Substance Use in Pregnancy

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Screening, Brief Intervention, Referral to Treatment (SBIRT) model

All pregnant people should be screened for substance use at the first prenatal or preconception counseling visit (NIDA Quick Screen, 4 P's)

Rates of Use by Pregnant Patients

~15% tobacco/nicotine, 9% alcohol, 5% illicit substances

Negative Screen – no current use, low-level use prior to pregnancy

-Provide education – recommendation is to avoid alcohol, tobacco, cannabis, and illicit substances in pregnancy

-Offer MotherToBaby fact sheets (available for most commonly used substances at https://mothertobaby.org/fact-sheets/

Positive Screen – current use and/or history of heavy use or SUD diagnosis

Further Assessment

-Open-ended questions, avoid judgmental language

"What substances have you been using in the last 2-3 months?"

"How is substance use affecting your life?"

"Are you currently in treatment or have you had prior treatment?"

If using currently:

"How often are you using each substance and how much at a time?

"How are you using these substances?" (ingesting, smoking, injecting)

Currently Using Substances – Brief Intervention

"Is it okay if we talk more about this?"

"Would you be interested in help quitting/decreasing use?"

"How ready are you to make this change on a scale from 1 to 10?"

"How confident are you that you can make this change on a scale from 1 to 10?"

Not Currently Misusing Substances – high risk history only or currently engaged in treatment

-If engaged in treatment – coordinate with SUD treatment provider, encourage continuing engagement

Referral to Treatment

-Provide medications if possible/indicated (see attached)

-Consider referral to treatment program (outpatient, intensive outpatient, inpatient)— resources attached)

-Warm handoff recommended

Plan and Follow Up – Collaborative with Patient

-If referred out follow up with patient to ensure they made connection

-Repeat screen at least every trimester

-Ask about cravings

-Screen for comorbid mental health conditions

-Make sure patient has Narcan kit if using opioids (including prescription) or any illicit substances given high risk of fentanyl contamination

-Call Perinatal PCL with questions

Risks of Substance Misuse in Pregnancy

*Overdose – make sure patient has Narcan kit https://stopoverdose.org/

*Lower engagement with appropriate prenatal care
*Infection with injection use
*Legal problems/loss of parental rights
*Risks to pregnancy/child depend on substance and frequency/amounts

Substance Use Screening

NIDA Quick Screen: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **P**regnancy?

2. Have you had a problem with drugs or alcohol in the **P**ast?

3. Does your **P**artner have a problem with drugs or alcohol?

4. Do you consider one of your **P**arents to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use.

-Treatment Resources in Washington State:

WA Recovery Helpline: https://www.warecoveryhelpline.org/

SUD Treatment with Medicaid: https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/substance-use-treatment

Chemical-using Pregnant (CUP) Women Program: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/chemical-using-pregnant-women

Parent-Child Assistance Program (PCAP): https://depts.washington.edu/pcapuw/

-Peer Support:

Alcoholic/Narcotics Anonymous: www.aa.org; www.na.org
SMART Recovery: www.smartrecovery.org

-Nicotine cessation:

Quit for Two: https://women.smokefree.gov/pregnancy-motherhood/quitting-while-pregnant/quit-for-two

Selecting a Medication for Opioid Use Disorder in Pregnancy

Is the patient currently on a medication for opioid use disorder?

YES

*Avoiding changing medication during pregnancy

*Monitor patient closely, ask about subjective medication efficacy, withdrawal symptoms, cravings

*May require increase in total daily dose or frequency (especially methadone) in pregnancy

NO

*What has worked in the past?

*What is readily available (may depend on treatment setting)?

*What does the patient prefer?

*Review below with patient

Considerations	**Buprenorphine**	**Methadone**
Prescribing setting	Office-based	Through Opioid Treatment Programs (pregnant patient have priority for access)
Dosing in pregnancy	May need to be increased	May need to be increased and converted from daily to twice per day
Risk of drug-drug interactions and QTc prolongation	Lower	Higher
Risk of overdose	Lower	Higher
Risk of sedation	Lower	Higher
Treatment retention	Lower	Higher
Risk of NOWS	Lower	Higher
Need to be in withdrawal to start	Yes *low-dose (micro) induction is a way to avoid this	No
Breastfeeding	Breastfeeding ok (and should be encouraged to decrease NOWS) if no other contraindications	Breastfeeding ok (and should be encouraged to decrease NOWS) if no other contraindications

Non-judgmental Language

Terms to Avoid:	Instead Use:
Alcoholic/drug addict/drug abuser	Person who uses substances
Addicted baby/born addicted	Child affected by maternal opioid use/Neonatal Opioid Withdrawal
Drug problem	Risky use/nonmedical use
Drug of choice	Substances used
Clean/dirty urine	Positive/Negative/Aberrant
Substitution/Replacement therapy	Medication for SUD/OUD, Medication-Assisted Treatment

Contact Perinatal PCL with questions:

Call 877-725-4666 or email ppcl@uw.edu

References:

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Jones HE, Kaltenbach K, Heil SH, Stine SM, Coyle MG, Arria AM, O'Grady KE, Selby P, Martin PR, Fischer G. Neonatal abstinence syndrome after methadone or buprenorphine exposure. N Engl J Med. 2010 Dec 9;363(24):2320-31. doi: 10.1056/NEJMoa1005359. PMID: 21142534; PMCID: PMC3073631.

SAMHSA Clinical Guidance for Treating Opioid Use Disorder in Pregnant and Parenting Women and their Infants. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf