCRIPTION OPIOIDS

- Codeine
- Morphine
- Oxymorphone
- Oxycodone and Hydrocodone
- Fentanyl
The amount of opioid prescriptions dispensed has QUADRUPLED since 1999. But the pain that Americans report remains UNCHANGED.
Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older, NSDUH 2016

- Given by, Bought from, or Took from a Friend or Relative: 53.0%
- From Friend or Relative for Free: 40.4%
- Bought from Friend or Relative: 8.9%
- Took from Friend or Relative without Asking: 3.7%
- Got through Prescription(s) or Stole from a Health Care Provider: 37.5%
- Some Other Way: 3.4%
- Bought from Drug Dealer or Other Stranger: 6.0%
- Prescription from One Doctor: 35.4%
- Stole from Doctor’s Office, Clinic, Hospital, or Pharmacy: 0.7%
- Prescriptions from More Than One Doctor: 1.4%

11.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year
PARENT TO CHILD ACCESS

It is not atypical for a child welfare system-involved parent with an OUD to have begun their use by intentional or unintentional access from their own parents.
Monica’s Case Scenario

- The timing and severity of the opioid crisis varies among communities around the country. However the tragic pattern is all too similar— prescription opioids first…but then those prescriptions end (sometimes abruptly) leaving some users desperate enough to try street heroin. That’s what happened to Monica. She was prescribed Percocet painkillers after a high school car wreck, then started buying stolen pills and finally heroin.
CONNECTED ADVERSITIES\textsuperscript{7, 8}

Women who have been diagnosed with OUD:

- Are more likely to have experienced DV, sexual violence, and childhood sexual abuse.
- Are more likely to have been prescribed opioids for chronic pain.
- Are more likely to self-medicate to cope with trauma.

Whether OUD increases risk for victimization or victimization leads to OUD, adverse consequences abound.
OPIOID USE AND SEXUAL EXPLOITATION

A perpetrator can leverage opioids:

- To exacerbate a parent’s/survivor’s vulnerability
- To coerce a parent/survivor to submit
- To offer to a parent/survivor for coping with the physical and mental traumas of exploitation
"If you take away substances and don't deal with the trauma and pain underneath, then you leave [survivors] completely bare and exposed, with no anesthesia." Angela Browne speaking at the Faces of Family Violence and Trauma conference, New Haven, CT, May 12, 2000
EFFECTS OF CAREGIVER OPIOID USE ON CHILDREN

- Toxic Stress
- Older Children and Adolescents
Excessively High Levels or Prolonged Exposures to Stress\textsuperscript{10}

- Increases in stress hormones are protective and even essential for survival.
- Excessively high levels or prolonged exposures can be harmful or toxic, and can lead to a chronic “wear and tear” effect on multiple organ systems, including the brain.
During this period, a child’s brain produces more than one-million neural connections each second—faster than any other time in life.

During the 1st year, a child’s brain doubles in size and by age 3, has reached 80 percent of its volume.¹¹

Excess neural connections make a child’s brain especially sensitive to external input (aka relationships and their environment).¹²

“Serve and return” interactions between young children and their caregivers are a major ingredient in healthy development.¹³
Early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain architecture and long-term health.

Increasing investments are being made in the preschool years to promote the foundations of learning.
Among children who grow up in homes with a parent with an OUD:

- 30-33% meet diagnostic criteria for disruptive disorder
- 21-30% meet diagnostic criteria for anxiety or mood disorder
- 47-59% exhibited substance misuse behaviors
Health Effects of Early and Prolonged Stress on Adolescents

- Stressful childhood events are linked to inflammation in adolescence.
- These bio markers could help health providers identify kids at risk for long-term health problems.
Children are likely to experience significant neglect, trauma, toxic stress, or at a minimum, lack of a responsive parent.

Parent-child relationship is likely to be problematic.

Parental capacities are likely to be impaired.

Parental sobriety will not necessarily by itself address child/adolescent development, mental health, or substance use disorders (SUDs).
Resilience is the ability to overcome serious hardship. It is evident when a child’s health and development tips toward positive outcomes, even when a heavy load of factors is stacked on the negative outcome side.

Though the brain and other biological systems are most adaptable early in life, the capabilities that underlie resilience can be strengthened at any age. It is never too late.
EFFECTIVE TREATMENT AND RECOVERY RESPONSES TO PARENTAL OPIOID USE

- Medication-Assisted Treatment (MAT)
- MAT and Pregnancy
After an initial pleasurable “rush,” people who use opioids may be very drowsy for several hours, with clouded mental functioning.

Repeated use often results in addiction – where seeking and using the drug becomes the primary purpose in life.
EFFECTS ON THE BODY AND BRAIN

- Drowsiness
- Mental confusion
- Nausea
- Constipation
- Respiratory depression

Opioid meds act on the brain’s reward centers, and can induce euphoria (particularly when taken at a higher-than-prescribed dose or administered in other ways than intended).
OPIOID WITHDRAWAL:  

- Excessive perspiration
- Shaking and muscle spasms
- Severe muscle and bone pain
- Vomiting, nausea, and diarrhea
- Irritability
- Insomnia/restlessness
- Dilated pupils
- Rapid heart rate/anxiety

Death is not likely from opioid withdrawal, but people may feel like they’re dying
“I had nothing. My life was broken down into four- to five-hour increments to get high, to put off feeling sick.”
Humans produce several endogenous (within the body) opioids. The most common are known as “beta-endorphins,” or simply “endorphins.”

Beta-endorphins are released during periods of extreme excitement or pain, such as:

- Delivering a baby or watching the birth of a baby, having sex, enjoying a good meal.
- Experiencing pain such as breaking an ankle (the pain is muted for several seconds to allow the person time to stop).
Beta-endorphins look and function like exogenous (introduced from outside the body) opioids, such as morphine, heroin, or oxycodone.

Beta-endorphins bind with a receptor in the brain and spinal column known as the mu ($\mu$) receptor, creating a sensation of analgesia (pain blocking) and releasing dopamine (pleasure and euphoria).
As individuals take more exogenous (external) opioids, their body’s production of beta-endorphins (within the body) decreases, creating an increased sensitivity to pain, both physical and emotional, when they stop using exogenous opioids.
Typically, the changes in the brain caused by opioid dependence will not correct themselves right away, even though the opioid use has stopped.

These changes can trigger cravings for the drug months and even years after a patient has stopped using opioids.

Overcoming opioid dependence is not simply a matter of eliminating opioid substances from the body (e.g., detox/withdrawal management).

Unless restorative, rebalancing treatment is provided, these functional brain imbalances can result in worsening or sabotage of recovery attempts.
MAT BENEFITS: MAT IS EVIDENCE BASED

- MAT is a well-studied, effective, evidence-based treatment that significantly improves treatment outcomes.
- Patients taking medication for OUD are considered to be in recovery.
- MAT increases social functioning and retention in treatment.
- Numerous studies have documented that patients treated with medication are more likely to remain in therapy compared with patients receiving treatment that does not include medication.
MAT BENEFITS: MAT IS EVIDENCE BASED²⁸

- Research has documented that the combination of medication with counseling and recovery support is more effective than substance use treatment without medications in treating OUD.

- Available research indicates that MAT improves treatment adherence, reduces the risk of overdose death, and reduces the risk of contracting associated infectious diseases, such as HIV and hepatitis B and C, among other outcomes.
MAT BENEFITS FOR PARENTS IN THE CHILD WELFARE SYSTEM WITH OUD

- While some clients with OUD may be stabilized with medications alone, the parents involved with the child welfare system typically have a range of interrelated problems for which counseling and recovery supports are essential.
- A study that specifically examined the use of MAT with child welfare clients found that MAT treatment improved the likelihood that program participants retained custody of their children.
A program in Kentucky found that clients with a history of opioid use who received a year of MAT increased the odds of retaining custody of their children by 120%, compared with those who did not receive MAT. However, fewer than 10% of opioid-using clients in the program received MAT, a factor the authors attribute largely to stigma against MAT.
Methadone may be provided only through opioid treatment programs (OTPs) that are regulated, certified, and accredited through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA).
Buprenorphine (e.g., Suboxone and Subutex) can be provided either by an OTP or by office-based providers, who may be primary care providers (physicians, nurse practitioners, and physician assistants) who have received training on the medication, as well as a waiver issued by SAMHSA in coordination with the DEA.

These waivers are called DATA waivers after the Drug Abuse Treatment Act of 2000, which permits qualified practitioners to treat OUD with certain narcotic-controlled substances that have been approved by the FDA for that purpose.
Naltrexone (e.g., Vivitrol) can be provided by any physician or health care provider who has the authority to issue prescriptions and who is operating within their scope of practice, without special certification or training.

In addition to these pharmacotherapy medications, naloxone (e.g., Narcan) is a medication that rapidly reverses opioid overdose. It is used to treat overdose but does not address the underlying OUD.
Methadone and buprenorphine (which are themselves opioids) both reduce the patient’s cravings and suppress symptoms of withdrawal, essentially by tricking the brain into thinking it is still getting the abused drug but without the euphoric effects of most commonly abused opioids.

Naltrexone blocks the euphoria as well as other effects (including pain relief) by preventing the opioids from attaching to the opioid receptors in the brain. The result is that even if a person relapses and uses an opioid, its euphoric effects are limited, which may help motivate the patient to reengage in treatment.
MAT BENEFITS AND SUBSTITUTION MYTH\textsuperscript{35}

Methadone and buprenorphine DO NOT substitute one addiction for another.

- When patients are treated for opioid addiction, the dosage of medication used does not get them high; it helps reduce opioid cravings and withdrawal.
- These medications restore balance to the brain circuits affected by addiction, allowing the patient’s brain to heal while working toward long-term recovery.
MAT AND PREGNANCY

The transition to parenthood is often a critical opportunity for intervention because parents often experience heightened motivation levels for addressing their addictions at this juncture in their lives.36
NEONATAL ABSTINENCE SYNDROME (NAS) 37, 38, 39

- Opioid medications taken by pregnant women also get into the baby’s system. Shortly after birth, many of these babies experience temporary withdrawal symptoms such as fussiness or shaking. This is called neonatal abstinence syndrome (NAS).
- NAS occurs in 30%-80% of opioid pregnancies, and is an expected and treatable consequence of opioid exposure.
- There has been a sustained increase in both maternal OUD and NAS diagnoses among rural residents.
Infant withdrawal usually begins a few days after the baby is born but may begin as late as 2 to 4 weeks after birth.

Reducing the dose of pharmacotherapy before delivery will **NOT** reduce NAS expression or severity.

Smoking cessation and minimization of other substance use can reduce NAS expression and severity.
BREASTFEEDING

- Highly recommended
  - Breastfeeding has positive physical and behavioral effects for the mother–infant dyad.
- Safe in most cases
  - Women who are stable on buprenorphine, combination buprenorphine/naloxone, or methadone should be advised to breastfeed, if appropriate.
  - Women living with HIV or women with ongoing illicit drug use should not breastfeed.

The mother can be reassured that the amount of prescribed pharmacotherapy to which the baby is exposed via breast milk is extremely small, while the risk of harm to the infant from her return to substance use is much greater.
Withdrawal of pharmacotherapy for OUD and tapering during pregnancy have a high failure rate (American Society of Addiction Medicine, 2015; Jones, O’Grady, Malfi, & Tuten, 2008; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; World Health Organization, 2014), and expectant women with OUD often return to opioid misuse and its attendant risks (e.g., Kaltenbach, Berghella, & Finnegan, 1998; Mattick, Breen, Kimber, & Davoli, 2009).
SAMHSA’s guidance is clear: Pregnant women with OUD should not be encouraged to withdraw from pharmacotherapy for OUD during their pregnancy or shortly after delivery. Pharmacotherapy is the recommended standard of care, and it is the best option for a pregnant woman with OUD. Remaining on pharmacotherapy will help her avoid a return to substance use, which has the potential for overdose or death. A decision to withdraw from pharmacotherapy should be made with great care on a case-by-case basis, and additional supports such as close observation should be put in place.
Caring for a young child can be viewed by a parent as a deeply meaningful opportunity to successfully navigate their addiction recovery.

Motivation can be harnessed by encouraging parents to take steps they have long been considering and are now ready for, including taking better care of themselves and their family.
Recovery support services (RSS) refer to the collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use.
Examples of recovery services and resources include:

- Housing
- Education
- Employment
- Social resources
- Overall health and well-being
IT’S MORE THAN CHECKING A BOX
Take a break
UNIQUE CHALLENGES OF CARING FOR CHILDREN OF THE OPIOID EPIDEMIC

- Discussion with Florida foster parents
- Circumstances surrounding the foster child(ren) impacted by opioid use
- Unique effects of parental opioid use on the children
- Bio parents’ experience with MAT or other substance use disorder treatment
- Insight for other foster parents, adoptive parents, and kinship providers on caring for the children of the opioid epidemic.
- What foster parents wished they had known, or STILL wish they knew, about opioid use and/or its impact on children.
FOSTER PARENT DISCUSSION

- Circumstances surrounding the foster child(ren) impacted by opioid use
- Unique effects of parental opioid use on the children
- Bio parents’ experience with MAT or other substance use disorder treatment
- Insight for other foster parents, adoptive parents, and kinship providers on caring for the children of the opioid epidemic.
- What foster parents wished they had known, or STILL wish they knew, about opioid use and/or its impact on children.
FOR QUESTIONS OR FOR ADDITIONAL INFORMATION

http://www.training.fadaa.org/
RESOURCES

OTHER RESOURCES

QUESTIONS?
CITATIONS

1. Florida foster parent interviewed on 4.5.19 to inform this presentation.


CITATIONS


22. Sample client response (not FL client)


24. Ibid

25. Ibid


31. Ibid


34. Ibid


42. Ibid


45. Ibid