

Specific Population Groups

In this section you will...

- Gain an understanding of how to deal with and manage clients from specific population groups.

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11 Specific Populations Receiving Opioid Pharmacotherapy

As stated throughout this document, a significant proportion of clients who present for opioid pharmacotherapy treatment will often have multiple and complex presentations. Sections 4 and 5 discuss many of these complexities in the context of treatment contraindications and precautions and assessing for risk and protective factors. The following section provides more detailed recommendations regarding specific population groups.

11.1 Comorbid Mental Health Disorders

Opioid dependent clients often present with comorbid mental health disorders, including mood disorders (e.g. depression or bipolar disorder), anxiety disorders (e.g. generalised anxiety disorder or post traumatic stress disorder) and other serious mental illnesses (e.g. psychotic disorders). It is often difficult to distinguish whether the comorbid mental health concerns commenced prior to, or as a result of, harmful drug use. Regardless of the direction of the causal link, clinicians should:

- aim to gain insight into and assess the client's presenting psychological issues;
- liaise with and seek advice from appropriately trained clinicians who have experience in working in mental health; and
- liaise with or refer to Mental Health Services when working with clients with chronic and enduring or severe psychiatric comorbidities.

It may be difficult to determine a client's mental state when they first enter the opioid pharmacotherapy program. After several weeks on the program it may be easier to determine their mental state and assess for the presence of perceptual or mood disturbances in the absence of erratic drug use. Therefore, it is important to monitor the client's mental state, especially during the early phases of treatment and induction.

11.1.1 Depression

Recommendations for the treatment of moderate to severe depression usually include cognitive behavioural therapy in combination with antidepressant medication. Indeed, depression has been linked to poor psychosocial outcomes and increased rates of relapse to unsanctioned opioid use in opioid dependent clients (Havard, 2006). However, combining antidepressants with opioid pharmacotherapy can pose risks to safety, as drugs such as fluvoxamine and tricyclic antidepressants can interact with opioids (see appendices for drug interactions). This needs to be taken into consideration when developing a treatment plan for such clients.

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Some antidepressant medications can have drug interactions effects when used in combination with opioids.

11.1.2 Anxiety

While some clients report only experiencing anxiety symptoms soon after using substances, there is evidence that substance use can also result in the development of longer term anxiety symptoms. Among opioid pharmacotherapy clients, it is common for clients with anxiety issues to have an anxiety disorder such as Post Traumatic Stress Disorder (PTSD), Panic Disorder and Generalised Anxiety Disorder (GAD) (Marsh & Dale, 2006).

The 2007 National Survey of Mental Health and Wellbeing (ABS, 2008) reported markedly higher rates of recent experience of both affective and anxiety disorders amongst people who regularly use drugs, in comparison with the general Australian population. The prevalence of affective disorders in the general population was estimated to be 6%, whereas amongst participants reporting regular drug use, this rate was 31%. Similarly, the estimated rate of anxiety disorders amongst the general population was 14%, and 38% amongst people regularly using drugs (ABS, 2008).

The coexistence of these types of disorders with substance disorders is important to consider as they can maintain and reinforce one another, particularly if left untreated.

Cognitive behavioural strategies such as goal setting and problem solving are recommended in the literature for treatment of anxiety disorders. Clients with anxiety are more likely to be prescribed benzodiazepines for the management of their anxiety symptoms. However, this is not considered appropriate as benzodiazepines have high dependence potential and can result in overdose when combined with other central nervous system depressants (Marsh & Dale, 2006). For these reasons benzodiazepines are not recommended for people who are drug dependent or have a history of dependence.

Treatment with benzodiazepines may place the opioid pharmacotherapy client at greater risk of overdose, falls, accidents and cognitive impairment. Access to an allied health professional who is able to provide psychological intervention and can assist the client to develop anxiety management skills and promote resilience is recommended.

Treatment of anxiety disorders with benzodiazepines for people who are drug dependent or have a history of dependence is not recommended by the Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards.

11.1.3 Psychotic Disorders

For clients with chronic and enduring serious mental illnesses, a shared care arrangement involving mental health services is recommended (see Section 3 for a discussion on shared care). If a client is receiving treatment for a psychotic illness, it is important to be aware of treatment compliance or non-attendance with their mental health service provider. If there are concerns about non-compliance, the opioid pharmacotherapy clinician should:

- actively liaise with the client's mental health key worker;
- encourage the client to adhere to their mental health treatment plan;
- increase the frequency of review; and
- review access to takeaway doses.

If clients are actively psychotic at any phase of the program it will affect their ability to consent to treatment and to adhere to the treatment plan. In such cases, the preference is to manage the psychotic illness first and then reassess for suitability on the opioid pharmacotherapy program once mental state is stable and managed by mental health professionals.

If a client with a well managed psychotic disorder experiences a deterioration of mental state resulting in an acute psychotic episode, the opioid pharmacotherapy clinician should:

- review takeaway dose arrangements;
- switch to daily dosing;
- increase frequency of review;
- engage in assertive follow up; and
- continue monitoring risks.

Finally, when clients are coming off the opioid pharmacotherapy program, there is an increased risk of exacerbation of positive symptoms as their pharmacotherapy dose decreases. To manage this risk, antipsychotic medication, and frequency of review by their mental health practitioner, may need to be increased. Hence, it is essential to inform the client's mental health practitioner about plans for opioid pharmacotherapy treatment cessation.

11.1.4 Mental Health Inpatient Admission

If a client is admitted to an inpatient psychiatric unit for an acute episode, the opioid pharmacotherapy provider should liaise with the treating doctor to ensure that:

- the client continues to receive their opioid maintenance treatment;
- the treating doctor is aware of the risks and restrictions associated with the prescription of benzodiazepines for clients receiving opioid maintenance therapy;
- there is a reduction regimen in place either prior to or on discharge if a client is receiving short term benzodiazepine treatment; and,

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- the opioid pharmacotherapy provider has access to discharge information including current mental health status, risks identified, medications prescribed and mental health follow-up arrangements.

11.1.5 Self-Harm

The risk of suicide or accidental death in the AOD population is higher than the general population (Haw & Hawton, 2011). Clients with extreme and rapidly changing mood cycles may be at a higher risk of impulsive self-harm. Therefore, assessing for suicidal thoughts, ideation, and risk of self-harm is a routine part of maintaining client safety on the opioid pharmacotherapy program. During the regular review of a client, if risk indicators are present, a referral should be made to an appropriately qualified mental health clinician for more thorough assessment.

Furthermore, if a client has a history of self-harm, particularly involving overdoses, this must be taken into consideration when assessing suitability for takeaway doses. More frequent reviews are required during a period of increased risk of self-harm.

If risk indicators are present, a referral should be made to an appropriately qualified mental health clinician for more thorough assessment.

11.1.6 Trauma

Many clients receiving opioid pharmacotherapy are likely to have been exposed to trauma, abuse, or even repeated traumas (Enoch, 2011). According to Simpson and Miller (2002), female AOD clients have a higher rate of childhood sexual abuse than male clients (31-74% compared to 16%). However, there is evidence to suggest that feelings of shame are particularly intense for males who have been sexually abused.

While trauma exposure does not always result in clients developing symptoms of PTSD, those who do develop symptoms have a high likelihood of abusing substances. Marsh and colleagues (2007) estimate that 25% of all AOD clients have symptoms of PTSD.

During the assessment interview:

- do **not** question the client about their experience of trauma unless they voluntarily share this information;
- be mindful of the feelings of shame, guilt, self-blame and powerlessness associated with trauma and abuse;
- be prepared to contain such feelings in a respectful and sensitive manner; and
- avoid asking questions that encourage the client to revisit their traumatic experience.

For some clients, substance use is a way of coping with their traumatic memories and experiences. Following stabilisation, clients may recall past traumatic events and memories more vividly, experience grief and loss in relation to their life trajectory, and

develop an increased awareness of how their abuse history has affected their life. This can become overwhelming and exacerbate symptoms of anxiety and PTSD. It may also increase the risk of self-harm, specifically related to the inability to regulate and tolerate extreme or negative emotions.

Pharmacotherapy clinicians are encouraged to monitor the client's experience of trauma and its impact on their mental health and wellbeing. Clinicians are advised not to question or pursue this issue if the client does not wish to discuss it, as this may re-expose the client to the trauma or result in destabilisation. When a client does disclose a history of trauma, it is important to normalise and validate their experience. Not all clients require trauma counselling; however, referral to specialist trauma counselling service is appropriate if requested by the client.

11.2 Cognitive Impairment

Acute and prolonged use of substances, particularly opioids, alcohol, cannabis, benzodiazepines and methamphetamine, can be associated with mild to severe cognitive impairment (Ornstein et al., 2000; Fernandez-Serrano, et al., 2011). Repeated alcohol withdrawal can also increase the risk of brain injury. Open and closed head injuries as a result of motor vehicle accidents, assaults and falls are also more likely amongst individuals with substance use issues (De Boni, et al., 2011; Gjerde, H, 2011; Cash & Philactides, 2006).

Cognitive impairment may be indicated by deficits in memory functioning (e.g. visual and verbal), information processing (e.g. slow to understand and process information) and executive functioning (e.g. problems with decision making or problem solving) (Chrisman & Zimmer, 2005). New learning ability, concentration difficulties and poor organisational and planning skills are also indicative of impairment.

Cognitive impairment is strongly linked to poor treatment retention and outcomes, and increased risk of relapse (Prosser et al., 2006 & Vocci, 2008). For example, clients with cognitive impairment may forget appointments and have difficulty understanding and remembering conversations, directions and instructions. They may also have difficulty learning new skills or making changes to their routine.

When cognitive impairment is suspected, clinicians should consider the following:

- use the Alcohol Related Brain Injury checklist with clients presenting with alcohol related issues;
- refer the client for further assessment by a qualified clinician, such as a psychologist, neuropsychologist or neurologist;
- refer the client for further medical investigations including brain imaging;
- consider the effects of the cognitive impairments on the treatment planning, for example, restricting access to takeaway doses; and
- use simple and straight forward behavioural interventions rather than complex cognitive interventions, such as lists, reminder services and clear and concise written information.

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11.3 Working with Families and Significant Others

Treatment outcomes can be improved by working with the client's family (with the client's consent) and significant others. According to the literature, approaches that build on the client's social support system have a much better chance of success (Rowland et al., (2000)). When working with families, the following areas should be considered:

- providing information about the program;
- providing psycho education about substance use;
- providing strategies that family members can use to help the client during stabilisation, e.g. craving management and relapse prevention;
- supporting the client's attendance and treatment compliance ;
- maintaining appropriate boundaries and supports;
- family safety (e.g. security and storage takeaway doses); and
- crisis management (e.g. what to do in the event of an overdose).

If the client has a partner who is also opioid dependent, the recommendation is to have both the client and the partner engaged in treatment. This reduces exposure to ongoing drug use, reduces the risk of relapse, and promotes program compliance and treatment adherence.

11.4 Female Clients

Recent research and consultations with clients and practitioners in AOD services has highlighted the need for consideration of female specific issues in mixed gender services (Marsh et al. 2007). Women's experience of substance use is psychologically, socially and physiologically unique compared to men (Bernard 1981; Cowen et al., 2003; Hser et al., 2005; Thomas 1997). The following are some of the critical issues to consider when engaging female clients (not limited to opioid treatment):

- Women tend to suffer from the physical effects of drug use sooner than men (e.g. liver cirrhosis, reproductive and sexual dysfunctions), despite evidence that men tend to use substances at more harmful levels (Thomas 1997);
- Women tend to suffer greater levels of shame and stigmatisation compared to men, partly due to societal norms in which women are not expected to have issues with drugs (Copeland et al., 1993; Cowen et al., 2003; Jarvis et al., 1998; Swift & Copeland 1998);
- The experience of shame and powerlessness is often amplified for women who display PTSD symptoms. This is a special consideration for women given the higher rates of experience of childhood sexual abuse and assault compared to men (Grupp 2006; Jarvis et al., 1998; Neale 2004);
- Early victimisation is associated with a greater risk of adult substance dependence among females than among males (Warren et al., 2002);
- Women are more likely to benefit from self-help groups and to benefit from additional support services in the community than men (Grella et al., 2006);

- Female clients are more likely to have children in their care than male clients; and
- In comparison to the general population, women presenting to AOD services survive (i.e. 'survivors' of rather than 'victims' of violence) significantly higher levels of violence at home (Miller et al., 1989).

The implications of these factors for opioid pharmacotherapy include that:

- women should be offered the option of a female worker (Grupp 2006);
- if possible, female clients with a known history of sexual assault and abuse should be offered a female clinician;
- the dose titration for female clients needs to be closely monitored during the induction phase to ensure that the dose is not increased too rapidly and that the client is not over sedated; and
- female clients may require more social welfare referrals and assistance, particularly when they have children in their care.

11.5 Pregnancy

There is an increased risk of the occurrence of complications during pregnancy among women who use opioids. Some of the primary risks include, but are not confined to the following:

- miscarriage;
- pre-eclampsia;
- intrauterine hypoxia or anoxia;
- intrauterine infection;
- intrauterine growth retardation;
- premature labour; and
- antepartum and postpartum haemorrhage.

A number of causal factors are associated with these complications, including poor antenatal care, tobacco use and inadequate maternal nutrition. Babies born to opioid dependent mothers are at risk of developing neonatal abstinence syndrome (NAS) (Ebner et al., 2007).

11.5.1 Opioid withdrawal in pregnancy

Acute opioid withdrawal during pregnancy is associated with significant risk to mother and child. Complications can result in:

- miscarriage during the first trimester;
- premature labour during the third trimester;
- foetal hypoxia and distress; and
- high risk of return to dependent illicit opioid use and/or other substance use, and associated harms.

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As a consequence, the provision of specialist care by an obstetrics team in combination with drug and alcohol specialists is required to manage opioid withdrawal in pregnancy.

Babies of opioid dependent mothers are at risk of neonatal abstinence syndrome and sudden infant death syndrome (SIDS). Section 11.6 outlines care for the neonate of an opioid dependent mother.

11.5.2 Opioid treatment during pregnancy

The provision of opioid pharmacotherapy treatment during pregnancy has a number of benefits which include:

- assists in the stabilisation of drug use and lifestyle;
- reduces or eliminates illicit opioid use, which may help to stabilise the in utero environment; and
- improve access to comprehensive antenatal and postnatal care.

Opioid treatment does not increase the risk of congenital abnormalities in the foetus.

There have been insufficient controlled studies involving adequate follow up periods to demonstrate the safety of buprenorphine during pregnancy and breastfeeding. Therefore, methadone remains the only registered treatment for pregnant and breastfeeding women.

Methadone remains the only registered treatment for pregnant and breastfeeding women.

Whilst it is the preferred option for a woman continuing with her pregnancy to transfer to methadone maintenance treatment, there may be situations in which a woman may opt to remain on buprenorphine. This is discussed in Section 11.5.5.

The Australian Drug Evaluation Committee (ADEC) has classified opioid analgesics (i.e. Buprenorphine and methadone) as Category C: “have caused, or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible” (Department of Health and Ageing, 2011).

In addition the ADEC note that opioid analgesics may cause respiratory depression in the neonate, and withdrawal symptoms have been identified in cases of prolonged use by the mother (Department of Health and Ageing, Therapeutic Goods Association, 2011).

The aims of treatment for pregnant women are consistent with those for the treatment aims of all pregnant women:

- minimise the likelihood of complications; and
- provide comprehensive antenatal and postnatal care.

Whenever possible, antenatal care should be managed collaboratively with obstetric services that have the resources to provide specialist care in the management of drug dependence during pregnancy. Some pregnant women may be reluctant to advise health

providers and practitioners that they are clients of the opioid pharmacotherapy program. Clients should be counselled and advised of the importance of a holistic, collaborative approach between alcohol and drug services and other relevant services throughout their pregnancy.

Antenatal care should be managed collaboratively with obstetric services.

11.5.3 Methadone treatment during pregnancy

Adherence to the following principles is important in the treatment of opioid dependence in pregnancy:

- Pregnant women should be maintained on an adequate dose of methadone to achieve stability and prevent relapse or continued illicit opioid drug use. Women already in methadone treatment who become pregnant can continue in treatment;
- The bioavailability of methadone is decreased in the later stages of pregnancy. It may be necessary to increase the dose in the third trimester of pregnancy to avoid withdrawal symptoms and minimise additional drug use;
- Antenatal and postnatal care should be managed in collaboration with a specialist obstetric service which is experienced in the management of drug dependency during pregnancy;
- The second trimester of pregnancy is the most suitable period to conduct dose reductions if required; and
- Breastfeeding can be promoted.

Although there are other treatment options available for opioid dependant pregnant women, methadone is the preferred treatment option for the client. Methadone generally provides safer and more stable conditions throughout the pregnancy. Alternative treatment options should be considered in cases when a pregnant opioid dependent woman uses opioids less than three times per week, has been using opioids for less than three months or has been using very small quantities of opioids.

The decision to start methadone treatment for a pregnant woman must include a thorough assessment of the risks associated with continuing drug use and, when some uncertainty about the level of opioid dependence exists, the risks associated with treating her with a dependence forming opioid pharmacotherapy.

In the case that a pregnant woman is assessed as suitable for methadone treatment, early stabilisation on a methadone program is critical.

As pregnancy progresses, there is a progressive lowering of maternal serum methadone levels associated with a constant methadone dose. This is the result of:

- an increase in the total body fluid space;
- an increase in tissue reservoirs binding methadone;

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- enhanced hepatic drug metabolism in late pregnancy; and
- metabolism of methadone by the foetus and placenta.

These physiological changes associated with the advancing stages of pregnancy reduce the bioavailability of methadone. This results in treatment at a previously stable dose becoming potentially less effective in maintaining the client in a comfortable state. This can cause problems for the client later in pregnancy (such as premature labour).

Consideration of increasing the methadone dose during the later stages of pregnancy must balance the benefits and risks. An increase in the client's methadone dose may be provided to avoid withdrawal symptoms and prevent concurrent drug use.

The aim is to achieve stability with the lowest dose possible and also importantly, a dose that is not associated with sedation. Nevertheless, if a woman requires a high dose to cease unsanctioned opioid use, then a high dose should be prescribed. If the mother is experiencing symptoms of opioid withdrawal, it is reasonable to assume that the foetus is also feeling the negative effects of these symptoms.

National Pharmacotherapy Policy for people dependent on opioids (Department of Health and Aging, 2007) advises that it is preferable for a woman to be maintained on methadone pharmacotherapy to the point of delivery. Intermittent opioid and other drug use is not recommended as it can be harmful to the foetus. For this reason, in the situation where a pregnant woman on methadone pharmacotherapy seeks to reduce or cease treatment, the advice and a review by an Addiction Medicine Specialist is recommended.

It is preferable for a woman to be maintained on methadone pharmacotherapy to the point of delivery.

11.5.4 Management of Methadone Dose after Birth of the Baby

When the daily methadone dose is increased substantially during the pregnancy, serious consideration should be given to reducing the dose to avoid sudden onset of sedative effects of methadone, which will in turn be associated with an increased risk of overdose and accidents, including a risk of dropping the new born baby. Any such dose reduction should occur immediately (first dose after parturition). While there is no evidence base to guide decision-making on such dose reductions, anecdotal reports suggest this reduction may need to be as much as 20-30% of the daily dose in clients receiving higher doses (over 100mg).

11.5.5 Use of buprenorphine in pregnancy

Whilst it is the preferred option for a woman continuing with her pregnancy to transfer to methadone maintenance treatment, there may be situations in which a woman may opt to remain on buprenorphine. In such situations, it is essential that the client is clearly informed of the risks and issues associated with buprenorphine maintenance, both to themselves and their babies.

It is preferable for Subutex® to be used rather than the cessation of all opioid treatment during pregnancy. Discontinuation of buprenorphine treatment results in increased risk to mother and baby.

Women who become pregnant while on the combination product (Suboxone®) should be switched to either methadone or to Subutex®. In the case that a stable client receiving unsupervised Suboxone® becomes pregnant, her continuation on Subutex® may be suitable. However, this should be done with an increased frequency of clinical reviews to monitor the changing nature in her health status throughout the pregnancy. Counselling regarding treatment options should be provided, and support offered when a choice of action is made. Should the client wish to continue with buprenorphine, it is preferable that the client sign a consent form (see Appendix X).

The management of women with Suboxone® is absolutely contraindicated in pregnancy and breast feeding.

Client education about the potential risks of buprenorphine treatment during pregnancy and breastfeeding involves a discussion of the current evidence of risks to the woman and baby, both in utero and postnatal; however, conclusive evidence about the assessment of buprenorphine safety in pregnancy will be unavailable for some years. It is critical that all pregnant women who have a preference for the continuation of buprenorphine treatment understand risk adverse outcomes during pregnancy as a result of that continued treatment course.

Should a practitioner suspect that a woman is not capable, or has impaired capacity, to provide informed consent for such decisions, the standard procedure for obtaining informed consent should be followed.

Because significant gaps in knowledge remain about the use of buprenorphine as a maintenance treatment during pregnancy, frequent and regular clinical reviews should be conducted by the treating doctor and the multi-disciplinary team. It is recommended that pregnant women should be reviewed on a weekly to fortnightly basis to 30 weeks gestation and weekly thereafter until delivery.

The Clinical Guidelines for the Use of Buprenorphine in Pregnancy (2003) suggest that the usual maintenance doses of buprenorphine associated with a significant reduction in heroin use are between 12 and 24mg per day. It is important that pregnant clients are encouraged to be stabilised on adequate doses of Subutex®. The available data for buprenorphine dose and incidence of NAS suggest no significant correlation. Therefore, low doses of Subutex® should not be encouraged as an end in itself. The maximum recommended dose for pregnant women should be no more than 32 mg daily.

In adhering to the general principles of opioid maintenance during pregnancy, dose increments may be required throughout the pregnancy, especially during the third trimester. It is important that withdrawal symptoms are avoided as much as possible as they may cause considerable distress to the foetus and lead to preterm labour and foetal loss.

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As there is inadequate data available regarding pregnancy and use of Subutex®, dosing on a frequency less than daily (e.g. alternate day dosing) is not recommended. A proportion of clients on buprenorphine will experience opioid withdrawal when dosing with buprenorphine occurs less frequently than daily. It is recommended that all pregnant women on buprenorphine be placed on a daily dosing schedule during pregnancy.

11.5.6 Use of other substances during pregnancy

There is a range of other substances, including nicotine, cannabis, benzodiazepines, alcohol, amphetamines and cocaine, which present potential risks to pregnant women and their babies. Pregnant women should be discouraged from using these substances; in particular the use of multiple sedative drugs increases the risk of fatal and non-fatal overdose.

Safety of use of sedatives whilst on buprenorphine treatment is unknown. Overdoses on combinations of buprenorphine and benzodiazepines have been reported and, as such, the use of benzodiazepines by pregnant women is generally not recommended.

A meta-analysis of studies reporting adverse outcomes of psychotropic medications used in pregnancy reported a 2-3 fold increase in cleft lip and palate with first trimester exposure to diazepam and a 7-fold increase with alprazolam, although these results have not been consistently replicated in other studies (Austin & Mitchell, 1998). No long term neuro-developmental sequelae were reported.

In addition, a benzodiazepine abstinence syndrome may occur, which may include tremors, hypertonicity, irritability, excessive sucking, vomiting and diarrhoea. The onset of these withdrawal signs may be delayed and the syndrome may persist for up to 5 weeks. A combination of opioid plus benzodiazepine dependence may be associated with a particularly severe and drawn out abstinence syndrome in the neonate.

Contrary to self-reporting, controlled studies of plasma, urine or hair markers of smoking demonstrate that most pregnant smokers do not quit. In Tasmania in 2008, 26.9% of pregnant women attending public sector ante-natal clinics smoked during their pregnancy (Department of Health and Human Services, 2010). In addition, amongst people who regularly inject drugs (PWID), the rate of tobacco use is dramatically higher than in the general population (93% v. 22%) (Stafford & Burns, 2011; ABS, 2010).

Cigarette smoking is associated with increased peri-natal morbidity and mortality, growth retardation & behavioural abnormalities. There is evidence of increased risk of in utero foetal demise associated with smoking, with highest risk amongst women over 40. There is an increased risk of infant mortality associated with smoking, with highest risk amongst women 20 - 29 years of age. There is a 3-fold increase in risk of Sudden Infant Death Syndrome (SIDS) associated with maternal smoking in pregnancy.

Both pre- and postnatal exposure to tobacco smoke has been identified as a major risk factor for SIDS (Fleming & Lair, 2007). It is important that all pregnant clients and parents of infants are informed of the risks associated with tobacco use, and provided with appropriate pharmacological and/or counselling support if requested. It is important to note that reducing tobacco use does not reduce exposure to nicotine and is not a helpful strategy.

11.6 Management of neonatal care

Neonates born to mothers on opioid pharmacotherapy programs, or women who have been regularly using other opioids (e.g. heroin, morphine) during their pregnancies, are at risk of developing a neonatal abstinence syndrome (NAS) from opioids.

11.6.1 Neonatal abstinence syndrome and its management

To date there is insufficient data to determine whether the neonatal abstinence syndrome (NAS) is more or less likely with buprenorphine compared to methadone. Early data suggests the incidence of NAS is similar to that seen with methadone. In accordance with current management strategies for neonates experiencing withdrawal, ideally the infant remains with the mother where possible.

Opioid dependent women are not recommended for out-of-hospital delivery as there is a need for prolonged monitoring of the neonate in the first five days after delivery. All babies born to opioid dependent mothers should be observed by experienced staff for withdrawal symptoms. A validated scale should be used to assess the presence and severity of NAS (see Appendix x Finnegan scale).

It is usual for withdrawal symptoms to commence within the first 12-48 hours after delivery; however they may not become apparent for up to one week. Withdrawal from additional substances (e.g. benzodiazepines) which are concurrently used with methadone or buprenorphine may delay the onset of symptoms. Experienced staff should regularly observe babies born to opioid dependent mothers to assess for any withdrawal signs in the baby.

The supportive treatment of neonatal withdrawal involves minimising environmental stimuli and enhancing the baby's comfort. Treatment with morphine should be considered for infants who exhibit severe signs of withdrawal, but morphine may depress respiration and should be used with extreme caution. It is recommended that neonatal care be managed in collaboration with a specialist obstetric or paediatric service experienced in the management of babies born to drug dependent mothers.

In addition, the use of opioid antagonist medication, such as naltrexone, is strictly contraindicated for neonates born to opioid dependent mothers due to the risk of seizures.

The use of opioid antagonists (e.g. naltrexone) is strictly contraindicated for neonates born to opioid dependent mothers due to risk of seizures.

11.6.2 Breastfeeding while on methadone

It is understood that only small amounts of methadone are present in breast milk. Women not using any other drugs should be encouraged to breastfeed regardless of their methadone dose. Two notable exceptions to this are when the woman is HIV positive, or when a woman who is Hepatitis C positive has cracked or bleeding nipples.

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Breastfeeding may reduce the severity of the neonatal withdrawal syndrome. Women receiving high doses of methadone should be advised to wean their babies slowly to avoid withdrawal in the infant.

11.6.3 Breastfeeding while on Buprenorphine

There is insufficient clinical data available on the safety of breastfeeding for women on buprenorphine, however, the amount of buprenorphine in breast milk is small and considered to be clinically insignificant.

Women who choose to breastfeed while taking Subutex® should be informed of the risks (i.e. the presence of reduced amounts of buprenorphine in the breast milk; reduced breast milk production) to enable them to make an informed decision. These women should be supported in their decision.

When a woman weans her baby from breast milk, she should be informed to do this slowly in order to avoid the infant experiencing withdrawal.

In cases where a decision is made to continue breastfeeding while the mother is on buprenorphine, neonates and infants should be regularly reviewed to monitor their development by Child Health, and/or a Paediatrician.

11.7 Blood- borne viruses

All clients accessing the Tasmanian Opioid Pharmacotherapy Program (OPP) should have their blood borne virus (BBV) status reviewed and monitored throughout treatment. Prior to BBV testing it is important to ensure that pre and post counselling is provided by appropriately trained clinicians. Hepatitis A & B Vaccinations should also be offered to all clients. When there are significant and complex issues related to the management of a BBV and opioid dependence (e.g. pain), it is recommended that regular and timely consultations occur between the specialists involved in the clients care.

Clients accessing the Opioid Pharmacotherapy Program should have their blood borne virus status reviewed, and monitored throughout treatment.

Hepatitis A and B vaccinations should also be offered.

11.7.1 HIV/AIDS

As previously stated, clients with HIV or AIDS have priority access to the Tasmanian OPP. Clients who are HIV-positive will require additional services and should be managed in collaboration with these. In the early stages of HIV infection, clients are usually able to cope with the routine and conditions of opioid treatment. However, the medical, psychological and social implications of HIV or AIDS may require some flexibility in the arrangements for ongoing treatment, especially when the HIV infection is advanced.

Client dosing must be monitored closely due to the interactions between medications for the treatment of HIV or AIDS and opioid pharmacotherapy treatment agents. Clients may require higher doses of methadone or buprenorphine if tolerance to opioids has developed as a result of other pain relief medications.

11.7.2 Hepatitis B

Both new and current OPP clients should be encouraged to undertake investigations to determine their Hepatitis B status. Hepatitis B vaccinations should be available and provided to all clients on the OPP who do not have immunity to the virus. It is strongly recommended that vaccinations should be provided to the sero-negative partners and close family contacts of clients who are Hepatitis B sero-positive and potentially infectious.

Refer clients who are chronic carriers of Hepatitis B to a gastroenterologist for specialist assessment and follow-up.

11.7.3 Hepatitis C

Hepatitis C is a major public health concern, and a significant source of spread is through injecting drug use. As with Hepatitis B, both new and current OPP clients should be encouraged to undertake investigations to determine their Hepatitis C status.

A high percentage of individuals entering opioid pharmacotherapy will be Hepatitis C positive. If an individual has been infected with Hepatitis C, it is important to ascertain their Hepatitis B status, as co-infection with Hepatitis B may increase the aggressiveness of the illness.

Offer education and counselling to clients about Hepatitis C infection; and encourage the client to reduce high-risk behaviours, with an aim to minimise the spread of the virus. Information should include advice on reducing hazardous use of all drugs (including alcohol) and managing ill health due to Hepatitis C.

Organise specialist assessment and follow-up according to National Health and Medical Research Council guidelines for clients infected with Hepatitis C. Clinicians may also like to view the National Hepatitis C Resource Manual (Online version of National Hepatitis C Resource Manual 2nd Edition & PDF printable version of National Hepatitis C Resource Manual 2nd Edition (PDF 1374 KB)).

11.7.4 General advice

Clients should be provided with education regarding harm minimisation strategies for reducing the risks of infection with blood borne viruses. Examples of these strategies include:

- not sharing injecting equipment (also including tourniquets, spoons, and water);
- not sharing objects that may be vehicles for exchanging blood (including razors, toothbrushes, and combs);
- safe injecting practices;

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- using other modes of administration, e.g. oral, nasal; Information regarding prevention and treatment of sexually transmitted diseases;
- information regarding safe sex practices;
- regular access to GP and other support services; and
- assertiveness and negotiation skills.

11.8 Culturally sensitive practice

It is important for health services ensure culturally responsive strategies that take into account the practices and beliefs of a particular population group, so that the relevant initiatives are acceptable, accessible, persuasive and meaningful (Ministerial Council on Drug Strategy, 2004). People who access alcohol and drug services and opioid pharmacotherapy treatment programs are not a homogenous group. There are numerous social and cultural groups within the Australian population, many of which have distinguishing features and different needs. These include culturally and linguistically diverse (CALD) people and Aboriginal people.

Culturally sensitive practice recognises these differences between cultures and groups. It takes account of differences in the way that groups communicate, relate to one another and how this translates into interactions with health care providers (Chrisman & Zimmer, 2000). Cultural sensitivity does not mean, however, that a person need only be aware of the differences. A culturally competent clinician views all clients as unique individuals and understands that their life experiences, beliefs, values, and language affect their impressions and expectations of clinical service delivery, including their acceptance of a diagnosis, treatment and their compliance (Chrisman & Zimmer, 2000).

11.8.1 Supporting Aboriginal Communities

The need for action to support the Aboriginal communities is entrenched in the National Drug Strategy and the Tasmanian Drug Strategy. It is also an identified priority action under the Alcohol, Tobacco and other Drug Services' Future Service Directions – A Five Year Plan 2008/09 – 2012/13. A key focus of this is to work closely with the Aboriginal communities to establish appropriate services and strategies that are designed to improve outcomes for clients.

The Alcohol and Drug Service recommends working collaboratively with the statewide Aboriginal Health Service and other Aboriginal organisations.

When working with Aboriginal clients, it is important to be mindful that the Aboriginal 'community' is heterogeneous. Mills and colleagues (2010) list the following as important considerations for clinicians engaging with clients from Aboriginal communities:

- The concepts of family (which include immediate and extended family) and community and their importance in the Indigenous culture;

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- A holistic concept of health that requires consideration and treatment that includes physical, psychological, social, cultural and spiritual health;
- Indigenous people are faced with death and serious illness within their extended family more often and at a younger age than non-Indigenous people. This can be associated with high rates of trauma, grief and loss in Indigenous communities;
- There are also issues of grief, loss and trauma regarding the European invasion and Indigenous treatment since then (e.g. stolen generations);
- Current issues of stigma and victimisation exist today which are likely to impact on mental health and AOD use. Issues of domestic violence, poverty and family AOD use are also likely to play a key role;
- Counsellors should be aware of the impact of intensely distressing levels of shame that many Indigenous clients experience. This shame can be exacerbated when dealing with a non-Aboriginal counsellor/worker;
- Consider that you may be viewed as a member of a culture that has caused damage to Indigenous culture;
- Direct questioning can be perceived as being threatening and intrusive and therefore should be kept to a minimum. A method of three-way talking may often be helpful, in which a client uses a third person (such as a family member) as a mediator to exchange information with the service provider;
- Be respectful of cultural prohibitions such as:
 - referring to a dead person by name;
 - referring to certain close relatives by name (for example, a Torres Strait Islander male may not refer to his brother-in-law by name);
 - do not appear to criticise elders or family members;
 - confiding personal information to a member of the opposite sex – men's and women's business are usually kept separate (this may require a same sex AOD worker);
 - clinicians should also use the words 'unsupervised dosing' rather than 'takeaways', because the latter term can be misconstrued and lessens the significance of opioid pharmacotherapy medications.
- Be aware of various levels of literacy.

To ensure that Aboriginal clients receive culturally safe and holistic service, the Alcohol and Drug Services shall work collaboratively with the statewide Aboriginal Health Service and other Aboriginal organisations as appropriate, where possible and with consent from the client.

11.8.2 Culturally and Linguistically Diverse Groups

In general, ethnic groups are underrepresented in Alcohol and other Drug Services (Alcohol & Other Drugs Unit of the Commonwealth Department of Health and Ageing, 2008). This is likely to reflect some of the difficulties associated with accessing

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treatment, rather than a lower prevalence of alcohol and other drug (AOD) use issues (Reid, Crofts & Beyer, 2001). Barriers to accessing treatment include:

- language difficulties;
- feelings of shame and guilt;
- lack of familiarity with services;
- stigma;
- fears associated with AOD treatment; and
- different expectations of treatment and difficulty clarifying cultural difference between the client and the clinician.

(Reid, Crofts & Beyer, 2001)

In working with people of culturally and linguistically diverse backgrounds it is important to consider:

- their particular experiences and circumstances in the context of their migration;
- any group or subgroup membership (e.g. religious affiliation; refugee); and
- the influence of their culture or country of origin on their values and beliefs.

(Marsh, Dale & Willis, 2007)

It is also important not to make assumptions about an individual's culture as this may vary significantly from person to person. However, the clinician should enquire about expectations of family; understanding of healing; perceptions related to substance use and any interpersonal communication conventions (Mills et al., 2010). When there is a language barrier, an accredited interpreter should be used. Clinicians should avoid using family members and friends as interpreters (except in emergency situations), as this can compromise the clinical interaction by restricting client disclosure and confidentiality.

Whenever possible the client should be referred to a clinician of the same culture. However, when this is not possible, efforts should be made to ensure that the client and the clinician are linked to a 'cultural consultant' (e.g. key worker at the Migrant Resource Centre). This consultant can assist both the client and clinician to identify any cultural issues that may need to be considered during treatment (Marsh & Dale, 2006).

It is important to note that the Tasmanian Opioid Pharmacotherapy Policy and Standards for Clinical Practice do not change as a result of an individual's cultural background. This program is bound by specific regulatory requirements. Culturally sensitive practice requires the clinician to consider their own cultural beliefs and values, and to adjust the way in which they communicate and relate to clients of different cultures. This is the key to culturally sensitive practice and to ensuring respectful and effective interactions and treatment.

11.9 Young people

Young people' or 'youth' are terms used to describe persons aged between 15 and 24 years (United Nations Division for Social Policy and Development, 2003). This term is generally used to reflect the developmental phase of the lifespan and the inherent challenges this

brings in the transition to adulthood. In general, of those using substances, young people tend to use alcohol and cannabis, and are often polydrug users. The proportion of young people using heroin and opioids is quite low (Petrooulos, et al., 2006). The rate of young people with problematic alcohol and other drug use issues is generally low; nonetheless, they do present to alcohol and drug services with significant drug use problems and serious social and psychological difficulties. There are high rates of lifetime and current mental health disorders amongst young people accessing AOD services (Grella et al., 2001).

Traditional adult style approaches to service provision are not appropriate or effective when working with young people because of the impact of the developmental processes, physical differences, and differences in belief and value systems (Winters, 1999). The young person's stage of cognitive and psychological development will influence their ability to engage and the types of treatment interventions offered. While cognitive behavioural strategies are considered first choice interventions for adults, behavioural strategies are often more suitable when working with young people.

The following are key strategies and considerations for assessing and engaging with young people who are affected by AOD issues:

- include the family;
- be flexible in your approach;
- provide practical and concrete strategies (e.g. harm reduction strategies);
- explore and be aware of the influence (good and bad) of their peers;
- work closely with other agencies already involved with the young person; and
- monitor mental and physical health issues and link clients to specialist youth services when required.

(Marsh et al. 1997)

11.9.1 Young people and opioid pharmacotherapy

Even if a young person has a serious opioid use problem, they may not be neuroadapted to opioids (a requirement of treatment entry). Therefore, opioid pharmacotherapy is not the treatment of choice for young people, especially for adolescents aged 12-17 years. If a young person does meet the criteria for treatment with opioid pharmacotherapy, buprenorphine is the preferred treatment option, unless the young person is pregnant or there are significant safety issues such as risk-taking. The clinician should also broaden their approach to include the role of significant others such as family.

If a young person is assessed as being suitable for opioid pharmacotherapy, buprenorphine is the preferred treatment option.

If possible, consent should be obtained from the young person to involve a family member in the treatment process. The success of opioid pharmacotherapy can be enhanced by inclusion of a family member who is able to provide support, assist with transport to appointments, monitor other drug use, and ensure regular daily dosing. The

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nature of family relationships should be assessed and taken into consideration when developing the treatment plan.

Family members and significant others should be provided with detailed information about the program and its requirements so that they can support and facilitate treatment compliance. Treatment planning might also include linking the family member or significant other into additional support services that can provide AOD psychoeducation and skills in relationship building and boundary setting.

Issues such as intergenerational drug use in the family of origin and the nature of peer networks should also be considered. Peers and families can either mitigate or magnify the risks for young people so it is important to assess and monitor these relationships. Research indicates that, regardless of the family's relationship to the young person's problem, they almost always need to be involved in the solution, as treatment that does not include the family is less likely to be successful.

11.10 Recently released prisoners

Clients usually have to demonstrate neuroadaptation to be eligible for the Tasmanian opioid pharmacotherapy program. However, recently released prisoners with a history of opioid dependence or a history of pharmacotherapy treatment are at an increased risk of overdose or death if they return to high levels of opioid use after their release (Kinner, 2006). For these clients, the risk of overdose or death if not on the program may outweigh the risk of placing a non-neuroadapted client on the program. Consequently, such clients are able to access the program even if they do not display neuroadaptation. However, they should be commenced on a lower dose, titrated slowly, and reviewed more frequently than other clients during the early phases of treatment.

For recently released prisoners with a history of opioid dependence, the following strategies are recommended:

- a well developed release plan that specifies readily accessible dosing arrangements once released;
- an initial appointment with a case manager or prescribing doctor within 1-2 days of release from prison;
- an assertive follow up model of service delivery; and
- supported access to multiple services such as housing, employment, and family support services.