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

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

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
References


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References


