Curbside Consultation

Substance Use Disorder in Pregnancy

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Case Scenario

G.L. is a 32-year-old patient with a history of nicotine use disorder who presents for their first prenatal visit for their third pregnancy. My clinic recently began universal screening for substance use disorders (SUDs) in the prenatal setting, and G.L. has screened positive for nonprescribed opioids. In addition to usual prenatal care, what should I offer G.L. today and in the future?

Commentary

SUDs, and the associated consequences for individuals and communities, have attracted the attention of physicians, the public, and policy makers. Deaths from drug overdose have continued to rise. In 2020, more than 91,000 deaths were caused by drug overdose in the United States; provisional data estimate 107,622 such deaths in 2021—a 15% increase in one year.[1] Pregnant patients are not immune from the overdose epidemic.[2] Between 2010 and 2017, the estimated rate of maternal opioid use disorder (OUD) increased from 3.5 to 8.2 per 1,000 delivery hospitalizations, a relative increase of 131%.[3] The rate of neonatal abstinence syndrome similarly increased during this period from 4.0 to 7.3 per 1,000 birth hospitalizations, a relative increase of 82%.[3]

Treating SUDs during pregnancy poses clinical challenges to physicians for several reasons. The stigma associated with SUDs may lead to institutional and structural barriers, limiting access to evidence-based treatment and physicians with appropriate training. The scarcity of comprehensive SUD treatment programs creates a significant treatment gap for pregnant patients. Between 2010 and 2017, only an estimated 37% of eligible patients received any treatment for SUD, and about 25% were prescribed medication for OUD during pregnancy.[4] Addressing SUD in pregnant patients is a public health priority to prevent pregnancy-related death of mothers and infants and to improve the health of families.

EVIDENCE-BASED APPROACH TO THE PATIENT AND RESOURCES

As part of routine prenatal care, a validated screening tool (e.g., 5Ps, https://ilpqc.org/wp-content/docs/toolkits/MNO-OB/5Ps-Screening-Tool-and-Follow-Up-Questions.pdf; NIDA Quick Screen, https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf; CRAFFT questionnaire, https://crafft.org/wp-content/uploads/2019/02/CRAFFT-2.0_Selfadministered_2018-01-16.pdf) may identify individuals who merit further assessment for SUD treatment.[5,6]

Family physicians and their care teams should be familiar with current clinic and hospital toxicology testing policies and mandated reporter and child welfare agency policies in their specific state related to perinatal substance use. Although toxicology testing is not a screening tool for substance use, many clinics and birthing hospitals' policies require toxicology testing in pregnant and laboring patients, triggering a mandated report to child welfare agencies. The American College of Obstetricians and Gynecologists recommends obtaining consent before toxicology testing and considering the role of toxicology test results in the care of the pregnant patient.[7]

If a patient screens positive for SUD during pregnancy, person-first, nonstigmatizing language is important in communicating with the patient and family.[8,9] Motivational interviewing techniques help determine to what extent a patient is ready for SUD treatment during their pregnancy.

Even if a patient is open to referral to a treatment expert or specialized program experienced in caring for pregnant patients with SUDs, in many areas, such individuals and programs are

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

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not available or do not offer evidence-based medications. Patients may have additional barriers to entering such programs, such as insurance coverage, childcare, and other personal and family responsibilities.

Family physicians who provide obstetric care are well-positioned to care for the pregnant patient with SUD, and several resources are available for health care professionals who have pregnant patients with SUDs *(Table 1)*. By initiating and managing evidence-based medications during pregnancy and utilizing effective partnerships with behavioral health specialists and community organizations offering doula, harm reduction, and peer support services, family physicians can play a key role in addressing the treatment gap for pregnant people with SUD. When indicated, referral to a residential SUD treatment center that offers specialized care for pregnant people is an essential component of perinatal SUD treatment. The family physician also has a key role in providing accurate family-centered health education in the prenatal setting on neonatal abstinence syndrome. This includes informing families of the benefit of nonpharmacologic measures, such as breastfeeding, skin-to-skin contact, and other consoling measures, that can mitigate neonatal abstinence syndrome.[10] A previous *American Family Physician* editorial provides more information on a mother-infant dyad treatment approach for neonatal abstinence syndrome.[11]

Opioid Use Disorder. Detoxification or withdrawal management is not recommended for maternal OUD; the Substance Abuse and

TABLE 1

Resources for Health Care Professionals Who Have Patients With Substance Use Disorders During Pregnancy

Resources	Comments
Academy of Perinatal Harm Reduction Pregnancy and substance use: a harm reduction toolkit https://www.perinatalharmreduction.org	Toolkit on perinatal harm reduction and other harm reduction resources
Children and Family Futures Infants with prenatal substance exposure https://www.cffutures.org/infants-with-prenatal-substance-exposure	Resource provides training and technical assistance to tribes, states, counties, and community agencies to improve outcomes for pregnant and postpartum people, their infants, and family members affected by prenatal substance exposure
Providers Clinical Support System Buprenorphine training for physicians https://pcssnow.org/medications-for-opioid-use-disorder/waiver-training-for-physicians	Training format for primary care physicians in the evidence-based prevention and treatment of OUD
Substance Abuse and Mental Health Services Administration Healthy pregnancy, healthy baby fact sheets https://store.samhsa.gov/product/Healthy-Pregnancy-Healthy-Baby-Fact-Sheets/SMA18-5071	Four fact sheets that emphasize the importance of continuing a mother's treatment for OUD throughout pregnancy; the series includes information on OUD and pregnancy, OUD treatment, neonatal abstinence syndrome, and considerations to address before hospital discharge
Clinical guidance for treating pregnant and parenting women with OUD and their infants https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf	Guide provides comprehensive, national recommendations for optimal management of pregnant and parenting women with OUD and their infants; it helps health care professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions

OUD = opioid use disorder.

Mental Health Services Administration clinical guidelines for treating pregnant and postpartum patients with OUD recommend initiating buprenorphine or methadone.[12] In addition, as with all patients seen in the primary care setting at risk for overdose, harm reduction education, including counseling on naloxone use for overdose prevention, should be addressed with a pregnant patient who has OUD.[13]

Finally, special consideration should be given to the complex social and legal context for pregnant people with SUD. Many states take punitive approaches, including criminalization, in pregnant patients with SUD. A comprehensive list of state policies has been compiled by the Guttmacher Institute and can be a useful reference to family physicians providing care to families affected by SUD.[14]

Case Resolution

An essential part of assessing G.L.'s readiness for SUD treatment involves assuring them that you are committed to providing care for them throughout their pregnancy and after. Ensure that you are asking questions in a nonstigmatizing manner, and explain that your concern is for their health and the health of their child (and any other children) as you continue to address prenatal care issues, including G.L.'s nicotine use disorder.

When exploring their readiness to start taking medication for OUD, several options are available, depending on G.L.'s preferences and degree of family and personal support. G.L. can begin taking buprenorphine today at home, be referred to a local methadone program, or be referred to the nearest residential treatment program that has expertise in caring for pregnant patients.

Before they leave the clinic, G.L. should be counseled on naloxone use for overdose prevention and be provided with a prescription for naloxone. A follow-up visit should be scheduled in two to three days, and G.L. should be provided with the after-hours service number in case they need to contact the on-call physician. Before the next visit, review resources for G.L. in the community for doula and peer support services, as well as relevant birthing hospital, clinic, and child welfare policies related to perinatal substance use.

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