Opioid Use Disorder in Pregnancy and Postpartum

Opioid crisis impacts Washington families, demands action

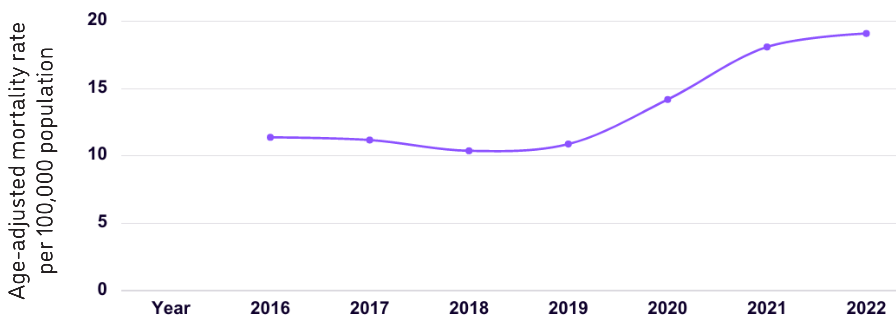
- Trauma history, family substance use, and lack of housing raise the risk of developing Opioid Use Disorder.
- Overdose is a leading cause of maternal deaths.
- Treatment for Opioid Use Disorder saves lives and improves health for infants and pregnant people.
- Investing in and expanding access to treatment is critical.

ABOUT PERINATAL OPIOID USE DISORDER

Opioid Use Disorder (OUD) is a chronic disease in which the recurrent use of opioids causes health problems, disability, or failure to meet major responsibilities at work, school, or home. OUD is a type of substance use disorder (SUD). Perinatal OUD happens during or within 1 year after pregnancy. Overdose deaths are rising in Washington (see Figure 1), especially overdoses involving opioids and psychostimulants like methamphetamine.[1]

Opioids are drugs like fentanyl, heroin, or oxycodone.

***Figure 1:* Overdose deaths rise among Washington women, 2016-2022.**[1]



Risk factors for perinatal OUD and other SUDs include childhood tobacco use, and having family with SUD.[2,3] Women with SUD are more likely to have histories of trauma and mood disorders like depression.[4] Opioid use in pregnancy is linked with childhood sexual abuse and stressful life events like job loss, deployment or a death in the family.[5,6] Intimate partner violence increases the risk of substance use and SUD.[7]

TREATMENT FOR OPIOID USE DISORDER

Treatment with methadone or buprenorphine, called Medications for Opioid Use Disorder (MOUDs), is the recommended therapy in pregnancy.[22] Treatment is effective—MOUDs lower the risk of death by 60%.[8] Starting an MOUD earlier in pregnancy lowers the risk of low birth weight and preterm birth.[9,10]

It's difficult for Washington families to access treatment for this stigmatized medical condition. Health care systems often miss chances to start OUD treatment, like doing routine prenatal SUD screening or providing withdrawal care for pregnant patients who come to the hospital.[11,12] Wait times are too long for treatment at facilities that accept patients with children.

Women with OUD report mistreatment from providers, even when fully engaged in treatment and many parents fear losing their baby to Child Protective Services if reported by health care providers.[13] This discourages pregnant individuals from seeking prenatal care, putting the patient, pregnancy and fetus at risk.[14] Racism increases these challenges. Despite similar rates of substance use among pregnant people, Black newborns are 4 times more likely to be reported to CPS than white newborns.[15] Black/African Americans and Hispanic/Latino Americans are less likely to receive MOUD treatment.[16]

Important factors that support recovery from OUD and a healthy pregnancy include supportive family or other strong social support, access to non-stigmatizing care, and ability to overcome barriers such as transportation.[17] Stable housing helps people stayin OUD treatment.[18,19]

JESSICA'S STORY

When Jessica found out she was pregnant, she knew she wanted to stop using. She was scared that going to treatment—and disclosing substance use to health care providers—might mean losing her future baby to CPS, but she got up the courage to try.

She called around asking for beds for pregnant women. A facility told Jessica they would have a bed for her in 4 days. Jessica didn't have anyone she could rely on to drive her there, and she didn't have anywhere safe to go while she waited.
She started feeling withdrawal symptoms—like a bad flu, on top of her pregnancy nausea. Her courage started to deflate and gave way to guilt and shame. Jessica kept getting high, and never found a way to get to that treatment bed. She still wanted the baby to be healthy, so she started taking prenatal vitamins. She also found a doula who could help support her. That support made all the difference. Without judgment, the doula helped Jessica get prenatal care and SUD treatment and drove her when a bed became available. Once stable on methadone, Jessica could start building a new life.

For support with substance use and finding treatment, call the Washington Recovery Help Line at 866-789-1511

Find more resources on DOH's Pregnant & Parenting Recovery Services website.

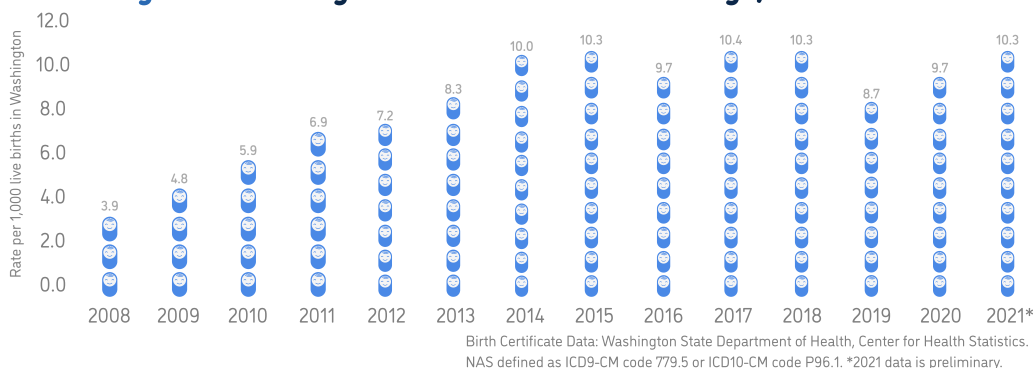
IMPACTS OF OPIOID USE DISORDER ON PREGNANCY AND FAMILIES

Impacts on the birth parent: Overdose is a leading cause of pregnancy-related death.[20] These overdoses usually happen postpartum, and most involved more than one substance.[20] 83% of overdose deaths involve opioids, followed by methamphetamine (30%) and alcohol (22%).[20] OUD is associated with higher odds of cardiac arrest, placental abruption, blood transfusion, cesarean delivery, and longer hospitalization for the birth parent.[21] Injection drug use increases risk of infections like Hepatitis C.[10]

Impacts on the infant: Untreated OUD increases risk of preterm birth and low birth weight.[9,10] Some studies find associations between opioid use and neural tube or heart defects.[21] Infants born to parents who take opioids or MOUDs may develop withdrawal symptoms, like difficulty sleeping and eating, called Neonatal Abstinence Syndrome (NAS).[23] NAS is over 2.5 times more common than it was 15 years ago (see Figure 2). The best care for these infants is called *Eat, Sleep, Console* (ESC).[24] With ESC, parents and infants stay in the same room, with low lights, little noise, and lots of skin-to-skin cuddling.

Impacts on the family: Involvement of Child Protective Services and the separation of families due to OUD can be profoundly distressing. This situation can interrupt attachment between the parent and infant and contribute to psychological distress. The removal of a child can exacerbate challenges for parents, potentially increasing the risk of overdose and death. When appropriate, a *Plan of Safe Care* can support the safety and well-being of birthing parents and their infants.

***Figure 2:* NAS diagnoses increase and remain high, 2008-2021.**[25]



Birth Certificate Data: Washington State Department of Health, Center for Health Statistics. NAS defined as ICD9-CM code 779.5 or ICD10-CM code P96.1. *2021 data is preliminary.

LOOKING FORWARD

Expanding access and improving care for perinatal OUD is a high priority for DOH and our partners. Our current work includes:

- Expanding Medicaid coverage for perinatal SUD care
- Adding more residential treatment beds to reduce wait times
- Washington State Perinatal Collaborative's SUD Quality Improvement Initiative
- Developing processes for Plan of Safe Care
- Establishing withdrawal and stabilization care for birth parents at the time of delivery
- Improving access to housing, especially transitional housing while waiting for treatment, and long-term housing after treatment
- Carrying out recommendations from Washington's Maternal Mortality Review Panel

Learn more about Opioid Use Disorder in Pregnancy and Postpartum

- 2023 Maternal Mortality Review Panel Report
- DOH Overdose Data Dashboard
- Washington's Pregnant, Parenting, Children, Families and Substance Use Workgroup

Questions, comments, concerns?
Contact: WAPerinatalCollaborative@doh.wa.gov

Washington State Department of HEALTH

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