NPA Position Statement 2017

Perinatal Substance Use

The United States is in the midst of what is understandably being called an opioid epidemic. Public health data describe rising rates of opioid use and misuse.[1] A dramatic increase in overdoses associated with opioid use has focused our attention on the risks of substance use and dependence.[2] Those risks are of special concern during the perinatal period when the effects of substance use can be amplified. While we know that pregnant people use illicit substances at half the rate of their non-pregnant peers - and use less during their third trimester - the rates of substance use and, therefore, infants exposed to substances is still high with more than 400,000 infants exposed to alcohol or illicit drugs in utero each year.[1]

While the perinatal period presents unique risks for those who are substance dependent and their babies, it is also a time when there are unique opportunities for positive intervention. As clinicians, mental health, and community health care providers, it is imperative that we understand the nature of perinatal substance use disorders and provide interventions and care that preserve the parent-infant dyad, promote parenting potential, and support the baby's health and development.

Substance use disorders seldom begin during a pregnancy.[3] People typically have long histories of problematic substance use that also include periods of abstinence which predate their pregnancy.[4] So the subset of pregnant people who continue substance misuse during pregnancy is most likely those who qualify for diagnosis of a Substance Use Disorder.[5]

Some factors that correlate with perinatal substance use disorder include depression, intimate partner violence, sexual abuse, and childhood trauma.[6] We know that many substances have positive psychotherapeutic effects.[7] In many cases, people initiate substance use to cope with and manage over-powering emotions associated with trauma. Because they are often criminalized and marginalized, substance use and illicit substance use can carry additional risks unrelated to their pharmacological effects. Substance use can increase risk of structural violence, imbalance of power in intimate relationships, and involvement with the criminal justice system, all of which can contribute to new experiences of trauma.[6, 7]

The National Perinatal Association views perinatal substance use as a major health care concern for perinatal providers, advocates, pregnant people, and their families. We are grateful for an emerging body of evidence that tells us how to deliver timely and appropriate perinatal care for this population. While we acknowledge that there are barriers that keep pregnant people from accessing this care, we believe that perinatal providers have a duty to help remove those barriers.

Background:

There is significant variability in health care, child welfare, and criminal approaches to caring for pregnant and parenting people with a perinatal substance use disorder. Many states have approached this health care issue as a legal issue and have criminalized substance use as a form of child abuse or neglect.[8] Ongoing research over the last twenty-five years has demonstrated that incarceration or the threat of incarceration does not decrease substance use disorder in pregnancy.[8, 9, 10. 11] All states are required to have a child welfare response for anyone using substances during pregnancy. Even though the child welfare system does not incarcerate parents, the initial call made to child protective services can result in babies being separated from their parents and may eventually result in the termination of parental rights.

Treating this personal and public health issue as a criminal issue - or a deficiency in parenting that warrants child welfare intervention - results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk.[12] Parents are rightly and understandably fearful that seeking prenatal care, disclosing substance use, and initiating treatment for a Substance Use Disorder may result in harmful and punitive child welfare involvement.[13] This, unfortunately, increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants. It also contributes to higher rates of unmanaged Neonatal Abstinence Syndrome. [8]

Health care providers should seek opportunities to educate themselves more fully on the issues that accompany and contribute to substance use, misuse, and dependence. Screening questions for problematic substance use should be a routine practice in every health care setting. Perinatal providers have a special responsibility because women are at highest risk for developing a substance use disorder during their reproductive years (18–44), especially ages 18–29.[14] It is also critical that we address the effects of poly-substance use, as it is the norm when we describe perinatal exposure and dependence.[5]

Optimal perinatal care requires a trusting relationship between providers and pregnant and parenting clients that supports open and honest communication about substance use. A patient-centered model for screening, brief intervention, and referral to treatment (SBIRT) that adopts the best practices of motivational interviewing is an effective way to determine the level of care that is appropriate for each client.[15] The use of screening models like SBIRT should not be confused with the practice of drug testing. The testing of a pregnant patients' blood, saliva, or urine for licit and illicit substances as a form of surveillance or as a tool for providing evidence of criminal conduct, child abuse, child endangerment, or criminal neglect undermines the trust between patients and providers and is contrary to professional ethics.[12]

It must also be noted that the negative consequences associated with perinatal substance use are disproportionately born by non-white perinatal patients even though evidence supports the notion that rates of use are similar across racial classifications.[16] The assumption that universal screening or surveillance can remedy those disparities is not supported by the evidence.[17]

Current research and practice has found that when parents partner in their prenatal care with supportive and knowledgeable staff, receive coordinated care to address the negative consequences of their substance use, and are able to room-in with their infant after delivery, the parent-infant bond is preserved and outcomes are better.[18, 19] Examples of potentially better practices are programs where pregnant people with a perinatal substance use disorder can receive both their prenatal care and substance use treatment in the same health care clinic or inpatient facility. Research is ongoing as to the efficacy of these models.

Position:

Pregnant and parenting patients with Substance Use Disorders have the same needs as any other pregnant and parenting client. They also have needs that are specific to their substance use. The National Perinatal Association supports comprehensive treatment programs for pregnant and parenting people with perinatal substance use disorder. Such programs must incorporate gender-specific, developmentally-appropriate, trauma-informed care. It is essential to work from a Harm Reduction model, promoting "Any Positive Change" as determined by the client, including plans ranging from abstinence, to decreased use, to safer use. Client abandonment in the case of continued use is unacceptable. Options for treatment should include, at minimum, Medication-Assisted Treatment (MAT), group and/or individual counseling, crisis intervention, overdose prevention, mental health assessment and treatment, dental care, parenting classes and support, and social services such as housing, employment assistance, and WIC.[1, 3, 8, 20]

In order to continue improvement in perinatal outcomes, NPA encourages ongoing research regarding rooming-in practices for parents and infants in the postpartum period and access to health care clinics that provide prenatal and substance use treatment in one setting.

The threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate perinatal care.[21] Perinatal providers promote better practices when they adopt language, attitudes, and behaviors that reduce stigma and promote honest and open communication about perinatal substance use.

The National Perinatal Association opposes any legal measures that involve the criminal justice system for drug use during pregnancy. Any statute which criminalizes substance use during pregnancy is inherently discriminatory in addition to being counterproductive to the goal of improving maternal and neonatal outcomes.[20] Criminalization and incarceration are ineffective and harmful to the health of the pregnant person and their infant.[8] The child welfare system is overwhelmed, and in too many cases, cannot provide appropriate support to either parents who are adjudicated neglectful because of perinatal substance use or to their children.[22]

The National Perinatal Association supports full funding for treatment services, prenatal care, and counseling to support clients in their safer use, recovery, and/or sobriety. Medicaid and

insurance companies must be committed to serving this population with evidence-based individual and public health approaches. It is imperative that perinatal substance use disorder be viewed as a health care issue comparable to other disease processes that have genetic, environmental, socioeconomic, clinical, and behavioral components.[15, 23]

Summary:

NPA encourages all health care providers and partners to discuss substance use during pregnancy with their clients and to support screening discussions and referral to appropriate treatment programs in a timely manner. NPA supports fully-funded health care clinics that care for those with perinatal substance use disorder as an effective solution to this crisis. NPA believes that criminal and civil-legal interventions are not effective and opposes their use with this uniquely vulnerable population.

Replaces: Substance Abuse among Pregnant Women, 2012

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