The Magnitude of the Opioid Epidemic and What We Can Do to Help

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For the past several months, I have been struggling trying to understand the magnitude of the opioid epidemic in the United States. I have been reading articles in the literature and in the newspapers, listening to discussions on National Public Radio, and talking with my colleagues. More recently, the Illinois Perinatal Quality Collaborative is organizing a Quality Improvement project to help mothers with a substance use disorder and their newborns who are passively addicted—the Mothers and Newborns affected by Opioids Initiative. The American Academy of Pediatrics (AAP) has produced fact sheets1 that include the following to provide perspective:

• 8.7 million children have a parent who suffers with a substance disorder
• 270,000+ children were placed in foster homes in 2016 and in more than one-third of those placements, parental substance use was a factor
• Every 25 minutes a newborn baby is suffering from opioid withdrawal, which can mean lower birth weight, feeding problems, respiratory problems, seizures, and longer length of stay in a hospital
• These traumatic experiences or adverse childhood experiences can lead to school failure, risky behaviors like alcohol and drug use, and increase a child’s chances of health conditions like obesity and heart disease

What do pediatric providers need to know to help their patients and families deal with this overwhelming problem?

It appears that more of the problem is secondary to ingestion of prescription opioids: unintentionally (by children younger than age 5 years) and intentionally (as young adolescents). According to Kane et al.,2 one-third of opioid-related hospitalizations occurred in children younger than age 6 years. In this study, 47% of children and teenagers exposed to buprenorphine were admitted to a health care facility. Teenagers have a greater likelihood of serious medical outcomes and the prescription-related opioid suicide rate in this group increased by 52.7% during the study period (2000-2015).3

What should pediatric professionals be doing to help our patients and their families?

1. We should educate ourselves and become involved with the assessment and management of the neonatal abstinence syndrome (NAS). It is important to ask pregnant women if they are taking prescription or other opioids and to have a treatment plan for mothers and their newborn infants.3-6 It is essential that newborn nursery settings in hospitals have structured guidelines for assessment and management of these infants, and that mother and baby be thought of as a maternal-infant dyad.6-8 The modified Finnegan score is the most commonly used tool for newborn NAS assessment; there is also a tool called the “eat-sleep-console” strategy.6,7

Infants with passive addiction to opioids usually become symptomatic 2 to 5 days after delivery.7 Newborn assessment is performed serially every 2 to 4 hours. Once it is decided that phar-
macologic management is necessary, the guideline approved by the pharmacy, therapeutics committee, and the providers should be in place and followed closely.  

2. Education and support of the mother and family is also very important. We should work to think of addiction as a chronic disease or illness and to be cognizant to rework our attitudes to minimize stigma and bias.

3. Ongoing support of the maternal-infant dyad after hospital discharge to facilitate the transition is vital. As having a newborn infant and making the adjustment is challenging when the mother and infant are otherwise healthy, dealing with the transition under difficult clinical circumstances is much more challenging and will require close follow up and ongoing communication.

4. Because most of the opioid epidemic stems from intake of prescription opioids and the over-prescribing of them, let us remember to discuss safe storage and disposal of prescription opioids with our patients and their families. Because a significant proportion of opioid overdoses in children occur in children younger than age 5 years, it makes sense to remind our families of that fact. Opioid substance use among teenagers and subsequent overdoses from the drug are typically initiated from an opioid prescription for pain. The AAP recommends screening adolescents for opioid use, and reported in 2016 that 1 in 13 high school seniors indicated nonprescription opioid use. The screening could be in the context of the HEADS (home, education/employment, activities, drugs, sexuality, suicide/depression) assessment, especially if there has been a change in grades or personality.

5. Then there is the transition from prescription opioids to heroin and other addictive drugs. Heroin and related drugs are accessible and overdose of these highly addictive drugs in adolescents (and for that matter in their parents) is more common. There is active discussion among providers and the US government that naloxone nasal spray be available to help patients with opioid overdose emergencies at the scene; there is a program where a concerned person can go to a pharmacy and purchase naloxone and receive an inservice about how to administer it.

REFERENCES