Opioid & Substance Use Disorders in Pregnant Women – An Update

PRESENTED TO THE STATEWIDE RURAL OPIOID TECHNICAL ASSISTANCE TRAINING

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Disclosures

- I have no actual or potential conflicts of interest in relation to this presentation.

- I believe in treatment and harm reduction strategies for substance use disorders during pregnancy. I agree that drug addiction is a chronic, relapsing brain disease that should receive at minimum adequate treatment during the perinatal time period. (Johnson, C., n.d.)

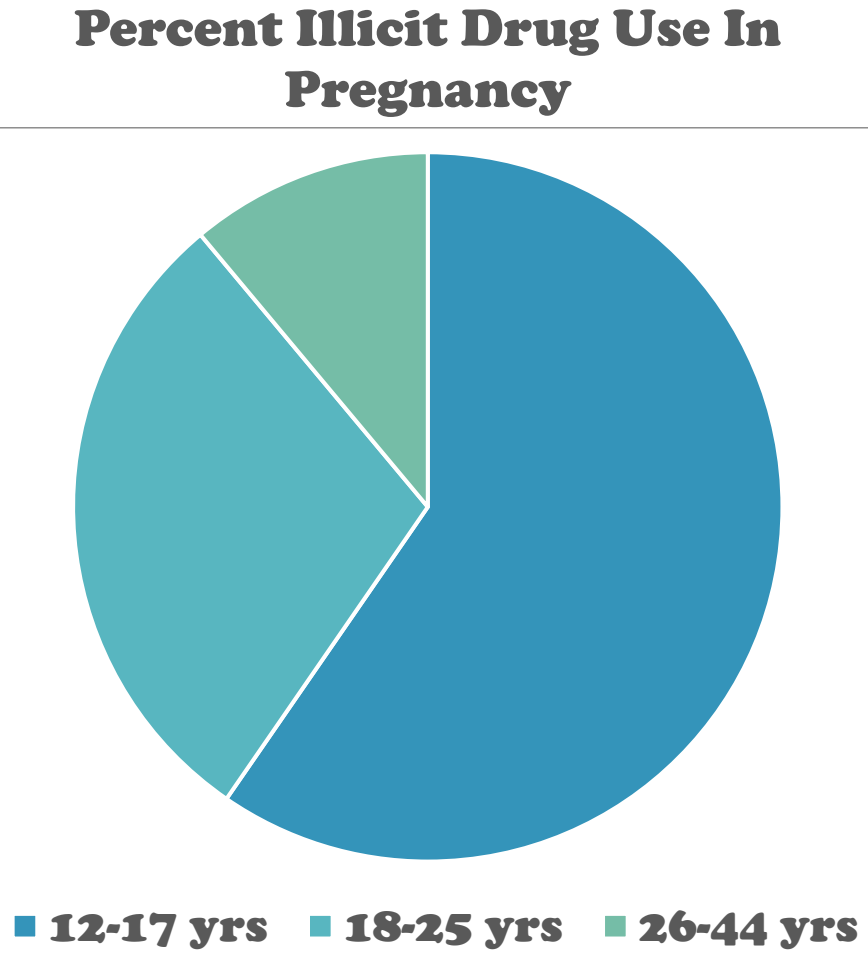
The Stats

DESCRIBING THE PROBLEM

National Level

2013 National Survey on Drug Use and Health: **5.4% of pregnant women** reported illicit drug use (Mittal & Suzuki, 2016)

"**Substance use disorders** remain some of the most commonly **missed and undertreated diagnoses** among pregnant women" (McLafferty, 2016, p. 116)



OUD and SUD in Montana

- Montana has comparatively higher rates of substance use disorders
- More than 90 percent of those with alcohol or drug problems do not receive treatment (Bachrach & Boozang, 2017)

OUD Specific

- The rate of opioid overdose deaths in Montana peaked in 2008-2009 and has decreased significantly since then, bucking national trends.

- Montana opioid overdose rate was 4.2 per 100,000 residents in 2014-2015. (DPHHS, 2018)

- Opioid use is the primary driver of drug overdose deaths in the state of Montana. Forty-four percent of all drug overdose deaths are attributable to opioids. (DPHHS, 2018)

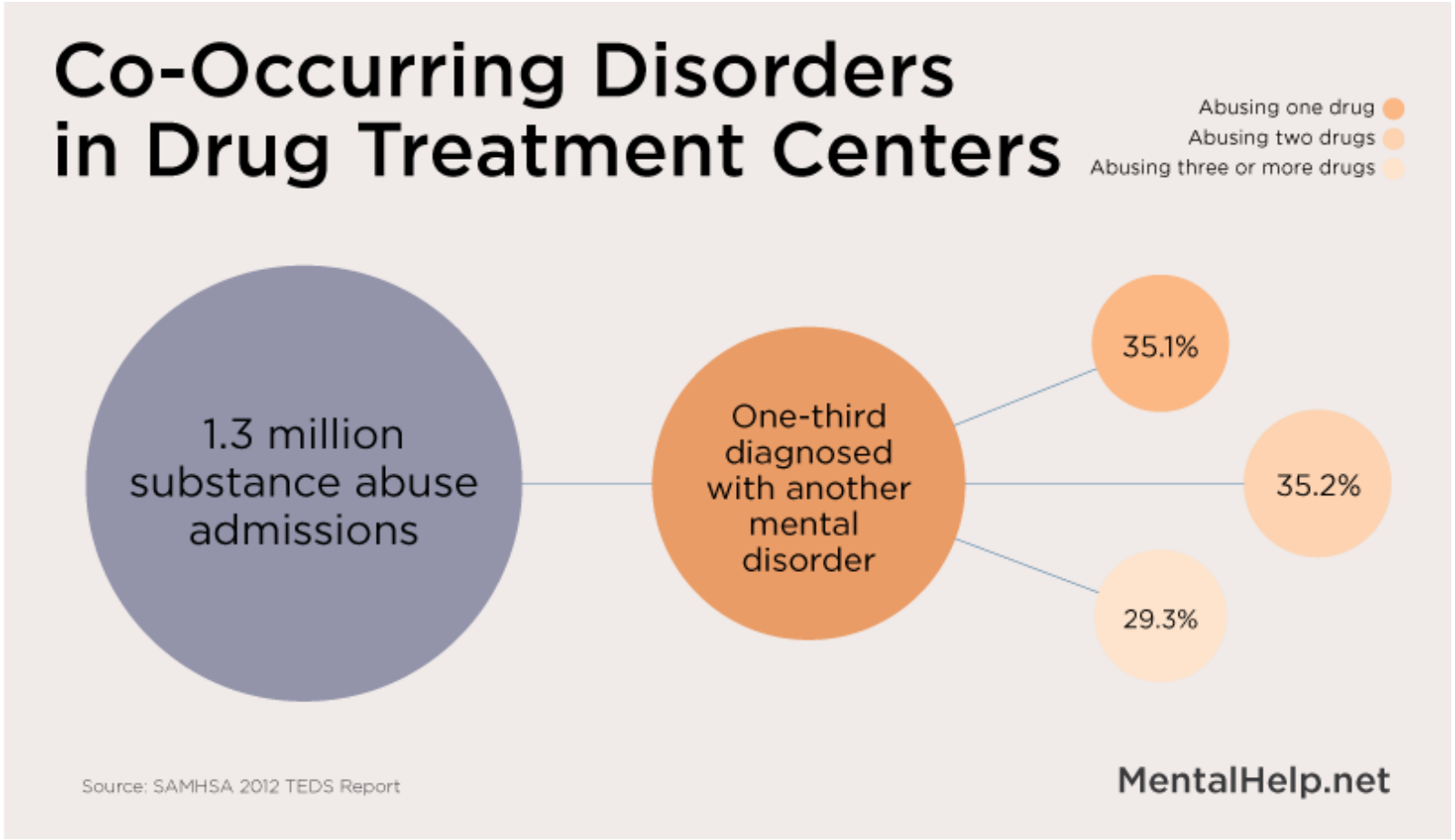
Characteristics of Those Impacted

- Women with SUDs during pregnancy are more likely to be young, low-income, and have histories of childhood trauma or intimate partner violence. (MHCF, 2018)
- Approximately 90% of pregnant women who use opioids for nonmedical reasons concurrently use other legal and illicit substances; drug overdose deaths involving opioids, cocaine, or other psychostimulants are increasing (Kroelinger, et al., 2019)
- Social determinants of health, described as contributors to the opioid crisis, include:
  - intergenerational or persistent poverty, unstable housing, substandard education, and bias by race or ethnicity that might introduce stigma and unequal access to treatment and care (Kroelinger, et al., 2019)

Characteristics of Those Impacted (cont.)

- Important to recall that there is a wide breadth of patient histories that can lead to and OUD in pregnancy:
  - addicted to either legal or illegal opioid drugs, illicit or street use, prescription misuse or over-prescription, chronic pain, those self medicating (mental illness, physical pain, trauma)
  - Keeping this in mind helps us confront personal and systemic biases we carry with us

Co-occurring mental health disorders



Most Common Psychiatric CODs for Women with SUDs

Most common co-occurring psychiatric disorders in women with SUDs (Agrawal et al., 2005):

- Mood disorders, particularly major depressive disorder
- Anxiety disorders
- Post-traumatic stress disorder (PTSD)
- Eating disorders

Other psychiatric disorders common in women with SUDs (SAMHSA, 2009):

- Personality disorders
- Psychotic disorders

Characteristic	Total (n=35)
Age (y)	
15–19	2 (5.7)
20–34	28 (80.0)
35 or more	5 (14.3)
Married	17 (48.6)
Medicaid at delivery	16 (45.7)
Drug misuse or substance use disorder	19 (54.2)
Chronic pain	15 (42.9)
Obesity	13 (37.1)
Mental health diagnosis	27 (77.1)
Depression	24 (69)
Anxiety	19 (54.2)
Schizophrenia	1 (2.9)
Bipolar	2 (5.7)
Prior suicide attempt	8 (22.9)
Prior overdose	9 (25.7)
Prior mental health hospitalization	6 (17.1)
History of lifetime abuse (emotional, mental, physical, sexual)	9 (25.7)
Intimate partner violence	6 (17.1)
Mental health services documented	9 (25.7)
Social work referral documented	14 (40.0)
Prenatal care record	n=26
Drug-related concern in prenatal chart	21 (60.0)
Delivery care record	n=24
Drug-related concern in delivery record (n=24)	18 (75.0)
No. of infants	31
Department of Child and Family Services involvement	7 (22.5)

Pregnancy and Drug Related Deaths

Treatment in Montana

- As of 2016, only 6% of Montana's state-approved substance use disorder (SUD) facilities reported programs for pregnant and postpartum women, and among the nation's lowest rates of buprenorphine treatment capacity for people with opioid use disorders.
    - This is improving!
- Peer Support Models Emerging
- Medicaid Expansion

Nuances of Perinatal SUD

Stigma is heightened

Legal concerns of disclosing substance use in perinatal period:

- arrest or incarceration
- child welfare involvement (Wexelblatt, et al., 2015)

Decreases likelihood of prenatal care access

- increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants, and higher rates of unmanaged NAS (Patrick, et al., 2017)

Poor outcomes:

- Untreated co-morbid psychiatric conditions, Untreated infectious diseases, At higher risk for violence (ASAM, 2017; Clark, 2015 in Johnson, n.d.)

Uniqueness of Pregnancy

Transition to Parenthood

- First and foremost see the parent, who is also experiencing an SUD
  - Parenthood as a developmental stage; changes in brains structure correlating to mothers perception of how she feels about her baby; SUDs dampen response to baby facial cues
  - Build parent confidence and their responses to child's stress and their own stress; how past trauma impacts that (Mayes, 2013)

Pregnancy is a unique time in behavior change

- It can increase motivation to reduce or abstain from substance use
- Pregnant people use illicit substances at half the rate of their non-pregnant peers - and use less during their third trimester – however more than 400,000 infants are exposed to alcohol or illicit drugs in utero each year. (Tenore, 2008)

Pregnancy is a unique time of engagement with the health care system

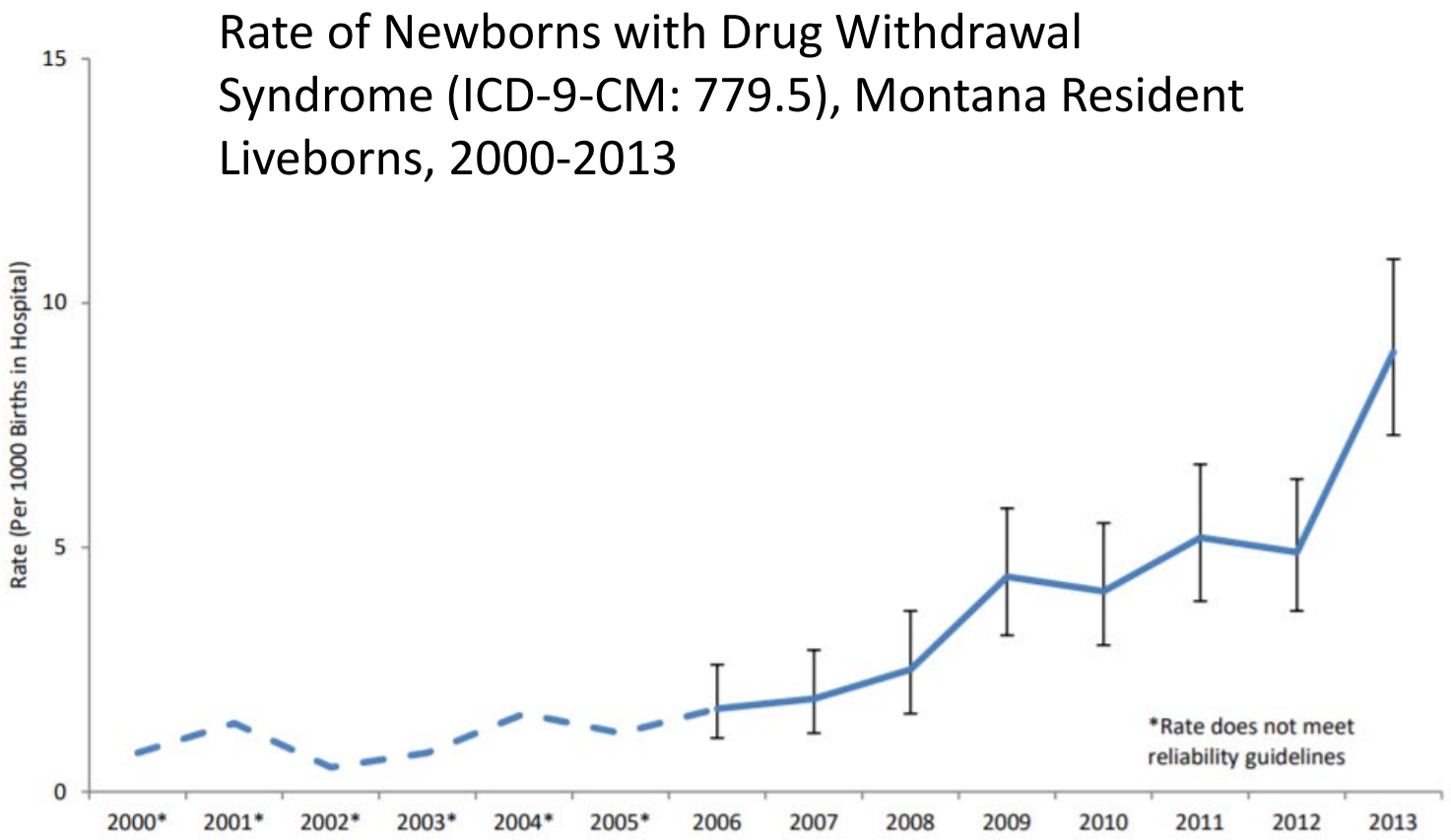
NAS/ NOWS

- Infants exposed to tobacco, alcohol, prescription medications, and illicit substances may exhibit signs of physiologic withdrawal from these substances after birth.
- *Neonatal abstinence syndrome* (NAS)
  - broad, nonspecific term assigned to this type of presentation in the newborn
  - widely applied both clinically and in the published literature to infants withdrawing from opioids.
- *Neonatal opioid withdrawal syndrome* (NOWS)
  - More specific becoming more widely used
  - capture more accurately the numbers of infants experiencing withdrawal from opioid exposure in utero
  - important to trigger specific protocols and create more accurate data

Published literature uses the more general NAS term and, in clinical practice, substance-exposed infants are typically exposed to multiple substances.

(Klaman, et al., 2017)

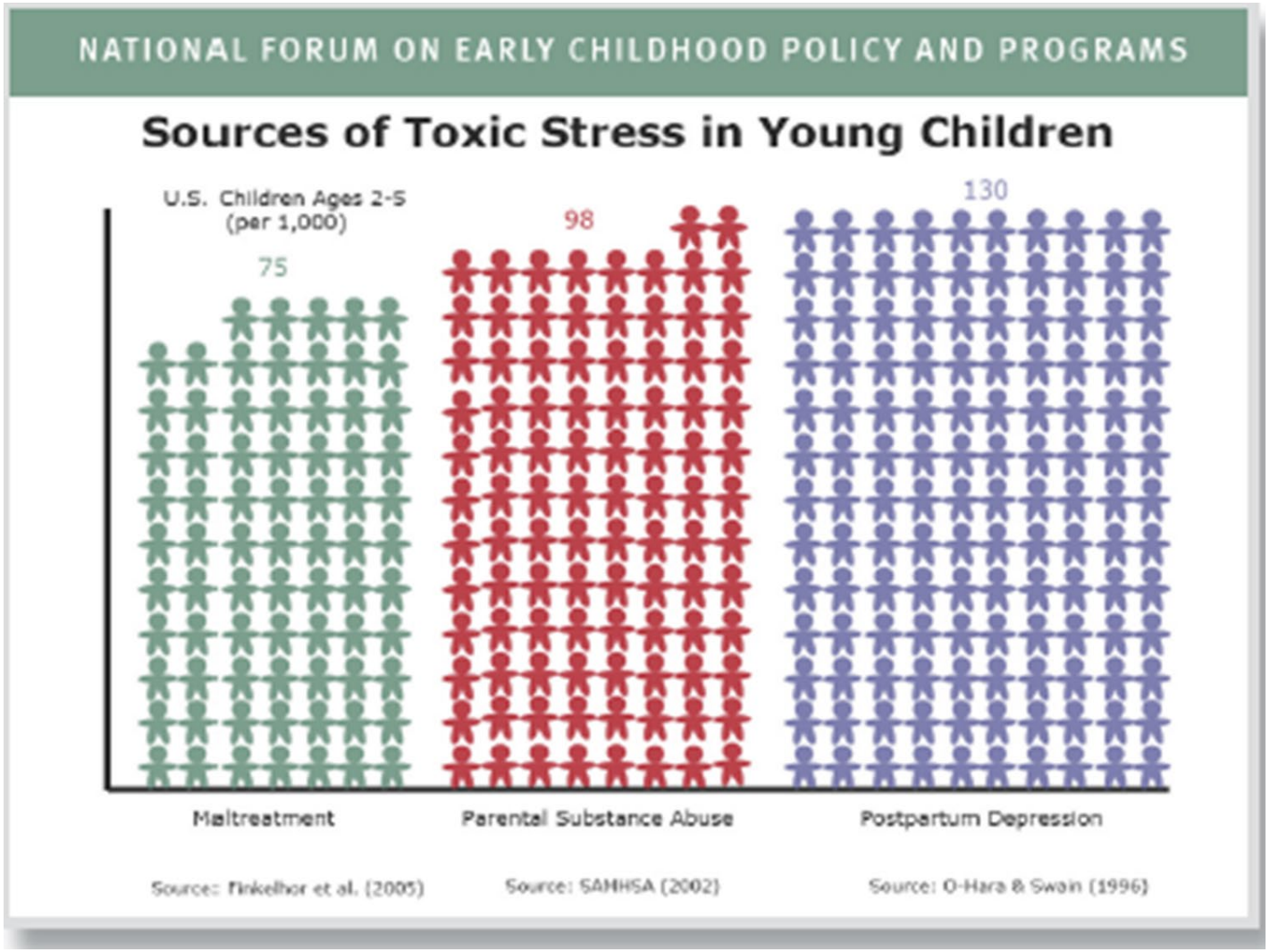
NAS MT Hospital Data



The rate of NAS in Montana newborns increased from 0.8 per 1,000 live births in 2000 to 9.0 per 1,000 in 2013, a tenfold increase.

301 NAS hospitalizations were recorded between 2016- 2018

(DPHHS, 2015)


NATIONAL FORUM ON EARLY CHILDHOOD POLICY AND PROGRAMS
Sources of Toxic Stress in Young Children
U.S. Children Ages 2-5
(per 1,000)
75
98
130
Maltreatment
Parental Substance Abuse
Postpartum Depression
Source: Finkelhor et al. (2005)
Source: SAMHSA (2002)
Source: O-Hara & Swain (1996)

Efforts to Address

Lots of efforts at the state and community level to address OUD and SUD!

Opportunities

Possibilities for Continued Progress

Create statewide agreement on NAS diagnosis, treatment and coding

Continue to address stigma with public messaging

Let pregnant people struggling with a SUD/OUD know what options are available to them

Continue expanding screening, treatment and support in OB, pediatric and primary care settings

Address SDOHs such as housing and transportation

What else?

For more information

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Thank you!

Thank you for your time today and for all the wonderful work you do for families and children in our state.

Questions?

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