Substance use and Mental Health in Pregnancy
Treatment approaches during pregnancy and coordination of care

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Disclosure

- I, Luke Peterson, hereby declare that the content for this activity, including any presentation on therapeutic options, is well balanced, unbiased, and to the extent evidenced based.
- My partner/spouse and I have no financial relationships with commercial entities producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients relevant to the content I am planning, developing, presenting, or evaluating.
- I will discuss use of non-FDA approved medications (buprenorphine in pregnancy).
- The following recommendations are organized by pregnancy trimester; however, this is done for conceptual reasons for this discussion, and all of the following recommendations can be employed despite presenting gestational age.
Disclosures - Dr. Kalia
- No Financial Disclosures
- Heteronormative Data and research
Objectives/Outcomes

Objectives
1. Approach substance use disorder in pregnancy with more confidence and compassion
2. Screen for and address common concerns with substance use in each pregnancy trimester (including the 4th trimester)
3. Implement tools to focus on long term retention in treatment after delivery

Outcomes
1. Use appropriate patient-first lexicon
2. Use validated screening tools to screen for substance use in all pregnant people
3. Initiate appropriate gestational age screening for factors commonly seen in patients who use substances while pregnant
4. Share with obstetric and primary care colleagues’ current evidence regarding antenatal testing in patients with substance use disorder
5. Feel more confident about prescribing medications for opioid use disorder in pregnant and lactating people
6. Treat substance use in pregnancy in context of a longitudinal dyad that extends beyond pregnancy and delivery
Pregnancy

- About 45% of pregnancies in the US are unplanned
- For patients with history of Substance Use Disorders this number increases to 60-90%.
- Many patients with SUD don’t find out they are pregnant until well into their first trimester
- This is especially notable in the context of discussions around birth control
Prevalence of PMADs

1 in 7 Women

Perinatal depression affects 1 in 7 women.

1 in 10 Men

1 in 10 dads are affected by postnatal depression
1. **Opioid-affected births** have quadrupled over the last decade, to 6.5/1,000 deliveries.

2. Methamphetamine-affected births have also increased over the last decade, to 2.4/1,000 deliveries.

3. Opioid use in pregnancy increases the **risk of maternal death and life-threatening health issues** by 50%, and meth use increases these risks by 150%.

Graphic from [Institute for Healthcare Policy & Innovation, University of Michigan](https://www.med.umich.edu/ip-i/)
4. SUDs are increasing among all groups of childbearing women, but the largest increases are among women in rural communities, low-income communities, and those with Medicaid coverage for their pregnancy care.

5. Women of color have greater risk for life-threatening health issues compared to white women when their pregnancies are complicated by SUD and other behavioral health conditions.

6. Substance-affected deliveries result in increased healthcare costs. Neonatal abstinence syndrome, a group of problems that can affect infants exposed to opioids in the womb, accounted for $3 billion in hospital costs over the last decade.
Burden of Perinatal Substance Use (Nationally)

• Pregnancy-associated deaths due to overdose more than doubled in the United States between 2007-2016. (Cleveland et al 2020)
• Ko et al 2020 used 2019 data from the Pregnancy Risk Assessment Monitoring System (PRAMS). They noted 6.6% of respondents reported using a prescribed opioid during pregnancy
• Furthermore, rates of maternal opioid use disorder at delivery increased over four times between 1999 and 2014. (Haight et al 2018)
• Inpatient treatment of pregnant women for methamphetamine abuse increased three times between 1996 and 2006. (ACOG Methamphetamine Abuse in Women of Reproductive Age)
• Volkow et al 2019 also showed that marijuana use doubled among pregnant women between 2010 and 2017.
# Estimates of Perinatal Substance Use

<table>
<thead>
<tr>
<th>Substance</th>
<th>Using During Pregnancy</th>
<th>Resuming Use Postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>35%</td>
<td>51%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10-43%</td>
<td>41%</td>
</tr>
<tr>
<td>Opioids</td>
<td>14-22%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Sedative-Hypnotic</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Stimulants</td>
<td>Cocaine: 1-10%</td>
<td>Cocaine: 27%</td>
</tr>
<tr>
<td></td>
<td>Methamphetamines: 1-5%</td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>12-25%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table from Textbook of Women’s Reproductive Health
Almost Half of All Pregnancy-Associated Deaths in Arizona Were Related to Mental Health Conditions or Substance Use Disorders

2016-2018 Deaths in Arizona of Women 15-49 Years Old with a Pregnancy in the Previous 365 Days

- Mental Health Conditions: 31.5% Pregnancy-Associated, 23.9% Pregnancy-Related
- Substance Use Disorder: 41.4% Pregnancy-Associated, 19.6% Pregnancy-Related
- And/or: 48.8% Pregnancy-Associated, 30.4% Pregnancy-Related
Almost Two Thirds of Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder Occurred between 42 and 365 Days Postpartum

American Indian/Alaska Native Women Experience the Greatest Disparity in Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder

<table>
<thead>
<tr>
<th>% of live births in AZ</th>
<th>% of Pregnancy Associated Deaths due to Mental Health Conditions or Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>43.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>41.2%</td>
<td>20.2%</td>
</tr>
<tr>
<td>5.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>5.4%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>
Almost Two Thirds of Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder Involved Opiates

- Opiates: 61.9%
- Sympathomimetics: 54.8%
- GABA Antagonists: 32.1%
- Alcohol: 27.4%
- Marijuana: 27.4%
- Unknown: 17.9%
- NSAID: 9.5%
- Other: 14.3%

AZDHS Data 2016-2018
Burden of Trauma

- About half of all women in the US will be exposed to at least one traumatic event in their lifetime. (1)
- Research indicates that women are more vulnerable to sexual assault and childhood sexual abuse than men. (2)
- Per CDC National Intimate Partner and Sexual Violence Survey conducted in 2010, 1 in 5 women (18.3%) in the US have been raped at some point in their lives. (3)

Comorbid SUD & PTSD

- 50% seeking SUD treatment meet criteria for current PTSD.
- 30-90% of women in SUD Tx experience physical/sexual abuse
- Co-occurring PTSD - SUD = poorer treatment outcomes

Finkelstein et. al. national trauma consortium, Parks and Miller, 1997, Berenz, Coffey 2013
Psychosocial Implications of SUD with Pregnancy

• High motivation to change.
• Lot of guilt/shame
• Legal implications around custody of baby and older children
• Poor self-care behaviors
• High likelihood of hx of childhood sexual abuse or physical abuse
• High incidence of PTSD
• Partners likely to be using as well
Alcohol Exposure


Association of Prenatal Alcohol Exposure With Psychological, Behavioral, and Neurodevelopmental Outcomes in Children From the Adolescent Brain Cognitive Development Study
Prenatal

- Recognize and lower stigma
- Dispel myths about neonatal effects of substance use
- Assess readiness of institution
“The profound gap between the science of addiction and current practice... is a result of decades of marginalizing addiction as a social problem rather than treating it as a medical condition. Much of what passes for "treatment" of addiction bears little resemblance to the treatment of other health conditions.”

- Center on Addiction, 2017, Addiction Medicine, Closing the Gap Between Science and Practice
<table>
<thead>
<tr>
<th><strong>USE</strong></th>
<th><strong>DO NOT USE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with substance use disorder</td>
<td>Addict, alcoholic, User, junkie, drunk</td>
</tr>
<tr>
<td>In recovery/remission</td>
<td>Clean, former addict</td>
</tr>
<tr>
<td>Positive/negative test result</td>
<td>Clean UA</td>
</tr>
<tr>
<td>Expected/not expected test result</td>
<td>Dirty UA</td>
</tr>
<tr>
<td>Use/misuse</td>
<td>Abuse</td>
</tr>
<tr>
<td>Medication for opioid use disorder</td>
<td>Substitution therapy, mediation assisted therapy</td>
</tr>
<tr>
<td>Passively dependent newborn</td>
<td>Addicted newborn</td>
</tr>
</tbody>
</table>
Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Bodine

L A ST WEEK in the city, Greater Southwest Community Hospital released a 7-week-old baby to her mother, drug-addicted mother seen though the child was at severe risk of pulmonary arrest. The hospital's decision, "dangerous" [the doctors] described the baby be released."

The hospital provided for mother with an arena moan as to warm her if the baby stopped breathing while spinning, and turned her in CPS. But on the very last night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like DAY's Warren, the 6-year-old boy in his mother's drug den, whose shocking story was reported in the Washington Post last week, the child was all but abandoned by the authorities.

USA TODAY

Surge in babies addicted to drugs

Prescription abuse on rise across USA

By Donna Leonardi Fege
USA TODAY

Medical authorities are witnessing explosive growth in the number of newborn babies born to prescription opiate addicts, innocent victims of their mothers' addictions. The trend affects hundreds of thousands of infants each year.

Chelsea Becker spent 16 months in jail after she was charged with murder for having a stillbirth. Illustration: Chelsea Becker, prosecuted for murder after her stillbirth, spent 16 months in jail. Why did the hospital call police?

Childhood's End: What Life Is Like for Crack Babies

Babies born to crack-addicted mothers are like no others. Brain damaged in ways yet unknown, they're oblivious to any affection. How do you care for a baby who hates to be held?
<table>
<thead>
<tr>
<th>Substance (prevalence)</th>
<th>Obstetric Complications</th>
<th>Neonatal Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Preterm birth</td>
<td>FAS/FASD</td>
</tr>
<tr>
<td>(8% drank/30 days)</td>
<td></td>
<td>Low birth weight</td>
</tr>
<tr>
<td>(2.7% 1 binge/30 days)</td>
<td></td>
<td>Leading preventable cause of intellect/devo, cognitive delay</td>
</tr>
<tr>
<td>(0.3 &gt;5 binges/30 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco (16%)</td>
<td>Preterm delivery (PROM)</td>
<td>Low birth weight</td>
</tr>
<tr>
<td></td>
<td>Placental abruption / previa</td>
<td>Stillbirth, SAB</td>
</tr>
<tr>
<td></td>
<td>Ectopic pregnancy</td>
<td>SIDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory infections</td>
</tr>
<tr>
<td>Opioids (0.9-1.7%)</td>
<td>Preterm birth</td>
<td>NAS</td>
</tr>
<tr>
<td></td>
<td>IUGR</td>
<td>Low birth weight</td>
</tr>
<tr>
<td></td>
<td>PreE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Third trimester bleeding</td>
<td></td>
</tr>
<tr>
<td>Stimulants (1-5%)</td>
<td>Placenta Abruption</td>
<td>Low birth weight</td>
</tr>
<tr>
<td></td>
<td>PreE</td>
<td>Stillbirth</td>
</tr>
<tr>
<td></td>
<td>PROM</td>
<td>Dose dependent behavioral deficits in heavy daily use</td>
</tr>
<tr>
<td></td>
<td>Preterm labor and birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SGA</td>
<td></td>
</tr>
<tr>
<td>Marijuana (2-28%)</td>
<td></td>
<td>Low birth weight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Behavioral deficits</td>
</tr>
</tbody>
</table>
Readiness

- Patient education
- Trauma informed/anti-racist training
- Clinical/non-clinical staff education
- Engage with partners
- Establish multidisciplinary care team
- Create clinical pathways
- Link referral resources

https://safehealthcareforeverywoman.org/
First Trimester (0-13 weeks)

- Utilize validated screening tools to identify drug and alcohol use.
- Medical stabilization
- Medications for opioid use disorder
“Screening ... only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma... Universal testing [preformed by questionnaires] avoids risk of implicit bias.”

- Miska Terplan, 2017, ACOG
Screening - Professional Society Recommendations

- **Universal Screening**
  - Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)
  - Voluntary (ACOG, SAMHSA, CDC)

- **Testing**
  - Not recommended - Not an appropriate measure of addiction (ASAM, ACOG, SAMHSA)
  - Definitive testing required “when results of testing inform decisions with major clinical or non-clinical implications for the patient” (ASAM)
  - Consent required (ASAM, ACOG, SAMHSA)
### Validated screening tools for substance use in pregnancy

<table>
<thead>
<tr>
<th>Screening tool (substance)</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-ACER3 (alcohol)</td>
<td>69-88%</td>
<td>-</td>
</tr>
<tr>
<td>TWEAK (alcohol)</td>
<td>71-91%</td>
<td>86%</td>
</tr>
<tr>
<td>AUDIT-C (alcohol)</td>
<td>96%</td>
<td>71%</td>
</tr>
<tr>
<td>SURP-P (alcohol/THC)</td>
<td>88%</td>
<td>-</td>
</tr>
<tr>
<td>4P Plus (substance)</td>
<td>81-95%</td>
<td>70-82%</td>
</tr>
<tr>
<td>NIDA 1 Question (substance)</td>
<td>Any use 41%</td>
<td>83%</td>
</tr>
</tbody>
</table>
Medical Stabilization

- **Alcohol and sedative/hypnotic**
  - Medically supervised withdrawal

- **Methamphetamine/cocaine/cannabis**
  - Supportive care

- **Opioid mu receptor agonists (opioids/kratom)**
  - Medications for opioid use disorder (MOUD)
Buprenorphine

- Partial opioid agonist
- High affinity, low disassociation
- Duration of action: 36 hours
- Monoproduct standard in pregnancy
- Naloxone added to prevent IV use and can be considered in pregnancy
- Patient must be in withdrawal (COWS>6)
- 12 hours: oxycodone, heroin, morphine
- 24 hours: MS Contin, OxyContin
- 48 hours: methadone, fentanyl (M30)

PCSS, MAT Course, 2019
Mattick et al, 2014, Cochrane Review
Buprenorphine

- **Induction (Standard)**
  - Start 2-4 mg SL
  - Repeat 2-4 mg q2-4 hours prn withdrawal, cravings, use, pain
  - Total prior day’s dose for maintenance dose
  - 16 mg more likely to reduce use
  - Max dose 24 mg/day
  - Consider split dose for chronic pain

PCSS, MAT Course, 2019
Mattick et al, 2014, Cochrane Review
Induction (microinduction)

• AKA Bernese Method
• Overlapping low dose buprenorphine with current opioid
• Initial dose 0.2-0.5 mg
• Slowly titrated up over 5-14 days
• Mild withdrawal commonly reported but no precipitated withdrawal
• Last day of taper, no standard induction wait period required
Methadone

- Full opioid agonist
- Duration of action: >48 hours
- Dosed daily outpatient at opioid treatment program

**Dose**
- Start 10-30 mg
- Do not exceed 40 mg on day 1 after repeat assessment
- Adjust dose every 3-5 days
- Split dose may be more therapeutic
- Start 10-15 mg BID
- Measure QTcF
- Drug interactions
- Hepatic metabolism

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**Figure 1:**
Steady-state methadone concentration reached in about 5 days.
Adapted from Payte 2002.

**Figure 3:**
Splitting the dose (red line) keeps SML within the therapeutic range (gray zone), which corrects a high peak and low trough level (black line).
Adapted from Payte 2002.
NOWS: MOTHER Trial

Maternal Opioid Treatment: Human Experimental Research
Double blind RCT
N=175

Maternal discontinuation rates:
- Methadone 18%
- Buprenorphine 33%

NAS occurrence was the same

Buprenorphine required less morphine, shorter hospital stay, shorter duration of NAS treatment

No difference in birth weight, gestational age at delivery, Apgars, positive drug screen at delivery, and medical compliance

Hendrée E. Jones, MOTHERs Study, 2010

Figure 2. Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome.
Lower the dose?

- Prospective studies show methadone dose not associated with rate of NAS
- Buprenorphine dose not associated with rate of NAS

Cleary et al, 2010
Lower the dose?

- Prospective studies show methadone dose not associated with rate of NAS
- **Buprenorphine dose not associated with rate of NAS**

Wong et al, 2018
Lower the dose?

- **What is the right dose?**
  - Treats withdrawal
  - Diminishes cravings
  - Prevents use
  - Stabilizes mother
  - Doesn’t cause side effects

- Dose of MAT and NOWS are not primary outcomes….

- **Desired outcome:**
  
  Health pregnancy, mother sober with baby in safe situation, parenting at 12 mo postpartum

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Ross et al, Neuropsychopharmacology. 1/2015
Thompson and Nelson, Americal Psychologist, 1/2001
Second Trimester (14-26 weeks)

- Co-located multidisciplinary care
- Sociopsychobiologic screening/interventions
- Considerations for MOUD in later pregnancy
- Drug toxicology
Collaborative co-located care model

- **Integrated care** reduces obstetrical complications:
  - Kaiser Early Start Program saw **similar outcomes as non-drug using women**
    - IUFD, low birth weight, preterm delivery, NICU admission, infant re-hospitalization, c-section, preterm labor, placenta abruption
  - Estimated net cost benefit of $6 million (50K)

- Addition + BeH + Prenatal care is the **gold standard**
  - Medication (methadone, buprenorphine, NRT)
  - Counseling (1:1, group, IOP, Residential Treatment)

Goler et al, 2012, Obstetrics and Gynecology
Social screens

- **Child care**
  “Do problems getting childcare make it difficult for you to work, study or get to health care appointments?”

- **Housing insecurity**
  “Are you worried that in the next 2 months, you may not have stable housing?”

- **Food insecurity** (Patil, 2018)
  “Within the past 12 months we worried whether our food would run out before we got money to buy more.”
  “Within the past 12 months the food we bought just didn't last, and we didn't have money to get more”
Social screens

- **Health literacy** (Hersh et al, 2015)
  “How often do you need someone to help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?”

- **Health insurance**
  “In the last 12 months, have you ever had to go without healthcare because you did not have a way to get there?”

- **Transportation barriers**
  “In the last 12 months, have you ever had to go without healthcare because you did not have a way to get there?”
Social screens

• **Physical and sexual violence - Abuse Assessment Screen**
  (Basile et al 2007)
  1. Have you ever been emotionally or physically abused by your partner or someone important to you?
  2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
  3. Since you’ve been pregnant, have you been slapped, kicked, or otherwise physically hurt by someone?
  4. Within the last year, has anyone forced you to have sexual activities?
  5. Are you afraid of your partner or anyone you listed above?
Social screens

- **Human Trafficking** (Chisolm-Straker et al 2021) RAFT Screening tool

1. “It is not common for people to stay in work situations that are risky or even dangerous simply because they have no other options. **Have you ever worked, or done things, in a place that made you feel scared or unsafe?**

2. In thinking back over your past experience, **have you ever been tricked or forced into doing any kind of work that you did not want to do?**

3. Sometimes people are prevented from leaving an unfair or unsafe work situation by their employers. **Have you ever been afraid to leave or quit a work situation due to fears of violence or threats of harm to yourself or your family?**

4. **Have you ever received anything in exchange for sex?** For example, a place to stay, gifts, or food

Inquire if patients have ever had **survival sex?**

ACOG, Committee Opinion 711
Psychologic screens

- Depression: EPDS, PHQ9
- Anxiety: GAD7
- Mood disorder: MDQ, CIDI, SCID, SADS
- Eating disorder: SCOFF, ED-QS

- Additional substances
  - Alcohol, stimulant, sedatives, tobacco/nicotine, etc
  - Supplements (kratom, phenibut, etc.)
Medical Screens

- **Blood borne pathogens (HIV, RPR, HCV)**
  - Tdap and Hep A/B series (Prenatal/Post partum)
  - HIV and RPR (in prenatal labs, q3m if active use)
  - HCV antibody, reflex to RNA

- **Sexually transmitted pathogens**
  - HIV Pre-Exposure Prophylaxis (PrEP) for at risk
  - Gonorrhea/Chlamydia screening

- TB screening

- Monitor blood pressure, alert OB when >140/90
Harm Reduction

- Naloxone
- Overdose Education
- Safe Use Education
- Syringe Access
- Good Samaritan Law
- Overdose Prevention Center
- Low Barrier MOUD
MOUD Dose in Pregnancy

- Decreased serum levels of methadone
  - Increased 450 activity
  - Increased Volume of distribution
  - Increased renal excretion
  - Decreased binding proteins

- Approximately 28 weeks may require 10-20% increase
  - Adjust when clinically evident
  - Reduce dose after delivery

- Low dose buprenorphine ≤8mg may require increase
  - This writer’s experience
A word about urine drug testing

- **ACOG Toolkit on State Legislation**: Pregnant Women and Prescription Drug Abuse, Dependence and Addiction
  - Urine drug tests are not a substitute for verbal, interactive questioning and screening
  - Urine drug tests should only be used with the patient’s consent
  - Urine testing should **not** be relied upon as the sole or valid indication of drug use.
  - Positive urine screens **must** be followed with a definitive drug assay.
  - Testing does not provide valid or reliable information about harm or risk of harm to children.
Third Trimester (27-40 weeks)

- Antenatal testing
- Acute pain management
- Neonatal opioid withdrawal syndrome
- Contraception
Antenatal Testing

- EKG if methadone >150 mg/day

- **Stable patient**
  - UDS at each visit (Q1-2 weeks)
  - No consensus on antenatal testing
    - Dating and Anatomy: **Routine**
    - Growth/AFI: Follow up growth at 30-34 weeks
    - NST/BPP: Preform as indicated

- **Un-stable patient (no consensus)**
  - Growth US q4w (20-32 wks) then q2w after 32 wks
  - Weekly biophysical profile (BPP) and UA doppler 36-38 wks
  - Twice weekly BPP and UA doppler >38 wks

Ryan et al, 2017
Acute pain management

- **Intrapartum**
  - **Confirm and continue** current dose of MOUD
    - Check AZ CSPMP, call doc, call methadone clinic
    - Methadone clinics open early AM
  - **AVOID partial agonists:** butorphanol, nalbuphine, pentazocine
  - Offer pain relief: **epidural**, full opioid agonists

Alford et al, 2006, Ann Intern Med
Acute pain management

- **Postpartum surgical pain in pt on MOUD**
  - Continue home dose MAT - not enough for acute pain
    - Often requires 2-5x dose high affinity opioids
    - Severe pain post op
      - Hydromorphone PCA for 12-24 hours post op
      - **Hydromorphone PO 4-8 mg q3h**
    - Morphine (Duromorph) spinal
    - **Transabdominal plan block**
    - **Utilize non-opioid medications like APAP & NSAIDs**
      - Gabapentin 300 mg BID/TID
      - **Self management (Mindfulness, color, pet therapy, music)**
  - No studies show prescribing opioids for pain will cause relapse if patient remains on MOUD

References:
- Alford et al 2006 Ann Intern Med
- Meyer et al 2007 Obstet Gynecol
Neonatal Opioid Withdrawal Syndrome

- Expected in 30-80% of infants exposed to opioids
- Peak symptoms 72-96 hours
- Nicotine, SSRI, BZD increase risk
- Not dose dependent with methadone or buprenorphine
- Encourage mother to be mother - maternal fetal dyad

**Evidence-based treatment**

- Monitor neonate ~5 days
- Eat - Sleep - Console
  - Rooming in and skin to skin
  - Quite calm environment
  - Improved with breastfeeding
- Opioid medications (methadone, morphine)
- Adjuncts: phenobarbital, clonidine
Fourth Trimester (Delivery - 12 weeks)

- Breastfeeding
- Retention in treatment
- Peripartum depression
- Navigating medicolegal landscape
Fourth Trimester (Delivery – 12 weeks)

• Breastfeeding
• Retention in treatment
• Peripartum depression
• Navigating medicolegal landscape
Retention in Treatment

- Factors that increase retention in treatment
  - Access to early treatment (<13 weeks)
  - Aggressive opioid withdrawal treatment
    - Higher buprenorphine dose (10-14 mg vs 15-17 mg)
    - Lower opioid withdrawal symptoms at last visit
  - Antidepressant prescribed in third trimester
  - Breastfeeding
  - Lower sedative use in third trimester
  - Buprenorphine providers available and comfortable with long term MOUD usage

O'Connor et al 2017; Ray-Griffeth et al 2020; Coker et al 2018; Lo-Ciganic et al 2019

~56% of patients discontinue MOUD at 6 mo (Wilder et al 2015)
Breastfeeding

- The Academy of Breastfeeding Medicine, the American Academy of Pediatrics, the American College of OB-GYN, the Substance Abuse and Mental Health Services Administration, and the American Society for Addiction Medicine recommend breastfeeding for women with substance use disorder who are in a treatment program and have had negative drug screens for 2 months prior to delivery.

- This includes women on MOUD.
Medicolegal

- AZ considers passive exposure of fetus to substances child abuse but is not grounds for civil commitment
- When to report to DCS: drug use or suspected in pregnancy
- **Early support and guidance**
  - Considering using Maricopa County SHIFT Prenatal family Care Plan
  - Hushabye Nursery

https://www.hushabyenursery.org/

https://www.maricopa.gov/5768/Maricopa-SHIFT
To call DCS or not

- These are state specific laws
- Guttmacher institute has a summary of many state laws
- Jacobs institute of Women’s Health Bridging the Divide: Pregnant women and Substance Abuse also has information
Arizona Policies on SUD during Pregnancy

- Arizona Considers Substance Use During Pregnancy as Child Abuse however, it is not grounds for Civil Commitment
- When Drug Use is Diagnosed, Suspected, AZ requires reporting
- In AZ Pregnant People are given priority access in General Programs
DCS call and patient discussion

- Discuss child protective service involvement during pregnancy
  - What will trigger a referral
  - What will likely happen with a referral
- Discuss with your patient what to do if a referral is made:
  - Be honest with child protective services
  - Have a plan for SUD treatment
  - Have a plan to ensure the baby is safe
Summary

1. Check stigma at the door - Use appropriate patient-first lexicon
2. Use validated tools to screen for substance/alcohol use in all pregnant people
3. Screen for sociopsychobiologic conditions in all pregnant patients who use substance and alcohol
4. As needed, share with OB current evidence regarding antenatal testing in patients with substance use disorder
5. Promote MOUD at the right dose and as long term treatment for opioid use disorder
6. Implement tools for long term retention: med management, co-located services, parenting support, sociopsychobiologic support
Provider considerations

Education
- MGH Center for Women’s Mental Health
  - Website
  - Weekly Virtual Grand rounds
- National Curriculum for Reproductive Psychiatry
- Marce Society – MONA (Marce of North America)
- NASPOG (North American Society for Psychological Obstetrics and Gynecology)
- BUMPS (Best use of Medicines in Pregnancy) Leaflets produce by UK Teratology Information Services
- Perinatal Mental Health Toolkit by the RCGP (Royal College of General Practitioners)
- NAMS North American Menopause Society
- Consult
- Bio ethics committees
- Risk management
Provider Resources

- MothertoBaby: (866) 626-6847 / www.mothertobaby.org
- Motherisk.org: (877) 439-2744 / www.motherisk.org
- InfantRisk.com: (806) 352-2519 / www.infantrisk.com
- Reprotox: www.reprotox.org
- E-Lactania: www.e-lactancia.org/ingles/inicio.asp
- Toxicology Data Network: www.toxnet.nlm.nih.gov

ACOG Committee Opinion No. 722: Marijuana use during pregnancy and lactation. Obstet Gynecol 2017;130:e205–9


Works Cited


Post Partum Support International (PSI)

- Patient resources options
  - Online Support Groups Over 14 specialty groups available 5 days a week
  - Chat with an Expert – for e.g Chat with Dad is the first Monday of every month
- PSI Help line – toll free number that anyone can call to get basic information, support and resources.
  - Call 1-800-944-4773 (4PPD) #1 En Espanol or #2 English
  - Text in English: 800-944-4773
  - Text en Español: 971-203-7773
PSI Online Support Groups

- Support for families after Maternal Death
- Perinatal OCD Support group for Moms
- Pregnancy after Loss
- Support for families touched by Postpartum Psychosis Group
- Apoyo Perinatal
- Black Moms connect
- Dad Support Group
- NICU parents
- Queer and Trans Parent Support Group
- Termination for Medical Reasons
Tucson Postpartum Depression Coalition (TPDC) is a non-profit, charitable organization committed to improving the lives of mothers by promoting the emotional health of pregnant and postpartum mothers in Pima County. There is a resource list that is routinely updated.
Tucson Postpartum Warmline 888-434-MOMS (6667)

- 888-434-MOMS (6667)
- Available in English and Spanish
- Phone volunteers are ready to assist you by simply listening or by helping you find a resource in your area.
- If you leave a message a volunteer will return your call between 9AM and 8PM.
Breastfeeding support

- La Leche League Tucson - [www.lllofaz.org/Tucson.html](http://www.lllofaz.org/Tucson.html)
  - 520-789-MILK
- Milk and Honey @ [milkandhoneytucson.com](http://milkandhoneytucson.com)
- Mama’s Latte - 520-628-4202
- TMC Women’s Breastfeeding Support Group 520-324-5730
- Northwest Women’s Center Breastfeeding Support Group - currently virtual. 520-877-4156
In Home Family Support

- **Healthy Families Arizona**: Healthy Families Arizona is a free program that helps mothers and fathers become the best parents they can be. *(For infants 3 months and under)*

- Teach and support appropriate parent-child interaction and discipline

- Provide periodic developmental assessments and referrals if delayed

- Link families with community services, health care, childcare, and housing Available in Mohave, Pima, Cochise, Pinal, Graham, Santa Cruz, Maricopa, Yuma and Yavapai county
In Home Family Support

Nurse-Family Partnership is a community healthcare program that will connect families with a nurse home visitor.

(For prenatal first-time mothers) starting from pregnancy to second birthday

Serving Maricopa and Pima
In Home Family Support

- FREE home visitation program that works with pregnant women, mothers of young children and their families.
- Pregnant women and families with children enrolled in the program receive additional supports such as navigating access to prenatal care; family medical care; and assistance in applying for AHCCCS, WIC and other program that help you and your family thrive.
- They have translation services that allow them to work with a variety of women, including many refugees. *(Pregnant Women or mothers with children up to 24 months old.)*
Pima County Parent Coalition

This is a great web page. It works as a triage for both information and referrals for both in-home and community based parent education programs.

The referral is on the page, they have an easy to use link and form. The resources offered are:

- In Home Class
- Community Class
- Educational Development for Children
- Learning how to Improve Parenting Skills
- Getting Children Ready for School
- Learning how to Keep Children Healthy
- Learning how to Better Manage Stress
- Behavior Management
- Healthy Pregnancy and Childbirth
BIRTH TO FIVE HELPLINE™

Call 877-705-KIDS (5437) for Free Child Development Support
Starting out right

- **SOR provides** health education and supportive services to pregnant and parenting adolescents ages 21 and younger, regardless of their financial situation.
- Several classes including pregnancy health education classes, parenting education classes, healthy relationship classes.
- Supportive services such as case management, support groups, free pregnancy classes, a scholarship program.
- **Jensen’s Corner** - a boutique of gently used baby and maternity items to purchase with SOR incentive dollars.
2-1-1 Arizona

Provides contact information for a wide range of services including:
• Food and meal services
• Housing and Shelter
• Income and Expenses
• Rent and Utility Expenses
• Employment services
• Pets and animals

The site is accessible by county
Southern Arizona Diaper Bank

Care Resource and Referral is a FREE statewide program in Arizona that helps families find childcare to fit their needs.
Addiction/Recovery

The Haven
- IOP
- Residential
- Outpatient

Las Amigas - Residential recovery program