Patient-centered Care to Address Barriers for Pregnant Women with Opioid Dependence

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KEYWORDS

• Perinatal substance use • Incarceration • Harm reduction

KEY POINTS

- Many women with substance use disorders in pregnancy are underserved and delay obtaining prenatal care because of comorbidities of homelessness, poverty, mental health issues, social stigma regarding substance abuse in pregnancy, and a lack of adequate resources for substance abuse treatment.
- Punitive laws for substance-using pregnant women are unproductive and may discourage women from seeking care.
- Optimal care involves multidisciplinary cooperation between maternity care, substance abuse treatment, case management, and neonatal care teams.
- A family-centered model using harm reduction methods can improve outcomes for mothers and babies.

BACKGROUND AND EPIDEMIOLOGY

Women who use substances in pregnancy are an underserved population with a higher risk for maternal morbidity and neonatal morbidity and mortality. Maternal substance use affects all socioeconomic classes and the current opioid epidemic has brought heroin and prescription opioid addiction to many communities with minimal resources for treatment. Exposure to illicit substances in pregnancy increases the rates of preterm birth, placental abruption, intrauterine growth restriction, and other poor outcomes.[1] Infants affected by maternal substance use in pregnancy face

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challenges of withdrawal in the neonatal period as well as possible developmental effects persisting into childhood.

By self-report in 2013 to 2014, 5.3% of women aged 15 to 44 years were using illicit drugs during pregnancy.[2] Marijuana was the most common substance used at 4.1%, followed by nonmedical use of prescription drugs at 1.3%.[2] Substance use was more common in the first trimester at 8.9%, tapering to 5.3% in the second trimester and 1.9% in the third trimester.[2] Illicit drugs other than marijuana were used by 2% of pregnant women, including cocaine, heroin, hallucinogens, inhalants, and methamphetamines.[2]

These rates, based on self-report, are known to underestimate the proportion of the pregnant population with substance abuse issues. Many pregnant women do not disclose substance use because of concerns for confidentiality, stigmatization, removal of their children, incarceration, and other legal repercussions. Even in a prenatal program designed specifically for women with substance use problems, the sensitivity of self-reported drug use for all illicit substances was less than 60%.[3] Women may also disclose use, but report the timing of drug use inaccurately because of feelings of guilt regarding use in pregnancy. In another study, most women in a prenatal clinic for women with substance use issues with a positive urine drug screen reported recent drug use (78% marijuana, 86% cocaine); however, the most recent use report was often outside of the assay detection window (14% marijuana, 57% cocaine) indicating a trend toward reporting drug use as having occurred earlier in pregnancy.[4]

Illicit drug use in 2013 to 2014 among all women of reproductive age (15–44 years) is reported at 12.1%, which is up from 10.7% in 2011 to 2012.[2] The largest increase in use was seen in marijuana and nonmedical use of prescription opioids and stimulants.[2] Marijuana is increasingly legal and widely available. There has been a rapid increase in prescription opioid abuse over the last decade.[1,5] The demographic characteristics of pregnant women using illicit substances has also changed, necessitating that all obstetrician gynecologists, family physicians, and nurse midwives offering prenatal care have an understanding of how to screen and care for women with substance use disorders. Safe and responsible prescribing of opioid medications is the responsibility of all physicians holding a federal prescribing license.[6] Recent efforts to educate physicians regarding appropriate chronic use of opioids and the importance of checking prescription registries is decreasing the supply available from diversion, which may be increasing the transition of addicted women to heroin.[6,7] There is emerging evidence that women may progress more rapidly than men in the disease course of addiction and have a unique set of medical, psychiatric, and social considerations.[8] Pregnant women with substance abuse are a particularly vulnerable population.[9]

HOUSING, FOOD, AND TRANSPORTATION INSECURITY

Pregnant women struggling with substance use have many barriers to accessing resources, including housing, transportation, food, and job security. These social barriers are not necessarily tied to substance use itself, but rather the combination of low socioeconomic status and chaotic lifestyles.[10]

Housing stability is an important consideration and may affect maternal and infant safety and relapse rates. A disproportionate number of women struggling with substance use experience housing instability through all or part of pregnancy.[11] Others may have unsafe housing environments, including environments in which a partner or members of a social network are still abusing drugs, or in which domestic violence is occurring. Other women may have estranged friends and family during their struggle