Substance Use Disorders (SUD) and the Maternal-Infant Dyad

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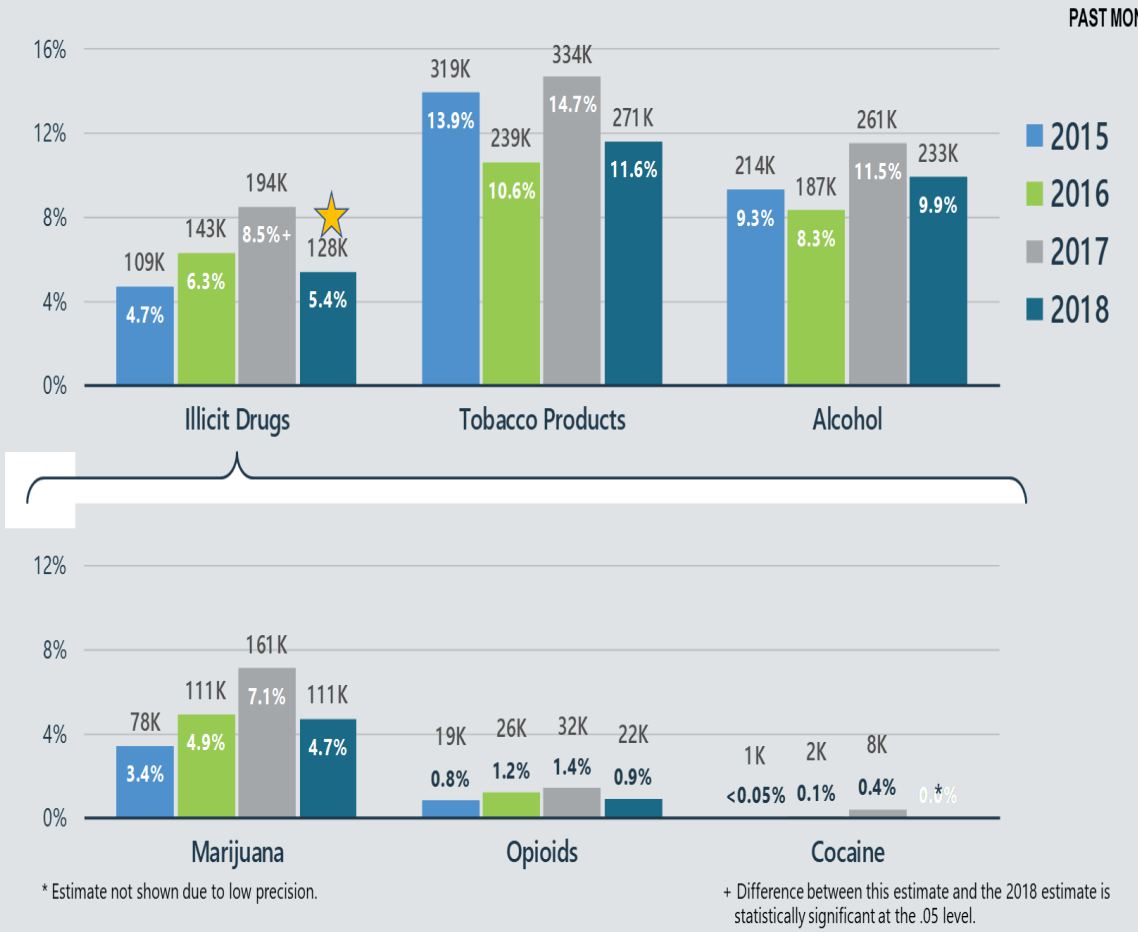
Substance Use Among Pregnant Women



Women are at highest risk for developing SUDs during reproductive years

- Polysubstance use during reproductive years is common
- Unintended pregnancy rate among women with SUDs is ~80%

SUDs in Pregnancy

- Connected to many complications and negative health outcomes for maternal-infant dyad

(SAMHSA, 2019). National Survey on Drug Use and Health: Women. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt23250/5_Women_2020_01_14.pdf)

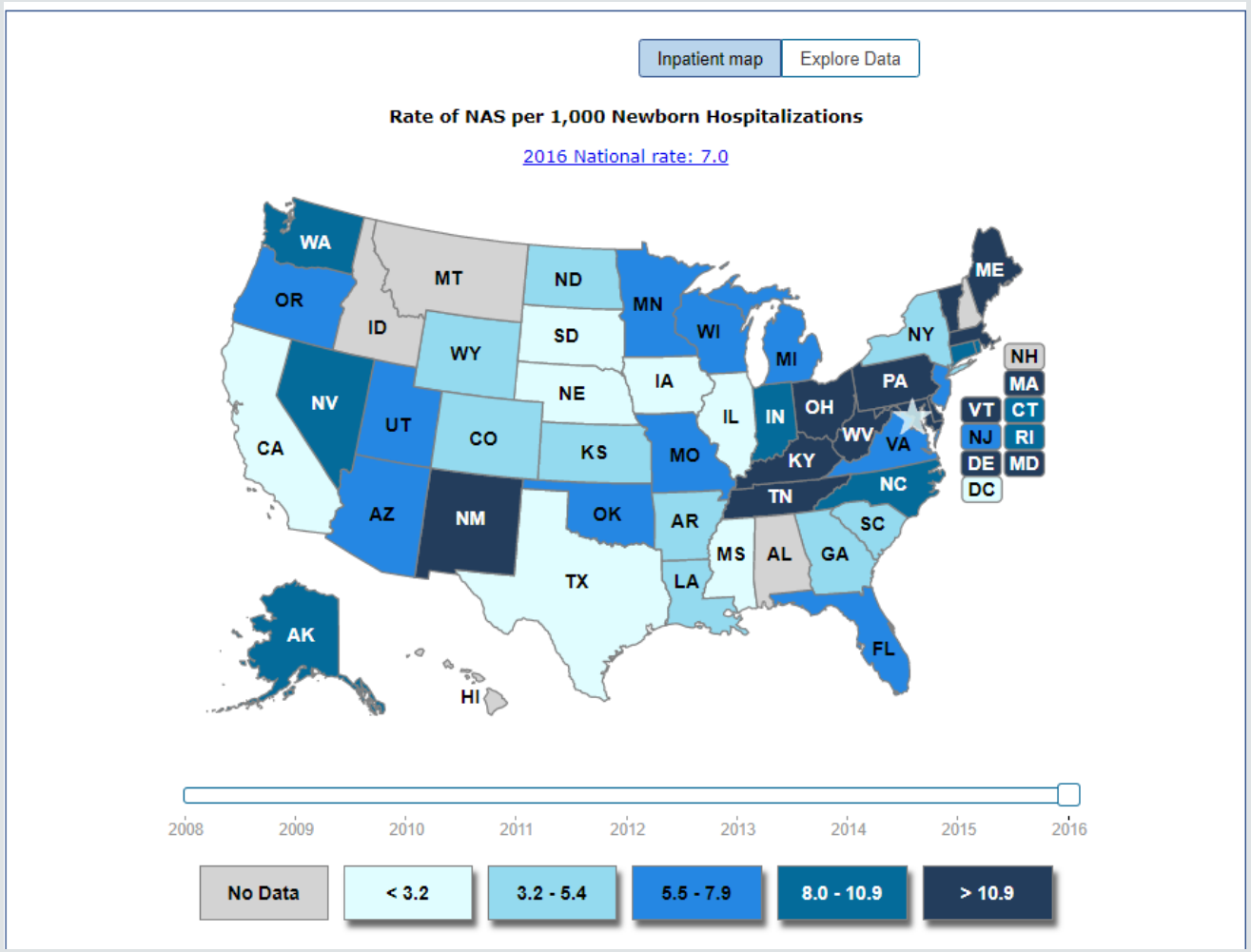
Opioid Use During Pregnancy

- Pregnancy associated mortality involving opioids more than doubled from 2007 to 2016
  - Maternal mortality is 4x higher for women with Opioid Use Disorder
  - 6x higher risk for obstetric complications
  - Opioid overdose has accounted for 11-20% of all pregnancy-associated deaths in the United States
  - Opioid Use Disorder particularly affects women of reproductive age in rural communities
    - Often connected to socioeconomic disparities, limited access to healthcare
    - Rural communities often lack resources and broader community supports to assist women who are pregnant, postpartum and/or breastfeeding with treatment and recovery of Opioid Use Disorder

Impact of Substance Use Disorders During Pregnancy

- A SUD is a chronic disease with lasting impact
- Potential Maternal Impact
  - Heart arrhythmias, high blood pressure, placental abruption, preterm labor/birth
  - Strongly associated with co-occurring disorders, likely history of trauma, increased risk for sexually transmitted diseases and higher-risk behaviors
  - Lack of social and emotional support, housing concerns, nutritional concerns
  - Continued use likely without access to treatment and adequate healthcare
- Potential Fetal/Infant Impact
  - Any maternal substance used has potential to cross over to the fetus
  - May impact growth, cause alterations in brain organization, trigger placental insufficiency, preterm labor/birth
  - Neonatal Abstinence Syndrome
    - Affects about 45-94% of infants exposed in utero
    - EXPECTED and TREATABLE condition
  - Neonatal Opioid Withdrawal Syndrome
    - Opioid specific, more difficult to track

NAS Rates Among Newborn Hospitalizations



Agency for Healthcare Research and Quality. (2019). Healthcare Cost and Utilization Project (HCUP). Rate of NAS per 1,000 Newborn Hospitalizations: 2106. Retrieved from https://www.hcup-us.ahrq.gov/faststats/NASMap

Mothers and Stigma

- Pregnant women with SUD are increasingly stigmatized and prosecuted for their substance use, leading to financial, emotional, and legal consequences
  - Stigma disproportionately noted among poor women and women of color
- During and after pregnancy, mothers with SUD perceive stigma from
  - Healthcare providers
  - General public
  - Loved ones
  - Themselves
  - Addiction community
- Heightened by misinformation, mislabeling, media, devaluing maternal relationship with child

Consequences of Stigma

- Shame, fear, depression/anxiety
- Suboptimal prenatal care and postpartum follow up
  - Directly impacts fetal growth
  - Obstetric complications and warning signs are missed
  - Lack of emotional/social support
  - Increases risk of NOT breastfeeding
- Stigma is one of the biggest barriers to addiction treatment
  - Lack of engagement in treatment services
  - Early withdrawal from treatment

Access Barriers to SUD Treatment During Perinatal Period

- In addition to stigma, barriers include:
  - Lack of access to gender-specific care
  - Limited child-care availability at treatment facilities
    - Not wanting to leave children or a partner at home
    - Minimal access to transportation or childcare, limited availability on housing units
      - Attendance and retention best predictors of treatment success
  - Few providers with obstetric and addiction treatment expertise
  - Fear of criminal or child welfare consequences because of SUD disclosure
    - The act of accessing treatment alone identifies the woman as having a Substance Use Disorder AND her infants/children who are potentially substance-exposed
  - Perinatal period is actually a very short interval of time to receive services
    - Wait times to access
    - Pregnancy is a “Window of Opportunity”

Treatment for SUDs is Vital

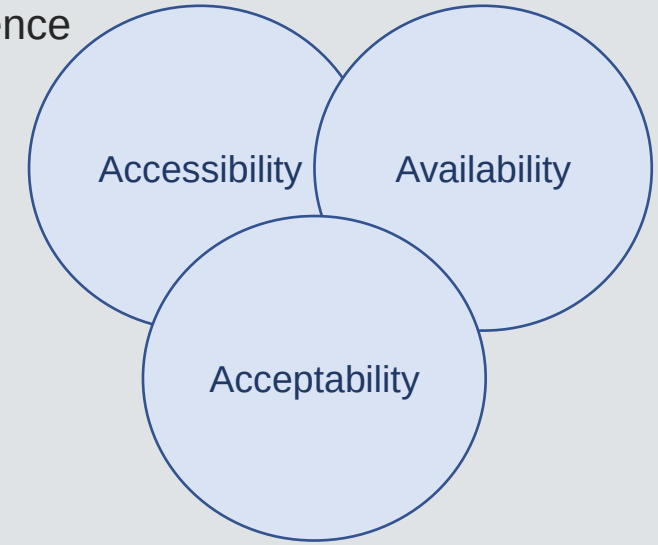
- Medication Assisted Treatment is the gold standard of care for treatment of Opioid Use Disorder: **This should NOT be altered by pregnancy, postpartum, breastfeeding**
  - Withdrawal and detoxification during pregnancy can be dangerous
- Medication Assisted Treatment:
  - Use of medications, in combination with counseling and behavioral therapies, to provide the whole-patient approach to the treatment of substance use disorders
    - Counseling can encourage and motivate women to continue with treatment, enhance coping skills and reduce risk of relapse
    - Connection with peer support specialists and community support can assist recovery
  - Medications to treat Opioid Use Disorder can be started any time during pregnancy or postpartum
    - Offered by waivered providers who see women with Opioid Use Disorder throughout the perinatal period
    - Buprenorphine and Methadone are considered safe for use during pregnancy and breastfeeding
- An opportunity to address polysubstance use, trauma, co-occurring disorders, and social service assistance

Medication Assisted Treatment During the Perinatal Period

- Impact:
  - Improve survival
  - Increase retention in treatment
  - Decrease illicit opiate use
  - Decrease hepatitis and HIV rates
  - Decrease criminal activities
  - Increase employment
  - Improve birth outcomes
- Goals:
  - Manage / prevent withdrawal symptoms
    - Reduce cravings
  - Prevent overdose
  - Reduce relapse risk
  - Provide opioid blockade (prevent euphoria from illicit use)
  - Increase adherence to prenatal care
  - Reduce risk of OB complications
    - Improve maternal nutrition
    - Improve infant birth weight

Considerations for Policymakers

- **Perinatal Care**
  - Includes preconception/interconception counseling, early entrance into prenatal care, and the first year postpartum
  - Universal screening for substance use and co-occurring disorders
  - Access to providers with obstetric & substance use treatment experience
  - Rural areas often encounter unique concerns:
    - Limited access to healthcare
    - Limited acceptability
    - Limited availability of providers with obstetric expertise and substance abuse treatment expertise



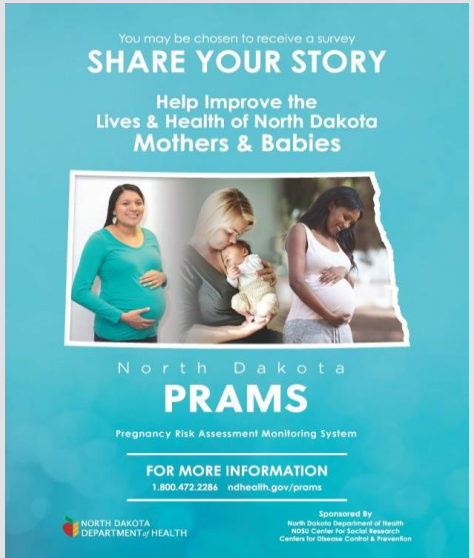
- **Gender-Responsive Care Options**
  - Integrated care
  - Address gender specific needs outside of pregnancy
    - Trauma history: Intimate Partner Violence, sexual trauma and victimization
    - Housing support
    - Income support
    - Contraception
      - Integrate family planning into treatment and recovery

Considerations for Policymakers

- **Community Support and Awareness**
  - Community support for mothers and families impacted by SUDs may help prevent perinatal relapse
    - Home visiting programs, peer support options
    - Doulas
      - Very few states currently reimburse for services
    - Improved perinatal education
- **Legislative and Policy Concerns**
  - Punitive laws/actions against pregnant women can serve as barriers to trusting patient-provider relationship and impede treatment as well as treatment success
  - Women may disengage from health care system in states where punitive policies regarding substance use in pregnancy are enacted

Increased Understanding Through National Data Collection

- **Neonatal Abstinence Syndrome Reporting**
  - Consistent, standardized NAS case reporting for public health surveillance may increase understanding of scope of issue
- **Maternal Mortality Review Committees**
  - Multidisciplinary committees in states/cities that perform comprehensive reviews of deaths among women within a year of the end of a pregnancy
    - Important to understand WHY preventable maternal deaths occur and prioritize ways to effectively reduce these deaths
- **Pregnancy Risk Assessment Monitoring System (PRAMS)**
  - Collaborative surveillance project of the CDC
  - 47 states, NYC, Puerto Rico, District of Columbia, Great Plains Tribal Chairmen's Health Board currently participate



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