

New Mexico House Memorial 14 Task Force Legislative Report

Submitted to Health and Human Services Committee

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FRAMING THE ISSUE

It is widely recognized that the incidence of substance abuse, and, in particular opiate addiction, in New Mexico is disproportionate to that of the remainder of the country, and that the rate of these problems is increasing.^{1,2} The toll which substance abuse and addiction takes on New Mexican families and communities is daunting,³ and particularly worrisome are the potential effects of the use of substances of abuse on pregnant women and their children.

Punitive approaches to the care of these women are not successful, and result in fear of seeking prenatal care and substance abuse treatment, failure to reveal substance abuse problems to medical care providers, and late presentation to prenatal care or lack of any care prior to delivery.⁴ This difficulty is compounded by the failure of health care providers and other professionals to adequately assess women for substance abuse issues in pregnancy,⁵ the lack of expertise in treating these women,⁶ inadequate availability of supportive services for women and their families, societal stigma and judgmental beliefs surrounding drug abuse, and fear among medical professionals regarding legal liability related to the care of women in pregnancy generally and specifically in the case of substance abuse in pregnancy.

Substance abuse in families is often generational, resulting in family dysfunction that is apparent as extreme poverty, lack of educational achievement, and severe medical morbidity and early mortality due to opiate overdose deaths and other associated health problems and violence. Models of service that emphasize longitudinal care, support gender sensitivity, acknowledge the chronic nature of addiction with expected relapses and remissions, and promote a multidisciplinary approach have resulted in substantial improvement in pregnancy outcomes, quality of life, ability to parent, optimal developmental progress of children, and ongoing abstinence from substances of abuse.^{6,7}

While these approaches are generally much less costly than incarceration, placement of children in foster or adoptive care, and emergency medical care related to the cycle of drug abuse, intoxication/overdose, and withdrawal,⁸ they do require a collective societal agreement to treat drug abuse and addiction as an illness rather than a crime.

To this end, the legislature of the state of New Mexico has supported the development of two task forces to address the evaluation and coordination of the care of women with substance abuse issues in pregnancy and their children. The first task force was created by Senate Memorial 19 to assess and improve access to substance abuse treatment and prenatal care for

pregnant women with substance abuse problems. This task force met monthly between September 2009 and August 2010, and included a diverse range of stakeholders, including members from the NM Governor's Office of Women's Health, the Women's Justice Project, the NM Department of Health, CYFD, the DA Association, the medical community, NM Human Services Department Behavioral Health Collaborative, the Drug Policy Alliance, and representatives from the field of ethics and from community family services agencies. The final report from this task force was submitted in November 2010 to the legislature (see below for summary and appendix for complete report).

One of the outcomes of the first task force was to propose continuation of these efforts via House Memorial 14, which assigned the development of a new task force to the UNM Health Sciences Center, again to be comprised of members from a variety of fields and organizations. The House Memorial 14 Task Force began monthly meetings in February.

House Memorial 14 Task Force partners shared a commitment to integrate the critical experiences and knowledge of women who have been impacted by this issue into the House Memorial 14 Substance Abuse & Prenatal Care Task Force. The Task Force was charged with offering recommendations to reduce unnecessary referrals to Children, Youth and Families Department; increase treatment instead of incarceration for non-violent drug related crimes; and change attitudes about substance use. HM 14 partner, Young Women United (YWU), worked to ensure that the voices of women who had experienced substance abuse and pregnancy at the same time were included in the Task Force recommendations. YWU worked to build the capacity of women who have experienced pregnancy while using substances of abuse as leaders and activists committed to organizing around policy efforts to decriminalize substance use.

Young Women United organized a series of working groups with over 30 women who had previously been pregnant and substance using simultaneously. YWU collected and assessed experiences of these women in attempting to access prenatal care and treatment across New Mexico. In building political engagement of these women, YWU carried their experiences into discussions of the HM 14 Substance Abuse and Prenatal Care Task Force. As the HM 14 Task Force began to develop policy recommendations towards improving outcomes for these families, their work was accurately informed by the insight and broad base of knowledge provided by these women. Seeing an immediate and concrete use for their experiences and analysis around the issue, these women became increasingly invested in impacting policies and practices related to substance use and addiction.

All the women involved in this project understood the serious potential consequences of being pregnant and using. Based on previous experiences or the lives of people close to them, these

women understood that being pregnant and using, they might face probation violations, criminal charges or CYFD investigations, with foreseeable outcomes that included losing the babies they were expecting and possibly their other children. Facing this situation, over half of women involved in this project did not seek prenatal care or received care late in their pregnancy. Of those that did access prenatal care, the majority attempted to hide their substance use and/or addiction. In the Espanola Valley all participants did disclose their substance use and/or the substance use of their partners. None of the Espanola participants had trusting relationships with their medical providers or felt like they received compassionate/competent care or treatment. Only one of the 30+ women across the state had a trusting relationship with a medical provider in which she felt safe to disclose her addiction and in turn receive appropriate medical care and attention for herself and baby.

Prenatal **Honest**
Awesome **Scared**
Resources
Homeless **Doctor**
CYFDMother **Care**
Trust

Some reasons women did not get prenatal care or delayed their prenatal care:

- “I got prenatal care late in my first pregnancy because I was scared to tell the truth about using while pregnant. I wasn’t honest with the doctor, I lied and lied and lied”.
- “My biggest fear while I was pregnant was going to the doctor. I was afraid that they would call CYFD or call the police to report that I was using.”
- “I didn’t get prenatal care because I didn’t want the hospital or family to know I was using.”
- “With my first child I was scared to let anyone know I was pregnant or go to the doctor because I was using cocaine, marijuana, and alcohol.”
- “When I was pregnant with my twins, it was so scary. I was using and had two miscarriages before. The whole time I was panicked because I was afraid that someone would find out. I was so scared that I would hurt my babies or lose them. It was the worst time in my life. I was on edge for the whole time.”
- “Feeling scared to be honest with doctor for the fact that authorities would be called (CYFD) putting other children at risk.”
- “I was 24 weeks pregnant when I found out. During those 24 weeks I smoked meth, took pain pills for migraines, and drank. I was DEATHLY afraid of revealing the meth use to anyone. I had an intense ultrasound done, all was good.”
- “Being homeless and with nowhere to go.”

Challenging experiences with accessing prenatal care:

- “After sharing with doctor that I used, I felt scared. I wasn’t given any resources, just told -Don’t use anymore-.”
- “I was pregnant with my son and I was and had been using. I worried all the time about when I had him that he would be okay or if he would get taken away from me. I kept trying to quit using but never felt strong enough!”
- During my pregnancy/pregnancies I was too ashamed to admit to my doctor I was using and even though I feel she had to know I was – she never brought it up.”

Positive experiences being pregnant:

- “I know my son was healthy, I got to experience ultrasounds and getting excited about the neat things I learned.”
- “I remember when he took his first picture, we just seen his butt! I enjoyed hearing my son’s heartbeat for the first time.”
- “First child was a great pregnancy. No downfalls, no bad experiences, used at the beginning but I stopped. Prenatal care was the best thing ever!”
- “Felt good about my doctor appointments and myself. I felt safe... he became my family doctor, for all of my children. He knew I had a problem and he kept helping me and my family. He gave me a lot of resources I could go to. I’ve been in his care now over 13 years and he never judged me!”

Positive experiences with being engaged in advocacy efforts around these issues:

- “By sharing my experience to help others, I’ve turned something bad into something good. I’m learning that I can be a part of something to make a difference”.

WORK PLAN FROM HOUSE MEMORIAL 14 TASK FORCE

Upon beginning its work in February of 2012, the House Memorial 14 Task Force outlined a set of goals upon which it recommended that state efforts be focused, derived from the recommendations of the Senate Memorial 19 legislative report. These goals were refined and honed in order to provide the greatest possible benefit to the population targeted for improved services under the prior task force, and achievable over a focused period of time, with attention to the unique needs of New Mexico as a rural state with a culturally diverse population.

1. Clarify which substance abuse programs in NM are currently capable of treating pregnant women, how many newly available facilities there would be if every program that served women could serve pregnant women, which programs are available to teens, and which prenatal care providers are offering substance abuse treatment.
2. Identify best practices (medical and behavioral health) regarding care of pregnant and post-partum women with substance abuse problems and their children, including standardization of drug testing and other manners of assessing substance abuse treatment needs of pregnant women.
3. Increase the number of providers in the state who offer prenatal care to women with substance abuse, including opiate replacement therapy. Focus on the population centers of Albuquerque, Roswell, Las Cruces, Espanola, Farmington, Las Vegas, and Silver City, so that women will not need to travel far from their home community to receive appropriate services.
4. Increase treatment over incarceration for drug-related crimes, including for juveniles in detention, etc.
5. Establish a safety net for families affected by substance abuse without need for child protective services involvement following a positive urine drug screen in the newborn (home visitation, case management, etc.). This requires promoting a better understanding by health care providers of laws regarding reporting and knowledge of resources for referral.
6. Approach the legislative efforts that came out of the Senate Memorial 19 Task Force instead via regulation change, including assessment of contraceptive needs for individuals who present to substance abuse programs requesting services, prioritization of pregnant women seeking substance abuse treatment, and payment by Medicaid for opiate replacement therapy (methadone or buprenorphine) regardless of pregnancy status.
7. Establish a central intake number for services for pregnant women with substance abuse problems to provide linkage to treatment, and a website with resources for women, their families, and health care providers, plus standardize and simplify the referral process.
8. Involve organizations that can assist to create and disseminate public service messages to help change attitudes of women, families, health care providers, and others regarding evaluation and treatment of women with substance abuse issues in pregnancy.
9. Design ways to measure success of interventions via research and data collection.

INTERVENTIONS IN-PROCESS AND FUTURE DIRECTIONS

1. Clarify current services/programs:

A significant barrier to improving services for pregnant women with substance abuse issues is the lack of a complete inventory of those programs and individuals currently providing some component of this care in New Mexico. Services for pregnant women with substance abuse issues can be organized around substance abuse programs that refer women to prenatal care services, or prenatal care providers who refer patients to substance abuse programs. A more comprehensive care model is one in which pregnant women with substance abuse issues are served in a multidisciplinary setting which includes prenatal care, substance abuse counseling, opiate replacement therapy when needed, case management, developmental and routine preventive health care for the newborn after delivery as well as for other children in the family, ongoing health care and substance abuse treatment for women following delivery, and similar services for partners/close family members who are involved in the lives of women and their children.

There are programs that provide some or all of these services in New Mexico, however assessment of the breadth and depth of services requires the ability to survey a very large number of programs, including all prenatal care and substance abuse treatment providers in the state. A convenience sample of referral sources from CYFD in Bernalillo and Sandoval Counties revealed 37 substance abuse treatment programs, of which 5 that were able to be reached verified that they offer services to pregnant women. These include PB&J Family Services, Turquoise Lodge, Milagro/ASAP, Almas de Amistad, La Familia Inc./Namaste. Of these, only Milagro provides prenatal care (in addition to multidisciplinary services). Given that Bernalillo County is the most populous of New Mexico with a high density of health care providers, certainly it can be inferred that other counties have fewer or no services for pregnant women with substance abuse issues.

This is an area that would be best addressed by a large-scale survey conducted by a research group, perhaps via the University of New Mexico, to determine services currently available and attitudes toward and barriers to development of new programs. The task force began work on designing such a survey, and it is hoped that it can be refined and implemented with the support of the University of New Mexico Health Sciences Center.

2. Identify best practices (medical and behavioral health):

Women with substance abuse issues in pregnancy cannot be offered appropriate services unless they are identified by appropriate screening measures. Universal screening using a survey-type tool has been shown to best determine women who would benefit from further evaluation and treatment of substance abuse problems in pregnancy.⁶ These surveys are ideally administered in person in a non-judgmental fashion.⁵ They must be concise and able to be administered in a brief time period in order to be useful in the clinical setting. They also provide an opportunity for education of women about the effects of substance abuse on pregnancy. Urine drug testing of all women discourages active users from seeking prenatal care and fails to identify many women with episodic but clinically significant use. Urine drug screening of those thought to be at “high risk” without requesting permission creates risk for racial and social profiling and raises ethical and legal concerns.⁴

Examples of screening tools include the “4Ps”:

Have you ever used drugs or alcohol during this **P**regnancy?

Have you had a problem with drugs or alcohol in the **P**ast?

Does your **P**artner have a problem with drugs or alcohol?

Do you consider one of your **P**arents to be an addict or alcoholic?

Ewing H. Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA 94553. Phone: (510) 646-1165.

A woman who answers “yes” to any of the 4Ps questions is referred for additional evaluation of substance abuse issues. Other brief surveys focus more on alcohol abuse. Examples of additional screening devices include “AUDIT”, “T-ACE”, “TWEAK”, and “Ten-Question Drinking History (TQDH)”. These are reviewed in the Health Resources & Services Administration (HRSA) document titled “Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health” published in 1997 and attached in the Appendix section below.

Prenatal care providers need to be encouraged to use one or more of these screening tools with each patient seen for care and to make appropriate referrals for women who screen positive.

Once women are screened and evaluated for substance abuse problems in pregnancy, they must be referred to appropriate treatment. Simply telling women that substance abuse is dangerous in pregnancy is not sufficient, as it contributes to shame and stigma without providing paths to real solutions. Ideally, women are served in a multidisciplinary program that provides prenatal care, substance abuse treatment, mental health services, and case management. Unfortunately, many geographic areas do not have such programs. Where fully

integrated programs do not exist, optimal care can be facilitated by coordination and communication between prenatal care providers, substance abuse treatment providers, and other professionals.⁹

Protocols that have been developed in accordance with supporting evidence from the medical and behavioral health literature should be shared among programs providing care to women and their families, so that common standards are followed within the state to ensure that the highest quality of care is offered. Examples include guidelines for initiation of opiate replacement therapy in pregnancy, drug testing of newborns, treatment of neonatal abstinence syndrome, assessment of appropriateness for breastfeeding, etc. Some of these guidelines are provided in the appendix to this report.

3. Increase the number of providers of care:

Increasing access to prenatal care and substance abuse treatment is a key component of improving outcomes for women and their children. Among the major barriers to this goal is the lack of providers trained in the provision of services to this group, and the lack of monetary support for development of programs and professional expertise.

The Milagro Program at UNM HSC has begun to offer a “mini-sabbatical” for health care providers interested in learning more about the care of pregnant women with substance abuse issues in pregnancy and their families. This experience is tailored to the needs of the individual clinician, and can include observation of inpatient initiation of opiate replacement therapy in pregnancy, prenatal care of women with substance abuse issues, labor management (including labor analgesia) for women with opiate dependence, monitoring and treatment of neonatal abstinence syndrome, and care of substance-exposed children in the outpatient setting. The experience would typically involve 2-3 days of observation of the program components. Following this experience, the clinician would serve as an advocate for the development of services in their geographical area, a process that would begin with in-service training of potential providers of buprenorphine for opiate replacement in pregnancy and treatment of neonatal abstinence syndrome. Ongoing consultation would be available from UNM physicians via the PALS (Physicians Access Line) hotline.

In addition, the Family Medicine Residency Program at UNM has a goal of preparing physicians for rural practice in New Mexico. By training family medicine residents and Maternal and Child Health fellows to care for women with substance abuse problems in pregnancy, this increases the likelihood that these services will be available in rural areas of the state, and also allows a greater number of women in the Albuquerque metropolitan area to be served.

Many nurse trainees also rotate through the Milagro clinic as an outpatient experience, which increases awareness and understanding of these issues among the newest generation of those who will work in medical settings across the state.

Further goals of the Milagro program include training residents and fellows in the Obstetrics and Gynecology program regarding the care of women with substance abuse issues in pregnancy, and specifically in the area of opiate replacement with buprenorphine in pregnancy. Currently Ob-Gyn Maternal and Fetal Medicine fellows rotate through the Milagro clinic to gain experience in the outpatient care of these women.

Focusing efforts on developing “centers of excellence” in several communities in New Mexico would ensure that women and their families can access care without the barrier of traveling far from home. Potential locations include Albuquerque, Roswell, Las Cruces, Espanola, Farmington, Las Vegas, and Silver City. Seed grants would allow these communities to establish perinatal substance abuse programs to serve families in their area. Keeping women in their communities also allows them to maintain access to their support system, facilitates care of children, and utilizes the unique knowledge of local practitioners about community culture and traditions.

4. Support treatment over incarceration:

From a Bureau of Justice Statistics bulletin, “Between 1990 and 2009, the number of incarcerated women increased 153%. Most women are incarcerated for nonviolent crimes, including drug and property offenses. On average, 6–10% of incarcerated women are pregnant, with the highest rates in local jails. Data on rates of pregnancy in juvenile facilities are limited, but indicate higher rates than in adult facilities.”¹⁰

There are many arguments to support treatment over incarceration: incarceration during pregnancy leads to poorer health outcomes for infants,¹¹ substance use is exacerbated by jail, especially for incarcerated pregnant women,¹² substance abuse treatment for pregnant women reduces crime and related costs, and this is especially true for residential treatment.⁸

Based upon referrals to the Milagro residential program, it is evident that judges in Albuquerque are willing to place some women in residential treatment rather than continue to incarcerate them. Unfortunately, the Milagro program is one of a very limited number of residential treatment programs for pregnant and postpartum women in New Mexico. Referrals to residential treatment programs also depend on the individual decisions of judges, and not systematic and transparent policies. During the 2011 Legislative Session, Task Force partners Young Women United, Women’s Justice Project and Drug Policy Alliance of New Mexico

collaborated to advocate for Treatment Instead of Incarceration legislation. With bipartisan support, Senate Bill 321 passed but was vetoed by Governor Martinez. This was the first time treatment instead of incarceration legislation was passed in New Mexico. Partners continue to build strategies for future legislative efforts.

In 2012 the Drug Policy Alliance of New Mexico stepped forward to initiate and co-chair the LEAD Santa Fe Task Force. From their work, the City of Santa Fe became the second city in the nation to pilot the Law Enforcement Assisted Diversion program (LEAD) when they voted unanimously to approve this program in July 2013. LEAD is a pre-booking diversion pilot program that allows police officers the discretion to transport arrested individuals to community-based services for treatment of substance abuse, rather than completing the booking and incarceration process. The Drug Policy Alliance describes that the LEAD model will keep families together, enhance public safety and save the criminal justice and health system millions of dollars.

”In order to maximize the success of women sentenced to community-based programs, it is critical for the programs to include comprehensive services, including therapy, parenting classes, and substance-abuse treatment. Family-based treatment programs as a sentencing alternative permit mothers and children to heal together and demonstrate consistently successful outcomes for children’s health and stability, family reunification, reduced rates of recidivism, and sustained parental sobriety.”¹³

In 2003, CSAT evaluated family residential treatment programs, and found that, at six months post-treatment¹⁴:

- 60% of the mothers remained completely clean and sober
- Criminal arrests declined by 43%
- 44% of the children were returned from foster care
- 88% of the children treated in the programs with their mothers remained stabilized, six months after discharge
- Employment rose from 7% before treatment to 37% post-treatment
- Enrollment in educational and vocational training increased from 2% prior to treatment to 19% post treatment

5. Develop a safety net for families

Health care professionals are often unclear regarding their role in the safety of children born to women with substance abuse issues. They may feel that any revelation of substance abuse in pregnancy requires a report to CYFD, however the CAPTA policy includes the option that where abuse/neglect are not alleged, referral resources and information can be given by community

providers or by CYFD without opening an investigation. When women/families seek care from a comprehensive prenatal care/substance abuse program during pregnancy and are supported for success in both abstinence from substances of abuse (often via opiate replacement therapy) and development of good parenting skills, the need for involvement of CYFD is reduced due to the presence of a community-based safety net. This allows CYFD resources to be reserved for families that are at the highest risk and need the greatest level of supervision.

Because families enter care at various points along the timeline of pregnancy and parenting, there is room for many models of care. The UNM Milagro/Focus program serves women from diagnosis of pregnancy until the youngest child in the family reaches three years of age, providing prenatal care, labor and delivery services, treatment of neonatal abstinence syndrome, provision of contraceptive services, primary care for children and adults, and comprehensive case management and child development services. PB&J Family Services is another example of a community organization that serves vulnerable families with substance abuse and incarceration histories, providing therapeutic pre-school, home visits, case management, parenting skills, job re-entry support, and other services.

Unfortunately, the need for services far outpaces the available resources. This is particularly true in the current economic environment, when funding sources are being cut for many established programs and the ability to fund new efforts is curtailed. Collaborations between existing programs and securing grant and other funding sources are some options for expanding the safety net to include more children and families, thereby helping to keep families intact and decrease trauma related to separation and instability. Case management services for mothers, newborns, and their families is crucial in providing needed support for parenting, and public funding needs to be prioritized in this area so that increased focus is placed on prevention. Ultimately, the availability of adequate services depends on reliable sources of funding that promote program stability and development of expertise, and allow growth when demand for services increases.

6. Promote regulatory and policy change

One of the most significant recent policy changes involves the coverage of opiate replacement therapy by New Mexico Medicaid. While buprenorphine has been covered for several years, methadone for opiate replacement therapy has only recently been added as a benefit to Medicaid recipients:

“Effective September 1, 2012 the New Mexico Medicaid program will begin covering medication assisted treatment (MAT) services for New Mexico Medicaid eligible recipients when provided by an Opiate Treatment Program (OTP). These centers are often called

methadone clinics.” (*State of New Mexico Medical Assistance Program Manual Supplement released September 24, 2012.*)

This will allow Medicaid-eligible individuals to choose the opiate replacement therapy that works the best for them as individuals and will help decrease the likelihood that women will be forced to discontinue opiate replacement therapy after the postpartum period, which is a high risk time for relapse to substances of abuse. It will also help stabilize families by allowing women’s partners to get treatment, as well.

Moving toward more comprehensive and harm-reduction oriented care of women with substance abuse issues in pregnancy also requires creation of policies that encourage women seeking substance abuse treatment to receive appropriate reproductive health care.

As an example, most women do not plan to be pregnant while substance-addicted, however knowledge about and access to contraceptive services is limited. Legislation has been explored in New Mexico which would have required substance abuse providers to assess contraceptive needs of clients and provide referrals to appropriate services, however this was not successful. The below research abstract, written by a UNM Obstetrics and Gynecology resident and supported by UNM Obstetrics and Gynecology and Family Medicine faculty, illustrates how care can be advanced by promoting policy change in instances where legislative change has not been successful. Research efforts such as this help to support institutional policy change among those who provide substance abuse care, and serve as an example of collaboration between academic centers and community service providers:

Increasing Long-Acting Reversible Contraception Use among Methadone Using Women

Mary T Sale, MD (Research Advisors: Joanna Hooper, MD and Tony Ogburn, MD)

Background: Upwards of 86% of pregnancies from women with substance abuse issues are unintended. Unintended pregnancy has a profound health and psychosocial impact on women of reproductive age. Women with unintended pregnancies are at an increased risk for poor prenatal care, greater likelihood of abortion, neonatal death, and child abuse. Concurrent substance abuse during pregnancy increases rates of deliveries with low birth weight, preterm labor, and neonatal abstinence syndrome. Long-acting reversible contraception (LARC) is more than 20 times more effective at preventing unintended pregnancy than other forms of contraception, and when women are counseled about the relative effectiveness of LARC, then tend to choose LARC 75% of the time compared to the baseline rate of use of about 8%.

Objective: To increase use of long-acting reversible contraception (LARC) among women enrolled in an Albuquerque area methadone clinic by providing focused training and resources

to the clinic's licensed drug and alcohol counselors. Clients enrolled in methadone clinics routinely receive one hour of substance abuse counseling per month at a minimum. Our hypothesis is that by providing brief yet thorough counseling tools regarding effectiveness and availability of LARC for the counselors, LARC awareness and utilization will increase among the facility's methadone dependent reproductive age female clients.

Methods: Female clients at the Recovery Services of New Mexico methadone clinic will complete baseline surveys regarding their knowledge and use of contraception. The surveys address current and past contraception use, knowledge of contraceptive options and access, experience with contraceptive counseling, and enrollment in Family Planning Medicaid. Eligible women include those who are enrolled at the Recovery Services of New Mexico methadone clinic, childbearing age (18-45), English speaking, and are not surgically sterilized. Anonymous surveys will be completed during the initial recruitment week. Concurrently, we will meet with the clinic's full-time licensed drug and alcohol counselors on two occasions, one week apart. During the first meeting, we will collect baseline surveys of contraceptive knowledge, discuss current contraception counseling techniques, and provide resources. We will provide contraceptive counseling incorporating the Contraceptive CHOICE Project counseling strategy, which was modeled for optimal use by non-medical staff. Information will be included on the requirements, availability, and benefits of New Mexico's Family Planning Medicaid. The second meeting will reiterate counseling strategies, address any specific strategies or obstacles the counselors foresee on behalf of their clients and include role-playing activities. Brief contraceptive counseling will then be included in the clients' required monthly substance abuse counseling sessions. We will then repeat the client survey after 3 months to assess changes in contraceptive practices and knowledge.

Conclusion: Pending Results

7. Establish a state-wide central intake number and website

One of the most difficult issues facing health care providers and families seeking care for women with substance abuse issues in pregnancy is the lack of a centralized access point for referrals. One of the key tenets of care of women with substance abuse in pregnancy is the recognition that services must be available on short notice for women who have arrived at the point that they are considering treatment. A delay in accessing care can mean that the moment of opportunity is lost and vulnerable women may not be able to seek care again for an extended period of time. Contributing to difficulty accessing care are housing insecurity, transportation difficulties, lack of telephone access, and caring for children.

The transient nature of many programs, often due to difficulties with funding (particularly substance abuse and behavioral health providers), means that referral resources must be constantly updated so that women and families do not encounter dead-ends that ultimately may discourage further seeking of care.

The Department of Family and Community Medicine at the University of New Mexico has agreed to host a website for the Milagro/Focus program which would include links to other similar programs in New Mexico and educational resources for women, their families, and their health care providers.

Nurse Advice New Mexico, a 24-hour hotline that provides telephone medical advice to callers from anywhere in New Mexico, receives many calls from women who are pregnant or parenting and are substance-using. Members of the task force have approached the advice line to consider serving as a resource for women and families who call seeking information on substance abuse in pregnancy and its treatment, and plans have been made to create an evidenced-based protocol that is specific to pregnancy, allowing for even more support for this vulnerable population. Referrals are already offered from the advice line to the Milagro Program and other substance abuse and mental health services.

8. Create public education campaign

YWU facilitated working groups with over 30 women designed to collectively build preliminary messaging and media plans for the foundation of a multi-dimensional public education campaign designed to de-stigmatize substance use and addiction. Women who have been pregnant and using at the same time have developed preliminary messages and identified target audiences to spark a more nuanced conversation about the impacts of addiction and the drug war on families. These women understand substance use to be incredibly complex and are working through ways to interrupt the popular thinking which says moms who use must love their drugs more than their kids, or that if addicts really loved their kids they would simply stop using. These women have so far created media pieces for others currently in this situation as well as for other New Mexicans who only see addiction from the outside. The work done so far will be carried into a longer-term project to shift dialog and debate about New Mexico's families and their struggles with substance use. Young Women United has received a small grant from the Drug Policy Alliance to collectively create the foundation of a public education campaign to reframe the dialog around addiction and families.

9. Design ways to measure success

Much data already exists to support comprehensive substance abuse, reproductive, prenatal, and child development services for women and their families affected by substance abuse. The ability to further the process of data collection and analysis specific to New Mexican families depends on funding to support such research. Areas that would benefit from further study include comparison of long term developmental outcomes of children exposed to methadone

versus buprenorphine, patient satisfaction with substance abuse counseling provided on-site with prenatal care versus at a distinct location, the role of continuity of care in the provision of prenatal and delivery and postpartum care and how it affects adherence to treatment, labor pain management issues for women on opiate replacement therapy, relationship of partner access to opiate replacement therapy to relapse risk for pregnant women, etc. Funding valuable research on these and other topics will inform care and assure that investment in services is made in a way that most benefits women and their families.

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APPENDICES: RESOURCES FOR WOMEN, THEIR FAMILIES, AND PROFESSIONALS

I. UNM HSC Drug Testing Policy for Pregnant Women and Newborns

Guidelines for obtaining maternal and neonatal UDM

Albuquerque, New Mexico

The following guidelines for urine drug screening for pregnant women and their newborns are to be utilized by all services. These guidelines have been approved by the medical directors and reviewed by University of New Mexico legal. They were developed for use by all the hospitals in Bernalillo County, New Mexico, and distributed to faculty and residents in Ob/Gyn, Pediatrics and Family Medicine, Certified, Nurse-midwives, and labor and delivery /mother-baby unit nursing staff.

- 1) UDM should only be ordered for specific indications and should be sent on all patients with these indications:

Maternal UDM in OB Triage or L & D

History of substance abuse in this pregnancy
 Preterm labor (Not POOC)
 Placental abruption
 Behavior consistent with acute intoxication

Neonatal UDM at newborn nursery

History of substance abuse in this pregnancy
 Preterm labor (Not POOC)
 Placental abruption
 Unexplained neonatal depression, seizures, jitteriness or possible neonatal abstinence syndrome

- 2) Informed consent

Pregnant woman and postpartum mothers are to be informed that a UDM will be sent based on our standard guidelines. Written consent is not required. If they refuse to send a maternal

UDM that request should be noted and honored. Parents do not have a legal right to decline a medically indicated infant UDM

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Tony Ogburn, MD, Chair of University Hospital Maternal and Child Health Committee

September 20, 2004

UNM HSC Guidelines for Drug Testing of Newborns

Introduction

Presbyterian, University and Lovelace Healthcare Systems in Albuquerque have collaboratively developed a community standard for drug testing of newborns. The purpose of the collaborative work, of this specific policy, and of drug testing in general is to ensure the best possible care and the best interests of newborns and their families. The importance of drug testing of newborns centers on the information the results provide to inform and direct clinical care of the patient.

Principles of drug testing of newborns

- Have ongoing discussions with pregnant women about use of alcohol and other drugs prior to and during the pregnancy and present the risks and dangers of licit and illicit substance use during pregnancy.
- Obtain drug testing for specific clinical situations, as listed below, in order to inform clinical management.
- Inform the parents of the clinical indications for drug testing of the newborn.
- Results of a positive test result should be communicated to the mother and members of the care team. The goal is to ensure the best possible care and the best interests of the baby and its family.
- End the practice of referring all positive drug tests to CYFD.
- Interpret the positive drug screen as one component of an assessment of the family milieu.
- Ascertain the safety of the mother and baby. In the course of assessing the family's abilities to care for the mother and baby, referral to CYFD exists as an option. Given other community resources (e.g. Los Pasos Program or appropriate programs located in the family's community) and the family's willingness to engage in care, the hospital social worker and healthcare providers will determine if a referral to CYFD is or is not indicated.
- Before discharge, the healthcare team will construct, in collaboration with the family, a plan of care that will address the significant social and medical conditions for both the mother and her baby.

Criteria for drug testing of newborns

1. Signs suggestive of neonatal abstinence syndrome
2. Maternal history of drug use <1 year prior to EDC
3. Positive drug screen in the mother during pregnancy or labor
4. Inadequate (i.e. little or no) prenatal care
5. Placental abruption (in the absence of hypertensive disease)
6. Neonatal seizures
7. Odor of alcohol on mother's breath or concerning maternal behavior

A urine drug test may aid in determining the etiology or associated factors leading to the presence of conditions such as infants who experience perinatal/neonatal depression (in the absence other probable etiology) or whose intrauterine growth makes them small for gestational age (in the absence of other probable etiology).

Recommended Guidelines for a Community Standard of Neonatal Drug Testing

Submitted by Andrew Hsi, Randy Nederhoff, and Tom Rothfeld
December 2001

Introduction

Many physicians practicing at the major hospitals in Albuquerque do not believe that an admission of drug use during pregnancy or a positive screen on a mother or baby constitutes *a priori* evidence of child neglect or abuse. For that reason, physicians have moved toward development of guidelines regarding drug testing that can become a community clinical standard of care. This guideline calls for ongoing discussions with pregnant women and new mothers about the risks and dangers of licit and illicit substance use during pregnancy and postpartum. This guideline recognizes the specific clinical situations that require drug testing to inform clinical management. This guideline for drug testing does not require the physician to obtain informed consent. Rather, the physician would inform the parents of the clinical indications for testing in the normal course of discussions about their baby's status, progress and plans for further care. If the physician receives a positive test result, then frank communication will ensue between the mother and the physician and members of the care team. The goal is to ensure the best possible care and the best interests of the baby and its family. The care team will complete assessments of the mother before discharge regarding her abilities to care for her baby. Based on our clinical experiences, the guidelines will not recommend a routine referral to CYFD based on a positive drug test. Rather, each mother who has had a positive drug test or whose baby tests positive will leave with a discharge plan to address the significant social and medical conditions for herself and her baby. The guidelines recommend that the medical team make a referral to CYFD for possible child neglect if the mother does not demonstrate abilities to provide care for her baby. Other options that the team will consider include referral to the FOCUS Programs (Los Pasos, Milagro, and Starting Early to Link Enhanced Comprehensive Treatment Teams or SELECTT Programs) coupled with close medical care with the baby's primary care physician. We anticipate implementation of this policy to result in better care for families and appropriate referrals to CYFD. Most importantly, adoption of these guidelines will mean mothers and babies with positive drug tests will not automatically come to the attention of law enforcement agencies in violation of the recent Supreme Court ruling.

Statement of purpose for community clinical standard of care guidelines

The clinical importance of urine or meconium drug testing centers on the information the results provide for patient care. A positive test for substances of abuse informs the obstetrician, pediatrician, neonatologist, or family practitioner that a mother and baby have serious and significant risk factors for medical problems. Those problems occurring for pregnant women include acute withdrawal from opiate drugs, abruptio placenta with resulting catastrophic hemodynamic effects to the baby, premature onset of labor, premature delivery, and acute intoxication. Medical problems for fetuses include episodic opiate withdrawal in utero, fluctuations in fetal circulation with damage to vital organs including the brain and intestines, intrauterine growth retardation, fetal distress with passage of meconium into amniotic fluid, and premature birth. For the newborn infant, common medical problems include acute opiate withdrawal known as the Neonatal Abstinence Syndrome, neonatal depression, abnormalities of neurological functioning such as jitteriness and decrease in the quiet-alert state, poor feeding, irritability, and seizures. To lack access to this important information places the medical providers and institutions at risk of failing to provide appropriate and optimal care.

Provision of appropriate and optimal medical care requires physicians to know with certainty what conditions affect a woman during pregnancy or her newborn. Some screening tests reveal possible medical risks to the pregnancy and fetus not common to all pregnant women. For example, prenatal laboratory tests include the Glucose Tolerance Test for pregnant women who may have diabetes. Protocols used in nurseries call for screening tests done on newborns born before 35 weeks, including a CBC and blood cultures, in addition to inpatient observation for at least 48 hours. All of the conditions screened for have corrective medical management. Medical providers are not required to obtain informed consent for these tests. They obtain the tests in the context of usual clinical care. The same criteria apply to the rationale for testing for drugs in pregnant women and their babies in the context of possible maternal drug use in pregnancy.

Guidelines for drug testing of newborns

- Have ongoing discussions with pregnant women about the risks and dangers of licit and illicit substance use during pregnancy.
- Obtain drug testing for specific clinical situations as listed below in order to inform clinical management.
- Inform the parents of the clinical indications for drug testing of the newborn.

- Results of a positive test result should be communicated to the mother and members of the care team. The goal is to ensure the best possible care and the best interests of the baby and its family.
- End the practice of referring all positive drug tests to CYFD.
- Interpret the positive drug screen as one component of an assessment of the family milieu.
- Ascertain the safety of the mother and baby. In the course of assessing the family's abilities to care for the mother and baby, referral to CYFD exists as an option. Given other community resources and the family's willingness to engage in care, the clinical social worker and care team may determine that a CYFD referral may not be the most appropriate course of care.
- At the time of discharge, the healthcare team will construct, in collaboration with the family, a plan of care that will address the significant social and medical conditions for both the mother and her baby.

Criteria for drug testing of newborns

Signs suggestive of neonatal abstinence syndrome.

Perinatal/neonatal depression (in the absence of an obvious cause).

Neonatal seizures.

SGA or marked IUGR (in the absence of an obvious cause).

Placental abruption (in the absence of hypertensive disease).

POOC (in the absence of an obvious cause) leading to premature delivery (<35 weeks).

Maternal history of drug use < 1 year prior to EDC.

Positive drug screen in the mother during pregnancy or labor.

Obvious odor of alcohol on the mother's breath.

Summary of documentation for guidelines

- A large percentage of pregnant women use alcohol, tobacco, and drugs of abuse.
- History taking for drug use does not discover all pregnancies at risk.
- Tests for drug use provide significant clinical information.
- Tests for drug use have methodological limitations.
- A positive drug test alerts physicians to monitor for medical complications.
- Babies with prenatal alcohol and drug exposure need follow up care for developmental problems through the first 3 years of life.

- Local policies have allowed pregnant women using drugs to elect a program of prosecution diversion that directs the women to prenatal care and drug treatment.

Prevalence of drug use among women of childbearing age in New Mexico

Studies conducted by the Substance Abuse Epidemiology Unit of the New Mexico Department of Health from 1990-1996 demonstrated that women seeking pregnancy testing have a high level of ethanol and drug use. The unit studied over 2000 women each year from across the state that completed an anonymous questionnaire and had a urine specimen submitted for pregnancy testing also analyzed for metabolites of drugs. The study received an exemption from the UNM HSC Human Research and Review Committee. The results showed that among women submitting a urine specimen for pregnancy testing, 20% indicated use of marijuana in the four weeks before presenting to the clinic. 2.8% had used methamphetamine, 3% cocaine, and 0.9% opiate drugs. For legal drug use, 40% had used ethanol and 45% had used tobacco. The questionnaire detected ethanol use better than urine drug testing, but urine drug testing detected use of "harder" drugs much better. Analyzing only the questionnaire responses would have missed two-thirds of those women who used cocaine or opiates. Many women used illicit and licit drugs in combination with the most common mixtures including tobacco, ethanol, and marijuana use. For those women who thought they might be pregnant, the prevalence of use of all substances appeared to be two-thirds that of the general study population. Thus the prevalence of illicit and licit drug use during pregnancy exceeds ten-fold most commonly screened complications of pregnancy and exceeds at least a thousand-fold conditions commonly screened for newborns. Although urine drug testing at the time of delivery may not detect use of illicit drugs early in pregnancy, the addictive potential of many of these drugs leads to the strong possibility that women will continue using them throughout pregnancy.

Screening tests provide an important method of detecting serious conditions when the condition to be detected occurs commonly and when the test does well in separating those who truly have the condition from those who do not. Drug testing has met both of the criteria for a successful clinical screening test. Illicit drug use during pregnancy may affect up to 5000 babies in New Mexico annually with marijuana exposure, 750 with cocaine exposure, and an additional 700 with methamphetamine exposure. The major limitation of most drug testing of pregnant women and newborns comes from the testing methodology that sets a threshold level below which the laboratory reports a negative test. For example, detection of ecogonine, the biological metabolite of cocaine, at any level in the urine or meconium of a patient should not occur unless the pregnant woman received prescribed cocaine shortly before delivery. However, due to the

possible error level of the test itself, detection of very small amounts of ecgonine will return a report of a negative result.

Other limitations include the timing of the test and difficulties distinguishing metabolites of licit from illicit drug use. Most urine drug tests cannot detect drug use greater than 48 to 72 hours before testing. A positive test for all drugs excepting marijuana indicates recent use. Marijuana, due to its storage in body fat with chronic smoking or ingestion, may pass into body fluids over a longer time with detection in some laboratories occurring for 30 days after last use. Current urine drug testing methodologies present problems in detecting methamphetamine use. Components of common over-the-counter medications contain ephedrine and related substances that serve as precursors in methamphetamine synthesis. However, other confirmatory tests can distinguish the presence of methamphetamine from legal compounds.

Alternatives to urine or meconium drug testing for detection of drug use

In the context of discussion of obtaining "informed consent" for drug testing, alternatives exist for detection of licit and illicit drug use during pregnancy. Consistent interviewing of all women presenting for prenatal care may allow frank discussion of substance use. Selected research provides insight into the history taking of health care providers. Publications analyzing the use of short sets of questions such as the MAST or CAGE as screening tests for the detection of ethanol abuse have repeatedly shown that health care providers do not ask for ethanol use history consistently. Literature on interviewing for substance use has shown that many health care providers find asking about use difficult in their practice. This difficulty arose from concerns that questioning might invade an individual's privacy, that disclosure of use would result in unanticipated additional demands of limited office visit time, and that the lack of treatment resources would result in referrals without timely services. In addition, many health care providers felt that their own patients would not have substance use problems. This perception increased as the estimated annual income of the patient increased. Research done in Pinellas County, Florida, demonstrated the same prevalence of substance use among pregnant women receiving prenatal care covered by private health insurance or covered by Medicaid.

Other indicators of possible drug use present greater difficulties for use as screening tests. In the past, individuals have undergone drug testing based on clinical assessments of behavior in the emergency room or on Labor and Delivery. Some health care providers have confidence in their abilities to detect alcohol on a person's breath or to detect intoxicated behaviors. Anecdotes abound about testing pregnant women based

on the presence of tattoos or on the behavior and appearance of their partners. Little information exists about the clinical reliability of subjective impressions by health care providers correlated with the prevalence of positive drug screens among those tested.

Ideally, a pregnant woman would start prenatal care early in pregnancy. As an empathetic and trusting relationship developed between the patient and physician, they would talk about all issues that could affect the outcome of the pregnancy. Some health areas would be reviewed at each prenatal visit including diet and drug and alcohol use with appropriate counseling, testing and referrals offered. For the reasons presented above, substance use continues to be a hidden behavior. More efforts directed at detecting the behavior might create additional costs of physician time not compatible with current clinical demands. In addition, for many women the decision to disclose raises many difficult issues often including the relationship with her partner, examination of her family life, and access to treatment. While making a decision about disclosing substance use behaviors, important events transpire in the woman's health and the development of her fetus, particularly the fetal brain. Some women decide to avoid prenatal care entirely due to conflicts around substance use.

A positive drug test for a woman at delivery or her baby: What does it mean?

A positive drug test alerts physicians to provide intensive observations in the care of the mother and baby. These observations include attention to maternal mental status, vital signs, breastfeeding, and handling of the baby. For the baby, physicians increase attention to neurological adaptations, responsiveness, vital signs, and feeding. In discharge planning, many physicians have additional considerations regarding the safety of the mother and baby, preparations in the home for the baby, and closer medical follow up for problems with feeding and weight gain. Over the first two years, the baby will need more attention to acquisition of normal fine and gross motor skills and expressive language abilities. In short, a drug test will provide potentially important information, but the test has meaning only in clinical context. This is true of a large number of tests done on women at delivery and on their babies.

Policy issues related to drug testing at delivery

Physicians should carefully discern the clinical indications for obtaining a screening drug test and providing clinical interventions from how the hospital or community policies interpret the results of the test. Physicians have clinical interest in both positive and negative test results while hospitals and child protection authorities only react to

positive results. With either test result, physicians will use the results to provide the best care for mothers and babies in that the results allow consideration of a narrower differential diagnosis for the clinical presentations. Child protection authorities will not view a negative result as confirmation of adequate or optimal ability to parent. Hospital policies do not anticipate risk management problems from negative drug test results. These guidelines separate the clinical utility of drug tests and appropriate discharge planning from mandatory reporting of positive drug test results to CYFD to protect patients, physicians, and institutions from discriminatory practices.

In years past, the community has experienced confusion about appropriate interventions around maternal drug use during pregnancy. Hospital legal departments responded to this confusion by mandating reports to child protection authorities here and in other jurisdictions although the Children's Code of New Mexico does not specifically mandate such reactions. In response, child protection authorities have decreased the promptness and intensity of their investigations and interventions when they receive a referral based only on a positive drug screen. Law enforcement authorities also have reacted inconsistently. At one extreme, the district attorney in Charleston, South Carolina, entered into an agreement with the hospital and medical school of the University of South Carolina and law enforcement agencies to prosecute women identified with positive drug screens. This agreement formed the basis for the recent Supreme Court decision to overturn the use of urine drug screens as part of evidence to hold against the mother. In our community, the District Attorney proposed a similar strategy in 1990 and then modified it after consultation with medical experts to develop a prosecution diversion program. This program has continued for over 10 years for pregnant women with substance use problems identified by history or drug testing incarcerated at BCDC.

The concerns raised by the Supreme Court decision actually affect a very small application of urine drug testing. The court did not rule against obtaining the test, but it ruled against release of the test results to law enforcement authorities without the mother's consent. The practice of the University of South Carolina does not apply directly to the practice in hospitals in Albuquerque. Different hospitals and physicians have taken different approaches to a positive drug test for a newborn or its mother. Among those hospitals that have mandated reporting a positive drug screen to the Statewide Centralized Intake of the Children, Youth and Families Department have experienced different responses to the reports. Physicians and other health care providers have documented varying levels of CYFD responses after making a report. Although CYFD has stated that a report of a positive drug test will result in the report moving to an investigation, health care providers from all hospitals have found different

levels of thoroughness in the investigative process. Most investigations are closed shortly after the hospital made the referral. Most families reported receive referrals from CYFD to community services without further monitoring.

Current practice at CYFD does not include taking legal custody of an infant based only on positive drug test in a baby or mother. Policies at Statewide Centralized Intake call for reports of suspected child abuse and neglect to be forwarded to appropriate law enforcement agencies. These agencies do not in practice acknowledge the forwarded report nor respond without input from CYFD personnel about imminent danger to the child named as the focus of the report. Although a report of a positive drug test made from a hospital whose policy requires reporting of all positives may arrive eventually at a law enforcement agency, in real practice the report by itself does not generate investigations or arrests. This is a major and significant departure from the practice addressed by the Supreme Court.

II. CAPTA Statement

P.L. 111-320 CAPTA Reauthorization Act of 2010

Included in the law is the following requirement for states:

(ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants, except that such notification shall not be construed to –

- (i) Establish a definition under Federal law of what constitutes child abuse or neglect or
- (ii) Require prosecution for any illegal action;

Children, Youth and Families amended their Statewide Central Intake (SCI) procedures (Pr 8 Purpose of Protective Services Intake) in response to the above requirement. Below is this procedure amendment.

5.2 Information and Referral: When the public contacts SCI to report or discuss situations that are not related to abuse or neglect of a child, the PSD intake worker will provide information or referral services as appropriate. Infants born with, or identified as affected by, illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder when there is no allegation of child abuse or neglect are referred to community based services such as the Family Infant Toddler Program, or home visitation for assessment and the development of a safe plan of care. The intake worker documents the information and referral on the “Information Referral” window in FACTS which is accessed by selecting “Create” on the menu bar, then “Intake” from the drop down menu, and then “Information and Referral.”

NM Children’s Code 32A-4-3. Duty to report child abuse and child neglect:

- A. Every person, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a schoolteacher; a school official; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or neglected child shall report the matter immediately to:
 - (1) a local law enforcement agency;
 - (2) the department; or
 - (3) a tribal law enforcement or social services agency for an Indian child residing in Indian country.

III. UNM Maternal and Child Health Treatment Map for Opiate Replacement in Pregnancy

Opioid use in pregnancy is associated with increased risk of preterm delivery, intrauterine growth restriction, neonatal abstinence syndrome, and sudden infant death syndrome. Pregnant women with opioid addiction are at increased risk for delayed prenatal care and many fail to disclose their addiction history. Treatment with prescribed long acting opioid replacement therapy improves pregnancy outcomes for opioid dependent women and their children by improving prenatal care, reducing illicit drug use and drug-related behaviors and decreasing the risk of in utero withdrawal for the fetus. While methadone therapy has a long history of safety and efficacy during pregnancy and remains the “gold standard” for opioid addicted pregnant women, current data on buprenorphine (Subutex) in pregnancy have shown it to be both safe and effective with a lower incidence and milder neonatal abstinence syndrome. As buprenorphine is a relatively new medication, data regarding the long-term effects on children exposed to buprenorphine in utero is not available. An alternative to methadone is especially important in areas of the country such as rural New Mexico where access to methadone is extremely limited. Many women who are addicted to prescription opioids or already using buprenorphine are not willing to initiate methadone treatment during pregnancy.

Initial Evaluation for Buprenorphine Initiation During Pregnancy

The evaluation should be done by a physician or nurse familiar with the risks and benefits of methadone and buprenorphine replacement therapy during pregnancy.

Contraindications to Initiation of Buprenorphine in Pregnancy

The patient has primary addiction to a substance other than opioids.

The patient has an inability or unwillingness to be seen for prenatal care and buprenorphine assessment every 1-2 weeks.

The patient has chronic active hepatitis with laboratory findings showing evidence of significant liver damage.

The patient expresses a preference for methadone treatment.

Obstetrical Assessment

Obtain prenatal labs with the addition of liver function tests, urine drug screen, and hepatitis C antibody.

If patient is at least 24 weeks gestational age, obtain a non-stress test (NST).

Obtain ultrasound for dating and anatomic survey if under 28 weeks; if over 28 weeks obtain ultrasound for fetal growth to rule out intrauterine growth restriction (IUGR)

Counsel regarding buprenorphine.

Help patient enroll in substance abuse counseling.

Prior authorization is required for buprenorphine treatment. Currently there is a one month grace period from Medicaid and some other third party payers. Do not delay prior authorization requests.

Initial Evaluation for Methadone Initiation During Pregnancy

The evaluation should be done by a physician or nurse familiar with the risks and benefits of methadone and buprenorphine replacement therapy during pregnancy.

Contraindications to Initiation of Methadone in Pregnancy

Methadone is contraindicated in those patients with a prolonged QTc, generally defined as 450 or greater. Risks and benefits should be discussed with patients, including potential limits on ability to increase the dose as needed to treat opiate withdrawal or cravings.

Obstetrical Assessment

Obtain prenatal labs with the addition of urine drug screen, and hepatitis C antibody.

If patient is at least 24 weeks gestational age, obtain a NST.

Obtain ultrasound for dating and anatomic survey if under 28 weeks; if over 28 weeks obtain ultrasound for fetal growth to rule out intrauterine growth restriction (IUGR).

Obtain baseline electrocardiogram to measure QTc interval. Follow-up needed in 30 days or if presents with seizure or syncope.

Help patient enroll in substance abuse counseling.

Schedule prenatal care appointments based on the individual medical and psychosocial needs of the patient.

References

Prenatal Buprenorphine (Subutex) Induction, 2012. UNMH MCH Guideline
Methadone Therapy During Pregnancy, 2011. UNMH MFM Protocol #43

IV. UNMH Breastfeeding and Substance Abuse Guideline

Introduction:

Breast milk provides optimal nutrition and opportunity for mother-infant bonding that may lead to better parenting skills. Breast milk provides benefits, including protection from infection and some forms of cancer, that cannot be provided by artificial milk (formula). Some drugs of abuse may be passed to the newborn via breast milk and be dangerous for the baby. These guidelines are intended to encourage a consistent approach between providers; however, each case should be managed on an individual basis after considering the mother's history of substance use, prenatal care, and treatment for substance abuse. When mother and baby have different providers, communication between teams is encouraged.

Guideline

1. Breastfeeding Supported

- 1.1. Breastfeeding should be supported/encouraged in mothers who have a history of occasional use of alcohol or marijuana and who:
 - 1.1.1. quit when they discovered they were pregnant in the first or second trimester or
 - 1.1.2. continued to use occasionally, i.e., small amounts and not every day, and
 - 1.1.3. plan not to drink alcohol or smoke marijuana while they are breastfeeding or plan only to use small amounts and not every day (i.e., occasional use vs. abuse).
- 1.2. A maternal or infant urine toxicology screen positive for THC at the time of delivery should not alone preclude breastfeeding if the provider has reason to believe the mother's use is occasional, as described above, and the provider documents his or her reasons for believing the mother's use is occasional and therefore the benefits of breastfeeding outweigh the potential risks of the infant's exposure to marijuana in the breast milk.¹

¹ There is little evidence regarding the effect of maternal marijuana use and breastfeeding. What evidence there is suggests that the risk would only be significant when the mother is a "heavy user" of marijuana. See Djulus, et al., Nice & Luo, LactMed, ABM, and AAP Committee on Drugs.

1.3. In a mother **with a known history of substance abuse** during the current pregnancy, breastfeeding **should be supported/encouraged** under the following circumstances:

1.3.1. Mother's urine toxicology screen is negative for illicit drugs and opiates at delivery (excepting opiates given during labor),

1.3.2. she has had no positive urine toxicology screens in the 90 days prior to delivery (unless mom was hospitalized or in jail during entire 90 days prior to delivery; see below),

1.3.3. she indicates she does not intend to use illicit drugs or non-prescription opiates while breastfeeding her baby, and

1.3.4. she has received consistent prenatal care starting in the first half of her pregnancy.

1.4. Mothers using methadone or buprenorphine may breastfeed if they are not using other drugs of abuse, are enrolled in a substance abuse program, and have a note in their chart indicating approval to breastfeed or there is an order okaying breastfeeding from the newborn's provider.

2. Breastfeeding Generally Discouraged

2.1. In a mother **with a known history of substance abuse** (including illegal substances, prescription or non-prescription opiates, and alcohol) during the current pregnancy, breastfeeding **should usually be discouraged** under the following circumstances:

2.1.1. Mother's urine toxicology screen is positive for, or she admits to use of, any illicit substance or opiate at the time of delivery (excepting opiates given during labor) or during the 30 days prior to delivery.

2.1.2. Mother did not receive prenatal care during this pregnancy.

2.2. Exceptions to this recommendation are permitted based on the evaluation of a licensed independent practitioner, chart documentation of the rationale for the exception, and a written order. In these situations it may be appropriate to "pump and dump" until the drugs are cleared and to check weekly maternal UDMs over the first month or longer.

3. Breastfeeding Dependent on Healthcare Provider Discretion

3.1. In a mother **with a known history of substance abuse** during the current pregnancy, breastfeeding **may be supported/encouraged or discouraged on a case by case basis with a written order** from the baby's provider in the following circumstances:

3.1.1. In the 30-90 day period prior to delivery (but not within 30 days of delivery) mother either admits to use of, or has a positive urine toxicology screen for, an illicit substance or non-prescription opiate. In this case, it is critical to talk with mother's prenatal providers or substance abuse counselors to obtain their opinion as to whether or not this was a limited relapse and whether or not they believe mom is likely to resume use upon discharge from the hospital.

3.1.2. Mother only obtained sobriety in an inpatient setting, including incarceration. Again, provider should talk with mother's prenatal providers and/or substance abuse counselors.

4. Provider Considerations

4.1. When deciding whether to encourage/support a mother's decision to breastfeed in the hospital, providers may consider:

4.1.1. mother's history of drug use (e.g., serious history of abuse vs. history of occasional recreational use).

4.1.2. mother's participation in a substance abuse treatment program.

4.1.3. mother's behavior on Mother-Baby Unit or Women's Special Care Unit (e.g., frequent absences from unit or evidence of intoxication on unit).

5. Provider Counseling

Whether a provider is encouraging or discouraging breastfeeding in a woman with a history of substance use or abuse, he or she must counsel the mother on the possible harm to her baby if she breastfeeds and continues to use illicit substances or non-prescription opiates or is a heavy user of alcohol or marijuana, including but not necessarily limited to:

5.1.1. mother being impaired in her ability to care for her infant.

5.1.2. baby becoming sleepy or agitated or having difficulty sleeping depending on the drug.

5.1.3. the possibility of long-term effects on her baby's neurobehavioral development.

5.1.4. the possibility of legal repercussions if baby is found to be positive for an illicit substance or non-prescription opiate.

6. Infectious Diseases

6.1. Mothers who are Hepatitis C or Hepatitis B positive and would otherwise be encouraged to breastfeed, may breastfeed unless

6.1.1. they have cracked and bleeding nipples or

6.1.2. have another contraindication to breastfeeding.

6.2. Mothers who are HIV (Human Immunodeficiency Virus) or HTLV (Human T-cell Lymphotropic Virus Type I or Type II) positive should not breastfeed.

6.3. Mothers who have active, untreated tuberculosis should not breastfeed and should be separated from their babies until

6.3.1. the mother has received 2 weeks of treatment and

6.3.2. it is documented that mother is no longer infectious.

6.3.3. Babies may receive mother's expressed breast milk as tuberculosis is not transmitted via breast milk.

6.4. Mothers with active HSV (herpes simplex virus) lesions on their breasts should not breastfeed. Babies may receive mother's expressed breast milk as HSV is not transmitted via breast milk.

6.5. Mothers who have contracted varicella within 5 days of delivery or 2 days postpartum should be separated from their infants but their babies may receive expressed breast milk as varicella is not transmitted via breast milk.

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CDC, Tuberculosis and Pregnancy.

<http://www.cdc.gov/tb/publications/factsheets/specpop/pregnancy.htm>

V. Summary of Senate Memorial 19 Recommendations

The SM19 Taskforce developed a comprehensive state plan for improving policies and systems relating to substance abuse in pregnancy. Specifically, the plan called for reducing unnecessary referrals to CYFD and increasing home visitation; increasing access to quality substance abuse treatment, prenatal care and family planning for women; increasing access to supportive services; increasing treatment over incarceration for non-violent drug-related crimes; changing attitudes about substance use; increasing research and data collection; and creating an Oversight and Implementation Taskforce to follow up on these recommendations. The following is a summary of the task force recommendations:

1. Reduce unnecessary referrals to CYFD and increase home visitation.
2. Create legislation mandating that drug testing of pregnant women follow statewide workplace standards including written consent.
3. Clarify in CYFD state plan that substance-exposed infants be referred to home visitation program rather than child protection.
4. Increase access to quality substance abuse treatment, prenatal care and family planning for women.
5. Develop and implement gender sensitive treatment standards and rules for New Mexico.
6. Develop a state-owned centralized referral system for pregnant and parenting women seeking substance abuse treatment in New Mexico.
7. Prohibit discrimination against pregnant women in accessing substance abuse treatment.
8. Increase access to opiate replacement therapy for pregnant and postpartum women and their partners.
9. Increase Medicaid coverage postpartum for family planning and substance abuse treatment.
10. Increase access to supportive services.
11. Increase access to case management for substance abusing women and their families by requiring assessment of case management needs and priority referral to core service agencies.
12. Increase the accessibility to public housing for pregnant and parenting women with a history of substance abuse and/or incarceration.
13. Increase treatment over incarceration for non-violent drug-related crimes.
14. Create a taskforce to evaluate and recommend alternatives to incarceration for drug offenses and more gender-sensitive probation and parole policies.

15. Change attitudes about substance use.
16. Educate healthcare and social service providers about the differences between use, abuse and dependence, frame addiction as a public health problem, and reduce misinformation about substance use in pregnancy.
17. Launch a social marketing campaign to educate the public about the availability and effectiveness of substance abuse treatment.
18. Increase research and data collection.
19. Improve data collection on substance abusing women by county to enable the state to track numbers of referrals, women completing treatment, and follow-up.
20. Improve data collection on women in the criminal justice system and their families.
21. Improve statewide prevalence estimates of numbers of pregnant substance abusing women by changing PRAMS surveillance questions and collecting toxicology screening results of newborns in New Mexico.
22. Create by legislative memorial or executive order an Implementation and Oversight Task Force to continue the work of the SM19 Task Force into the next 5 years.

VI. Health Resources & Services Administration *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*



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Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health



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Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health

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SUMMARY

Substance Abuse Is a Major Problem During Pregnancy

- Five to 10 percent of all women have substance abuse problems during pregnancy
- Substance abuse contributes to obstetric and pediatric complications, including fetal alcohol syndrome, prematurity, and abruptio placenta
- Treatment for substance abuse during pregnancy is significantly more effective than at other times in a woman's life

Screening Tools Are the Most Effective Way to Determine Risk

- Laboratory tests and urine toxicologies are ineffective tools for determining substance abuse
- Quick, brief questionnaires have been demonstrated to be effective in prenatal care for assessing alcohol and drug use
- Pregnant women describe their health care providers as the best source of information and will generally follow the provider's advice

How to Use Screening Tools

- Choose a screen that fits your style
- Be nonjudgmental and supportive when asking about use
- Stress benefits of abstinence and offer to help the patient achieve it
- Know where to refer a patient for further assessment

Screening Example: T-ACE

- How many drinks does it take for you to feel high? (**T**olerance)
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt you ought to **C**ut down on your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)

(Sokol et al. 1989)



THE PROBLEM

“Not in my practice.” This statement describes the belief of many health care providers regarding the occurrence of domestic violence, HIV, and substance abuse among their patients (Schwartz 1993). Everyone agrees that these problems exist—but not in their practice. As a result, inquiring about drug and alcohol use is often neglected when providing prenatal care.

In today’s fiscal climate, it is difficult to hear of one more problem that should be addressed in the medical setting. Time allotted with each patient is reduced, and successful practice is measured by cost containment as often as by patients’ health. Yet attention to substance abuse problems during pregnancy is one area in which patient health can be improved and costs can be reduced. This manual was developed to provide prenatal providers with the background and skills to successfully recognize alcohol and drug abuse among patients, to institute protocols to improve the health of both mother and newborn, and to reduce the financial and physical costs associated with prenatal substance abuse.

Alcohol abuse and/or drug abuse occurs in 5 to 10 percent of women in the childbearing years, evenly spread across all ethnic, geographic, and socioeconomic groups (Stratton et al. 1996; Chasnoff et al. 1990). There are multiple risks to both mother and child when alcohol or drugs are abused during pregnancy. Alcohol abuse is associated with fetal alcohol syndrome (FAS) or fetal alcohol effect (FAE), which represent neurologic disorders and physical anomalies. FAS and FAE affect as many as 30,000

births each year (Abel and Sokol 1991). Cocaine or crack abuse contributes to extreme prematurity and possible long-term central nervous system disorders. Estimates of the number of infants in the United States born exposed to cocaine each year range from 91,500 to 240,000 (GAO 1990; Gomby and Shiono 1991). Opiate use can cause physical addiction in the newborn, requiring intensive medical intervention at birth. Substance abuse can also contribute to decreased birthweight and the risk of increased obstetrical problems such as poor weight gain, abruption placenta, and HIV.

The most recent nationally cited estimates report that 5.5 percent of all pregnant women use an illicit drug during pregnancy (National Pregnancy and Health Survey 1996). Abuse of drugs and alcohol among pregnant women often remains unnoticed and untreated. Outward signs of substance abuse may be subtle. Pregnant women who are abusing drugs or alcohol may not present with the same stereotypical symptoms seen in an older or late-stage abuse population. Studies at Boston City Hospital in the late 1970s found that heavily drinking women were no more likely than nonabusing patients to miss appointments, register for prenatal care late, or come in intoxicated. They were, however, slightly older and more likely to use other drugs and cigarettes (Rosett et al. 1983). Early studies of alcohol abuse among prenatal patients found that clinic staff reported no alcohol abuse among their patients, when, in fact, screening identified between 9 and 11 percent drinking at risk levels (Rosett et al. 1983; Sokol 1980; Larsson 1983). Addiction

specialists estimate that in the early stages of heavy use as many as 90 percent of all people who abuse drugs or alcohol are able to maintain their normal lifestyle, keeping appointments, jobs, and relationships. It would be a rare professional today who does not have someone in his or her practice

with drug or alcohol problems. Attention to illicit drug abuse has alerted practitioners that addictions are more widespread than might be expected. However, many are still unclear how to routinely and comfortably identify women at risk, and how to provide effective interventions.



THE SOLUTION

A number of clinical methods have been developed to detect substance abuse. These include blood tests, urine toxicology screens, and educated guessing based on clinical experience. Blood tests (such as liver function tests) may detect organ damage or malfunction, but only identify those patients with long-term use in whom secondary symptoms have occurred. Early stage substance-abusing women are rarely identified by this means. In spite of the popularity of urine toxicologies (in response to illicit drug use), these screens are able to identify only fairly recent use of a substance (i.e., cocaine may be detected for no more than 36 hours after use) and provide no information about frequency or length of use. Women who have not used drugs in the day or two prior to a prenatal visit will not be identified. Urine, blood, and breath tests are all unreliable indicators of alcohol use, as alcohol is metabolized quickly and is unlikely to be detected in body fluids (Christmas 1992). Educated guessing based on clinical experience may identify some users, but is heavily dependent on the practitioner's attitudes and experiences. The majority of at-risk women who do not fit stereotypic molds will be missed. The most effective method for

detecting substance abuse remains a screening tool.

Screening tools are questionnaires designed to be administered face-to-face, patient to provider. They are not designed to diagnose a substance abuse problem, but are intended to determine if a patient may be at risk for alcohol or drug problems and would benefit from a more comprehensive evaluation by a specialist. Effective screening tools in the prenatal setting are those that:

- Can be administered in 5–10 minutes
- Are used routinely with every patient, not just those in whom substance abuse is “suspected”
- Can be adapted to fit a provider's personal history-taking style
- Can be administered multiple times across a pregnancy, since patients may be more forthcoming as they develop trust with a provider
- Provide an opportunity to educate about alcohol and drug abuse and the benefits of stopping while pregnant

A screening tool for substance abuse should be incorporated into every prenatal intake

and history form. Asking *every* patient questions in a health context lessens the stigma associated with the topic, and expresses concern for the health of the mother and baby. Just as screening for diabetes is a routine and ongoing part of prenatal care, questions about substance abuse are most effective when used consistently and routinely. Intervention can be provided for problems as soon as they are identified, reducing the chances of obstetrical and newborn complications.

Pregnancy may be a window of opportunity to intervene for substance abuse problems (Weiner and Larsson 1987). It may be the first time that a woman has sought medical care (Woods 1993). Denial—a concern whenever questions are asked about substance abuse—may be less common during pregnancy. Pregnant women as a group are invested in the health of their babies and can no longer deny that their alcohol or drug abuse is hurting anyone but

themselves. Women in recovery have reported that they wanted help during pregnancy but didn't know how to ask (McElaney 1991). Pregnant women report that they consider health care providers one of their best sources of information, and are likely to comply with advice given (Minor and Van Dort 1982). This makes the prenatal setting the ideal place for discussion of substance abuse.

Even for women who do not have substance abuse problems, a routine screening offers the chance to discuss the risks of alcohol and drug use, particularly use that may have occurred prior to knowledge of pregnancy. Substance abuse problems in a partner may also be discussed. Initiating this discussion in what is generally a nonjudgmental, health-oriented setting conveys the message that these issues are important to the healthiest possible pregnancy.



THE BENEFITS OF SCREENING

Screening can have several immediate benefits:

1. Substance abuse during pregnancy is placed as an issue critical to the health of mothers and babies.
2. Education can be provided about the risks of alcohol and illicit drugs, and about behaviors that might have occurred prior to the prenatal visit.
3. Identification of women whose pregnancies are at risk due to their

substance abuse allows for the earliest possible intervention or referral to specialized treatment.

While each of these benefits is important, the greatest one is identification of women at risk. Over the past 20 years multiple studies have demonstrated benefits to both mothers and their infants when substance abuse treatment was provided. Rosett et al. (1983) demonstrated that women identified as heavy drinkers in the prenatal setting were responsive to treatment. Those who

completed at least three counseling sessions (66 percent) had babies who were significantly healthier at birth. Obstetrical complications were also reduced. Larsson (1983) and Smith et al. (1986) had similar findings. Follow-up studies of children born to heavily drinking women who responded to treatment demonstrated a persistence of the benefits observed at birth (Larsson 1985).

Chasnoff (1989) reported a reduction of one-half in the incidence of abruptio placenta and prematurity among a group of women who reduced cocaine abuse during pregnancy. Low birthweight was not observed among the group participating in treatment, but was 25 percent among those who continued cocaine use.

Cost savings from screening and identification of substance-abusing mothers are also substantial. For every birth with cocaine exposure that can be prevented, more than \$5,000 in medical costs can be saved. Reductions in crack use, other drug use, or the use of foster care can add substantially to the savings. At the national level, the total medical cost for neonatal cocaine exposure is estimated to be \$500 million (Phibbs et al. 1991).

Preventing FAS could save at least a portion of the \$74.6 million dollars estimated to be the annual cost for the care of affected individuals (Abel and Sokol 1991). Thus the 5–10 minutes of screening followed by an appropriate intervention during prenatal care is a relatively modest investment that can result in enormous cost benefits.



THE ROLE OF THE HEALTH CARE PROVIDER

Physicians, nurses, and others involved in prenatal care can play a unique role in the reduction of substance abuse during pregnancy and its related problems. In this positive, health-oriented context, supportive inquiry about all aspects of a woman's life, including her use of drugs or alcohol, can open the door to referral and treatment. Many pregnant women will reduce their use of drugs and/or alcohol following supportive advice from a health care professional, even if they never disclose that use (Rosett and Weiner 1981). Health care professionals can also help women see the benefits of stopping through improved sense of well-being, physical measures such

as weight gain, and better personal relationships.

All health care professionals have the basic skills to identify and refer at-risk women for treatment. While the topic may be difficult for patients and providers alike to discuss, the basic skills of interviewing, being empathic and supportive, providing education on the risks of continuing the adverse behaviors, and describing the benefits of treatment, referral, and follow-up are no different than they would be for any other medical problem. Providers can make the difference.



FINDING AND USING A SCREENING TOOL

The first question that occurs to most practitioners about screening is, “When am I going to find the time to do this?” followed by, “There’s really no point in asking anyway. Denial is so powerful that no one will tell you the truth.” Finding time for any additional procedure is a challenge for every provider. Yet most screening will take a relatively short amount of time—perhaps 30 seconds for the majority of patients who do not have a substance abuse problem and 5–10 minutes for the 10–15 percent of patients who do. Many professionals find that the time taken for the screening actually saves time in other ways, either by answering questions that might have come up at another time, or in reduced care time for a patient in whom obstetrical complications can be prevented.

While denial may occur, routine screening begins the discussion. For those patients in whom you suspect substance abuse, even if they have been unable to disclose it to you, it is important to review the benefits of reduction or abstinence. Some women may seek help or cut down on their own, based on your advice. However, statements such as “Now that you’re pregnant, just don’t drink” or “You don’t drink or use drugs, do you?” may inadvertently reinforce denial and may convey the message that there is no benefit to be achieved by stopping now. The purpose of the screening should be to begin an open discussion about alcohol and drug use.

HOW TO ASK AND HOW TO RESPOND

1. *Find an approach that is comfortable for you.*

Choose a screening tool that you can use with all patients. For convenience, five screens are listed in the back of this document. Remember that there is no one perfect way to ask, and that screens can be adapted to fit each person’s preferred style.

2. *Be nonjudgmental.*

Experience has shown that patients are generally not offended by questions about alcohol and drug use if they are asked in a nonjudgmental, nonmoralistic, nonthreatening manner, and if the health implications and benefits of reduction and abstinence are stressed. As each of us comes with experiences, attitudes, and beliefs that may be intentionally or unintentionally conveyed during an interview, it is always important to recognize and address personal attitudes that may influence a patient’s response. In an office or clinic setting, it is important that all staff understand the reasons for asking about substance abuse, even those who may not be involved in the actual interview. This helps reduce bias that may be conveyed to patients.

3. *Make it a routine part of prenatal care.*

Just as women are routinely screened for gestational diabetes, appropriate weight gain, anemia, etc., screening for substance abuse should be seen as another low-cost way to provide optimal prenatal care. Asking the same questions of every patient reduces subjectivity in deciding who should and should not be screened.

4. *Know how to respond.*

Prepare yourself for patients' questions about why you are asking. Become familiar with the risks of substance abuse and the benefits of stopping during pregnancy. Set the tone with introductory statements such as "I ask all my patients these questions because it is important to their health and the health of their babies." Know how to counsel women with both negative and positive screens.

For patients with a *negative* screen (no risk determined):

- a. Review the benefits of abstinence for the duration of the pregnancy.
- b. Reassure patients that small amounts of alcohol (one drink or less in any 24-hour period) consumed prior to the visit need not be a concern, that occasional use before conception does not pose a risk, and that foods containing alcohol (such as Kahlua ice cream or rum cake) are not a problem.

For patients who have a *positive* screen (risk determined):

- a. Review for the patient what she has just reported to you.
- b. State your concern for the health of the mother and the baby.

- c. State your belief that you know the mother wants her baby to be as healthy as possible and that she can improve the health of her baby by stopping use of alcohol and drugs.
- d. State the need for her to stop using drugs and/or alcohol during pregnancy, and that you and she will work together to achieve this.
- e. Discuss possible strategies for her to stop—e.g., individual counseling, 12-step programs, and addiction treatment programs.
- f. Suggest a referral for a more in-depth assessment by a specialist. Become knowledgeable regarding specialists and treatment centers for appropriate referrals. If feasible, call and make the appointment while the patient is in the office.
- g. Make a follow-up appointment to see the patient after her drug/alcohol assessment and keep an ongoing interest in the problem. Praise any reduction in use that she reports to you.
- h. Maintain communication with the treatment provider to monitor progress.

5. *Be positive.*

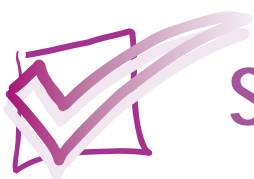
While no one can promise any woman a perfect pregnancy outcome, you can assure women that they will improve the chances that their babies will be healthy by discontinuing drug and alcohol use. Emphasize that benefits will begin as soon as the woman reduces or stops use, and that the earlier she is able to stop the better. It is never too late.



REFERRAL SOURCES

Most hospitals have substance abuse treatment programs and should be able to provide you with patient assessments. If a program is not available where you practice, contact your state Division of Substance Abuse Services (usually part of the Department of Public Health) and ask for a referral. Pregnant women have unique treatment needs, and will do best in a program that can address these needs. Most states now have programs specifically designed for pregnant women and for mothers. There are also numerous private hospitals and counselors who treat substance abuse. Twelve-step programs such as Alcoholics (or Cocaine or Narcotics) Anonymous can also provide useful support to women addressing these problems. All of these programs are listed in the Yellow Pages.

If you live in an area where no formal treatment programs exist or access to them is extremely limited, you may be the only resource available to a woman to help her reduce her substance use during pregnancy. In these circumstances, meeting weekly or even biweekly (as is done with other high-risk pregnancies) may be a first step towards expressing your concern and the seriousness of the situation. Suggest that the woman reduce her use by one-half each day, over several days until abstinence is achieved. Determine if her use is related to other problems in her life (depression, marital problems or domestic violence, history of sexual or physical abuse) and seek referrals for these issues. Above all, maintain support for her and affirm your belief that you know she can reduce her use and improve the health of her baby.



SCREENING INSTRUMENTS

Five screening instruments are presented on the following pages. They were chosen from a large field of instruments for their brevity, validity, specificity, and sensitivity in detecting alcohol and drug problems. All have been tested with populations of pregnant women. While most substance abuse screens were initially developed to inquire about alcohol use, it is possible to add the term “drugs” (or specifically list drugs of concern) to any of the screens listed here. Some of these screens

inquire about the frequency and quantity of use; others ask about problems associated with substance abuse. Ideally the questions are asked face-to-face while taking a history. However, many providers have had success screening for substance abuse by placing these questions on an intake form that the patient fills out, and then doing follow-up when reviewing the history.

The screens are presented in alphabetical order.

AUDIT

1. How often do you have a drink containing alcohol?
 - (0) Never
 - (1) Monthly
 - (2) 2–4 times a month
 - (3) 2–3 times a week
 - (4) 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
 - (0) 1–2
 - (1) 3 or 4
 - (2) 5 or 6
 - (3) 7–9
 - (4) 10 or more
3. How often do you have six or more drinks on one occasion?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
4. How often during the last year have you found that you were unable to stop drinking once you started?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
7. How often during the last year have you felt guilt or remorse after drinking?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of drinking?
 - (0) never
 - (1) less than monthly
 - (2) monthly
 - (3) weekly
 - (4) daily or almost daily
9. Have you or someone else been injured as the result of your drinking?
 - (0) no
 - (2) yes, but not in the last year
 - (4) yes, during the last year
10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
 - (0) no
 - (2) yes, but not in the last year
 - (4) yes, during the last year

Scores are in parentheses. A score of 8 or more is considered a positive screen.

4Ps

Have you ever used drugs or alcohol during this **P**regnancy?

Have you had a problem with drugs or alcohol in the **P**ast?

Does your **P**artner have a problem with drugs or alcohol?

Do you consider one of your **P**arents to be an addict or alcoholic?

This screening device is often used as a way to begin a discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

Ewing H. Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA 94553. Phone: (510) 646-1165.

T-ACE

How many drinks does it take for you to feel high? (**T**olerance)

Have people **A**nnoyed you by criticizing your drinking?

Have you ever felt you ought to **C**ut down on your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)

Any woman who answers more than two drinks on the tolerance question is scored 2 points. Each yes to the additional three questions scores 1. A score of 2 or more is considered a positive screen, and the woman should be referred to a specialist for further assessment.

Sokol RJ, Martier SS, Ager JW. 1989. The T-ACE questions: Practical prenatal detection of risk drinking. *American Journal of Obstetrics and Gynecology* 160(4).

TWEAK

How many drinks does it take for you to feel high? (**T**olerance)

Does your partner (or do your parents) ever **W**orry or complain about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
(**E**ye-opener)

Have you ever **A**wakened the morning after some drinking the night before and found that you could not remember part of the evening before?

Have you ever felt that you ought to **K**/Cut down on your drinking?

A woman receives 2 points on the tolerance questions if she reports that she can hold more than five drinks without falling asleep or passing out. A positive response to the worry question scores 2 points, and a positive response to each of the last three questions scores 1 point each. A total score of 2 or more indicates that the woman is a risk drinker and requires further assessment.

Russell M. 1994. New assessment tools for risk drinking during pregnancy. *Alcohol Health and Research World* 18(1).

TEN-QUESTION DRINKING HISTORY (TQDH)

Beer: How many times a week do you drink beer?
How many cans do you have at one time?
Do you ever drink more?

Wine: How many times per week do you drink wine?
How many glasses do you have at one time?
Do you ever drink more?

Liquor: How many times per week do you drink liquor?
How many drinks do you have at one time?
Do you ever drink more?

Has your drinking changed during the past year?

Any woman who reports drinking more than four drinks once a week or more is considered at risk and requires further evaluation.

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VII. *ACOG Committee Opinion. Number 511. November 2011. Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females*



The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

COMMITTEE OPINION

Number 511 • November 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females

ABSTRACT. Clinicians who provide care for incarcerated women should be aware of the special health care needs of pregnant incarcerated women and the specific issues related to the use of restraints during pregnancy and the postpartum period. The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary.

Between 1990 and 2009, the number of incarcerated women increased 153% (1). Most women are incarcerated for nonviolent crimes, including drug and property offenses (2). On average, 6–10% of incarcerated women are pregnant, with the highest rates in local jails (3). Data on rates of pregnancy in juvenile facilities are limited, but indicate higher rates than in adult facilities (4, 5).

The women in the criminal justice system are among the most vulnerable in our society. Pregnancies among incarcerated women are often unplanned and high-risk and are compromised by a lack of prenatal care, poor nutrition, domestic violence, mental illness, and drug and alcohol abuse (6). Upon entry into a prison or jail, every woman of childbearing age should be assessed for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and tested for pregnancy, as appropriate, to enable the provision of adequate perinatal care and abortion services. Incarcerated women who wish to continue their pregnancies should have access to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period. Incarcerated pregnant women also should have access to unscheduled or emergency obstetric visits on a 24-hour basis. The medical care provided should follow the guidelines of the American College of Obstetricians and Gynecologists (see Box 1) (7).

Special Clinical Considerations

Because of high rates of substance abuse (8) and human immunodeficiency virus (HIV) infection (9) among incarcerated women, prompt screening for these conditions in pregnant women is important. All pregnant

Box 1. Recommended Care

Intake

- Assess for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and test for pregnancy as appropriate

During Pregnancy

- Provide pregnancy counseling and abortion services
- Provide perinatal care following guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists*
- Assess for substance abuse and initiate treatment; prompt initiation of opioid-assisted therapy with methadone or buprenorphine is critical for pregnant women who are opioid-dependent
- Test for and treat human immunodeficiency virus (HIV) to prevent perinatal HIV transmission
- Screen for depression or mental stress during pregnancy and for postpartum depression after delivery and treat as needed
- Provide dietary supplements to incarcerated pregnant and breastfeeding women
- Deliver services in a licensed hospital that has facilities for high-risk pregnancies when available
- Provide postpartum contraceptive methods during incarceration

*American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6th ed. Elk Grove Village (IL): AAP; Washington, DC: ACOG; 2007.

women should be questioned about their past and present use of alcohol, nicotine, and other drugs, including the recreational use of prescription and over-the-counter medication (7). Identification of pregnant women who are addicted to opioids facilitates provision of opioid-assisted therapy with methadone or buprenorphine. Maintenance of opioid-assisted therapy can reduce the risk of withdrawal, which can precipitate preterm labor or fetal distress (10). In addition, substance abuse can continue during incarceration despite efforts to prevent drugs from entering correctional facilities. Effective drug and alcohol treatment programs are essential. Pregnant women universally should be tested for HIV infection with patient notification unless they decline the test as permitted by local and state regulations (7). Screening for HIV infection allows for the initiation of essential treatment to optimize maternal health and to prevent perinatal HIV transmission for HIV-positive pregnant women. Incarcerated pregnant women should be screened for depression or mental stress and for postpartum depression after delivery and be appropriately treated.

Good maternal nutrition can contribute positively to the delivery of a healthy, full-term newborn of an appropriate weight. The recommended dietary allowances for most vitamins and minerals increase during pregnancy (7). Therefore, provision of dietary supplements to incarcerated pregnant and breastfeeding women is recommended, as is access to a nutritious diet and timely and regular meals.

Pregnant women who are required to stand or participate in repetitive, strenuous, physical lifting are at risk of preterm birth and small for gestational age infants. In addition, a recovery period of 4–6 weeks generally is required after delivery for resumption of normal activity (7). This should be taken into consideration when assigning work to incarcerated pregnant women and during the postpartum period.

Pregnant women are at high risk of falls. Activities with a high risk of falling should be avoided (7). Specifically, incarcerated women should be given a bottom bunk during pregnancy and the postpartum period.

Although maintaining adequate safety is critical, correctional officers do not need to routinely be present in the room while a pregnant woman is being examined or in the hospital room during labor and delivery unless requested by medical staff or the situation poses a danger to the safety of the medical staff or others. Delivery services for incarcerated pregnant women should be provided in a licensed hospital with facilities for high-risk pregnancies when available. Incarcerated pregnant women often have short jail or prison stays and may not give birth while incarcerated. Postpartum contraceptive options should be discussed and provided during incarceration to decrease the likelihood of an unintended pregnancy during and after release from incarceration (11).

It is important to avoid separating the mother from the infant. Prison nurseries or alternative sentencing of

women to community-based noninstitutional settings should be considered for women during the postpartum period. Correctional facilities should have provisions for visiting infants for women in facilities without prison nurseries. When adequate resources are available for prison nursery programs, women who participate show lower rates of recidivism, and their children show no adverse effects as a result of their participation. In fact, by keeping mothers and infants together, prison nursery programs have been shown to prevent foster care placement and allow for the formation of maternal–child bonds during a critical period of infant development (12).

The American College of Obstetricians and Gynecologists strongly supports breastfeeding as the preferred method of feeding for newborns and infants (13). Given the benefits of breastfeeding to both the mother and the infant, incarcerated mothers wishing to breastfeed should be allowed to either breastfeed their infants or express milk for delivery to the infant. If the mother is to express her milk, accommodations should be made for freezing, storing, and transporting the milk. This can be difficult to facilitate and is another argument for prison nurseries or alternative sentencing of women to community-based noninstitutional settings.

Barriers to Care

Barriers currently exist to the provision of recommended care for incarcerated pregnant women and adolescents. Thirty-eight states have failed to institute adequate policies, or any policies, requiring that incarcerated pregnant women receive adequate prenatal care. Forty-one states do not require prenatal nutrition counseling or the provision of appropriate nutrition to incarcerated pregnant women, and 48 states do not offer pregnant women HIV screening (14).

Limiting Use of Restraints

Use of restraints, often called *shackling*, is defined as using any physical restraint or mechanical device to control the movement of a prisoner's body or limbs, including handcuffs, leg shackles, and belly chains. In 2007, the U.S. Marshals Service established policies and procedures for the use of authorized restraining devices, indicating that restraints should not be used when a pregnant prisoner is in labor, delivery, or in immediate postdelivery recuperation (15). In 2008, the Federal Bureau of Prisons ended the practice of shackling pregnant inmates as a matter of routine in all federal correctional facilities (16). That same year, the American Correctional Association approved standards opposing the use of restraints on female inmates during active labor and the delivery of a child. The standards also state that before active labor and delivery, restraints used on a pregnant inmate should not put the woman or the fetus at risk (17). More recently, in October 2010, the National Commission on Correctional Health Care, which accredits correctional facilities, adopted a position statement that opposes the

use of restraints on pregnant inmates (18). These standards serve as guidelines and are voluntary, not mandatory. State and local prisons and jails are not required to abide by either the Federal Bureau of Prisons policy or the National Commission on Correctional Health Care standards, but several state legislatures and departments of corrections have enacted antishackling policies recently. Despite progress, 36 states and the Immigration and Customs Enforcement agency of the Department of Homeland Security, which detains individuals who are in violation of civil immigration laws pending deportation, fail to limit the use of restraints on pregnant women during transportation, labor and delivery, and postpartum recuperation (14).

The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary. The apparent purpose of shackling is to keep incarcerated women from escaping or harming themselves or others. There are no data to support this rationale because most incarcerated women are nonviolent offenders. In addition, no escape attempts have been reported among pregnant incarcerated women who were not shackled during childbirth (19). This demonstrates the feasibility of preserving the dignity of incarcerated pregnant women and adolescents and providing them with compassionate care. The safety of health care personnel is paramount and for this reason, adequate correctional staff must be available to monitor incarcerated women, both during transport to and from the correctional facility and during receipt of medical care.

Physical restraints interfere with the ability of health care providers to safely practice medicine by reducing their ability to assess and evaluate the mother and the fetus and making labor and delivery more difficult. Shackling may put the health of the woman and fetus at risk (see Box 2). Shackling during transportation to medical care facilities and during the receipt of health services should occur only in exceptional circumstances for pregnant women and women within 6 weeks postpartum after a strong consideration of the health effects of restraints by the clinician providing care. Exceptions include when there is imminent risk of escape or harm. If restraint is needed, it should be the least restrictive possible to ensure safety and should never include restraints that interfere with leg movement or the ability of the woman to break a fall. The woman should be allowed to lie on her side, not flat on her back or stomach. Pressure should not be applied either directly or indirectly to the abdomen. Correctional officers should be available and required to remove the shackles immediately upon request of medical personnel. Women should never be shackled during evaluation for labor or labor and delivery. If restraint is used, a report should be filed by the Department of Corrections and reviewed by an independent body. There should be consequences for individuals and institutions when use of restraints was unjustified.

Box 2. Examples of the Health Effects of Restraints

- Nausea and vomiting are common symptoms of early pregnancy. Adding the discomfort of shackles to a woman already suffering is cruel and inhumane.
- It is important for women to have the ability to break their falls. Shackling increases the risk of falls and decreases the woman's ability to protect herself and the fetus if she does fall.
- If a woman has abdominal pain during pregnancy, a number of tests to evaluate for conditions such as appendicitis, preterm labor, or kidney infection may not be performed while a woman is shackled.
- Prompt and uninhibited assessment for vaginal bleeding during pregnancy is important. Shackling can delay diagnosis, which may pose a threat to the health of the woman or the fetus.
- Hypertensive disease occurs in approximately 12–22% of pregnancies, and is directly responsible for 17.6% of maternal deaths in the United States*. Preeclampsia can result in seizures, which may not be safely treated in a shackled patient.
- Women are at increased risk of venous thrombosis during pregnancy and the postpartum period†. Limited mobility caused by shackling may increase this risk and may compromise the health of the woman and fetus.
- Shackling interferes with normal labor and delivery:
 - The ability to ambulate during labor increases the likelihood for adequate pain management, successful cervical dilation, and a successful vaginal delivery.
 - Women need to be able to move or be moved in preparation for emergencies of labor and delivery, including shoulder dystocia, hemorrhage, or abnormalities of the fetal heart rate requiring intervention, including urgent cesarean delivery.
- After delivery, a healthy baby should remain with the mother to facilitate mother–child bonding. Shackles may prevent or inhibit this bonding and interfere with the mother's safe handling of her infant.
- As the infant grows, mothers should be part of the child's care (ie, take the baby to child wellness visits and immunizations) to enhance their bond. Shackling while attending to the child's health care needs may interfere with her ability to be involved in these activities.

*Diagnosis and management of preeclampsia and eclampsia. ACOG Practice Bulletin No. 33. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2002;99:159–67.

†Thromboembolism in pregnancy. Practice Bulletin No. 123. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;118:718–29.

Recommendations

- Federal and state governments should adopt policies to support provision of perinatal care for pregnant and postpartum incarcerated women and adolescents that follow the guidelines of the American College of Obstetricians and Gynecologists. Mechanisms to ensure implementation of these policies and adequate funding to provide this care need to be put in place.
- Educational efforts are needed to increase the knowledge of health care providers and correctional officers about issues specific to incarcerated pregnant and postpartum women and adolescents.
- Obstetrician–gynecologists should support efforts to improve the health care of incarcerated pregnant and postpartum women and adolescents at the local, state, and national levels. Activities may include the following:
 - Advocating at the state and federal levels to restrict shackling of incarcerated women and adolescents during pregnancy and the postpartum period.
 - Partnering with other organizations in the medical community opposed to shackling incarcerated pregnant women such as the American Medical Association and the Association of Women’s Health, Obstetric and Neonatal Nurses (20, 21).
 - Gaining representation on the boards of correctional health organizations.
 - Working in correctional facilities to provide services to incarcerated pregnant and postpartum women and adolescents and continuing care after the woman’s release, when feasible.
 - Undertaking efforts to ensure that medical needs of pregnant and postpartum incarcerated women and adolescents are being addressed appropriately, such as by providing training or consultation to health care providers and correctional officers in prison settings.

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VIII. ACOG Committee Opinion. Number 524. May 2012. Opioid Abuse, Dependence, and Addiction in Pregnancy.



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 524 • May 2012

Committee on Health Care for Underserved Women
and the American Society of Addiction Medicine

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.



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 informa-

tion 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

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?

F Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?

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.

Center for Adolescent Substance Abuse Research, Children's Hospital Boston. The CRAFFT screening interview. Boston (MA): CeASAR; 2009. Available at: http://www.ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf. Retrieved February 10, 2012.

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pregnant woman. 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 anti-inflammatory 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 oversatiation 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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