Addressing the behavioral health needs of pregnant women
Behavorial Health Concerns Among Pregnant Women

- **Perinatal mood disorders (anxiety/depression)**
  - Edinburgh Postnatal Depression Scale (EPDS) assesses for both anxiety and depression

- **Substance use disorders (SUD)**
  - May mask an underlying, untreated mood disorder
  - Despite current attention to opioid use during pregnancy, alcohol remains the most commonly used substance in pregnancy (after tobacco)
  - American College of Obstetricians & Gynecologists (ACOG) endorses SBIRT model, including universal verbal screening for substance use, for all women in prenatal care
    - Urine drug screening reserved for women with history of SUD or other indications
Behavioral Health Treatment for Pregnant Women

- Both mood disorders and substance use disorders are responsive to treatment
- Pregnant women tend to be highly motivated for treatment
- Women have more contact with the health care system during pregnancy than at any other time during their childbearing years
- Medicaid covers behavioral health services during pregnancy, including for women with Medicaid for Pregnant Women ("pregnancy Medicaid") coverage
Behavioral Health Treatment for Pregnant Women: Barriers

- Concerns about treatment options if coverage ends after the postpartum period → work with LME-MCO
- Some BH providers less willing to accept pregnant women due to concerns about short-term Medicaid coverage or due to lack of expertise or comfort serving pregnant women
- Partner with LME-MCO to build knowledge of BH providers willing to work with and with expertise in treating pregnant women
  - Identify the right contact(s) at the LME-MCO who can respond to issues related to treatment needs of pregnant women
Psychosocial Concerns Among Pregnant Women

- **Tobacco use**
  - >35% of NC women with Medicaid coverage are smokers at the time they learn they are pregnant; half quit by first prenatal visit

- **Unintended pregnancy**
  - Nearly 46% of NC Medicaid pregnancies are unintended (down from 52% since the launch of Pregnancy Medical Home)
  - Higher rates among women with substance use disorder

- **Domestic violence**
  - 3% of NC women insured with Medicaid getting care at a Pregnancy Medical Home report physical violence in the past year at 1st prenatal visit
  - A 2000 study found 5% of women whose pregnancy was intended experienced domestic violence vs. 15% of women whose pregnancy was unwanted
Psychosocial Concerns Among Pregnant Women

Other common risk factors:

- History of child abuse, childhood sexual abuse, sexual assault
- Food insecurity
- Unstable housing
- Educational opportunities

Psychosocial risk factors are more prevalent among women with behavioral health diagnoses, predispose women to behavioral health problems, and affect the ability to obtain treatment for behavioral health concerns

- Interaction of gender and economic disadvantage
Working with Pregnant and Parenting Women with Substance Use Disorder
Treatment Considerations

- A pregnant woman may or may not be ready to stop her use and enter treatment
  - Importance of hearing and respecting the woman’s choice
  - Interaction with the court system, fear of loss of custody, concern for the health of the fetus are strong motivators
  - Adding to feelings of shame, guilt is counterproductive

- Experience of stigma and mistrust of the healthcare system are common
  - Possible history of reports to DSS, loss of custody of other children
  - Possible experience of poor treatment due to bias of healthcare providers and staff
Treatment Considerations

- Need for gender-specific and gender-responsive treatment settings
  - Models that incorporate trauma-informed care, given the high prevalence of trauma history among low-income women of childbearing age

- Family-centered treatment
  - Need to acknowledge that women have families!
  - A woman’s willingness to enter residential treatment may be dependent on her ability to bring her children or reassume custody of children during treatment
Treatment Options

- NC DMH/DD/SAS supports 26 maternal/perinatal substance abuse treatment programs
  - Focus on pregnant/parenting women
  - Cross-area – can serve women from any part of the state
  - Ability to serve uninsured women
  - Residential and outpatient options
  - Ability to bring children up to a certain age

- NC DSOHF prioritizes pregnant women for services at all 3 Alcohol & Drug Abuse Treatment Centers (ADATCs) for short-term stabilization
  - Walter B. Jones in Greenville can serve women at all gestational ages
NC DMH/DD/SAS and NC DPH support the NC Perinatal Substance Abuse Specialist (Judith Johnson-Hostler)

- Based at Alcohol & Drug Council of NC
- Contact when arranging treatment for a pregnant woman
- Coordination between LME-MCO and treatment provider
- Assist with medication-assisted treatment, if needed

NC DMH/DD/SAS employs the state’s “Women’s Services Coordinator” for substance use disorder treatment (Starleen Scott Robbins) – key leader for ensuring access to treatment for pregnant and parenting women
Working with Opioid-Dependent Pregnant Women
Types of Opioid Dependence

- Opioid use disorder – the woman is currently in medication-assisted treatment (MAT), including methadone or buprenorphine
- Opioid use disorder – the woman is not in treatment, active use of illicit opioids (heroin) or misuse of prescription drugs
- Opioid dependence is due to pain treatment with prescription opioids (no substance use disorder)
Key Messages for Opioid-Dependent Pregnant Women

- Pregnant women who are obtaining opioids without a prescription or illicitly should be counseled about available treatment options

- Standard of care for pregnant women with opioid use disorder is MAT with methadone or buprenorphine
  - Better birth outcomes with MAT than withdrawal from/discontinuation of opioids and/or ongoing illicit use
  - Women should not be encouraged to discontinue MAT during pregnancy
    - Risk of relapse to illicit use and possible infectious disease exposure outweigh benefits of withdrawal
Key Messages for Opioid-Dependent Pregnant Women

- Pregnant women in MAT may need temporary dose adjustments to reduce onset of withdrawal, due to metabolic changes of pregnancy
  - Prevention of withdrawal symptoms reduces risk of relapse
- Partnership between MAT provider and prenatal care provider is needed to ensure optimal care during pregnancy
  - Facilitate signing of consent forms that enable MAT provider to share current dose, treatment plan, urine drug screening results, etc.
Key Messages for Opioid-Dependent Pregnant Women

- Educate about the possibility of neonatal abstinence syndrome (NAS) and its management
  - Avoid scare tactics; provide factual, objective information
  - Not all opioid-exposed infants will experience NAS
- NAS onset may occur within 24 to 72 hours, or it may be delayed until 5 to 7 days of age or later
  - Possible increased length of stay for observation of the infant
- NAS is treatable with pharmacological and nonpharmacological approaches
  - “Rooming in”, breastfeeding, skin-to-skin promote bonding, reduce need for pharmacologic treatment of withdrawal symptoms – empower the woman to help manage NAS
Key Messages for Opioid-Dependent Pregnant Women

- Create an individualized pain management plan for labor and after the baby is born

- After delivery, opioid therapy should not be interrupted; dose adjustment under medical supervision may be needed

- The postpartum period is a challenging time with an associated risk of relapse for women with a history of addiction
  
  - Some women may request to start tapering off MAT but should not be rushed to do so
  
  - Be attentive to risk of postpartum mood disorders
Key Messages for Women of Childbearing Age

- Importance of using a reliable form of birth control to prevent unintended pregnancy
  - Access to family planning services for women of childbearing age in substance use disorder treatment
- If a woman with opioid dependence decides she wants to become pregnant, it is important that she work closely with her health care provider to develop a plan of care
  - Support the woman to obtain prenatal care as early as possible in pregnancy and to discuss her opioid use with her prenatal care provider
Resources

- Pregnancy Medical Home Care Pathway on the Management of Substance use in Pregnancy

- North Carolina Pregnancy and Opioid Exposure Project
  http://ncpoep.org/

- NC Perinatal Substance Use Specialist:
  1-800-688-4232
American College of Obstetrics & Gynecology (ACOG) Committee Opinions:

- No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice – June 2015
- No. 524: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice – May 2012
- No. 496: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice – August 2011 (reaffirmed 2013)
Resources

Association of State and Territorial Health Officials (ASTHO):

  
  http://www.astho.org/Prevention/Rx/NAS/

American Academy of Pediatrics (AAP) Committee on Substance Use and Prevention

- A Public Health Response to Opioid Use in Pregnancy – Feb. 2017
  
  http://pediatrics.aappublications.org/content/early/2017/02/16/peds.2016-4070