Questions Asked During Live Webinar Broadcast on 3/18/2022

Women, Part 1: Substance Use Disorder (SUD) in Women with a Focus on Pregnant and Parenting Persons

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Do you have any data on the increase in fentanyl use since 2019 in women?
A: No, there hasn’t been data released from the CDC, NSDUH, NYS, or NYC yet doing a subanalysis of fentanyl use in women since 2019. We know substance use increased during the COVID-19 pandemic, but the only data we have specific to women has been from studies on the increase in alcohol use during the COVID-19 pandemic.

What is the difficulty in getting people successfully onto MAT when they have a Fentanyl addiction as opposed to other opioids?
A: Fentanyl and its analogues are lipophilic substances, meaning that they are stored in the fat tissue and released slowly over time. So, despite the euphoria associated with fentanyl use being brief and despite the subjective symptoms of opioid withdrawal syndrome that someone may experience after using fentanyl, because of the lipophilicity, precipitated opioid withdrawal syndrome has occurred more often than previously when an individual is trying to initiate buprenorphine (a partial agonist opioid). Some individuals are having to wait 24-72 hours after last using fentanyl to initiate buprenorphine; this is in contrast to initiating buprenorphine 4-8 hours after last using heroin or other short-acting opioids. It is challenging for someone with physiological opioid dependence to tolerate that amount of time (24-72 hours) in opioid withdrawal. This is not an issue when initiating methadone (a full agonist opioid), only buprenorphine.

Has Suboxone been approved for MOUD in pregnancy?
A: I assume the individual is asking if buprenorphine-naloxone dual formulation can be used in pregnancy. The answer is yes. There is plenty of data that has now been published demonstrating the safety of the dual formulation during pregnancy. The only reason the mono formulation of buprenorphine was recommended initially for individuals who are pregnant was due to the theoretical risk of someone who is pregnant misusing buprenorphine-naloxone via injection and exposing the developing fetus to naloxone (which would be bioavailable via injection; the naloxone is not bioavailable sublingually) and precipitating withdrawal in the developing fetus which could lead to miscarriage in the first trimester and premature delivery in the third trimester. Again, this was a theoretical risk, not based on data.

Would you say that those in SUD treatment should be treated on a more short-term basis?
A: I am not sure exactly what this individual is asking. SUD is a chronic medical condition. Individuals may have different goals and needs at different times. Engagement in care should be at whatever level works well for the individual, whether via harm reduction services/supports, outpatient treatment, inpatient treatment, treatment based in primary care, etc. If the question is specifically about MOUD, then the individual should remain on MOUD as long as they derive benefit from it. Studies clearly indicate that no MOUD or short term MOUD lead to worse outcomes, including overdose mortality, compared with longer term MOUD and engagement in care. I would think of MOUD as longer term or lifetime treatment for OUD.

Should Suboxone be discontinued with illicit benzo use?
A: No, buprenorphine, as a partial agonist, has a ceiling effect and is a far safer opioid than any other opioid, including with concomitant benzodiazepine use. So whether someone is using prescribed benzodiazepines appropriately, misusing prescribed benzodiazepines, or taking benzodiazepines illicitly, doing that in combination
with buprenorphine is a far safer option than them doing that in combination with a full agonist opioid (heroin, fentanyl, oxycodone, etc.).

**Should mothers continue MOUD while breastfeeding?**

A: Yes, breastfeeding should be encouraged with either methadone or buprenorphine. The amount of medication transferred via breast milk is negligible. Breastfeeding also promotes bonding between the parent and the infant. The act of breastfeeding, via closeness, snuggling, and physical touch, also mitigates the possibility of NOWS (neonatal opioid withdrawal syndrome) in infants exposed to methadone, buprenorphine, or other opioids in utero.

**In thinking about co-occurring SU/MH inpatient treatment, do you have additional research on not mandating additional support?**

A: Mandated treatment has not been shown to be effective in most instances. Research supports this. In my clinical experience, persons with OUD should be stabilized first on medication. Typically, patients can identify themselves as likely to benefit from additional services and supports, once they have stabilized medically.

**Can you please clarify when you shared with us that individuals do not need counseling if receiving methadone?**

A: Here is the regulation:

§ 8.12 - Federal opioid treatment standards.

(f) **Required services**

5) **Counseling services.** (i) **OTPs must provide adequate substance abuse counseling to each patient as clinically necessary.** This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient and to monitor patient progress.

(ii) OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV) disease for each patient admitted or readmitted to maintenance or detoxification treatment.

(iii) OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational rehabilitation, education, and employment services for patients who either request such services or who have been determined by the program staff to be in need of such services.

The key here in the phrasing is “as clinically necessary.” Counseling must be offered in an OTP setting, but the patient may decline it.