Pregnancy & Prescription Drug Abuse, Dependence and Addiction

Presentation to
Medical Assistance Program Oversight Council
Women’s Health Committee

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Thank you

- For the opportunity to address this critically important issue
ACOG

- American College of Obstetricians and Gynecologists
- American Congress of Obstetricians and Gynecologists
- 58,000 members, most of whom are actively practicing ObGyns around the country
The Issue

- Drug and alcohol abuse among pregnant women is a health issue that deserves greater attention.
- Our shared goal must be a healthy outcome for mother and baby.
Background

Every leading medical and public health organization that has addressed this issue (the AMA, ACOG, ACNM, AAP, APHA, AAFP, ASAM, MoD) has concluded that this problem is best addressed through education, prevention and community-based treatment, not through punitive drug laws or prosecution.
For a pregnant woman abusing drugs or alcohol,

- Obtaining prenatal care
- Staying connected to health care, and
- Being able to speak openly with a doc about drug problems

all improve birth outcomes

However, many other interventions do not.
Background

Neonatal Abstinence Syndrome

- NAS follows prenatal exposure to opioids
  - Some newborns exposed prenatally to opiates experience an abstinence (withdrawal) syndrome at birth.
  - In utero physiologic dependence on opiates is characterized by hyperactivity of the central and autonomic nervous systems.
- NAS is expected, readily diagnosed, and treatable
NAS is temporary

- There is no evidence to indicate that, with effective modern treatment, NAS itself is life threatening or results in permanent harm.

- For infants with NAS, there are safe, effective, and evidence-based treatment protocols endorsed by the AAP, and used today.
NAS is temporary

- Unlike neonatal exposure to maternal alcohol and tobacco use, there have been no reported long term effects of maternal opioid use on the developing child.

- Longitudinal studies have shown that children who experienced NAS as infants do not exhibit signs of physical or cognitive impairment as they mature.
In what situations might a pregnant women receive opioids for treatment?

We will discuss:
1. Medically supervised opioid agonist therapy (OAT)
2. Treatment of pain
Safe Prescribing

Scenario #1
“Opioid Agonist Therapy (OAT)”

- Pregnant women who use/abuse prescription opiates require and deserve appropriate medical interventions to treat their disease.
- Physician prescribed and supervised use of opioid-based medications (known as opioid agonist therapy) improves outcomes for both mom and baby.
- OAT with methadone or buprenorphine is the medical standard of care.
Safe Prescribing

Scenario #1

“Opioid Agonist Therapy (OAT)”

- Methadone is dispensed on limited-dose basis within state-licensed treatment programs
- Buprenorphine is dispensed by specially trained/licensed physicians from medical office
  - Increased availability of treatment
  - Decreased stigma a/w methadone clinics
Safe Prescribing
Scenario #2
Treatment of pain in pregnancy

- Short term use of opioids during pregnancy for episodic pain has **not** resulted in symptoms of neonatal abstinence syndrome.
- For severe pain during pregnancy including labor and delivery, **there are well-established, safe protocols for the use of opioid medications** that have been developed by obstetrician-gynecologists and anesthesiologists.
In trying to achieve the goal of a healthy mother and baby, some interventions do more harm than good.
What’s NOT working

Any serious approach to misuse/abuse of prescription opiates by pregnant women must start from a scientifically sound foundation and prioritize positive health outcomes.

Much of the current rhetoric AND many popular policy responses fail to achieve this goal.

Simply put, punitive drug enforcement policies don’t work.
What’s NOT working

- Criminal penalties
  - These are a **deterrent** to health care!
  - Ineffective in reducing the incidence of drug/alcohol abuse
What DO criminal penalties do?

- Discourage prenatal care
- Discourage disclosure about drug use
  - Prevent treatment for pain or addiction
- May encourage termination of wanted pregnancies
- Drive a “wedge” into the physician-patient relationship
Examples of punitive policies

- Mandatory urine drug testing
- Mandatory reporting to law enforcement
- Punitive drug courts
- Over-reliance on fragmented prescription drug monitoring policies
What’s NOT working

- Misleading drug prescribing warnings
ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME

Addiction, Abuse, and Misuse
[TRADENAME] exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient’s risk prior to prescribing [TRADENAME], and monitor all patients regularly for the development of these behaviors or conditions [see Warnings and Precautions (5.X)].

Life-Threatening Respiratory Depression
Serious, life-threatening, or fatal respiratory depression may occur with use of [TRADENAME]. Monitor for respiratory depression, especially during initiation of [TRADENAME] or following a dose increase [see Warnings and Precautions (5.X)].

Accidental Ingestion
Accidental ingestion of even one dose of [TRADENAME], especially by children, can result in a fatal overdose of [active moiety] [see Warnings and Precautions (5.X)].

Neonatal Opioid Withdrawal Syndrome
Prolonged use of [TRADENAME] during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [see Warnings and Precautions (5.X)].
What’s NOT working

- Misleading drug prescribing warnings
  - Do not distinguish between heroin, misuse of RX opioids, and RX by providers for legitimate pain management or OAT
  - May result in:
    - Denial of access to needed therapy
    - Abrupt discontinuation -> withdrawal / relapse
    - Discourage continuation of wanted pregnancies

- Blanket restrictions on medication access
  - Block access to appropriate medication for treatment
What’s NOT working

- Forced withdrawal
  - Extremely dangerous to the fetus
    - Preterm labor
    - Fetal distress
    - Ultimately, pregnancy loss
  - High risk of relapse to illicit opioids

These outcomes can be prevented through medically approved opioid maintenance treatment.
What’s NOT working

- Lowering the dose of maternal opioid agonist therapy (OAT)
  - Does not lessen severity of NAS
  - Increased incidence of maternal / fetal withdrawal
    - Induced fetal stress
    - Maternal relapse
What’s NOT working

- Drug treatment programs that are not tailored to pregnant or parenting women
  - Lack of child care
  - Do not account for family responsibilities
  - Do not provide affordable treatment
  - Do not give priority access to pregnant women
  - Pressure to detox

Substance abuse treatment that supports the family unit is effective for maintaining maternal sobriety and child well-being.
For addicted women, the alternatives to opioid agonist (i.e. forced withdrawal OR ongoing drug abuse) are much more dangerous.
What’s needed:

Evidence-based, public health oriented approaches.
What’s needed:

- Use of validated tools, with consent
  - i.e. prenatal screening (the “4Ps”):
    - Parents
    - Partners
    - Past
    - Pregnancy

ACOG protocols call for all women to be screened annually for substance abuse.
A note on urine testing

ACOG policy suggests that urine drug testing may be used to identify drug use, but advises that this is best done as an adjunct to confirm suspected/reported drug use and only with the patient’s consent.
What’s needed:

- Appropriate drug treatment programs for women
  - Outpatient, community based options that are responsive to women’s complex responsibilities
  - OAT improves outcomes for both mom and baby
What’s needed:

- Appropriate drug treatment programs for women
  - Goal of *ongoing management* of this chronic disease
  - Ideally integrated with prenatal and postpartum care (a particularly susceptible time)
  - Infants with NAS should not be removed from mothers engaged in treatment
What’s needed:

- Safe prescribing for the treatment of pain
  - Education on proper use, storage, disposal
  - National standards for prescribing/dispensing
What’s needed:

- Improved PDMPs
  - Integrated, interstate
  - Enhanced staffing and data sharing
  - Reliable funding
What’s needed:

- Counseling on pregnancy:
  - Planning
  - Prevention
  - Contraception options
What’s needed:

- Increased focus on postpartum care visits:
  - Markedly improves contraceptive use
  - Provides additional opportunities for continued care planning
What’s needed:

- More focus on alcohol/tobacco use during pregnancy
  - Concurrent use is common
  - Alcohol/tobacco are the **greatest preventable threats** to a healthy pregnancy
    - Long term serious health consequences for mother/baby
    - Smoking is **#1 risk factor for prematurity**
    - Concurrent use may explain many harmful outcomes often attributed to other illicit substances
Suggested Legislative Approaches:

- State Study:
  - Authorize a multi-disciplinary task force to study and make evidence-based recommendations, including **early intervention and prevention strategies**.
  - Recommendations should **prioritize public health interventions that will optimize health outcomes for both moms and babies**.
  - Data can help identify areas of the state where treatment services and community outreach are needed.
Suggested Legislative Approaches:

- Legislation should task an existing perinatal advisory group or quality collaborative with making recommendations specific to pregnant women and neonatal abstinence syndrome (NAS)
What’s a Perinatal Quality Collaboratives (PQC)?

- Network of perinatal care providers & public health professionals working to improve pregnancy outcomes for women and newborns by **advancing evidence-based clinical practices and processes**
- Include hospitals, pediatricians and neonatologists, obstetricians and perinatologists, midwives, nurses, and state health department staff
- Identify processes that need to be improved and use best available methods to make changes / improve outcomes
When considering legislation, remember this:

Criminal penalties and the threat of incarceration are ineffective in reducing drug and alcohol abuse and more likely to deter women from seeking beneficial care than they are to protect children or further the state’s goal of decreasing prescription drug abuse and diversion.
Suggested Legislative Approaches:

- If considering mandatory reporting of suspected or reported drug use, legislation should specify:
  - Reporting is to the health department
  - Direct reporting to child protective services only for actual indications of impaired parenting
Suggested Legislative Approaches:

- Each case should be evaluated independently to serve the goals of protection and provision of services to maintain or reunify families.
- Consider an affirmative defense or exceptions to legal prosecution for pregnant women who are in drug treatment programs or who seek help for their drug problems.
Suggested Legislative Approaches:

- If promoting use of drug courts, consider
  - Better training for drug court officials on the disease of substance abuse and addiction and unique medical needs of pregnant women
  - Drug courts may be helpful for some but they are not a remedy for pregnant women
    - Some pressure women to detox -> not safe or recommended
    - Inpatient treatment often only option, not always feasible
Suggested Legislative Approaches:

- If considering adoption of state rules or guidelines on appropriate prescribing, legislation should:
  - Not interfere with legitimate treatment options incl. OAT (the standard of care) for pregnant women
  - Avoid setting arbitrary dosing limits and permit individualized treatment plans
  - Provide a ‘safe harbor’ for clinicians who treat pregnant women with substance dependence
Suggested Legislative Approaches:

- If considering mandatory urine testing, legislation should specify:
  - Testing only with patient consent and to confirm suspected / reported use
    - This includes during labor & delivery
  - Eligibility for Medicaid and reimbursement for prenatal/labor/delivery care should not be contingent on mandatory testing
Suggested Legislative Approaches:

- When assessing drug and alcohol abuse treatment programs and services in the state, legislation should:
  - Give pregnant women priority admission (especially to programs that receive public funding)
  - Ensure that outpatient and family-oriented drug treatment is available and affordable for women
  - Expand the type of substance abuse treatment programs, facilities, and providers eligible for reimbursement under Medicaid
Suggested Legislative Approaches:

When appropriating funds, consider legislation that:

- Targets funds to local jurisdictions to assist in development and implementation of multidisciplinary teams that collaborate on identification/referral/provision of family-centered, outpatient services.
- Establishes a pilot intervention program in specific cities/counties that includes supportive services for the family.
- Increases funding for substance abuse and mental health services in the Medicaid program.
Suggested Legislative Approaches:

- When considering prevention measures, legislation should support:
  - Community-based psychosocial services for new mothers.
  - Preventative & other health care for women in prisons.
  - Expanded coverage of preconception care/counseling & family planning services for low-income women & women who rely on Medicaid.
  - Maintain focus on the most harmful substances: alcohol and tobacco.
Suggested Legislative Approaches:

- When considering public awareness initiatives, legislation should:
  - Support responsible media reporting about drug abuse and addiction, including NAS.
  - Consult with medical experts and community anti-drug coalitions.
  - Ensure that school-based prevention efforts are evidence-based and evaluated.
We covered a lot of territory

Most important elements:

1. Approach this as a medical problem - not a legal problem
2. Avoid punitive new laws and provide resources for treatment
Thank you very much

- ACOG appreciates the opportunity to meet with you and have input as this critically important issue is discussed.