Policy Brief on Providing Best Practices for Opioid-Dependent Pregnant Women

By

Yolanda Ross

Policy Brief on Providing Best Practices for Opioid-Dependent Pregnant Women

Audience

The Texas 89th Legislature is scheduled to begin on January 14, 2025, and is anticipated to end on June 2, 2025. As the state's population continues to increase and becomes more diverse in terms of urbanicity, income, race, and ethnicity, the healthcare challenges in Texas will also become greater. For example, Texas remains one of only a handful of states that has yet to expand Medicaid under the Affordable Care Act. Additionally, due to an increase in maternal mortality in recent years and recent state laws banning abortion, this places a greater burden on the state to provide health care resources to low-income women and pregnant people in the state. Texas State Representative Jolanda Jones of District 147 is on the Public Health Committee and is committed to addressing the opioid crisis among pregnant and postpartum women in her district and in the State of Texas.

Scope of the Problem

Opioids are a group of drugs that includes both legal and illegal narcotics, such as heroin and fentanyl, as well as prescription drugs, including hydrocodone, oxycodone, morphine, and methadone (Centers for Disease Control and Prevention [CDC], 2022). In 2021, approximately 106,000 people in the United States died from drug-related overdoses, including illegal substances and prescription opioids (National Institute on Drug Abuse, 2023). In the United States alone, the number of women with opioid use disorder (OUD) has increased, specifically among pregnant women (Preis et al., 2020). Women with OUD during pregnancy are a vulnerable population with specific characteristics and needs (Preis et al., 2020). For example, due to the high prevalence of chronic pain in women, the presence of gender-specific disorders and psychosocial factors such as heightened sensitivity and emotional response to pain may help

explain why women are prescribed opioids and why there are gender-specific trajectories associated with the development of OUD (Preis et al., 2020). In addition, infants born to mothers with an OUD are at risk of developing withdrawal symptoms, known as neonatal abstinence syndrome (NAS), which often requires specialized care, extended hospital, and increased health care cost (Klaman et al., 2017). As a result, laws have been passed, and existing laws have been enforced as a means to deter and penalize women from using substances while pregnant (Stone, 2015). More importantly, this has also fostered an environment of fear and a myriad of barriers to adequate prenatal health care and accessibility to gender-specific substance use treatment for pregnant and postpartum mothers with an OUD.

Relevant Background

In the United States alone, it is reported that opioid use and misuse among pregnant and postpartum women have resulted in a public health crisis (Koehlinger et al., 2020). In addition, the rate of newborns diagnosed with NAS, which is typically related to opioid withdrawal symptoms, rose by 433% between 2004, and 2014 and this has resulted in 1.5 cases per 1000 hospital births to 8.0 cases per 1000 hospital births (Koehlinger et al., 2020). Here in the State of Texas, roughly one out of every four pregnant women treated to DSHS-funded treatment programs is opioid-dependent, resulting in over 1,000 deliveries of children with NAS in 2014 (Conduent, 2017). As a result, newborns with NAS symptoms have a greater risk of low birth weight and severe withdrawal symptoms, such as dysregulation of their central and autonomic nervous systems, sweating, fever, and uncontrollable seizures (Logan et al., 2013). It is important to note that all socioeconomic classes are affected by maternal substance use, and the present opioid crisis has impacted many communities, and sadly, this has resulted in limited resources for effective treatment (Sutter et al., 2016). For example, research shows that a significant

number of pregnant women may choose not to report their ongoing substance use due to concerns about confidentiality, fear of social stigma, fear of having their children taken away, fear of incarceration, and other potential legal implications (Sutter et al., 2016). Moreover, Sutter et al. (2016) argue how some healthcare practitioners have demonstrated unfavorable attitudes about pregnant women with an OUD and how some in the medical community often lack the expertise, training, and support networks necessary to serve this vulnerable population. As a result, women who are who are struggling with a SUD are often subjected to discrimination and stigma within the healthcare system (Sutter et al., 2016).

Recommendations about How to Address the Disparity via Policy

The American College of Obstetricians and Gynecologists (ACOG) (2021) created policies and recommendations regarding opioid use and OUD to help address and improve maternal and infant outcomes. These recommendations include the following:

- Utilize early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder to improve maternal and infant outcomes.
- Screen universally for substance use at the first prenatal visit in partnership with the pregnant woman.
- Include strategies for chronic pain, practice goals to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (e.g., exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.
- Recommend opioid agonist pharmacotherapy for pregnant women with an OUD, to help assist with medically supervised withdrawal. Withdrawal is associated with high relapse rates, which lead to worse outcomes. More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal.
- Have a pediatric care provider monitor infants born to women who used opioids during pregnancy for NAS.
- Modify some elements of prenatal care (such as expanded sexually transmitted infection testing, additional ultrasound examinations to assess fetal weight if there is a concern for fetal growth abnormalities, and consultations with various types of health care providers) to meet the clinical needs of the situation of a pregnant patient with opioid use disorder.

- Ensure that opioids are appropriately indicated before prescribing; discuss the risks and benefits of opioid use and review treatment goals; and take a thorough history of substance use and review the PMP to determine whether patients have received prior opioid prescriptions.
- Encourage breastfeeding in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.
- Enable access to adequate postpartum psychosocial support services, including substance use disorder treatment and relapse prevention programs.
- Counsel women of reproductive age undergoing substance use disorder treatment about contraception and access to contraceptive services.

Rationale for the Recommendations

As a licensed clinical social worker (LCSW) and licensed chemical dependency counselor (LCDC), and a woman in long-term recovery, I strongly identify with this population and the challenges of ongoing substance use. I am in full agreement with the recommendation of the ACOG because research shows there are effective interventions to help treat an OUD, which include such as MAT services and gender-specific substance use treatment, and how these measures may lead to good results for both the mother and her newborn. More importantly, the ACOG is a strong advocate for evidence-based practices to help address opioid use during pregnancy, supports a pregnant woman's access to appropriate treatment, and believes that pregnant women who have an OUD should receive medical care and counseling services, not be subjected to punitive measures. From a social work perspective, without a comprehensive, coordinated response that includes child welfare and healthcare, including obstetrics, pediatrics, substance use treatment, and mental health professionals, I believe pregnant and postpartum opioid-dependent women are not well served with dignity and respect. Therefore, I advocate for a cross-system initiative, which may lead to better results by facilitating better communication, clearly defining the roles of the various professionals who serve women with an OUD, and

maximizing the resources of multiple stakeholders who have a vested interest in accomplishing shared goals.

Expected Outcomes

I currently work at a non-profit facility known as Santa Maria Hostel and we are one of the largest residential and outpatient substance use treatment centers in the State of Texas. Our population is specifically designed for pregnant and postpartum women with children. The Caring for Two is one of the 18 state-funded pregnant and postpartum intervention (PPI) programs that focused on opioid-using women and is designed to help improve mothers' birth outcomes women in order to reduce various risk factors for SUDs and encourage a healthy lifestyle. These programs are designed to be intensive wraparound services, providing intensive case management, educational programs (e.g., parent education, child development), individual and family counseling, peer recovery support, healthy mom-child bonding activities, assistance with finding MAT services, and residential/outpatient drug treatment as needed. Community outreach and engagement are also a strong component of the Caring for Two program, which involves targeting high-risk neighborhoods and high-risk individuals in order to provide education on high-risk behaviors, safe sex kits, safe drug kits, and HIV and hepatitis C testing.

With the recommendation of the ACOG, I believe the expected outcome will result in women achieving healthier pregnancies and births and better child safety outcomes and will help facilitate the development of an effective evidence-based work plan that addresses the needs of pregnant and postpartum women with an OUD and other issues related to substance use. However, without these recommendation, opioid use during pregnancy can expose an unborn child to a number of health complications, including low birth weight, behavioral issues, developmental delays, learning difficulties, birth defects, and even stillbirth. Moreover, in 2016,

hospital costs for NAS births totaled $572.7 million after adjusting for inflation, and the incidence rate of NAS in Texas in 2017 was 2.5 cases per 1,000 hospital births and is the most recent data available (National Institute on Drug Abuse [NIDA], 2020). Therefore, it is imperative to consider the recommendation of the ACOG.

Funding Considerations/Sources

The economic consequence of an OUD is substantial, and according to White et al. (2005), the annual healthcare expenditures for individuals with an OUD are estimated to be almost nine times higher than annual expenditures for those without such a disorder. However, cost-effectiveness and comparative effectiveness studies regarding opioid treatment found greater savings from use of MAT than from use of psychosocial treatment alone (Substance Abuse and Mental Health Administration [SAMHA], 2018). In the state of Texas, funding considerations and sources include the following:

- The Texas Targeted Opioid Response (TTOR) program, through the Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds, which allows the Health and Human Service Commission (HHSC) to expand prevention and treatment efforts that promote recovery and early intervention for populations identified as high risk for opioid use disorders.
- MAT services are primarily provided by the Opioid Treatment Programs (OTPs), which is covered under Medicaid as well as Federal grants, including SAMHSA's State Targeted Response, State Opioid Response, and the Substance Abuse Block Grant (SABG) that is administered by the State.
- The State of Texas also expanded substance use disorder treatment services designated for pregnant and postpartum women who have exhausted their pregnancy-related Medicaid coverage to allow for a seamless transition and to avoid any disruption in their opioid treatment services.
- The Neonatal Abstinence Syndrome (NAS) program, funded by the 84th Legislative Session, aims to reduce the incidence, severity, and costs associated with NAS in Texas. This program takes a multi-pronged approach to address NAS by:
    - Increasing targeted outreach services to engage women earlier in care.
    - Increasing availability of intervention and substance use disorder treatment services to pregnant and postpartum women to improve birth outcomes.
    - Educating and coordinating with the medical community to collaborate and integrate care.

- Funding research components to better utilize funds and resources of hospital and community partners and implementing specialized programs to reduce the severity of NAS.

Conclusion

Macro-level scrutiny of policy, along with advocacy is greatly warranted in ensuring policies that do not enhance stigma and punish pregnant women nor restrict access to evidence-based treatment for OUD. Moreover, there should be measures on the state level that are focused on sustainable funding mechanisms for policies and programs that promote access to comprehensive care, which includes medical and behavioral health. Lastly, there should be policy measures within Medicaid to expand treatment and outreach to women with a substance use disorder and ensure there are policies that can help increase the number of providers who specializes in the treatment of NAS and offers OUD medications and adequate wraparound services for women.

References

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion. (2017). Opioid use and opioid use disorder in pregnancy. https://ww.acog.org/clinical/clincal-guidance/committeeopinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.

Centers for Disease Control and Prevention (CDC). (2022, May 23). Substance use during pregnancy. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/substance-abuse-during-pregnancy.htm

Conduent. (2017). Texas medicaid opioid use during pregnancy management. https://www.hhs.texas.gov/sites/default/files/documents/jan-2023-durb-agenda-item9ciii.pdf

Klaman, S., Isaacs, K., Leopold, A., Perpich, J., Hayashi, S., Vender, J., Campopiano, M., & Jones, H. E. (2017). Treating women who are pregnant and parenting for opioid use disorder and the concurrent care of their infants and children: Literature review to support national guidance. *Journal of Addiction Medicine*, *11*(3), 178–190. https://doi.org/10.1097/ADM.0000000000000308

Koehlinger, C. D., Addison, D., Rodriguez, M., Rice, M. E., Frey, M. T., Hickner, H. R., Weber, M. K., Mueller, T., Velonis, A., Uesugi, K., Romero, L., Akbarali, S., Foster, N., Ko, J. Y., Pliska, E., Mackie, C., Cox, S., Fehrenbach, S. N., & Barfield, W. D. (2020). Implementing a learning collaborative framework for states working to improve outcomes for vulnerable populations: The opioid use disorder, maternal outcomes, and

neonatal abstinence syndrome initiative learning community. *Journal of Women's Health (Larchmont, N.Y. 2002)*, *29*(4), 475–486. https://doi.org/10.1089/jwh.2020.8303

Legislative Budget Board Staff Reports. (2019, April). *Overview of opioid crisis in Texas.* (ID:4830). https://www.lbb.texas.gov/Documents/Publications/Staff_Report/2019/4616_Opioid_Crisis.pdf

Logan,B. A., Brown, M. S., & Hayes, M. J. (2013). Neonatal abstinence syndrome: Treatment and pediatric outcomes. *Clinical Obstetrics and Gynecology*, *56*(1), 186–192. https://doi.org/10.1097/GRF.0b013e31827feea4

National Institute on Drug Abuse. (2023, February 9). Drug overdose death rates. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

National Institute on Drug Abuse. (2020, April). Texas: Opioid-involved deaths and related harms. https://nida.nih.gov/download/21987/texas-opioid-involved-deaths-related-harms.pdf?v=84c6dcf6e6fc9937ce09187d9cb0165c

Preis, H., Inman, E. M., & Lobel, M. (2020). Contributions of psychology to research, treatment, and care of pregnant women with opioid use disorder. *The American Psychologist*, *75*(6), 853–865. https://doi.org/10.1037/amp0000675

Stone. R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice*, *3*(1), 1–2. https://doi.org/10.1186/s40352-015-0015-5

Substance Abuse and Mental Health Administration (2018). Medicaid coverage medication assisted treatment for alcohol and opioid use disorders and medication for the reversal of opioid overdose. https://store.samhsa.gov/sites/default/files/d7/priv/medicaidfinancingmatreport_0.pdf

Sutter, M. B., Gopman, S., & Leeman, L. (2016). Patient-centered care to address barriers for pregnant women with opioid dependence. *Obstetrics and Gynecology Clinics of North America*, *44*(1), 95–107. https://doi.org/10.1016/j.ogc.2016.11.004

White, A. G., Birnbaum, H. G., Mareva, M. N., Daher, M., Vallow, S., Schein, J., & Katz, N. (2005). Direct costs of opioid abuse in an insured population in the United States. Journal of Managed Care & Specialty Pharmacy, 11(6), 469–479.