Opioid Use Disorder (OUD) in Pregnancy: Confronting the Truth

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Director, Montana Perinatal Center
Director, Maternal Fetal Medicine at KRH
Opioid Crisis in United States: It is Everywhere including Montana

Pregnant Women are at High Risk and Fly Under the Radar
Hot Topics

• “Use of Opioids, Amphetamines during Pregnancy has Skyrocketed in the Last Decade” - Am J Pub Health
  – Huffington Post, Forbes, Newsweek, Health Day, and NPR 11/29/18

• Opioid use increased 4 fold

• Amphetamine use increased 2 fold particularly in Western US
Neonatal Abstinence Syndrome (NAS) in Montana

The rate is increasing 9.0 cases/1000 live births in 2013.
The absolute number of cases is low approximately 299.
Truths about Neonatal Abstinence Syndrome (Neonatal Withdrawal Syndrome)

- Self limited and treatable condition
- Increasing in incidence
  - Clearly in part to the increase in opioid use in pregnancy: illicit and prescribed
  - Can see similar symptoms in neonates exposed to multiple other medications/drugs
    - Tobacco, marijuana, methamphetamines, SSRI’s
No Newborn is Born “Addicted”

- Term is incorrect and highly stigmatizing.
- Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences.
- Babies cannot be born “addicted” to anything regardless of drug test results or clinical evidence of physical dependence.
“Healthcare professionals have also noted a significant rise in **babies born addicted to drugs**”

“This epidemic now gets directly transmitted to the next generation in our poorest, most vulnerable communities”

“We all need to invest in reducing addiction stigma to help patients find treatment and advocate for greater investment in mental health access”
Identification of Women with Substance Use Disorder (SUD) including Opioid Use Disorder (OUD) in Pregnancy
Why are Women Afraid to Disclose SUD to Providers?

- Guilt
- Legal ramifications
- Child custody issues
- Stigma
Identification of Women with SUD Requires Universal Screening

• SUD is not defined by geography, ethnicity, gender or socio-economic factors
• Use standardized assessment tool
• Limited data comparing tools especially in pregnancy
• UDS screens??
THE 4 P’S

4 P’s for Substance Abuse

1. Have you ever used drugs or alcohol during Pregnancy?
2. Have you had a problem with drugs or alcohol in the Past?
3. Does your Partner have a problem with drugs or alcohol?
4. Do you consider one of your Parents to be an addict or alcoholic?

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.
### Short Alcohol Monitor (SAM)
These questions are to help you and your medical team monitor how your drinking may be affecting you.
Circle one best answer for each question.

<table>
<thead>
<tr>
<th>How often in the past 2 weeks...</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you bothered by how your drinking impacted your health, relationships, goals or life?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>2. Did you have trouble controlling your drinking, drink too much or spend too much time drinking?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>3. Was it difficult to get the thought of drinking out of your mind?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>4. Did you disappoint yourself or others due to drinking?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>5. Have you had trouble getting things done due to drinking?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
</tbody>
</table>

### Short Drug Use Monitor (SDUM)
These questions are to help you and your medical team monitor how your drug use may be affecting you.
Circle one best answer for each question.

<table>
<thead>
<tr>
<th>How often in the past 2 weeks...</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you bothered by how your drug use impacted your health, relationships, goals or life?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>2. Did you spend a lot of time using drugs?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>3. Were drugs the only thing you could think about?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>4. Did you disappoint yourself or others due to drug use?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
<tr>
<td>5. Did you feel your drug use was out of control?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Almost always</td>
</tr>
</tbody>
</table>
**NIDA Drug Screening Tool**

**NIDA-Modified ASSIST (NM ASSIST)**

Clinician's Screening Tool for Drug Use in General Medical Settings*

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### In the past year, how often have you used the following?

#### Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

- **Never**
- **Once or Twice**
- **Monthly**
- **Weekly**
- **Daily or Almost Daily**

#### Tobacco Products

- **Never**
- **Once or Twice**
- **Monthly**
- **Weekly**
- **Daily or Almost Daily**

#### Prescription Drugs for Non-Medical Reasons

- **Never**
- **Once or Twice**
- **Monthly**
- **Weekly**
- **Daily or Almost Daily**

#### Illegal Drugs

- **Never**
- **Once or Twice**
- **Monthly**
- **Weekly**
- **Daily or Almost Daily**

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* KALISPELL REGIONAL HEALTHCARE
“Quick” Intervention

• SBIRT
• Assess, Advise, Assist, and Arrange
• Referral for treatment
• You need to know your local resources if it is going to be quick
• Warm handoff’s work!!
Obstetric Complications of Opioids

- Preeclampsia
- Miscarriage
- Reduced fetal growth
- Fetal death
- Premature delivery

(The Medical Letter 59, 6/5/17)
Obstetrical Management

- Screening for infections
- Additional ultrasound for growth and consultations
- Use of state Prescription Drug Monitoring Programs
- Encouraging breast feeding if no relapse or other contraindications
- Postpartum psychosocial support, OUD Rx and relapse prevention programs
- Contraceptive services
Management of Co-morbidities

- Mental health conditions
  - Depression
  - History of Trauma
  - PTSD
  - Anxiety
- Use of other substances
- Poor nutrition
- Disrupted support systems
Recommendations for Treatment of OUD in Pregnancy

Pregnant women who are opioid dependent should receive opioid agonist maintenance therapy; it is safer than detoxification alone.

(The Medical Letter 59, 6/5/17, ACOG 2018, SMFM 2018)
Treatment Options in Pregnancy

• Medication Assisted Therapy Preferred Therapy
  – Methadone- Gold standard
  – Buprenorphine – increasingly used
  – Naltrexone:
    “There is no information on the safety of extended-release injectable naltrexone during pregnancy or the long-term effects on the infant of in utero exposure to this medication”. SAMHSA 2018
Recommended Treatment for OUD in Pregnancy

• Buprenorphine is safe and effective with shorter durations of Neonatal Abstinence Syndrome (NAS) treatment, but treatment retention is higher with methadone

• Long term outcome trials limited

(The Medical Letter 59, 6/5/17, The MOTHER trial)
Medically Supervised Withdrawal

- Relapse rates 59-90%
  - Communicable disease transmission
  - Accidental overdose because of loss of tolerance
  - Obstetric complications
  - Lack of prenatal care

- If patient refuses MAT or unavailable it often requires prolonged inpatient care and intensive outpatient behavioral health follow up

- Limited outcome data
Detoxification from Opiates during Pregnancy

• Over 5 years, 34 gravidas elected opioid detox at mean GA of 24 weeks
  – 14 (41%) failed
  – Of the 20 women who successfully underwent detox, 10 (50%) relapsed during pregnancy and 4 didn’t complete detox, so
  – Of 34, 6 (18%) were successful with no adverse fetal outcomes

• Over 5 years, 95 women elected inpatient detoxification
  – 53 (56%) were successful and their babies had shorter stays and were less likely to be treated for NAS (10 vs 80%)
  – No long term data available
Detoxification from Opiates during Pregnancy

• Over 5.5 years, 301 opiate-addicted pregnant patients were fully detoxified
  – There was no fetal harm, believed by the authors to be related, but there were 2 fetal demises later in pregnancy after the detox
  – Highest success rate in the incarcerated group (108 patients)
  – Also, 31% of the newborns had NAS, though lower in those with intensive follow-up

• Key is to recognize low success rates and persistence of some NAS
Opioid Detox during Pregnancy: A Systematic Review

Evidence does not support detox due to low completion and high relapse rates and limited data on maternal/neonatal outcomes beyond delivery

(Terplan et al.,)
Untreated OUD

• Engagement in high risk activities
  – Prostitution
  – Trading sex for drugs
  – Criminal activities

• Consequences
  – Exposure to STI’s
  – Violence
  – Legal consequences: loss of custody, criminal proceedings or incarceration
# MAT for OUD and Pregnancy

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
<th>No Treatment</th>
<th>Number needed to treat</th>
<th>Number needed to harm</th>
<th>Every 1000 people treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention in treatment methadone</td>
<td>75%</td>
<td>25%</td>
<td>2</td>
<td></td>
<td>500 stay in treatment</td>
</tr>
<tr>
<td>Retention in treatment buprenorphine</td>
<td>65%</td>
<td>35%</td>
<td>3.3</td>
<td></td>
<td>333 stay in treatment</td>
</tr>
<tr>
<td>Relapse</td>
<td>60%</td>
<td>80%</td>
<td>6.7</td>
<td></td>
<td>143 prevent relapse</td>
</tr>
<tr>
<td>OD mortality methadone</td>
<td>0.2%</td>
<td>0.5%</td>
<td>341</td>
<td></td>
<td>300 deaths avoided</td>
</tr>
<tr>
<td>OD mortality buprenorphine</td>
<td>0.1%</td>
<td>0.5%</td>
<td>316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAS</td>
<td>50%</td>
<td>70%</td>
<td>5</td>
<td></td>
<td>200 NAS due to illicit use avoided</td>
</tr>
<tr>
<td>HLHS</td>
<td>2.4/10000</td>
<td>5.8/10000</td>
<td>2941</td>
<td></td>
<td>0.3 CHD caused</td>
</tr>
<tr>
<td>Open NTD</td>
<td>7/10000</td>
<td>14/10000</td>
<td>1428</td>
<td></td>
<td>0.6 ONTD caused</td>
</tr>
</tbody>
</table>
Additional Benefits MAT

- Reduction in termination of parental rights cases/CPS
- Reduction in infections including HIV
- Reduction in high risk behaviors
- Reduction in ED visits
- Reduction in incarceration
Barriers for Pregnant Women to Receive Treatment

- Cost
- Availability- no spaces
  - Only 55% of residential/detox accept pregnant women on Medicaid
- Programs do not provide childcare
- No one available to cover family responsibilities
- Montana: travel and housing
Management of Co-Occurring Issues

- Psychiatric comorbidities are common
- Smoking – huge problem
- Marijuana
- Methamphetamines
- Alcohol
Priorities for Wrap Around Services

• Behavioral health
• Financial counseling
• Transportation
• Housing
• WIC
• Outpatient groups/classes
• Dental care
Relapse or Recurrence is the Norm Not the Exception

THE CYCLE OF ADDICTION

Guilt, remorse, shame
Unmet needs
Old behavior patterns
Unsatisfying outcomes
Confusion and frustration
Pain, fear, anxiety

Someone is hurt by what happened
Physical release and relief
Explosion of anger/rage
Feelings of powerlessness
Building anger, frustration
Real Life Lessons: There is no stick!

- If pregnant patients relapse or are non-adherent with treatment recommendations or do not receive prenatal care, what are our options?
  - Refuse to treat and let patient spiral out of control?
  - Risk withdrawal and potential consequences: preterm labor/birth, fetal stress, or infectious morbidity
  - Maternal death
Relapse is the Norm NOT the Exception

- Relapse rates range from 40-60% on MAT
- Providers, Family Members, and Patients are all frustrated and angry when it occurs
- We all need to take a deep breath and count to three! It can take many attempts to win this lifelong battle
- "Punishing" the patient doesn’t help
- Need to reengage the patient and wrap her in services
Punishment

• Proponents:
  – Effective tool in deterring pregnant women from using drugs
  – Force women to get treatment they would otherwise avoid

• Opponents:
  – “In reality, these measures are more likely to deter women from seeking prenatal care or from being completely forthcoming with their health care providers”
Is Punishment Worth It?

• “When the arrests, detentions, and prosecution of women have been challenged, they are nearly always found, eventually, to be without legal basis or to be unconstitutional”

• Constitutional issues:
  – “due process principles of notice, vagueness, and overbreadth, as well as privacy and sex discrimination
  – Preferentially target poor and minority groups
How Do We Best Use Our Scant Resources?

• Develop local effective treatment models
• Partner with every resource available
• Avoid duplication of services
• REDUCE BARRIERS TO CARE
Partners for Pregnancy Recovery of KRH

Identify Patient*

OB | FP | ER | Other Clinic | L&D | BH

Family Member
Cold Calls
CPS

Phone screening 24 hours

Transfer/Transport
Psych
Case Management/Foundation
Primary Care Navigators

Financial counseling
Transportation
Temporary housing

1st Medical Contact goal < 72 hours from presentation

Case Manager
Mary Jane Seefeldt – ACLC/PCLC CMS
Healthy Montana Families
1st Medical Contact goal < 72 hours from presentation

- < 24 Weeks
  - CMS or L&D
- > 24 Weeks
  - L&D

Evaluation
- Screening Tools
- Physical Exam
- LFT’s/UDS
- Serologies

If OUD is confirmed and patient consents to program: Initiate methadone/subutex and provide Peer Support

- Stabilize with Subutex
- Inpatient Admission if Methamphetamine abuse persists

Community Reintegration Following Stabilization
If OUD is confirmed and patient consents to program: Initiate methadone/subutex and provide Peer Support

- Stabilize with Buprinorphine
- Inpatient Admission if Methamphetamine abuse persists

Community Reintegration Following Stabilization

Outside Flathead Valley
- Outpatient Referral to MD
- Peer Support in Community
- Case Manager from CMS establishes connections within the community

Flathead Valley Wrap Around Services
- Behavioral Health
- Neonatology
- CSW
- Hope
- CPS
- Neighbors Helping Neighbors
- Nurturing Center
- Outpatient Groups/Classes
- Dental care
What Have I Learned?

• This is an incredibly difficult issue
• It is not simply having a “waiver”
• Need a system of care in place
• Excellent communication between partners is essential for a good outcome
• We must reduce any barriers to care
• Medical management without housing and “security” will increase likelihood of failure
• We can be successful!!!
# Parting Thoughts

<table>
<thead>
<tr>
<th></th>
<th>OUD</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic predisposition</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Environment/Choices</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Effective medical treatment available</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Teratogen</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stillbirth</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Prematurity</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NICU admissions</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Life long effects on offspring</td>
<td>?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Stigma and Bias

• Be very careful what you say: words hurt
  – Your baby is going to withdraw!
  – No baby should be born addicted!
  – If you can’t control yourself, how are you going to be a good parent?
  – CPS is going to fix it!
  – Your baby is going to suffer!

• Our goal is to engage our patients in a non threatening and transparent manner!