TREATMENT OF PREGNANT AND PARENTING WOMEN WITH SUBSTANCE USE DISORDERS

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Epidemiology of Substance Use in Pregnancy
Challenges and Opportunities Unique to this Population
Evidence-Based Treatment of SUD in Pregnancy
Role for Integrated Care
Creating a Recovery-Friendly Practice
Resources
Q & A

Substance Use in Past Month among Pregnant Women

CANNABIS USE IN PREGNANCY

Daily or Near Daily Marijuana Use (%)

Obstetrics: Original Research

Recommendations From Cannabis Dispensaries About First-Trimester Cannabis Use

“Technically with you being pregnant, I don’t think you are supposed to be consuming that, but if I were to suggest something, I’d suggest something high in THC.”

“In the context of edibles, start with a low dose and see how it works out for you because those types of things would, um, not cross the blood-brain barrier so even if you have got the CBDs and the other good parts of the plant would get in your baby’s blood system but the psychotropic properties, the THC molecule, would not get near your baby, so basically would not be getting your baby stoned.”

“The doctor will probably just tell you that ‘marijuana is bad for kids and will just try pushing pills on you’. Maybe you have a progressive doctor that will not lie to you. All the studies done back in the day were just propaganda.”

“Google it first. Then if you feel apprehensive about it, you could ask.”

“Most of them out here tell them not to smoke weed. Even the cancer doctors. It is so messed up. I do not know how the baby doctors work, if they are chill or not. Just do not go stoned when you talk to them.”

Safe?
Effective?
Elicit reasons for use
Assess for marijuana use disorder
Recommend treatments with more data for nausea, appetite, pain, sleep, anxiety
Opioid Use Disorder in Pregnancy

Data source: Kaiser Family Foundation

Rural and Urban Differences in Neonatal Opioid Withdrawal (NAS/NOWS) and Maternal Opioid Use

Impact of Opioids on Maternal-Child Health

Consequences of Untreated Substance Use Disorders for Mother and Baby

Treatment Transforms Outcomes

What is known about Treatment of OUD during Pregnancy?

- Research strongly favors opioid agonist treatment
  - Reduces risk of morbidity and mortality
  - Prevents relapse compared to abstinence-based approaches
  - Allows women to concentrate on self-care and raising a family
  - Methadone and buprenorphine both safe during pregnancy
  - Neonatal abstinence less severe with MAT than illicit drug use
  - Buprenorphine equivalent in effectiveness, with decreased duration and severity of NOWS/NAS
- Data on detoxification are not reassuring
  - Promoted in some practice environments
  - Low rates of completion (5-10%) and high rates of relapse (0-100%)
  - High rates of loss to follow up in some studies

Terplan, M, et al. Obstetrics and Gynecology 2018; 0;0:1-12; McCarthy, J, Leamon, M, Fassbender, C. AJOG 2017

“Treatment that addresses the full range of a woman’s needs is associated with increased abstinence and improvement in other measures of recovery, including parenting skills and overall emotional health. Treatment that addresses alcohol and other drug abuse only may fail and contribute to a higher potential for relapse.”

Centers for Substance Abuse Treatment, 2007
Dartmouth-Hitchcock Moms in Recovery

Demographics

Primary Substance at Admission (%)
Co-occurring Disorders

- 83.9% current tobacco users
- 67.2% current cannabis users (7% with Cannabis Use Disorder)
- 74.5% with psychiatric diagnosis
  - Depression 65.0%
  - Anxiety 23.4%
  - PTSD 21.9%
  - ADHD 8.8%
  - Borderline PD 4.4%
  - Bipolar Disorder 4.4%
- 45.6% prescribed psychotropic medication

Infant Outcomes (n=131)

- Length of gestation (weeks), m(sd) 38.4 (2.5)
- Birthweight (grams), m(sd) 3054 (553)
- Requiring NAS pharmacologic treatment, n(%) 15 (12.8)
- Length of stay (days), m(sd) 6.8 (7.0)
- Delivery Type, n(%):
  - Vaginal delivery 74 (56.5)
  - Cesarean delivery 42 (32.1)
  - VBAC 21 (15.5)
  - Operative vaginal delivery 13 (9.9)
- Normal admission to the nursery, n(%) 107 (82.3)
- Admission to the NICU, n(%) 25 (19.1)
- Documented active child protection involvement at discharge, n(%) 46 (34.9)

Maternal Outcomes (n=137)

- Estimated gestational age (weeks) at entry to:
  - Obstetrics (OB) care, m(sd) 11.0 (5.8)
  - Addiction treatment, m(sd) 13.0 (10.8)
- Number of OB visits, m(sd) 14.8 (5.7)
- Number of OB visits at PATP, m(sd) 6.4 (5.0)
- Pregnancy weight gain (pounds), m(sd) 24.9 (19.8)
- Postpartum OB visit, n(%) 102 (75.0)

Umbilical Cord or Meconium Toxicology (%)

- Negative/prescribed only
- THC Only
- Elicits other than THC

Becoming Recovery-Friendly

Trauma and SUD

PTSD

SUD

Trauma
Trauma and SUD

95% of those with SUD have lifetime trauma hx

25-50% of those with SUD have PTSD

30-50% of those with PTSD have SUD

Trauma Informed Care ≠ PTSD Treatment

Trauma Informed Care

TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.


Safety

Trustworthiness and Transparency

Peer Support and Mutual Self-Help

Collaboration and Mutuality

Empowerment, Voice, and Choice

Cultural, Historical, and Gender Issues

Words Matter

Addict, junkie Person with a substance use disorder

Clean, dirty (for person) Using substance or abstain from substance

Clean, dirty (for urine drug test) Positive or negative for a substance

Abuse (of substance) Harmful use, risky use, misuse

Harmful Quoted

Replacement or substitution therapy Medication assisted treatment

Habit or drug habit Substance use disorder
It Takes a Team!

Flexibility
Requirements
Acceptance
Change
Validation
Accountability
Support
Independence

Honesty
Attendance
Addressing life problems
Urine drug testing
Caring for medical problems

Resources

https://med.dartmouth-hitchcock.org/carpp.html

It Takes a Team!
QUESTIONS?

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