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CARING FOR PREGNANT PERSONS WITH SUBSTANCE USE DISORDER: SHIFTING FROM CRIMINALIZATION TO CHRONIC DISEASE MANAGEMENT

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[video transcript]

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Presenter Dr. Alexandra Douglas is an attending OB GYN in the generalist division at Montefiore Medical Center, where she serves as the residency residency rotation director for the wider labor floor and leads their program on substance use disorders in pregnancy. Her broad background is somewhat atypical, she studied International Studies and feminist and queer studies at Macalester College. Her early research focused on harm reduction and sex worker unionization efforts. She lived and worked all over the world, from Thailand, Venezuela and Bolivia to Norway and Burundi. before finally settling on settling on a career in medicine. Dr. Douglas completed her post baccalaureate premedical program at Hopkins and medical school in addition to a Master's in Public Health here at Sinai, before continuing on to residency at Montefiore. She continues to be involved in global health and passionate about social justice. Over to you Dr. Douglas.

01:09
All right. Thank you so much. Good morning, everyone. Thank you for that kind introduction, Lauren. As she said, I'm Dr. Alexandra Douglas and today I will be presenting on caring for pregnant persons with substance use disorders shifting from criminalization to chronic disease management. I have no financial disclosures, I will say that I will be mentioning some off label uses of medications, as they're used within addiction medicine. And I'll just highlight these medications as such. So our objectives today are fourfold. First to understand through example, how racial and moral constructs have historically and into the present day shaped medical diagnoses of substance use disorders in pregnancy. I'll then provide a brief overview of the scope and impact of substance use disorders in pregnancy and shift briefly into a review of evidence based management of use specific disorders. through the lens of chronic disease management will then review key issues faced by pregnant persons with substance use disorders while navigating pregnancy and our care system. And finally, we'll review how to provide appropriate referral for these patients. So focus, focusing on our first goal. I like to just take a moment and have everybody just visualize when you think of the following terms such as crack, baby, trunk, baby, cocaine kid, what are the images that come to mind? We don't have the microphones enabled. But I just want you to think of these images and note for yourself, have you made any racial associations with these first images that come to your mind and a class association? Do you think of areas that are more urban versus rural? And do you have any ideas about what the long term outcomes or abilities of these children may be? And when you ask yourself, Where do these images come from? And why are those the things that come into your mind, it's really important to begin to contextualize this history. Because if we look back at the data going back to the 1980s, and the 1990s, and through today, what you see is that the rates of drug use, as well as the rates of drug sales have been almost identical between races. In fact, if anything use is actually higher among white identified people. However, when we begin to look at the rates of drug related criminal legal measures, black people are 6.5 times more likely to be criminalized or incarcerated for drug related crime. And when you begin to look

specifically at pregnancy related drug criminalization, black pregnant women are almost 10 times more likely than white women to be charged with drug related crimes. And so when we look at the history of this, we have to recognize that there is a very long history of family regulation and separation within the legal system. And this goes back to slavery and taking children away from enslaved parents, a pattern that was perpetuated into segregation and into the drug wars, and the ongoing industrialized criminalization of black people in this country. Harriet Washington, who's the author of medical apartheid, who in her book, document how the history of medicine is intertwined with racist ideology shows how medicine is made up of quote, unquote, medical myths. Academics may know that these myths are not factually true, but they are so grounded in the thoughts and values of our culture that they've actually become academic medicine. And so in her chapter on the drug war, she exposes how in 1985 there was a New England Journal of Medicine article that was published by Dr. Ira Chasma, which describes the babies born to cocaine using mothers as smaller moodier, sicker and less social than their counterpoint. their counterparts. Dr. chesnoff was very clear Despite the limitations of this study, as there were only 23 infants involved and there was no control group. But it sparked an entire cultural phenomena based on the findings of these studies. If you begin to look at news articles, and the role that news played with how we began to respond to these babies, and to pregnant mothers within the medical fields, you begin to see a plethora of articles like what we see here, the Washington Post warned that quote, the inner city crack epidemic is now giving birth to the newest horror of bio underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth.

05:45

I think it's clear here that inner city, inner city was referring to urban poor black population, and that we are assigning an underclass and biological inferiority with explicit racism. This is very different from what evidence based practice actually tells us. Yes, cocaine crosses the placenta and the fetal blood brain barrier. vasoconstriction is the major purported mechanism of placental impact, and there is likely an association between cocaine use and preterm birth and low birth weight. But the applicability of most of these studies on cocaine use has been limited by major methodological shortcomings, such as the failure to account for maternal age, parity, socioeconomic status, or other substance use, particularly alcohol and tobacco. Most of what has been perpetuated by this myth that a baby can be born addicted to crack cocaine, that children exposed to crack cocaine in utero have lower IQs and that there is a difference between perinatal exposure to crack and cocaine has been completely debunked. But the impact of this myth has persisted within obstetric practice. If you look throughout any major news outlet, you can see the same thing. Drug orphans, parents who can't say no, for the pregnant addict crap comes first crack smallest costliest victims a time bomb and cocaine babies. There are these major headlines asking, Can the children be saved. This created this idea that a single episode of substance use was equal to a substance use disorder, which was equivalent to bad parenting, and therefore that these individuals were criminals. In 2018, The New York Times editorial board actually published an apology stating, quote, that news organization shouldered much of the blame for the moral panic that cast mothers with crack addiction as irretrievably depraved, and the worst enemies of their children. We demonize black women addicts, by wrongly reporting that they were given birth to a generation of neurologically damaged children. The myth of the crack baby crafted from equal parts, bad science and racist

stereotypes was debunked by the turn of the 2000s. But by then it had been written into social policy and legal code. And we still see this within hospital policy, the 1980s and the crack epidemic led to the policy of test and report. This means that we as doctors, particularly obstetricians should test pregnant woman who had scant prenatal care, a history of drug use, placental abruption, intrauterine fetal demise, and a behavior suspicious for drug use, and report them to child protective services if the urine toxicology was positive. And you can see here that behavior suspicious for drug use can lead to all sorts of implicit bias and policies, such as scant prenatal care, which do not take into account then many barriers to accessing our health system. Yet, even as I stand and give this presentation, this is the primary policy at most hospitals in this country. And yet, we know and I can say this from data of my own institution that this leads to racist practices. This study was performed at Montefiore in the early 2000s. It showed that performing urine toxicology under these policies resulted in black women and their newborns being tested 1.5 times more frequently than their white counterparts, even though positivity rates were equal. And a current retrospective study review is showing that these trends have persisted. So where does that leave us? We have to begin to recognize that we as OB GYN and other pregnancy care providers and medical providers have been complicit in perpetuating a war on drugs and in participating in the separation and regulation of black and brown families. As Jamila Paris, the President and CEO of physicians for reproductive rights said the notion that medical providers are unbiased and objective. Practicing within a profession free from the legacies of racism, genocide and white supremacy is fictitious. This a historical view has caused tremendous harm. visits to the OBGYN to seek pregnancy care or for delivery can be an entry point into the criminal legal system for parents and into state custody for children. Unless you think that this is something of only the past, there are innumerable examples of women in the present day, being criminally charged for substance use in pregnancy, such as native woman, Britney Pula, who was just charged with manslaughter, and charged was four years in state prison after having cocaine in her system at the time of her second trimester loss. These myths are so ingrained in our systems and our policies that most providers are not aware of evidence based management of substance use disorders in pregnancy. Most of us lack the knowledge of professional society recommendations, and we misinterpret urine toxicology screening and do not understand the difference between a toxicology screening and a confirmatory test. And we do not know our own legal requirements, all of which leads to over reporting. But it also results in an inherent conflict between the healthcare provider and patient. We cannot be both prenatal care providers and law enforcement agents. This leads to mutual mistrust as well as reified systematics met medical racism.

11:34

So we're now going to switch on to our second objective. My goal here is to provide a very brief overview of the scope of substance use in the US, as well as provide use specific management and pregnancy through the lens of chronic disease. So what is the scope of substance use in the US this is from a national survey that's published every year in the US on people 12 or older. 60% of US Nationals report using some substance including alcohol or tobacco within the last month. If we narrow this down to just illicit substance use, we see that 20% of us Americans report using an illicit substance within the last year. And if nope, marijuana is included in this because while it's legal for recreational use in 15 states and medical use and 30 states at the

federal level, it is still considered illicit. What do we take from this substance use is very common, and while substance use is common, and can result in a positive toxicology screen. Substance use is very different from a substance use disorder, which is defined as the problematic pattern of substance use, leading to clinically significant functional impairment, or distress as manifested by health problems, disability, or failure to meet responsibilities at work, school or home. What we see in pregnancy is that substance use is also quite common. Well, overall pregnancy is considered a protective factor, almost 20%. If you look down here at the bottom of pregnant persons in 2018, and 2019, reporting using some substances including alcohol or tobacco in pregnancy, of these the majority of substances used for alcohol or tobacco, but five to 6% of pregnant women do report using some illicit substance. Of all those women reporting, use, about 15% will meet criteria for a substance use disorder. Substance use and substance use disorders do have a significant impact on pregnancy and postpartum. When we look at pregnancy associated deaths, which is defined as death from all causes within one year of pregnancy, an estimated four to 10% of these deaths in the United States are due to substance use and unintentional overdose. This number is even higher in some areas. There have been studies in Maryland in Utah, which show that as many as 24 to 38% of pregnancy associated deaths have been associated with overdose. To give a comparison that many of us is obese are more familiar with both postpartum hemorrhage and preeclampsia are hypertensive disorders account for eight to 10% of these pregnancy associated deaths. New York City actually just released their data from 2016 to 2018. From the maternal mortality review, and Dr. Nice

14:30
Lisa Nathan was kind enough to allow me to use her slide with you today. What we see, which is consistent with data across the country, is that mental health accounts for the largest portion of pregnancy associated morbidity and mortality in New York City. And that overdose accounts for 75% of these deaths, which makes overdose alone one of the leading causes of maternal mortality in New York City. And while the final data is still pending, it does look like this percentage is rising for 2019 and 2020 data. The contributing factors of this are many. One is that postpartum physiology is postpartum physiology and the fact that tolerance has often changed in the postpartum period, and so the risk of overdose is actually much higher. We also know that the postpartum period is high risk for depression, and access to Postpartum Support and therapy can be very challenging for patients. In addition, postpartum patients face the demands of newborn care, child welfare law, insurance change or loss in the postpartum period and accessible treatment programs for parents, lack of prioritization of treatment in the postpartum period, and clinician lack of knowledge of treatment continuation, as well as discrimination in the pregnancy and postpartum period. I also like to highlight that there are studies showing that the risk of overdose is higher in parents who choose adoption due to grief over the loss of a child, and in women who have chosen termination, often because they are not offered treatment at the time of their termination. There was a study done in Canada that showed that the removal of a child from the home increased the rates of overdose by 55%, and that there's an emerging body of evidence demonstrating a link between child custody loss, grief, and maternal morbidity and mortality. This study also showed that the risk further increased if the mother identified as indigenous or from a marginalized community. But what it comes down to is that the postpartum period can easy stabilizing for patients with substance

use disorders, particularly when combined with the family regulation system and child custody law. It's also important to note that most of these deaths occur in women and persons with unrecognized and untreated substance use disorders. And that most of these deaths that have been investigated through maternal mortality review committees, that most of these persons have been in contact with the healthcare system, or obstetricians before their death, which means that there were probably missed opportunities for intervention and prevention. I'm now going to briefly overview the evidence of individual substances in pregnancy. And I'm gonna go quite quickly through this section. As it's probably the easiest to look up. There is a February 2022 edition of the green journal that has an excellent clinical expert series on what OB GYN and pregnancy care providers should know about substance use disorders in the perinatal period that provides an excellent overview to refer back to. So how do we actually manage substance use disorders in pregnancy? In summary, yes, abstaining from substance use in pregnancy and lactation is the safest option. However, it can be very challenging to do so. And it is definitely not the only treatment option. In fact, abstinence can increase the risk due to in pregnancy due to the risk of return to use and relapse, but returned to use does not mean that treatment has failed. It merely means that treatment needs to be modified. And it's important to remember that abrupt absences abstinence from certain substances can actually be very dangerous, and even life threatening.

18:34
I think it is most helpful to think of substance use disorders. As the management of chronic disease. We all know that the management of chronic disease involves changing deeply rooted behaviors. And we also know that relapse and chronic disease is quite common. If you think of pregnant patients with chronic hypertension, asthma, diabetes, and you think of patients who have worsening hypertension due to not taking their medication, or due to the physiologic changes in pregnancy, worsening asthma exacerbations due to pregnancy, or because they could not access their meds. Substance use disorders are no different. And I find this table helpful because it provides a visual rate of the rates of relapse between substance use disorders and other chronic diseases. And what you see is that the rate of return to use with substance use disorders is actually significantly lower. So if we begin to look at individual substances, we all know that alcohol is illegal substance, with about 10% of pregnant patients reporting alcohol use in pregnancy. It is significantly associated with increased rates of miscarriage and stillbirth and causes fetal alcohol spectrum disorder, which is the leading modifiable cause of intellectual disability and developmental delay in the United States. It is unclear how much alcohol is safe or unsafe in pregnancy, because not everyone who drinks will have a child with fetal alcohol Through disorder, but even low levels of alcohol have been associated with fetal alcohol spectrum disorder, which is why ACOG recommends against any alcohol use in pregnancy. However, the most important thing to remember is that the abrupt cessation of alcohol can be very dangerous, and that a patient who is alcohol dependent trying to cut back or abstain and pregnancy should be referred for inpatient management. There are three FDA approved medications for the treatment of alcohol use disorder. But none of these have been evaluated in pregnancy. Most likely they are all safe. We have limited data on the use of naltrexone for the on the use of naltrexone for opioid use disorder and pregnancy, and have experience with similar classes of medications as I fell for a minute can proceed. But with as with anything, you must weigh the risk of untreated alcohol use disorder, in pregnancy and

postpartum with the possible risk of medication in terms of benzodiazepines. Historically, there has been some concern for an association with cleft lip or palate, but most prospective studies have failed to report this finding. Some studies show increased risk of low birth weight, but others have not. There is evidence that a prolonged in uterine exposure can lead to a neonatal abstinence syndrome, similar to opioids, but it is treatable is appropriately monitored, and there have been no long term effects on childhood cognitive development or intelligence. benzodiazepine can worsen the withdrawal from other substances, and like alcohol the abrupt sensation of benzodiazepines can be very dangerous. And a person who has benzodiazepine dependence and trying to cut back should be referred to for inpatient management with a taper. But given that there are no notable fetal effects, there's no additional fetal surveillance that is required. Tobacco is probably the most common substance use in pregnancy, with approximately 10 to 12% of all pregnancies reporting some tobacco use. It probably has some of the most pregnancy associated morbidity. Tobacco use increases the risk of ectopic pregnancy and also is associated with a significant increased risk of stillbirth pre term pre labor rupture of membranes, preterm birth, fetal growth restriction and placental abruption. It does have significant post birth effects with doubling the risk of sudden infant death syndrome. And it may be associated with attention deficit disorders and children an increased risk of infection and breathing problems. And I think this is the area that at least is obese we are the most familiar with and behavioral intervention is the mainstay of our treatment in pregnancy. Data for nicotine replacement and other pharmacologic AIDS is fairly limited, and should only be performed in detailed discussion of the risks of smoking in pregnancy. In general, nicotine replacement is probably safer than smoking because of the particular harms of smoke itself. But some studies have not shown improvement in perinatal outcomes. Bupropion and Periclean have not been studied specifically in pregnancy, but do not appear to cause any specific teratogenicity. It is recommended that due to the significant placental effects that pregnant persons with significant smoking and pregnancy, we monitor with gross comas every four to six weeks.

23:35
The evidence on the fetal effects of cannabis is conflicting and unclear. Some studies associate cannabis use with increased rates of preterm birth, but they were unable to control for many confounding factors. There have also been concerns about the neurodevelopmental impact, but a 2020 systematic review showed that children with cannabis exposure largely fell within the normal range. Of note given the unknown effects ACOG still recommends against any cannabis use in pregnancy. And it should most pregnancy care providers should be aware that the newer synthetic cannabinoids may have effects on hypertension and respiratory distress. But the perinatal effects are currently limited to just case reports. In general if a patient presents with cannabis use, we should explore if patients are using it to treat nausea, pain or anxiety, as it is often perceived as safer and more natural than other pharmacologic agents. And if so we should work with patients to provide alternative management option. There are no FDA approved medications for treatment of cannabis use disorder, but no additional fetal surveillance is required in pregnancy. will now transition to opioid use disorder. opioid use disorder probably has the largest amount of D EDA available given the current opioid epidemic, important to recognize is that opioid use has no associated adverse effects. Untreated opioid use disorder has been associated with placental abruption, preterm labor, fetal death, and overdose and the parent, which can lead to possible hypoxia or death of the fetus. The risk of opioid use disorder

in pregnancy is largely due to the baby experiencing neonatal abstinence syndrome or opioid withdrawal, but it is very treatable when recognized. Overall, the long term effects of children born to parents with opioid use disorder appear similar to children born with no exposure. So when you identify a patient with opioid use disorder historically, it was believed that patients needed to withdrawal from opioids and pregnancies. However, we have very effective treatments for the management of opioid use disorder and it is not recommended that patients undergo detox or medically supervised withdrawal in pregnancy, as the risk of overdose significantly increases due to the loss of tolerance. There are three FDA approved medications for opioid use disorder, methadone, buprenorphine, and naltrexone, only to have significant evidence in pregnancy, methadone and buprenorphine. However, there are smaller studies demonstrating the safe use of an L TracPhone. The mechanisms are different and they are differently regulated by the DEA, which can have an impact on the patient's experience with these medications. As I'm sure this audience is all very familiar. Methadone is a full new opioid agonist and is a long acting medication and has a very long effect. But it is a schedule two drug and so must be dispensed at an outpatient treatment program. And you're required to participate in counseling, which can be very onerous, particularly on pregnant patients. Because especially well beginning and treatment and methadone, you must pick up daily medications. And even with prolonged treatment, you're limited to a limited 14 days supply. And contrast, buprenorphine is a partial new opioid receptor agonist with high affinity for the receptor. It's a schedule three DEA medication and therefore can be prescribed in the outpatient setting and dispensed at community pharmacies. And while we must have the ability to refer for counseling, it's not required in order to receive this medication. However, patients do need to be within my withdrawal to start buprenorphine, which can be a limiting factor in pregnancy. Naltrexone is immune receptor antagonist it finds and blocks the mu opioid receptor and blocks the euphoric effects of opioids which can also decrease cravings. It is not a controlled substance, however, there's very limited data in pregnancy. All of these medications have been shown to reduce all cause mortality, to decrease illicit opioid use increased retention and treatment and decreased criminal legal involvement. With regards to pregnancy.

28:09

Historically, treatment was limited to just methadone. However, the mother trial was the first large randomized trial comparing methadone and buprenorphine. And what we saw is what is shown in the graph on the right, that people in orphan results and lower doses of morphine for neonatal abstinence syndrome, shorter duration of neonatal abstinence syndrome and a shorter hospital stay. Three subsequent multicenter randomized controlled trials have shown no difference in the maternal and neonatal effects, and outcome, both are safe. However, buprenorphine may be associated with fewer adverse effects for the mother. It's important to recognize that patients who are interested in treatment for opioid use disorder should be referred. In New York State pregnant patients get priority access to opioid treatment, and we'll be able to skip any waitlist for treatment programs. And any patient who you believe requires inpatient stabilization at any gestational age should be referred for inpatient management on antepartum. And I would encourage you to establish these referral protocols with your antepartum unit. Otherwise, at least at my institution, if a patient desires to start pooping orphan and is under 24 weeks, or the age of viability, they are most likely a candidate for outpatient induction of buprenorphine. However, if they're greater than 24 weeks in most institutions

across the country, we do refer them for inpatient induction on antepartum. However, there are some studies looking at options for outpatient induction beyond 24 weeks. One of the most important aspects of caring for a patient with opioid use disorder is providing anticipatory guidance. It is very very common for patients to experience increased withdrawal symptoms and cravings, even when they have previously been stable on methadone or buprenorphine for years. This is normal and common in pregnancy due to physiologic changes, but it can cause patients great anxiety. If they're not prepared for it, often patients will need their dosing split or will have dose increases throughout their pregnancy. That patient should be counseled that this can be rapidly titrated down after delivery. pregnant patients and their loved ones should receive naltrexone if they have opioid use disorder. their risk of overdose is increased in pregnancy due to again physiologic changes, changes in weight and body mass that affect tolerance. And Well historically, there were concerns about precipitating withdraw, the risk of fetal hypoxia and death from overdose far far outweigh the risk of fetal distress from overdose reversal. And given that there are no significant fetal effects, there's no additional fetal assessment that is required in pregnancy. Finally, coming back to stimulants, which is what we began our presentation on today. As we discussed, there is data that shows that stimulants such as cocaine, decreased blood flow to the placenta, which can lead to increased blood pressures and the risk of preeclampsia, seizures, heart attack, stroke, and pulmonary edema in the pregnancy period. There is an increased risk of preterm pre labor rupture of membranes, which can cause fetal growth restriction, low birth weight, but the data is not clear and likely confounded by smoking and diet. Additionally, while classically there's an association with placental abruption, that evidence is actually quite poor and likely does not control for confounding factors, such as smoking, which we know leads to an increased risk on placental abruption and the absolute risk is still quite low.

32:01

There is no evidence of a stimulant withdraw and neonates and long term outcomes of children exposed to stimulants are similar to children who are not exposed. There are no FDA approved medications for the treatment of stimulant use disorder. Many medications are being trialed, but their use is still off label. Multiple studies have been done on antidepressants which appear to have no effect. There is modest improvement in periods of absence with buprenorphine and Topiramate and psychostimulants. But this use is still off label, and therefore each individual medication would need to be checked for defects in pregnancy, as some do have associated teratogenicity. We must always remember that the beta blockade that beta blockade is contra indicated after cocaine use, because it can lead to unopposed Alpha adrenergic stimulation leading to visa spasm. And so if there are concerns that a patient may have recently used cocaine, pregnancy care providers should avoid using the law in the setting of acute hypertension. However, it's often asked if this is a medical indication of a urine for urine toxicology. And it's important to recognize if you were ever consulted for these patients, that most of the time, pregnancy care providers will need to make clinical decisions about how to manage acute hypertension before they would have the results of a urine toxicology screen back. And so if you're concerned, it's better to just avoid labetalol from the get go. And a toxicology screen is not likely indicated for this decision alone. Due to time, I'm not going to spend a lot of time going over these next two slides and Jeff in detail. But in general, what you should know about breast for chest feeding is that you should familiarize with yourself with a

varying time to take for each of the substances to leave the body. And that patient should be recommended to pump and dump for these periods. A cog does formally recommend against breastfeeding with any cannabis use. However, most data suggests that it's probably still safer to breast for chest feed and smoke than formula feed and smoke. So one notable exception is that patients who are in treatment for opioid use disorder that breastfeeding is absolutely encouraged if a patient is on methadone, or buprenorphine as it significantly reduces the rates of neonatal abstinence syndrome or neonatal opioid withdrawal syndrome, but breastfeeding should still be avoided if there is use of heroin or other unregulated opioids.

34:42
So I'm now going to move on to our third objective to review key issues faced by pregnant persons with substance use disorders for navigating care system. I think this is probably the most important section of my talk today, because in the first part, we reviewed how bad science and racist media lead sucks Since use disorders and pregnancy being criminalized, we then reviewed the evidence which shows that while substance use disorders can have a significant impact on maternal morbidity and mortality, especially when combined with the family regulation system and child custody law, that most substances apart from alcohol and tobacco, have no long term fetal or neonatal effects. And so when managed appropriately substance use disorders can have significant impacts on the family unit, but that most data shows that it is family separation, that has the greater impact on childhood development and maternal health. And so in this section, I'm reviewing key places where we as providers can help mitigate a massive amount of harm. So how do we identify patients with substance use disorders? If we look at a COC and other professional society recommendations, they state that screening only based off of factors such as poor adherence to prenatal care, or adverse pregnancy outcomes, will lead to miss cases of substance use disorders as well as leads to stereotyping and stigma. Therefore, ACOG Wrexham recommends that it is essential that screening be universal, and that it'd be performed with a validated verbal tool. And it is important to note that ACOG recognizes that a positive biochemical direct test is not in itself a screening test, or diagnostic for a substance use disorder for its severity. ACOG recognizes that urine toxicology screening does not test for alcohol or tobacco, which as we mentioned, have the greatest fetal impact. And in addition, urine toxicology screens have the potential for a ton of false positive and false negative results, and that there are varying lab cut offs for sensitivity. Most pregnancy care providers do not use urine toxicology screening appropriately. Because a positive test actually requires confirmation. I've given this talk to obese and I've often asked how many providers have ever sent a confirmatory test after you talked. And the majority say no, because it is not part of our training, and most people have never seen the algorithm for confirmatory testing. But in addition, the use of urine toxicology screen due to this historic and present day legacy of testing report leads to increased risk of child welfare involvement, which increases risk of adverse outcomes for both the child and the neonate. And even though there is no association between the test results and parenting capabilities, a positive urine toxicology screen has been used by the state for the basis of child removal and almost half of removal of children under one month old, and it is often applied selectively and in a racist fashion. So a cop recommends a universal verbal screening tool. There are multiple validated screening tools in pregnancy, such as the knight equip screen, the integrated five P's, a substance use risk profile pregnancy scale, and the four Ps plus, I personally like the night a quick screen because you can essentially just use

a one question screening tool for each alcohol, tobacco prescribed medications with unintended use and illicit drugs. And then if somebody answers yes, you can then follow up with a number of questions, such as lifetime use of substance over the last three months, if you've ever had a strong desire or craving, and whether or not it leads to health, social, financial or legal problems. And you can see this is very, very different from the sort of screens that a urine toxicology does, which has a high chance of false positives that only shows whether or not a person has a substance in their system, versus if the patient substance use is actually impacting their life and their ability to meet functional needs. And what I like about the non NIDA modified screen for pregnancy care providers, it then gives you a risk assessment of the idea of their risk of their current substance use, which somewhat correlates to the actual guidelines for a diagnosis of substance use disorder. So when we talk about urine toxicology, and when it should actually be used in pregnancy, it's important to recognize that if you look at evidence based use of urine toxicology, screening, urine toxicology, is really limited and it's as an evidence based tool to its use and therapeutic monitoring and evidence based addiction treatment. That's it. It is not recommended during pregnancy, Perry or postpartum or in the newborn unless it's medically indicated. I have tried to look at what a medically indicated use means outside of addiction treatment, and there is not a clear definition. It is likely left vague for the provider to decide from the cells as needed. But as we discussed in the setting of cocaine, most clinical decisions can be made and will be made without the results of a urine talk Psychology and the Utak is not a confirmatory test. But it is used all professional societies from a call to the American Society of Addiction Medicine state that informed consent must be obtained by the patient or the parent, and must include a medical indication for the test, the ramifications of positive results, and the right to refusal. So one of the most important things when we're caring for patients with use disorders in pregnancy is that we understand our legal landscape. The laws around substance use disorders in pregnancy vary vastly by state, even within one state varying providers and agencies will interpret laws differently.

40:43
And so in that can be within a state and within one hospital. And it's important to note particularly if you move outside of New York, that the laws can be so severe around substance use disorder in pregnancy, that some in some states, it's recommended that a pregnant person consult with a lawyer prior to disclosing substance use to their prenatal care provider. When we look specifically at New York State.

41:10
This is this is the summary slide that I would just burn into your mind substance use in pregnancy is not a crime in New York State and it is not legally considered child abuse. A person cannot be involuntarily committed for substance use disorder in pregnancy. Healthcare workers are not mandated to report substance use during pregnancy delivery or postpartum periods to Child Protective Services, and health care providers are not required to perform urine toxicology testing. We know that prenatal care improves birth outcomes that disclosure of a substance use disorder is a personal choice. And patients may have many reasons for not disclosing substance use. But when it is disclosed, it allows for referrals to treatment, coordination of care, and the development of plans of safe care, which I will discuss briefly afterwards. But we must counsel patients that even once you have developed a therapeutic

relationship with your patient, the doctor delivering the patient is often not their prenatal care provider. And what's challenging is that any member of a care team, doctor, nurse, social worker pediatrician, can report the patient to the statewide central register all for child abuse in the administration of Child Services, even if other members do not want to report files. And once a report is made, it is out there. And the prenatal care provider may then legally be required to answer questions and disclose any discussion about a patient's substance use. And just to outline what this looks like for a patient when there's a finding or suspicion. In the ideal world, there would be a verbal screening and a plan of safe care developed. But if a report is made by anyone on the care team, the call becomes known as what is an oral report transmittal and then sent to the appropriate jurisdiction, you get assigned a caseworker and the investigation begins. And with or without patient permission, state officials will begin to speak to family, friends, health care providers, about you and your parenting ability. These questions can be broad and very intrusive. And there are often blanket requests for medical and mental health records and surveillance of medical and mental health services. Officials can drop into your home at literally any time for an unannounced visit. And if there's suspicion for an unsafe home, the child is removed from the home and a court case open. A conditional plan may be developed which requires parenting classes entering treatment programs, frequent check ins and home visits. And if you don't comply, this can result in open court cases, which requires obtaining an attorney and legal fees. And if your child is out of the home for 15 to 22 months, your parental rights may be terminated. These investigations can be very disruptive, it can disrupt patient's ability to go to work to keep a job to seek treatment, which leads to compounding system which favors family regulation and separation over keeping families together. And as we discussed, child custody loss increases the risk of return to use an overdose. And it also has significant harm as data shows that removing children from the family of origin and placing them outside the home has been associated with negative developmental consequences. In 2016, and amendments, the Federal Comprehensive Addiction and Recovery Act provide a new provision to the Child Abuse Prevention and Treatment Act which will now call cap Takara. To support newborns and their caregivers affected by substance use. This amendment does reiterate that substance abuse alone is not an indicator of child abuse and maltreatment or neglect. It requires data collection on the number of substance affected newborns by hospitals, and requires the development of plans of safe care as a tool to support family he's impacted by substance use, with the goal to ensure that families are receiving comprehensive support, care and treatment that meets their needs. And yet, while this law passed in 2016, it has not been implemented by states in a way that held any sort of legal action until now. And November of last year, New York State finally issued guidance on how it's going to implement these amendments. A letter was sent on November 23, to hospital, which reiterates again that substance use is not an indicator for child abuse. But that requires hospitals develop a plan of safe care for all pregnant persons diagnosed with a substance use disorder. There is no requirement that the administration of child services be involved in the development of a plan of safe care. And it's reiterated the New York state support for ACOG guidelines that we should be using universal verbal screening to evaluate for substance use disorders and pregnancy, and that they do not recommend the use of urine toxicology and screening postpartum or in the new form, unless medically indicated, they also state that hospitals must develop an informed consent policy demonstrating the medical indication and the right of refusal. Hospitals has 60 days to implement this. And so this technically went into effect on January 22. However, many

hospitals have not yet finalized their policies for developing these plans. So what actually is a plan of safe care, we all now have this legal requirement whether we know it or not, and most of us don't really know what it is. It is essentially a document which identifies how a provider, family and community can support the family, the safety and well being of the newborn and the person who gave birth. It should be personalized for each individual patient and it addresses their basic needs, identify support systems, and creates links to necessary services or community based organization as appropriate for each patient. A plan a safe care should be developed for all pregnant persons who are diagnosed with a substance use disorder, receive medication for addiction treatment, or who are under the care or supervision of a health care provider who is prescribed opioids. A played in a safe care can be developed by any healthcare or social services provider, including the pregnancy care provider, primary care physician, substance use treatment programs, social workers, case managers, or hospital discharge planners. This is the suggested plan of care by New York State, it should identify the person who their support people are, how they contact them, who their medical team is, and the types of assistance that they may need and how who they can call on for help. In addition, there is this third page which highlights the patient's strengths, what are their potential triggers and what they could do to support themselves and their baby in the setting of return to use. New York State recommends that healthcare providers should obtain consent to document the existence of planet safe care, and that patients should be given a copy to carry with them to the hospital or birthing center. If a patient does not have a plan of safe care on arrival, it should be developed on discharge, and were legally required to create provide a warm linkage to appropriate community based support and health care providers. And this just essentially provides the workflow for us in the hospital setting that, particularly if a neonate is identified with symptoms of withdrawal, that first and foremost, we should evaluate true safety if there are concerns for the true safety of a child a report should. But otherwise, that should be developing a plan of

48:37
care and establishing referrals for support and treatment. But what's most important is how this changes the experience. disorder and I do apologize for my dog in the background. Or our words and our approach to patients matters. There have been studies that show bias and discrimination experienced by patients, particularly their OB negatively impact them and their ability to receive high quality prenatal care. And it's our job to emphasize that substance use disorders are chronic diseases that can be effectively treated. And we must tailor our care to patients specific needs, because they will have higher retention rates, reductions in substance use and fewer barriers to care. And so I'm sure all of you are familiar with this, but how we can just change our language. Instead of using words like pregnant addict, user junkie, shifting our language to a pregnant person with a substance use disorder or instead of talking about drug babies or crack babies Nast babies to an infant with signs of withdrawal from prenatal drug exposure.

49:54
I'm about to move on to our last objective which I'm going to try and wrap up fairly quickly about appropriate referrals. But I just want to provide these last two points about providing knowledge and non judgmental and supportive care. The decision to carry a pregnancy to term is a very personal one. And it is very common to have conflicting emotions. It is important that we tell our

patients that medications for the treatment of substance use, or that using alcohol, tobacco or other drugs should never ever be the reason a patient needs to have an abortion if she otherwise does not want one. However, as we discussed, there is increased risk of overdose following termination. And so if a patient does opt for termination, we should be establishing referrals for treatment for these patients. Similarly, early pregnancy loss which as you can see here, is extraordinarily common, particularly as we get older, should never be blamed on substance use. And as providers, we should be providing reassurance and support for these patients. So lastly, just to summarize our last goal on providing appropriate referrals, the exact instance protocols will vary by institution, but care for pregnant patients with substance use disorders does require a multidisciplinary approach. At most institutions, we tend to be very, very siloed. But providing coordinated care for our patients with anticipatory guidance is extremely important for harm reduction. And these teams should include the pregnancy care provider, substance use treatment providers, neonatologist, anesthesiologist, and lactation consultants. And it may also include social work or community health workers, I recommend that we tailor the frequency of prenatal visits to each person's individual needs. I often find that patients who are new to treatment may need to be seen every one to two weeks. And I will often coordinate these visits with their substance use treatment provider, but patients who are in long term treatment may be very comfortable with our standard prenatal templates. We also need to make sure that we are obtaining active verbal consent to perform verbal screening for substance use to develop plans of safe care and the coordination of care. And we ideally should be obtaining written consent prior to any urine toxicology screening, if it is even needed at all. But most importantly, we should be providing patients with anticipatory guidance, that it is common to have increased cravings and that medications may may or may need to be titrated in pregnancy, and we should be working closely as substance use treatment providers and prenatal care providers to find the optimal dosing for our patients. We also must make sure that our patients understand the legal landscape around substance use disorders and pregnancy and that they understand their rights. I personally recommend that all patients be given referrals for legal counsel. And this is a list of legal referrals that I've provided for all of my patients here in New York City. And lastly, we should be exploring patient's goals for their pregnancy, we should discuss their goals for pain management and set reasonable expectations as well as provide referrals for anesthesia consults. If the person is using a substance use with a significant neonatal withdrawal syndrome or that has fetal effects, we can refer for a NICU console to provide anticipatory guidance about the workup and the hospital say for the neonate. We can also provide breasts to explore patients breastfeeding goals and provide recommendations by substance. And because the postpartum period can be so destabilizing for patients, especially when combined with family regulation, and child custody loss, I do recommend that the first postpartum visit occur within two to three weeks. However, if a patient has an opioid use disorder and required assists area and I also recommend a high acuity postpartum visit within two to three days to follow up on pain management. And then I recommend ongoing postpartum care until at least six to 12 weeks, typically at six and 12 weeks postpartum, and to encourage a warm handoff to the primary care and treatment programs. Because ideally, this transition should be seamless to avoid a lapse in care that increases the risk of morbidity and mortality in the postpartum period. So I'm going to end here these last two slides merely provide a slide of the recommendations as I have discussed, and I will now take any questions from anyone which I believe Lauren is going to facilitate.

54:38
Thanks so much, Dr. Douglas, we we have a few questions and I want to thank all of our attendees who tried to answer while you were while you were speaking. So question one, do they still administer a drug to the unborn baby to prevent severe withdrawal? And we have a few responses from attendees. Very helpful thing only if they've exhausted At all other non medical treatment. Thank you to Kelly for that. Sara had quite a thorough response. Ideally, the pregnant person with an IUD would be started on medication assisted treatment or mats that includes buprenorphine, methadone, naltrexone, etc. Most newborns who are exposed to opioids, or mat medications during pregnancy will exhibit some level of withdrawal symptoms. And in Sarah's health system, they use the eat sleep console approach to care for these infants. Sarah, I'm not going to continue reading your full response. But thank you so much for that. And finally, from cat. Oh, go right ahead. Sorry,

55:42
I was just going to add, I think one of the things that given that we come from multiple hospital systems is to check with the policies at your hospitals. Because by and large, it's going to depend on your nursing support. So many hospitals, there's not a nursing the patient ratio on the postpartum service to actually allow for rooming in, which means that the baby stays with the neonate and is evaluated for withdrawal syndrome. If you can establish this, this is by far and away best practice. Because a baby who is experiencing any sort of withdrawal, best practice is breastfeeding if the patient is on treatment, as well as skin to skin and exactly responding on demand with the baby in the room. We've done a review at our hospital that when this is done, we can reduce postpartum stays for the infant to about four days, and most of the time, they don't require a NICU admission. However, historically, we counsel patients that babies may need to stay for up to 10 to 14 days if they're requiring morphine. But in I know that at Montefiore in our two hospitals, I'm very specific about which hospital I prefer our patients to deliver at because at one hospital, I have the nursing capacity to allow for rooming in. And at others I don't. So it is something to explore with your individual system. But I agree otherwise, with all of the recommendation.

57:06
Thanks. And just one addition from Kat on this same subject that an addiction consult team might be able to help start buprenorphine through microsuction as well. So really going along with everything that you included in your discussion. Then we have another this is just a comment from Tammy, that there's a new study in the OBGYN literature which documents the ill effects of cannabis on pregnancy. Tammy, I'd love to see that if you can drop a link into the chat box, we can share that with everyone as well. And let's see, we have one final comment here from Kendra. Their Hospital has included within its admission policy and under the scope of practice that universal drug screening is obtained on all admitted patients. This prevents discrimination between patients and it's still necessary. The question here is it still necessary to obtain verbal consent from the patient as it as part of the admission policy?

58:05

So two things First, I would ask if you're referring to a verbal consent versus a urine toxicology consent, I do still recommend obtaining a verbal consent for patients. Just asking. I'm now going to ask you a few questions about substance use. Is that okay? Otherwise, many patients will feel uncomfortable disclosing and patients do have the right to refuse even screening. It is not recommended by ACOG to do any sort of universal urine toxicology screening. We do really do recommend verbal screening only. Thank you.

58:44
Great follow up question here from Caitlin. Is there any role for routine urine toxicology screening in the prenatal period in patients with a positive verbal screen?

58:57
With a positive verbal screen, you only if it's being used for the monitoring of treatment, like as you would in the addiction medicine setting. Otherwise, you don't necessarily need a urine toxicology screen. Because really, if somebody's willing to disclose to you verbally and you're able to provide a true, appropriate referrals, the urine toxicology screen is not going to add anything to your treatment.

59:28
Final question here from Sarah, what level of care do you recommend for inpatient antepartum mmap induction.

59:38
So it's going to vary by patient. And so really, it's very safe. And we have pretty good literature particularly out of Boston U which probably has one of the largest programs for prenatal care with substance use disorders in pregnancy, that under 24 weeks outpatient inductions at that You shouldn't otherwise stable is extraordinarily safe. It is probably safe to do outpatient inductions even beyond 24 weeks. But given the historical concerns, once you're at viability, they are recommending some fetal monitoring. It's going to vary often it can just be a day or to it's going to depend on the patient and the doses that are required. Now in most institutions, the providers on the antepartum units are not going to be trained and how to do buprenorphine injections, or methadone inductions, and so it often will require coordination with an addiction medicine team. The length of stay will vary by patients. Thank you so much, Dr. Douglas..

[End Transcript]