

Partner support has limited influence on clinical outcomes in pregnant patients with substance use disorder

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Abstract

PURPOSE: Evaluate the influence of partner support on maternal outcomes and neonatal measures including the frequency of neonatal abstinence syndrome (NAS).

METHODS: We included consenting patients in a longitudinal cohort study of pregnant patients with substance use disorder (SUD) receiving care through a multispecialty treatment program between 2015 and 2021. Partner support was assessed on enrollment by self-report during the initial behavioral health assessment. Specifically, patients were asked, "Who do you designate as recovery support?" and "Are you partnered with the father of the baby?" Neonatal outcomes included frequency of NAS, pharmacologic treatment, length of NAS treatment, and duration of neonatal stay. Fisher's exact test was used in analysis of variables.

RESULTS: 386 antepartum patients answered designated recovery support. 265 (70%) reported being partnered with the father of the baby; however, only 155 (40%) suggested the father was designated as recovery support. A different significant other was identified as recovery support for 22 patients (5.7%). 125 patients (33%) did not report sexual orientation and 6 identified as lesbian, bisexual, or other (1.5%). The final subgroup of 177 women with partner support for recovery were compared to the remainder identifying family support, friends, or 14 without a support system (3.7%). Maternal characteristics were similar between those with and without partner support including MAT started prior to the pregnancy 31 (19.4%) vs 29 (14.6%), $P=.48$; MAT started during pregnancy 123 (71.1%) vs 150 (72.1%), $P=.52$; Total Suboxone dose (mg/day) 11.9 vs 10.2, $P=.14$; History of overdose 32 (52.5%) vs 36 (46.8%), $P=.51$; Concurrent psychiatric diagnosis at enrollment 98 (55.4%) vs 123 (58.9%), $P=.49$; Edinburgh Score ≥ 12 21 (50%) vs 58 (51.3%), $P=.62$; Generalized Anxiety Disorder-7 scores 9.5 vs 9.8, $P=.84$; Total prenatal care visits 12.4 vs 12.0, $P=.62$. However, the Abuse Assessment Screen (AAS) differed significantly between groups: 80 (45%) with a partner vs 121 (58%) without a partner, $P=.01$. The other maternal and neonatal outcomes did not differ significantly between the partner-supported patients and no or other supported patients, including vaginal delivery 91 (52%) vs 113 (55.4%), $P=.51$; Operative vaginal delivery 9 (5.1%) vs 12 (5.9%), $P=.75$; Cesarean section 75 (42.9%) vs 79 (38.7%), $P=.41$; Postpartum Edinburgh Score ≥ 12 11 (36.7%) vs 13 (26.5%), $P=.34$; Preterm birth 28 (15.8%) vs 40 (19.1%), $P=.39$; Small for Gestational Age 28 (16.2%) vs 24 (12.1%), $P=.25$; NAS frequency 67 (39%) vs 86 (42.6%), $P=.48$; Duration of neonatal stay 16.3 vs 15.3 days, $P=.65$; NAS pharmacologic treatment 67 (39.0%) vs 86 (42.6%), $P=.48$; Infant admitted to NICU 121 (69.9%) vs 158 (77.8%), $P=.08$.

CONCLUSIONS: Partner support did not appear to influence maternal and neonatal outcomes in our population with SUD. This may be due to a type 2 error or smaller sample size. However, we did find that women without partner support were at higher risk for abuse based on their Abuse Assessment Screen. Further studies are needed.