PENNSYLVANIA

SECTION
OF ACOG
District III

On behalf of the Pennsylvania Section of the American Congress of Obstetricians and Gynecologists (ACOG), which represents more than 1300 physicians and partners in women's health in the Commonwealth, we would like to thank you for the opportunity to submit testimony on addressing Pennsylvania's opioid drug epidemic. Additionally we would like to thank you for all of your prior and ongoing efforts to address the public health crisis we are seeing with opioid abuse disorders.

As an organization vested in the well-being of pregnant and postpartum women and their newborns, we agree this public health issue is deserving of wider attention, but we submit that the issues of management of opioid abuse for our population are unique and deserving of special attention. We recognize the growing reality of opioid use disorders in the community at large, but specifically in pregnant women and their infants. The number of infants requiring treatment for opioid dependence has nearly quadrupled in a decade due to ever rising use and abuse of opioid medications in their mothers. We have seen firsthand the devastation this disease can have on Pennsylvania mothers, infants and families, including maternal deaths, newborn and infant deaths and destruction of the family units. At this time and moving forward, we welcome the opportunity to work with you and other stakeholders to respond appropriately to this escalating public health issue. Our shared goal must be positive health outcomes for both mother and baby. We ask that policy and legislative approaches take into account the standard of care and circumstances that are unique to the patients whom we serve.

While the standard of care for non-pregnant persons with opioid abuse disorders may be detoxification with or without medication assistance, the standard of care for pregnant women with opioid addiction is medication assisted therapy (MAT), which includes methadone and buprenorphine. Withdrawal and detoxification is discouraged during pregnancy as it has been associated with high relapse rates of illicit opioid use, placing both the mother and baby at increased risk for overdose and death. Chronic untreated heroin use during pregnancy is associated with increased risk of fetal growth restriction, placental abruption, fetal death, preterm labor and intrauterine passage of meconium. Abrupt discontinuation of opioids in an opioid-dependent woman can also result in preterm labor, fetal distress, or fetal demise.

It is much safer for women with opioid use disorders to be on prescribed and supervised opioid-based medications rather than ongoing use of illicit opioids. Unlike illicit opioid use, MAT provides a known quantity of a known medication and has been demonstrated to be a safe and effective treatment for opioid addiction during pregnancy. While either methadone or buprenorphine may be used for MAT in pregnancy, buprenorphine is preferred as it can have higher compliance, lower risk of overdose, and it may lead to lower rates or less severe cases of neonatal abstinence syndrome (NAS) in the newborn. There are no proven birth defects associated with maternal opioid agonist therapy.

In conjunction with the medication therapy, care for the woman with opioid abuse disorder must be multidisciplinary, including addiction medicine specialists, behavioral health intervention (individual and family counseling), and social services (resources and education) along with other necessary medical care. During the postpartum period, women should continue in their treatment and addiction support as this time of high physical and emotional stress can lead to higher rates of relapse.

Some, but not all, newborns exposed prenatally to opiates experience withdrawal symptoms at birth. Neonatal abstinence syndrome (NAS) is an anticipated, readily diagnosed and treatable condition that can follow prenatal exposure to opioid agonists. Most women using MAT have uncomplicated pregnancies and babies with average birth weights and high Apgar scores, although they may still then suffer the symptoms of withdrawal that can include high-pitched, inconsolable crying, difficulty feeding, jitteriness, irritability and if untreated, seizures. There are safe, evidence-based treatment protocols endorsed by the American Academy of Pediatrics being used today that begin with scoring scales for the observance of the symptoms and lead to opioid therapy to reduce symptoms. Additionally important for these newborns are dim lights, white noise, and frequent swaddling and skin-to-skin care. Where and when this can occur with this infant's mother, improved mother-infant bonding may be seen. Unlike neonatal exposure to maternal alcohol and tobacco use, there have been no reported long-term effects of maternal opioid use, although the data is limited.

Although pregnant women and women who have custody of their children are more likely to complete substance abuse treatment, there are multiple barriers to accessing treatment, including stigma, fear of prosecution or losing custody of children, and inability to enter a treatment program due to a myriad of factors. Existing treatment programs are overwhelmed, and many reject pregnant women, fail to provide childcare, are geographically remote, or do not account for a woman's family responsibilities or accommodate women and children together. Inpatient treatment facilities often focus on detoxification and often require

the mother to separate from her other children and family. Very few treatment programs give priority access to pregnant women.

Solutions should focus on a comprehensive, non-punitive public health approach. Promoting pregnant women's health through advocacy of healthy behavior, early referral for substance abuse treatment with MAT and mental health services, pregnancy planning and maintenance of a good physician-patient relationship is always in the best interest of both mother and baby.

Pregnancy offers a unique opportunity for treating substance abuse as a woman's health care issue. The welfare of a baby is a powerful driving force to motivate a pregnant woman to make positive decisions for her own health and the future of her infant. Obstetrical providers are in a key position to oversee the screening, early diagnosis, counseling and initiation of treatment of pregnant women who use these substances. We must, however, educate healthcare providers about the scope of the disease and about how to use non-judgmental inquiry to gain patient's trust. ACOG's current medical protocols calls for all women – not just those at risk or with a history of drug use or past involvement with child protective services – to be screened annually for substance abuse, including prescription drug abuse. Screening is done in partnership with the woman using validated screening tools and with her permission.

Staying connected to the health care system and being able to speak openly with a physician about drug problems is essential. The pregnant woman and her family will benefit from factual, non-judgmental information about the maternal and fetal risks of substance use and treatment options that will improve outcomes for both mom and baby.

Efforts to criminalize pregnant women or mandate immediate revocation of child custody for women whose babies are born with neonatal abstinence syndrome (NAS) are more likely to deter pregnant women from seeking needed prenatal care or discourage those who do seek prenatal care from disclosing critical information about their drug use. Likewise, substance use should not disqualify women from access to necessary services or eligibility for public benefits. This practice does not curb the harmful behavior and will only worsen conditions for the health of the pregnancy. Similarly, while family drug courts may be a helpful step for some, they are not a remedy for all women, especially those who are pregnant and reliant on substances. Family drug courts often treat drug use as a behavior that needs to be corrected, rather than a disease that needs to be treated. Drug court officials should be trained on the disease of substance abuse and addiction and the unique medical needs of pregnant women.

Pressuring women into detoxification is not a safe or medically recommended approach for pregnant women and their babies.

Pregnant women and women with children need specialized treatment services tailored to meeting their needs as well as the needs of their children. A woman should not be separated from her family in order to receive appropriate treatment nor should infants with NAS be removed from their mothers who are engaged in treatment. Treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being. Women need the option of family-centered, community-based, outpatient treatment programs; this is especially true for those who are pregnant or parenting and may be the primary breadwinner or caretaker in their families. These services include a full continuum of treatment services including individual, group and family counseling, prenatal and postpartum care, training in parenting, help in navigating the health and social service system, identifying resources and preparing pregnant women for what to expect following birth.

We caution against legislation that would interfere with or foreclose legitimate treatment options including opioid-assisted therapy with methadone or buprenorphine for pregnant women. Legislation should avoid setting arbitrary dosing limits and permit individualized treatment plans for women. Giving pregnant women priority admission to available treatment slots in licensed methadone clinics and priority access when referred by a clinician to a drug abuse treatment program that receives public funding is highly recommended. Equally important is ensuring that outpatient and family-oriented drug treatment is affordable. We urge you to place a greater priority on education, prevention and community-based treatment to address this public health threat to women and their newborn babies and families. Punitive or coercive measures could drive women away from health care when they need it the most.

We thank you for your strong commitment to this public health issue, and we look forward to working with you to find constructive and evidence-based ways to address the needs of Pennsylvania's mothers, infants and families. Please do not hesitate to contact our organization as a resource.

KEY POINTS:

- Pregnancy provides a unique opportunity where women may be more motivated to seek and be compliant with treatment for their substance abuse in order to protect their fetus and newborn.
- Treatment for opioid abuse disorder in pregnancy is accomplished through medication assisted therapy using methadone or buprenorphine and not through detoxification.
- Treatment of the neonate includes scoring systems to assess withdrawal symptoms and treatment of NAS when appropriate. Programs that support the mother and infant together in their treatment and encourage non-separation show the best outcome for both mother (less relapse) and the infant (decreased medication requirements).
- It takes a village. Opioid abuse treatment requires a multidisciplinary team including but not limited to addiction medicine specialist, behavioral health and counseling, social services, and also medical doctors such as an obstetrician and a pediatrician.
- Access to treatment for pregnant women is limited by a multitude of factors, and we need to support the establishment of programs in the communities that provide the necessary care for women and their families.