Caring for Pregnant Women with Opioid Use Disorder: Challenges and Opportunities

Mishka Terplan MD MPH FACOG FASAM
Professor Departments Obstetrics & Gynecology and Psychiatry
Virginia Commonwealth University
Addiction Medicine Consultant
Virginia Medicaid
LAUDANUM—Poison

Each fluid ounce contains 12-20 grains opium and 40% alcohol.


- 3 mo. old: 1 drop
- 1 yr. old: 5 drops
- 4 yrs. old: 5 drops
- 10 yrs. old: 10 drops
- 20 yrs. old: 20 drops
- Adult: 25 drops

McCORMICK & CO., Baltimore, Md., U.S.A.
Turn of the century treatment:
Addiction is a disease

- Addiction – seen as medical condition and treated like one
  - Short acting opioids
  - Specialty clinics – detoxification and maintenance
- Neonatal abstinence syndrome (NAS) – described and treated
The Current Opioid Crisis: Iatrogenic

MMWR 11/4/11
Drug Overdose Deaths Are Outpacing Other Public Health Epidemics

Drug overdose deaths per year compared to past epidemic death peaks.

- Car crashes (1972)
- HIV (1995)
- Firearm homicide peak (1993)
- Drug overdoses

Source: CDC, NHTSA

The Huffington Post
Change in mortality rate, urban vs. rural

White women and men in small cities and rural areas are dying at much higher rates than in 1990, while whites in the largest cities and their suburbs have steady or declining death rates.

Since 2010

Prescription opioid overdose deaths increased

237% for men

400% for women

Deaths per 100,000 population

- All opioids
- Commonly prescribed opioids
- Heroin and Synthetic opioids like fentanyl


### Heroin Use Has INCREASED Among Most Demographic Groups

<table>
<thead>
<tr>
<th>SEX</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>AGE, YEARS</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
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<tbody>
<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
<td>--</td>
</tr>
<tr>
<td>18-25</td>
<td>3.5</td>
<td>7.3</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
</tr>
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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
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</thead>
<tbody>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>ANNUAL HOUSEHOLD INCOME</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
</tr>
<tr>
<td>$20,000–$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>HEALTH INSURANCE COVERAGE</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
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</table>

### Heroin Addiction and Overdose Deaths are Climbing

**Heroin-Related Overdose Deaths**
- (per 100,000 people)

**Heroin Addiction**
- (per 1,000 people)

**Sources:** National Survey on Drug Use and Health (NSDUH), 2002-2013; National Vital Statistics System, 2002-2013.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent Reporting</th>
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<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Serious Psychological Distress</td>
<td>6.0%</td>
</tr>
<tr>
<td>(past month)</td>
<td></td>
</tr>
<tr>
<td>Any Mental Illness</td>
<td>26.2%</td>
</tr>
<tr>
<td>(past year)</td>
<td></td>
</tr>
<tr>
<td>Serious Mental Illness</td>
<td>5.0%</td>
</tr>
<tr>
<td>(past year)</td>
<td></td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>8.5%</td>
</tr>
<tr>
<td>(past year)</td>
<td></td>
</tr>
</tbody>
</table>

Gender and Behavioral Health Burden

National Survey on Drug Use and Health 2014, 2015
### Gender and Prescription Drug Use and Misuse

<table>
<thead>
<tr>
<th>Past Year</th>
<th>Male</th>
<th>Female</th>
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</thead>
<tbody>
<tr>
<td>Prescription psychotherapeutic drugs</td>
<td>40.9%</td>
<td>47.8%</td>
</tr>
<tr>
<td>“Pain Relievers”</td>
<td>33.9%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>11.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Sedatives</td>
<td>5.6%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>6.5%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

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

NSDUH 2015
Recent trends in treatment admissions for prescription opioid abuse during pregnancy

Caitlin E. Martin, M.D., M.P.H. 1, Nyaradzo Longinaker, M.S. 1,2, Mishka Terplan, M.D., M.P.H. 1,3

1 Department of Medicine and pediatrics, University of North Carolina Chapel Hill

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**Graph**: 
- **Y-axis**: Frequency %
- **X-axis**: Year (1992 to 2012)
- **Lines**:
  - Blue dots: proportion of pregnant women among all female treatment admissions
  - Orange line: proportion reporting any opioid abuse among pregnant admissions
  - Gray line: proportion reporting prescription opioids as primary substance among pregnant admissions

*Cochran-Armitage Trend Test p<0.01
• 2002-2009:
  – Rate of NAS increased
• Cost of care 2009
  – NAS = $53,400
  – All other births = $9,500
• Proportion of NAS paid for from Medicaid
  – 2002 = 69%
  – 2009 = 78%
The Opioid Crisis and Child Welfare

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

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

Source: AFCARS Data, 2014
The Opioid Crisis and Maternal Mortality

Overdose is more common cause of maternal death in US than obstetric causes
Helping the Helpless: Fighting Hampton Roads’ Heroin Epidemic

Number of children born addicted to drugs rockets in the Tampa Bay area

Number of mothers using opioids while pregnant is rising in Tennessee

More women using opioids while pregnant

Pill-Popping Mommas: ‘Many’ Pregnant Women Take Opioids, CDC Finds
Case Explores Rights of Fetus Versus Mother

Alicia Sefertan, 28, was sent to a drug-treatment center despite insisting she was not using drugs.

By ERIK ECHOLM
Published: October 23, 2013 | 670 Comments
No bystander could be more innocent. No damage so helplessly collateral.
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
Stigma

Discrimination and Prejudice
Stigma

 Discrimination and Prejudice

 Punishment
States where pregnant women have been prosecuted for drug use

The first known indictment of an American woman for drug use in pregnancy was in California in 1977.

Women prosecuted for drug use during pregnancy in all states but: DE, IO, ME, RI, VT

https://projects.propublica.org/graphics/maternity-drug-policies-by-state
# State Policies on Substance Use during Pregnancy

<table>
<thead>
<tr>
<th>Policy</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Considered Child Abuse</td>
<td>24+DC</td>
</tr>
<tr>
<td>Substance Use Grounds for Civil Commitment</td>
<td>3</td>
</tr>
<tr>
<td>Mandatory Reporting</td>
<td>23+DC</td>
</tr>
<tr>
<td>Targeted Programs for Pregnant Women</td>
<td>19</td>
</tr>
<tr>
<td>Pregnant Women Given Priority Access</td>
<td>17+DC</td>
</tr>
<tr>
<td>Pregnant Women Protected from Discrimination</td>
<td>9</td>
</tr>
</tbody>
</table>
Punishing Pregnant Women for Addiction is Unnatural

Maternal-Fetal Unit
A structurally and functionally interconnected metabolic unit shared by a mother and fetus through the placenta
Punishing Pregnant Women for Addiction is Unnatural

Maternal-Fetal Unit
A structurally and functionally interconnected metabolic unit shared by a mother and fetus through the placenta

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)

Refusal of Medically Recommended Treatment During Pregnancy

COMMITTEE OPINION
Number 864 • June 2016
(Replaces Committee Opinion Number 371, November 2005)

Committee on Ethics
This Committee Opinion was developed by the American College of Obstetricians and Gynecologists’ Committee on Ethics in collaboration with committee members Mary Faith Marshall, M.D., and Bonnie Whyte Packard, M.D., M.P.H. The Committee on Ethics wishes to acknowledge the assistance of Myke R. Hilsenrath, M.D., in the development of this document. While this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Refusal of Medically Recommended Treatment During Pregnancy

ABSTRACT: One of the most challenging scenarios in obstetric care occurs when a pregnant patient refuses recommended medical treatment that aims to support her well-being, her fetus’s well-being, or both. In such circumstances, the obstetrician-gynecologist’s ethical obligation to safeguard the pregnant woman’s autonomy may conflict with the ethical desire to optimize the health of the fetus. Forced compliance—the alternative to respecting a patient’s refusal of treatment—raises profoundly important issues about patient rights, respect for autonomy, violations of bodily integrity, power differentials, and gender equality. The purpose of this document is to provide obstetrician-gynecologists with an ethical approach to addressing a pregnant woman’s decision to refuse recommended medical treatment that recognizes the centrality of the pregnant woman’s decisional authority and the interconnection between the pregnant woman and the fetus.
What happens when women who use drugs get pregnant?

National Survey Drug Use and Health 2013/2014 Past Month Use Data
Those who can’t quit or cut back – have a substance use disorder

Continued use in pregnancy is pathognomonic for addiction
Addiction: A Brain-Centered Disease Whose Symptoms are Behaviors

Salient Feature: Continued use in spite of adverse consequences
The Pregnancy Box

- Addiction Life Course
- Reproductive Health Life Course
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)
Women with SUD in pregnancy

• Reproductive Health
  – Unplanned pregnancy: 80% (Heil 2012)
  – Low rates of contraception (Terplan 2015)
  – Higher rates of HIV

• 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
• 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

- Prenatal Care
- Behavioral Counseling
- Medication

Comprehensive co-located service delivery
Comprehensive Care (PNC + SUD treatment) Works

- Methadone treatment during pregnancy + comprehensive prenatal care reduced OB risk to a comparable level of “non-addicted” women of similar socio-medical circumstances.

Strauss et al., AJOG, 1974
Integrated care ameliorates adverse outcomes associated with drug use.

![Table 2: Obstetrical Complications in 367 Drug-Dependent Women and 215 Controls; Family Center Program, 1969-1976](image)

<table>
<thead>
<tr>
<th></th>
<th>PNC</th>
<th>No PNC</th>
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</thead>
<tbody>
<tr>
<td><strong>LOW BIRTH WEIGHT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No drug use</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Drug Use</td>
<td>19%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Integrated 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: Pharmacotherapy plus behavioral counseling
  – Methadone or Buprenorphine
Benefits of Pharmacotherapy

**Maternal**
- 70% reduction in overdose related deaths
- Decrease in risk of HIV, HBV, HCV acquisition/transmission
- Increased engagement in prenatal care and recovery treatment
- Treatment is platform for delivery of other services

**Fetal**
- Reduces fluctuations in maternal opioid levels; reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery
Pharmacotherapy

- Pharmacotherapy supported by:
  - CDC
  - WHO
  - SAMHSA
  - BOP
  - NCCHC
  - ACOG
  - ASAM
  - AAP
  - AAFP
  - Federal Guidelines for Opioid Treatment 2015
  - (partial list)

- Pharmacotherapy not supported by:
Opioid Crisis:
Renewed interest in “detox” in pregnancy

The obstetrical and neonatal impact of maternal opioid detoxification in pregnancy
Robert D. Stewart, MD; David B. Nelson, MD; Emily H. Adhikari, MD; Donald D. McIntire, PhD; Scott W. Roberts, MD; Jodi S. Dashe, MD; Jeanne S. Sheffield, MD

Opioid Detoxification in Pregnancy
JODI S. DASHE, MD, GREGORY L. JACKSON, MD, DEBORA A. OLSCHER, RNC, NP, ELIZABETH H. ZANE, MSW, AND GEORGE D. WENDEL, Jr, MD

Opioid detoxification during pregnancy: the door continues to open
Winston A. Campbell, MD

Detoxification from opiate drugs during pregnancy
Jennifer Bell, MD; Craig V. Towers, MD; Mark D. Hennessy, MD; Callie Heitzman, RN; Barbara Smith; Katie Chatten
What about “detox”?

Stopping the opioid crisis in the womb

Knoxville, Tennessee (CNN) — The sound of a heartbeat pulsates through the air, and a grainy image of a baby flashes on screen. Jessica Hill smiles from her chair in the ultrasound room.

Gathered around are her doctor, nurse and best friend.

They are all eager, anxious, excited -- and worried about the health of the baby. In that way, this ultrasound is like most.

But what’s happening in this room is anything but routine: Jessica, 28, is hooked on opioids and detoxing during pregnancy. Dr. Craig Towe is the pioneering -- and controversial -- obstetrician shaking the common medical belief that this approach could lead to the death of the fetus.
What about “detox”?

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“Detox” Revisited

• Relapse
  – 48% relapse by time of delivery (range 17-96%)

• Neonatal Abstinence Syndrome
  – 20-90% (c50% among women receiving MAT)

• Overall data case series, poor quality, limited fetal monitoring

• “Optimal control of maternal disease offers the best neonatal outcome”
“Detox” Revisited

- Relapse
  - 48% relapse by time of delivery (range 17-96%)
- Neonatal Abstinence Syndrome
  - 20-90% (c50% among women receiving MAT)
- Overall data case series, poor quality, limited fetal monitoring
- “Optimal control of maternal disease offers the best neonatal outcome”

Addiction is a chronic disease
Detox is an acute intervention: Clinical Mismatch
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)
• 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])
• 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])

There is no evidence that pregnant women receive preferential access to treatment
• 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)
MAT receipt among pregnant women in treatment for OUD
TEDS 1996-2014
Comprehensive treatment and pharmacotherapy are rare and unavailable for most pregnant women with OUD.
Treatment and Punishment

- One reason people support punishment is because women are choosing not to attend treatment – their continued drug use is irresponsible because they didn’t attend treatment.
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 identify pregnant women who use drugs?
Universal Assessment During Pregnancy: Recommended

• Early identification is key
  – Allows for early intervention and treatment that minimizes potential harms to the mother and her pregnancy
  – Maximizes motivation for change during pregnancy

• Selective screening based on “risk factors” perpetuates discrimination and misses most women who would benefit from treatment
Universal Assessment During Pregnancy: Recommended

• Patients are usually not offended by questions about substance use if asked in caring and nonjudgmental manner.

• Normalize questions:
  – Embed them in other health behavior questions
  – Preface questions by stating that all patients are asked about substance use

• Ask permission
  – “Is it OK if I ask you some questions about smoking, alcohol and other drugs?”

• Avoid closed-ended questions
  – “You don’t smoke or use drugs, do you?”
Screening Instruments

• No single best screening instrument to identify pregnant women with substance problems
  – Self-administered or part of the patient interview

• Developed for or validated in pregnant women (partial list)
  – Alcohol: T-ACE (Sokol 1989); TWEAK (Chang 1999)
  – Alcohol and other drugs: DAST and MAST (Kemper 1993); 4P’s Plus (Chasnoff 1999); CRAFFT (Chang 2011) for pregnant adolescents
## Barriers to Screening

### Patient
- Fear of discrimination or judgment
- Previous bad experience with health care provider
- Fear of Child Protective Services
- They don’t consider their use problematic

### Provider
- “My patients don’t use drugs”
- “I don’t have time”
- “I won’t get paid”
- “I don’t know what to do if they screen positive”
# Prenatal Care Screening

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic Fibrosis (Caucasians)</td>
<td>1/2500 = 0.0004%</td>
</tr>
<tr>
<td>HIV</td>
<td>1/500 = 0.002%</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>2%</td>
</tr>
<tr>
<td>Anemia</td>
<td>2-4%</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>2-8%</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>2-10%</td>
</tr>
<tr>
<td>Post partum depression</td>
<td>10-15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>9.4%</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>15.4%</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>5.4%</td>
</tr>
</tbody>
</table>
Screening: Urine Toxicology?

- Essential component of SUD treatment
- Do not use as sole assessment of substance use/use disorder (ACOG 2012, 2017)
  - Short detection window (substance dependent)
  - Might not capture binge or intermittent use
  - Rarely detects alcohol
  - Doesn’t capture prescription opioids (without confirmation testing)
- Ethical issues – patient consent prior to specimen collection on L+D
  - (Ferguson vs the City of Charleston, decided 2001)
- Confirmatory testing necessary prior to action on screening test
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!
The Treatment Gap

• Most individuals with a substance use disorder do not receive treatment

• Only c10% of individuals with SUD report treatment

• Minimal change over 2 decades
National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment

August 2015, Vol 105, No. 8 | American Journal of Public Health

Christopher M. Jones, PharmD, MPH, Melinda Campopiano, MD, Grant Baldwin, PhD, MPH, and Elinore McCance-Katz, MD, PhD

FIGURE 1—Trends in past-year opioid abuse or dependence and opioid agonist medication-assisted treatment capacity: United States, 2003-2012.

Note. OA-MAT = opioid agonist medication-assisted treatment; OTP = opioid treatment program.

GAP >1 million

FIGURE 2—Comparison of state rates of past-year opioid abuse or dependence and capacity for opioid agonist medication-assisted treatment: United States, 2012.

Note. OA-MAT = opioid agonist medication-assisted treatment.
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

Reproductive Health Lifecourse

Addiction Lifecourse

The Pregnancy Box
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
The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.

**FIGURE 1.1**

<table>
<thead>
<tr>
<th>Event</th>
<th>Median Age</th>
</tr>
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<tbody>
<tr>
<td>Menarche</td>
<td>12.6</td>
</tr>
<tr>
<td>First intercourse</td>
<td>17.4</td>
</tr>
<tr>
<td>First pregnancy</td>
<td>22.5</td>
</tr>
<tr>
<td>First marriage</td>
<td>25.1</td>
</tr>
<tr>
<td>First birth</td>
<td>26.0</td>
</tr>
<tr>
<td>Intend no more children</td>
<td>30.9</td>
</tr>
<tr>
<td>Menopause</td>
<td>51.3</td>
</tr>
</tbody>
</table>

Note: *Age by which half of women have experienced event.
Source: Reference 6.
We must avoid the “Crisis at Delivery”
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 have a SUD
• Engagement in care improves outcomes
• Pregnant women with SUDs have unique set of needs and experience discrimination
• Care needs to be compassionate and non-judgmental, comprehensive and coordinated with PNC provider
• Access to care is limited – we need more waivered providers and women-centered treatment
• Preventing substance exposed pregnancies means decreasing unplanned pregnancies, increasing access to reproductive health services, specifically contraception
Thank You

• Mishka Terplan
• Follow me on Twitter @do_less_harm
• Mishka.Terplan@vcuhealth.org