ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

Volume 28 Number 15
April 11, 2016
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

This week's leads look at two stories affecting the SUD field. First, the best treatment for neonatal abstinence syndrome, which in addition to medication in moderate to severe cases, is always the mother: breastfeeding, holding, skin-to skin contact. We also look at how marijuana legalization in Washington has affected use in that state.

. . . *See stories beginning on this page*

Baby's mother is the best treatment for neonatal abstinence syndrome

The best treatment for neonatal abstinence syndrome (NAS) is the baby's mother. This isn't new news, but in a country in which some mothers are still sent to jail and many lose custody of their newborns simply because they were in doctor-ordered treatment with methadone or buprenorphine, the message bears repeating. *ADAW* spent the past week talking to the country's top experts on treating NAS in babies whose mothers were in medication-assisted treatment (MAT) with opioid agonists.

Bottom Line...
The mother of a baby with NAS is the best treatment — via breastfeeding, skin-to-skin contact, holding and being together.

Instead of being in the Neonatal Intensive Care Unit (NICU) or even the nursery, the baby is best "rooming in" with the mother, but this practice is rare in the United States, even for normal babies. Many babies with NAS need supplemental medication — usually morphine or methadone — to treat their withdrawal symptoms, but the mother — breastfeeding, skin-to-skin contact and bonding — greatly reduces the amount of medication needed, studies show.

"I tell mothers, 'You are the most important thing in NAS — you're

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more important than morphine,'" said John McCarthy, M.D., assistant professor of psychiatry at the University of California, Davis, who for decades has treated patients in opioid treatment programs (OTPs) with methadone. Babies with severe NAS need medication such as morphine drops to treat withdrawal symptoms. "It's so important to empower them and to deal with their fear," he said. Going into the hospital to deliver makes them "feel like they're going into enemy territory — and often they are."

McCarthy gives the women his phone number and tells them to call him if something goes wrong at the hospital. "If the nurses take the baby to the NICU even though you don't see any withdrawal, that's a problem," he told *ADAW*. "Sometimes the nurses say, 'We're taking the baby down the hall to weigh him,'" he said. "I tell the mom, 'It's your baby — tell them to weigh him in your room.' We see the baby go down the hall and all of a sudden they're in the NICU on morphine." He tells the mothers how the babies are "scored" in the hospital for withdrawal, telling the mothers about the Finnegan scale. He tells the mothers to tell the nurses they want to watch them score the baby, and have the nurses explain the symptoms. "Don't get into an argument with the nurses," he tells the mothers. "Just say, 'I know the Finnegan scale, I've been taught that, I want to see how you score.'" That score can make the difference between allowing the baby to stay with the mother and putting the baby in the NICU.

The NICU isn't necessary even for babies on morphine, he said. "As soon as the baby goes to the NICU, you have the absence of the mother, the noise, the lights, the crying," he said. "Hospitals could save a lot of money if they didn't use NICUs — if the baby needs morphine, they could do it in the hospital room with the mother there." But that kind of rooming in is very rare. "That's the next step," said McCarthy. More and more hospitals, however, are getting the message that "the first treatment is the mother."

Breastfeeding

Both breastfeeding and skin-to-skin contact in the absence of breastfeeding reduce both the severity (measured by Finnegan score or the amount of medication needed) and duration (how long the baby is in the hospital) of NAS, said Mishka Terplan, M.D., assistant professor in the Division of Obstetrics and Gynecology at the University of Maryland School of Medicine. The breastfeeding benefits have little to do with the methadone or buprenorphine being passed from the mother's breast milk, because the amounts are so minimal, and more to do with bonding, he said.

Hospital policy, and not the mother's OTP or physician, dictates how the NAS is treated. "There are places where all babies at risk of NAS are initially evaluated in the NICU," Terplan told *ADAW*. "Of course this leads to a greater likelihood that NAS will be managed in the NICU, leads to a longer length of stay and interferes with maternal bonding and breastfeeding," he said. "Therefore, hospitals that allow for rooming in and have adequate staffing to support this will lead to more breastfeeding and bonding."

Hospital staff may not have the education to know that NAS is best treated with maternal bonding, said Terplan. "Breastfeeding should be encouraged in women in general, and especially among those with opioid use disorder, providing there are no contraindications." Breastfeeding should be encouraged "not only because breastfeeding promotes bonding and decreases the severity/duration of NAS, but also

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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Mondays in July and September and the last Mondays in November and December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S./Can./Mex.), $839 (individual, rest of world), $6504 (institutional, U.S.), $6656 (institutional, Can./Mex.), $6707 (institutional, rest of world); Print & electronic: $765 (individual, U.S./Can./Mex.), $909 (individual, rest of the world), $7805 (institutional, U.S.), $7988 (institutional, Can./Mex.), $8049 (institutional, rest of the world); Electronic only: $555 (individual, worldwide), $6504 (institutional, worldwide). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at (800) 835-6770; email: cs-journals@wiley.com.

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because women with opioid use disorder have low rates of both initiation and continuation of breastfeeding," he said.

One pediatrician who has had great success treating babies with NAS is Prabhakar Kocherlakota, M.D., who works at St. Luke's Cornwall Hospital in Newburgh, New York (for his review article published in *Pediatrics* two years ago, go to http://pediatrics.aappublications.org/content/134/2/e547). Ninety-nine percent of the mothers in treatment with methadone (mostly) or buprenorphine breastfeed, Kocherlakota told *ADAW*. "I tell the mothers to breastfeed, to keep the baby close to the skin, to stay for a long time," said Kocherlakota. When the mothers hear this advice, they are relieved, he said. "They say they want to be involved," he said. Although, as in most hospitals, there is no provision for the mother to stay with the baby once the mother is discharged, she can visit the baby in the nursery for 12 hours during the day, and Kocherlakota tries to encourage them to sleep overnight as well. "I get some kind of pullout couch where she can sleep," he said. If the mother can't stay, the baby is fed during the night with her stored breast milk, he said.

"Breastfeeding is very important," said Loretta P. Finnegan, M.D., who invented the Finnegan score used to assess withdrawal severity in newborns. Some babies going through NAS are too difficult to handle in a routine nursery, but they should still be breastfed, she said. "The protocol in many hospitals is to begin to score the babies right away," she said. "We found that once the score gets to 8 and it's sustained, that baby is going to be so irritable that he won't feed well and won't sleep well," she said. "That's when we provide medication." But once the discomfort of withdrawal is alleviated by the medication, the baby can breastfeed more easily and bond with the mother, she said. "Breastfeeding and skin-to-skin contact can reduce the need for medication, but they don't take away the need," said Finnegan.

Breastfeeding can be more difficult for these babies, which is why the mother needs extra encouragement, said Finnegan. "In our studies, we found that a baby not exposed to any drugs in utero will suck at 40–50 sucks per minute by the third day of life, whereas a baby exposed to heroin or methadone will suck at 20–25 sucks a minute," she said. The fewer sucks per minute, the longer the baby has to suck to get adequate nutrition, which makes the baby tired, she said. But just as with normal newborns, a good nurse can help the baby latch on and suck.

'Breastfeeding and skin-to-skin contact can reduce the need for medication, but they don't take away the need.'

Loretta Finnegan, M.D.

"We know breastfeeding is associated with bonding and reduced NAS, and in general is the best nutrition that the baby can have," said Hendree Jones, Ph.D., director of the Horizons program at the University of North Carolina Department of Obstetrics and Gynecology, where she is also a professor. Jones' program is unique: it is a residential program for pregnant women in treatment with methadone or buprenorphine, and the mothers return to the program after delivery to live with their babies until both are ready to leave. "The mothers I work with have a tremendous amount of trauma, especially physical and sexual abuse," said Jones, who was a co-author of the seminal MOTHER study funded by the National Institute on Drug Abuse (NIDA), which found that babies born to mothers on buprenorphine did well (see *ADAW*, Dec. 13, 2010). "They have a lot of body issues, and may not feel comfortable with their breasts, so we work with them to help them feel positive about themselves," she said. "Sometimes it can be harder for babies to latch on, but once they do, it's fantastic for the mothers and the babies." The Horizons program has lactation consults who work with the women in the hospital and afterward.

The amount of methadone in breast milk is very small — about 1 milligram a day, said Jones. And buprenorphine has very low availability when taken orally, so "whatever tiny amount is even in the breast milk isn't getting into the baby," she said. This underscores the fact that breastfeeding isn't being promoted as a delivery mechanism of medication — it's being promoted for its importance in bonding and nutrition. "We tell moms it's the act of breastfeeding — holding the baby close, the sucking reflex, the nurturance behavior — that's important," she said. "But that said, the babies might not even need medication if the act of breastfeeding is helping to reduce signs and symptoms of NAS."

Beyond breastfeeding, rooming in — in which the baby stays in the room with the mother and not in any nursery — can cut medication treatment in half, said Jones. "The mom is there, paying attention to the baby, versus the child stuck in the NICU all alone with bright lights," she said.

CPS

Finnegan serves as an expert witness for public defenders in New Jersey, where mothers who have been on methadone or buprenorphine are accused of harming their children who are born with NAS.

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She speaks on behalf of those mothers. "I have to write these long testimonies showing the data," she said. "Here is a mom who is doing well, and they take the baby away." Policy has not kept up with science, she said. "There are individuals who are steered by ideology, who think we have to get this mother off all drugs, and methadone and buprenorphine are drugs — but that's not the way this disease works," she said. "You have to heal the brain."

Still, even hospital nurses can be steered by their own ideology, not science. That call to Child Protective Services (CPS) is what mothers dread the most. "CPS is a pickle," said Terplan. "State laws differ, and any individual can report suspected abuse." At both state and federal levels, it's important to clarify substance-exposed newborn reporting guidelines "to make it clear that a woman adherent to MAT whose infant develops NAS should not be reported."

Kocherlakota, in New York, has made it a point to tell the nurses not to report babies with NAS or the mothers to CPS. "I tell the nurses, when the mother is on methadone or Subutex or Suboxone, there is no need for CPS," he told *ADAW*. "I put it in the file." Most babies born to these mothers stay in the hospital for a maximum of two to three weeks, he said, and some can go home in five to six days. The length of stay depends on the severity of the NAS.

Most of the mothers on MAT come to the hospital from the local methadone clinic, where Kocherlakota goes every month to explain what will happen in the hospital when the pregnant women there deliver. "That way we meet face to face, I tell them what we're going to do and what the plan is," he said. He has no funding for this. "I spend from my own pocket $250 a month to give them booklets, to help," he said. "You would be surprised how many women do not know what will happen to their babies in the hospital." Every month there are 10 to 15 pregnant women near delivery in the OTP, he said.

Educating hospital staff

McCarthy goes to five different hospitals in the Sacramento area, giving the labor and delivery nurses a presentation on methadone and its uses, and how to support the mothers. "That education made a big difference," said McCarthy. But not enough of it is done, he added, with heavy criticism for the for-profit OTPs that cut costs. McCarthy said he did a pregnancy group for years in his OTP, which he has since sold, he said. "If you educate nurses and doctors, that's usually effective," he said.

Another problem is cultural, said Finnegan. "Many of the nurses just don't understand these mothers, who didn't grow up in middle-class neighborhoods," she said. "These women are frightened, and if a nurse looks down upon them, that's another reason they are scared."

The fact that the women are usually discharged a day or two after delivery makes it even more difficult for them, said Finnegan. "Sometimes they have to take three buses" to get to the hospital to visit the baby, she said. The studies proving that rooming in decreases the severity and duration of NAS are powerful, she said. But in this country, insurance will not pay for rooming in, even though it will pay for costly NICU stays.

Heading into the wind

Stephen Kandall, M.D., a neonatologist based in North Carolina, refers to the struggle to educate hospitals — and CPS — about NAS in the context of headwinds versus tailwinds. "When you advocate for a woman — or any patient — on drugs, in this field you always have headwinds," he said. "This is an angry country; people are angry towards these women, and it's very difficult to change policy."

"Here in North Carolina we have a terrible misunderstanding — there was a bill proposed to report all the mothers, unless the woman had completed treatment," he said. "What does 'completed treatment' mean — that the woman has to be off all drugs, all medications?"

The goal should always be family unification, said Kandall. "It doesn't make sense to prosecute the women or do serial foster care placement — I think that the people who advocate this are misinformed," he said. But informing them correctly requires constant education, he said. "I spend most of my time doing this, and sometimes I wonder whether the message is getting through," he said.

Finally, getting the message through to hospital staff is one thing; getting it through to CPS is another. First of all, CPS is very local. Second, it's usually a law enforcement, not a public health, tool. As Jones said, there are 100 counties in North Carolina, and in every one of them CPS is run by the district attorney. And that's where the compassion and science both disappear, and dissolve into a need for retribution. "It always comes down to anger," said Jones. "So many people are angry at these women."

Next steps for advocates: convincing CPS and the district attorneys that it is the mothers who are the solution to treating NAS. •

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- www.ncbi.nlm.nih.gov/pubmed/?term=Is+breastfeeding+useful+in+the+management+of+neonatal+abstinence+syndrome%3F
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