Office of Addiction Services and Supports

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OUD in Women: Focus on Pregnant and Parenting Persons, Stigma, and Treatment Options

Presentation for MOMD Webinar Series, 4/7/21

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Disclosures

Dr. Ramsey has no significant financial disclosures

Learning Objectives

1. Summarize the epidemiology of SUD in women, with a focus on opioid use disorder (OUD)

2. Discuss stigma towards women who use drugs, particularly pregnant and parenting persons, and discuss the role of language in stigmatization

3. Describe harm reduction practices and trauma-informed care to engage persons with SUD more effectively and sensitively

4. Discuss medication for opioid use disorder (MOUD) options and best practices in pregnant and breastfeeding persons

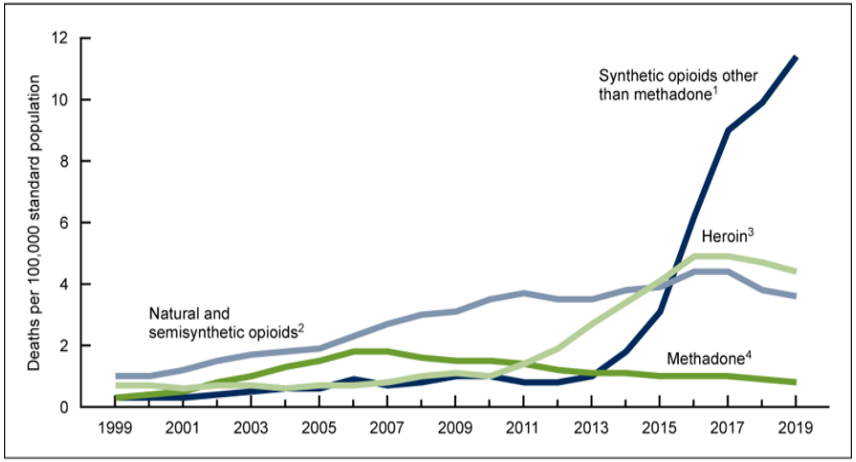
Epidemiology of SUD in Women, with a Focus on OUD: Background for Understanding Your Patient/Client

The First Opioid Epidemic Among Women in the US

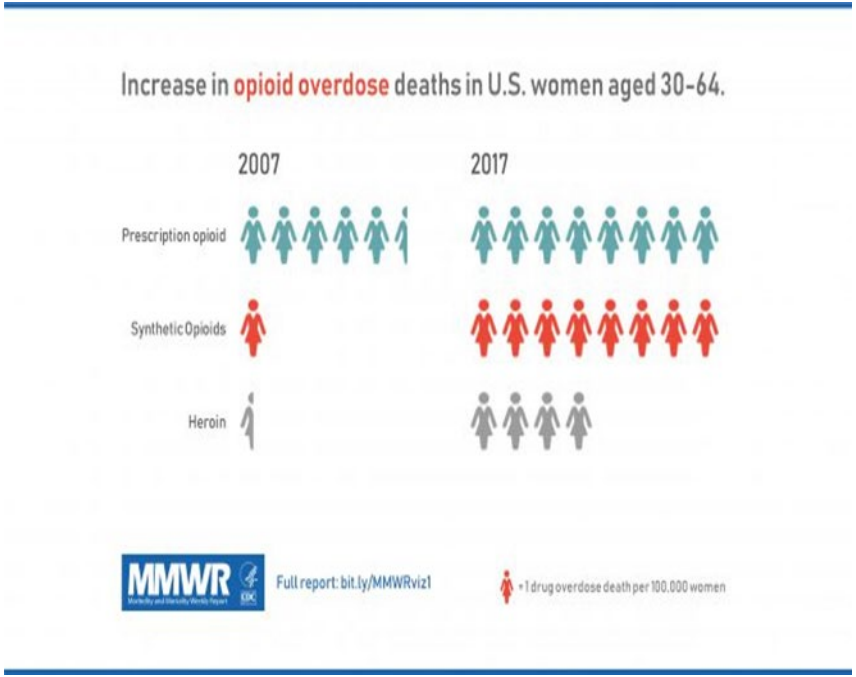
- First surviving records of OUD ("opium addiction") date from the end of the 18th century
- Morphine was isolated in 1804, heroin was synthesized in 1874, and dependence to these opioids became more common after their commercial production
- Throughout the early 1900s, opioid and coca (cocaine) based products were marketed as (unregulated) "medicinal tonics" for use with women and children for common maladies (cough and fatigue, respectively); doctors commonly prescribed opiates for middle- and upper-class white women for "nervousness" and "female problems"
- An increase in the incidence of OUD among women was noted as early as the 19th century; however, infants were not thought to be affected because it was believed that morphine use among women was associated with sterility and loss of sexual desire
- This fallacy was corrected with the first reported case of an affected neonate with opioid withdrawal at birth in 1875, labeled "congenital morphinism"; in 1903, the first infant with congenital morphinism survived after being treated with morphine

Opioid Overdose Deaths Pre-COVID-19

Figure 3. Age-adjusted rates of drug overdose deaths involving opioids, by type of opioid: United States, 1999–2019

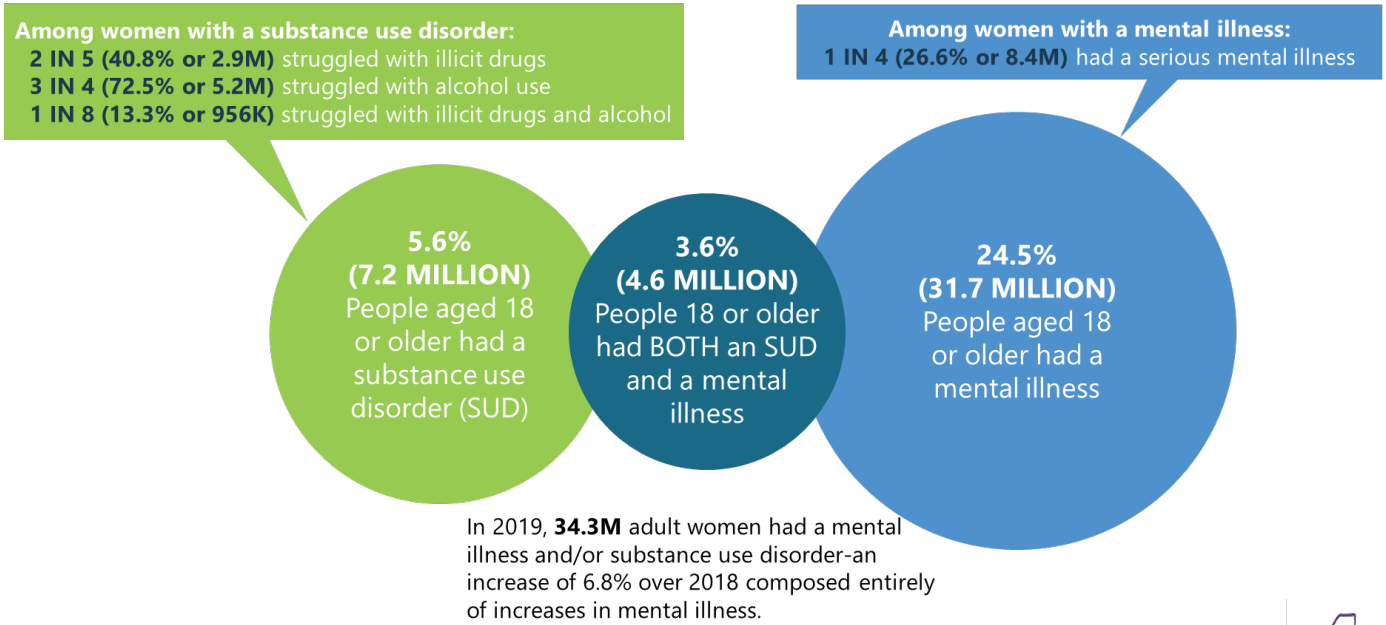


[1]Significant increasing trend from 1999 through 2006 and 2013 through 2019, with different rates of change over time, $p < 0.05$.
[2]Significant increasing trend from 1999 through 2017, with different rates of change over time, $p < 0.05$.
[3]Significant increasing trend from 2005 to 2016, with different rates of change over time, then significant decreasing trend from 2016 through 2019, $p < 0.05$.
[4]Significant increasing trend from 1999 to 2006, with different rates of change over time, then significant decreasing trend from 2006 through 2019, $p < 0.05$.
NOTES: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* (ICD–10) underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4. Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid) are counted in both categories. Natural and semisynthetic opioids include drugs such as morphine, oxycodone, and hydrocodone; and synthetic opioids other than methadone include drugs such as fentanyl, fentanyl analogs, and tramadol. The percentage of drug overdose deaths that identified the specific drugs involved varied by year, ranging from 75%–79% from 1999 through 2013 and increasing from 81% in 2014 to 94% in 2019. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db394-tables-508.pdf#3.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.



Mental Health Issues and Substance Use Among Women >=18 yo in the US, 2019

PAST YEAR, 2019 NSDUH, Women 18+



In 2019, **34.3M** adult women had a mental illness and/or substance use disorder-an increase of 6.8% over 2018 composed entirely of increases in mental illness.

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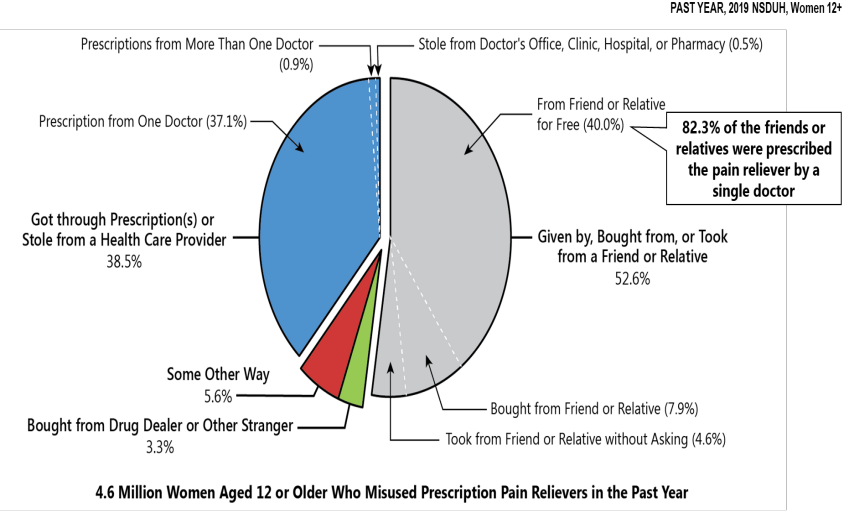
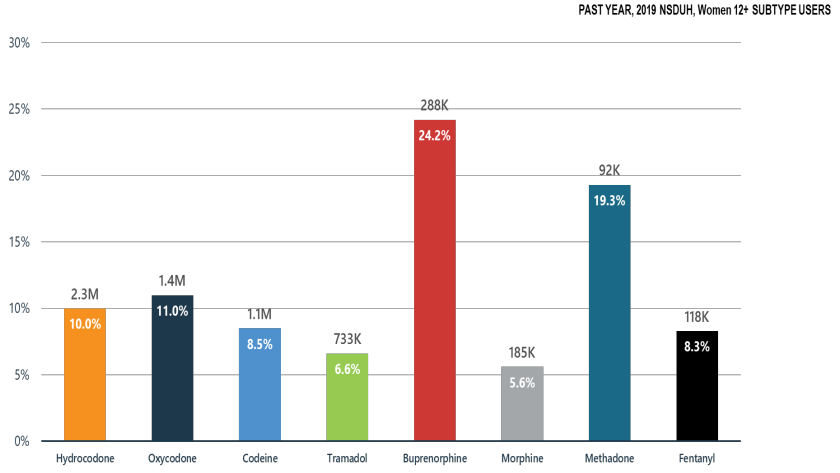
Misuse of Prescription Opioids by Women

Source of Opioid Pain Prescriptions Among Women for Misuse



Misuse of Prescription Opioid Subtypes by Women



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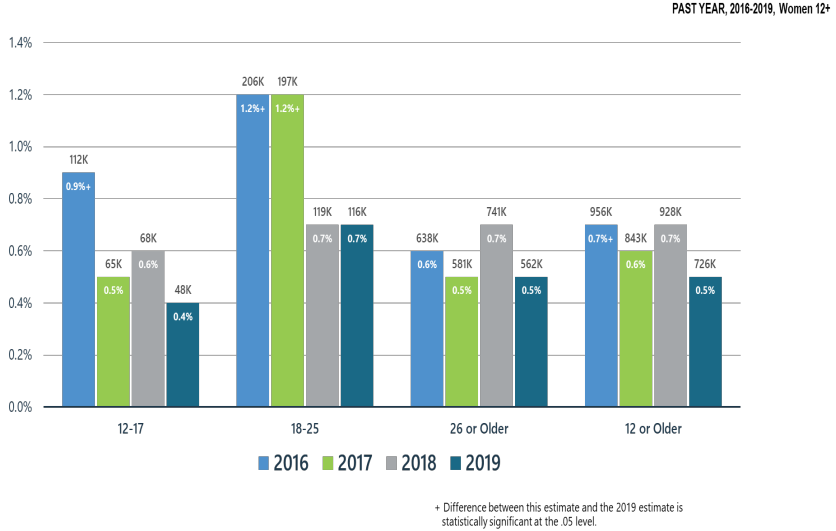
Medical Consequences of Opioid Use for Women

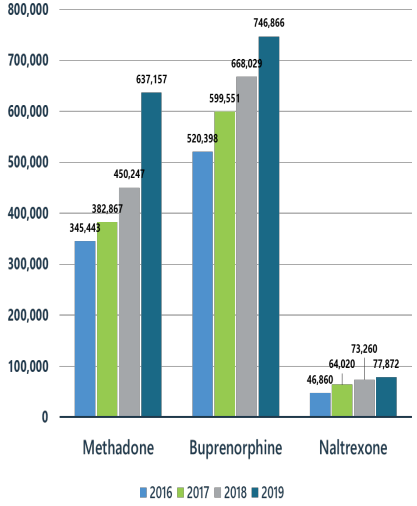
- **Medical Consequences**
  - Women's use of heroin increased to similar rates in men
    - 1960s 4:1 Male to Female by 2010s: 1:1 Male to Female
    - Greater risk of contracting Hepatitis C and HIV with IV heroin use
    - May be more likely to inject with a previously used needle (or share needles with a male partner)
  - More likely to be prescribed prescription opioids for pain than men
    - Greater likelihood of reporting chronic pain
  - Women are less likely to die of prescription opioid overdose but:
    - Women: 596% increase in overdose between 1999 and 2016
    - Men: 312% increase in overdose during the same time period
  - 2016 study showed women who died from opioid overdose were three times less likely to receive naloxone than men

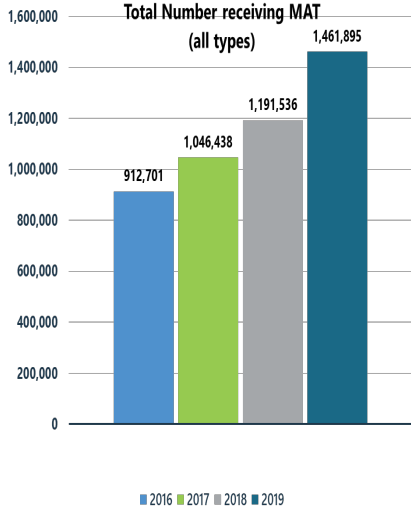
Opioid Use Disorder Among Women and MOUD

Opioid Use Disorder Among Women



Treatment Gains: Number of Persons on MOUD





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Co-occurring Substance Use, SUD, and Mental Illness in Women

Depression

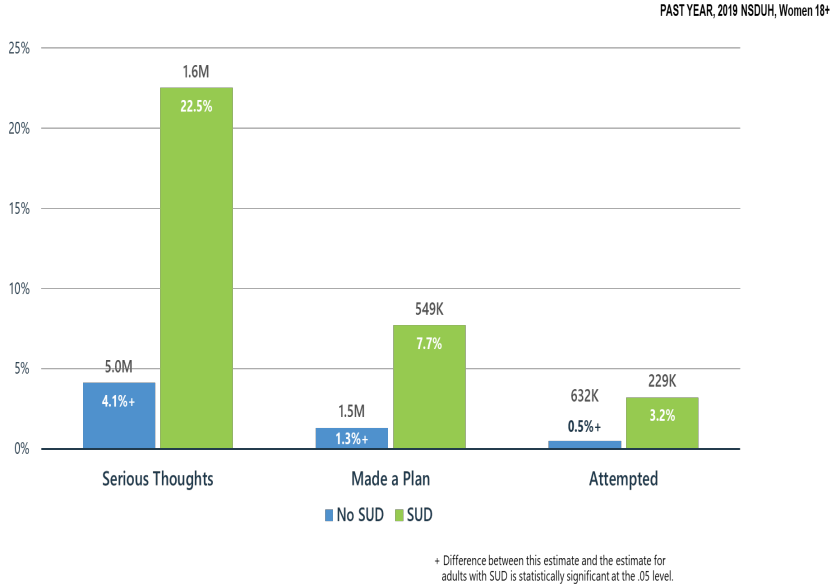
- Male: Female differences in psychiatric disorders and their relationship to the onset of substance use emerge in adolescence
  - Depression increases risk of substance use in adolescent females
  - Conduct disorder and ADD increase risk in adolescent males
- One Australian study showed:
  - Adolescent males drank alcohol to have fun
  - Adolescent females drank to cope with depressed mood
- Adult women report using substances to manage negative affective states
- Adult women with SUD have been shown to have higher prevalence of depressive and anxiety disorders compared to men
- Treatment seeking women with SUD are more likely than men to be diagnosed with multiple co-occurring psychiatric disorders

PTSD/Trauma

- Trauma exposure, posttraumatic stress disorder, and substance use
  - Women more likely to report a history of trauma than men
    - Particularly childhood sexual trauma
- PTSD as a result of childhood sexual trauma and other traumas
  - Highly correlated with and often proceeds development of SUD
- Missouri Adolescent Female Twin Study (MOAFTS) – 2009
  - Women exposed to trauma:
    - 1.85x more likely to develop alcohol dependence
  - Women exposed to trauma with PTSD:
    - 3.54x more likely to develop alcohol dependence
- Substance use to manage PTSD symptoms may lead to an increased risk of experiencing sexual victimization and engaging in risky sexual behaviors

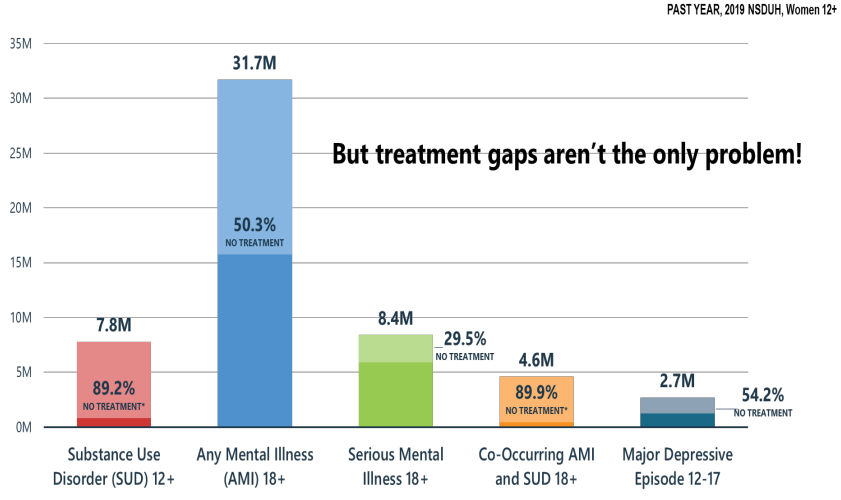
Co-occurring Disorders: High Prevalence/ High Treatment Gaps

SUD Is Associated with Suicidality Among Adult Women >=18 yo



+ Difference between this estimate and the estimate for adults with SUD is statistically significant at the .05 level.

Mental Health Disorders and SUD Among Women: High Prevalence/High Treatment Gaps



* No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

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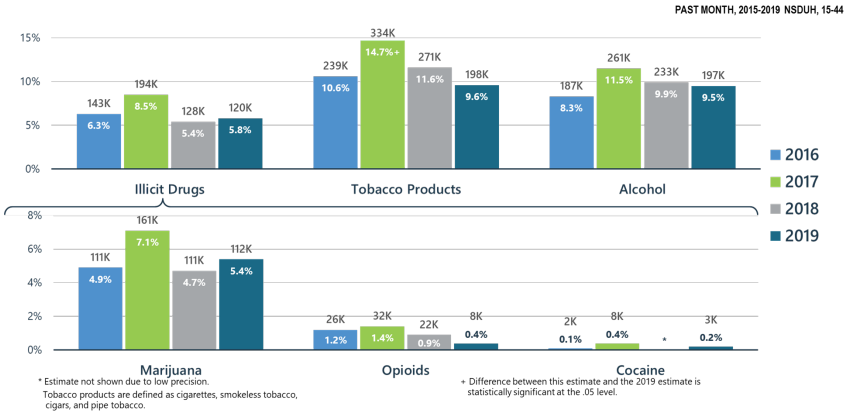
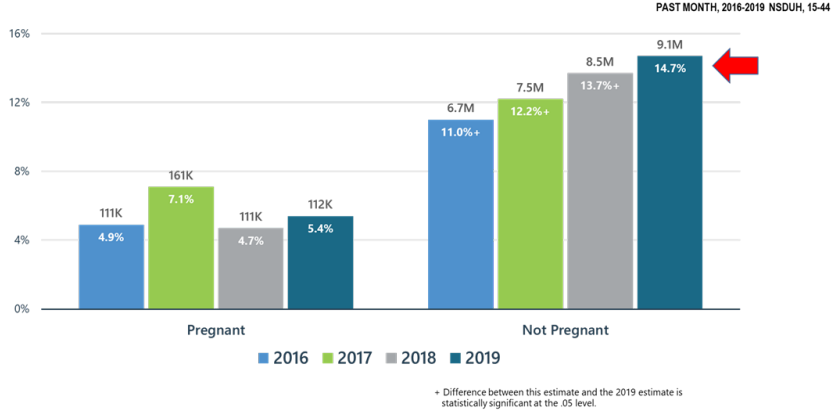
Substance Use Among Pregnant Persons

Past Month Substance Use Among Pregnant Persons



Marijuana Use by Pregnancy Status



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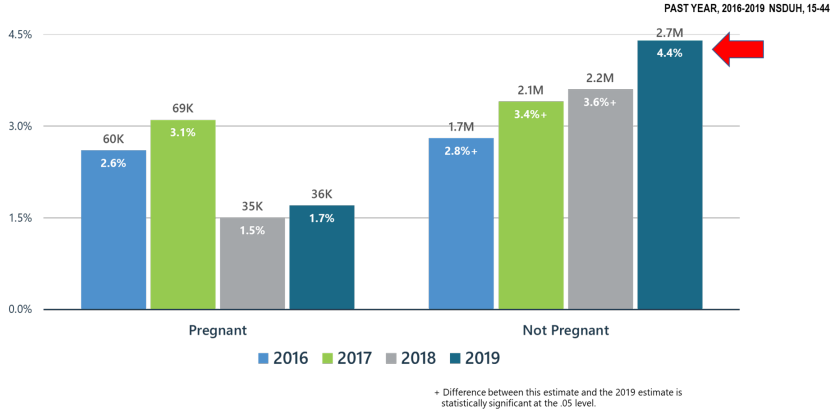
Substance Use, Pregnancy, and Mental Health Issues

Daily or Almost Daily Marijuana Use by Pregnancy Status



+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Past Year Substance Use and Mental Health Issues, Pregnant Persons Aged 15-44 yo, by Marijuana Use Status

PAST YEAR, 2019 NSDUH, 15-44

Substance	No Past Year Marijuana Use Number (Thousands)	No Past Year Marijuana Use Percentage	Any Past Year Marijuana Use Number (Thousands)	Any Past Year Marijuana Use Percentage
Cocaine	4+	0.3+	29	8.5
Crack	1	0.1	*	*
Heroin	1	0.1	*	*
Hallucinogens	2+	0.1+	28	8.3
LSD	*	*	17	5.2
PCP	*	*	0	0.1
Ecstasy	2	0.1	5	1.5
Inhalants	*	*	*	*
Methamphetamine	*	*	18	5.5
Misuse of Psychotherapeutics	48	2.7+	89	26.7
Pain Relievers	24	1.4+	60	17.9
Stimulants	6+	0.3+	38	11.5
Tranquilizers or Sedatives	20	1.2+	42	12.5
Tranquilizers	19	1.1+	42	12.5
Sedatives	1	0.1	*	*
Benzodiazepines	19	1.1+	40	12.1
Opioids	25	1.5+	60	17.9
Illicit Drugs Other than Marijuana	51+	2.9+	101	30.3
ALCOHOL (PAST MONTH)	105	6.1+	91	27.3
Binge Alcohol Use	54	3.1+	46	13.7
Heavy Alcohol Use	*	*	6	1.7
MENTAL HEALTH STATUS				
SUICIDAL BEHAVIORS				
Suicidal Thoughts	56	3.3+	45	14.0
Suicide Plans	11	0.7+	23	7.3
Suicide Attempts	13	0.8	17	5.4
Serious Mental Illness	55	3.2+	46	14.3
Major Depressive Episode (MDE)	111+	6.6	44	14.0
MDE with Severe Impairment	73+	4.3	24	7.6

+ Difference between this estimate and the estimate for people with past year marijuana use is statistically significant at the .05 level.

* Estimate not shown due to low precision.

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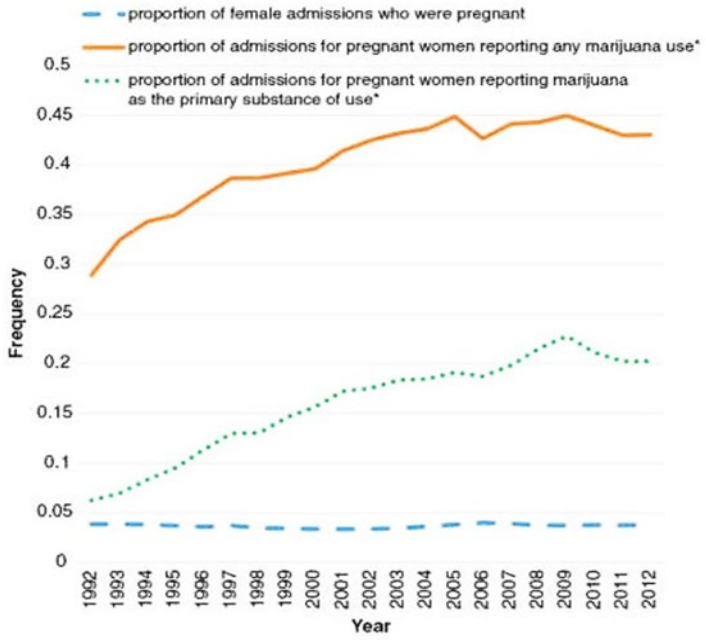
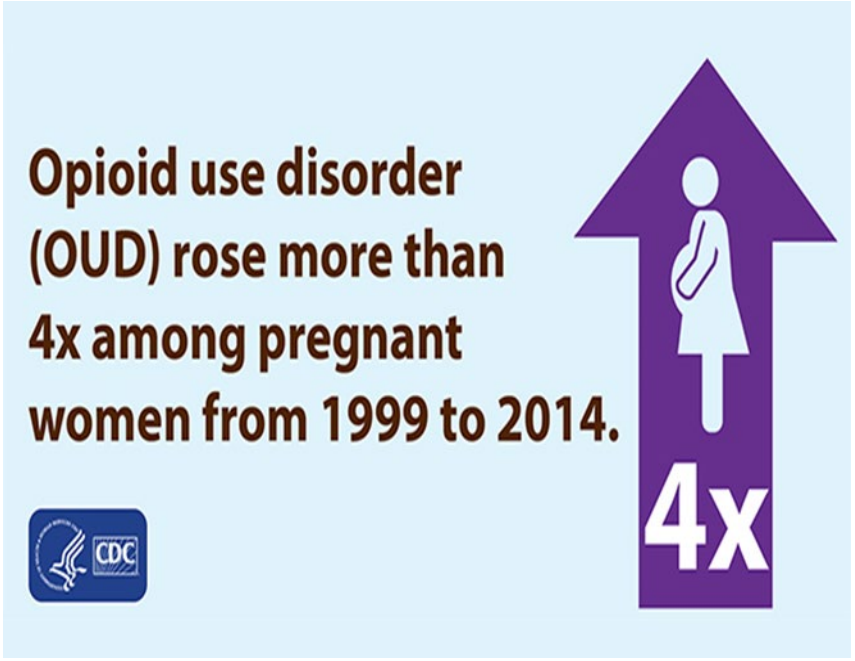
Pregnancy and Prescription Opioid Misuse Among SUD Treatment Admissions





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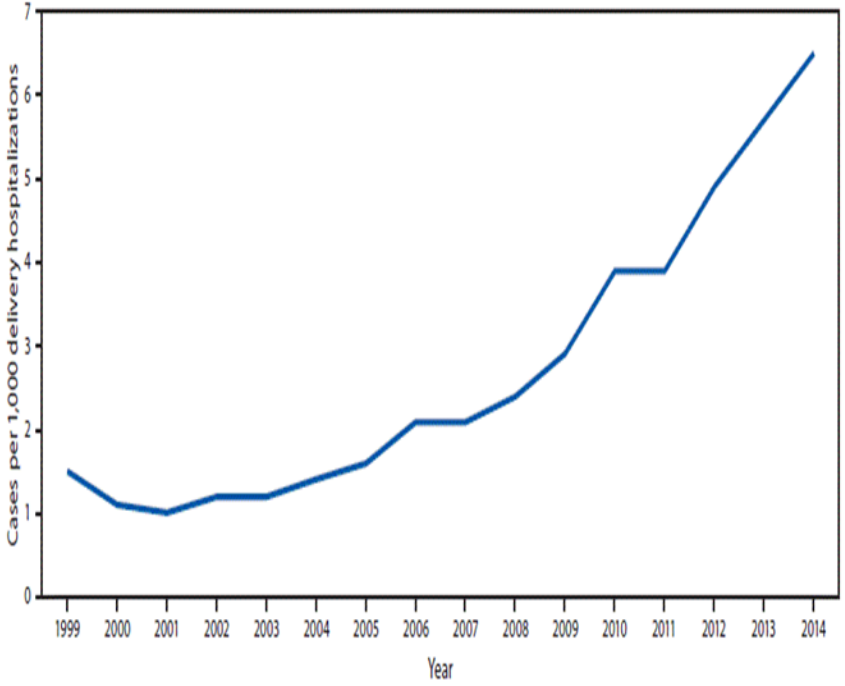
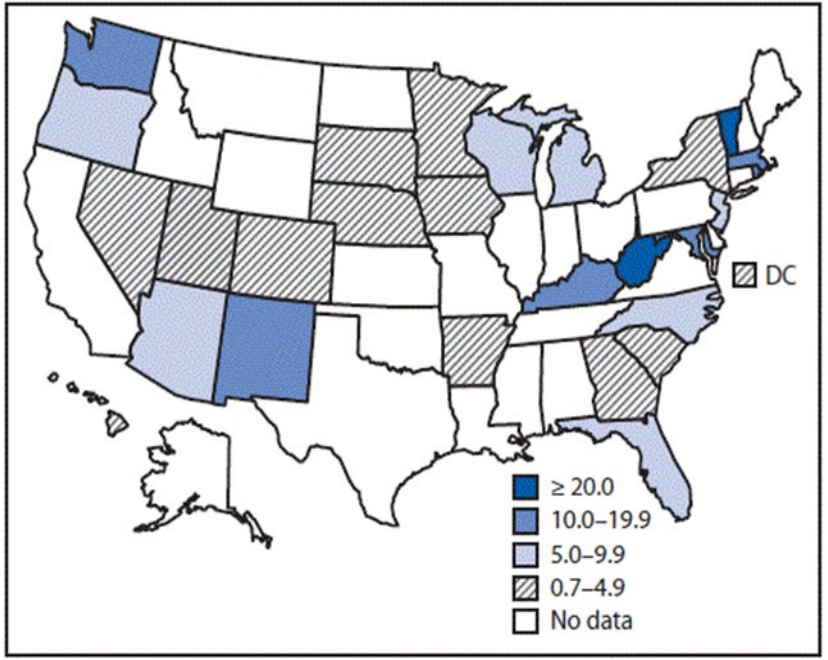
Prevalence of Opioid Use Disorder Per 1000 Delivery Hospitalizations





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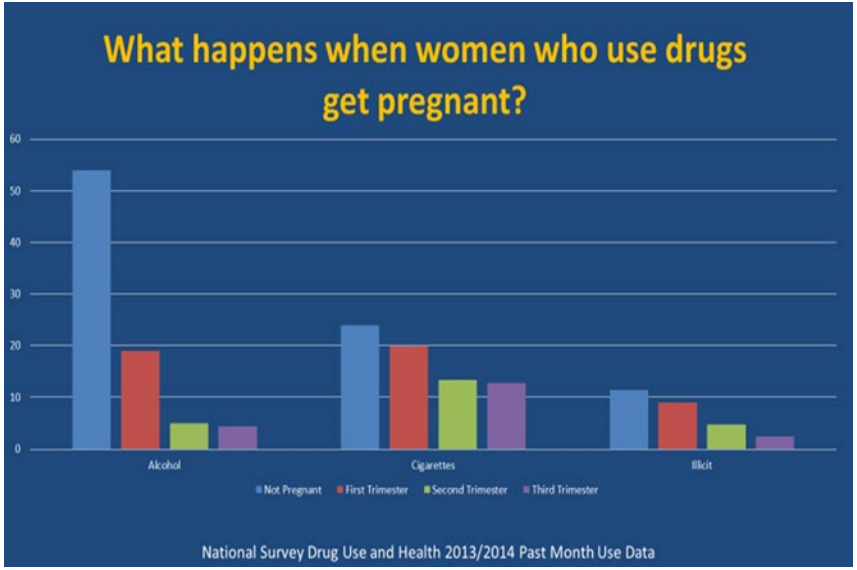
Substance Use Among Pregnant Persons

Substance Use Progressively Decreases During Pregnancy by Trimester



Teasing Out Substance Use v. SUD in Pregnant Persons

- The *vast majority* of pregnant persons are motivated to maximize their own health and the health of their developing fetus
- Those pregnant persons who can't cut back or quit using, *likely* have a substance use disorder
- Continued use in pregnancy *could indicate* a substance use disorder

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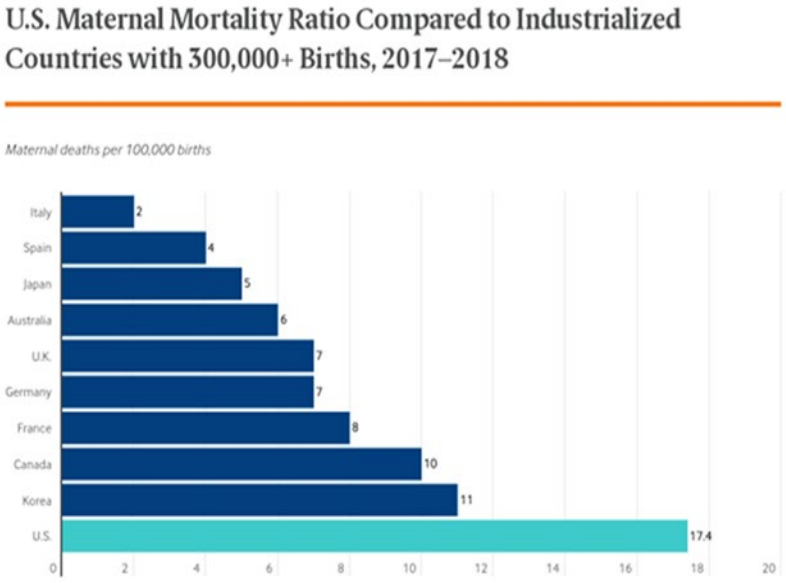
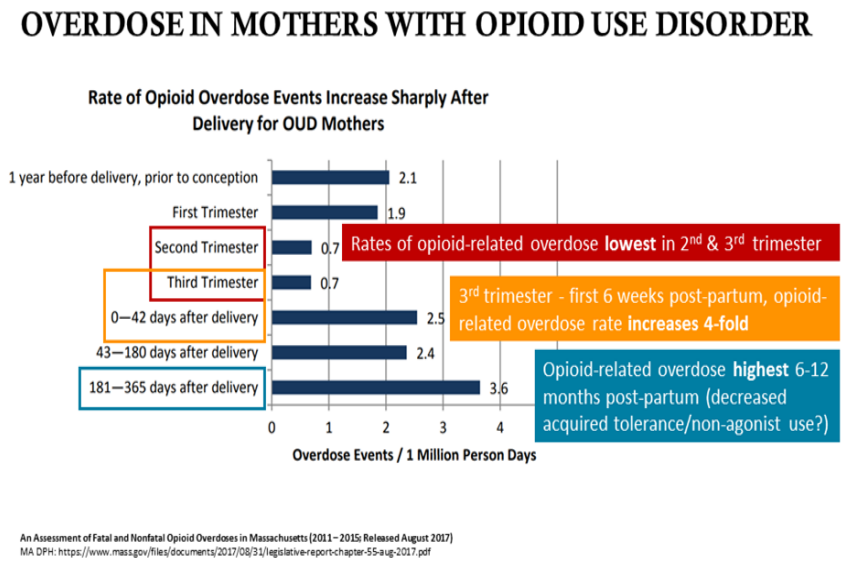
Maternal Mortality in the US

Higher Compared with Other Industrialized Countries



Maternal Mortality due to Fatal Overdose: MA Data



An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015; Released August 2017)
MA DPH: https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf

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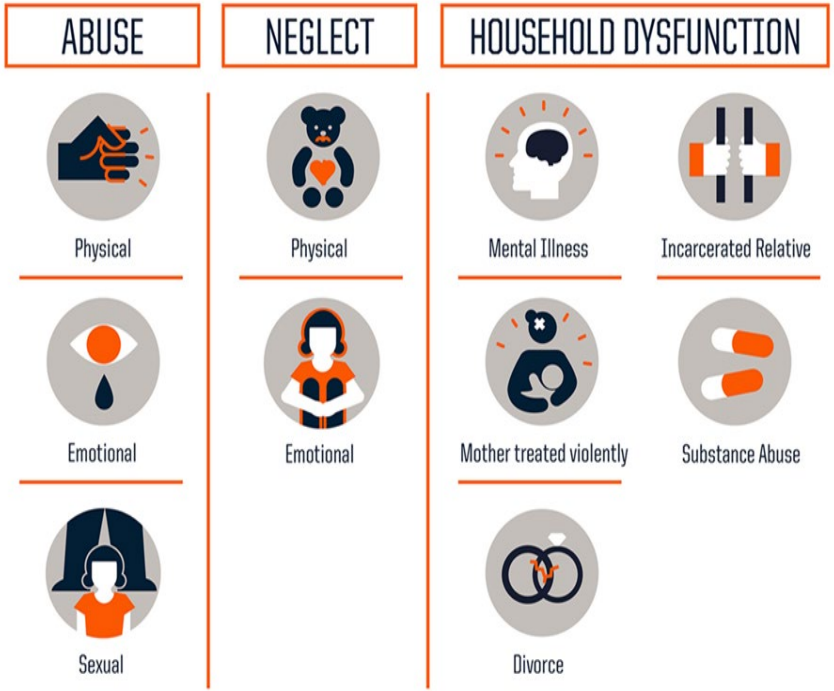
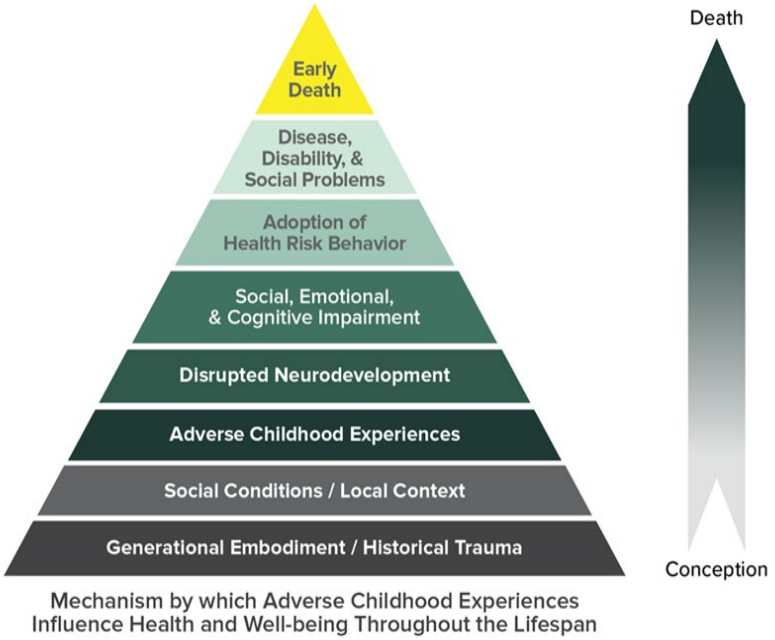
Vulnerabilities for Developing SUD

- Genetic predisposition (40-60% of risk)
- Concomitant mental health diagnoses: bipolar disorder, anxiety (panic disorder, PTSD, social anxiety), major depression, ADHD, personality disorders (borderline, antisocial), antisocial conduct disorder (especially in adolescence); whether undiagnosed or undertreated or untreated or treated inappropriately
- History of trauma and/or abuse: preadolescent sexual trauma (especially females), victim/witness to violence (males/females)
- Poor coping mechanisms; escapism
- Impulsivity: plays a role in the initiation of substance use
- Sensation/novelty seeking: plays a role in the initiation of substance use
- Environmental triggers/sensory cues: triggers to use/resume use
- Lack of homeostatic reward regulation; reward “deficiency”: orientation towards pleasurable rewards, priming of the brain by early substance use

The Role of Trauma: Adverse Childhood Experiences and Outcomes





Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

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What Is Trauma?

What Is Trauma?

Exposure to actual or threatened death, serious injury, or sexual violence in one or more of four ways:

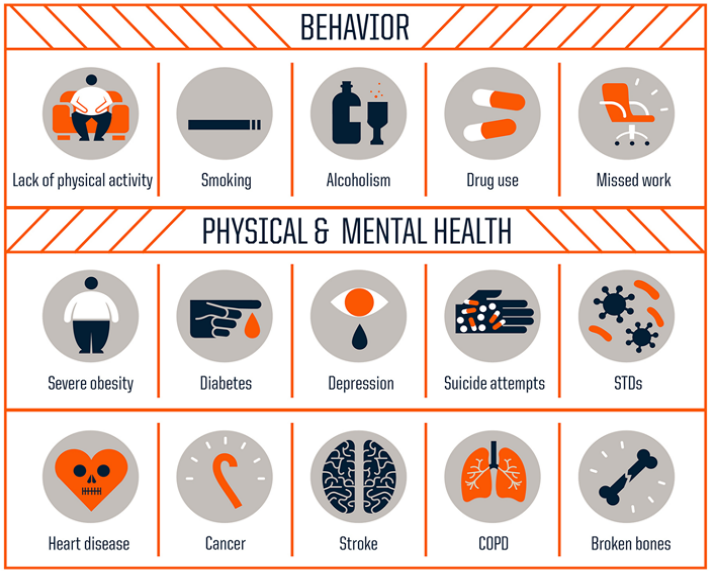
-directly experiencing the event

-witnessing, in person, the event occurring to others

-learning that such an event happened to a close family member or friend

-experiencing repeated or extreme exposure to aversive details of such events (i.e., first responders)

Its Effects



Pregnant Persons with SUD

- ***Mental Health:***

  -2/3 with co-occurring mental health diagnoses (MDD, GAD, PTSD)

  -Majority with childhood trauma (pre-adolescent sexual or physical trauma)

  -High level of IPV (intimate partner violence) in the last year

- ***Reproductive Health:***

  -Unplanned pregnancy (80%); low rates of contraception use

- ***Other Substance Use:***

  -Tobacco use: >90%

- ***Social Functioning:***

  -Inadequate social supports; social isolation; exposure to poor parenting models

Stigma, Language, and Barriers to Care

Barriers to SUD Treatment for Women

- **Women experience more barriers to treatment than men**
  - **Social stigma and discrimination**
    - **Number one reason for not seeking treatment**
  - Less likely to be screened in primary care and MH settings for SUDs
  - Lack of treatment services for pregnant persons
  - Lack of childcare services for parenting persons
  - Economic barriers
  - Lack of insurance
  - Lack of transportation or funds for transportation
  - Trauma histories
  - Intimate partner violence (IPV)

Stigma and PWUD

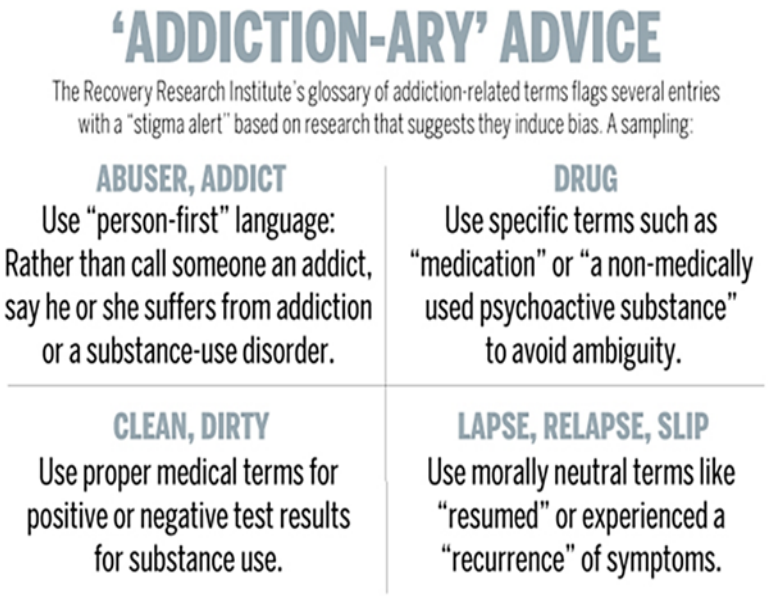
- Healthcare providers have high levels of stigma and bad feelings towards people who use drugs, in part from derogatory or dehumanizing language that is commonplace
- Studies indicate that the language used corresponds with providing poorer treatment

What We Say and How We Say It Matters: Bad Language Perpetuates Stigma

This is not simply a matter of policing language. Rigorous research has proven that terms like "substance abuser" elicit bias and negative attitudes in health care and policymaking settings.

One study by the Recovery Research Institute at Mass General Hospital found that describing a person as a “substance abuser” increased the likelihood of evoking more punitive attitudes. "Substance abusers" were more likely to be viewed as: less likely to benefit from treatment; more likely to benefit from punishment; and more likely to be blamed for their illness.

These results have been confirmed by the Johns Hopkins Stigma Lab and recovery scientist Robert Ashford.



Stigma: Then and Now

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What Does Stigma Look Like?

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What Does Stigma Look Like?

- Misrepresentation of NOWS: “newborn’s death sentence”, “drug addicted baby”
- Pitting parent VERSUS child, rather than seeing birth parent and child as a dyad

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Wisconsin

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A parent's heroin addiction, a newborn's death sentence

Mike De Sisti

Nicole Beltrame with her 18-month-old daughter, Nevaeh, with whom she was recently reunited. Beltrame became addicted to painkillers after a bad car accident, but she's off the drugs now and pregnant again, with her baby due this month.

By Crocker Stephenson of the Journal Sentinel

Nov. 14, 2014

Photo Gallery

No bystander could be more innocent. No damage so helplessly collateral.

Trysten Jacob Powell, delivered by C-section at Wheaton Franciscan-St. Joseph hospital on March 28, 2013, lived three months.

f of his life was spent in St. Joe's neonatal intensive care unit,

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Stigma and Engagement (or Lack Thereof) in Prenatal Care

- *"Research has identified the stigma around NAS [NOWS] and substance use disorders in general as a significant barrier to treatment for pregnant women [persons]. Many mothers [pregnant persons] do not self-disclose their drug use during pregnancy due to stigma, complicating the treatment process. In addition, when they do reach out for help, 'they often encounter misinformation, denial, inaction, and even judgmental and punitive attitudes toward their substance use.' In some cases, policies that initiate punitive responses to pregnant women [persons] with substance use disorders may also create barriers to treatment.*
- *In 2013, 40 leading medical experts sent a letter to several prominent news outlets describing how sensationalized terminology commonly used in the media to describe NAS [NOWS] is medically inaccurate and reinforces stigma. 'Drug-addicted babies', for example, is not an accurate description of babies born with NAS [NOWS]. These newborns may exhibit physiologic dependence, but they cannot exhibit the compulsive behaviors associated with addictive disorders. This language is successful at eliciting a strong emotional response, but may also help to reinforce many of the negative attitudes that discourage women [pregnant persons] from accessing the treatment they need."*

Substance Use Disorder Treatment During Pregnancy: Most Pregnant Persons Receive No Treatment

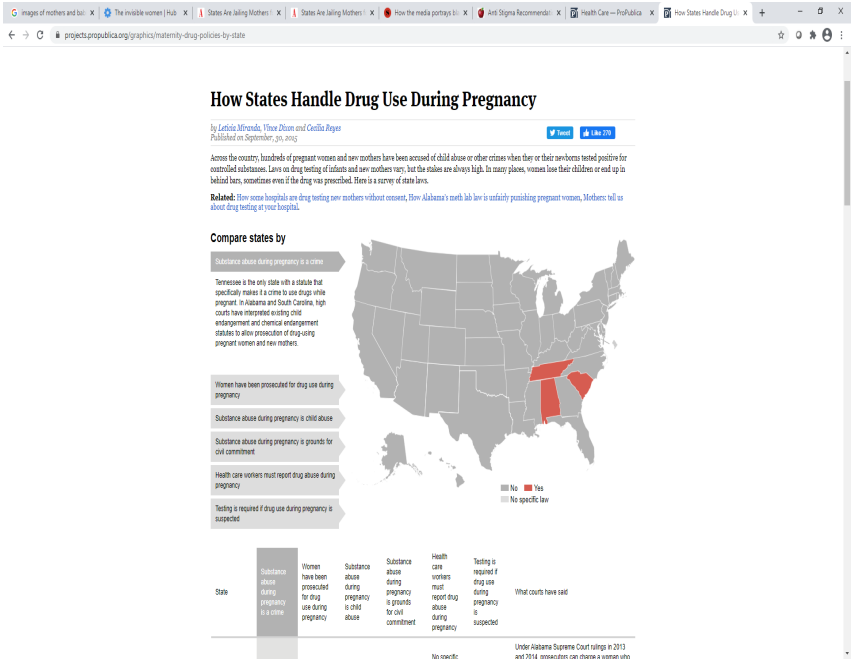
NSDUH 2007-2014	Pregnant	Not pregnant
Need Treatment	744,361 30.2%	43,239,606 15.7%
Received Treatment	87,388 11.7%	2,938,403 6.8%

Low Birth Weight Outcomes for Persons with SUD in Pregnancy

LOW BIRTH WEIGHT	PNC	No PNC
No drug use	14%	19%
Drug Use	19%	48%

How Stigma Leads to Punishment of Persons of Childbearing Age

- *Stigma*: a mark of disgrace associated with a particular circumstance, quality, or person
- *Dehumanization*: the process of depriving a person or group of positive human qualities
- *Discrimination*: the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex
- *Prejudice*: preconceived opinion that is not based on reason or actual experience
- *Punishment*: the infliction or imposition of a penalty as retribution for an offense
- *Stigma* -> *Dehumanization* -> *Discrimination*/*Prejudice* -> *Punishment*



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State Policies on Substance Use During Pregnancy

- 23 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and 3 consider it grounds for civil commitment.
- 24 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use.
- 19 states have either created or funded drug treatment programs specifically targeted to pregnant persons, and 17 states and the District of Columbia provide pregnant persons with priority access to state-funded drug treatment programs.
- 10 states prohibit publicly funded drug treatment programs from discriminating against pregnant persons.

Punishment of Pregnant Persons: Is This Utilizing Best Practices?

- ***Discriminatory***: persons of color and poor persons are more likely to be prosecuted, despite white persons being more likely to use during pregnancy
- ***Not evidence-based***: risks of illicit substances are often exaggerated in comparison to the risks of legal substances
- ***Unintended consequences***: punitive policies drive pregnant persons away from SUD treatment and prenatal care
- ***Engagement***: in prenatal care counteracts the adverse effects of substance use during pregnancy

Harm Reduction Practices and Trauma-informed Care

Evolution of Approaches to SUD Treatment

Historical Approach to SUD Treatment: The Stick

- Change is motivated by discomfort
- If you make PWUD feel badly enough, they will change
- People have to hit bottom before they are ready for change
- Someone who continues to use is in denial
- The best way to break through the denial is through confrontation
- Effectively, people don't change unless they have suffered enough ("you better or else…")
- If the stick is big enough, no carrot is needed…

A Better Approach to SUD Treatment: The Carrot

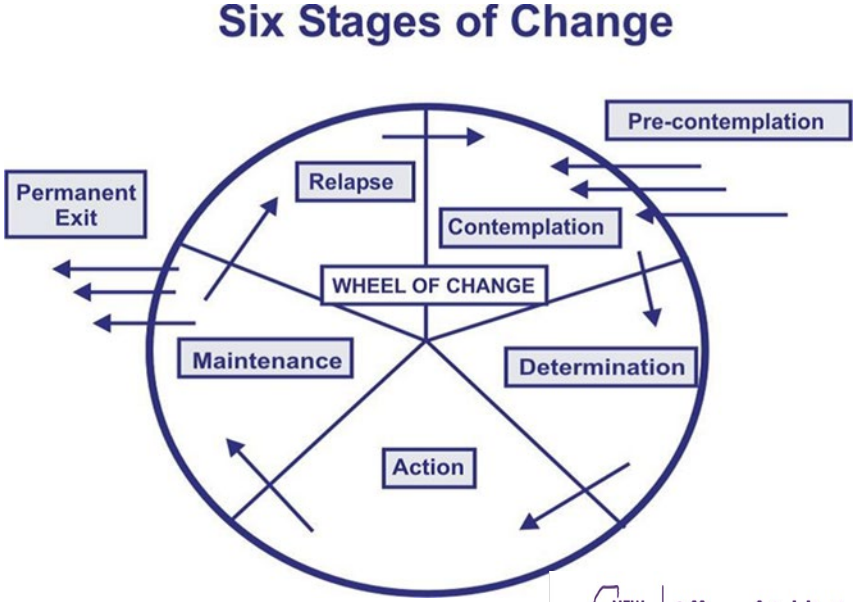
- People, in general, are ambivalent about change
- PWUD continue their substance use because of their ambivalence
- *All* change contains an element of ambivalence
- Resolving ambivalence in the direction of change is a key element in motivational interviewing
- Motivation for change can be fostered by an accepting, empowering, and safe atmosphere
- *Person-centered approaches enhance motivation and reduce risk*

Ambivalence and the Transtheoretical Model

The Concept of Ambivalence

- Ambivalence is normal
- People usually enter treatment with conflicting and fluctuating motivations
- People want to change, but don't want to change
- Working with ambivalence is working with the heart of the problem
- Counseling depends on the person's current stage of change for *each* substance; mismatched counseling and stage of change lead to an ineffective interaction

Stages of Change



Recovery Is Individualized

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

***Health*:** overcoming or managing one's disease(s) or symptoms;

***Home*:** a stable and safe place to live;

***Purpose*:** meaningful daily activities and the independence, income, and resources to participate in society; and

***Community*:** relationships and social networks that provide support, friendship, love, and hope.

What Is Person-Centered Care?

From SAMHSA:

Person-centered care—also known as patient-centered care—means consumers have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.

Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.

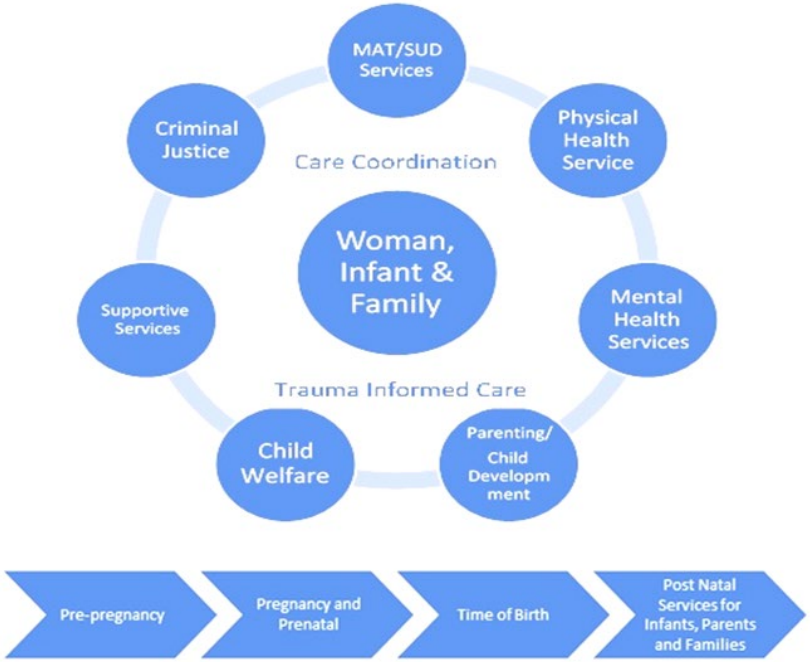
Effective person-centered care planning strengthens the voice of the individual, builds resiliency, and fosters recovery. It is important to note that while person-centered planning is respectful and responsive to the needs of the individual, it also occurs within the professional responsibilities of providers and care teams.

Harm reduction is a strategy employed in person-centered care.

Best Practice: Motivational Interviewing: Principles of Person-Centered Care

- ***Services exist for patients***
- ***Change is self-change***
- ***People are experts on themselves***
- ***We don't have to make change happen***
- ***We don't have to come up with good ideas***
- ***People have their own strengths, motivations, and resources that are vital in order for change to occur***
- ***Change requires partnership***
- ***It is important to understand the person's perspective***
- ***Change is not a power struggle***
- ***Motivation is evoked***
- ***We cannot take away people's choice about their behavior***

Components of Patient-Centered and Family-Centered Care



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Trauma-informed Care

4 R's of Trauma-informed Care

- **Realizing** the widespread impact of trauma
- **Recognizing** signs and symptoms of trauma in people, including patients, their families, staff and clinical team members
- **Responding** by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeking to actively resist **Re-traumatization**

General Principles of Trauma-informed Care

- Universal Trauma Precautions
- Ability to adapt
- One trauma is not ALL trauma!
- Anticipate shame and stigma

What Is Harm Reduction?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. It is based on a strong commitment to public health and human rights.

Harm Reduction Principles

- Substance use exists along a continuum abstinence is ONE of many possible goals
- Substance-related harm(s) cannot be assumed
- PWUD are more than their substance use; their substance use is just one of their attributes

- Targeting risk and harms to PWUD, understanding the roots of these risks, and tailoring interventions to reduce them
- Acknowledging the significance of any positive change that PWUD make in their lives
- **Accepting PWUD as they are and treating them with dignity and compassion**
- Protecting the human rights of PWUD
- Maintaining transparency in decisions about interventions as well as their successes and failures

What Does Harm Reduction Mean for PWUD?

Meeting people where they are at: not forcing PWUD to be where you want them to be and not leaving them behind

Harm reduction lies on the treatment continuum: with active use at one end and (perhaps)sustained abstinence from all substances on the other end

Change is positive: embrace it and encourage self-efficacy and resilience

Keeping patients alive is harm reduction: using buprenorphine intermittently to decrease heroin use *is* harm reduction as it decreases the risk of death by overdose (i.e., "dead drug us recover")

Identifying SUD During Pregnancy

- ***Universal screening (not risk-based screening):*** identify at risk persons early; utilize motivational interviewing; normalize questions and embed in EMR; use validated screening tools (DAST, MAST, 4 P's Plus, CRAFFT: for adolescents)
- ***Urine toxicology NOT recommended for screening:*** for myriad reasons (short detection window, confirmation testing needed, may not capture intermittent or binge use, may capture one-time use, ethical issues)
- ***Patient/Provider Barriers to Screening:*** patient fear of discrimination/mistreatment/CPS; provider lack of training/time/knowledge regarding how to address positive results

Innovative Harm Reduction Practices During COVID-19 and Beyond

Innovative Harm Reduction Practices

- Virtual naloxone trainings
- Mail-order naloxone and other harm reduction supplies directly to the homes of PWUD (www.nextdistro.org)
- Never Use Alone overdose prevention call line:

1-800-484-3731
(https://neverusealone.com/)

NYS DOH Guidance: Build a Safety Plan

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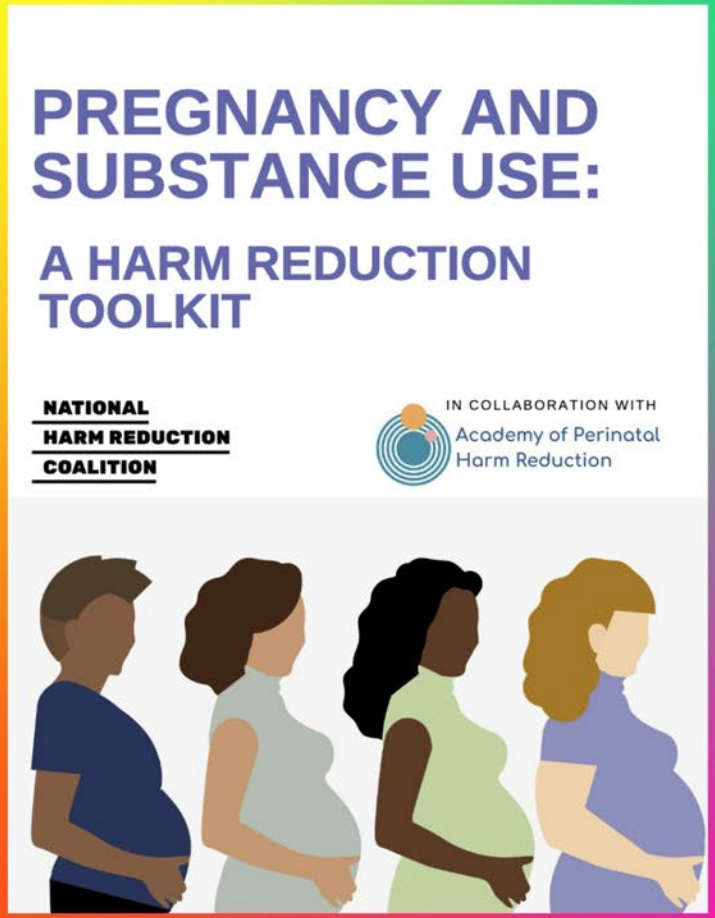

PREGNANT PEOPLE WHO USE DRUGS DESERVE ACCESS TO SERVICES AND HIGH-QUALITY, EVIDENCE-BASED CARE.

Know your rights and learn how to find quality care in this toolkit.

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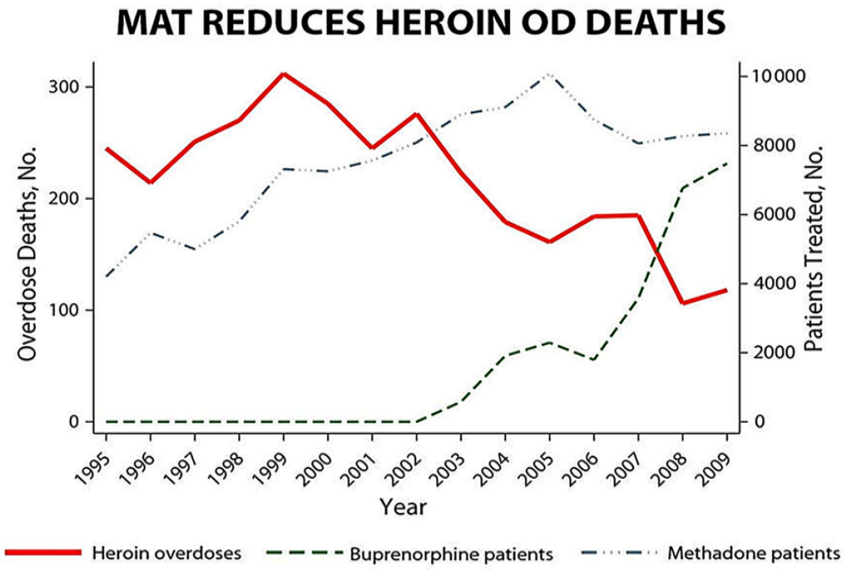
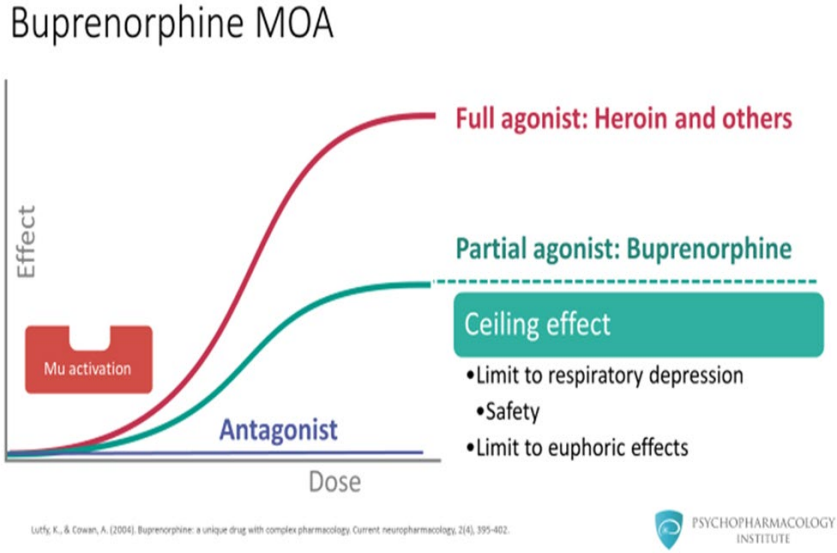
MOUD and Best Practices in Pregnant and Parenting Persons

MOUD

Why Use MOUD?



MOUD: Mechanism of Action and Mu Opioid Receptor Activity



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Standard of Care for the Treatment of OUD During Pregnancy *and* Post-Partum

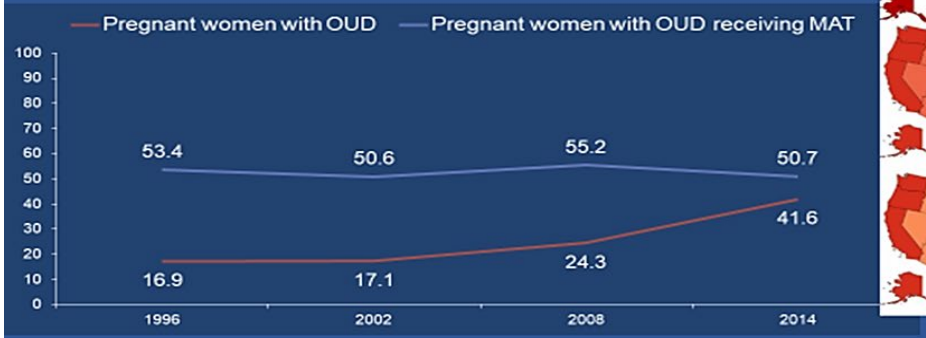
- MOUD with either methadone or buprenorphine: pregnant persons do not need to meet DSM-V criteria for OUD to receive MOUD
- MOUD endorsed by CDC, WHO, SAMHSA, ACOG, ASAM, AAFP, AAP (essentially all professional medical organizations)
- Access to behavioral counseling, as an adjunctive treatment, if needed
  - Either with the MOUD provider/staff or by referral to mental health or an SUD (OASAS) program or a dual diagnosis program (outpatient)

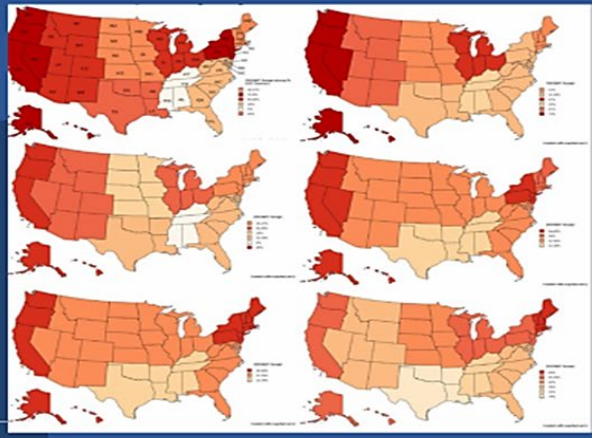
MOUD During Pregnancy: Most Pregnant Persons Receive No Pharmacotherapy

Trends and disparities in receipt of pharmacotherapy among pregnant women in publically funded treatment programs for opioid use disorder in the United States

Journal of Substance Abuse Treatment 89 (2018) 67–74

Vanessa L. Short[a,*], Dennis J. Hand[a,b], Lauren MacAfee[c], Diane J. Abatemarco[a], Mishka Terplan[d]





Only half of pregnant women in treatment receive pharmacotherapy

No Role for Medically Assisted Withdrawal (“Detox”) for OUD During Pregnancy

”Withdrawal management has been found to be inferior in effectiveness over pharmacotherapy with opioid agonists and ***increases the risk of relapse without fetal or maternal benefit***.” (ASAM); increased rates of NOWS; increased rates of relapse

Increased rate of relapse with associated overdose mortality following detox

Increased access to MOUD with opioid agonists is associated with a reduction in heroin overdose deaths

Offering MOUD in pregnancy increases treatment retention, # of OB visits attended, and in-hospital deliveries

Benefits of MOUD in Pregnancy

Pregnant Person

70% reduction in maternal overdose deaths

Decrease in acquisition/transmission of HIV, HCV, HBV

Increased engagement in prenatal care and SUD treatment

Improved maternal outcomes

Fetal

Decrease in fetal stress due to stable opioid levels

Decrease in intrauterine fetal demise

Decrease in intrauterine growth restriction

Decrease in preterm delivery

Goals for MOUD and MOUD Options

Goals for MOUD

- Decrease risk for fatal and nonfatal overdoses
- Eliminate OWS
- Decrease opioid cravings
- Increase patient functionality
- Normalize brain anatomy and physiology
- Decrease transmission/acquisition of viral infections (HBV, HCV, HIV) and infection complications (abscesses, cellulitis, endocarditis)

3 FDA Approved Medications

- Methadone: opioid full agonist; must be dispensed from an OTP; associated with decreased mortality
- Buprenorphine: opioid partial agonist; Schedule III drug; requires DEA "X" waiver to prescribe; associated with decreased mortality
- Naltrexone: opioid antagonist; not a controlled substance

MOUD: Methadone v. Buprenorphine

Methadone

Pregnancy Category C

No risk of precipitating opioid withdrawal

Historically, has been the gold standard treatment in pregnancy

Potential for prolonged QT

May require split dosing

May contribute to low birth weight compared with buprenorphine

Buprenorphine

Pregnancy Category C

Gaining first-line recognition for OUD treatment in pregnant persons

Retention in care for pregnant persons may now favor buprenorphine over methadone

More flexible dosing (more times per day)

Less severe NOWS

Some neonatal outcomes better

Reduced risk of overdose during induction and in children exposed to buprenorphine

NYS OASAS/DOH Best Practices: Prescribing Buprenorphine

Prescribers should ensure continued access to buprenorphine **even in the absence of counseling**.

Prescribers should **ensure immediate and continued access** to buprenorphine for patients who, at the time may be unwilling or unable to participate in counseling or other formal psychosocial services.

Prescribers **should not discharge patients** solely based on the use of prescribed or unprescribed substances including, but not limited to, cannabis and benzodiazepines.

Prescribers **should ensure continued access** to buprenorphine even in the presence of other drug use.

Prescribers should strive to minimize diversion and **avoid allowing concerns about diversion to prevent them from treating O**

MOUD During Pregnancy, Intrapartum Care, Postpartum Care: Dosing

Pregnancy: dose to the comfort level of the pregnant person (no withdrawal symptoms, no opioid cravings); dose will likely increase during the pregnancy due to increased metabolism and increased circulating blood volume; educate pregnant persons that neither a higher methadone dose nor a higher buprenorphine dose is associated with an increased risk of NOWS

Intrapartum Care: ***continue methadone or buprenorphine dose through labor and postpartum at the prenatal dose***; most labor pain and c-section pain can be managed with regional anesthesia, non-opioids, an increased dose of methadone or buprenorphine, or, if necessary, by using opioids IN ADDITION TO the prenatal methadone or buprenorphine dose

Postpartum Care: continue prenatal dose of MOUD: individualize dose deceases; if opioid pain management is needed, requirements wil

The 4th Trimester: Post-Partum Care

Reality check…

- caring for a newborn, breastfeeding, bonding
- mood changes, sleep disturbance, physiologic changes
- cultural norms; pressure to be the "ideal parent"
- social isolation
- often CPS involved…

Less focus on the person who gave birth

- shift of attention from the parent (prenatal care) to the baby (pediatric care)
- 40% of persons who give birth miss their postpartum visit (ACOG, 5/2018)
- care often shifts to social service agencies (WIC, etc.)
- Often the MOUD provider is the only continuity of care for the parent
- Remember contraception (long-acting reversible contraception: LARC)!

MOUD: How Long Should Patients Remain on MOUD?

- LONG ENOUGH...!!! As long as the patient receives benefit from taking the medication, the patient should stay on the medication
- It is different for every patient, but...relapse rates and fatal overdose rates are higher for shorter courses of treatment and for no treatment
- At a minimum, patients should remain on MOUD for 6-12 months; but, in reality, MOUD is often much longer, and, often chronic
- Per one study, the average duration on buprenorphine treatment: 8-9 years
- OUD is a CHRONIC disease, and, like other chronic diseases, may require medication CHRONICALLY (think long term v. lifetime, but NOT short term); like a person with diabetes needing insulin for life to manage their diabetes

MOTHER Study: Outcomes at 36 Months

- n=96
- No pattern of differences in physical or behavioral development to support medication superiority
- No pattern of differences for infants treated for NAS v. infants who did not receive treatment for NOWS
- Results indicate children born in the MOTHER study are following a path of normal development in terms of growth, cognitive and psychological development

Breastfeeding

Methadone and buprenorphine are safe for breastfeeding: <1% maternal opioid intake transmitted to breast milk

Published guidelines from ACOG, AAP, and the Academy of Breastfeeding Medicine (ABM) all support breastfeeding for persons on opioid agonist therapy for OUD (MOUD)

Maternal benefits of breastfeeding: increased oxytocin levels lead to decreased stress and increased bonding which lower relapse risk

Newborn benefits of breastfeeding: reduction in the need for pharmacologic treatment of NOWS and shorter hospital stays

Breastfeeding more controversial with active use of EtOH (alcohol) and MJ (marijuana)

Defining NOWS: A Brief Word…

Neonatal Opioid Withdrawal Syndrome (NOWS) often results when a pregnant person uses opioids during pregnancy: ***"an expected and treatable consequence of opioid exposure in utero"*** (ACOG, 2012 and GAO, 2015)

NOWS is defined by alterations in the:

- CNS (central nervous system): high-pitched crying, irritability, exaggerated reflexes, tremors, tight muscles, sleep disturbance
- Autonomic nervous system: sweating, fever, yawning, sneezing
- Gastrointestinal distress: poor feeding, vomiting loose stool
- Signs of respiratory distress: nasal congestion and rapid breathing

NOWS is NOT like fetal alcohol syndrome (FAS)

NOWS is treatable: it is withdrawal only, not "addiction" (absence of compulsion/behaviors)

NOWS and treatment for NOWS are not known to have long-term effects; interactions between the caregiver and the child can impact resiliency/risk with potential long-term effects in some cases

Pregnant Persons with SUD: Addressing Their Needs

- Pregnant persons with SUD have a unique set of needs across multiple domains; domains that affect both obstetric health and outcomes and SUD treatment
- Care needs to address all those complex needs, ideally, with co-located, integrated services

From ACOG Committee Opinion: Opioid Use and OUD in Pregnancy

"…it is important to advocate for this often-marginalized group [pregnant persons with OUD] of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women [persons] with OUD who seek prenatal care are not criminalized.

Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with SUD to discourage the separation of parents from their children solely based on SUD, either suspected or confirmed."

ACOG Committee Opinion: Opioid Use and OUD in Pregnancy, August 2017, p. 3

Additional Resource: https://www.acog.org/community/districts-and-sections/district-ii/programs-and-resources/medical-education/opioid-use-disorder-in-pregnancy OR https://oasas.ny.gov/education-modules-oud-pregnancy

Conclusions

- There is a complex milieu of factors that underlie SUD in women
- Understanding the principles and practical application of person-centered care, harm reduction, and trauma-informed care leads to better outcomes in our patients/clients
- For pregnant persons with SUD, engagement in prenatal care improves outcomes, regardless of substance use or engagement in SUD treatment; decreasing stigma increases engagement in care
- Pregnant persons and parenting persons with SUD experience discrimination and scrutiny on an unparalleled level
- MOUD is the standard of care for all persons with OUD, including pregnant persons
- Care, ideally, is co-located, multidisciplinary, non-judgmental, and patient-centered; if care is not co-located, a warm handoff facilitates care engagement
- ***Remember:*** substance use and/or SUD in and of itself is ***not*** an indicator of child abuse or maltreatment or neglect

Opioid Overdose Prevention During COVID-19: OASAS Resources

- **OASAS overdose prevention landing page:**
https://oasas.ny.gov/prevent-overdose

- **OASAS video on overdose prevention:**
https://www.youtube.com/watch?v=m1xySbqok5k&feature=youtu.be

- **OASAS 24/7 HOPEline:**
Call 1-877-8-HOPENY | Text 467369

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Questions?

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