Prescription Opioid Use

A guide for service providers and health care professionals to support a harm reduction approach to prescription opioid use of individuals who are parents, are pregnant or thinking about becoming parents.

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About This Resource

The purpose of this resource is to equip service providers and health care professionals with information that supports a harm reduction approach to prescription opioid use. While the content included in this resource is specific to prescription opioid use, misuse, and addiction, some of the information is also relevant to other forms of opioid use.

This resource is relevant for service providers and health care professionals who work with individuals:

- Using prescription opioid medications.
- Thinking about becoming parents, are pregnant, or who are new parents.

This resource summarizes current research relating to:

- Best practices for treatment of substance use and opioid use disorders.
- The effects and risks of opioid use during pregnancy, on newborn outcomes, and on parenting behaviours.
- Evidence-informed strategies for mitigating the effects and risks of opioid use disorders.
- Recommended programs and resources to support opioid use disorders.

Examples of service providers and health care professionals may include:

- Physicians.
- Nurses.
- Midwives.
- Indigenous health care providers.
- Public health providers.
- Sexual health service providers.
- Substance use workers.
- Social workers.
- Child protection workers.

Service providers and health care professionals can use the table of contents to find and review the information that is most relevant to them. Hence, some content may be repeated across different sections. This resource is not necessarily intended to be read in its entirety.

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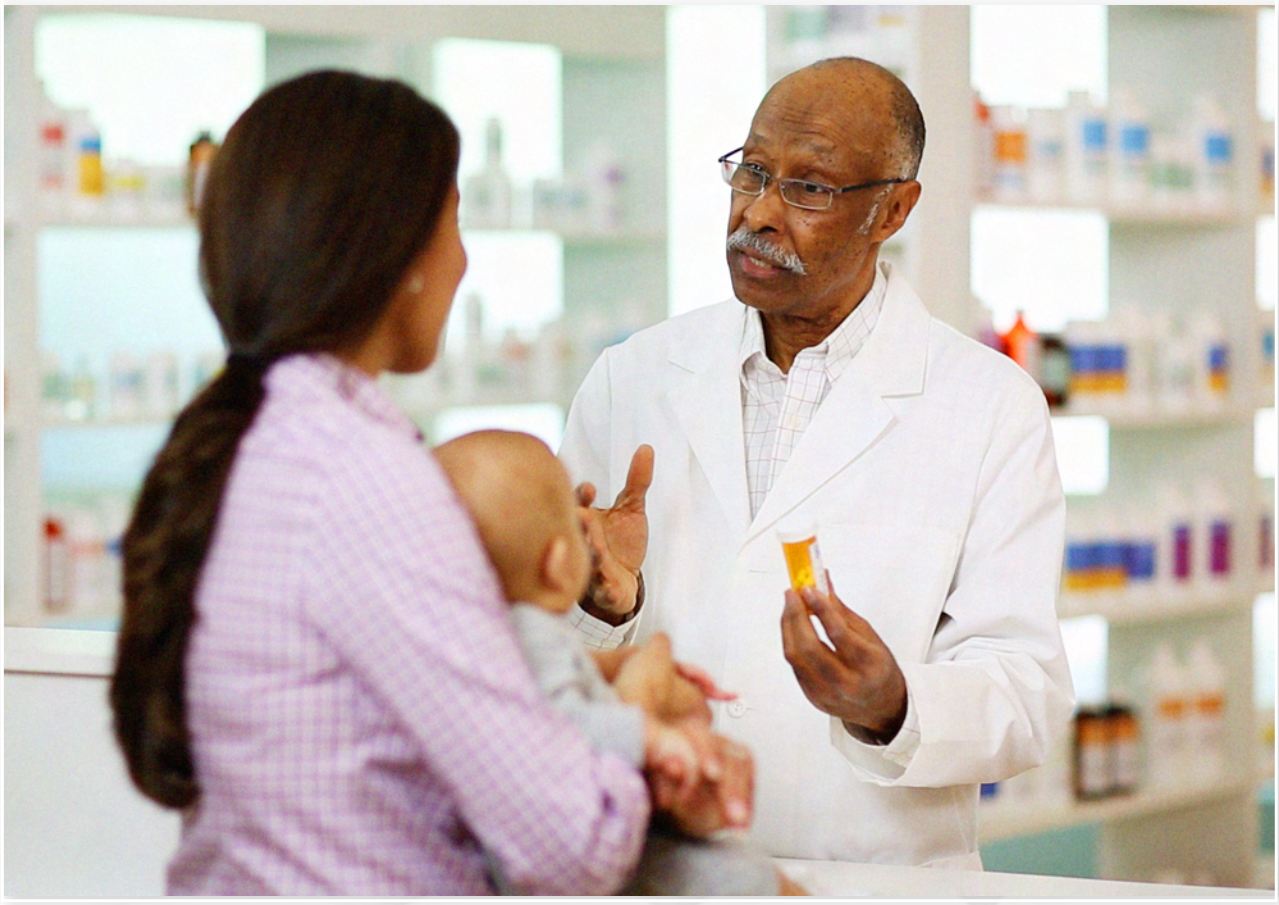

Prescription Opioid Use and Opioid Use Disorder

About prescription opioids

Opioids are a type of medication often prescribed to relieve pain associated with disease, surgery, or injury. Common opioid medications include morphine, codeine, oxycodone, hydrocodone, hydromorphone, fentanyl, methadone, tramadol, and buprenorphine. Prescription opioid medications come in various forms, including tablets, syrups, patches, and suppositories (Centre of Excellence for Women's Health, 2017).

Effects and risks

In addition to temporarily reducing pain, the short-term effects of opioid use may include:

- Feelings of euphoria.
- Relaxation.
- Drowsiness and lack of energy.
- Difficulty concentrating and lack of motivation.
- Constricted pupils.
- Difficulty breathing.
- Loss of appetite.
- Nausea and vomiting.
- Constipation.
- Sweating.

(Centre for Addiction and Mental Health, 2012; Centre of Excellence for Women's Health, 2017)

Long-term effects of opioid use may include:

- Increased tolerance (e.g., needing a greater amount of opioids to get the desired effect).
- Physical dependence (e.g., developing tolerance and needing a greater amount of opioids to get the desired effect).
- Substance use disorder.
- Anxiety and depression.
- Hormonal changes that could result in infertility.
- Strained relationships.
- Diminished parenting behaviours.

(Centre for Addiction and Mental Health, 2012; Centre for Addiction and Mental Health Provincial System Support Program, n.d.; Centre of Excellence for Women's Health, 2017)

Opioid dependence

Dependence on prescription opioids is possible if they are taken over a period of time. If an individual suddenly stops taking opioids, they may experience withdrawal symptoms that include sweating, chills, shivering, restlessness, depression, clammy or prickly skin, yawning, poor sleep, uneasiness, agitation, severe anxiety, nausea, and diarrhea (Centre for Addiction and Mental Health, 2012; Centre for Addiction and Mental Health Provincial System Support Program, n.d.). Dependence is not the same as opioid misuse or addiction.

Opioid misuse and opioid use disorders

Opioid misuse occurs when opioids are not used as prescribed, and can lead to an opioid use disorder. Opioid use disorders occur on a continuum based on the following criteria from the American Psychiatric Association (2013):

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving or a strong desire to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
10. Tolerance, as defined by either of the following:
    a. Need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. Markedly diminished effect with continued use of the same amount of opioid.
11. Withdrawal, as manifested by either of the following:
    a. Characteristic opioid withdrawal syndrome.
    b. Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

The severity of an opioid use disorder is dependent on how many criteria are present. Two or three criteria indicate a mild opioid use disorder. Four or five criteria indicate a moderate opioid use disorder. Six or more criteria indicate severe opioid use disorder (American Psychiatric Association, 2013).

Influences on opioid use and risk of opioid use disorders

There are a number of factors that may cause an individual to use opioids, and help to explain why they may be vulnerable to developing an opioid use disorder:

- Biological factors (e.g., genetic predisposition, development).
- Psychological factors (e.g., personality and high levels of impulsive risk-taking and aggression, concurrent disorders).
- Social-environmental factors (e.g., social determinants of health, social relationships).

A combination of these factors can influence an individual's susceptibility to substance use disorders, including those specific to opioids (Herie, Godden, Shenfeld & Kelly, 2010; Leyton & Stewart, 2014; Substance Abuse and Mental Health Services Administration, n.d.-b).

Certain risk factors are known to make it more likely for an individual to develop a substance use disorder, including:

- Stress.
- Having other illnesses or chronic pain.
- Personal experiences with unemployment, poverty, and inequitable access to education, health, and other social services.
- Using multiple substances.
- Personal or family history of mental health conditions.
- Experiences with adverse childhood experiences (ACEs) such as physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, or an incarcerated household member.

(Centre for Addiction and Mental Health Provincial System Support Program, n.d.; Substance Abuse and Mental Health Services Administration, 2018)

Certain protective factors may help reduce the risk of substance use disorders, including:

- Responsive parenting that includes warmth, consistency, age-appropriate expectations, encouragement, and consistent rules and routines.
- Healthy peer relationships.
- Supportive school and work environments.
- Community connectedness and cultural supports.
- Individual coping skills and ability to deal with stress and trauma.

(National Institute on Drug Abuse, 2016)

Use a harm reduction approach

- Harm reduction is an approach that supports people in reducing the negative consequences associated with substance use. It can involve a spectrum of strategies, including:
- Safer use and managed use.
- Non-judgmental approaches and strategies that enhance knowledge, choice, collaboration, and skills.
- Access to resources and supports for individuals, their families, and communities.

(Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-d)

Consider sharing the following messages with individuals to enhance their own personal safety when using prescription opioids:

- Avoid taking medication with other depressant drugs, including alcohol, anxiety medication, or sleeping pills.
- Only take medications that are prescribed to you, at the dose prescribed, and at the frequency prescribed.
- Only take medications that were prescribed by a licensed medical practitioner.
- Return any unused medication to a pharmacist.
- Understand that your tolerance will be reduced after a period of not taking medication, which can result in an accidental overdose.
- Don't use opioids alone to prevent not having support in the case of an overdose.
- Ensure those you use opioids with are aware of the signs of an overdose:
  - Slow breathing.
  - Gurgling.
  - Pinpoint pupils.
  - Bluish lips, nails, and skin.
  - Cold, clammy skin.
  - Limp body.
  - Lack of response to shouting.
- Receive education and training about take-home naloxone.

- Understand that using opioid agonist therapy (OAT), such as methadone or buprenorphine, can effectively prevent withdrawal and reduce cravings for opioids, thereby reducing the harms related to opioid use.

(Centre for Addiction and Mental Health, 2012; Centre for Addiction and Mental Health Provincial System Support Program, n.d.; Centre of Excellence for Women's Health, 2015; Taha, 2018)

In Practice:

Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder, Canadian Centre on Substance Use and Addiction (p. 4-5)

www.ccdus.ca/Resource%20Library/CCSA-Best-Practices-Treatment-Opioid-Use-Disorder-2018-en.pdf

Acknowledge and reduce stigma

An individual experiencing an opioid use disorder – and their families – can face discrimination, guilt, shame, and anxiety, which can contribute to low self-esteem, an unwillingness to ask for help, and feelings of fear when accessing support services (Herie et al., 2010; Substance Abuse and Mental Health Services Administration, n.d.-a; Substance Abuse and Mental Health Services Administration, 2016). Service providers and health care professional should be aware and mindful of how systemic racism and stereotypes can bias professional decision-making and impact service delivery and treatment of substance use when working with racialized communities.

It has been found that racialized communities, including African Canadians and Indigenous populations, experience mistrust because they are disproportionately charged, prosecuted, and incarcerated for drug-related offences (United Nations Human Rights, 2017). Race-related stereotypes pertaining to substance use have also been linked to disparities experienced by racialized communities in the child welfare system (Motherisk Commission, 2018).

One approach to reduce stigma is through language. Examples include:

- Using people-first language that focuses on the individual, not the action (e.g., "person who uses substances", not "drug user" or "addict").
- Using language that reflects the health and adaptive nature of substance use (e.g., recognizing substance use disorders as an illness or coping strategy, not a choice).
- Using language that is compassionate, open, honest, and non-judgmental.
- Using body language that is respectful (e.g., making eye contact) (BC Centre for Disease Control, 2017; Government of Canada, 2018; Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-b).

In Practice:

Changing how we talk about substance use, Government of Canada

www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma/stigmatips-talk-substance-use.html

Recognize sex and gender-based differences

Unlike illegal drugs, women use prescription opioids at equal or higher rates than men (Centre of Excellence for Women's Health, 2018-c). Women are more vulnerable to opioid use disorders for several reasons:

- Different patterns of health care: women visit health care providers more often, are more likely to be prescribed opioids, and are more likely to use prescription opioids.
- Differing experiences with chronic pain: women report more pain than men, which is related to differences in hormones and genetics, as well as how their bodies absorb and metabolize opioids.
- Histories of trauma and violence: some women have past or current experiences of violence and trauma, and resulting increased substance use.

(Centre of Excellence for Women's Health, 2015; Centre of Excellence for Women's Health, 2018-c; Substance Abuse and Mental Health Services Administration, n.d.-a)

A sex- and gender-specific approach can result in more effective treatment when it considers the specific needs, characteristics, and concurrent issues women may be facing (Niccols et al., 2010; Taha, 2018).

In Practice:

Women and Prescription Pain Medications, Centre of Excellence for Women's Health

www.bccewh.bc.ca/wp-content/uploads/2015/03/Women-Prescription.Pain_.Meds-infograph.Feb2014.pdf

Adopt trauma-informed practices

Trauma-informed care is a universal approach to providing services that are based on an understanding of the prevalence of many forms of trauma, and how experiences with trauma can affect an individual's ability to access and benefit from support (Substance Abuse and Mental Health Services Administration, n.d.-a).

Substance use is a very common response to trauma, and individuals who have experienced trauma are more likely to misuse substances, including prescription opioids (Centre for Addiction and Mental Health Provincial System Support Program, n.d.; Centre of Excellence for Women's Health, 2018-b; Niccols et al., 2010). Recognizing, accepting, and talking about trauma can help move away from stigma, guilt, and shame, and toward improved self-esteem, empowerment, and self-reliance (Best Start Resource Centre, 2015).

Trauma-informed services avoid re-traumatizing individuals by prioritizing safety, choice, and control. In practice, this includes:

- Providing welcoming spaces.
- Offering choice, voice, and control to all individuals accessing services.
- Creating physical, emotional, and cultural safety.
- Offering opportunities to learn wellness skills and coping skills for managing trauma responses.
- Providing information about the effects of trauma, and how to access trauma treatment in the community.
- Identifying and working with individual strengths.

(Centre of Excellence for Women's Health, 2018-b)

In Practice:

Trauma-Informed Practice & the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers, Centre of Excellence for Women's Health

www.bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

Acknowledge stages of change

Change, including change related to substance use behaviours, is a process that occurs in stages or cycles based on an individual's readiness (Prochaska & DiClemente, 1982). It is important for service providers and health care professionals to recognize readiness, and tailor the support they provide accordingly. The stages of change include:

- Pre-contemplation: the individual does not recognize a problem or the need to change.
- Contemplation: the individual has acknowledged that a problem exists but has mixed feelings about the need to change.
- Preparation: the individual decides to make a change in recognition of a problem.
- Action: the individual takes the initial steps to make a change.
- Maintenance: the individual is working on sustaining changes over time by incorporating new behaviours and habits into their life.
- Relapse: the individual returns to the previous behaviour, and can return to any of the previous stages of change.

There are different strategies that can be used to promote substance use change based on the stage an individual is in.

Stage	Recommend and encourage individuals to…
Pre-contemplation	• Keep track of their substance use including when they use, how much they use, how they were feeling, and who they were with. • Identify the benefits they receive from substance use, and what would be hard about reducing/stopping. • Consider if other people, such as friends, family members, and practitioners, are concerned with their substance use, and why they think others are concerned. • Consider completing an online questionnaire to determine if the substance use is problematic (Herie et al., 2010).
Contemplation	• Write down the pros and cons of changing their substance use. • Write down the pros and cons of not changing their substance use. • Reflect on what supports are needed to be able to change. • Think about how substance use impacts the things that are most important to them (Herie et al., 2010).
Preparation	• Set a goal for change. • Remind themselves of their reasons for making a change. • Get support from family, friends, and community services and programs. • Think about their strengths and the supports they have available to promote change (Herie et al., 2010).
Action	• Seek support in treatment. • Avoid people, places, and things that put them at risk of not achieving their substance use goals. • Celebrate small accomplishments. • Assess the effectiveness of change strategies. • Revise the initial goal(s) set during the preparation stage, if necessary (Herie et al., 2010; Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-a).
Maintenance	• Develop a proactive relapse prevention plan that includes recognizing triggers, noticing early warning signs, and identifying coping skills (Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-a; Ward, Wiseman & Barry, 2018).
Relapse	• Accept that relapse is a normal experience and should not be viewed negatively. • Review and reflect on the circumstances associated with the relapse. • Reassess and modify coping skills. • Seek out additional community or social supports if needed (Ward et al., 2018).

In Practice:

Enhancing Motivation for Change in Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment

Appendix B – University of Rhode Island Change Assessment Scale (URICA) (p. 226-229)

www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf_NBK64967.pdf

Enhance motivation

Motivation is a key component of substance use behaviour change. Research indicates that an individual's level of motivation is a very strong predictor of whether substance use behaviours will change or remain the same (Substance Abuse and Mental Health Services Administration, 2012).

Greater motivation is associated with positive treatment outcomes including:

- More successful referrals to treatment.
- Increased participation in treatment.
- Reduced consumption.
- Higher abstinence rates.
- Better social adjustments.

(Substance Abuse and Mental Health Services Administration, 2012; Taha, 2018)

Tips and strategies for supporting people to increase their motivation include:

- Focusing on an individual's strengths rather than weaknesses.
- Respecting an individual's autonomy and decisions.
- Ensuring treatment is individualized and client-centred.
- Avoiding stigmatizing language that results in depersonalization.
- Developing a therapeutic partnership.
- Using an empathetic approach that avoids power and authority.
- Recognizing that substance use disorders exist along a continuum.
- Acknowledging that individuals may have more than one substance use disorder, or coexisting disorders, that will affect the change process.
- Encouraging interim, incremental, and temporary steps toward ultimate treatment goals.
- Integrating substance use treatment into other disciplines.

(Substance Abuse and Mental Health Services Administration, 2012)

In Practice:

Enhancing Motivation for Change in Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment

www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf_NBK64967.pdf

Integrate care for concurrent disorders

Concurrent disorders refer to mental health and substance use disorders occurring together (Taha, 2018). Research shows that more than 50% of those seeking help for substance use disorders also have concurrent mental health conditions (Canadian Centre on Substance Abuse, 2009). This number increases to two-thirds for women, including conditions such as anxiety, depression, posttraumatic stress disorder, and panic disorder (Finnegan, 2013).

Substance use and mental health conditions can interact in many ways:

- Substance use can make mental health conditions worse.
- Substance use can mask symptoms of mental health conditions.
- Substances can be used to temporarily alleviate mental health conditions.
- Some substances can make mental health medications less effective.
- Relapse related to substance use can trigger mental health conditions, and relapse related to mental health conditions can trigger substance use.

(Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-c)

Recommended approaches for responding to concurrent disorders emphasize:

- Identifying concurrent disorders through screening and assessment.
- Providing integrated care that is tailored to the individual being treated.
- Establishing partnership and collaborative relationships between substance use and mental health programs.

(Substance Abuse and Mental Health Services Administration, n.d.-a; Taha, 2018)

In Practice:

Concurrent substance use and mental health disorders: An information guide, Centre for Addiction and Mental Health

www.camh.ca/-/media/files/guides-and-publications/concurrent-disorders-guide-en.pdf

Prescription Opioid Use and Pregnancy

Effects and risks

According to the most recent Canadian Tobacco, Alcohol and Drugs Survey results, 12% of women used prescription opioids in 2017.

Many women are prescribed opioids before they become pregnant and continue to use opioids during pregnancy (Centre of Excellence for Women's Health, 2018-c).

Prescription opioid use during pregnancy can result in both maternal and fetal risks (Klie, 2018; Lacaze-Masmonteil & O'Flaherty, 2018; Ordean et al., 2015; Ordean, 2018; Stanhope, Gill & Rose, 2013).

The use of prescription opioids can lead to an increased risk of:

- Miscarriage.
- Intra-uterine growth restriction.
- Low birth weight.
- Premature birth.
- Neonatal morbidity and mortality.

(Klie, 2018; Lacaze-Masmonteil & O'Flaherty, 2018; Ordean, 2018; Stanhope et al., 2013)

A newborn may experience signs of withdrawal when exposed to opioid use in-utero. This is known as Neonatal Abstinence Syndrome (NAS), or more recently, Neonatal Opioid Withdrawal (NOW). There are many factors that increase the risk for NAS/NOW and its severity including: the type, amount, and timing of exposure; whether there was exposure to other substances in addition to opioids; and whether the mother accessed prenatal care (Substance Abuse and Mental Health Services Administration, n.d.-a; Substance Abuse and Mental Health Services Administration, 2016). Researchers have reported that NAS/NOW can occur in 50-94% of newborns who experienced in-utero exposure to opioids (Canadian Institute for Health Information, 2018). More information about NAS/NOW is included in the next section: Opioid Use and Newborns.

Additionally, pregnant women who use opioids may fear being reported to social services, and having their children apprehended by child protection authorities (Klie, 2018). Accordingly, they may not access prenatal care, which can increase the risk of inadequate treatment for conditions such as pre-eclampsia/eclampsia, placenta previa, placenta accreta, bacteremia, endocarditis, sexually transmitted infections, or infectious disease (Klie, 2018). Additionally, opportunities for support referrals to community services and other assistance (e.g., housing, financial support) are missed.

Screen for opioid use and offer information

The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends that all pregnant women be asked periodically about alcohol, tobacco, and prescription and illicit drug use (Ordean, Wong & Graves, 2017). Pregnant women should be asked about their past and present substance use (including opioids) as early as possible in the pregnancy, and throughout the pregnancy (Provincial Council for Maternal and Child Health, 2016; World Health Organization, 2014).

Information, in the form of a brief intervention, should be offered to pregnant women who are using opioids (Ordean, Wong & Graves, 2017). A brief intervention is a patient-centred form of counselling using the principles of motivational interviewing (Centre of Excellence for Women's Health, 2018-a; Taha, 2018). During a brief intervention, the health care provider should engage in a collaborative conversation to explore motivation to change substance use, provide information about the impact and risks of opioid use, and offer strategies for reducing harm (Centre of Excellence for Women's Health, 2018-a; Substance Abuse and Mental Health Services Administration, 2016; Taha, 2018). During brief intervention, it is important that approaches are non-confrontational, recognize constraints that women may be experiencing, and offer practical supports while reducing stigma and shame (Centre of Excellence for Women's Health, 2018-a).

In Practice:

Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder, Canadian Centre on Substance Use and Addiction (p. 5)

www.ccdus.ca/Resource%20Library/CCSA-Best-Practices-Treatment-Opioid-Use-Disorder-2018-en.pdf

Increase motivation through motivational interviewing

Pregnancy offers a unique opportunity to positively impact opioid use because of the desire for most women to have a healthy pregnancy and a healthy infant (Johnson, n.d.; Klie, 2018; Ordean, 2018).

Motivational interviewing is a strengths-based approach that builds motivation for change, and is based on collaboration between a service provider and a client (Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-a; Substance Abuse and Mental Health Services Administration, 2012; Taha, 2018).

The foundational elements of motivational interviewing include:

- Collaboration: service provider acts as a partner that supports rather than persuades.
- Evocation: service provider helps the individual explore ideas and perspectives that shape reasons for change.
- Autonomy: service provider acknowledges that it is the responsibility of the individual to make change, and the service provider must respect the individual's choices.

(Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-a)

Service providers should understand and adhere to the following principles of motivational interviewing:

- Express empathy through reflective listening.
- Help a client consider the discrepancy between their goals or values and their current behaviour.
- Avoid argument and direct confrontation.
- Adjust to client resistance rather than oppose it directly.
- Support self-efficacy and optimism.

(Substance Abuse and Mental Health Services Administration, 2012)

Through motivational interviewing, a service provider recognizes and resists the "righting reflex" and instead focuses on empowering the client to identify and shift toward change (Canadian Centre on Substance Use and Addiction, 2017).

In Practice:

The Essentials of… Series – Motivational Interviewing, Canadian Centre on Substance Use and Addiction

www.ccsa.ca/Resource%20Library/CCSA-Motivational-Interviewing-Summary-2017-en.pdf

Encourage use of opioid agonist therapy

Opioid agonist therapy (OAT) is recommended for pregnant women who are using opioids (The College of Physicians and Surgeons of Ontario, 2011; Ordean et al., 2015; Ordean, Wong & Graves, 2017; Provincial Council for Maternal and Child Health, 2016; Taha, 2018; World Health Organization, 2014).

Prescribed medications, such as methadone or buprenorphine (including combined buprenorphine and naloxone), prevent opioid withdrawal, reduce opioid cravings, and result in improved maternal and neonatal outcomes (British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions & Perinatal Services B.C., 2018; Klaman et al., 2017; Ordean et al., 2015; Ordean, 2018; Provincial Council for Maternal and Child Health, 2016; Substance Abuse and Mental Health Services Administration, 2016).

There are many benefits of OAT, including:

- Decreased maternal opioid use and withdrawal symptoms.
- Increased likelihood of prenatal care, and resulting improvements to maternal health status.
- Reduced fetal stress.
- Reduced rates of prematurity, low birth weight, and infant mortality.
- Increased likelihood of maternal custody of baby at discharge.

(Klaman et al., 2017; Klie, 2018; Ordean, 2018)

Methadone and buprenorphine (including combined buprenorphine and naloxone) are safe and effective treatment options during pregnancy (Committee on Obstetric Practice, 2017; Taha, 2018).

Making a decision regarding treatment should be individualized to the woman, factoring in preferences, available community and social supports, previous treatment experiences, severity of opioid use, and intensity of treatment needed (British Columbia Centre on Substance Use, 2018; Klie, 2018). Detoxification during pregnancy should be avoided (Taha, 2018; World Health Organization, 2014).

It is important to highlight that OAT does not prevent the onset of NAS/NOW for infants after birth (Ordean et al., 2015).

In Practice:

Treatment of Opioid Use Disorder During Pregnancy Guideline Supplement, British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions & Perinatal Services BC (p. 14-18)

www.bccsu.ca/wp-content/uploads/2018/06/OUD-Pregnancy.pdf

Ensure access to comprehensive and multidisciplinary care

OAT should be provided as a component of comprehensive care that best meets the needs of women experiencing substance use disorder. This care includes prenatal care, education/skill building, counselling, and community support services (e.g., childcare, housing, employment, transportation services, peer support) (Johnson, n.d.; Milligan et al., 2011; Neger & Prinz, 2015; Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-d; Provincial Council for Maternal and Child Health, 2016; Taha, 2018).

Counselling should involve non-judgmental support and advice, motivation assessment, exploration of strategies for change, development of a holistic treatment plan, and appropriate referrals for additional support, where desired (Johnson, n.d.; Taha, 2018).

Research demonstrates that women attending comprehensive care and treatment programs have improved maternal outcomes (e.g., increased treatment adherence, more prenatal visits, improved nutrition, enhanced self-esteem) and improved neonatal outcomes (e.g., fewer preterm births, higher birth weight, fewer birth complications) (The College of Physicians and Surgeons of Ontario, 2011; Johnson, n.d.; Niccols et al., 2010; Ordean et al., 2013; Provincial Council for Maternal and Child Health, 2016).

In Practice:

Toronto Centre for Substance Use in Pregnancy (T-Cup), St. Joseph's Health Centre Toronto

www.stjoestoronto.ca/areas-of-care/addiction/toronto-centre-substance-use-pregnancy-t-cup/

Prepare parents for potential Neonatal Abstinence Syndrome (NAS)/ Neonatal Opioid Withdrawal (NOW)

Discussions should take place with pregnant women and their partners/families/supports regarding what to expect after their baby is born. Doing so will help them emotionally prepare for realistic outcomes associated with:

- Signs of NAS/NOW.
- Medical observation and extended time in the hospital.
- Promoting early attachment through rooming-in.
- Caring for a newborn with NAS/NOW.

(Centre of Excellence for Women's Health, 2017; Ordean, Wong & Graves, 2017; Ordean, 2018; Provincial Council for Maternal and Child Health, 2016)

In Practice:

A guide for parents of babies at risk of Neonatal Abstinence Syndrome, Hamilton Health Services Patient Education

www.hamiltonhealthsciences.ca/documents/Patient%20Education/NeonatalAbstinenceSyndromePlanningCare-lw.pdf

Opioid Use and Newborns

Effects and risks

Some infants exposed to opioid use in-utero will experience signs of withdrawal. This is called Neonatal Abstinence Syndrome (NAS), or more recently Neonatal Opioid Withdrawal (NOW).

Data from the Canadian Institute for Health Information demonstrates that the prevalence of NAS/NOW is on the rise. Across Canada, the rate of hospitalization for NAS/NOW has increased by 21% from 2013-2017. In 2017, more than 1,900 infants received treatment in hospital related to NAS/NOW (Canadian Institute for Health Information, 2018).

Infants with NAS/NOW are not born "addicted" to opioids (Substance Abuse and Mental Health Services Administration, 2016). They have developed a physical dependence after exposure in-utero (including exposure to OAT) (Ordean, 2018). Newborns may show signs of withdrawal after birth. The presentation, severity, and duration of withdrawal symptoms vary depending on a variety of factors: the opioids exposed to; the frequency, dose, and timing of last exposure; and maternal use of other substances (Klaman et al., 2017; Lacaze-Masmonteil & O'Flaherty, 2018). Signs of withdrawal typically appear shortly after birth, with the majority exhibited within the first 72 hours (Lacaze-Masmonteil & O'Flaherty, 2018). Signs of withdrawal may also appear two to four weeks after birth and may last several weeks or months (Centre for Addiction and Mental Health, 2016).

NAS/NOW is characterized by the following signs, which are treatable:

- Central nervous system: seizures, tremors, high-pitched crying, increased muscle tone, irritability, exaggerated startle reflex, exaggerated rooting reflex, and uncoordinated sucking and swallowing mechanism.
- Autonomic nervous system: sneezing, yawning, skin colour changes, increases in temperature, sweating, and shedding of tears.
- Gastrointestinal system: regurgitation, projectile vomiting, loose stools, and poor intake resulting in dehydration, excessive weight loss, electrolyte imbalance, shock, coma, and death.
- Respiratory system: excessive secretions and nasal stuffiness, blue colouring of the lips and fingertips, and respiratory distress causing aspiration, and apnea.

(Finnegan, 2013; Ordean, 2018)

Because NAS/NOW can be life-threatening if not identified and treated, it is important that opioid use be disclosed to a service provider or health care professional prior to the infant's birth.

Ongoing newborn assessment

Infants who were exposed to opioids while in-utero should be assessed for signs of NAS/NOW using a standardized scoring tool (Provincial Council for Maternal and Child Health, 2016). An example is the Finnegan scoring system, which identifies behaviours associated with withdrawal including central nervous system disturbances, metabolic/vasomotor/respiratory disturbances, and gastro-intestinal disturbances (Lacaze-Masmonteil & O'Flaherty, 2018). Another option is the Eat, Sleep, Console approach, which identifies that NAS/NOW is well managed if an infant:

(1) eats more than one ounce per feed/breastfeeds well;

(2) sleeps undisturbed for greater than one hour;

(3) is consolable, when crying, within ten minutes (Grossman et al., 2018).

An assessment should be completed every two to four hours, for a minimum of 72 hours (120 hours if in-utero exposure to methadone or buprenorphine) (Provincial Council for Maternal and Child Health, 2016). Results from the assessment will help determine appropriate interventions to prevent complications associated with NAS/NOW, and restore normal newborn activities (e.g., sleep, sufficient feeding, weight gain, environmental adaptations) (Lacaze-Masmonteil & O'Flaherty, 2018).

In Practice:

A Novel Approach to Assessing Infants with Neonatal Abstinence Syndrome, Grossman, Lipshaw, Osborn & Berkwitt

www.doi.org/10.1542/hpeds.2017-0128

Use of rooming-in to promote non-pharmacological treatment

The goal of NAS/NOW treatment is to reduce and soothe the signs of withdrawal. To improve health outcomes, the Canadian Paediatric Society recommends keeping mothers and newborns together. In addition to developing hands-on parenting skills and promoting integral early attachment, rooming-in also results in:

- Lower Neonatal Intensive Care Unit (NICU) admissions.
- Higher breastfeeding initiation rates.

- Shortened hospital stays.
- Decreased need for prescription medications.

(Canadian Institute for Health Information, 2018; Lacaze-Masmonteil & O'Flaherty, 2018; Provincial Council for Maternal and Child Health, 2016)

In Practice:

Neonatal Abstinence Syndrome (NAS) Clinical Practice Guidelines, Provincial Council for Maternal and Child Health

www.pcmch.on.ca/wp-content/uploads/2016/12/NAS-Clinical-Guideline-Update-2016Nov25.pdf

Non-pharmacological interventions that should be implemented as soon as possible following birth include:

- Breastfeeding.
- Skin-to-skin contact.
- Safe swaddling.
- Gentle waking and handling.
- Quiet environments.
- Low lighting.
- Minimal stimulation.
- Frequent feedings.
- Non-nutritive sucking.

(British Columbia Centre on Substance Use, 2018; Finnegan, 2013; Klaman et al., 2017; Lacaze-Masmonteil & O'Flaherty, 2018; Ordean, 2018; Provincial Council for Maternal and Child Health, 2016)

If non-pharmacological treatment does not improve signs of NAS/NOW, pharmacological therapy should be considered (e.g., morphine) (Lacaze-Masmonteil & O'Flaherty, 2018; Ordean, 2018; Provincial Council for Maternal and Child Health, 2016).

Support with breastfeeding

Breastfeeding is beneficial for all babies, and can improve NAS/NOW in opioid-exposed infants by:

- Decreasing the severity of NAS/NOW signs.
- Decreasing the need for pharmacological treatment.
- Increasing bonding between mother and infant.

(Finnegan, 2013; Lacaze-Masmonteil & O'Flaherty, 2018; Provincial Council for Maternal and Child Health, 2016; Welle-Strand et al., 2013)

Methadone and buprenorphine are considered safe while breastfeeding, as these medications enter the breast milk in very small amounts (The College of Physicians and Surgeons of Ontario, 2011; Finnegan, 2013; Klaman et al., 2017; Ordean, Wong & Graves, 2017; Taha, 2018). However, because infants with NAS/NOW have trouble coordinating their sucking and swallowing reflexes, there may be challenges with breastfeeding (Finnegan, 2013; Lacaze-Masmonteil & O'Flaherty, 2018).

Women using OAT are also less likely to initiate breastfeeding successfully, and more likely to stop breastfeeding early (Klaman et al., 2017; Lacaze-Masmonteil & O'Flaherty, 2018). Accordingly, women should be supported and encouraged.

Referral to an International Board Certified Lactation Consultant is recommended to provide assistance with breastfeeding (Patel & Patel, 2016).

In Practice:

Find a Lactation Consultant, Canadian Lactation Consultant Association

www.clca-accl.ca/Find-an-IBCLC-in-your-area

Individualized discharge planning

The length of time an infant with NAS/NOW will spend in the hospital is dependent on the signs present, their severity, and the treatment necessary. Infants should be observed for a minimum of 72 hours (Lacaze-Masmonteil & O'Flaherty, 2018). When an infant is eligible for discharge following the necessary assessment, a discharge plan should be developed that includes:

- Continuity of care by an interprofessional team (e.g., team members specialized in nursing, neonatal medicine, social work, pharmacy, and nutrition).
- Referral to a primary health care provider familiar with NAS/NOW.
- Identification of community supports (e.g., substance use disorder treatment programs, public health, child and youth services, a lactation consultant, a community support worker, infant development programs, parenting support groups).
- Availability of a supportive and safe home environment.

(Lacaze-Masmonteil & O'Flaherty, 2018; Provincial Council for Maternal and Child Health, 2016)

In Practice:

Neonatal Abstinence Syndrome (NAS) Clinical Practice Guidelines, Provincial Council for Maternal and Child Health

Appendix C – Algorithm for Assessment and Care of Infants at Risk of Neonatal Abstinence Syndrome (p. 20)

www.pcmch.on.ca/wp-content/uploads/2016/12/NAS-Clinical-Guideline-Update-2016Nov25.pdf

Parental preparation for ongoing NAS/NOW signs

It is possible for some signs of NAS/NOW to last for several weeks (e.g., irritability, constant sucking and exaggerated rooting reflex, increased muscle tone, sweating, sensitivity to sounds, lessened response to visual stimulation, high-pitched crying, irregular sleep patterns, loose stools) (Finnegan, 2013). Accordingly, parents should be informed of the supportive measures below that can help calm an infant experiencing NAS/NOW signs:

- Skin-to-skin contact.
- Safe swaddling.
- Frequent feeding.
- Non-nutritive sucking.
- Decreased stimulation (e.g., low light and low noise).
- Gentle handling.
- Appropriate dressing to avoid overheating.

(British Columbia Centre on Substance Use, 2018; Finnegan, 2013; Lacaze-Masmonteil & O'Flaherty, 2018; Ordean, 2018)

In Practice:

A guide for parents of babies at risk of Neonatal Abstinence Syndrome, Hamilton Health Services Patient Education

www.hamiltonhealthsciences.ca/documents/Patient%20Education/NeonatalAbstinenceSyndromePlanningCare-lw.pdf

Opioid Use and Parenting

Effects and risks

Parental substance use can impact children both indirectly (e.g., chaotic living environment, issues with food, housing, and financial security) and directly (e.g., safety concerns, neglect, abuse) (Child Welfare Information Gateway, 2014; Niccols et al., 2010; Ordean, 2018). However, it is important to recognize that not all children of parents who use substances will experience negative outcomes (Child Welfare Information Gateway, 2014). Additionally, research has shown that when mothers receive support early in the postnatal period, there are improved outcomes for both mother and child (Child Welfare Information Gateway, 2014).

Below are some examples of the ways in which substance use can affect children:

- Children of parents with substance use disorders may lack basic nutrition, hygiene, and medical needs due to the impact substance use can have on parent's memory, attention and perception (Child Welfare Information Gateway, 2014; Substance Abuse and Mental Health Services Administration, n.d.-b).
- Children may be exposed to dangerous and traumatic situations, such as being left alone while parents use substances, having access to substances that have not been stored or disposed of properly, or being present while parents buy or sell substances (Centre of Excellence for Women's Health, 2017; Substance Abuse and Mental Health Services Administration, n.d.-a; Substance Abuse and Mental Health Services Administration, n.d.-b).
- Children may experience poor cognitive, social, and emotional development (e.g., communication difficulties, anxiety, depression, trauma, inability to regulate emotions, future substance use) as a result of diminished parenting behaviours and attachment disturbances (e.g., lack of parental engagement and interaction, difficulty controlling anger and impulsivity, estrangement from family and other social supports, an inability to provide a stable home life) (Child Welfare Information Gateway, 2014; Niccols et al., 2010; Ordean, 2018; Substance Abuse and Mental Health Services Administration, n.d.-a).
- Children may feel stress, anxiety, guilt, shame, or self-blame connected to a parent's substance use.

(Substance Abuse and Mental Health Services Administration, n.d.-a; Substance Abuse and Mental Health Services Administration, n.d.-b)

Include family-centred treatment services

Family-centred treatment is a comprehensive strategy that works with families by recognizing the strengths of family relationships, and addressing the roles and needs of all family members to achieve optimal outcomes (Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-d; Substance Abuse and Mental Health Services Administration, n.d.-a; Taha, 2018).

Programs that accommodate families are more successful in establishing trust, engaging mothers, increasing the safety of children, and reducing family risk factors (Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-d; Substance Abuse and Mental Health Services Administration, n.d.-a).

An ideal treatment program targets a parent's opioid use disorder, while strengthening family relationships (Neger & Prinz, 2015; Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-d). Example program components include:

- Providing treatment for the opioid use disorder (e.g., opioid agonist therapy) and any concurrent disorders (Ordean, 2018; Substance Abuse and Mental Health Services Administration, n.d.-a; Taha, 2018).
- Supporting positive mental health for children and adults to enhance resilience (Substance Abuse and Mental Health Services Administration, n.d.-b).
- Empowering parents to develop positive parenting skills (e.g., attachment-based parent-child interventions) (Neger & Prinz, 2015; Substance Abuse and Mental Health Services Administration, n.d.-b).
- Assisting with relapse prevention through counselling (e.g., identifying coping skills, recognizing triggers and early warning signs).

(Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health, n.d.-a; Ordean, 2018; Taha, 2018; Ward et al., 2018)

In Practice:

Breaking the Cycle, Mothercraft

www.mothercraft.ca/index.php?q=ei-btc

Integrate elements of effective parenting programs

Parenting programs have the ability to build the protective capacity of parents (Neger & Prinz, 2015; Substance Abuse and Mental Health Services Administration, n.d.-a). The following elements are typically included in effective parenting programs:

- Structured curriculum informed by principles of social-learning and attachment theories.
- Relationship-enhancing strategies for both children and parents.
- Strong and productive therapeutic alliances with the parent.
- Use of role-play and at-home practice to develop skills.
- Relevant information pertaining to child development and mental health.
- Focus on parent and child progress.
- Strategies to maintain parent engagement.
- Use of praise and reward to increase positive behaviour.
- Program delivery by appropriately trained group leader and facilitators.

(Barth & Liggett-Creel, 2014; Substance Abuse and Mental Health Services Administration, n.d.-a)

In Practice:

Canadian Best Practices Portal, Public Health Agency of Canada

www.cbpp-pcpe.phac-aspc.gc.ca/

Focus on social support

A strong social support network can reduce social stressors, buffer risks, and provide increased support to families (Child Welfare Information Gateway, 2014; Ordean, 2018). Developing social connections, and establishing community supports can promote protective factors that diminish the risks of substance use disorders (Child Welfare Information Gateway, 2014; Taha, 2018).

For an individual with a substance use disorder, social support can provide:

- A sense of belonging and inclusion.
- A sense of safety and security.
- Hope and optimism about the future.
- Reduced feelings of shame, isolation, and loneliness.

(Horvath, Misra, Epner & Cooper, n.d.)

In Practice:

EarlyON Child and Family Centres

www.ontario.ca/page/find-earlyon-child-and-family-centre

Enhance household safety

Emphasize to parents that prescription opioids are extremely dangerous for children, and that children should not have access to medication. This can be achieved by:

- Keeping prescription opioids in a safe place where children cannot reach them.
- Returning unused prescription opioids and used medication patches to a pharmacy for safe disposal.
- Talking to older children about the risks of prescription opioids.
- Seeking medical attention right away if a child accidently ingests medication.

(Centre of Excellence for Women's Health, 2017)

In Practice:

Safe Storage and Disposal of Medications, Institute for Safe Medication Practices Canada

www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-06-StorageDisposal.pdf

Parental preparation for sharing information with older children

A parent with a substance use disorder may need information about how to talk to older children about their substance use.

The following talking points can serve as a guide for parents:

- Addiction is a disease. Explain that substance use is a complex situation influenced by many factors that are not always in the parent's control. Provide information that is appropriate to the child's age and maturity.
- The child is not responsible. Emphasize that the child is not the reason the parent uses substances, and that the child should not feel responsible for stopping their parent's use.
- The child is not alone. Explain that the child's situation is not unique, and that there are many children going through similar experiences.
- Support is available. Highlight that there are people the child can talk to about their experiences, such as a trusted adult or peer support group, and that they shouldn't feel scared, embarrassed, or ashamed.

(Substance Abuse and Mental Health Services Administration, n.d.-a)

In Practice:

Parent Talk Kit, Partnership for Drug-Free Kids

www.drugfree.org/medicine-abuse-project/resources/

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Barth R. P. & Liggett-Creel K. (2014). Common components of parenting programs for children birth to eight years of age involved with child welfare services. *Children and Youth Services Review,* 40, 6–12. https://doi.org/10.1016/j.childyouth.2014.02.004

BC Centre for Disease Control. (2017). Language matters: reduce stigma, combat overdose. Retrieved from www.bccdc.ca/about/news-stories/news-releases/2017/language-matters

Best Start Resource Centre. (2015). *A Facilitator's Guide: Planning a First Nations Workshop for Parents*. Toronto, Ontario, Canada.

British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions & Perinatal Services BC. (2018). A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement. Retrieved from http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/OUD-Pregnancy.pdf

Canadian Centre on Substance Abuse. (2009). Substance abuse in Canada: concurrent disorders. Ottawa, ON: Canadian Centre on Substance Abuse. Retrieved from www.ccsa.ca/Resource%20Library/ccsa-011811-2010.pdf

Canadian Centre on Substance Use and Addiction. (2017). The Essentials of… Series: Motivational Interviewing. Retrieved from www.ccsa.ca/Resource%20Library/CCSA-Motivational-Interviewing-Summary-2017-en.pdf

Canadian Institute for Health Information. (2018). *Opioid-Related Harms in Canada*. Retrieved from https://secure.cihi.ca/free_products/opioid-related-harms-report-2018-en-web.pdf

Centre for Addiction and Mental Health. (2012). Do You Know… Prescription Opioids. Retrieved from www.camh.ca/-/media/files/guides-and-publications/dyk-prescription-opioids.pdf

Centre for Addiction and Mental Health. (2016). Making the Choice, Making It Work: Treatment for Opioid Addiction. Retrieved from: www.camh.ca/-/media/files/guides-and-publications/making-choice-en.pdf

Centre for Addiction and Mental Health Provincial System Support Program. (n.d.). Preventing opioid overdose. Retrieved from www.camh.ca/-/media/files/preventing-opioid-overdose-pdf.pdf

Centre of Excellence for Women's Health. (2015). Women, Girls, and Prescription Medication. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2015/09/CRISM-Report-21-Aug-2015.pdf

Centre of Excellence for Women's Health. (2017). *Women and Prescription Opioids*. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2018/03/InfoSheet-Women-Opioids0308.pdf

Centre of Excellence for Women's Health. (2018-a). *D*oorways to Conversation: Brief Intervention on Substance Use with Girls and Women. Retrieved from: http://bccewh.bc.ca/wp-content/uploads/2018/06/Doorways_ENGLISH_July-18-2018_online-version.pdf

Centre of Excellence for Women's Health. (2018-b). Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

Centre of Excellence for Women's Health. (2018-c). Women and Opioids Media Guide. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2018/05/CanFASD_WomenAndOpiods_180504_1504_MediaGuide.pdf

Committee on Obstetric Practice, American Society of Addiction Medicine. (2017). ACOG Committee Opinion Number 711: Opioid Use and Opioid Use Disorder in Pregnancy. Retrieved from www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf

Finnegan, L. (2013). *Licit and Illicit Drug Use During Pregnancy: Maternal, Neonatal and Early Childhood Consequences.* Retrieved from www.ccsa.ca/Resource%20Library/CCSA-Drug-Use-during-Pregnancy-Report-2013-en.pdf

Government of Canada. (2018). Changing how we talk about substance use. Retrieved from https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma/stigmatips-talk-substance-use.html

Grossman, M. R., Lipshaw, M. J., Osborn, R. R., & Berkwitt, A. K. (2018). A novel approach to assessing infants with neonatal abstinence syndrome. Hospital Pediatrics, 8(1). https://doi.org/10.1542/hpeds.2017-0128

Herie, M., Godden, T., Shenfeld, J. & Kelly, C. (2010). Addiction: An information guide. Retrieved from www.camh.ca/-/media/files/guides-and-publications/addiction-guide-en.pdf

Horvath, T., Misra, K., Epner, A. K. & Cooper, G. M. (n.d.). Recovery from Addiction: Social Support. Retrieved from https://www.mentalhelp.net/articles/social-learning-theory-and-addiction/

Johnson, C. (n.d.). Treatment of Opioid Use Disorder during Pregnancy [PowerPoint slides]. Retrieved from http://interprofessional.ubc.ca/files/2018/03/B4iii_Johnson.pdf

Klaman, S. L., Isaacs, K., Leopold, A., Perpich, J., Hayashi, S., Vender, J., Jones, H. E. (2017). Treating women who are pregnant and parenting for opioid use disorder and the concurrent care of their infants and children: Literature review to support national guidance. Journal of Addiction Medicine, 11(3), 178-190. https://doi.org/10.1097/ADM.0000000000000308

Klie, K. (2018). Substance Use in Pregnancy and Breastfeeding: Opioids & Marijuana [PowerPoint slides]. Retrieved from https://injoyhealtheducation.com/substance-use-pregnancy-and-breastfeeding/

Lacaze-Masmonteil, T. & O'Flaherty, P. (2018). Managing infants born to mothers who have used opioids during pregnancy. Retrieved from www.cps.ca/en/documents/position/opioids-during-pregnancy

Leyton, M., & Stewart, S. (Eds.). (2014). Substance abuse in Canada: Childhood and adolescent pathways to substance use disorders. Retrieved from www.ccsa.ca/Resource%20Library/CCSA-Child-Adolescent-Substance-Use-Disorders-Report-2014-en.pdf

Milligan, K., Niccols, A., Sword, W., Thabane, L., Henderson, J. & Smith, A. (2011). Birth outcomes for infants born to women participating in integrated substance abuse treatment programs: A meta-analytic review. Addiction Research & Theory, 19(6), 542-555. https://doi.org/10.3109/16066359.2010.545153

National Institute on Drug Abuse. (2016). Chapter 2: Risk and Protective Factors. *In Principles of Substance Abuse Prevention for Early Childhood* (pp. 21-32). Retrieved from: www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/chapter-2-risk-protective-factors

Neger, E. N. & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review*, 39, 71-82. https://doi.org/10.1016/j.cpr.2015.04.004

Niccols, A., Milligan, K., Sword, W., Thabane, L., Henderson, J., Smith, A., Jack, S. (2010). Maternal mental health and integrated programs for mothers with substance abuse issues. *Psychology of Addictive Behaviors*, 24(3), 466-474. https://doi.org/10.1037/a0020139

Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health. (n.d.-a). Module 3 – Engaging with caregivers. Supporting Families Affected by Substance Misuse [Program of studies]. Toronto, Ontario: Ontario Association of Children's Aid Societies.

Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health. (n.d.-b). Module 4 – Stigma, power relations and family strength. Supporting Families Affected by Substance Misuse [Program of studies]. Toronto, Ontario: Ontario Association of Children's Aid Societies.

Ontario Association of Children's Aid Societies & Centre for Addiction and Mental Health. (n.d.-c). Module 5 – Assessment for substance misuse and other concerns. Supporting Families Affected by Substance Misuse [Program of studies]. Toronto, Ontario: Ontario Association of Children's Aid Societies.

Ordean, A., Kahan, M., Graves, L., Abrahams, R., & Boyajian, T. (2013). Integrated care for pregnant women on methadone maintenance treatment: Canadian primary care cohort study. *Canadian Family Physician,* 59(10), e462-e469. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC3796993/pdf/059e462.pdf

Ordean, A., Kahan, M., Graves, L., Abrahams, R., & Kim, T. (2015). Obstetrical and neonatal outcomes of methadone-maintained pregnant women: A Canadian Multisite Cohort Study. *Journal of Obstetrics and Gynaecology Canada, 37(3), 252-257*. https://doi.org/10.1016/S1701-2163(15)30311-X

Ordean, A., Wong, S., & Graves, L. (2017). SOGC Clinical Practice Guidelines No. 349-Substance Use in Pregnancy. *Journal of Obstetrics and Gynaecology Canada, 39(10), 922-937 e2*. https://doi.org/10.1016/j.ogc.2017.04.028

Ordean, A. (2018). Supporting women and families of newborns with opioid-related neonatal abstinence syndrome [PowerPoint slides]. Retrieved from https://en.beststart.org/past-events/webinar-SupportingWomenAndFamiliesOfNewbornsWithOpioidRelatedNeonatalAbstinenceSyndrome-25Jul2018

Patel, S. & Patel, S. (2016). The effectiveness of lactation consultants and lactation counselors on breastfeeding outcomes. *Journal of Human Lactation, 32(3), 530-541*. https://doi.org/10.1177/0890334415618668

Prochaska, J. O. & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, 19(3), 276-288. http://dx.doi.org/10.1037/h0088437

Provincial Council for Maternal and Child Health. (2016). Neonatal Abstinence Syndrom (NAS) Clinical Practice Guidelines. Retrieved from www.pcmch.on.ca/wp-content/uploads/2016/12/NAS-Clinical-Guideline-Update-2016Nov25.pdf

Stanhope, T. J., Gill, L. A. & Rose, C. (2013). Chronic opioid use during pregnancy: Maternal and fetal implications. *Clinics in Perinatology,* 40(3), 337-350. http://doi.org/10.1016/j.clp.2013.05.015

Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment. (n.d.-a). Tutorial 1: Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals. Retrieved from https://ncsacw.samhsa.gov/training/

Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment. (n.d.-b). Tutorial 2: Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals. Retrieved from https://ncsacw.samhsa.gov/training/

Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment. (2012). Enhancing Motivation for Change in Substance Abuse Treatment. Retrieved from www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf_NBK64967.pdf

Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment. (2016). A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Retrieved from https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Substance Abuse and Mental Health Services Administration, Centre for Substance Abuse Treatment. (2018). Adverse Childhood Experiences. Retrieved from www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

Taha, S. (2018). Best Practices across the Continuum of Care for Treatment of Opioid Use Disorder. Retrieved from https://www.drugsandalcohol.ie/29621/

The College of Physicians and Surgeons of Ontario. (2011). Methadone Maintenance Treatment Program Standards and Clinical Guidelines. Retrieved from https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/assessments/mmt-guidelines.pdf

United Nations Human Rights, Office of the High Commissioner. (2017). Report from the Committee on the Elimination of Racial Discrimination. Retrieved from https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fCAN%2fCO%2f21-23&Lang=en

Ward, A., Wiseman, J. & Barry, K. (2018). Relapse Prevention Planning with Parents with Co-Occurring Disorders in Child Welfare (Practice Notes 31). Retrieved from https://cascw.umn.edu/portfolio-items/relapse-prevention-planning_pn31/

Welle-Strand, G. K., Skurtveit, S., Jansson, L. M., Bakstad, B., Bjarkø, L., & Ravndal, E. (2013). Breastfeeding reduces the need for withdrawal treatment in opioid-exposed infants. ACTA Paediatrica, 102(11), 1060-1066. https://doi.org/10.1111/apa.12378

World Health Organization. (2014). Guidelines for the identification and management of substance use and substance use disorders in pregnancy. Retrieved from https://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/

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