DATA & TRENDS – SIDEBAR

# Pregnant Mothers With Substance Use Problems and Their Treatment in North Carolina

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North Carolina has a nationally recognized statewide approach to family and perinatal substance use disorders (SUD) care [1]. Drug-related morbidity and mortality are worsening in the nation and require providers to refine and improve the diagnosis-referral-treatment pathway.

A few shared recommendations for the treatment of SUD in pregnancy may help streamline the treatment pathway.

Providers do not need to perform screening tailored to level of risk, but rather can apply universal screening to identify persons at risk early utilizing motivational interviewing, and normalize and embed screening questions in electronic health records using validated brief screening tools [2]. This contributes to increased awareness of the conditions and expands treatment while reducing stigma. Urine toxicology is not recommended as a first screening tool for multiple reasons: a short detection window for urine drug screens, the need for confirmation testing, the inability to capture intermittent or binge use, and the tendency to instead detect single-time users, which raises ethical issues for clinical reports [3].

In particular, according to the standard of care for the treatment of opioid use disorder (OUD) during pregnancy and postpartum, pregnant persons who use opioids do not need to meet full DSM-V criteria for moderate or severe disorder in order to receive medications for OUD (MOUD), including either methadone or buprenorphine [4]. Access to behavioral counseling, as an adjunctive treatment, can be performed with the MOUD provider/staff if the referral to mental health, an SUD program, or an outpatient dual diagnosis program is difficult.

It is important to clarify with the patient that a referral for SUD assessment with a behavioral health provider is a consultation, and not a requirement that she enter SUD treatment. For those pregnant women who do not want a medication for OUD—and there are still many [5]—referral to a specific syringe services program or prescription of needles/syringes, together with the formulation of a safety plan that includes counseling on not using substances alone, is fully in line with a harm-reduction approach [6].

Once the patient accepts treatment, those providers who cannot refer the patient directly to a suitable community-based SUD treatment program may refer to the North Carolina Perinatal Substance Use Coordinator through the Alcohol/Drug Council of North Carolina for assistance (https://www.alcoholdrughelp.org/home). This information is offered through a toll-free number and a weekly list of available beds at residential treatment sites can be emailed to providers across the state. The Perinatal Substance Use Coordinator can also refer patients to Local Management Entity/Managed Care Organizations for community-based SUD services and outpatient supports.

In North Carolina, the Perinatal and Maternal Substance Use Disorder Initiative and CASAWORKS for Families Residential Initiative coordinate 28 SUD treatment programs for pregnant and parenting women statewide.

All residential programs accept women who have MOUD as part of their recovery. Pregnant patients who are uninsured or on Medicaid and those with intravenous drug use are at the center of the process.

An increasing maternal mortality rate in the postpartum period in North Carolina points to the urgent need for health care providers to realize the importance of fourth-trimester care [7]. Despite a well-defined treatment structure, care coordination with health, judicial, and social systems continues to be limited, and providers may need to assume some of the role of case managers for their patients [8]. To strengthen a comprehensive continuity of care, the perinatal substance exposure clinic Project CARA in Western North Carolina has developed the complex care navigator (CCN) role (https://mahec.net/obgyn/project-cara). The CCN can assist at each step in the referral process to an outpatient or inpatient program. Moreover, this professional figure may become particularly helpful for pregnant patients who have high levels of care-related needs (e.g., chronic medical comorbidities, uninsured/Medicaid, and intravenous drug use). Assisting and supporting high-risk pregnant beneficiaries in navigating prenatal and postpartum care with their children helps address a crucial barrier. Years of research show that women are driven to initiate treatment and recovery by concern for their children or pregnancy, but that they are often unable/unwilling to seek treatment if that means leaving their children [9].

Of course, the barriers to treatment are not limited to the postpartum phase, but begin with the gaps in screening: women are overall less likely to be vetted in primary care and mental health settings for SUDs [10]; local treatment services for pregnant persons and child care services for parenting persons are lacking for women who are not willing or able to leave their community for care; and economic resources, especially insurance and transportation, may also be scarce [11]. Perhaps an even more difficult barrier to care are the effects of trauma and a history of intimate partner violence [12].

Despite the urgent need for assistance, there are still health care providers who have a conscious or unconscious bias against pregnant SUD patients and may be reluctant to provide care or may make erroneous judgments about a patient's fitness as a parent [13]. This erroneous interpretation and other sources of discrimination and prejudice can impede engagement in care, including prenatal care even when available, and can negatively impact parental and neonatal health outcomes [14]

The COVID-19 pandemic has affected access to care at the global level and offered the opportunity to reflect on pre-pandemic quality of services. A recent survey determined that almost half of the buprenorphine clinics in North Carolina were refusing pregnant patients before the pandemic [15]. During the pandemic, only 34% accepted pregnant patients [15]. We must conclude that the significant loss of services following the pandemic was preceded by a chronic lack of providers, inevitably influencing health outcomes.

The management of SUD in pregnancy is a complex clinical challenge. We have highlighted the increasing numbers of effective treatment options for pregnant women with SUD, but must recognize that the social stigma they suffer often leads to hopelessness and guilt, and may serve to prevent attainable results. In a preliminary survey regarding patients receiving MOUD, medical students and medical residents agreed that women with OUD, compared to women with bipolar disorder or diabetes, should not try to get pregnant, due to the particular

challenges associated with OUD [16]. These stigmatizing biases among both patients and providers are a reminder that a continuing education process must accompany the clinical treatment effort. NCMJ

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