Substance Use in Pregnancy

By: F. Sevy Gurule, MD

February 22, 2025

About Me

- Family Doctor
  - Board Certified in Addiction Medicine
  - Fellowship trained in Maternal and Child Health, Fellowship Director
  - UNM Milagro Provider
- Native New Mexican
- Medical Director of the New Mexico Perinatal Collaborative
  - Clinical Lead for CDC Grant focused on Care of Pregnant and Postpartum People with SUD across NM
- Avid Mushroom Hunter

I have no financial disclosures.

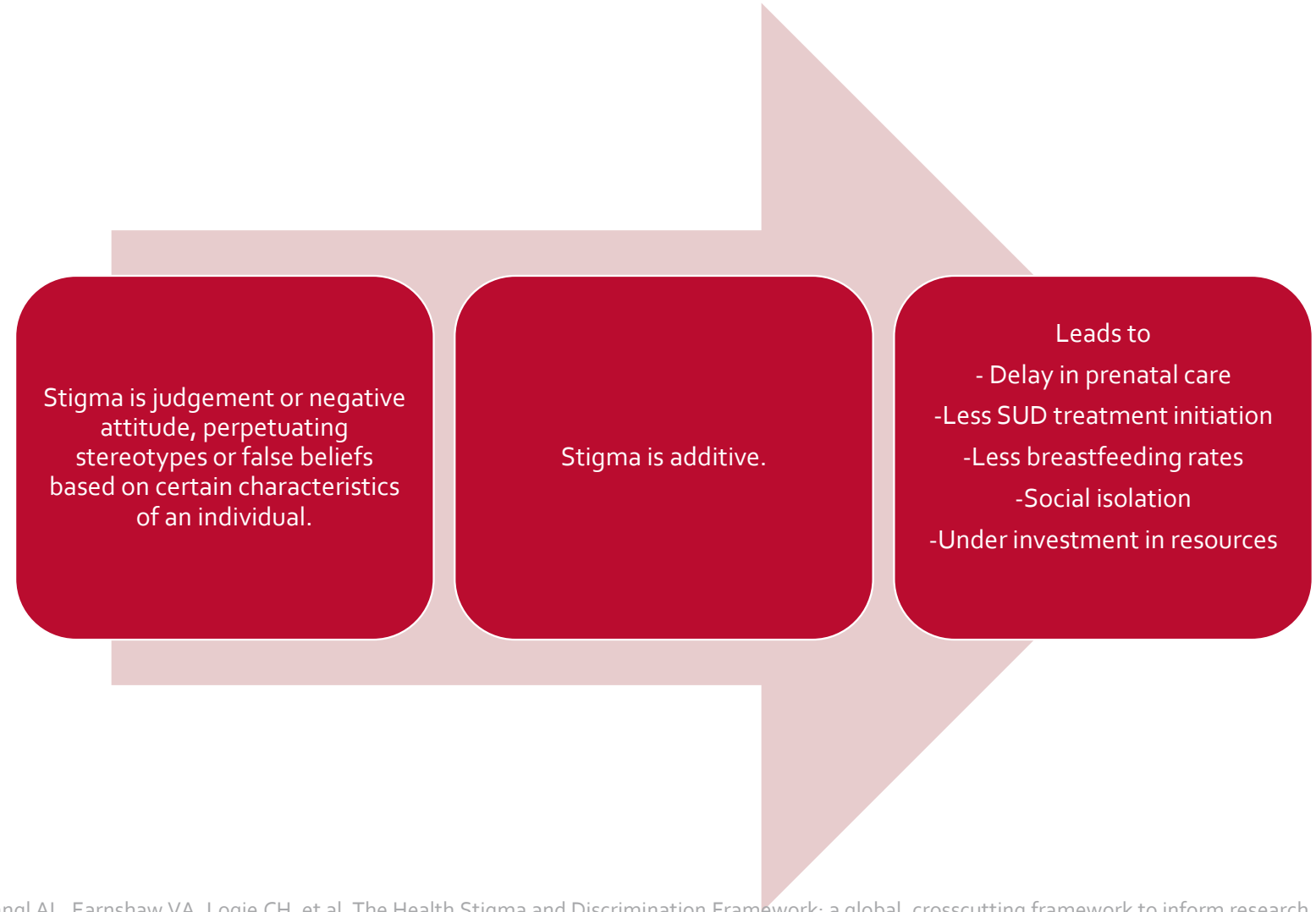
I will often refer to women, maternal, breastfeeding or use other gendered terminology. I am working to use more gender inclusive language and encourage providers to ask and match their patient's preferred terminology.

Objectives

- Recognize how stigma manifests and impacts patient care, as well as how you can mitigate the stigma your patients experience in healthcare settings.
- Understand the scope and risks of substance use in pregnancy.
- Become familiar with best practices of screening and testing for substance use in pregnancy and implications specific to pregnancy.
- Review the various treatment options, including risks and benefits of each, and nuances specific to treatment in pregnancy.
- Briefly cover peripartum and postpartum considerations, including how best to support breastfeeding when safe to do so.

Stigma

Stigma



3. Stangl AL, Earnshaw VA, Logie CH, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med*. 2017;17(1):31. doi:10.1186/s12916-019-1271-3

Bright V, Riddle J, Kerver J. Stigma Experienced by Rural Pregnant Women with Substance Use Disorder: A Scoping Review and Qualitative Synthesis. *International Journal of Environmental Research and Public Health*. 2022; 19(22):15065. https://doi.org/10.3390/ijerph192215065

Wright ME, Temples HS, Shores E, Chafe O, Lannamann R, Lautenschlager C. Pregnant and Parenting Women's Experiences with Substance Use Disorder. MCN Am J Matern Child Nurs. 2021 Sep-Oct 01;46(5):271-276. doi: 10.1097/NMC.0000000000000741. PMID: 34398828.

Stigma Free Care

Avoid stigmatizing words (addict, user, junkie, alcoholic)

Use person first language (person with a SUD, person in recovery)

Instead of abuse, simply say "use" or "misuse" if referring to prescription medications

Move to avoid MAT, opioid substitution or replacement therapy and instead use MOUD

Avoid describing urine test as clean or dirty, but simply positive or negative

Never refer to a baby as addicted

Avoid stigmatizing language in your documentation

Be aware of your body language.

Combatting Stigma

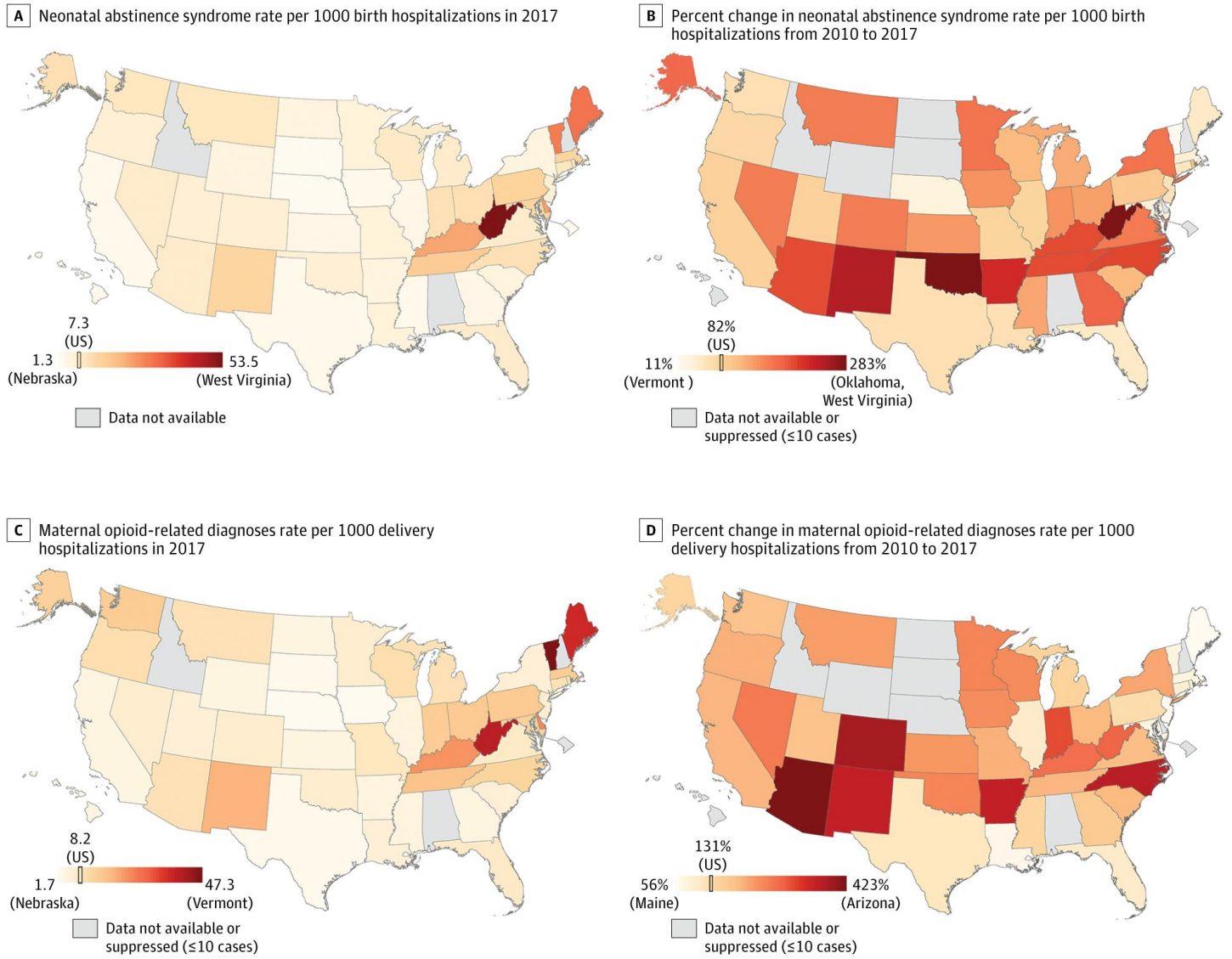
- Lead by example, recognize and correct bias
- Communicate hope and respect
- Staff training
- Using peer support specialists, hiring individuals with lived experience
- Integrated prenatal and substance use care
- Improve readiness to meet patients' needs
- Incorporate system level interventions and policy changes
- Recognize SUD is a chronic condition and recovery is a process

SUD in Pregnancy

OUD in Pregnancy

8.2 per 1000 births in 2017

113% increase since 2010



Hirai AH, Ko JY, Owens PL, Stocks C, Patrick SW. Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017. *JAMA.* 2021;325(2):146–155. doi:10.1001/jama.2020.24991

New Mexico Birth Cohort Study from 2016-2019 found that 34.9% of infants were exposed to a psychoactive substance in utero.

- 57.1% of these infants were found to have been exposed to drugs
- 38.8% to alcohol
- 31.1% to tobacco
- <1% the substance could not be specified
- In utero exposure decreased for alcohol and tobacco through the pregnancy.

"Substance Use During Pregnancy in New Mexico, 2016-2019. New Mexico Epidemiology Volume 2023, Number 1. Published March 8, 2023. https://www.nmhealth.org/data/view/report/2769/

Risks associated with Substance Use

- Less participation in prenatal care
- May disrupt access to substance use treatment
- Higher rates of STI (syphilis) and Hepatitis C
- Worse obstetric outcomes (2x more likely to have preterm birth, blood transfusion, c-section, stillbirth and pre-eclampsia. Increased risk of
- Psychiatric disorders
- Poorer nutrition
- Death
  - Overdose
  - 4.6x more likely to die during hospitalization
  - 2.5x more likely to die of cardiac arrest
- Stigma
- Growth restriction (in utero and post natal)
- Neurodevelopment/behavioral concerns
- Neonatal opioid withdrawal
- Difficulties feeding
- Birth defects- Fentanyl embryopathy, cocaine and alcohol most associated with anomalies
- Fetal death
- SIDS

https://library.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf

Screening & Testing

Screening for Substance Use Best Practices

- ACOG: Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.

- AAFP, SMFM, ASAM, CDC, USPSTF echo this recommendation.

- Best practices for screening in prenatal care settings:
  - Universal and not based on predetermined risk factors
  - Completed through verbal validated screening tools like NIDA Quick Screen, U-SURP, and The 5 Ps
  - Not accomplished with urine drug testing
  - Recognize risks and barriers to disclosing use
  - Create safe, stigma-free environments
  - Standardize a process

- Screen > Referral/Treatment > Improved outcomes.

Validated screening tools systematically improve information gathering through use of consistent, deliberate language, potentially reducing the impact of stigma on screening.

- **4 Ps, 5 Ps**

- 1. Did any of your Parents have problems with alcohol or drug use?
- 2. Do any of your friends (Peers) have problems with alcohol or drug use?
- 3. Does your Partner have a problem with alcohol or drug use?
- 4. Before you were pregnant did you have problems with alcohol or drug use? (Past)
- 5. In the past month, did you drink beer, wine or liquor, or use other drugs? (Pregnancy)

SURP-P

CRAFFT

DAST

NIDA QUICK SCREEN

NIDA QUICK SCREEN

In the past year how often have you used the following?	Never	1-2 times	Monthly	Weekly	Daily Or almost
Alcohol Men- 5 drinks per day Women-4 drinks per day					
Tobacco					
Prescription drugs for non-medical reason					
Illegal drugs					

Risks of Screening

- Stigma
- Legal Ramifications
- Incarceration
- Family Surveillance and Separation

Risks are not to be down played.

- States that criminalize substance use do not reduce substance use, but rather
  - Have lower rates of prenatal care
  - Have lower rates of screening
  - Have higher rates of neonatal abstinence syndrome
  - May contribute to increased risk of isolation and suicidality
  - Result in increased rates of opioid overdose
  - Reduce rates of SUD treatment like methadone and therapy
  - Lead to disproportionate enforcement among black women

Weber A, Miskle B, Lynch A, Arndt S, Acion L. Substance Use in Pregnancy: Identifying Stigma and Improving Care. *Substance Abuse and Rehabilitation*. 2021;12:105-121.

C Margerison et al Changes in Racial and Ethnic Inequities in Pregnancy-Associated Death in the United States During the COVID-19 Pandemic, American Journal of Public Health, **114**, 7, (733-742), (2024).

N Tabatabaeepour et al Journal of Substance Abuse Treatment, 2022-09-01, Volume 140, Article 108800,

It is critical that we, as healthcare providers, committed to the health of our patients and their babies stand against any attempts to criminalize substance use in pregnancy given the mountain of evidence that demonstrate the harm of these laws.

Screening for Pregnancy

- Unintended pregnancy rate in people with substance use is as high as 86% compared to about half of pregnancies in general population.
- Assess desire to become pregnant in people seeking SUD treatment. Offer contraception when appropriate.

Heil SH, Jones HE, Arria A, Kaltenbach K, Coyle M, Fischer G, Stine S, Selby P, Martin PR. Unintended pregnancy in opioid-abusing women. J Subst Abuse Treat. 2011 Mar;40(2):199-202. doi: 10.1016/j.jsat.2010.08.011. Epub 2010 Oct 30. PMID: 21036512; PMCID: PMC3052960.

Urine Drug Testing in Pregnancy

- More significant consequences and legal ramifications
- Obtain consent (risks of testing, benefits, and alternatives or the right to decline testing)
- Limit UDT to medically necessary
  - Standard protocols
- Use confirmatory gas chromatography/mass spectrometry testing when rapid tests differ from patient report
- Discuss results with patients
- UDT centers abstinence-based success. Remember harm reduction saves lives. Consider alternatives to measuring a patient's success likereduced use, meaningful employment, regaining custody of children, securing housing, etc.

J Womens Health (Larchmt). Author manuscript; available in PMC 2010 Apr 24.
Published in final edited form as:
J Womens Health (Larchmt). 2007 Mar; 16(2): 245–255.
doi: 10.1089/jwh.2006.0070
PMCID: PMC2859171
NIHMSID: NIHMS182195
PMID: 17388741

The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting

HILLARY VEDA KUNINS, M.D., M.P.H., M.S., ERAN BELLIN, M.D., CYNTHIA CHAZOTTE, M.D., EVELYN DU, Ph.D., and JULIA HOPE ARNSTEN, M.D., M.P.H.

› Am J Obstet Gynecol MFM. 2022 Jan;4(1):100453. doi: 10.1016/j.ajogmf.2021.100453. Epub 2021 Aug 2.

Racial differences in indications for obstetrical toxicology testing and relationship of indications to test results

Nicola C Perlman [1], David E Cantonwine [2], Nicole A Smith [2]

Affiliations + expand

PMID: 34352428 DOI: 10.1016/j.ajogmf.2021.100453

Drug Alcohol Depend. Author manuscript; available in PMC 2020 Mar 31.
Published in final edited form as:
Drug Alcohol Depend. 2018 Nov 1; 192: 371–376.
Published online 2018 Aug 6. doi: 10.1016/j.drugalcdep.2018.05.033
PMCID: PMC7106601
NIHMSID: NIHMS1546677
PMID: 30122319

Racial disparities in discontinuation of long-term opioid therapy following illicit drug use among black and white patients

Julie R. Gaither,[a,b,c,d] Kirsha Gordon,[b] Stephen Crystal,[f] E. Jennifer Edelman,[d,e] Robert D. Kerns,[a,g] Amy C. Justice,[b,c,d,e] David A. Fiellin,[a,d,e] and William C. Becker[b,e]

Utility of Urine Drug Testing in Outpatient Addiction Evaluations

Authors: Bhanu Prakash Kolla, Guillermo Leoz Callizo, Terry D Schneekloth

Article 2019
in **Journal** of **Addiction Medicine** v13 n3 (20190501): 188-192

Summary: Data examining usefulness of **urine drug testing** in **addiction** settings for accurately establishing diagnoses and informing treatment is limited. In this retrospective-cohort study we examined the **utility** of performing **urine drug testing** in patients presenting for an **outpatient addiction** assessment. **Urine drug testing**

Show More

Family physicians' proficiency in urine drug test interpretation.

Authors: Gary M Reisfield, Fern J Webb, Roger L Bertholf, Paul A Sloan, George R Wilson

Article 2007
in Journal of opioid management v3 n6 (2007): 333-7

Medications for OUD

- Medications for Opioid Use Disorder, like methadone and buprenorphine, are the standard of care for OUD in pregnancy.
- MOUD
  - Increases patient survival
  - Improves retention in treatment
  - Decreases illicit opioid use and other criminal activity
  - Increases patient's ability to gain and maintain employment
  - **Improves birth outcomes**
  - **Reduces fetal exposures to risky maternal behaviors and situations (polysubstance use, infections, poor nutrition, violence, etc)**
  - **Improves adherence to prenatal care**
  - **Improves neonatal outcome (higher birthweight, longer gestational age at birth, less severe NOWS)**

https://library.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf

Integrated care

- Integrated prenatal care and substance use treatment leads to increased engagement in obstetrical care, lower risk for substance use at time of delivery and reduced preterm birth rates, and shorter infant hospitalization stays.
- Family Medicine should be at the forefront of this care.
  - We can care for the mamas, the dadas, and the babies!

(2024). 2024 ASAM Annual Conference Poster Abstracts. *Journal of Addiction Medicine*, *18* (5), e9-e76. doi: 10.1097/ADM.0000000000001384.

Treatment

Medications for OUD

Methadone

Buprenorphine

Naltrexone

Medications for Opioid Use Disorder reduce cravings, effects of other opioids, and withdrawal symptoms.

Methadone

- Full opioid agonist
- Pros: no ceiling effect, more structure and supervision
- Cons: daily dosing, limited access (especially for adolescents), may prolong Qtc, slow dose titration

Buprenorphine

- Partial opioid agonist
- Pros: more accessible, less overdose risk, quickly reach therapeutic dose, Less severe NOWS and shorter length of stay compared to methadone
- Cons: must enter withdrawal prior to initiation, ceiling effect*

Naltrexone

- Opioid antagonist
- Not first line of therapy in pregnancy
- Extended period of abstinence required, may interfere with pain control

Medications for OUD- nuances of pregnancy

- Medication Choice
  - Methadone and buprenorphine are both options. Given the easier access of buprenorphine, difficulties transitioning from methadone to buprenorphine, and the reduced severity of NOWS, I recommend starting with buprenorphine. Ultimately whatever works is best!
  - Buprenorphine (monoproduct) and Buprenorphine-naloxone are considered safe in pregnancy. Combination product may limit diversion or discourage injection.
  - Long-acting injectable buprenorphine with limited safety data
- Dosing
- Other considerations

Medications for OUD- nuances of pregnancy

- Medication Choice
- Dosing
  - In pregnancy there is 30% increased activity of CYP450 enzyme and 600% more effective UDT glucuronidation
  - This leads to more rapid metabolization of certain drugs.
  - To maintain effective dosing in pregnancy, patients frequently require split dosing and higher doses
- Other considerations

Medications for OUD- nuances of pregnancy

- Medication Choice
- Dosing
- Other considerations
  - Treat constipation and nausea.
  - Encourage routine dental hygiene and care.
  - Standard doses of naloxone are safe in pregnant people.

Why not detox and abstinence?

- ACOG, WHO, SAMHSA and other national organizations specify that MOUD is standard of care for the treatment of OUD in pregnancy.

- Detox/Supervised withdrawal has unnecessary risks
  - Fetal distress
  - Frequent intoxication-withdrawal cycles
  - Preterm labor is not well demonstrated in the literature, but anecdotally a real risk

- There is an abundance of literature to show that MOUD saves lives and is superior to abstinence.

A word about stimulant use

- No MOUD equivalent for Stimulant Use.
- Behavioral Health Therapy
- Contingency Management
- Residential Treatment
- Some medications have shown modest benefit.
- Routine prenatal care, serial growth ultrasounds, fetal testing, and consider induction of labor at 39 weeks.

Harm Reduction

Harm Reduction

Harm reduction prioritizes the values of those with lived experience and allows providers to assist and not direct care, and to cultivate relationships. It is the idea that there are different pathways to wellbeing.

Harm Reduction

- Syringe exchange
- Safer smoking supplies
- Access to safe and secure housing
- Access to safe and stigma-free spaces to find respite, practice safe use, and find resources that are maintained by the communities they serve
- Recognizing that sometimes the goal is reduced use and considering other markers of “success”
- Overdose education and prevention

Overdose Prevention

- Recognize people at high risk of overdose
  - Release from incarceration
  - Motivated discontinuation
  - Pregnancy
  - Using different derivative
  - Different supplier
  - Socially vulnerable (housing and food insecurity)
  - Medically vulnerable (chronically ill, dehydrated, infected)
- Overdose plan
  - Naloxone
  - Never use alone hotline
  - Test dose
  - Don’t mix respiratory depressants

Peripartum Considerations

Peripartum Considerations

- Trauma informed delivery care
- Management of pain
- Referral for a CARA Plan, Plan of Safe Care
- Planning for Neonatal Opioid Withdrawal Syndrome and anticipatory guidance for families
  - Nonpharmacologic treatment
  - Dyad separation (especially in rural settings)

A word about mandatory reporting

if when how
Lawyering for Reproductive Justice

WHAT YOU NEED TO KNOW FOR PROVIDERS

Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals[1]

Note: This resource is up to date as of February 2024.

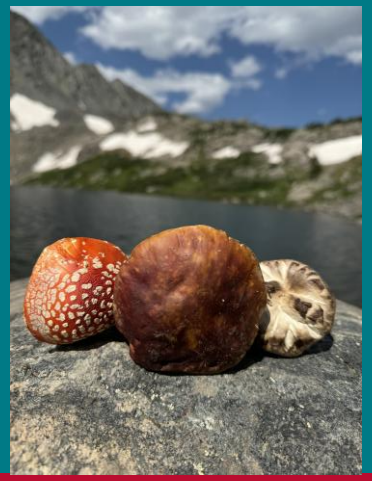
New Mexico[83]

- A drug test on a pregnant or birthing person is **NOT** required by law.
  - If screening indicates the need for a drug test, providers should ask for and get informed consent prior to drug testing a pregnant or birthing person.
- A drug test on a newborn is **NOT** required by law.
- A positive drug test or indication that a newborn is substance-affected does **NOT** trigger a mandatory report.[84] New Mexico courts have held that prenatal substance use alone does not indicate or prove child neglect.[85]

https://ifwhenhow.org/resources/prenatal-drug-exposure-capta/

Postpartum Considerations

Breastfeeding



- ABM revised its 2015 protocol in 2023 to provide recommendations guided in patient-centered care and literature-based recommendation.

- Why the change?
  - A 2020 study of 503 women found that third trimester urine drug test had PPV of only 36% for ongoing postpartum substance use compared to urine drug test at time of delivery.
  - Most substances are eliminated from breastmilk in hours to days.
  - To align with more progressive and informed guidelines on breastfeeding decision-making practices.

BREASTFEEDING MEDICINE
Volume 18, Number 10, 2023
© Mary Ann Liebert, Inc.
DOI: 10.1089/bfm.2023.29256.abm

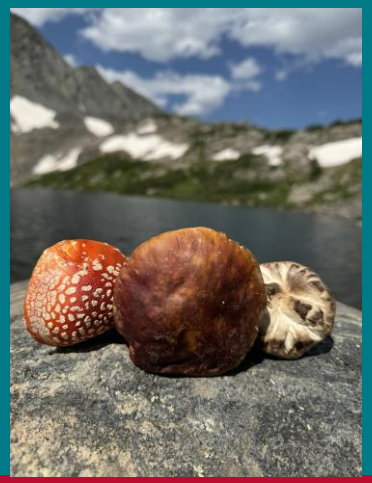
ABM Protocol

Open camera or QR reader and scan code to access this article and other resources online.

Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023)

Miriam Harris,[1,2] Davida M. Schiff,[3,4] Kelley Saia,[2,5] Serra Muftu,[3,4] Katherine R. Standish,[6] and Elisha M. Wachman[2,7]

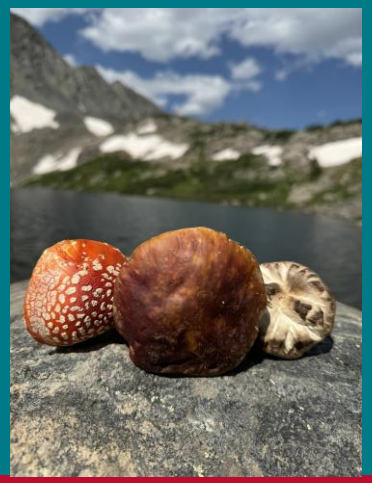
Breastfeeding



- Reduced severity of NOWS specifically less need for pharmacologic treatment and shorter hospital stay
- Improved bonding, reduced stress for parents, support recovery
- All the other greats benefits that breastmilk confers

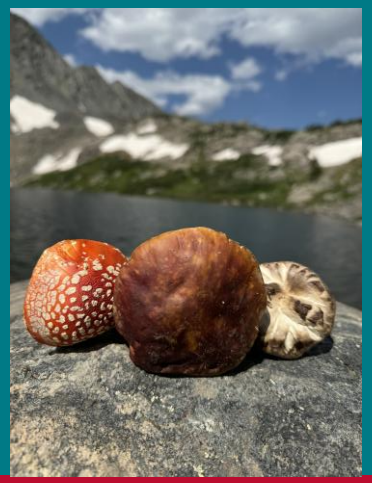
Mohamed E. Abdel-Latif, Jason Pinner, Sara Clews, Fiona Cooke, Kei Lui, Julee Oei; Effects of Breast Milk on the Severity and Outcome of Neonatal Abstinence Syndrome Among Infants of Drug-Dependent Mothers. *Pediatrics* June 2006; 117 (6): e1163–e1169. 10.1542/peds.2005-1561

Breastfeeding



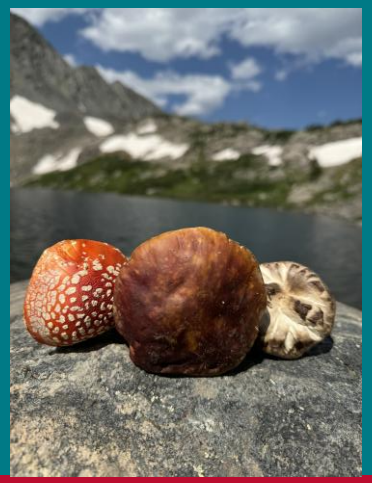
- Psychiatric Medications
- Infections
- Polysubstance Use
- Incarceration
- Social isolation
- Drug adulteration
- NICU Stays (Parent-Infant separation)
- Tobacco use
- Parental sedation
- Bedsharing

Breastfeeding



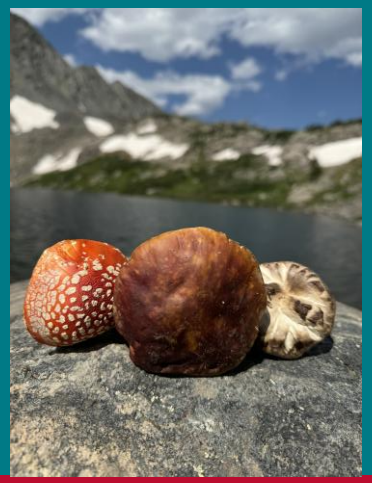
- Methadone and Buprenorphine are compatible with breastfeeding.

Women who discontinue use of nonprescribed substances by the time of delivery hospitalization can be in breastfeeding initiation. eding



- Arrange appropriate postpartum SUD and lactation follow-up.
- If recent use or toxicology positive, support in expressing milk to initiate milk supply. **Then use multi-disciplinary and patient-involved approach in deciding when to give EBM.**
- If mom returns to use, a similar approach of expressing and discarding breastmilk until consultation to decide when to return to feeding.
- Counseling should take a trauma-informed approach and span prenatal, intrapartum and postpartum care.
- Breastfeeding should not be supported with ongoing use of nonprescribed opioids, stimulants and sedative hypnotics.

Neonates with In Utero Drug Exposure



- Early intervention
- Ongoing lactation support and guidance
- Hepatitis C screening
  - Viral load at 2 months
- Develop best practices for child welfare referrals.
  - Team based approach

Pediatric Overdose

- Pediatric overdose rates from opioids is on the rise.
  - A 2018 study found that opioids caused deaths of almost 9,000 children and adolescents in the US between 1999 and 2016.
  - Opioids are the most common cause of poisoning deaths in children.
- Naloxone (nasal OTC kits) can be safely administered to kids if suspected overdose
- Always counsel on safe storage of medications

Gaither JR, Shabanova V, Leventhal JM. US National Trends in Pediatric Deaths From Prescription and Illicit Opioids, 1999-2016. *JAMA Netw Open.* 2018;1(8):e186558. doi:10.1001/jamanetworkopen.2018.6558

Resources

- New Mexico Perinatal Collaborative Cohort
- Improving Perinatal Health Echo
- UNM Milagro Clinic
- UNM Admission for MOUD Start
- UNM PALS Line