Treatments for opioid use disorder among pregnant and reproductive-aged women

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The increased prevalence of opioid use disorder and access to medical insurance is subsequently increasing the likelihood that medical professionals will encounter individuals with opioid use disorder. Sharp increases in opioid use disorder among women mean that obstetricians, gynecologists, and other reproductive medicine providers may be especially likely to encounter such patients. Medical professionals' understanding of treatment for opioid use disorder and their roles in their patients' treatment may increase referrals to treatment, reduce stigma, and improve the quality of medical care. Treatment for opioid use disorder falls into four overlapping domains: medication management, medical care, behavioral/mental health care, and psychosocial support. In this review, we discuss these domains with an emphasis on pregnant women and women of reproductive age. Treatment for opioid use disorder is most effective when all providers coordinate care in an informed, nonjudgmental, patient-centered approach. (Fertil Steril® 2017;■:■–■. ©2017 by American Society for Reproductive Medicine.)

Key Words: Buprenorphine, methadone, medication-assisted treatment, opioid, substance use disorder

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Opioid use disorder (OUD) among pregnant women and women of reproductive age has been increasing since the 1990s with demographics shifting toward young, white females (1). The increased prevalence means that medical practitioners who typically do not encounter women with OUD are now more likely to encounter patients who need or are receiving treatment for OUD. This article reviews how OUD is treated, with an emphasis on the unique needs of pregnant women and women of reproductive age.

In 1965, the first controlled trial demonstrating that a daily dose of methadone could provide a 24-hour reduction in withdrawal symptoms and craving revolutionized treatment for OUD (2). Methadone clinics were created and quickly grew to become centers where patients could receive their daily dose of methadone, counseling, and other needed services, and they demonstrated effectiveness in reducing illicit substance use and increasing social functioning (3). More recently the introduction of the opioid partial agonist/antagonist buprenorphine and long-acting formulations of the opioid antagonist naltrexone have increased alternatives for medication-assisted treatment and the settings in which treatment can take place. Regardless of the pharmacologic intervention provided, an evidence-based biopsychosocial assessment helps determine placement of the patient into the most appropriate level of care.

The American Society of Addiction Medicine (ASAM) placement criteria (4) include five broad levels of care (Table 1) spread across a continuum of treatment intensity. Early intervention is the least intensive, involving brief interventions with minimal follow-up observation. Outpatient treatment can range from occasional office visits for counseling and medication management to a more intensive outpatient program involving 9 or more hours per week of counseling and group therapy. In partial hospitalization, individuals receive services for several hours each day, and physicians are readily available to deal with emergent medical problems, such as dangerous withdrawal symptoms. In residential treatment, the individual resides at the treatment facility in a structured living environment and receives treatment services throughout their stay. Inpatient treatment is reserved for the most severe cases requiring constant medical supervision, such as a high likelihood of dangerous withdrawal symptoms or co-occurring medical or psychiatric issues that present a danger to self or others.

The level of care reflects the setting and intensity of treatment, but treatment across all levels is multifaceted and can be described as falling into four domains: medication management, medical care, behavioral/mental

Received June 1, 2017; accepted June 6, 2017.
D.J.H. has nothing to disclose. V.L.S. has nothing to disclose. D.J.A. has nothing to disclose.
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Fertility and Sterility® Vol. ■, No. ■, ■ 2017 0015-0282/$36.00

http://dx.doi.org/10.1016/j.fertnstert.2017.06.011

TABLE 1

American Society of Addiction Medicine (ASAM) levels of care and descriptions.

Level of care	Description
0.5	Early Intervention: Brief motivational counseling or other brief interventions to prevent addiction from developing, further assessment to rule out addiction is recommended.
1.0	Outpatient Treatment: Clinical services provided for up to 5 hours per week.
2.0	Intensive Outpatient Treatment and Partial Hospitalization: Nine or more hours per week provided near-daily or daily with ready access to acute medical care.
3.0	Residential Treatment: Individuals reside in a facility with 24-hour staffing and clinical services are provided throughout the day.
4.0	Medically Managed Intensive Inpatient Services: Individuals reside in a facility with 24-hour staffing by medical professionals and receive clinical services throughout the day.

Hand. Treatments for opioid use disorder. Fertil Steril 2017.

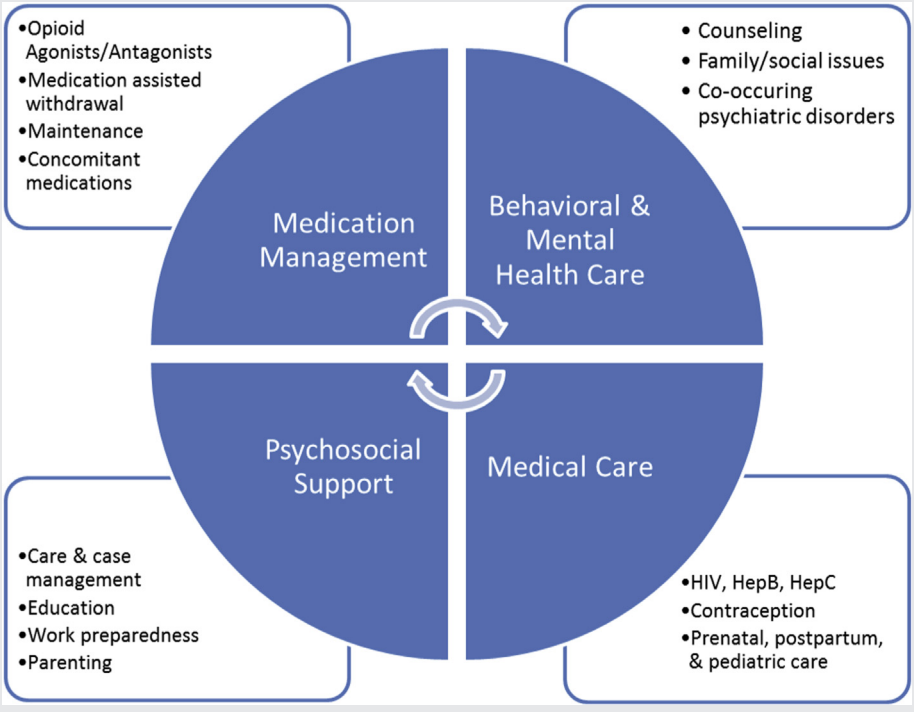
health care, and psychosocial support (Fig. 1). Medication management includes detoxification, maintenance on methadone or buprenorphine, or the use of oral or injectable naltrexone as well as management of concomitant medications. Medical care involves addressing medical needs that may have arisen as a result of addiction or have gone untreated. In the context of pregnancy, coordination and provision of prenatal care improves pregnancy and infant outcomes among women with OUD (5). Behavioral/mental health care involves treatment of co-occurring psychiatric and behavioral issues, which are common among individuals with OUD. Finally, psychosocial support involves addressing the social determinants of health, such as poverty, housing, education, and employment. The four domains are not orthogonal, and integration between the domains is important to comprehensive care and relapse prevention; these domains are intended to serve as a conceptual framework for evidence-based treatment for OUD.

MEDICATION MANAGEMENT

All individuals with OUD will require some form of medication management as part of their treatment. Ceasing chronic opioid use produces extremely unpleasant withdrawal symptoms such as diarrhea, vomiting, sleeplessness, tachycardia, hypertension, all of which may be relieved by using an opioid. Depending on the severity of the problem, medication management options range from maintenance with full or partial opioid agonists, to medication-assisted withdrawal (often called detoxification).

In the context of pregnancy complicated by OUD, maintenance with full or partial opioid agonists is the current consensus guidance from ASAM (6) and the American College of Obstetricians and Gynecologists (7). Methadone

FIGURE 1



A conceptual framework for treatment of opioid use disorder.

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