Improving Treatment for Pregnant and Postpartum Women Act

Background – The Rise in Opioid Addiction:

Addiction to opioids – prescription painkillers or heroin – has risen dramatically over the past few years. Especially important are pregnant women at risk for opioid dependence and opioid exposure during pregnancy, and infants born with neonatal abstinence syndrome (NAS).

- The numbers:
  - According to the CDC, from 1999-2013, the amount of prescription opioids dispensed in the US nearly quadrupled, despite no overall change in the amount of pain reported.\(^1\)
  - The rate of neonatal intensive care unit (NICU) admissions for NAS increased from 7 cases per 1,000 admissions in 2004 to 27 cases per 1,000 admissions in 2013.\(^2\)

- Solutions should focus on a comprehensive, non-punitive public health approach.
- Opioid use during pregnancy can be medically appropriate. Opioids are often the safest and most appropriate treatment for a variety of medical conditions and severe pain during pregnancy.
- Our shared goal for pregnant women with addiction to drugs and alcohol, including opioids, must be a healthy outcome for both mother and baby.

The Problem – Why We Need Federal Legislation:

- Criminal approaches don’t work.
- 9 states have moved thus far to either criminalize pregnant women or mandate immediate revocation of child custody for women whose babies are born with NAS.
- The GAO, in 2015, found that “the program gap most frequently cited was the lack of available treatment programs for pregnant women…”
- Substance abuse treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being. There is a need for increased availability of out-patient treatment options that are responsive to women’s complex responsibilities, often as the primary or sole caregivers for their families.

The Solution – Improving Treatment for Pregnant and Postpartum Women Act:

- Reauthorizes residential treatment programs for pregnant and postpartum women. These programs provide substance use treatment to women in residential facilities, and to their minor children. Family-based treatment services include:
  - Individual, group, and family counseling;
  - Prenatal and postpartum care; and
  - Training in parenting.
- Establishes pilot program grants to address service delivery gaps for pregnant and postpartum women, including services in non-residential settings, and to encourage new approaches and models of service delivery across the continuum of care.

ACOG House Ask:

ACOG Senate Ask:
Cosponsor S. 2226, the Improving Treatment for Pregnant and Postpartum Women Act, sponsored by Senators Kelly Ayotte (R-NH) and Sheldon Whitehouse (D-RI).

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Improving Treatment for Pregnant and Postpartum Women Act
FAQ

How do you treat pregnant women with an opioid use disorder?
The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone or buprenorphine. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise.

What is ACOG doing to help address the opioid epidemic?
- Established Opioid Expert Work Group. Members are select ACOG Fellows, including those with maternal-fetal medicine and addiction medicine expertise.
- Buprenorphine Training Course. Scheduled for April 29th and tailored to women’s health.
- Partnering with the Administration to ensure safe prescribing.
- Participate in the AMA Opioid Task Force.

What are the barriers to accessing treatment?
There are multiple barriers. Most commonly cited are stigma, fear of prosecution or losing custody of children.

Why do we need to create new treatment models?
Existing treatment programs are primarily in-patient. While some do allow women to bring minor children with them, these programs have limited capacity. These women may be the primary breadwinner or caretaker in their families, or otherwise may not seek out in-patient treatment, so they need options that are responsive to their needs.

What about Neonatal Abstinence Syndrome (NAS)?
NAS is an expected and treatable condition that follows prenatal exposure to opioid agonists. It is much safer for women with opioid use disorders to be on opioid-assisted therapy than ongoing use of illicit opioids. When women access treatment, their provider can ensure delivery at a hospital equipped to manage any complications, including NAS.

What about birth defects?
While limited studies observed an increase in some birth defects following prescription opioid exposure in utero, observed birth defects remain rare with a minute increase in absolute risk. Concern about a potential small increased risk of birth defects associated with opioid-assisted therapy during pregnancy must be weighed against the clear risks associated with the ongoing use of illicit opioids by a pregnant woman.

In addition, chronic untreated heroin use during pregnancy is associated with an increased risk of fetal growth restriction, abruptio placentae, fetal death, preterm labor, and intrauterine passage of meconium.

Does ACOG support mandatory drug testing?
No. Urine drug testing is an adjunct to detect or confirm suspected substance use, but should be performed only with the patient’s consent and in compliance with state laws.

Screening for substance abuse is a part of complete obstetric care and should be done using a validated screening tool and in partnership with the pregnant woman.

Does this legislation cost money?
The House and Senate versions differ slightly. The House version includes an authorization for $40 million/year until 2020, while the Senate version does not specify an amount, instead calls for necessary sums. We do not yet have a score from the Congressional Budget Office (CBO).
Bringing Postpartum Depression Out of the Shadows Act

Background:
- About 1 in 7 new mothers experience perinatal depression, including major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery.
- Over 400,000 women suffer from perinatal depression every year, making it one of the most common medical complications during pregnancy and the postpartum period.
- Maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality.
- It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families.
- ACOG recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Several screening instruments have been validated for use during pregnancy and the postpartum period to assist with systematically identifying patients with perinatal depression.¹
- The United States Preventive Services Task Force (USPSTF) recognizes that screening for depression is appropriate for all adults, including pregnant and postpartum women.²

The Problem – Why We Need Your Help:
- Only 15% of women suffering from perinatal depression receive treatment.
- There is variation in resources to effectively treat or refer patients, resulting in access gaps for women who screen positive for perinatal depression.

The Solution – Bringing Postpartum Depression Out of the Shadows Act:
- This legislation would make grants available for States to establish, expand, or maintain programs for maternal depression screening and treatment to improve access to effective care.
- Eligible programs must:
  - Train and enable health care professionals to make community and family care connections
  - Make available information and resources for patients
  - Provide enhanced treatment options for women

ACOG House Ask:
Cosponsor H.R. 3235, the Bringing Postpartum Depression Out of the Shadows Act, sponsored by Representatives Katherine Clark (D-MA) and Ryan Costello (R-PA).

ACOG Senate Ask:
Cosponsor S. 2311, the Bringing Postpartum Depression Out of the Shadows Act, sponsored by Senators Dean Heller (R-NV) and Kirsten Gillibrand (D-NY).

Opioid Abuse, Dependence, and Addiction in Pregnancy

ABSTRACT: Opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists.

Opioid abuse in pregnancy includes the use of heroin and the misuse of prescription opioid analgesic medications. According to the 2010 National Survey on Drug Use and Health, an estimated 4.4% of pregnant women reported illicit drug use in the past 30 days (1). A second study showed that whereas 0.1% of pregnant women were estimated to have used heroin in the past 30 days, 1% of pregnant women reported nonmedical use of opioid-containing pain medication (2). In this study, the rates of use varied by setting and by mode of assessment. The urine screening of pregnant women in an urban teaching hospital resulted in a detection rate for opioids of 2.6% (2). The prevalence of opioid abuse during pregnancy requires that practicing obstetrician–gynecologists be aware of the implications of opioid abuse by pregnant women and of appropriate management strategies.

Pharmacology and Physiology of Opioid Addiction

Opioid addiction may develop with repetitive use of either prescription opioid analgesics or heroin. Heroin is the most rapidly acting of the opioids and is highly addictive (3). Heroin may be injected, smoked, or nasally inhaled. Heroin has a short half-life, and a heroin user may need to take multiple doses daily to maintain the drug’s effects. Prescribed opioids that may be abused include codeine, fentanyl, morphine, opium, methadone, oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene, and buprenorphine (the partial agonist). These products may variously be swallowed, injected, nasally inhaled, smoked, chewed, or used as suppositories (4). The onset and intensity of euphoria will vary based on how the drug was taken and the formulation; however, all have the potential for overdose, physical dependence, abuse, and addiction. Injection of opioids also carries the risk of cellulitis and abscess formation at the injection site, sepsis, endocarditis, osteomyelitis, hepatitis B, hepatitis C, and human immunodeficiency virus (HIV) infection.

Opioids bind to opioid receptors in the brain and produce a pleasurable sensation (3). Opioids also depress respiration, potentially resulting in respiratory arrest and death. Opioid addiction is associated with compulsive drug-seeking behavior, physical dependence, and tolerance that lead to the need for ever higher doses (4). Once physical dependence to an opioid has developed, a withdrawal syndrome occurs if use is discontinued. With short-acting opioids, such as heroin, withdrawal symptoms may develop within 4–6 hours of use, may progress up to 72 hours, and usually subside within a week. For long-acting opioids, such as methadone, withdrawal
symptoms are usually experienced between 24 hours and 36 hours of use and may last for several weeks. Obsessive thinking and drug cravings may persist for years, thus leading to relapse. Although heroin withdrawal is not fatal to healthy adults, fetal death is a risk in pregnant women who are not treated for opioid addiction because their offspring experience acute opioid abstinence syndrome (5).

**Effects on Pregnancy and Pregnancy Outcome**

An association between first-trimester use of codeine and congenital heart defects has been found in three of four case-control studies (6–9). Previous reports have not shown an increase in risks of birth defects after prenatal exposure to oxycodone, propoxyphene, or meperidine (10, 11). The authors of one retrospective study observed an increased risk of some birth defects with the use of prescribed opioids by women in the month before or during the first trimester of pregnancy (12). However, methodological problems with this study exist, and such an association has not been previously reported. The observed birth defects remain rare with a minute increase in absolute risk. Although none of these studies investigated methadone or buprenorphine specifically, concern about a potential small increased risk of birth defects associated with opioid-assisted therapy during pregnancy must be weighed against the clear risks associated with the ongoing use of illicit opioids by a pregnant woman.

During pregnancy, chronic untreated heroin use is associated with an increased risk of fetal growth restriction, abruptio placentae, fetal death, preterm labor, and intrauterine passage of meconium (13). These effects may be related to the repeated exposure of the fetus to opioid withdrawal as well as the effects of withdrawal on placental function. Additionally, the lifestyle issues associated with illicit drug use put the pregnant woman at risk of engaging in activities, such as prostitution, theft, and violence, to support herself or her addiction. Such activities expose women to sexually transmitted infections, becoming victims of violence, and legal consequences, including loss of child custody, criminal proceedings, or incarceration.

**Screening for Opioid Use, Abuse, and Addiction**

Screening for substance abuse is a part of complete obstetric care and should be done in partnership with the pregnant woman. Both before pregnancy and in early pregnancy, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids and other medications used for nonmedical reasons. To begin the conversation, the patient should be informed that these questions are asked of all pregnant women to ensure they receive the care they require for themselves and their fetuses and that the information will be kept confidential. Maintaining a caring and nonjudgmental approach is important and will yield the most inclusive disclosure. Routine screening should rely on validated screening tools, such as questionnaires including 4P’s and CRAFFT (for women aged 26 years or younger) (Box 1) (14, 15).

In addition to the use of screening tools, certain signs and symptoms may suggest a substance use disorder in a

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**Box 1. Clinical Screening Tools for Prenatal Substance Use and Abuse**

**4 P’s**

Parents: Did any of your parents have a problem with alcohol or other drug use?

Partner: Does your partner have a problem with alcohol or drug use?

Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?

Present: In the past month have you drunk any alcohol or used other drugs?

Scoring: Any “yes” should trigger further questions.

Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990.

**CRAFFT—Substance Abuse Screen for Adolescents and Young Adults**

C Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself or ALONE?

F Do you ever FORGET things you did while using alcohol or drugs?

T Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.


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 Pregnant women with opioid addiction often seek prenatal care late in pregnancy; exhibit poor adherence to their appointments; experience poor weight gain; or exhibit sedation, intoxication, withdrawal, or erratic behavior. On physical examination, some signs of drug use may be present, such as track marks from intravenous injection, lesions from interdermal injections or “skin popping,” abscesses, or cellulitis. Positive results of serologic tests for HIV, hepatitis B, or hepatitis C also may indicate substance abuse. Urine drug testing is an adjunct to detect or confirm suspected substance use, but should be performed only with the patient’s consent and in compliance with state laws. Pregnant women must be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements (16). Laboratory testing for HIV, hepatitis B, and hepatitis C should be repeated in the third trimester, if indicated (17).

The use of an antagonist, such as naloxone, to diagnose opioid dependence in pregnant women is contraindicated because induced withdrawal may precipitate preterm labor or fetal distress (13). Naloxone should be used only in the case of maternal overdose to save the woman’s life.

Treatment

Since the 1970s, maintenance therapy with methadone has been the standard treatment of heroin addiction during pregnancy (13). Recently, this treatment also has been used for nonheroin opioid addiction (13) although the benefits are less well documented than for the treatment of heroin dependence.

The rationale for opioid-assisted therapy during pregnancy is to prevent complications of illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient of associating with a drug culture. Comprehensive opioid-assisted therapy that includes prenatal care reduces the risk of obstetric complications (13). Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists and requires collaboration with the pediatric care team. Methadone has significant pharmacokinetic interactions with many other drugs, including antiretroviral agents.

Methadone maintenance, as prescribed and dispensed on a daily basis by a registered substance abuse treatment program, is part of a comprehensive package of prenatal care, chemical dependency counseling, family therapy, nutritional education, and other medical and psychosocial services as indicated for pregnant women with opioid dependence. Perinatal methadone dosages are managed by addiction treatment specialists within registered methadone treatment programs. A list of local treatment programs for opioid addiction can be found at the Substance Abuse and Mental Health Services Administration’s web site (http://dpt2.samhsa.gov/treatment/directory.aspx). Obstetricians should communicate with the addiction treatment program whenever there are concerns about the patient’s care and methadone dosage. The dosage should be adjusted throughout the pregnancy to avoid withdrawal symptoms, which include drug cravings, abdominal cramps, nausea, insomnia, irritability, and anxiety. If a woman is treated with a stable methadone dosage before pregnancy, pharmacokinetic changes may require dosage adjustments, especially in the third trimester (18). Some women develop rapid metabolism to the extent that it becomes difficult to control withdrawal symptoms for 24 hours on a single daily dose; in these cases, split dosages may be optimal. Not all women require dose increases during pregnancy and any dosage adjustments should be made on clinical grounds by the addiction specialist. Methadone dosages usually are initiated at 10–30 mg/d (13). If a woman begins treatment with methadone while pregnant, her dosage should be titrated until she is asymptomatic in accordance with safe induction protocols. An inadequate maternal methadone dosage may result in mild to moderate opioid withdrawal signs and symptoms and cause fetal stress and increased likelihood for the maternal use of illicit drugs. Separate studies examined the extent to which the maternal methadone dosage is related to the severity of neonatal abstinence syndrome. The results are inconclusive and conflicting (19, 20). One systematic literature review and meta-analysis concluded that the severity of neonatal abstinence syndrome does not appear to differ based on the maternal dosage of methadone treatment (21). These maternal, fetal, and neonatal findings all underscore the need to provide pregnant women with an adequate methadone dosage that relieves and prevents opioid withdrawal signs and symptoms and also blocks the euphoric effect of misused opioids.

In most situations, it is advisable for pregnant women to initiate methadone induction in a licensed outpatient methadone program. In situations when a pregnant woman requires hospitalization for initiation of methadone treatment, an arrangement must be made before discharge for next day admission to an outpatient program. With the exception of buprenorphine, it is illegal for a physician to write a prescription for any other opioid for the treatment of opioid dependence, including methadone, outside of a licensed treatment program (22). Buprenorphine, when prescribed by accredited physicians who have undergone specific credentialing, is the only opioid approved for the treatment of opioid dependence in an office-based setting (23). Physicians should be familiar with federal and state regulations regarding prescribing of medications for the treatment of opioid dependence.

Emerging evidence supports the use of buprenorphine for opioid-assisted treatment during pregnancy. Buprenorphine acts on the same receptors as heroin and morphine (24). With appropriate informed consent, including disclosure of the lack of evidence from long-
term neurodevelopmental studies, buprenorphine also may be offered to patients in need of opioid-assisted therapy during pregnancy (25). The advantages of buprenorphine over methadone include a lower risk of overdose, fewer drug interactions, the ability to be treated on an outpatient basis without the need for daily visits to a licensed treatment program, and evidence of less severe neonatal abstinence syndrome (25). The disadvantages compared with methadone include reports of hepatic dysfunction, the lack of long-term data on infant and child effects, a clinically important patient dropout rate due to dissatisfaction with the drug, a more difficult induction with the potential risk of precipitated withdrawal, and an increased risk of diversion (ie, sharing or sale) of prescribed buprenorphine (25). Buprenorphine is available as a single-agent product or in a combined formulation with naloxone, an opioid antagonist used to reduce diversion. Buprenorphine with naloxone is formulated to prevent injected use because naloxone causes severe withdrawal symptoms when injected. However, because of poor naloxone absorption, the formulation has rare adverse effects when used sublingually as directed (24). The single-agent product is recommended during pregnancy to avoid any potential prenatal exposure to naloxone, especially if injected (25). The single-agent buprenorphine product has a higher potential to lead to abuse as well as a higher street value than the combination product. Thus, all patients should be monitored for the risk of diversion of their medication, especially if the single product is prescribed. Unlike methadone, which may be administered only through very tightly controlled programs, buprenorphine may be prescribed by trained and approved physicians in a medical office setting, which potentially increases the availability of treatment and decreases the stigma (24). The Substance Abuse and Mental Health Services Administration publishes a directory of physicians licensed to dispense buprenorphine (http://buprenorphine.samhsa.gov/bwns_locator). Patients considered for using buprenorphine need to be able to self-administer the drug safely and maintain adherence with their treatment regimen. Compared with methadone clinics, the less stringent structure of buprenorphine treatment may make it inappropriate for some patients who require more intensive structure and supervision (17).

Until recently, data on use of buprenorphine in pregnancy were relatively limited (25). A 2010 multicenter, randomized clinical trial compared the neonatal effects of buprenorphine and methadone in 175 opioid-dependent gravid women (26). In that study, the buprenorphine–exposed neonates required, on average, 89% less morphine to treat neonatal abstinence syndrome, a 43% shorter hospital stay, and a 58% shorter duration of medical treatment for neonatal abstinence syndrome (26). These results support the use of buprenorphine as a potential first-line medication for pregnant opioid-dependent women who are new to treatment. It is important to understand that buprenorphine will not be effective for all patients.

Women who become pregnant while already undergoing a treatment with a stable co-formulated buprenorphine dosage generally are advised to continue the same dosage but to transition to the single-agent product. The indications for the use of buprenorphine during pregnancy are in flux currently. Previous recommendations have limited use of buprenorphine to women who have refused to use methadone, have been unable to take methadone, or those for whom methadone treatment was unavailable. The current trend is moving toward considering a patient as a potential candidate for buprenorphine if she prefers buprenorphine to methadone, gives informed consent after a thorough discussion of relative risks and benefits, and is capable of adherence and safe self-administration of the medication. If the pregnant woman is receiving methadone therapy, she should not consider transitioning to buprenorphine because of the significant risk of precipitated withdrawal. The potential risk of unrecognized adverse long-term outcomes, which is inherent with widespread use of relatively new medications during pregnancy, should always be taken into consideration.

Medically supervised withdrawal from opioids in opioid-dependent women is not recommended during pregnancy because the withdrawal is associated with high relapse rates (27). However, if methadone maintenance is unavailable or if women refuse to undergo methadone or buprenorphine maintenance, medically supervised withdrawal should ideally be undertaken during the second trimester and under the supervision of a physician experienced in perinatal addiction treatment (13). If the alternative to medically supervised withdrawal is continued illicit drug use, then a medically supervised withdrawal in the first trimester is preferable to waiting until the second trimester.

It is important that frequent communication be maintained between the patient’s obstetric care provider and the addiction medicine provider to coordinate care. The federal confidentiality law 42 CFR Part 2 applies to addiction treatment providers. Patient information release forms with specific language regarding substance use are required (28).

Intrapartum and Postpartum Management

Women receiving opioid-assisted therapy who are undergoing labor should receive pain relief as if they were not taking opioids because the maintenance dosage does not provide adequate analgesia for labor (29, 30). Epidural or spinal anesthesia should be offered where appropriate for management of pain in labor or for delivery. Narcotic agonist–antagonist drugs, such as butorphanol, nalbuphine, and pentazocine, should be avoided because they may precipitate acute withdrawal. Buprenorphine should not be administered to a patient who takes methadone.
Pediatric staff should be notified of all narcotic-exposed infants.

In general, patients undergoing opioid maintenance treatment will require higher doses of opioids to achieve analgesia than other patients. One study showed that after cesarean delivery, women who used buprenorphine required 47% more opioid analgesic than women who did not use buprenorphine treatment, but adequate pain relief was achieved with short-acting opioids and anti-inflammatory medication (31). Injectable nonsteroidal antiinflammatory agents, such as ketorolac, also are highly effective in postpartum and postcesarean delivery pain control. Daily doses of methadone or buprenorphine should be maintained during labor to prevent withdrawal, and patients should be reassured of this plan in order to reduce anxiety. Dividing the usual daily maintenance dose of buprenorphine or methadone into three or four doses every 6–8 hours may provide partial pain relief; however, additional analgesia will be required (29).

Women should be counseled that minimal levels of methadone and buprenorphine are found in breast milk regardless of the maternal dose. Breastfeeding should be encouraged in patients without HIV who are not using additional drugs and who have no other contraindications (32). The current buprenorphine package insert advises against breastfeeding; however, a consensus panel stated that the effects on the breastfed infant are likely to be minimal and that breastfeeding is not contraindicated (33). Swaddling associated with breastfeeding may reduce neonatal abstinence syndrome symptoms, and breastfeeding contributes to bonding between mother and infant as well as providing immunity to the infant.

Although most pregnant women who receive methadone will experience dosage increases during pregnancy, and a need for dosage reduction might be expected, one study demonstrated little need for immediate postpartum methadone dosage reduction (34). Most women who undergo buprenorphine maintenance therapy will not experience large dosage adjustments during their pregnancies and may continue the same dosages after delivery (34). However, the postpartum patient who receives opioid therapy should be closely monitored for symptoms of oversedation with dosages titrated as indicated. Women should continue in their treatment and addiction support postpartum. Discussions of contraceptive options should begin during pregnancy and contraception, including long-acting reversible contraceptive methods, should be provided or prescribed before hospital discharge. Access to adequate postpartum psychosocial support services, including chemical dependency treatment and relapse prevention programs, should be ensured (33).

**Neonatal Abstinence Syndrome**

Although maternal methadone or buprenorphine therapy improves pregnancy outcomes and reduces risky behavior, its use puts the neonate at risk of neonatal abstinence syndrome, which is characterized by hyperactivity of the central and autonomic nervous systems (13). Infants with neonatal abstinence syndrome may have uncoordinated sucking reflexes leading to poor feeding, become irritable, and produce a high-pitched cry. In infants exposed to methadone, symptoms of withdrawal may begin at anytime in the first 2 weeks of life, but usually appear within 72 hours of birth and may last several days to weeks (13). Infants exposed to buprenorphine who develop neonatal abstinence syndrome generally develop symptoms within 12–48 hours of birth that peak at 72–96 hours and resolve by 7 days (35). Close communication between the obstetrician and pediatrician is necessary for optimal management of the neonate.

All infants born to women who use opioids during pregnancy should be monitored for neonatal abstinence syndrome and treated if indicated (13). Treatment is adequate if the infant has rhythmic feeding and sleep cycles and optimal weight gain (13).

**Long-Term Infant Outcome**

Recent data on long-term outcomes of infants with in utero opioid exposure are limited. For the most part, earlier studies have not found significant differences in cognitive development between children up to 5 years of age exposed to methadone in utero and control groups matched for age, race, and socioeconomic status, although scores were often lower in both groups compared with population data (36). Preventive interventions that focus on enriching the early experiences of such children and improving the quality of the home environment are likely to be beneficial (37).

**Summary**

Early identification of opioid-dependent pregnant women improves maternal and infant outcomes. Contraceptive counseling should be a routine part of substance use treatment among women of reproductive age to minimize the risk of unplanned pregnancy. Pregnancy in the opioid-dependent woman should be co-managed by the obstetrician–gynecologist and addiction medicine specialist with appropriate 42 CFR Part 2-compliant release of information forms. This collaboration is particularly important when the woman receives opioid maintenance treatment or is at high risk of relapse. When opioid maintenance treatment is available, medically supervised withdrawal should be discouraged during pregnancy. It is essential for hospitalized pregnant women who initiated opioid-assisted therapy to make a next-day appointment with a treatment program before discharge. Infants born to women who used opioids during pregnancy should be closely monitored for neonatal abstinence syndrome and other effects of opioid use by a pediatric health care provider.

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Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice

**ABSTRACT:** Alcohol abuse and other substance use disorders are major, often underdiagnosed health problems for women, regardless of age, race, ethnicity, and socioeconomic status, and have resulting high costs for individuals and society. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, defines *substance use disorder* as a pathologic pattern of behaviors related to the use of any of 10 separate classes of substances, including alcohol and licit and illicit substances. In order to optimize care of patients with substance use disorder, obstetrician–gynecologists are encouraged to learn and appropriately use routine screening techniques, clinical laboratory tests, brief interventions, and treatment referrals. The purpose of this Committee Opinion is to propose an ethical framework for incorporating such care into obstetric and gynecologic practice and for resolving common ethical dilemmas related to substance use disorder.

Alcohol abuse and other substance use disorders are major, often underdiagnosed health problems for women, regardless of age, race, ethnicity, and socioeconomic status, and have resulting high costs for individuals and society. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, defines *substance use disorder* as a pathologic pattern of behaviors related to the use of any of 10 separate classes of substances, including alcohol and licit and illicit substances. These behaviors are grouped under the categories of impaired control, social impairment, risky use, and pharmacologic criteria (ie, tolerance and withdrawal) (1). The term “substance use disorder” will be used throughout the document and will be inclusive of these 10 substance classes, including alcohol.

Substance use disorder includes the abuse and misuse of a wide variety of licit and illicit substances, the most common of which are listed in Box 1 (2, 3). (Although tobacco is listed in Box 1, tobacco abuse is beyond the scope of this Committee Opinion.) Prescription medications (included in Box 1) often are categorized separately from illicit substances; however, because these drugs fall into similar pharmacologic classes as licit substances and also are commonly used in excess, they must be considered in any discussion of this issue. In fact, the nonmedical use of prescription drugs, particularly opioids, sedatives, and stimulants, has reached epidemic proportions in the United States (4).

In order to optimize care of patients with substance use disorder, obstetrician–gynecologists are encouraged to learn and appropriately use routine screening techniques, clinical laboratory tests, brief interventions, and treatment referrals. More detailed guidance on this clinical protocol for the management of substance use disorder is provided in other documents published by the American College of Obstetricians and Gynecologists (the College) (4–6). The purpose of this Committee Opinion is to propose an ethical framework for incorporating such care into obstetric and gynecologic practice and for resolving common ethical dilemmas related to substance use disorder. Based on this framework and underlying ethical principles, the College offers the following recommendations:

- Routine screening for substance use disorder should be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status. Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not required.
• Obstetrician–gynecologists have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with these patients. Obstetrician–gynecologists should familiarize themselves with resources available through their local hospital, community, or state in order to appropriately and effectively refer patients for treatment.

• When a legal or medical obligation exists for obstetrician–gynecologists to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain informed consent.

• Obstetrician–gynecologists have an ethical responsibility to follow current best prescribing practices for controlled medications in order to avoid inadequate or inappropriate treatment of pain and patient misuse or diversion (ie, redistribution) of prescription medications.

• Obstetrician–gynecologists should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder. Physicians should be aware that reporting mandates vary widely and be familiar with the legal requirements within their state or community.

• Obstetrician–gynecologists should, when possible, advocate evidence-based and consensual interventions related to substance use disorder.

Box 1. Substances That Are Commonly Misused or Abused

- Alcohol (ethanol)
- Cannabinoids (marijuana and hashish)
- Club drugs (methyleneoxymethamphetamine [MDMA], flunitrazepam, and gamma-hydroxybutyrate [GHB])
- Dissociative drugs (ketamine, phencyclidine [PCP] and analogs, Salvia divinorum, and dextromethorphan)
- Hallucinogens (lysergic acid diethylamide [LSD], mescaline, and psilocybin)
- Opioids (heroin and opium)
- Other compounds (anabolic steroids and inhalants)
- Prescription medications (central nervous system depressants, stimulants, and opioid pain relievers)
- Stimulants (cocaine, amphetamine, and methamphetamine)
- Tobacco


• Obstetrician–gynecologists have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.

• It is unethical for obstetrician–gynecologists to practice medicine with diminished capacity resulting from the use of alcohol or licit or illicit substances because it may put patients at risk of harm. If obstetrician–gynecologists identify substance use disorder in themselves or their colleagues, they have an ethical responsibility to safeguard patients by modifying their own practice and by seeking guidance from professional organizations to assist with resources for support and intervention.

**Ethical Rationale for Clinical Recommendations and Guidelines Related to Substance Use Disorder**

This Committee Opinion proposes an ethical rationale for routine screening, brief intervention, and referral to treatment for substance use disorder in obstetric and gynecologic practice. Support for this protocol is derived from the following four basic principles of medical ethics: 1) beneficence, 2) nonmaleficence, 3) justice, and 4) respect for autonomy.

**Beneficence**

Therapeutic intent, or beneficence, is the foundation of medical knowledge, training, and practice. Positive behavior change arises from the trust implicit in the patient–physician relationship, the respect that patients have for physician knowledge, and the ability of physicians to help patients see the links between physiologic dysfunction and behavior and their physical and psychologic consequences. The Centers for Disease Control and Prevention suggests that all patients be asked about alcohol and substance use regularly and in plain language (7). Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not required. There are several examples of evidence-based screening tools that can be used in the evaluation of alcohol and substance use disorder (4–7). It may be most efficient and effective to screen using a team approach, in which nonphysician members of the health care team are educated about screening and how to assist women who have positive screening results.

Obstetrician–gynecologists have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with these patients. Obstetrician–gynecologists should familiarize themselves with resources available through their local hospital, community, or state in order to appropriately and effectively refer patients for treatment. The core ethical purpose of routine screening for
substance use disorder is the beneficent provision of timely and effective care, rather than stigmatization or punishment. Physicians who identify alcohol use disorder, for example, may offer their patients alternatives to their continued drinking, including stopping drinking, cutting down on use, and seeking help. Brief intervention by physicians or peer educators has been shown to be as effective as conventional treatment for alcohol and substance use disorder and can produce dramatic reductions in use, improved health status for the patient, and reduced costs to society (8–14).

Nonmaleficence
The obligation to prevent, or not to impose, harms (nonmaleficence), including harms of omission, also is relevant to care for patients with substance use disorder. Medical care can be compromised if a physician is unaware of a patient’s substance use disorder, which results in missed diagnoses, unexpected or dangerous medication interactions, or psychosocial harms. Patients also may be harmed when substance use disorder is viewed as a moral failing rather than a medical issue (15). Women with substance use disorder particularly are likely to be stigmatized and labeled as hopeless (16). Humiliation as a tool to force change is ethically and professionally inappropriate, engenders resistance, and acts as a barrier to successful treatment and recovery (16). As leaders of the health care team, it is important for physicians to model empathy and support rather than criticism when caring for patients with substance use disorder.

Justice
The principle of justice in medicine governs equitable access to care, fair distribution of resources, and nondiscriminatory medical practices. This principle requires that routine screening for substance use disorder should be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status. Physicians may fail to apply principles of universal routine screening. When women are less likely to be screened or referred for treatment for substance use disorder, their burden of disability is increased and health status decreased. Another source of injustice is that punitive measures related to substance use disorder are not applied evenly across sex, race, and socioeconomic status. For example, in a landmark study among pregnant women who were anonymously tested for drug use, the prevalence of use was found to be similar between African American women and Caucasian women but African American women were 10 times more likely to be reported to law enforcement as a result of positive screening results (17). And, despite the significant involvement of male partners in perpetuating a pregnant woman’s substance use disorder (18) and the implications of paternal substance use disorder on the functioning of the family unit, there has been no attempt to impose legal sanctions for paternal substance use disorder such as those imposed for pregnant women (19). Universal application of substance use disorder screening questions, brief intervention, and referral to treatment eliminates these disparities.

Justice also requires that preventive education and treatment referral should be provided for all patients in whom substance use disorder is identified. Experts at the National Institute on Drug Abuse confirm that substance use disorder is a “brain disease” with psychologic and physiologic manifestations and should be included in a medical review of systems consistent with that of any other biologic disease process (20). Failure to diagnose and treat substance use disorder with the same evidence-based approach applied to other chronic illnesses reduces a patient’s access to health care services and resources. Just as with any chronic medical condition, physicians should counsel their patients with substance use disorder and refer them to an appropriate treatment resource when available, even if there might be a low likelihood of response to treatment. Obstetrician–gynecologists’ knowledge of available community resources is critical for such patient education and referral.

Respect for Autonomy
Respect for autonomy directs that patients have the right to full information about their health and health care and the power to make their own health care decisions. A climate of respect and trust within the patient–physician relationship promotes patient autonomy and enables effective intervention for women with substance use disorder by increasing motivation to change, supporting self-efficacy, and offering hope and resources (21, 22). When a legal or medical obligation exists for obstetrician–gynecologists to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain informed consent. Patients who fear sensitive information may be disclosed to others will be inhibited from honest reporting to their physicians (23). If a patient has the capacity to make her own decisions and declines to discuss alcohol and substance use, the physician should respect her decision. However, strong claims for public health concerns related to a patient’s substance use may set limits on what that patient can refuse or choose (24). A significant ethical dilemma is created by state laws that require physicians to report the nonmedical use of controlled substances (drugs or other chemicals that are potentially addictive or habit forming) by a pregnant woman and laws that require toxicology tests of the woman, her newborn, or both after delivery when there is clinical suspicion for fetal exposure to potentially harmful controlled substances. Such laws may unwittingly result in pregnant women concealing substance use from their obstetricians or even forgoing prenatal care entirely. State lawmakers are encouraged to look to science-based guidelines, medical evidence, and ethical principles to guide appropriate public health interventions. The American Congress of Obstetricians and Gynecologists

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has developed a tool kit for obstetrician–gynecologists and policy makers interested in optimizing autonomy and beneficence in state legislation related to pregnant women’s use of licit or illicit substances (25, 26).

**Ethical Approach to Common Patient-Care Issues Related to Substance Use Disorder**

Obstetrician–gynecologists have a responsibility to respond in a medically and ethically appropriate manner, within legal requirements, to patient-care issues involving substance use disorder. Cornerstones of an ethical approach to the management of substance use disorder include patient education and safe prescribing practices; care and advocacy for patients with substance use disorder who are parents, pregnant, or seeking pregnancy; and protection of patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by law.

**Patient Education**

Patient education is central to the prevention of intentional and unintentional therapeutic drug diversion, with a trusting relationship between physicians and their patients at the core of this education process. This relationship is especially vital when patients ask their physicians to prescribe medications that are not indicated. In partnership with local pharmacies, physicians also should be a resource for their patients regarding proper use, storage, and disposal of medications (4).

**Safe Prescribing Practices**

When treating patients with acute or chronic pain, obstetrician–gynecologists have an ethical responsibility to follow current best prescribing practices for controlled medications in order to avoid inadequate or inappropriate treatment of pain and patient misuse or diversion (ie, redistribution) of prescription medications such as opioids. It is inappropriate to avoid treating acute pain because of concerns for opioid addiction, although alternative and complementary pain relief modalities also should be considered. Obstetrician–gynecologists can be proactive in developing careful postoperative care plans for patients with a history of opioid use disorder. Consultation with pain specialists often is appropriate for patients at risk of opioid withdrawal and for patients with chronic pain syndromes who may be at risk of opioid dependence.

**Reporting Substance Use in the Medical Record**

Because of concerns regarding patient confidentiality, physicians may be reluctant to record information related to substance use or substance use disorder in patients’ medical records. On the one hand, the physician may be concerned about nonmaleficence. Because medical records may not be safe from inappropriate or state-mandated disclosures of a positive drug test result or a diagnosis of substance use disorder, the patient may experience real harms—including job loss unrelated to workplace performance issues, eviction from public housing, loss of public assistance benefits, termination of insurance, arrest and incarceration, and removal of child custody. On the other hand, the principles of beneficence and nonmaleficence require that physicians ensure the accuracy of the medical record to optimize collaborative care with other clinicians. Pertinent medical information obtained by obstetrician–gynecologists may be vital for other clinicians to provide appropriate patient care and avoid harm. Concerns about breaching confidentiality and causing harms through disclosure can be appropriately addressed by including only accurate and medically necessary information in the medical record and informing the patient why and how this information will be included.

**Maternal Substance Use Disorder**

**Fetal Exposure**

Published evidence should guide physician concern for the fetal effects of any substance exposure. Although a full description of the multiple possible effects of alcohol on offspring cognition and behavior is beyond the scope of this document, the effect of alcohol use in pregnancy remains the best studied among prenatal substance exposures. There are few data linking maternal opioid use to fetal growth restriction or congenital anomalies; however, a transitory and treatable opioid withdrawal syndrome (neonatal abstinence syndrome) is well described, and may be seen in 55–94% of neonates with significant fetal exposure to opioids and more infrequently after exposure to a number of other substances (27–29). Although stimulants such as cocaine and methamphetamine have not been clearly linked to neonatal abstinence syndrome, intrauterine exposure to these agents has been associated with fetal growth restriction and adverse effects on infant neurobehavior (28, 29).

**Biologic Testing**

It is important to consider carefully whether biologic testing is needed when there is clinical suspicion of fetal exposure to potentially harmful substances. Although several maternal biologic specimens, neonatal biologic specimens, or both can be used to test for drug exposure, each has its limitations, and it is more likely that fetal exposure will be identified through a structured interview. In fact, routine testing of maternal or neonatal biologic specimens when a maternal history is positive for substance use disorder might increase medical costs without providing information that actually guides the care of the neonate (27–29). Despite suspicion of or a known history of substance use disorder, alternate diagnoses for any neonatal abnormalities should always be considered and appropriately investigated.
Conversely, unawareness of a maternal history of opioid use may lead to a failure to recognize the signs of withdrawal because many of these findings may be seen in other common neonatal problems such as sepsis or hypoglycemia, thus delaying timely care of neonatal abstinence syndrome. Clarifying whether and when a pregnant patient may have last used licit or illicit substances is best undertaken through respectful dialogue with that patient, focusing on benefits to her and her child. If an obstetrician suspects, based on screening, that there is an immediate risk to the neonate, there is an ethical obligation to communicate this suspicion to the patient and pediatrician.

**Reporting Laws**

Courts have long upheld a right to privacy, which includes the right to decide whether to have a child, the right to bodily integrity, and the right to “be let alone” (30). The U.S. Supreme Court also recognized the importance of privacy to the patient–physician relationship when it ruled in 2001 to prohibit a public hospital from using results from drug testing done for medical purposes to further a criminal investigation without a warrant or specific consent (31). This decision held that individual physicians could be held liable in such cases for participating in illegal searches that violate patients’ constitutional rights.

Nevertheless, some state laws may compel physician reporting of a positive drug test result or suspicion of illicit drug use during pregnancy. As a result of judicial interpretation, some states now specifically authorize prosecutions of women who become pregnant and use controlled substances. Although one of these laws applies to women who continue their pregnancies to the point of viability, another state’s law applies to women from the moment they become pregnant; as a result of judicial interpretation, this appears to permit arrest for the use of all controlled substances during pregnancy, including those prescribed to the pregnant woman (32). In addition, prosecutors have relied on existing criminal laws, such as general child abuse laws, to punish pregnant women for using a criminalized drug (33). State civil commitment laws may permit commitment of pregnant women who expose their fetuses to alcohol or other substances of abuse (34). States vary in the specific substances triggering such actions, as well as in the level of evidence required to report a case to the child welfare system.

Obstetrician–gynecologists should function as patient advocates and oppose coercive screening, testing, and treatment interventions and prosecution of a particular population for substance use disorder. Obstetrician–gynecologists should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder. Physicians should be aware that reporting mandates vary widely and be familiar with the legal requirements within their state or community. As previously noted, when a legal or medical obligation exists for physicians to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain their informed consent. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions (35).

**Treatment**

Obstetrician–gynecologists should, when possible, advocate evidence-based and consensual interventions related to substance use disorder. Putting pregnant women in jail, where substances may be more available but treatment is not, jeopardizes the health of pregnant women and that of their existing and future children (33, 36, 37). Work being done on a state level to make treatment of substance use disorder more readily available to pregnant women has been bolstered by federal regulations requiring that pregnant women be provided with priority access to programs (38). Physicians are encouraged to continue to advocate the creation of treatment and rehabilitation centers that prioritize options for pregnant women, and it is hoped that policy makers, legislators, and physicians will work collaboratively to retract punitive legislation and identify evidence-based strategies outside of the legal system to improve treatment options and access for pregnant women with substance use disorder (26, 35).

**Breastfeeding**

Breastfeeding is important for maternal and infant health and bonding and provides an inexpensive and safe alternative to formula. For these reasons, a woman with a current or past history of substance use disorder should not be summarily excluded from or criminalized for nursing her infant. For women in well-supervised methadone-maintenance programs for treatment of opioid dependence, breastfeeding is encouraged and may be important to avoid neonatal abstinence syndrome (39). Obstetrician–gynecologists must have accurate information, however, regarding the potential dangers of transmission of illicit substances and high concentrations of alcohol through breast milk so that they can accurately advise their patients on the relative benefits or harms of breastfeeding (40).

**Parental Substance Use Disorder**

Obstetrician–gynecologists have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed. Despite this, many physicians support efforts to separate women with substance use disorder from their children. More than one half of physicians surveyed supported a statute that would permit removal of children from any woman who abused
alcohol or drugs (41). This position is especially concerning because these responding physicians did not require evidence of physical or emotional neglect or physical or sexual abuse in providing this survey response. Physician support of efforts to separate women with substance use disorder from their children most often reflects a desire to protect children, although some physicians also may feel that substance use disorder is a moral failing that deserves punishment. However, threats and incarceration have proved ineffective in reducing the incidence of substance use disorder.

Furthermore, removing children from the home not only violates child welfare goals of family integrity, but actually may subject children to greater risks in the foster care or child welfare systems (42). Treatment of substance use disorder is more effective and less expensive than restrictive policies (43) and results in a net medical savings per mother–infant pair (44). Women who have custody of their children during treatment of substance use disorder also complete treatment at a higher rate than women whose children are taken from them (45, 46).

Parental substance use disorder does not necessarily result in child harm or neglect. Nevertheless, when there is strong evidence of harm to children that is due to parental substance use disorder, obstetrician–gynecologists have an ethical obligation, along with their pediatrician colleagues, to engage child protective services to more fully assess risk of child harm. Each case should be evaluated independently and fairly, and available services should focus on maintaining or reuniting families rather than punishing and stigmatizing parents.

Infertile Patients With Substance Use Disorder
Obstetrician–gynecologists or other providers of infertility services may be faced with ethical dilemmas in which they must balance the interests of infertile patients with substance use disorder, the potential interests of future offspring, and their own conscientious practice interests (47). Although substance use disorder in a parent does not necessarily result in child neglect or inadequate parenting capacity, every effort should be made to identify and treat this disorder before conception in order to optimize maternal health and the health of future offspring. Any decision to decline to provide infertility treatment based on child safety concerns should be supported by clear evidence, made in conjunction with a multidisciplinary team of health care providers (47), and applied equally regardless of age, race, ethnicity, and socioeconomic status.

Adolescent Substance Use and Substance Use Disorder
Confidentiality is as important to the patient–physician relationship with adolescents as with adults, and physicians must build a relationship of trust with their adolescent patients in order to facilitate candid discussions regarding health-related behaviors that include the use of alcohol and other substances. Physicians should consider issues of informed consent, parental permission, and adolescent assent when dealing with detection and treatment of adolescent substance use disorder. Obstetrician–gynecologists should be aware of state laws that protect the confidentiality of minors regarding testing or treatment for substance use disorder. Minors, in general, may not be subjected to involuntary testing at their parents’ request.

Physicians may discuss issues of confidentiality with the parents or guardians of their adolescent patients to encourage parental involvement in health care decisions and, when appropriate, facilitate communication between these parties. In that discussion, parents and adolescents may be counseled that the information shared between each of them and the physician is treated as confidential. Any restrictions on the confidential nature of the relationship would involve disclosure of risks to self or others (48).

Physician Personal Use of Medications and Illicit Substances
If obstetrician–gynecologists identify substance use disorder in themselves or their colleagues, they have an ethical responsibility to safeguard patients by modifying their own practice and by seeking guidance from professional organizations to assist with resources for support and intervention. Except in emergencies, it is never appropriate for physicians to write prescriptions for controlled substances for themselves or their family members (49). It is unethical for obstetrician–gynecologists to practice medicine with diminished capacity resulting from the use of alcohol or licit or illicit substances because it may put patients at risk of harm (50, 51). The American Medical Association’s Code of Medical Ethics and the American College of Obstetricians and Gynecologists’ Code of Professional Ethics also direct that physicians have an ethical obligation to respond to evidence of questionable conduct or impairment in colleagues that may be related to substance use disorder. Physicians are obligated to assist with timely intervention and identification of a local treatment program for these colleagues felt to be at risk of impairment; appropriate intervention often is directed by state or national professional organizations (51, 52). Physicians are obligated to cooperate with appropriate authorities who may be investigating unsafe behaviors and to report colleagues to local medical boards if “reasonable offers of assistance” and referral have been fruitless (53). Hospitals and state medical societies have similarly been empowered to identify physicians who may be impaired and to refer them for rehabilitation, with the future goal to return to their professional roles (54).

Conclusion
Incorporating the ethical frameworks presented in this Committee Opinion will help obstetrician–gynecologists
navigate difficult professional situations involving substance use disorder. These ethical frameworks support the routine screening of all patients for substance use disorder, and brief intervention and treatment referral for those patients with positive screening results. Obstetrician–gynecologists also have a responsibility to respond in a medically and ethically appropriate manner, within their local regulatory boundaries, to patient-care issues involving known or suspected substance use disorder. Maintenance of a therapeutic relationship will optimize care and advocacy for patients with substance use disorder who are parents, parents, or seeking pregnancy. It also is important to advocate patient autonomy and confidentiality in the face of legally mandated drug testing and reporting. Finally, it is good medical practice and ethically appropriate for obstetrician–gynecologists to ensure their safe prescribing practices for legal therapeutic drugs and to be vigilant against licit or illicit substance use disorder in themselves or their medical colleagues in order to optimize personal and patient wellness and safety.

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22. Center for Substance Abuse Treatment. Substance abuse treatment: addressing the specific needs of women.


Screening for Perinatal Depression

**ABSTRACT:** Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Several screening instruments have been validated for use during pregnancy and the postpartum period. Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

**Recommendations**
- Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists (the College) recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders warrant particularly close monitoring, evaluation, and assessment.
- Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
- Systems should be in place to ensure follow-up for diagnosis and treatment.

**Introduction**

The purpose of this document is to increase awareness of depression and mood disorders in pregnant and postpartum women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Regular contact with the health care delivery system during the perinatal period should provide an ideal circumstance for women with depression to be identified and treated. The College recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms. This document discusses the obstetric provider’s role in the initiation of medical therapy and referral of patients to appropriate behavioral health resources when indicated.

Depression, the most common mood disorder in the general population, is approximately twice as common in women as in men, with its initial onset peaking during the reproductive-age years (1). Therefore, it is not surprising that perinatal depression, which includes major and minor depressive episodes that occur during pregnancy
Perinatal depression often goes unrecognized because changes in sleep, appetite, and libido may be attributed to normal pregnancy and postpartum changes. In addition to clinicians not recognizing such symptoms, women may be reluctant to report changes in their mood. In one small study, less than 20% of women in whom postpartum depression was diagnosed had reported their symptoms to a health care provider (5). Therefore, it is important for clinicians to ask the pregnant or postpartum patient about her mood. Newborn care appointments also may be an opportunity to ask a mother about her mood. Obstetric providers should collaborate with their pediatric colleagues to facilitate treatment for women with mood disorders identified during newborn care (6).

Anxiety is a prominent feature of perinatal mood disorders, as is insomnia. It may be helpful to ask a woman whether she is having intrusive or frightening thoughts or is unable to sleep even when her infant is sleeping. Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders (Box 1) warrant particularly close monitoring, evaluation, and assessment. These women may benefit from evidence-based psychologic and psycho/social interventions and, in some cases, pharmacologic therapy to reduce the incidence and burden of perinatal depression (7). If there is concern that the patient suffers from mania or bipolar disorder, she should be referred to a psychiatrist before initiating medical therapy because antidepressant monotherapy may trigger mania or psychosis (8). Mania symptoms include inflated self-esteem or grandiosity, feeling rested after only 3 hours of sleep, or engaging in risky behaviors that worry her friends and family (3).

Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Recent evidence suggests that collaborative care models implemented in obstetrics and gynecology offices improve long-term patient outcomes (9). For example, in one model of collaborative care, a depression care manager, such as a nurse or social worker, can provide psychotherapy and support under the supervision of a mental health specialist and a primary care clinician. Systems should be in place to ensure follow-up for diagnosis and treatment (7, 8).

Box 1. Risk Factors for Perinatal Depression

<table>
<thead>
<tr>
<th>Depression during pregnancy:</th>
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<tr>
<td>Maternal anxiety</td>
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<td>Life stress</td>
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<td>History of depression</td>
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<td>Lack of social support</td>
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<tr>
<td>Unintended pregnancy</td>
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<td>Medicaid insurance</td>
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<td>Domestic violence</td>
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<td>Lower income</td>
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<td>Lower education</td>
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<td>Smoking</td>
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<td>Single status</td>
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<tr>
<td>Poor relationship quality</td>
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<tr>
<td>Postpartum depression:</td>
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<tr>
<td>Depression during pregnancy</td>
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<tr>
<td>Anxiety during pregnancy</td>
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<tr>
<td>Experiencing stressful life events during pregnancy or the</td>
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<td>early postpartum period</td>
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<td>Traumatic birth experience</td>
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<tr>
<td>Preterm birth/infant admission to neonatal intensive care</td>
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<tr>
<td>Low levels of social support</td>
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<tr>
<td>Previous history of depression</td>
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<tr>
<td>Breastfeeding problems</td>
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Screening Tools

Several screening instruments have been validated for use during pregnancy and the postpartum period to assist with systematically identifying patients with perinatal depression (Table 1). For example, the Edinburgh Postnatal Depression Scale consists of 10 self-reported items, takes less than 5 minutes to complete, has been translated into 12 languages, has a low required reading level, and is easy to score. The Edinburgh Postnatal Depression Scale includes anxiety symptoms, which are a prominent feature of perinatal mood disorders, and excludes constitutional symptoms of depression, such as changes in sleeping patterns, that are common in pregnancy and the postpartum period. The inclusion of these constitutional symptoms in other screening instruments, such as the Patient Health Questionnaire 9, the Beck Depression Inventory, and the Center for Epidemiologic Studies Depression Scale (Table 1), reduces their specificity for perinatal depression. With the exception of the Patient Health Questionnaire 9 and the Edinburgh Postnatal Depression Scale, other instruments have at least
20 questions and, thus, require more time to complete and to score. As with any screening test, results should be interpreted within the clinical context. A normal score for a tearful patient with a flat affect does not exclude depression; an elevated score in the context of an acute stressful event may resolve with close follow-up.

Conclusions
Although the adverse consequences of perinatal depression, as well as the benefits of its treatment, are clear, there is only limited evidence that screening to identify and treat this condition improves outcomes (10). This seeming paradox may be due in part to variation in resources to effectively treat or refer patients if screening identifies concerns. Nevertheless, perinatal depression is a common complication of pregnancy with potentially devastating consequences if it goes unrecognized and untreated. Therefore, although definitive evidence of benefit is limited, the College recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Obstetric providers should be prepared to initiate treatment and refer patients as needed. Systems should be in place to ensure follow-up for diagnosis and treatment.

Resources
(Also found at http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression)
The following resources are for information purposes only. Referral to these sources and web sites does not imply the endorsement of the American College of Obstetricians and Gynecologists. These resources are not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice.

Beck CT, Gable RK. Postpartum depression screening scale (PDSS). Los Angeles (CA): Western Psychological Services; 2002.

References


