



Setting families up for success

Opiate use disorders in pregnancy

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PMADS 101 Series, Healthy Mother, Healthy Babies

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Objectives

Provide person-centered language to use when caring for persons with substance use disorder

Describe the of treatment options for opiate use disorder during the peripartum period

Understand the presentation of neonatal opiate withdrawal and how to support families to minimize withdrawal symptoms

Explore the role of health care workers in screening for SUD and reporting

Discuss how we can create environments that are safe and welcoming to people experiencing SUD in the peripartum period



Disclosures

I HAVE NOTHING TO DISCLOSE



Who is in the room?

Obstetrics Nurse

0%

Community Health Worker

0%

Social Worker

0%

Home Visiting Service

0%

WIC

0%

Behavior Health Specialist

0%

Lactation Support

0%

Doula

0%

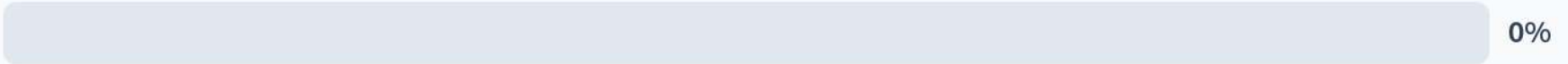
Obstetrics provider

0%

SEE MORE 

Do you currently work with patients/clients experiencing SUD?

Yes



0%

No



0%

Not sure



0%

What is your comfort supporting patients/clients experiencing SUD?

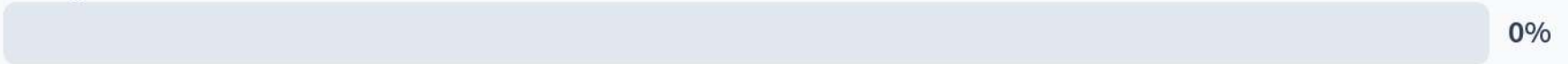
I am new to this



I have some comfort and want to increase it



I've got this



Definitions



Substance use disorder (SUD)

- Chronic, treatable disease often with expected lapses
- Can refer to legal or illicit substances including caffeine, nicotine, cannabis, alcohol, opiates or opioids, stimulants

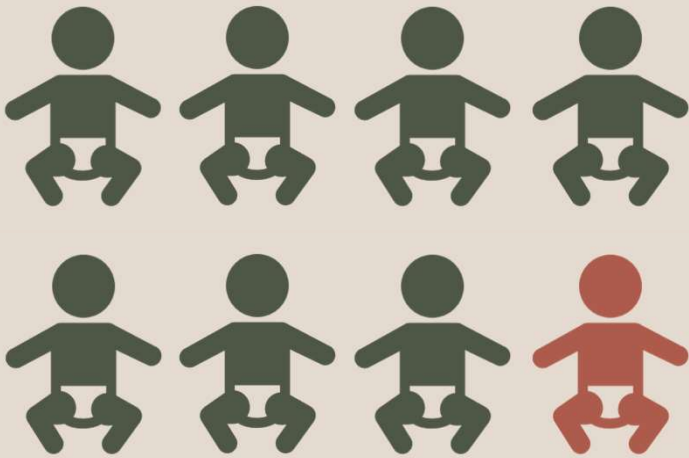
Opiate use disorder (OUD)

- A problematic pattern of opiate use leading to clinically significant impairment or distress. Typically experience a strong desire for opioids, inability to control or reduce use, continued use despite interference, use of larger amounts over time and/or development of tolerance, spending a great deal of time obtaining or using
- Can be treated with a combination of medication, behavioral therapy and support

Withdrawal

- Physical or psychological symptoms from dependence on a substance related to tapering or stopping with symptoms including negative mood, nausea or vomiting, muscle aches, diarrhea, fever and insomnia

Epidemiology of substance use disorders in pregnancy



- Most common: alcohol and tobacco
 - Alcohol- Fetal alcohol spectrum disorders
 - Tobacco- growth restriction, preterm birth
- Marijuana is the most common illicit
- In 2015, more than 27 million people in the US reported use of an illicit drug or misuse of prescription drugs in the past 30 days
- 1 in 8 births insured by Medicaid in MT experienced perinatal substance exposure

The opioid epidemic and pregnancy

- Opiate use disorder is undergoing the most rapid increase
 - The rate of OUD in pregnancy increases 131% from 2010-2017
- 2019 self-report data 7% of women reported use of prescription opioid medication, with 1 in 5 reporting misuse
- Methamphetamine now also increasing, often in combined with opiates
 - Acute impacts often in later pregnancy
- In the US, most illicit opiates are fentanyl
- OUD is often combined with other SUD, including tobacco (92%)



OUD impacts on pregnancy

No clear data that opioids alone are associated with birth defects

Confounding: Opioid use is often associated with use of other substances and high-risk behaviors related to substance use

OPIOID USE ASSOCIATED WITH

- Inconsistent PNC
- Poor nutrition
- Fetal growth restriction
- Abruptio placentae
- Preterm labor
- Intrauterine passage of meconium
- Fetal death/ stillbirth
- Risks associated with prostitution/trading drugs for sex and/or IVDU including STIs, HIV and interpersonal violence
- Maternal overdose and/or death

The opioid epidemic and pregnancy: Barriers to care

Pregnant individuals with SUD face legal consequences which may deter accessing care

SUD in pregnancy is also associated with shame and stigma which may lead patients to avoid accessing care

SUD and PMADs are often co-occurring, compounding barriers

Avoidance of care and thus lack of resources for treatment and incomplete PNIV leads to worsening obstetrics outcomes

Trauma-informed and social justice lens

- Many of our patients have a history of trauma including violence and victimization
- Trauma impacts patients lives, behaviors and interaction with systems including healthcare
- Beyond personal trauma, pregnant and reproductive people have historical trauma that impacts approach to care

Be aware of the role trauma plays

Minimize re-victimization

Provide a comforting, welcoming and accessible environment

Assume unconditional positive regard

Empower and emphasize a patient's strengths

Respect a patient's choices and autonomy in their recovery, pregnancy and birth

Recognize the bias you bring to interactions

Create mutual and collaborative goals

Facilitate recovery and healing

Language matters

Judgement Forward	Value Neutral
Substance abuse	Substance use
Addict, drug user, junkie	Person with a SUD
IV drug user	Person who injects drugs
Drug of choice	Substance of use
Clean or sober	Abstinent, in remission, no longer using drugs
Dirty	Using x substance, testing positive for x
Relapse	Return to use
Resistant	Declines, chooses not to, is not ready for
Unfit parent	Person experiencing barriers to success
Addicted baby	Neonate with NAS



Harm reduction is our goal



Recovery is not linear

While abstinence from substance use is ideal, this may not always be achievable

Other goals may be:

- Safer use
- Reduced use
- Access to medical care to have a healthy pregnancy

Universal screening

- SUD affects a diverse population of patients
- SUD in pregnancy is underrecognized and undertreated
- Screening based on RF alone leads to missed cases and contributes to stigma and stereotyping
- ACOG: Screening should be part of comprehensive obstetrics care and done at the first PNV and should be universal
- Universal screening with a validated verbal screening tool allows our focus to be on supports for success instead of punishment for use



Substance use screeners

NIDA-4

In the last year have you...

- Smoked or vaped tobacco
- Had more than 4 drinks of alcohol in one day or more than 10 in one week
- Used a prescription for something other than prescribed
- Used an illegal or illicit drug
- Used marijuana*

If the answer is yes to any then the screen is positive and an assessment should be done

The 4Ps Plus©

Parents

Did any of your parents have a problem with alcohol or drug use?

Partner

Does your partner have a problem with alcohol or drug use?

Past

In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?

Pregnancy

In the month before you knew you were pregnant, how many cigarettes did you smoke? How much alcohol did you drink? How much marijuana did you smoke?

Screening for SUD ≠ urine toxicology screening



- Urine tox screenings are NOT recommended as a routine screening test
- Should be done with a clear indication and with explicit CONSENT to a screen
- Urine tox screens are often disproportionately used in BIOPIC and poor women and disproportionately results in child removal
- Point of care (and even hospital screening tests) have high false positive and negative rates, which can lead to false assumptions
- Confirmatory testing may have a role in compliance follow up for medication assisted treatment
- Urine toxicology says nothing about severity of use, chronicity of use, and is incomplete and is complicated by potential for false positive results

Prenatal care for patients with OUD

SBIRT MODEL

Screen, Brief intervention, Referral to Treatment

Collect a comprehensive substance use hx

Screen for high-risk behavior including injection use, exchanging sex for drugs, IPV, anxiety, depression and trauma

Identify and address barriers such as housing, transportation, food access, insurance

Discuss options for medication treatment for SUD and refer to treatment as desired

- Routine STI screening in 1st trimester, consider repeat in 3rd trimester if ongoing risks
- HepB vaccine if non-immune with ongoing risk
- Consider TB testing for patients with RF
- Consider obtaining LFTs and renal function
- Consultation with MFM, pain management or other specialists
- Consider growth scans in 3rd trimester
- *All patients with OUD should have Naloxone at home*
- Prenatal counseling
 - Potential legal risks of SUD and ongoing use
 - Discuss how trauma may present in the delivery room
 - Discuss peripartum pain management plans
 - Postpartum course including infant care and breast/chest feeding

The many faces of OUD in pregnancy

Casey is a 30yo G3P2002 at 16wk GA. They present for a first PNV to your clinic from jail

They have a PMH of tobacco use and current everyday fentanyl use. They do not have custody of their two children ages 6 and 10. Their pregnancy was unplanned, but desired. They did present to a local OB office at 6wk GA to establish care but felt judged by staff and the provider told them they “don’t treat addiction there.” They subsequently tried to quit on their own but were not successful. They express desire for substance use treatment and to parent this child. They have already gone through withdrawal in jail but fear return to use when they are released.

What are my options for treatment?



The many faces of OUD in pregnancy

Amber is a 30yo G3P2002 at 20wk GA presenting for initiation of MAT. She is married and a mom to her 2 older children ages 6 and 10

She has a PMH of depression, recurrent nephrolithiasis and chronic pelvic pain. Early in pregnancy she experienced kidney stones and was prescribed acetaminophen-hydrocodone for ~8 weeks by her prior OB provider and several ED providers

When she ultimately stopped taking her prescribed opioid medication, she experienced withdrawal symptoms. Looking through MPDR she had had numerous prescriptions for opiate pain medication and benzodiazepines from multiple providers in the last 9 months. She is currently on sertraline 100mg daily

What are the side effects of my medication to my baby?



The many faces of OUD in pregnancy

Tara is a 30yo G3P2002 at 10wk GA here to establish prenatal care.

She has a hx of OUD in remission for 4 years and stable on methadone as well as HCV in remission. This is a planned and desired pregnancy. She had 2 other children in the past, both via cesarean that were adopted out. She is currently on 170mg methadone QAM and 120mg QPM


Should I...

...come off methadone to avoid any potential side effects to my baby?

...switch to buprenorphine?

...at least lower my dose of methadone?






Medication for Opioid Use Disorder (MOUD)

Mainstay is opiate agonist therapy
(methadone or buprenorphine)

Neither buprenorphine or methadone
show increased risks of birth defects or
changes in child development

MOTHER STUDY

- Decreases withdrawal and risk-taking behaviors
 - Lessens likelihood of return to use
 - Improved adherence to prenatal and SU treatment
 - Decreased infection exposure
 - Improved maternal nutrition
 - Improved neonatal birth weight
- 

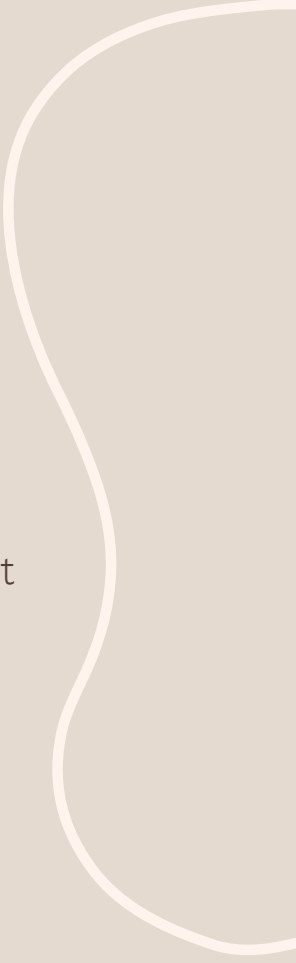


Alternatives to MOUD

MEDICALLY SUPERVISED WITHDRAWAL NOT RECOMMENDED

- Relapse rates of 59-90%
- Increased risk of overdose

OPIATE ANTAGONIST THERAPY: NALTREXONE

- Oral or injectable formulations
 - Limited data on use in pregnancy
 - Data on success- less compared to agonist therapy
 - Requires withdrawal first
- 

MOUD options

Methadone

- Full agonist
- Dispensed daily at a treatment program

- **Advantages**
 - Wider dose range
 - Treatment environment may be more appropriate for patients that need higher level of care/supports
- **Disadvantages**
 - Prolonged QTc
 - Significant drug interactions
 - More restrictive dispensing
 - May be associated with more significant NOWS

Buprenorphine

- Partial agonist
- Can be prescribed in office by any provider with a DEA
 - Typically a combo buprenorphine/naloxone. In pregnancy generally switch to buprenorphine alone
 - SL/transdermal Increasing use of injectable formulation- little data for use in pregnancy
- **Advantages**
 - Fewer drug interactions
 - No QTC prolongation
 - Ease of access
 - Less severe NAS
- **Disadvantages**
 - More limited dosing range
 - Patients typically need to experience moderate withdrawal to start



MOUD in pregnancy

REGARDLESS OF TREATMENT CHOSEN

Treat to resolution of withdrawal sx and reduction of cravings

- Undertreating increases risk of return to use
- DO NOT taper doses in pregnancy to reduce risk of return to use
- In setting of fentanyl, higher doses may be required (24-32mg) and consider microdosing due to long wash-out period

Doses often need to be titrated up throughout pregnancy or split

- Increased metabolism and clearance in pregnancy, particularly 3rd trimester

Stick with one medication to reduce side effects

*In an ideal world medication therapy is partnered with counseling support
Remember harm REDUCTION is the goal*

The many faces of OUD in pregnancy



Started on 8mg buprenorphine BID. At 30wk GA had return to use and a lapse in care for ~6weeks.

Goes into labor spontaneously at 39wks



Started on 8mg buprenorphine BID and in the third trimester increased to 24mg total

Induced at 39 weeks for gestational hypertension



Continued on methadone with dose increase in the second and third trimester

Scheduled for a repeat cesarean at 39 weeks

AM I GOING TO BE TREATED DIFFERENTLY BECAUSE OF MY HISTORY?

CAN I STILL GET AN EPIDURAL?

AM I GOING TO BE ABLE TO GET PAIN MEDICATION FOR MY C-SECTION?

Intrapartum management

- Patients on MOUD have increased opioid tolerance and may have hypersensitivity to pain
- Intrapartum pain management should be discussed prenatally
- Continue maintenance dose of their agonist therapy during labor and postpartum
 - Can consider dividing dose into 3 or 4x daily for partial relief but DO NOT treat with additional doses
- Epidural/spinal anesthesia should be used as desired
- If IV/PO opiate medication is indicated- higher doses will be needed to achieve therapeutic effect
 - One study showed patients on buprenorphine undergoing a cesarean required 47% more opioid analgesia
 - Consider use of epidural/intrathecal morphine in neuraxial analgesia for patients undergoing cesarean sections and/or TAPS blocks
 - Consider use of a PCA for post-op patients
 - Maximized non-opiate pain medications including injectable NSAIDs and gabapentin*
 - Avoid partial agonists-agonist therapy like butorphanol, nalbuphine
- Treating pain DOES NOT increase rates of relapse
- Fetal heart rate tracings of babies of birthing persons on MOUD may be less reactive

The many faces of OUD in pregnancy



Won't my baby just withdrawal when they are born?



How long will we be in the hospital? Will I be able to stay with the baby once it is born?



What can I do to help my baby?

Neonatal Opiate Withdrawal Syndrome (NOWS)

- AN EXPECTED AND TREATABLE CONDITION SEEN IN 30-80% OF INFANTS BORN TO A PARENT ON OPIATE AGONIST THERAPY, AND HIGHER IN PATIENTS WITH UNTREATED OUD
 - Usually presents within the first 5 days of life
 - Earlier onset typical with methadone (within 72hr), later peak in buprenorphine (onset within 12-48h, peak 72-96hr)
 - Dose of medication **DOES NOT** correlate with likelihood of onset or severity of NOWS
- NEONATAL ABSTINENCE SYNDROME (NAS) CAN ALSO OCCUR WITH OTHER EXPOSURES INCLUDING
 - SSRIs
 - Nicotine
 - Alcohol
 - Benzodiazepines
 - Stimulants
- WE SHOULD ENCOURAGE TITRATING OFF CO-OCCURRING SUBSTANCES WHEN APPROPRIATE
- INFANTS ARE TYPICALLY KEPT FOR 5 DAYS FOR OBSERVATION OF NOWS AFTER BIRTH

NOWS Treatment

NOWS is characterized by GI, autonomic and CNS sx leading to

- Irritability
- Jitteriness
- High-pitched cry
- Poor sleep
- Uncoordinated suckling reflex contributing to poor feeding and faltering weight
- Temperature instability
- Sneezing
- Tachypnea, tachycardia

Traditional Treatment:
Finnegan Scoring

More use of medication
Separation of infant-parent dyad
No focus on non-pharmacologic supportive measures
High inter-rater variability (less reliable)

Eat, Sleep,
Console
(ESC)

Focuses on the family unit being part of the care team and harnessing comfort measures to support transitioning babies
Priorities newborn milestone achievement over stand-alone symptoms
Utilizes less medication
Significantly reduces hospital days

Eat Sleep Console

Maximize non-pharmacologic interventions

- Low stimulation environment
 - Dim lights, reduced noise, minimize visitors
 - Avoid waking baby, “cluster care”
- Autonomic soothing
 - Rooming in, skin-to-skin
 - Swaddling, holding/cuddling/rocking, kangaroo care
 - Non-nutritive sucking
- Encourage breastfeeding

Baby should be able to

- **Eat:** At least 1oz per feeding or breastfeed well for 10min
- **Sleep:** Undisturbed for 1 hour
- **Console:** Able to be consoled within 10 minutes

If baby not meeting one or more milestones, maximize non-pharmacologic interventions FIRST

- If sx remain uncontrolled initiate PRN morphine
- If sx remain uncontrolled transition to standing doses

The many faces of OUD in pregnancy



I never breastfed my others, but would like to try. Am I allowed to breastfeed on this medication?



I breast fed my other children and what to this time too. But will my milk will be bad for my baby?



Because I used, how long do I have to wait to breastfeed, or will they tell me I can't at all?

YOUR PATIENT
WANT TO KNOW
ABOUT
BREASTFEEDING

Breastfeeding and OUD

Breast/chest feeding should be ENCOURAGE in patients stable on opiate agonist therapy or other patients with SUD in remission (Level of evidence 2, SOR B)

Breast/chest feeding is beneficial for

- Infant-parent bonding
- Positive reinforcement for birthing parent's recovery
- Is associated with decreased severity of NOWS by 30%
- Decreased length of hospital stay by 50%

Transfer of opiate agonists in breastmilk is minimal. AAP recommends breastfeeding REGARDLESS of maternal dose

- Recommendations on opiate dose maximums in breastmilk are not evidence based and DO NOT APPLY to opiate tolerant birthing persons/babies



Breastfeeding and OUD

- Individuals who discontinue use of non-prescribed substances by delivery should be supported in breast/chest feeding (Level of evidence 2, SOR B)
- In the case of return to use, patients should be counseled on cessation of breast/chest feeding (Level of evidence 2, SOR B)
- Generally, 48-72hrs sufficient for substances to clear
 - Consider initiating breast/chest feeding 72hr after last fentanyl use
- We should encourage pumping and dumping if desired



The many faces of OUD in pregnancy

Kat is a 30yo G3P2002 presenting to L&D in active labor at 35 weeks. She had late entry to prenatal care at 16 weeks and had several missed visits. She has a PMH of SUD and was seen in your clinic by another provider shortly before pregnancy and started on buprenorphine, but never continued care. During prenatal care she reported being in remission since early pregnancy, but admits to daily fentanyl use including this morning.

Kat gives birth to a 5# 6 oz baby later that day and baby is admitted to the NICU for respiratory distress. Shortly after birth Kat expresses desire to be started on methadone. She reports being afraid treatment during pregnancy would harm her baby and jeopardize the custody of her other children.

On PPD 0 she is started on 30mg methadone and tapered up daily by 10mg



The many faces of OUD in pregnancy



Are they
going to
drug test
me and
my baby?

Is CPS
going to
take away
my baby?

Reporting

- Many patients harbor fear of social services involvement or criminalization of use in pregnancy which may impact willingness to present to care
- Toxicology screening is of variable utility as far as indication of level of use, timing of use or ability to parent
- Providers do have reporting requirements, which should be transparent to patients
 - **CAPTA (Child Abuse Prevention and Treatment Act):** Requires states to have policies and procedures requiring HCP to notify child protective services if they are involved in the delivery of an infant born and identified as being affected by substance abuse or withdrawal symptoms

IN MONTANA

HCP MUST NOTIFY CPS OF ALL INFANTS BORN AND IDENTIFIED AS AFFECTED BY *ILLEGAL* SUBSTANCE ABUSE, WITHDRAWAL SYMPTOMS RESULTING FROM PRENATAL DRUG EXPOSURE OR FETAL ALCOHOL SPECTRUM DISORDER

- Notification is clarified as not equivalent to a report of suspected abuse or neglect
- CPS is ultimately responsible for assessing the level of risk and whether the circumstance constitutes abuse/neglect

The many faces of OUD in pregnancy



OK, I know you didn't want me to come off meds in pregnancy, but can I stop now?



Postpartum

- Postpartum period is the time of highest vulnerability of return to use
 - Data shows highest risk of death from overdose is between 7-12mo PP
 - Make sure patients have naloxone on hand (include in discharge meds)
 - Engage wrap around resources for improved transitions home
- Despite potential for increased doses in pregnancy, rarely do doses need to be tapered immediately. Usually plan to taper over the first couple of months postpartum
- MOUD should be continued for at least 1 year after delivery
- Unintended pregnancy rates are higher (80%) in patients with SUD. Discussing contraception is an important part of recovery and stability
- Rates of PMADs and suicide are higher in patients with SUD and patients should be screened regularly
- Access to co-located treatment and family housing supports decreases return to use rates and increases families staying together, but are limited

Summary recommendations

- All pregnant and birthing persons, regardless of SUD should be treated with respect, autonomy and be treated appropriately for pain intrapartum and postpartum
- We should avoid punitive responses to perinatal substance use and honor the road to recover while preventing perpetuation of further harm
- Pregnancy and birth can be a transformative experience for patients experiencing SUD if we properly support
- We should recognize recovery is not linear and our goal is to reduce harm, support patients through the transition of recovery, pregnancy and parenthood, and provide resources for success
- We should train staff to support a trauma informed, social justice lens to caring for pregnant patients with SUD
- Patients with current use of non-prescribed opioids should be referred for MAT, which any provider can prescribe
- While ideally started antenatally, patients with an OUD not on treatment can and should be offered MAT during their delivery hospitalization
- We should adjust clinic/unit policies to be in line with evidence-based therapy and recommendations including guidance on treatment of NOWS, breast/chest feeding and evidence-based pain management

References

Academy of Perinatal Harm Reduction. Pregnancy and Substance Use: A Harm Reduction Toolkit. 2022. Accessed Apr 12, 2024: <https://www.perinatalharmreduction.org/toolkit-pregnancy-substance-use>

Alliance for Innovation on Maternal Health. Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle and Element Implementation Details. 2021. Accessed Apr 4 2024: <https://saferbirth.org/psbs/care-for-pregnant-and-postpartum-people-with-substance-use-disorder/>

Child Welfare Policy Manual. Accessed: April 12, 2024. https://leg.mt.gov/content/Committees/Interim/2023-2024/Court-System-for-Dependency-and-Neglect-Task-Force/Meetings/2024_March/CAPTA_Policy_Manual_Update.pdf; Harris M, Schiff DM, Saia K, Muftu S, Standish KR and Wachman EM.

Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). Breastfeeding Medicine 2023; 18(10):715-733.

Hirai AH, Ko JY and Owens PL. Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017. JAMA 2021;325(2):146-155.

Jones, HE, Fischer G, Heil SH, Kaltenbach K, Martin PR, Coyle MG, Selby P, Stine SM, O'Grady KE, Arria AM. Maternal Opioid Treatment: Human Experimental Research (MOTHER) – Approach, Issues, and Lessons Learned. Addiction 2012;107(1): 28–35

Kaltenbach K, O'Grady KE, Heil SH, Salisbury AL, Coyle MG, Fischer G, Martin PR, Stine S, Jones HE. Prenatal Exposure to Methadone or Buprenorphine: Early Childhood Developmental Outcomes. Drug and Alcohol Dependence 2018;185:40–49

Ko JY, D'Angelo DV, Haight SC, et al. Vital Signs: Prescription Opioid Pain Reliever Use During Pregnancy — 34 U.S. Jurisdictions, 2019. MMWR Morb Mortal Wkly Rep 2020;69:897–903.

Opioid Use and Opioid Use Disorder in Pregnancy. ACOG Committee Opinion Number 711. American College of Obstetrics and Gynecologists. Obstet Gynecol 2017; 130:e81-94.

Perinatal Substance Use Disorders (PSUDs) 101: Exploring Evidence-Based Recommendations for Care. Mountain Area Health Education Center. Online Course. Accessed April 12, 2024: <https://mahec.net/home/course-catalog>.

Perinatal Substance Use Disorders (PSUDs) 201: Expanding Skills and Knowledge to Care for Families Affected by Substance Use Disorders. Mountain Area Health Education Center. Online Course. Accessed April 12, 2024: <https://mahec.net/home/course-catalog>.

Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD. Substance Abuse and Mental Health Services Administration, 2018.

❄️ **FROZEN** ❄️
THE BROADWAY MUSICAL

AT FLATHEAD HIGH SCHOOL

What are you currently doing?

What would you like to change?

Any questions?

