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Spotlight on Perinatal Substance Use Disorder

Issue Brief from the New York State Maternal Mortality Review Board

The audience for this issue brief is addiction medicine providers, mental health providers, social workers, emergency medicine providers, internists, family medicine providers, obstetrician-gynecologists (ob-gyns), midwives, nurse practitioners, physician assistants, and other medical and clinical multi-disciplinary team members taking care of people with substance use disorder in the perinatal and postpartum period.

INTRODUCTION

The New York State Maternal Mortality Review Board is releasing an issue brief that is designed to offer multi-disciplinary providers an in-depth examination of key recommendations from a comprehensive review of 2018-2020 pregnancy-associated deaths in New York State.

Perinatal Substance Use Disorder is a large and growing problem. According to reviews of 2018 deaths, substance use disorder caused more than one in four statewide pregnancy-associated deaths. Of these, 13% occurred during pregnancy, 18% occurred within 42 days of the end of pregnancy, and 69% occurred between 43 days and one year after the end of the pregnancy. Ninety-two percent (92%) of pregnancy-associated deaths caused by substance use disorder occurred outside of New York City, and these deaths comprised nearly half (48%) of all pregnancy-associated deaths in the rest of state. Preliminary analyses of review results from 2019 and 2020 suggest that substance use disorder remained one of the most common causes of pregnancy-associated deaths.

This issue brief uses a composite case of a fictitious patient (who uses they/them pronouns) to incorporate key aspects of substance use related conditions that were identified in actual cases during the Board's review of 2018-2020 pregnancy-associated deaths. Specific recommendations follow the case description.

COMPOSITE CASE

The patient was a 32-year-old pregnant person who had recently given birth to their second child and who died 53 days postpartum with the cause of death mixed drug intoxication including fentanyl, heroin, and cocaine. The patient had a history of substance use disorder as well as depression and anxiety. They were on sertraline 100 mg daily for depression throughout the pregnancy and were in treatment for substance use disorder utilizing buprenorphine 16 mg daily and weekly counseling. The patient had a history of receiving naloxone one year ago for an overdose. Their older child was engaged in child protective services and under the care of the patient's mother. The patient's surgical history includes a cesarean birth.

The patient entered prenatal care at 11 weeks and was consistent in keeping appointments throughout the pregnancy. Verbal screenings for depression and substance use were performed during the first prenatal visit. The patient verbalized during screening that they were under the care of a mental health provider and were on medication for opioid use disorder. A urine toxicology was performed and was positive for only buprenorphine. The patient expressed concerns about child protective services. They reported seeing their mental health and substance use providers regularly. There was no mention in the chart that the prenatal care provider attempted to connect with the patient's opioid use disorder or mental health provider. The New York State Prescription Monitoring Program indicated that they had a monthly prescription for buprenorphine.

While keeping consistent with prenatal visits, there were two emergency department visits during the pregnancy at 13 weeks and 16 weeks for nausea and vomiting. The emergency department verbally screened the patient for suicidal ideation, domestic violence, depression, and substance use, which were all negative. Urine toxicology was positive for only buprenorphine in the emergency department. They received hydration and medication for nausea each time and were discharged. During the patient's prenatal care visits, the patient verbalized that they wanted to continue not using, so they would not jeopardize the health of their baby.

They presented in labor at 38 weeks, attempting a trial of labor. An epidural was placed. However, they delivered by cesarean birth due to a concerning fetal heart tracing, birthing a 3,150-gram baby girl that remained in the hospital for neonatal opioid withdrawal syndrome for 7 days. The epidural remained in place for 24 hours for patient controlled epidural anesthesia, and buprenorphine was continued throughout the hospital stay. Oxycodone was needed on day 2, and a one-day supply of oxycodone was provided at discharge home.

The patient was discharged on postpartum day 3 with an established Plan of Safe Care, with contact information and appointments for opioid use disorder and mental health therapy. The newborn was discharged in the care of the patient with monitoring by child protective services. They returned for a post-op visit at two weeks for a wound check. At this visit the record states they were doing well and reported the baby was doing well. There was no depression screening, no mention of substance use disorder, or mental health treatment noted in the chart. The patient did not return for their next postpartum care visit.

At 53 days postpartum, they were found unresponsive on the floor by their mother. Naloxone was administered by emergency medical services, but the patient could not be resuscitated. The mother later reported that the new baby and work obligations were causing the patient excessive stress, and they had feared they may return to using. The cause of death was acute drug intoxication, including fentanyl. Buprenorphine was listed in the toxicology report.

DISCUSSION AND RECOMMENDATIONS

The postpartum period is a particularly vulnerable time for individuals with substance use disorder. Even if the patient is engaged in treatment at the time of delivery, special attention must be taken to ensure the patient receives enhanced support during that first year following pregnancy, including warm hand offs, and engagement with medical providers that treat substance use disorder, including but not limited to Office of Addiction Services and Supports certified providers. Addiction treatment providers should be knowledgeable about the special needs of postpartum patients and make referrals for additional supportive care such as home visiting services or peer support services as needed. Furthermore, all providers seeing patients with substance use disorder should offer both the patient and their support system a prescription for naloxone and education on how to administer it. Naloxone alone may not be an adequate response in polysubstance overdose. Patients and support systems should be educated that overdose response includes calling 911 and, if no response to naloxone, giving rescue breaths and performing cardiopulmonary resuscitation, if trained, and staying with the person.

Recommendation 1

Provide early, universal verbal screening for substance use utilizing appropriate standardized tools.

Universal verbal screening is recommended during the prenatal period and should be initiated at minimum during the first prenatal visit (refer to the Provider Resources Section for a listing of verbal screening tools for substance use disorder). Providers should utilize a person-centered approach that is non-judgmental, respects patient autonomy, and seeks to reduce stigma associated with substance use disorders.

Biological testing (toxicology testing) is not recommended universally. When biological testing (toxicology testing) is used:

- Informed consent should be obtained prior to testing;
- Biological testing should NOT be used to assess the severity of substance use, as the test only captures one moment in time;
- Medical professionals should be aware of what is included in the panel;
- All toxicology panels should be comprehensive enough to include substances of concern (e.g., fentanyl), medications prescribed (e.g., buprenorphine), and their metabolites (e.g., norfentanyl and norbuprenorphine); and
- All positive results from point of care or immunoassay tests should have confirmatory testing.

Recommendation 2

A naloxone prescription should be provided at the first prenatal visit and on discharge following an emergency department visit or hospitalization (including the birth hospitalization), and the patient's support system should be educated on the use and administration of naloxone.

For patients that screen positive on a verbal screen for substance use disorder, a naloxone prescription should be provided, not only to the patient, but to their support persons (partner, friend, relative). The prescription should be accompanied by educational pamphlets for the patient and support persons on how to use it and how to recognize the signs and symptoms of overdose. Medical professionals can choose to participate in the New York State Department of Health's opioid overdose prevention program to directly dispense naloxone. Naloxone availability and education can reduce mortality.

Recommendation 3

Obstetric providers should engage community resources and treatment programs and provide closed-loop referrals particularly at discharge after delivery.

The postpartum period is a known high-risk interval for overdose and death. Linkage to support, a Plan of Safe Care, and an initial follow-up with the prenatal provider[1] and the opioid use disorder provider within three weeks of delivery, in person or by phone, should be part of the discharge treatment plan. Coordination of care with newborn providers may also offer opportunities for intervention. Obstetric and newborn providers need to recognize this vulnerable period and initiate follow-up mechanisms to assess the patient's progress and well-being.

The interdisciplinary hospital team should be knowledgeable about local substance use disorder treatment, harm reduction resources, and mental health resources in the community to assist patients. Contact Project Teach for more information. Home visiting and/or peer support programs should be part of the Plan of Safe Care.

Recommendation 4

Substance use disorder treatment providers caring for birthing people should develop expertise for treatment in the perinatal and postpartum (up to one year after the end of pregnancy) periods.

Substance use disorder treatment providers need to be acutely aware of the postpartum period as a vulnerable time in a patient's health journey. Special follow-up, outreach, and interventions need to be initiated for postpartum patients. Available resources to develop expertise include the Clinical Education Initiative (CEI) and the Providers Clinical Support System.

Recommendation 5

Substance use alone, whether disclosed through a self-report, verbal screening, toxicology testing, Plan of Safe Care, medical record note, or newborn symptoms is not evidence of child neglect.

As noted in guidance from the New York State Department of Health, providers must be aware that substance use and/or substance use disorder alone are not evidence of child abuse or neglect and should not be the sole reason for reporting to child protective services. Only when there is reasonable cause, beyond substance use, to suspect a child is at risk of abuse or neglect, hospitals and birth centers should continue to follow existing policies and protocols for making a report. Educating all staff, including physicians, nurses, and others is critical.

Recommendation 6

Patients with substance use disorder, especially those taking buprenorphine or methadone, should have an anesthesia consult during pregnancy to discuss pain management during labor or cesarean birth and the postpartum course.

On admission for delivery, an anesthesia evaluation and early epidural for pain management is recommended. Opioid use disorder treatment with buprenorphine or methadone should continue throughout labor and during the hospital stay. Patient controlled epidural anesthesia is optimal for pain management for the first 24 hours after a cesarean birth. Opioids, most typically oxycodone or hydrocodone, should be used for additional pain management as needed; however, only a very limited amount should be prescribed on discharge from the hospital.[2,3,4]

1. The American College of Obstetricians and Gynecologists, Presidential Task Force on Redefining the Postpartum Visit. (May 2018, Reaffirmed 2021). *Optimizing Postpartum Care*.
2. Landau R. Post-cesarean delivery pain. Management of the opioid-dependent patient before, during and after cesarean delivery. *Int J Obstet Anesth* (2019). https://doi.org/10.1016/j.ijoa.2019.01.011
3. Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.
4. Lim, Grace., et. al. (2022). A Systematic Scoping Review of Peridelivery Pain Management for Pregnant People with Opioid Use Disorder: From the Society for Obstetric Anesthesia and Perinatology and Society for Maternal Fetal Medicine. *Obstetric Anesthesiology*, 135 (5), 912-925.

PROVIDER RESOURCES

American College of Obstetricians and Gynecologists (ACOG)

ACOG Statement of Policy: Substance Use Disorder in Pregnancy

ACOG Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy

ACOG Committee Opinion: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice

ACOG District II: Implementing Screening, Brief Intervention, and Referral for Treatment (SBIRT), An Effective Approach to Care: Introduction to SBIRT (video)

Verbal Screening Tools for Substance Use Disorder

Parents, Partner, Past, and Present (4P's Plus)

Tobacco, Alcohol, Prescription Medication, and Other Substance Use Tool (TAPS)

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST-lite)

Drug Abuse Screening Test (DAST-10)

Tolerance, Annoy, Guilt, Eye-opener (T-ACE)

Screening for Drug Use in General Medical Settings Resource Guide (NIDA Quick Screen)

Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD) (for adolescents only)

Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) (for adolescents only)

The Alcohol Use Disorders Identification Test (AUDIT-C) (for alcohol use only)

New York State Perinatal Quality Collaborative

The New York State Perinatal Quality Collaborative, American College of Obstetricians and Gynecologists District II, Healthcare Association of New York State, Greater New York Hospital Association, and the National Institute for Children's Health Quality worked (2018-2023) to support New York State birthing hospitals to provide appropriate and respectful care to individuals with opioid use disorder through the New York State Opioid Use Disorder in Pregnancy and Neonatal Abstinence Syndrome Project. For more information and resources, please visit: NYSPQC website.

NYS Office of Addiction Services and Supports: Reversing the Stigma (English and Spanish)

OASAS I Reversing the Stigma (video)

Listing of NYS Prevention, Treatment, and Recovery Services by County

Regional Support Services | Office of Addiction Services and Supports (ny.gov)

Alliance for Innovation on Maternal Health: Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle

AIM Patient Safety Bundle

New York State Child Abuse and Prevention Treatment Act (CAPTA) and Comprehensive Addiction and Recovery Act of 2016 (CARA) Information and Resources

CAPTA CARA

Plans of Safe Care for Infants and Their Caregivers

OASAS I Plans of Safe Care

Project TEACH and Maternal Mental Health Referral Resources

Project TEACH - Maternal Mental Health

For more information on the NYS Maternal Mortality Review Initiative, visit: Maternal Health Matters

RESOURCES FOR PATIENTS AND SUPPORT PERSONS

Below are two brochures, developed by the New York State Department of Health, to educate patients and families on opioid overdose and naloxone administration. Both brochures are available in 12 languages. English versions of the brochures are listed below. Additional languages can be obtained on the New York State Department of Health website at: Opioid Overdose Facts. Quick Response (QR) codes on the brochures direct individuals and families to a list of pharmacies in New York State that offer naloxone without a prescription.

Naloxone Patient Education Brochure: Do You or Someone You Know Take Opioids? Be Safe. Prevent a Fatal Overdose. Have Naloxone Available.

Naloxone Family Education Brochure: Do You Know Someone at Risk for Opioid Overdose? Get Naloxone. Save a Life.

Availability of Naloxone in Pharmacies in New York State

Naloxone is now available over the counter in all pharmacies throughout New York State. Individuals at risk for an overdose and their family members/friends may acquire naloxone in these pharmacies without bringing in a prescription. Inquire about this at the pharmacy counter.

New York State Naloxone Co-Payment Assistance Program

The New York State Naloxone Co-Payment Assistance Program improves access to naloxone by making it available to individuals at low or no cost. Frequently Asked Questions (FAQ) about the Naloxone Co-Payment Assistance Program is available.

Toll Free HOPEline

HOPEline is available 24 hours per day/7 days per week and is staffed by specially trained and supervised mental health professionals and people who have experienced addiction. Individuals may call or text to receive free and confidential information about addiction. For toll-free, confidential help and hope 24 hours per day/7 days per week, call 1-877-8-HOPENY (467369) or text HOPENY (467369).