ADDICTION AND PREGNANCY

Objectives:
- Recognize common fears and myths associated with substance use in pregnancy
- Identify available local resources for barriers commonly experienced with substance using pregnant women
- Discuss best practices with opiate replacement therapy in pregnant women
- Identify effective approaches of providing professional services to substance using pregnant women

ADDICTION & PREGNANCY

Fear
Shame
Commitment
Barriers
Opportunities

ADDICTION & PREGNANCY

Fear

ADDICTION & PREGNANCY

Fear
ADDICTION & PREGNANCY

Fear
- Child Protection Services
  - Possible previous involvement and trauma
  - Demands often feel mysterious
- CPS criteria for parenting:
  1. Sober mom with strong support plan for recovery
  2. Stable living situation
  3. People around mom and baby are sober, safe, and stable
- CPS offers many resources for support
  - Paradoxical (what is avoided actually offers resources to help navigate that which is avoided)

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Potential harmful effects of substances:
- Teratogenic/Birth Defects
- Obstetrical Problems
- Neurodevelopmental Effects

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Birth Defects
…probably not or ...
…at least not much

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Obstetrical Problems
- Preterm Labor (4x)
- Low Birth Weight (5x)
- Placental Abruption (10x)
- Fetal Demise (5x)

→ caused by vasoconstriction leading to decreased placental perfusion

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- Obstetrical Problems
- Low Birth Weight
- Placental Abruption
- Fetal Demise

→ On average, a baby of a mother continuing to use cocaine into the 3rd trimester is 1 pound smaller than babies of non-using mothers, but still within normal limits

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- Neurodevelopmental Effects
  - Difficult to find a proper comparable group to study
  - Excluding alcohol, deficits in global assessments (IQ) have not been clearly attributed to substances

However....

All studies confirm that growing up in a "using" household impacts intelligence and emotional well being

Arch Pediatr Adolesc Med. 2003 Sep; 157: 824-834
Acute Neonatal Effects of Cocaine Exposure During Pregnancy
Bauer CR

Maternal treatment with opioid analgesics and risk for birth defects.
Broussard CS

Paediatr Perinat Epidemiol. 1996 Jul; 10(3):269-78
Cocaine and cigarettes: a comparison of risks.
Kistin N, Handler A

JAMA 2001 March 28; 285(12):1613-1625
Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A systematic review.
Frank DA, Augsburger M
ADDICTION & PREGNANCY

- To promote the well being of a baby whose mother is using illicit substances:
  - Shift the focus from birth and brain defects to preventing obstetrical harm
  - Promote a sober environment for child rearing

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- Shame
  - “I couldn’t possibly be pregnant. I’m sure I’ll miscarry anyway.”
  - “I want to quit (on my own) before I go to the clinic.”
  - “My inability to quit must mean I don’t care about my baby.”
  - “I’m a terrible mom.”
  - Shame often leads to continued use or is a relapse trigger

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- Commitment
  - Pregnant women are usually very determined to quit using
  - Pregnancy often moves a woman from the contemplation stage of change into the preparation and action stages
  - Determination may not be enough

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- Barriers
  - Physical challenges of pregnancy
  - Emotional challenges of pregnancy
  - Additional mental health challenges
  - Pregnancy’s impact on the demands of parenting
  - Past trauma associated with pregnancies
  - Increased need for social support—lack of support
  - Insufficient resources
  - Desire for nuclear family

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- Opportunities
  - CUPW (Chemically Using Pregnant Women Programs)
    - Hospital Based
    - 26-day intensive inpatient treatment
    - Available Immediately
  - Swedish Addiction Recovery Services—Ballard
  - Harbor Crest Treatment Center—Aberdeen
  - Valley General Treatment Center—Monroe
  - Inspirations through Triumph Treatment Services—Yakima
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Opportunities
- PPW (Pregnant and Parenting Women Programs)
  - Residential Treatment
  - 6 months (considered long term)
  - Mothers and Pre-K Children
- Evergreen Manor, Everett & Seattle
- Isabella House, Spokane
- Casita Del Rio—Beth’s Place—Riel House, Yakima

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Opportunities
- Case Management Outreach
  - One-to-one relationship-based professional support
  - Multi-year relationships
- PCAP (Parent Child Assistance Program), varying counties
- Nurse-Family Partnership, various counties
- First Steps (Public Health RN), various counties
- Safe Babies, Safe Moms, Everett
- Bridget Collins Center, Bellingham

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Outpatient Treatment
- Outpatient programs (1-5x/week) focused on needs of parenting women
- Childcare available
- New Traditions, Seattle
  - Great lack of services at this level of care due to lack of childcare

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Opiate Replacement Therapy Programs (ORT)
- Opiate Substitution (methadone or buprenorphine)
  - Pregnant women are first priority in ORTs

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Opiate Dependence
- Withdrawal Symptoms
  - EARLY—agitation, anxiety, tearing, insomnia, runny nose, sweating, yawning
  - SEVERE—abdominal cramping, diarrhea, dilated pupils, goose bumps, nausea, vomiting, uterine contractions (in pg)
- Withdrawal for the fetus
  - Miscarriage
  - Preterm Delivery
  - Intra-uterine Fetal Demise

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Safety of Opiate Detoxification in Pregnancy
- Why not detox from opiates in pregnancy?
  - The detox is challenging and most do not complete
  - 20% of first trimester women miscarried
  - Less than 1% of third trimester women delivered prematurely
  - VERY few that attempt detox go to treatment
  - Most (almost all) that attempt detox in pregnancy are not abstinent at time of delivery
  - Over half that chose ORT do NOT relapse in pregnancy
  - Average birth weight for ORT > detox in pregnancy (by more than one pound)

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- Opiate Dependence
  - Methadone is the gold standard
  → Leads to improved obstetrical outcomes (approaching population norms)
  → Improved recovery efforts

- Requires post delivery observation and possible treatment of opiate withdrawal in the baby: Neonatal Abstinence Syndrome (NAS)

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- Neonatal Abstinence Syndrome (NAS)
  - Treated with controlled wean in the hospital
  - No known short or long term harms
  - Average length of stay: 3 weeks
  - Worsened by:
    - Other drugs, especially benzodiazepines
    - Smoking
    - SSRIs
  - Less severe with buprenorphine (Subutex)

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- Problems with buprenorphine
  - Restrictive regulations with state DSHS coverage
  - Medication is expensive, even generic
  - Finding a buprenorphine registered physician willing to care for pregnant women
  - Many physicians don’t accept DSHS/Healthy Options
  - Diversion
    - Usually prescribed, not daily observed dosing like methadone
    - Temptation to share with loved ones in opiate withdrawal or sell
    - Some clinics are beginning to offer daily observed dosing

ADDICTION & PREGNANCY

- Breastfeeding and OMT
  - Methadone
    - The amount of methadone transferred through breast milk is less than 1% of the morphine given for NAS
    - Shorter length of stay for NAS babies that are breast fed
  - Buprenorphine
    - Bioavailability is low, even less absorbed making breast fed babies exposure very low

ADDICTION & PREGNANCY

<table>
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<tr>
<th>Babies</th>
<th>Tx for NAS</th>
<th>Peak score</th>
<th>Total morphine dose</th>
<th>Length of NAS tx</th>
<th>Total LOS</th>
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<tbody>
<tr>
<td>buprenorphine</td>
<td>58</td>
<td>47%</td>
<td>11.0</td>
<td>1.4 mg</td>
<td>4.1 days</td>
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<tr>
<td>methadone</td>
<td>73</td>
<td>57%</td>
<td>12.8</td>
<td>10.4 mg</td>
<td>9.9 days</td>
</tr>
</tbody>
</table>

*Neonatal abstinence syndrome after methadone or buprenorphine exposure. Jones HD*

ADDICTION & PREGNANCY

- Take aways:
  - Pregnancy is a highly motivated time for sobriety and recovery
  - Motivation ≠ necessary tools and support
  - More support services available during the pregnancy
  - More accountability required with having a baby
  - Know the scope of your role as a professional
  - Every baby is an opportunity for a new start