

Wrap Around Services For Pregnant and Postpartum Patients with a Substance Use Disorder

VCU Health System OB MOTIVATE Clinic

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Presentation Goals

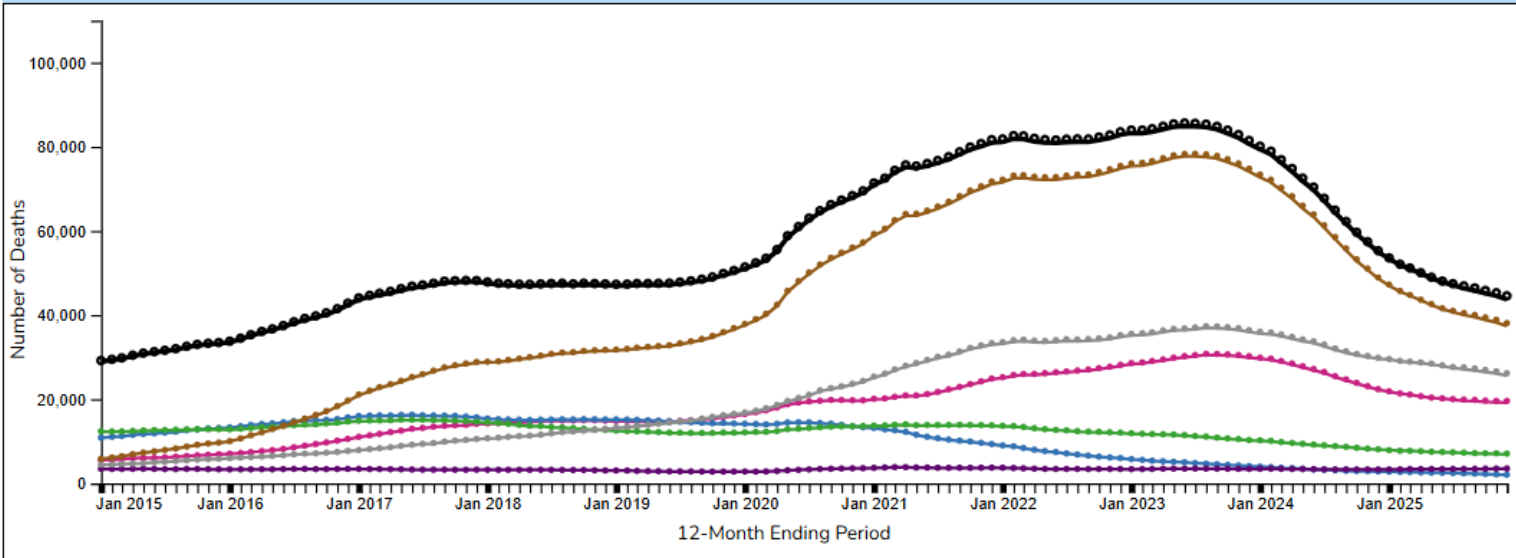
- ✓ Define addiction and review how a substance use disorder is diagnosed.
- ✓ Present evidenced- based treatment for pregnant or postpartum people diagnosed with an opioid use disorder.
- ✓ Offer strategies to reduce harm and mitigate risks to the pregnant or postpartum patient with a substance use disorder.
- ✓ Review the evaluation and treatment of newborns of mothers with a substance use disorder.
- ✓ Review social determinants of health impacts on pregnant and parenting women with substance use disorders.
- ✓ Discuss general CPS reporting laws and processes during the postpartum period.

Addiction is
a primary, chronic disease of the
brain's reward, motivation, memory
and related circuits.

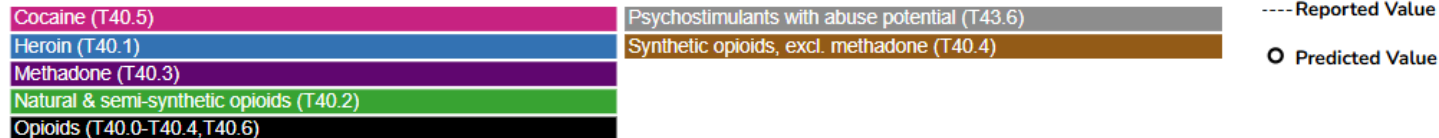
~ American Society of Addiction Medicine

Overdoses are a Leading Cause of Mortality

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States



Legend for Drug or Drug Class



- Substance use related deaths have increased rapidly in recent years, especially during the COVID-19 pandemic.
- In November 2025: **44,989 people died** from overdose involving opioids in the preceding 12 months
- Compared to 33,293 deaths documented in November 2015

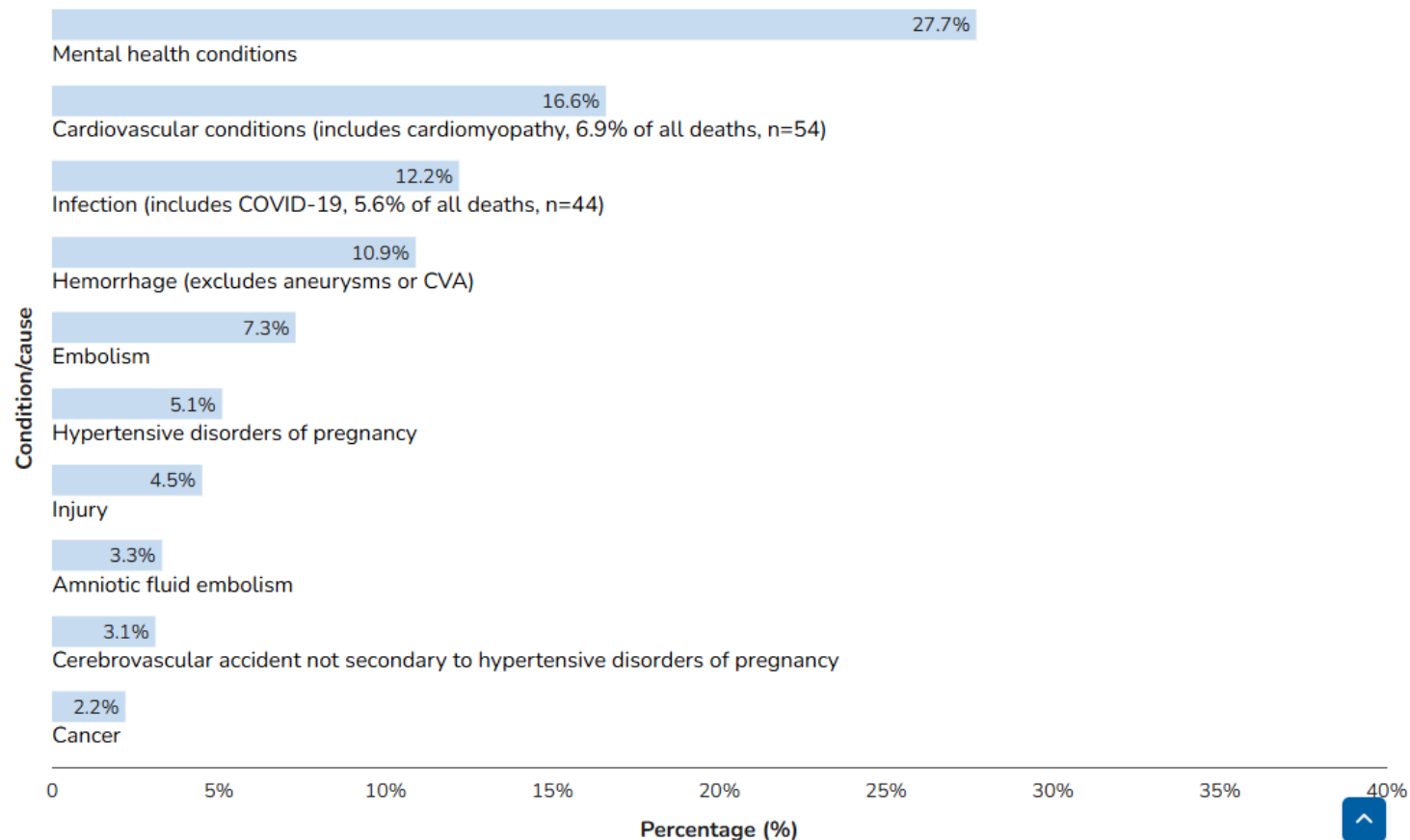
✓ That's a 35% increase!

Underlying causes of pregnancy-related deaths, overall and by race-ethnicity, 2022^{a-d}

This chart displays the top underlying conditions or causes of pregnancy-related death for the selected race or ethnicity group. The data table below displays the full data including additional underlying conditions or causes. [About the data](#) provides more information on select underlying causes of death.

Race or ethnicity:

Overall



The Overdose Crisis is Intersecting With the Maternal Mortality Crisis

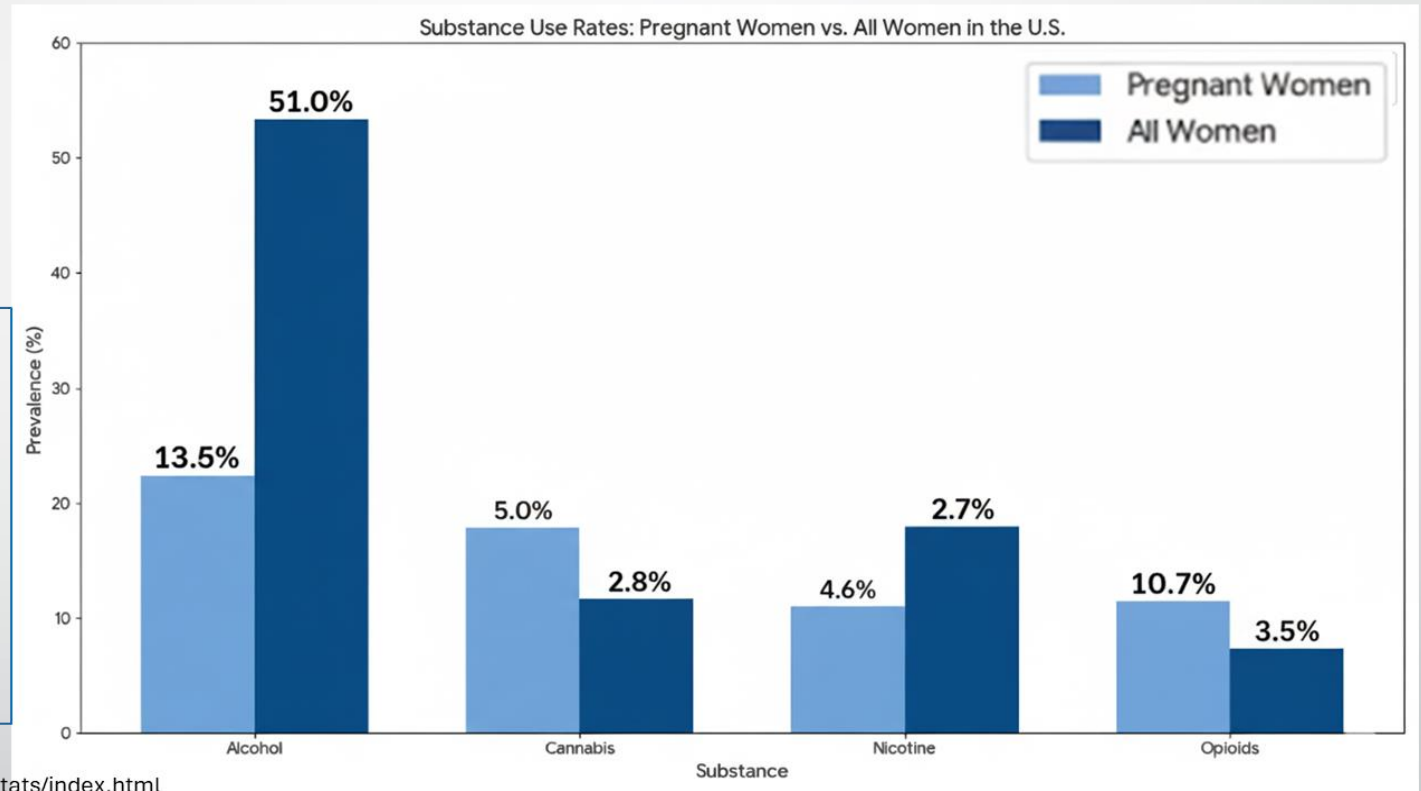
The leading cause of pregnancy-related deaths are mental health conditions

Largely driven by postpartum overdose-related mortality

Alcohol, Nicotine and Cannabis are the most commonly used substances in the U.S. by all people, including during pregnancy



Nearly 14% (or 1 in 7) pregnant women report current drinking



<https://www.cdc.gov/alcohol-pregnancy/data-research/facts-stats/index.html>

SUD (vs. substance use) DIAGNOSIS: DSM-V Criteria

Term	Definition
Substance use	Sporadic use of psychoactive substances
Substance misuse	Excessive use of psychoactive substances, which may lead to physical, social, or emotional harm
Substance use disorder	<p><i>Diagnostic and Statistical Manual-V</i> uses the same overarching criteria for all substances to diagnosis mild (2–3 symptoms), moderate (4–5 symptoms), and severe (6 or more symptoms) states⁸⁸:</p> <ul style="list-style-type: none">• Impaired control<ul style="list-style-type: none">◦ Use in larger amounts or longer periods than intended◦ Persistent desire or unsuccessful efforts to decrease or stop use◦ Craving or strong desire to use◦ Excessive time spent obtaining or using substance or recovering from the effects• Social impairment<ul style="list-style-type: none">◦ Failure to fulfill major role obligations at work, school, or home◦ Persistent or recurrent social or interpersonal problems exacerbated by use◦ Reduction or cessation of important social, occupation, or recreational activities because of use• Risky use<ul style="list-style-type: none">◦ Use in physically hazardous situations◦ Continued use despite knowledge of persistent physical or psychological problems arising from use• Pharmacologic properties<ul style="list-style-type: none">◦ Tolerance as demonstrated by increased amount needed to achieve desired effect; diminished effect with continued use of the same amount◦ Withdrawal symptoms with cessation or decreased use <p>Note: Solely pharmacologic symptoms are not sufficient to meet criteria for substance use disorder</p>
Recovery ⁸⁹	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

Adapted from Smid M, Terplan M. What Obstetrician–Gynecologists should know about substance use disorders in the perinatal period. *Obstetrics & Gynecology*. 2022;139(2):317-337. <https://doi.org/10.1097/AOG.0000000000004657>; with permission.

Screening for Substance Use Disorders is Done With Asking Questions, NOT Drug Testing

- SURP-P (pregnant)
 1. Have you ever smoked marijuana?
 2. In the month before you knew you were pregnant, how many beers, how much wine, or how much liquor did you drink?
 3. Have you ever believed that you needed to cut down on your drug (including the nonmedical use of prescription medications) or alcohol use?

TAPS : Tobacco, Alcohol, Prescription medication and other Substance use tool

In the past 12 months:

- How often have you used any tobacco product?
- How often have you had 4 or more drinks containing alcohol in one day?
- How often have you used any drugs including marijuana, cocaine or crack....?
- How often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?

Yonkers KA, Gotman N, Kershaw T, Forray A, Howell HB, Rounsaville BJ. Screening for prenatal substance use: development of the substance use risk profile-pregnancy scale. *Obstetrics Gynecol* 2010;116:827-33

<https://nida.nih.gov/taps2>

Recommended alcohol screener

The Alcohol Use Disorders Identification Test (AUDIT-C)

How often did you have a drink containing alcohol in the past year?	Never	0
	Monthly or less	1
	Two to four times a month	2
	Two to three times a week	3
	Four or more times a week	4
How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	1-2 drinks	0
	3 or 4	1
	5 or 6	2
	7 or 9	3
	10 or more	4
How often did you have six or more drinks on one occasion in the past year?	Never	0
	Less than monthly	1
	Monthly	2
	Weekly	3
	Daily or almost daily	4

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

- The AUDIT-C has demonstrated 95% sensitivity and 85% specificity in pregnancy
- USPSTF: *"When patients screen positive on a brief screening instrument **clinicians should ensure follow-up with a more in-depth risk assessment to confirm unhealthy alcohol use and determine the next steps of care.**"*

**CLINICAL GUIDANCE FOR
TREATING PREGNANT
BREASTFEEDING WOMEN WITH
OPIOID USE DISORDER
AND THEIR INFANTS**

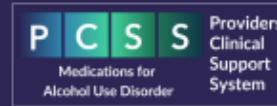


SAMHSA Clinical Guide Recommendations for Perinatal Opioid Use Disorder

- Opioids: lowers the sensation of pain, increased relaxation and pleasure, high doses may inhibit respirations
- Medications for opioid use disorder (MOUD)
- Increased medication metabolism during pregnancy
- Medically supervised withdrawal is not recommended during pregnancy
- Anesthesia consult is advised for LD and PP

Medication	Pregnancy	Breastfeeding
Buprenorphine (Subutex)	Yes	Yes
Buprenorphine-Naloxone (Suboxone)	Yes	Yes
Buprenorphine XR (Sublocade or Brixadi)	Yes	Yes
Methadone	Yes	Yes
Naltrexone (oral) XR (Vivitrol)	Limited data but reassuring perinatal outcomes	Yes

Medications for Alcohol Use Disorder in Pregnancy

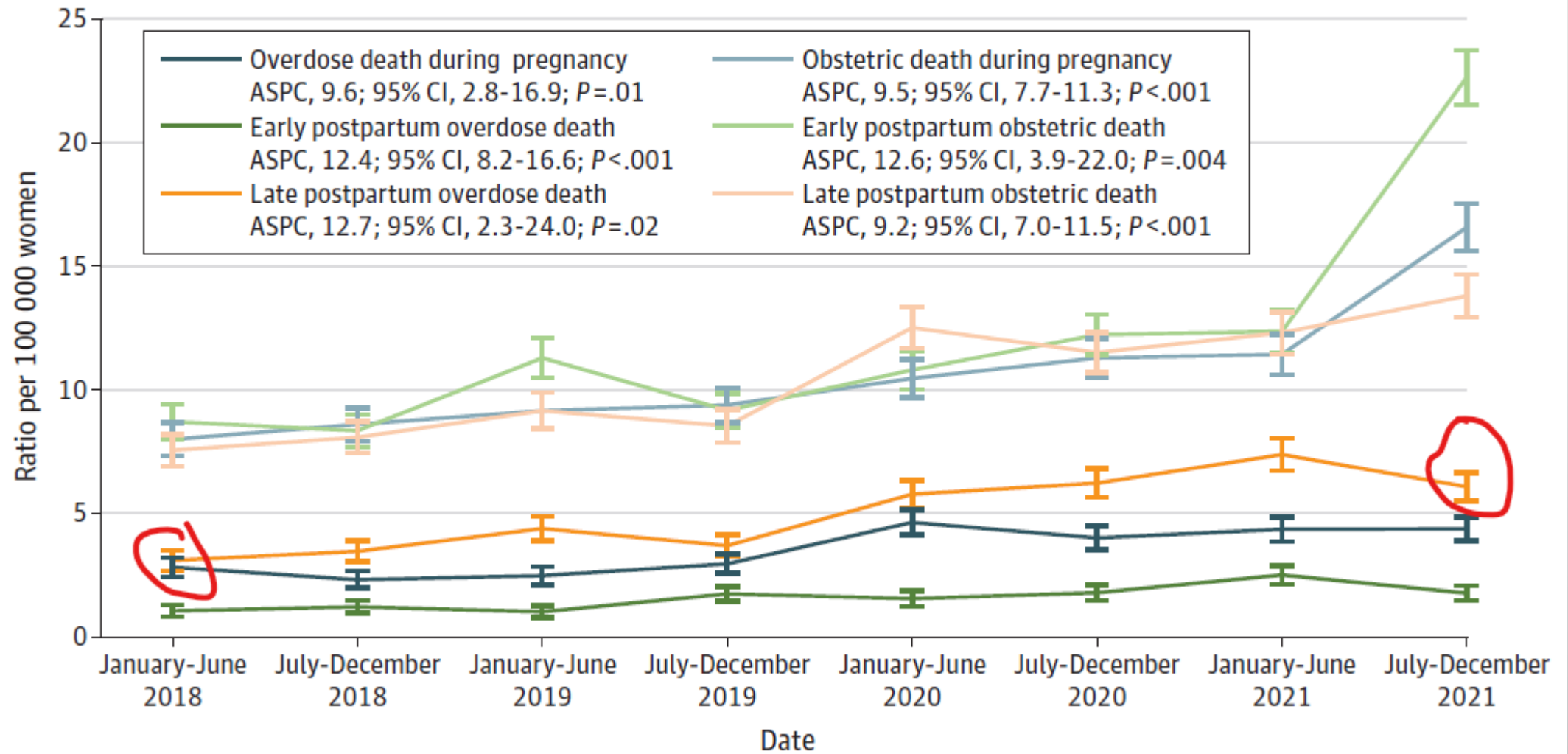


Safety of Medications for Alcohol Use Disorder During Pregnancy

Medication	Safe in Pregnancy?	Safe in Breastfeeding?	Notes
Naltrexone	Likely safe	Recommended	Supported by OUD studies
Acamprosate	Likely safe	Consider its use	Lack of data in pregnancy and breastfeeding
Disulfiram	Avoid	Not recommended	Potential higher risk of anomalies

<https://www.pcass-maud.org/>

Figure. US Trends in Pregnancy-Associated Drug Overdose or Obstetric Mortality Ratio Among Women Aged 10 to 44 Years by Pregnancy Timing





Reduce Harm: Improve Health

- Person-First Language
- Naloxone (Narcan)
- Safe storage of medication
- Patient Education
- Access to birth control
- Folic Acid
- Screening for infectious disease
- Screening for sexually transmitted infection
- Pre-exposure prophylaxis
- Mental Health resources
- [Findtreatment.gov](https://www.findtreatment.gov)
- NEVER USE ALONE: 800-484-3731

WORDS MATTER

Decrease Harm

Instead of...	Use...	Because...
Pregnant opiate addict Addict User Substance or drug abuser Junkie	Pregnant women with an OUD Person with substance use disorder Person with OUD or person with opioid addiction Patient Person in active use; use the person's name, and then say "is in active use"	Person-first language helps to focus on the person and not their disorder The change shows that a person "has" a problem, rather than the "is" the problem Avoids elicit negative associations, punitive attitudes, and individual blame
Alcoholic Drunk	Person with alcohol use disorder Person who misuses alcohol or engages in unhealthy/hazardous alcohol use	Same as above
Addicted Baby Neonatal Abstinence Syndrome Baby Crack Baby	Baby born to mother who used drugs while pregnant Baby with signs of withdrawal from prenatal drug exposure Baby with neonatal opioid withdrawal Newborn exposed to substances	Babies cannot be born with addiction because addiction is a behavioral disorder; they are simply born manifesting a withdrawal syndrome

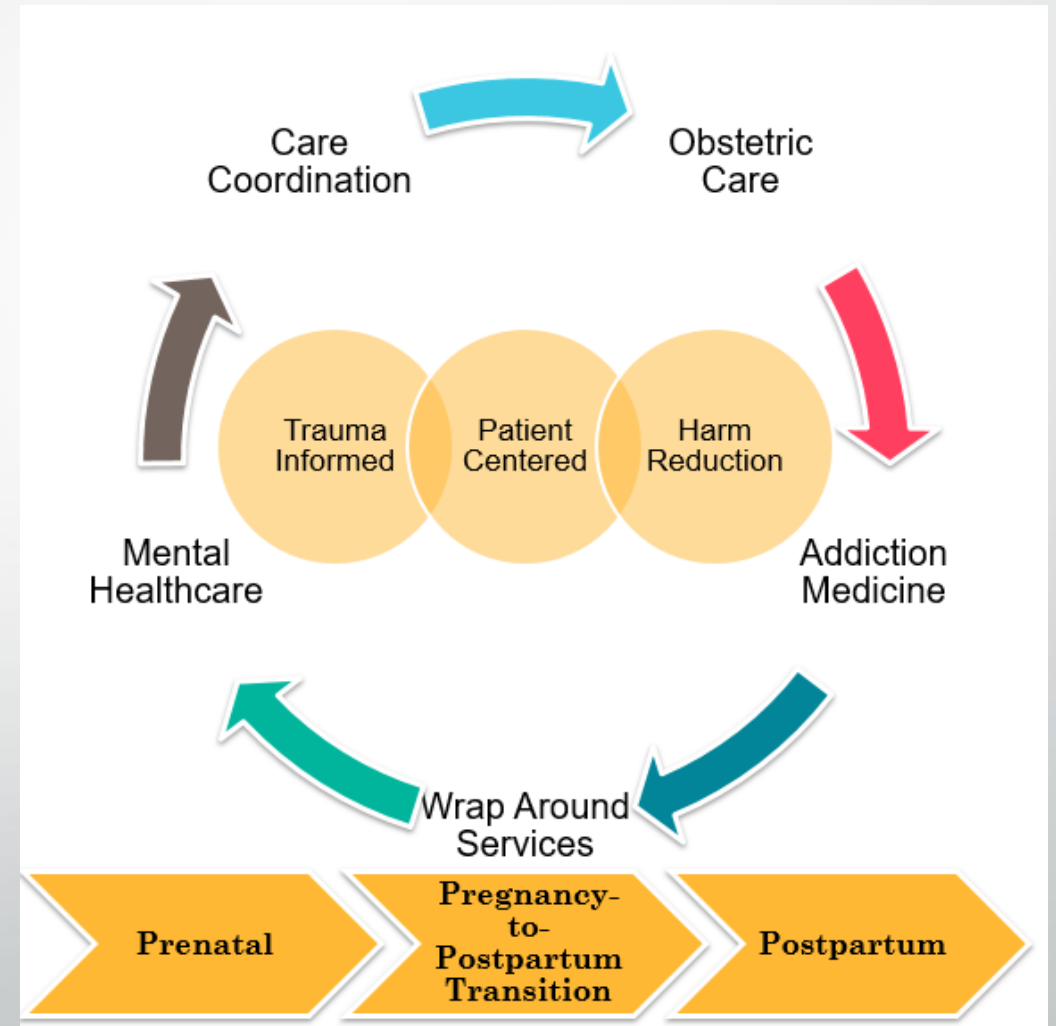
POSTPARTUM PLANNING

- Pain Management
- Birth Control
- Postpartum Mood and Anxiety Disorder
- CPS
- Continued MOUD



VCU OB MOTIVATE

- ASAM Level 1 outpatient clinical program
- Co-located care model
 - Addiction medicine
 - Obstetrics (low and high risk)
 - Dedicated OB-Addiction nurses
 - Social work
 - Behavioral health counseling



NAS/NOWS

- Neonatal Abstinence Syndrome (NAS) describes physiologic and neurobehavioral signs of withdrawal that may occur in newborns exposed in utero to prescribed and non-prescribed substances
- Neonatal Opioid Withdrawal Syndrome (NOWS) – a subset of NAS
 - Describes withdrawal symptoms exhibited by newborns chronically exposed in utero to prescribed and non-prescribed opioids

NAS/NOWS

- Physical dependence in utero leading to a temporary period of withdrawal symptoms
- **NOT an addiction!**
- Can occur with:
 - Opioid analgesics
 - Heroin
 - Buprenorphine
 - Methadone

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Neonatal Opioid Withdrawal Syndrome

Stephen W. Patrick, MD, MPH, MS, FAAP,^a Wanda D. Barfield, MD, MPH, FAAP,^b Brenda B. Poindexter, MD, MS, FAAP,^c COMMITTEE ON FETUS AND NEWBORN, COMMITTEE ON SUBSTANCE USE AND PREVENTION

Pediatrics.

2020;146(5):e2020029074

Symptoms of NAS

Autonomic dysfunction

- Frequent yawning, sneezing, nasal congestion
- Sweating, mottling, low-grade fever

Sleep irregularities
Easily overstimulated
Irritability
Excessive crying
Skin breakdown (knees)
Seizures



Poor feeding
Excessive suck

Tachypnea

MSK

- Hypertonicity
- Tremors
- Jitteriness

GI

- Loose stools
- Vomiting
- Poor weight gain

Frequency of NAS

- 50% to 80% of newborns exposed to opioids prenatally develop symptoms of NAS
- Approximately 50% of newborns exposed to buprenorphine or methadone maintenance therapy prenatally are treated for NAS
 - These percentages are higher with polysubstance exposure
- Newborns exposed to opioids prenatally should be monitored inpatient for symptoms of NAS for 4-7 days after delivery

Factors that Influence NAS

- Type of opioid exposure
- Gestational age at delivery
- Maternal polysubstance exposure (opioids, nicotine, benzodiazepines, antidepressants, anticonvulsants)
- Maternal/fetal/placental metabolism
- Genetics and epigenetics
- Sex of baby
- Care environment after birth



MOUD and NAS

- NAS is an EXPECTED and TREATABLE outcome of fetal exposure to medications for opioid use disorder (MOUD)
- Maternal MOUD dose does **NOT** generally correlate with NAS severity.
- Maternal/fetal withdrawal during pregnancy may have adverse long-term impacts on the child. Maternal dose of MOUD should be titrated to control maternal symptoms of withdrawal and limit cravings.

* No evidence that Suboxone or Methadone cause birth defects and studies show minimal long-term neurodevelopmental impacts to child

Toxicology Testing of Newborn

- Used as a tool to manage NAS (along with ESC)
- Does not determine if newborn will have symptoms of NAS
- Should be used along with maternal interview of substances (prescribed and non-prescribed) taken during pregnancy and newborn clinical status
- Maternal toxicology testing requires informed consent. Newborn toxicology testing does not require informed consent as NAS/NOWS impacts newborn medical treatment

Treatment of NAS

- Non-pharmacologic (parent/caregiver involvement key to success!)
 - Parent/caregiver rooming-in
 - Feeding on demand (breastmilk if appropriate)
 - Consoling/swaddling/pacifier use/skin to skin
 - Low stimulation environment
- Pharmacologic
 - Methadone
 - Morphine
 - Other medications: clonidine, phenobarbital



Benefits of Breastfeeding

- Breastfeeding has many benefits for newborns exposed to MOUD in utero including:
 - Decreased NAS severity
 - Reduced need for pharmacologic therapy in newborn
 - Decreased length of hospitalization
- Methadone and buprenorphine are excreted into human milk at very low concentrations.



Long-term Outcomes

The adverse developmental outcomes that occur in children exposed to substances prenatally are likely the result of a combination of factors (biological, genetic, and environmental)



Children have the greatest potential for success when their mothers are healthy and supported. It is important to advocate for increasing access to treatment for women with SUD including postpartum programs that integrate interventions for the parent-child unit to mitigate impacts of prenatal substance exposure through every stage of child development.

Impacts of Prenatal Substance Exposure

- Legal ramifications – CPS, civil, and criminal charges
- Criminalizing prenatal substance use led to higher rates of NAS
 - 25 states plus DC consider prenatal substance use child abuse
 - AL, TN, and SC consider substance use during pregnancy a crime
 - MN, SD, and WI allow civil commitment of pregnant women
 - VA requires reporting of prenatal substance use (including MOUD and THC) to CPS, can lead to a charge of abuse and neglect and removal of a child
- <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>

Social Work Role Prenatally



Maslow's Hierarchy of Needs

Assessing social determinants of health

- Housing, financial, food, transportation

Referrals for community programs

Discussing NOWS including hospital policies regarding length of stay

- Four-day observation period; possible boarding

Discussing CPS reporting laws in Virginia

Legal Reporting Requirements

- Child Abuse and Prevention Treatment Act (CAPTA) - Federal, 1974
 - Provided federal funding for prevention, assessment, investigation, prosecution, and treatment related to child abuse and neglect
- Comprehensive Addiction and Recovery Act (CARA) - Federal, 2016
 - Required Plan of Safe Care
 - States must report number of infants "affected" by substance use, withdrawal symptoms, or fetal alcohol spectrum disorder (for prescribed and non prescribed substances)
- Virginia Laws:
 - Section 63.2-1509 of the Code of Virginia, Subsection B, a “reason to suspect that child is abused or neglected shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born **affected** by substance abuse or **experiencing withdrawal symptoms resulting from in utero drug exposure**; (ii) a diagnosis made by a health care provider within four years following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When ‘reason to suspect’ is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.”

Social Work Role Prenatally



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Completing Plan of Safe Care

Discussing perinatal mood and anxiety disorders

- Meta analysis showed 29% of pregnant women who used substances would experience PPD (general population is 17%)

Doula referrals

- Accept Virginia Medicaid
- Benefits of a doula:
 - Decreases rate of c-sections
 - Decreases length of labor
 - Less likely to use pain-relief medications
 - More positive birth experiences

Treatment Options and Barriers

- Inpatient/residential
 - Restrictions on MOUD, not allowing children, unable to work, withdrawal management not accepting pregnant women
- PHP/IOP
 - 20 – 9 hours a week, difficult to find childcare, difficult to schedule work
- Outpatient Counseling/Peer Recovery Programs (NA/AA/SmartRecovery)
- Recovery Houses
 - Most do not allow children, Medicaid does not help pay

Effective Behavioral Health Modalities

- Cognitive Behavioral Therapy
 - Thoughts affect emotions and behaviors
- Motivational Interviewing
 - Overcoming ambivalence, increase internal motivation for a goal
- Contingency Management
 - Behavioral therapy, reinforce positive behavioral change
- Dialectical Behavioral Therapy
 - Derived from CBT, accepting reality while focusing on change, emotion regulation
 - More research needs to be conducted, but early research is optimistic

Barriers to Treatment

- Judgement and shame
 - Women avoid sharing honestly or avoid prenatal care entirely
- Fear and anxiety about CPS
- Transportation
- Insurance – Medicaid re-enrollment process, post-incarceration insurance
- Photo ID

Patient Resources

- Findtreatment.gov
- Alive RVA: Addiction Recovery Support Warm Line: 1-833-473-3782 (call to speak with a Peer Recovery Coach 7 days/week from 8:00am – 12 midnight).
- Postpartum Support Virginia
- AA: Virtual meeting: aa-intergroup.org
- AA: In Person meetings : call locality: for Richmond: 804-355-1212 or www.aarichmond.org/meetings
- Narcotics Anonymous (NA) virtual meetings: virtual-na.org
- NA: In Person meetings: 804-965-1871 RVAna.org
- Smart Recovery: www.smartrecovery.org/community (must register on this page to access online meetings)
- 24 hr. Mental Health Crisis Lines : contact local Community Service Board in the county
- Domestic/Sex Violence hotline: 804-612-6126
- SAMSHA National Helpline: 1-800-662-HELP (4357)

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