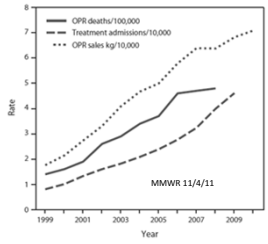
Pregnant Women Who Use Drugs: Stigma, Science and Society

Mishka Terplan MD MPH FACOG FASAM
Professor Departments Obstetrics and Gynecology and Psychiatry
Associate Director Addiction Medicine
Virginia Commonwealth University

March Of Dimes, CA 2017

The current opioid epidemic: Iatrogenic

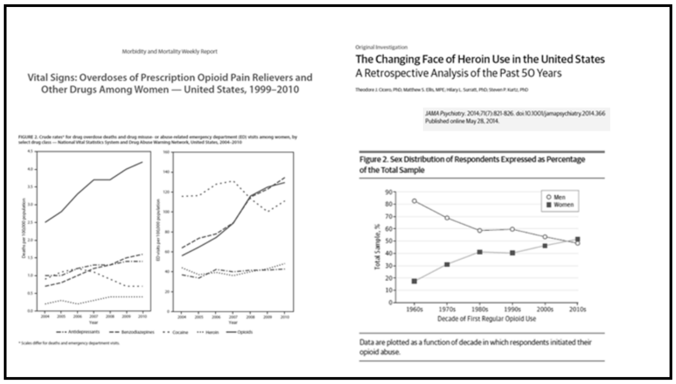


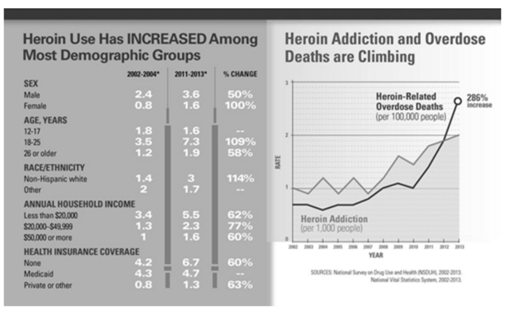
Gender and Prescription Drug Use and Misuse

Past Year	Male	Female
Prescription psychotherapeutic drugs	40.9%	47.8%
"Pain Relievers"	33.9%	38.8%
Tranquilizers	11.3%	17.9%
Sedatives	5.6%	8.2%
Stimulants	6.5%	6.3%

NSDUH 2015

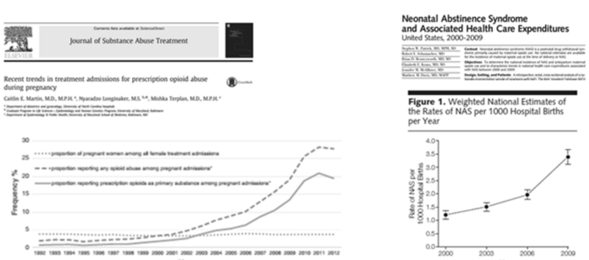
- 2.1 million Past Year Initiates Opioid Misuse
  - 0.9 million males (0.7%)
  - 1.2 million females (0.9%)
  - 3300 women per day


Morbidity and Mortality Weekly Report
Vital Signs: Overdoses of Prescription Opioid Pain Relievers and Other Drugs Among Women — United States, 1999–2010
Year
Antidepressants
Benzodiazepines
Cocaine
Heroin
Opioids
Original Investigation
The Changing Face of Heroin Use in the United States
A Retrospective Analysis of the Past 50 Years
JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366
Published online May 28, 2014.
Figure 2. Sex Distribution of Respondents Expressed as Percentage of the Total Sample
Men
Women
Total Sample, %
1960s
1970s
1980s
1990s
2000s
2010s
Decade of First Regular Opioid Use
Data are plotted as a function of decade in which respondents initiated their opioid abuse.


Heroin Use Has INCREASED Among Most Demographic Groups
Heroin Addiction and Overdose Deaths are Climbing
Heroin-Related Overdose Deaths
(per 100,000 people)
286% increase
RATE
Heroin Addiction
(per 1,000 people)
YEAR
SOURCES: National Survey on Drug Use and Health (NSDUH), 2002-2013.
National Vital Statistics System, 2002-2013.

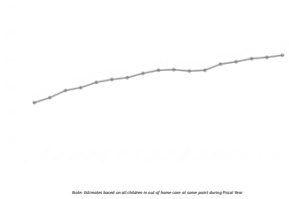
	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than $20,000	3.4	5.5	62%
$20,000–$49,999	1.3	2.3	77%
$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

The current opioid epidemic: pregnancy

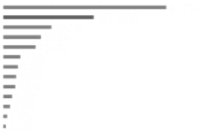

Journal of Substance Abuse Treatment
Recent trends in treatment admissions for prescription opioid abuse during pregnancy
Caitlin E. Martin, M.D., M.P.H., Nyaradzo Longinaker, M.S., Mishka Terplan, M.D., M.P.H.
proportion of pregnant women among all female treatment admissions
proportion reporting any opioid abuse among pregnant admissions*
proportion reporting prescription opioids as primary substance among pregnant admissions*
Frequency %
Year
Neonatal Abstinence Syndrome and Associated Health Care Expenditures
United States, 2000-2009
Figure 1. Weighted National Estimates of the Rates of NAS per 1000 Hospital Births per Year
Rate of NAS per 1000 Hospital Births
Year

Opioids and Child Welfare Epidemic

Parental AOD as Reason for Removal in the United States, 1999-2014



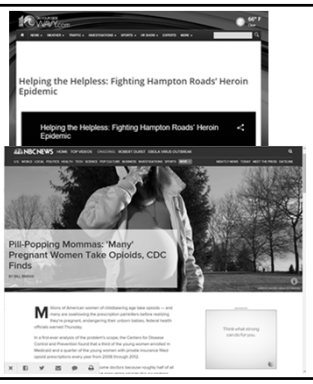
Percent of Children with Terminated Parental Rights by Reason for Removal in the US 2014

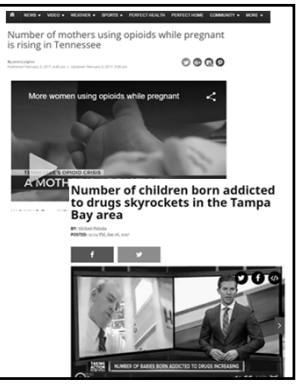


Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2014

Pregnancy and Substance Use Today





No bystander could be more innocent. No damage so helplessly collateral.

Washington Post 1989

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

Stigma

- Pregnant women who use drugs endure a particular "stigma"
- Pregnant women are treated differently by the CJ system
- Stigma – applies to treatment (medication assisted treatment)
- More appropriate terms:
- Discrimination or Prejudice

State Policies on Substance Use during Pregnancy

Policy	Number of States
Substance Use Considered Child Abuse	23+DC
Substance Use Grounds for Civil Commitment	3
Mandatory Reporting	23+DC
Targeted Programs for Pregnant Women	19
Pregnant Women Given Priority Access	16+DC
Pregnant Women Protected from Discrimination	9

Guttmacher Institute Feb 1 2017

Punishing Pregnant Women: Not Best Practice

Maternal-Fetal Unit

A structurally and functionally interconnected metabolic unit shared by a mother and fetus through the placenta

COMMITTEE OPINION

Refusal of Medically Recommended Treatment During Pregnancy

Maternal-Infant Dyad

"There is no such thing as a baby … If you set out to describe a baby, you will find you are describing a baby and someone. A baby can not exist alone, but is essentially part of a relationship" (D.W. Winnicott 1966)

Punishing Pregnant Women: Not Best Practice

- Discriminatory in how applied
  - Although SUDs affect all, white women more likely to use in pregnancy, black women and poor women far more likely to be prosecuted.
- Not grounded in evidence
  - Harms of illicit substances exaggerated; effects of licit substances minimized
- Unintended consequences
  - Policies drive women from PNC, SUD treatment
  - PNC ameliorates adverse effects of substances in using women

What happens when women who use substances get pregnant?

Substance use by trimester		Not pregnant	Abstinence during pregnancy	Postpartum
Alcohol				
First	19.0	54.0	92%	45.4
Second	5.0			
Third	4.4			
Cigarettes				
First	19.9	24.0	47%	20.1
Second	13.4			
Third	12.8			
Illicit drugs				
First	9.0	11.4	79%	8.7
Second	4.8			
Third	2.4			

NSDUH 2012/13 Past Month

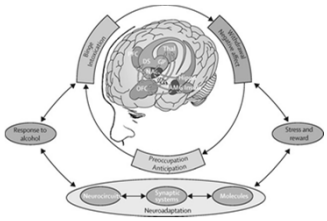
All pregnant women are motivated to maximize their health and that of their baby-to-be

- All women are aware of the risks associated with substance use
- All employ a range of strategies to reduce or change intake
  - Decrease or stop use
  - Switch drugs
  - Enter prenatal care
  - Enter SUD treatment

All pregnant women are motivated to maximize their health and that of their baby-to-be

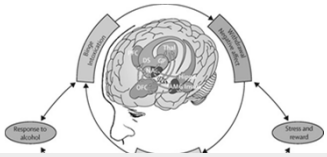
Those who can't quit or cut back – have a substance use disorder

Continued use in pregnancy is pathognomonic for addiction



– A primary, **chronic** disease of **brain reward**, **motivation**, **memory** and **related circuitry**. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. (ASAM)

– A chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain. (NIDA)



Addiction: Brain-centered disease whose visible symptoms are behaviors

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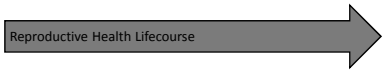
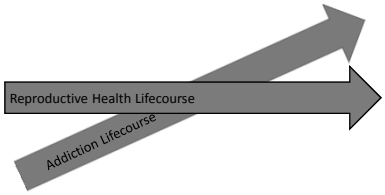
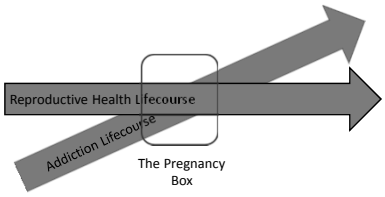


Pregnant Women Who Use Drugs



Pregnant Women Who Use Drugs



Women with SUD in pregnancy

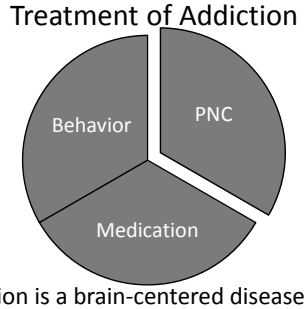
- Mental Health
  - Two thirds co-occurring mental health disorders (Benningfield 2010)
    - Past 30 days: Mood disorder (50%), Anxiety (40%), PTSD (16%)
  - Childhood trauma: 50-90% physical or sexual abuse (Cormier 2000)
  - 60-80% past year intimate partner violence (Engstrom 2012, Tuten 2004)
    - Chronic pain worse in IPV survivors (Wuest 2008)
- Reproductive Health
  - Unplanned pregnancy: 80% (Heil 2012)
  - Low rates of contraception (Terplan 2015)
  - Higher rates of HIV

Women with SUD in Pregnancy

- Other substance use
  - High rates of smoking (>90%)
- Nutritional other medical needs
- Social functioning
  - Inadequate social supports
  - 67% their parents used drugs (Finnegan 1991)
  - Unpredictable parenting models
  - Children – childcare needs
- Stigma and Shame
- Prior poor experiences with providers
- Fear of CPS

- Pregnant women with SUD have unique set of needs across multiple domains – domains that affect both obstetric health and outcomes and addiction treatment
- Care needs to address those needs
- "Gold Standard" – Integration
  - Comprehensive co-located service delivery
  - Close collaboration between SUD and PNC provider

Treatment of Addiction



Addiction is a brain-centered disease whose symptoms are behaviors

Comprehensive prenatal care (PNC) ameliorates adverse outcomes associated with drug use

MANAGEMENT OF PREGNANT DRUG-DEPENDENT WOMEN

Loretta P. Finnegan 1978

Department of Pediatrics
Thomas Jefferson University
Philadelphia, Pennsylvania 19107

140 Annals New York Academy of Sciences

TABLE 2

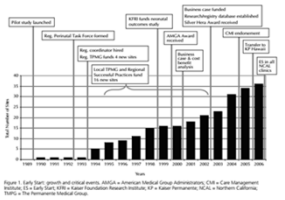
OBSTETRICAL COMPLICATIONS IN 367 DRUG-DEPENDENT WOMEN AND 215 CONTROL FAMILY CENTER PROGRAM, 1969-1976

Groups	No. of Patients	Average no. of Prenatal Visits	Obstetrical Complications %	LBW Incidence %	Pre-eclampsia %
A	65	9	36.9	47.7	9.2
B	109	1.9	32.1	35.5	2.8
C	193	8.2	33.7	19.7	4.7
D	93	9	32.3	19.4	8.6
E	122	9.2	32.0	13.9	8.2

LOW BIRTH WEIGHT	PNC	No PNC
No drug use	14%	19%
Drug Use	19%	**48%**

Comprehensive Treatment Works

- Kaiser Early Start – Behavioral Health embedded in PNC
- Birth outcomes among Early Start moms were same as non-drug-using women (Goler 2008)
- Cost effective – net cost benefit of $6 million (50,000 individuals) (Goler 2012)
- Early Start expanded to all Kaiser NoCal OB clinics



Treatment for Opioid Use Disorder in Pregnancy

- Standard of care: Medication Assisted Treatment plus behavioral counseling
  - Methadone or Buprenorphine
- Benefits
  - Stable intrauterine environment (no cyclic withdrawal)
  - Increased maternal weight gain
  - Increased newborn birth weight and gestational age
  - Increase PNC adherence
  - Decrease in (illicit) drug use - reduction of HIV/HCV acquisition and transmission
  - Decrease risk of overdose
  - Other supportive services

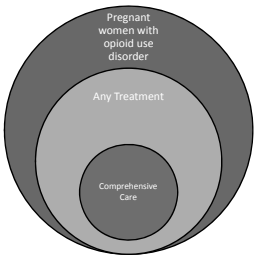
Principles of Treatment

- Empathy
  - Treating people with dignity and respect
- Adherence
  - People come back
  - Increase adherence by addressing needs/barriers:
    - Women/child friendly services
    - Transportation
    - Trauma informed care
    - Incentives

Pregnant Women: A Priority Population?

- "Because it is crucial that pregnant women engage in treatment for their addictions, OTPs should **give priority to admitting pregnant patients at any point during pregnancy** and providing them with all necessary care, including adequate dosing strategies as well as referrals for prenatal and follow-up postpartum services." *Federal Guidelines for Opioid Treatment Programs, 2015*
- Pregnant women – don't need to meet DSM criteria for use disorder to receive MAT (TIP 43)

Many pregnant women with opioid use disorder receive little or no care



- 20-80% of pregnant women with opioid use disorder are engaged in care
- Comprehensive treatment is rare and unavailable to most women
- Political climate – specifically Substance Exposed Newborn Reporting – discourages engagement in care

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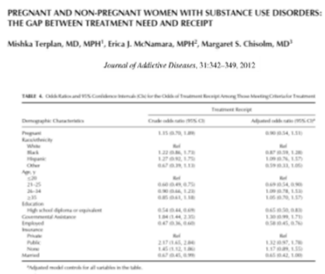
- NSDUH 2002-2006
- Overall <20% of women who need treatment received it
- Among women with recent drug use, pregnant women are more likely to need treatment (OR 1.92 [1.46, 2.52])
- But no more likely to receive it (OR 0.90 [0.54, 1.51])



PREGNANT AND NON-PREGNANT WOMEN WITH SUBSTANCE USE DISORDERS: THE GAP BETWEEN TREATMENT NEED AND RECEIPT

Mishka Terplan, MD, MPH[1], Erica J. McNamara, MPH[2], Margaret S. Chisolm, MD[3]

Journal of Addictive Diseases, 31:342–349, 2012

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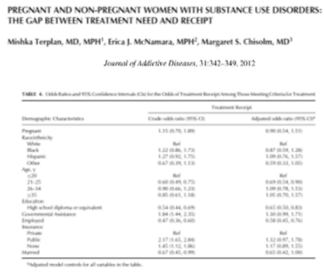

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There is no evidence that pregnant women receive preferential access to treatment

The treatment gap is greater for pregnant women

- GAO (2015): "the program gap most frequently cited was the lack of available treatment programs for pregnant women…"
- Overall provision of women-centered services in drug treatment facilities declined 2002-2009 (43%-40%, p<0.001)
- As did services specific for pregnant or postpartum women (19% in 2002 to 13% in 2009)

Women-Centered Drug Treatment Services and Need in the United States, 2002–2009

| Mishka Terplan, MD, MPH, Nyaradzo Longinaker, MS, and Lindsay Appel, MD

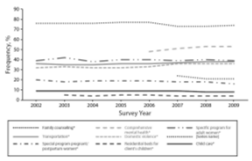


FIGURE 1–Proportion of substance use disorder treatment facilities offering specific women-centered services: National Survey of Substance Abuse Treatment Services (N5SATS), 2002–2009, United States.

How do we narrow the treatment gap for pregnant women who use drugs?

How do we narrow the treatment gap for pregnant women who use drugs?

- 1) Assessment: Universal assessment for substance use, misuse and addiction

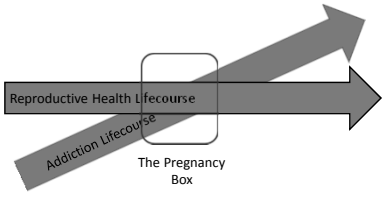
How do we narrow the treatment gap for pregnant women who use drugs?

- 2) Increase treatment capacity
  - Buprenorphine waivered physicians
  - Under CARA (Comprehensive And Recovery Act, 2016) buprenorphine prescribing authority expanded to NPs and PAs – but not to CNMs!

How do we narrow the treatment gap for pregnant women who use drugs?

- 3) Need comprehensive lifecourse approach
  - Public Health Programming beyond the "Pregnancy Box"

Pregnant Women Who Use Drugs



Postpartum: The 4th Trimester

- Critical Period
  - Newborn care, breastfeeding, maternal/infant bonding
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, "the ideal mother" in conflict with what it is actually like to have a newborn
- Neglected Period
  - Care shifts away from frequent contact with PNC provider – to pediatrician
  - Care less "medical" (for mom) and shifts to other agencies (WIC)
  - Insurance and welfare realignment
  - SUD treatment provider(s) – care is constant
- Gaps in care – addressed through public health interventions – home visiting etc

Original Research

Higher Risk of Homicide Among Pregnant and Postpartum Females Aged 10–29 Years in Illinois, 2002–2011

Abigail R. Koch, MD, Deborah Rosenberg, MD, and Stacie E. Geller, PhD, for the Illinois Department of Public Health Maternal Mortality Review Committee Working Group

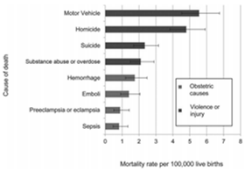
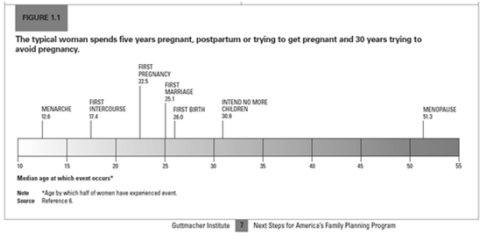


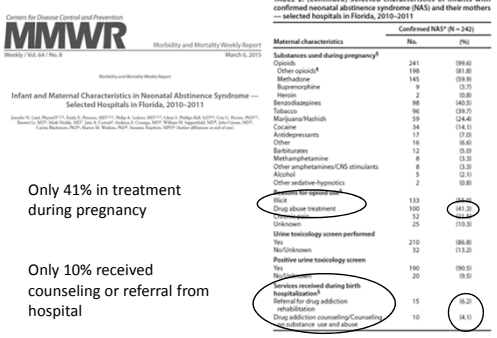
Fig. 1. Ten-year pregnancy-associated mortality rates for deaths by violence and injury compared with the leading obstetric causes in Illinois, 2002–2011.

Koch. Pregnancy-Associated Homicide in Illinois. Obstet Gynecol 2016.

Pregnancy Planning



Prevention to avoid “Crisis at Delivery”



Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 64 / No. 8 March 6, 2015

Infant and Maternal Characteristics in Neonatal Abstinence Syndrome — Selected Hospitals in Florida, 2010–2011

TABLE 2. (*Continued*) Selected characteristics of infants with confirmed neonatal abstinence syndrome (NAS) and their mothers — selected hospitals in Florida, 2010–2011

Maternal characteristics	Confirmed NAS* (N = 242) No.	(%)
Substances used during pregnancy§		
Opioids	241	(99.6)
Other opioids¶	198	(81.8)
Methadone	145	(59.9)
Buprenorphine	9	(3.7)
Heroin	2	(0.8)
Benzodiazepines	98	(40.5)
Tobacco	96	(39.7)
Marijuana/Hashish	59	(24.4)
Cocaine	34	(14.1)
Antidepressants	17	(7.0)
Other	16	(6.6)
Barbiturates	12	(5.0)
Methamphetamine	8	(3.3)
Other amphetamines/CNS stimulants	8	(3.3)
Alcohol	5	(2.1)
Other sedative-hypnotics	2	(0.8)
Treatment for opioid use**		
Illicit	133	(54.9)
Drug abuse treatment	100	(41.3)
Other treatment	52	(21.5)
Unknown	25	(10.3)
Urine toxicology screen performed		
Yes	210	(86.8)
No/Unknown	32	(13.2)
Positive urine toxicology screen		
Yes	190	(90.5)
No/Unknown	20	(9.5)
Services received during birth hospitalization†		
Referral for drug addiction rehabilitation	15	(6.2)
Drug addiction counseling/Counseling for substance use and abuse	10	(4.1)

Only 41% in treatment during pregnancy

Only 10% received counseling or referral from hospital

Putting it all together

- All pregnant women manifest motivation to maximize their health during pregnancy
- Most women stop or decrease use in pregnancy
- Those that can’t likely have a SUD
- Engagement in care improves outcomes
- However pregnant women with SUDs have unique set of needs and experience discrimination
- Therefore care needs to be compassionate and non-judgmental, comprehensive and coordinated with PNC provider
- Preventing substance exposed pregnancies means decreasing unplanned pregnancies, increasing access to reproductive health services, specifically contraception

Thank You

- Mishka.Terplan@vcuhealth.org