Pregnancy and Medication for Opioid Use Disorder
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No Disclosures

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Pregnant and Post-partum Women

• Why are they struggling to find and engage in treatment?
  • Fear of possible legal consequences
  • Possible involvement of child protective services
  • Misinformation among healthcare professionals and systems that results in reluctance to provide care for such women
  • Twelve-step abstinence meeting requirement by the Court or treatment facility
  • Shame
  
  Stigma can reduce the willingness of individuals with substance use disorder to seek treatment. Stigma can also negatively influence health care providers and impact the care they provide.

SAMHSA (2018)
National Institute on Drug Abuse (2021)
Pregnant and Post-partum Women

- Why are they struggling to find and engage in treatment?
  - Lack of available options
  - Fear of immediate inpatient requirement and possible loss of home and/or job
  - Possible inability to receive continuity of care with mental health medications
  - Lack of transportation and childcare to attend treatment
  - Misunderstanding of Medicaid versus State-funded services and how to connect to one when the other ends
How Stigma Leads to Punishment of Women of Childbearing Age

Stigma: a mark of disgrace
Dehumanization: depriving a person or group of positive human qualities
Discrimination: the unjust or prejudicial treatment
Prejudice: preconceived opinion
Punishment: the infliction or imposition of a penalty

Stigma ➔ Dehumanization ➔ Discrimination/Prejudice ➔ Punishment
The vast majority of pregnant women are motivated to maximize their own health and the health of their developing fetus.

Campopiano von Klimo (2019, February 28)
PREGNANCY AND OUD

• Opioid Use Disorder (OUD) has increased among pregnant women in all states.
• 6.5 per 1,000 women have OUD at delivery.
• Pregnant women who took opioids for non-medical uses were more likely than non-pregnant women to obtain their opioids from doctors.
• There has been a sustained increase in both maternal OUD and Neonatal Abstinence Syndrome (NAS) diagnoses among rural residents.

Campopiano von Klimo (2019, February 28)
PREGNANCY AND OUD

• Women experience a faster onset and progression of OUD as they are more sensitive to cravings compared to men.

• Women experience greater impairment in social and occupational function than men.

• Women are less likely to engage in treatment than men.

• Women may use a smaller amount of drugs for a shorter amount of time before they become dependent in comparison to men.

• Differences in use and body fat percentages, metabolic rates, and hormonal fluctuations have an impact.

Campopiano von Klimo (2019, February 28)
Pregnant Women with OUD

All need harm reduction (during pregnancy and post partum). What does harm reduction mean?

All need evaluation for domestic violence and co-occurring psychiatric disorder.

Almost all need psychosocial interventions.
- Case Management (housing, food stamps, referral to a crisis center if needed)
- Referral to counseling or treatment
- Peer supports

All need evaluation for tobacco use.
Pregnant women with OUD have a unique set of needs across multiple domains: domains that affect both obstetric health and outcomes and OUD treatment.

Comprehensive behavioral health support and treatment with continuity of care and medications is critical.
Prenatal Care

Women with substance use disorder (OUD) and no prenatal care (PNC) had highest risk for prematurity, low-birth weight and small for gestational age infants.

Providers are unwilling to treat pregnant women with OUD.

As PNC increased, risk for prematurity, low-birth weight and small for gestational age babies decreased. (1)

Women will often delay or not seek PNC because of stigma and fear of consequences, including being reported to child protective services. (2)

(2) Bishop, et al. (2017)
The path to initiation of opioid use is complex and may include:

- Childhood physical and/or emotional abuse and/or neglect
- Living in a culture that allows gender inequality/discrimination
- Chronic stress
- Psychiatric co-morbidities
- Poor nutrition/Food insecurity
- Intimate partner abuse and adult trauma
- Intergenerational substance use
- Economic challenges
- Previous child welfare and court involvement
Medication Assisted Therapy (MAT)

Also known as Medication Assisted Treatment

Abstinence-based therapy is NOT recommended during pregnancy for anyone who is actively using opioids. (1)

Medication Assisted Therapy (Pharmacotherapy) is the STANDARD OF CARE for pregnancy.

Kampman, & Jarvis (2015)
Treatment options for Women with OUD

Medications for Opioid Use Disorders (MOUD) for Pregnant/Breastfeeding Women
<table>
<thead>
<tr>
<th>MOUD can be done with either methadone or buprenorphine. Conversation on choice should include the patients needs and current medications.</th>
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<tbody>
<tr>
<td>Pregnant women, with a history of OUD, do not need a current diagnosis of OUD to receive MOUD</td>
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<tr>
<td>Methadone has been around longer but must be given in specific clinics. Some patients may have childcare or transportation challenges to attend a daily dosage program.</td>
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<tr>
<td>Buprenorphine can be more accessible for patients and more physicians can prescribe this medication.</td>
</tr>
<tr>
<td>Data regarding naltrexone is limited, but it is probably safe to continue in pregnancy if patient wishes. It should not be started in pregnancy.</td>
</tr>
<tr>
<td>Access to behavioral counseling, as an adjunctive treatment.</td>
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</table>
OUD Treatment During Pregnancy, Intrapartum Care, and Postpartum Care: Dosing

**Pregnancy:** dose to comfort level of the pregnant woman. It is important to note that dosages may increase during pregnancy as the body tends to metabolize faster during pregnancy.

It is also important that treatment providers and services understand this so that they do not believe the person is substance seeking. In addition, the patient needs to be aware of this so they can address this with the MOUD provider and understand that this can occur while pregnant.

Additionally pregnant women who use illicit substances miss more prenatal appointments. Regular prenatal care makes a positive difference in the health of the infant.

**Intrapartum Care:** continue methadone or buprenorphine dose through labor and postpartum at the prenatal dose.

Campopiano von Klimo (2019, February 28)
OUD Treatment During Pregnancy, Intrapartum Care, and Postpartum Care: Dosing

Postpartum Care: continue prenatal dose of MOUD; individualize dose decreases; if opioid pain management is needed, requirements will be higher.

It is important to note that mothers with SUD die at a rate of 8.4 times higher than other women of similar age.

Also, ongoing substance use disorders by caregivers and the dysfunctional home environment may lead to negative effects on the child’s psychological growth and development.

The mother’s well-being has been recognized as the key determinant of the health of the next generation.

Campopiano von Klimo (2019, February 28)

Hser et al. 2012; Funai et al., Staton et al., 2003 and Wagner et al., 1998; El-Mohandes et al., 2003; Roberts and Pies, 2011 and Schempf and Strobino, 2009; Chatterji and Markowitz, 2001, Clark et al., 2004 Hanson et al., 2006 and Linares et al., 2006
What are the long-term effects of MOUD on the Baby?

- Very hard to control for other factors, such as poor socioeconomic status, inadequate pre-natal care and other drug use.
- Infants born to mothers who received MOUD were found as toddlers to have no more problems than those from a sample without substance use disorders (SUD). \(^{(1)}\)
- Neonatal outcome is improved if mothers with an OUD get on methadone (MTD) early in pregnancy or even before pregnancy. \(^{(2)}\)

\(^{(1)}\) SAMHSA (2018)
\(^{(2)}\) Logan, Brown, & Hayes (2013)
Despite evidence that medications for opioid use disorder improve outcomes for mothers and infants, most pregnant women with opioid use disorder in the U.S. are not receiving these medications.
What about Medically-Assisted Withdrawal?
• It is NOT recommended for pregnant women with OUD
• Pharmacotherapy is the recommended standard of care and the best option for a pregnant woman with OUD.
• Remaining on pharmacotherapy helps pregnant women with OUD avoid a return to substance use, which has the potential for overdose or death.
• Risks include:
  • High relapse rates
  • Low completion rates
Maternal Mortality

Although most are preventable, maternal deaths have been increasing in the United States since 2000. This ratio is twice that of most developed countries. More than half of these death occur after delivery or postpartum.

Gunja, Gumas, & Williams (2022)
Pregnancy-Associated Drug Overdose Mortality 2017 to 2020

(A) Drug types involved

(B) Pregnancy timing from 2017 to 2020

Bruzelius, & Martins (2022)
Overdose in Pregnancy

• According to one study, 14% of pregnant women reported a non-fatal overdose in the past year.
• Younger age was the only risk factor identified.
• Most had received opioid overdose education and naloxone.

Another study found
  • Postpartum risk of overdose was 4 times higher than in the 3rd trimester.
  • Risk of overdose was highest 7 to 12 months post-partum.
Medically-Assisted Withdrawal

Some studies show that it can be done with low risk of fetal mortality. \(^{(1,2)}\)

Most studies show a high rate of relapse. \(^{(1,2)}\)
Relapse Rates range from 17-96 %. \(^{(1,2,3)}\)
Relapse rate is lower on MOUD. \(^{(3)}\)

\(^{(1)}\) Dashe et al. (1998)
\(^{(2)}\) Bell et al. (2016)
\(^{(3)}\) Jones et al. (2017)
A decision to withdraw from pharmacotherapy should be made with great care on a case-by-case basis. A pregnant woman receiving treatment for OUD may decide to move forward with medically supervised withdrawal if:

- It can be conducted in a controlled setting.
- The benefits to her outweigh the risks.

Campopiano von Klimo (2019, February 28)
Pregnant patients should be advised that withdrawal during pregnancy increases the risk of relapse without fetal or maternal benefit. Neonatal Abstinence Syndrome does not decrease if the patient detox's during pregnancy.

Campopiano von Klimo (2019, February 28)
Caring for Mothers with OUD
• “...it is important to advocate for this often-marginalized group [pregnant women with OUD] of patients, particularly in terms of working to improve the availability of treatment and to ensure that pregnant women with OUD who seek prenatal care are not criminalized.

• Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with SUD to discourage the separation of parents from their children solely based on SUD, either suspected or confirmed.”

American College of Obstetricians and Gynecologists (2015)
Post-partum Women and OUD

Stigma of having a substance-exposed infant is intense
Experiencing hormonal changes and a high risk for depression
More likely to leave treatment
No longer have Medicaid
High risk of relapse to other substances

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Post-partum Moms and OUD

High risk of relapse. Encourage continued recovery behaviors and MOUD.

Often, do not have good parenting skills. Benefit from home nursing, parenting classes.

May have a fussier baby and on average, need a lot of support.
Breastfeeding

Methadone and buprenorphine are safe for breastfeeding: <1% maternal opioid intake transmitted to breast milk.

Published guidelines from ACOG, AAP, and the Academy of Breastfeeding Medicine (ABM) all support breastfeeding for women on opioid agonist therapy for OUD

Maternal benefits of breastfeeding: increased oxytocin levels lead to decreased stress and increased bonding which lower relapse risk

Newborn benefits of breastfeeding: reduction in the need for pharmacologic treatment of NAS/NOWS and shorter hospital stays
After delivery, a new mother’s body goes through multiple physiological changes. Her previously effective dose may need to be adjusted. If there is over-sedation and Mom’s breastfeeding, she and the infant should be assessed.

The mother could be drowsy because she has a demanding newborn who does not sleep or eat well.

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Pharmacotherapy Adjustments Postpartum

✓ Dose changes need to be individualized.
✓ The healthcare professional should schedule a follow-up visit with the mother as early as possible after delivery.
✓ Mothers being treated for OUD with pharmacotherapy need to be especially careful to avoid alcohol or any sedating medications, especially benzodiazepines.
✓ Ensure naloxone is at home and caregivers know how to use it.

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Return to substance use is common for people with SUDs and should not be viewed as a failure.

Discontinuation of pharmacotherapy for OUD should generally be avoided in the immediate postpartum period.

A woman with OUD should be counseled regarding contraception and have immediate, easy access to her contraceptive of choice before her discharge.
Addiction is a brain disease.
Addiction is A Brain Disease

- As with other diseases, it affects function and reoccurrence in symptoms may occur if left untreated or not treated effectively.
- The focus in the past has been generally on drugs.
- This new definition makes clear that addiction is not just about drugs, it’s about brains.
- It is more about reward circuitry ...brain pathways and what goes wrong.
- Addiction is basically a tale of two different brain regions.
- Our rational brain (frontal and pre-frontal cortex) and our survival brain –Midbrain/limbic system.
Just like other diseases, it affects function

Decreased Brain Metabolism in *a pt with SUD*

Control

Cocaine use disorder

Decreased Heart Metabolism in *Heart Disease Patient*

Healthy Heart

Diseased Heart

Sources: From the laboratories of Drs. N. Volkow and H. Schelbert
Just like other diseases, it affects function

Prefrontal Cortex

Role:
- Decision making
- Thinking
- Reasoning
- Learning

ADDICTION IS A BRAIN DISEASE
What you can do:

- Think strengths-based
- Use positive, affirming language
- Consider Mother & Child, NOT Mother vs. Child
- Use SAMHSA and American College of Obstetrics Materials
- Tell stories of success
Support a More Comprehensive Health Approach for Women

- Reimbursement for comprehensive services
- Access to appropriate identification, assessment, and treatment for OUD across the lifespan
- Access to whole body/whole person health care
- Responsible/safe prescribing by medical providers and training on SUD diagnosis and treatment
- Support efforts to stop smoking
- Support specialized programs to address the complex needs of this population
Improving Language and Establishing Stigma-Free, Supportive Service Delivery Environments

• Use non-stigmatizing language that reflects an accurate, science-based understanding of substance use disorder and is consistent with your professional role.

• Take any steps needed to reduce the potential for stigma and negative bias

• Learn the terms both to avoid and to use.

• Use person-first language, and let individuals choose how they are described.

• Lead stigma-reduction efforts in your practice.

U.S. DHHS. (2023, November 17)
Key Facts

- Identify and refer early in pregnancy
- Adopt universal screening using validated tools.
- NAS/NOWS is a treatable condition.
- Remember, MOUD is evidence-based, safe and effective.
- Be aware: Continued use of opioids and other drugs is common among women with OUD and other substance use disorders (SUDs).
Conclusions

- Most pregnant women are motivated to maximize their own health and the health of their fetus during pregnancy.
- Engagement in care improves outcomes.
- Pregnant women with SUD experience discrimination and scrutiny.
- Care, ideally, is co-located, multidisciplinary, non-judgmental, and patient-centered.
- Preventing substance-exposed pregnancies means preventing unplanned pregnancies.

Campopiano von Klimo (2019, February 28)
Thank you!

If you would like more information about training through the Peer Prescriber Mentor Program Please contact:

Diana L. Snyder
Director Opioid Response Training Project
Florida Alcohol and Drug Abuse Association
Phone: 850.878.2196
Email: diana@floridabha.org
Resources

• Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants
  A resource from SAMHSA

• About Opioid Use During Pregnancy
  A resource from the Center for Disease Control and Prevention (CDC)
  https://www.cdc.gov/pregnancy/opioids/basics.html

• Opioid Use and Opioid Use Disorder in Pregnancy
  A resource from The American College of Obstetricians and Gynecologist
Resources

• **Anti-Stigma Toolkit: Guide to Reducing Addiction-Related Stigma**
  A resource from the Addiction Technology Transfer Center Network

• **Recovery-Friendly Care for Families Affected by Opioid Use Disorder**
  A resource from the American Academy of Pediatrics

• **Pregnancy and Opioid Pain Medications**
  A resource from the Center for Disease Control and Prevention (CDC)