

Opioid use Disorder in Pregnancy

AKPQC and MCDR Joint
Summit

March 27 & 28, 2025

Sarah Spencer, DO, FASAM



Learning Objectives

1

Identify trends in rates of OUD and related deaths, associated maternal mortality and rates of neonatal abstinence syndrome

2

List 3 benefits of medication for opioid use disorder in pregnancy

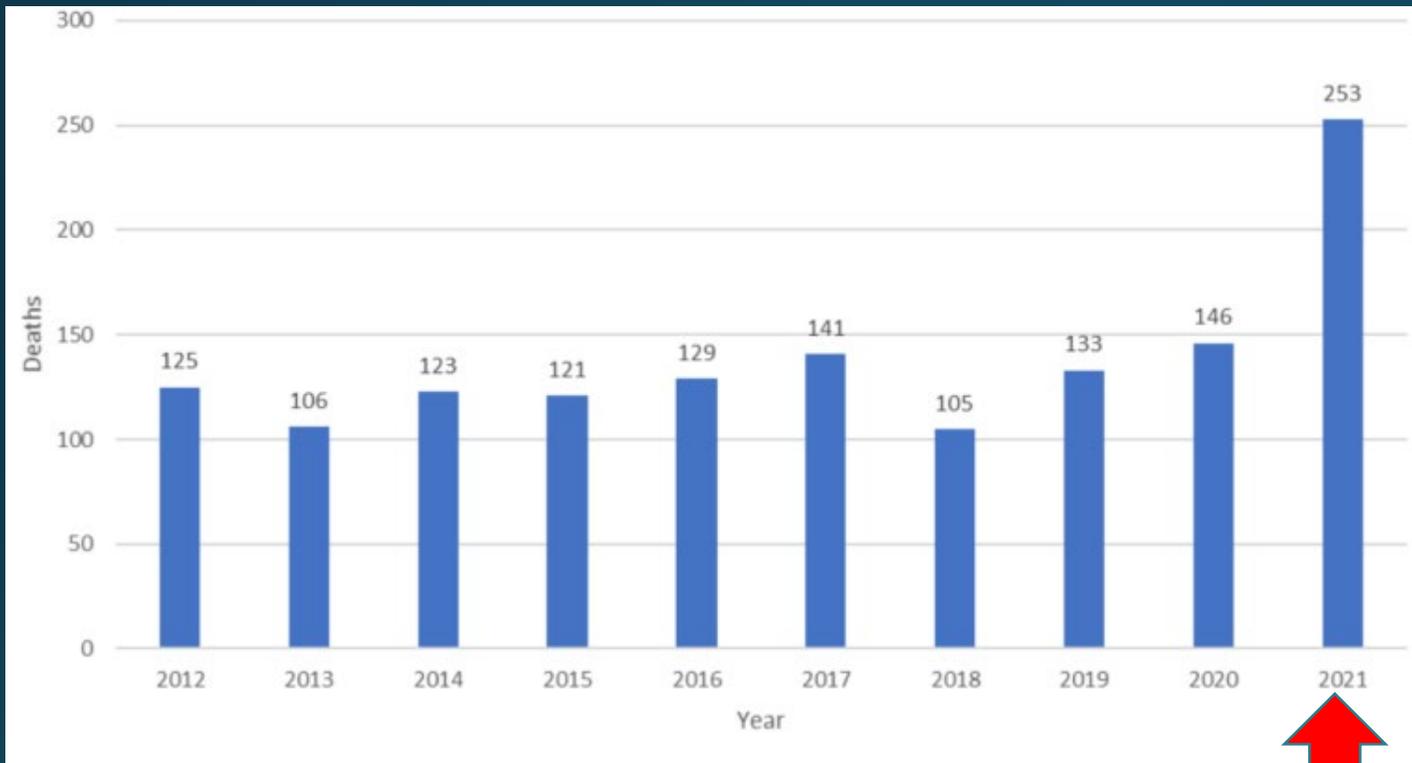
3

Explore the intersection between child welfare and substance use in Alaska

4

Identify 3 ways to reduce barriers to care for pregnant and parenting people who use drugs

Overdose deaths in Alaska rose by 75% in 2021, highest increase nationwide



- Alaskan Natives OD rate 77/110K

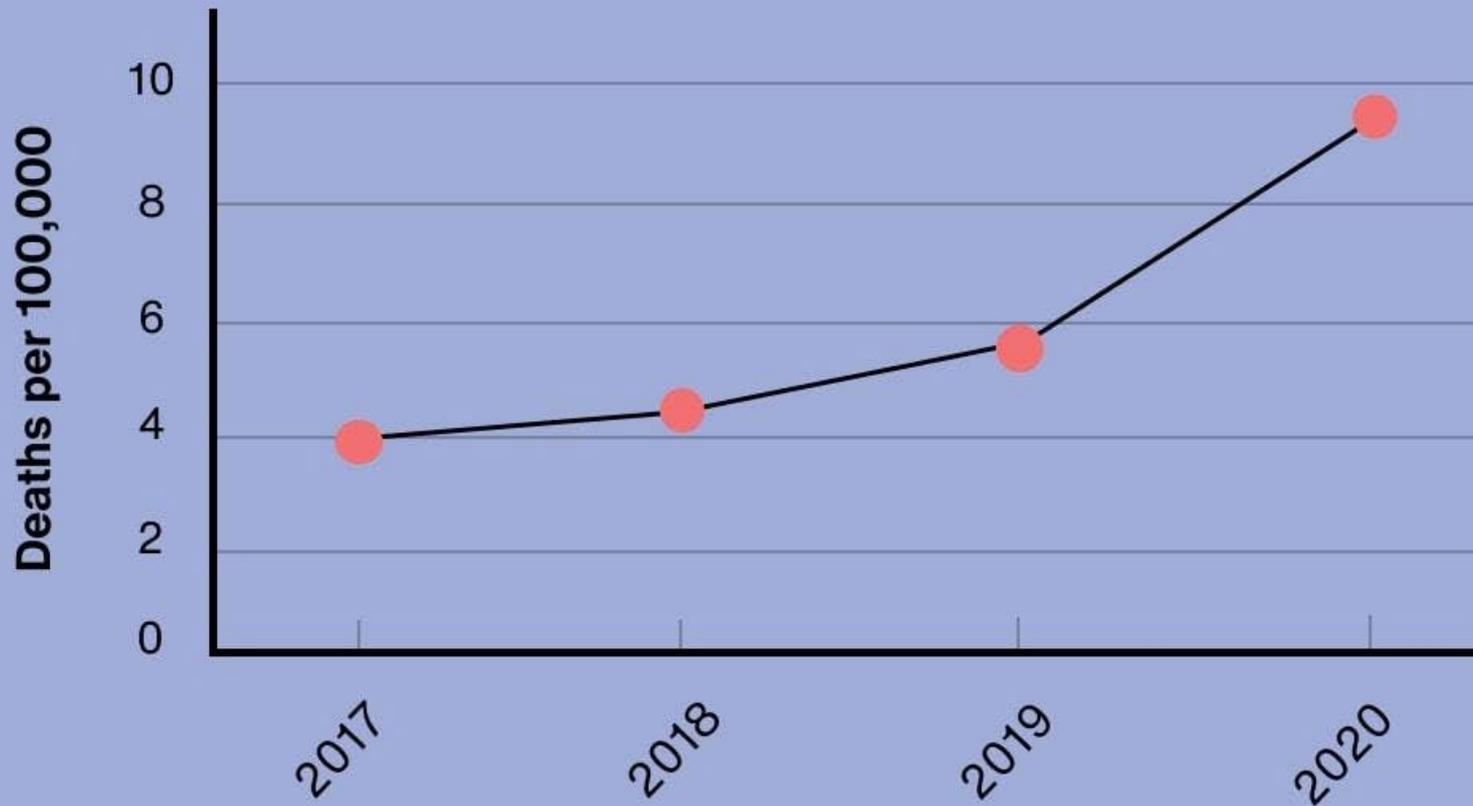
- White OD rate 28/100K

- Meth OD up 150%

- Fentanyl OD up 150%

Opioid deaths rates + motherhood

Pregnancy-related fentanyl overdose deaths



Sources: <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html>



Increasing Rates of Maternal Mortality: How Do Overdose Deaths Contribute?

By MGH Center for Women's Mental Health | March 26th, 2024 | Perinatal Substance Use | 0 Comments



While maternal mortality is declining in most developed countries, it is **on the rise in the United States**. In the US, the rate of pregnancy-related deaths (**defined by the Centers for Disease Control** as death occurring during pregnancy up to one year after delivery) in 2021 was 32.9 deaths per 100,000 live births, a rate that is much higher than in other high-income countries. Pregnancy-related deaths are three times more common in American women than in Canadian women and six times more common than in Scandinavian women.

Exactly why we are seeing this increase in maternal mortality is not entirely clear. Some attribute this increase in mortality to the fact that the average age of mothers is increasing; however, **maternal mortality rates have increased in all age**

Between 2018 and 2021, pregnancy-associated overdose mortality rates ...more than tripled, increasing from 4.9 per 100,000 mothers in January to June 2018 to 15.8 in July to December 2021.

- Neonatal abstinence syndrome incidence rates have increased from 1.5 to 8.0 per 1000 hospital births in the United States from 2004 to 2014
- The overall incidence rate of NAS was 6.7 per 1000 in-hospital births in 2016
- Rates were highest among American Indian/Alaska Native individuals (15.9 per 1000) and non-Hispanic white individuals (10.5 per 1000), the lowest income quartile (9.3 per 1000), rural areas (10.6 per 1000)
- Infants with NAS had a 15.9-day (20.4-day) mean (SD) length of stay
- The average cost per infant with NAS was \$22 552.

Prenatal Substance Exposure and Neonatal Abstinence Syndrome: State Estimates from the 2016–2020 Transformed Medicaid Statistical Information System

[Kristina D West](#)^{1,✉}, [Mir M Ali](#)¹, [Martin Blanco](#)¹, [Brenda Natzke](#)², [Linda Nguyen](#)²

Between 2016 and 2020, the estimated national rate of NAS experienced a 18% decline, while the estimated national rate of prenatal substance exposure experienced a 3.6% increase. At the state level in 2020, the NAS rate ranged from 3.2 per 1000 births (Hawaii) to 68.0 per 1000 births (West Virginia). Between 2016 and 2020, 28 states experienced a decline in NAS births and 20 states had an increase in NAS rates. In 2020, the lowest prenatal substance exposure rate was observed in New Jersey (9.9 per 1000 births) and the highest in West Virginia (88.1 per 1000 births). Between 2016 and 2020, 38 states experienced an increase in the rate of prenatal substance exposure and 10 states experienced a decline.

Neonatal Abstinence Syndrome in Alaska

Explore national- and state-level data for hundreds of health, environmental and socioeconomic measures, including background information about each measure. Use features on this page to find measures; view subpopulations, trends and rankings; and download and share content.

 [How to use this page](#)

Alaska Value:

10.7

Number of birth hospitalizations with a diagnosis code of neonatal abstinence syndrome (withdrawal symptoms due to prenatal exposure to illicit drugs) per 1,000 birth hospitalizations

Alaska Rank:

39

Value and rank based on data from 2021

Past Month Substance Use Among Pregnant Women

Aged 15-44



Data from a national survey showed that **among pregnant women**

about **10%** had **at least one alcoholic drink** in the past 30 days



of those using alcohol, **40% also used other substances** (most often tobacco & marijuana)

Increased screening and interventions could improve the health of women and their children

Screening for Opioid Use and Opioid Use Disorder in Pregnancy (ACOG)

Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. **Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome can lead to missed cases, and may add to stereotyping and stigma.** Therefore, it is essential that **screening be universal.** 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. **Maintaining a caring and nonjudgmental approach,** as well as screening when the patient is alone, are important and will yield the most inclusive disclosure. Obstetric care providers should **protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship** to the extent allowable by laws regarding disclosure of substance use disorder

Clinical Screening Tools for Prenatal Substance Use and Abuse

4 Ps*

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.

**“The truth is, getting
through pregnancy is
the easiest part”**

Katie Raftery, MGH Recovery Coach



MassGeneral Hospital
for Children



ASAM American Society of
Addiction Medicine

"Where things fall apart is postpartum. We actually abandon women after delivery."

Mishka Terplan, obstetrics and gynecology physician

VIRGINIA COMMONWEALTH UNIVERSITY SCHOOL OF MEDICINE

Why Are Postpartum Women Vulnerable?

- ◆ Loss of access to special services designed for caring for pregnant women
- ◆ High rates of postpartum depression among women with substance use
- ◆ Shame and stigma women feel watching their infants experience symptoms of neonatal opioid withdrawal
- ◆ Stresses of having a new baby
- ◆ Heartbreak of being separated from baby
- ◆ Desire to discontinue medication treatment



MassGeneral Hospital
for Children



ASAM

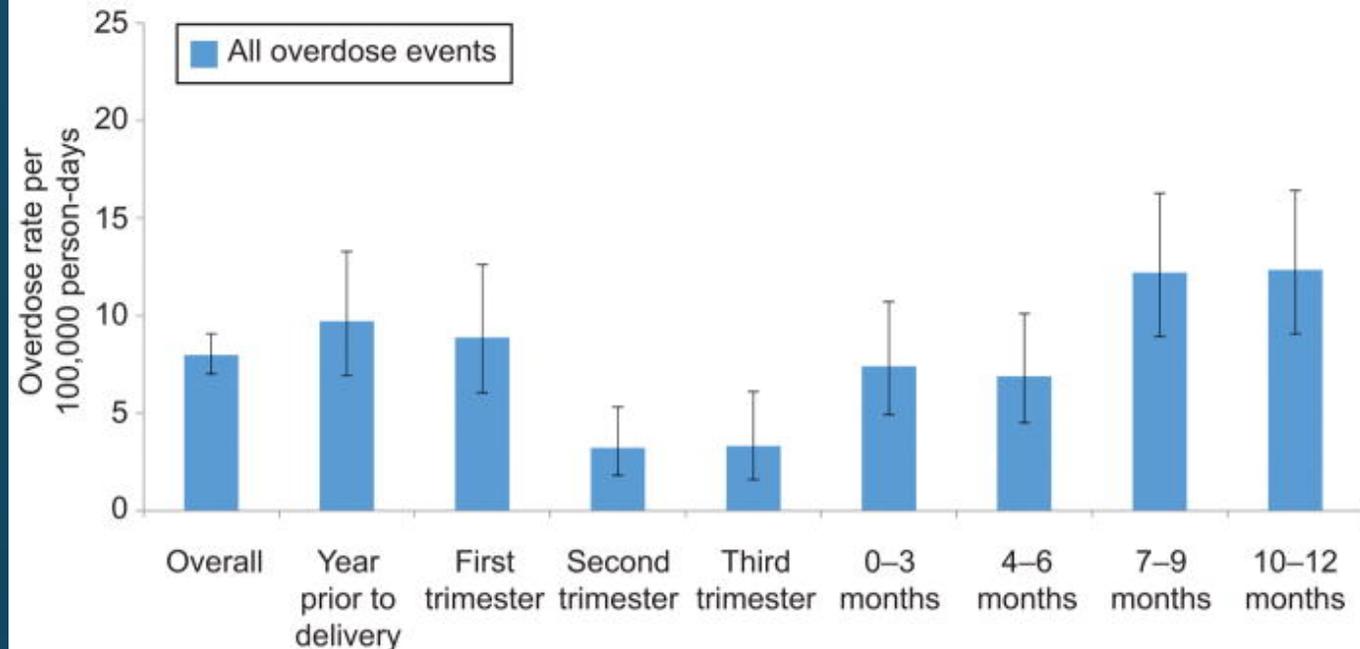
American Society of
Addiction Medicine

Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

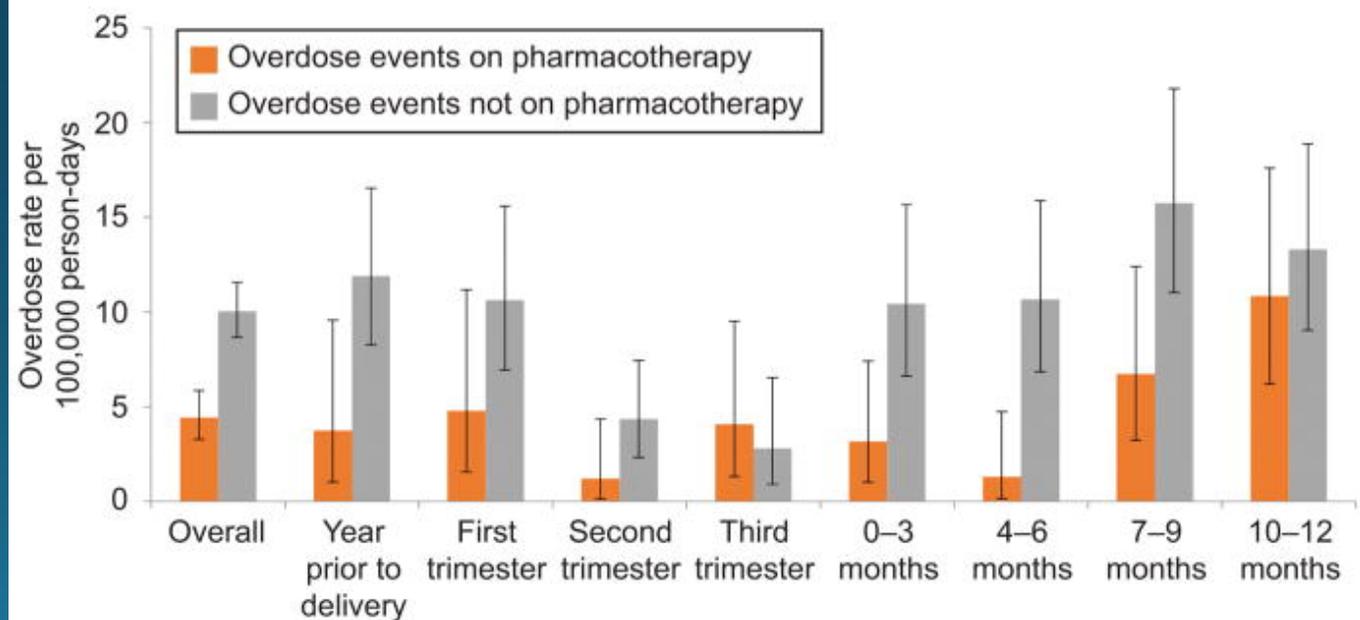
David M Schiff¹, Timothy Nielsen, Mishka Terplan, Malena Hood, Dana Bernson, Hafsatou Diop

The year after delivery is a vulnerable period for women with OUD. Additional longitudinal supports and interventions tailored to women in the first year postpartum are needed to prevent and reduce overdose events.

<https://doi.org/10.1097/aog.0000000000002734>



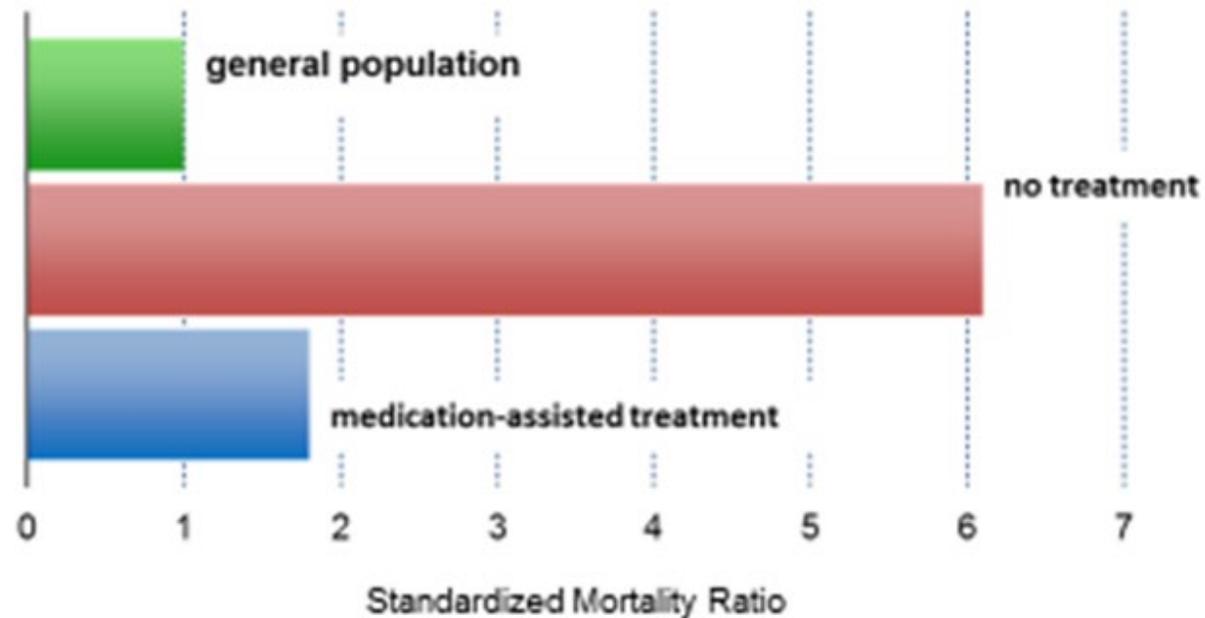
A



B

Benefits of MAT: Decreased Mortality

Death rates:



**Stopping MOUD
Increases Risk of
Overdose**

MOUD can reduce death rates by 60+%

“Detox” is not a treatment for OUD

Treating opioid disorder without meds more harmful than no treatment at all

Non-medication-based treatments for opioid use disorder may be more harmful than no treatment at all, a new Yale study finds.

When the researchers calculated the risk of fatal overdose death for each treatment, they found that, compared with no treatment at all, methadone and buprenorphine reduced the risk of death...

“However, non-medication-based treatments increased the risk of death compared to no treatment by over 77%,”

Detoxification from opiate drugs during pregnancy

Am J Obstet Gynecol. 2016 Sep;215(3):374.

CONCLUSION:

With these data and other published studies, more than 600 patients have been reported to detoxify from opiates during pregnancy with no report of fetal harm related to the process. These data highly suggest that detoxification of opiate-addicted pregnant patients is not harmful. The rate of neonatal abstinence syndrome is high but primarily when no continued long-term follow-up occurs. Once a patient is drug free, intense behavioral health follow-up is needed for continued success.

No fetal death, but relapse rates up to 74%!

- ACOG recommends opioid agonist pharmacotherapy care
 - Buprenorphine or methadone

Maternal Benefits

70% reduction in overdose related deaths

Decrease in risk of HIV, HBV, HCV

Increased engagement in prenatal care and recovery treatment

Fetal Benefits

Reduces fluctuations in maternal opioid levels; reducing fetal stress

Decrease in intrauterine fetal demise

Decrease in intrauterine growth restriction

Decrease in preterm delivery

Child Welfare Outcomes of Medication-Assisted Treatment

A program in Kentucky found that clients with a history of opioid use who received a year of MAT increased the odds of retaining custody of their children by 120 percent, compared with those who did not receive MAT (Hall et al., 2016).

MAT Study Results:

- Compared to families who received no MAT:
 - 6 months of MAT: **60%** more likely to retain custody of children
 - 9 months of MAT: **90%** more likely to retain custody of children
 - 14 months* of MAT: **140%** more likely to retain custody of children
- Duration of MAT also positively associated with **reduced illicit opioid use** (Condelli & Dunteman, 1993), **other drug use and criminal activity** (Simpson & Sells, 1982), and **risk of viral infection and STDs** (Greenfield & Fountain, 2000)

*average length of START case

Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System

Hall, Martin T. et al. Journal of Substance Abuse Treatment, Volume 71, 63 - 67

CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS



Features of Methadone



- Full opioid agonist
- Stimulates opioid receptors to reduce cravings and illicit opioid use
- Provides some opioid blockade at higher doses
- **Available only at an opioid treatment program** (Methadone clinic), daily observed dosing Long acting, once daily dosing
- OTP provides counseling and social support services with methadone
- Many drug-drug interaction and QT prolongation
- Also treats chronic pain
- Best retention in treatment of all forms of MAT

Pharmacology of Buprenorphine

Buprenorphine is a partial opioid agonist/antagonist

Treats withdrawal symptoms and minimizing cravings = positive reinforcement

- The agonist effects of buprenorphine reach a **plateau** and no longer continue to increase with further increases in dose—the “ceiling effect.”
 - **lower risk of abuse, addiction, and side effects** compared to full opioid agonists.
 - Maximal effects are less than those of full agonists like heroin and methadone,
Hard to get “high” off it
- Buprenorphine binds very tightly to the opioid receptor and **blocks other full agonists from binding** and can precipitate withdrawal symptoms if administered to an opioid-dependent individual while a high dose of full agonist is in the bloodstream.
- **Kappa antagonist: Antidepressant effect**

Reframing the perception of buprenorphine prescribing

OLD

A high-risk medication requiring specialized training and integrated behavioral health to prescribe



NEW

A very safe lifesaving medication that is the gold standard treatment for a deadly disease, that all providers should be comfortable prescribing

This is why the X-waiver was eliminated



The Waiver is Gone!!!

- All prescribers authorized to Rx Schedule 3 can prescribe buprenorphine for OUD or pain
- No limits on dose or formulation of BUP
 - No limits on numbers of patients
- No requirement to refer for counseling
 - No educational requirements
 - 8-hour waiver course meets the DEA MATE act requirements

**NO EXCUSE NOT TO PRESCRIBE
THIS LIFESAVING MEDICATION!**

FORMULATIONS OF BUPRENORPHINE



Brixadi
Weekly/monthly SQ
injection, various doses



Mono-SL Product

Buprenorphine SL tab
(2 & 8mg) (Subutex)

Combo-SL Products



Buprenorphine/naloxone
SL/buccal films (Generic/brand,
many strengths)

**Long-Acting
Injectables**

Buprenorphine/naloxone
SI tabs (generic/brand)

Sublocade
Monthly Buprenorphine SQ depot injection



IV Buprenorphine

(Transdermal and Buccal Buprenorphine products used for Chronic Pain (Butrans/ Belbuca) are general considered too low dose and not legal to treat OUD)

Does Maternal Buprenorphine Dose Affect Severity or Incidence of Neonatal Abstinence Syndrome?

RESULTS:

In 89 infants, NAS incidence requiring morphine was 43.8%. Means for morphine-treated infants included: 55.2 hours to morphine start, 15.9 days on morphine, and 20 days hospital stay. NAS requiring morphine treatment occurred in 48.5% and 41.4% of infants of mothers receiving ≤ 8 mg/d buprenorphine versus > 8 mg/d, respectively ($P=0.39$). **We found no significant associations of maternal buprenorphine dose with peak NAS score**, NAS severity requiring morphine, time to morphine start, peak morphine dose, or days on morphine. Among the other factors examined, **only exclusive breastfeeding was significantly associated with neonatal outcomes, specifically lower odds of morphine treatment** (odds ratio 0.24, $P=0.003$).

CONCLUSIONS:

These findings suggest higher buprenorphine doses can be prescribed to pregnant women receiving medication therapy for addiction without increasing NAS severity. Our finding of reduced risk of NAS requiring morphine treatment also suggests breastfeeding is both safe and beneficial for these infants and should be encouraged.

Monday, May 1, 2023

“Eat, Sleep, Console” reduces hospital stay and need for medication among opioid-exposed infants

Researchers have found the “Eat, Sleep, Console” (ESC) care approach to be more effective than using the Finnegan Neonatal Abstinence Scoring Tool (FNAST) to assess and manage opioid-exposed newborns, according to a national, randomized controlled clinical trial funded by the National Institutes of Health. Newborns cared for with ESC were medically ready for discharge approximately 6.7 days earlier and 63% less likely to receive medication as part of their treatment, compared to newborns cared for with FNAST. ESC prioritizes non-pharmacologic approaches to care, such as a low-stimulation environment, swaddling, skin-to-skin contact and breastfeeding. ESC also encourages parental involvement in the care and assessment of their infants. These findings are

Long-Acting Injectable Buprenorphine (LAIB)

Advantages in Rural Alaska

No concern for diversion

Diversion concerns and stigma around sublingual buprenorphine can be a barrier, clinics and patients may face reduced stigma to offer/access LAIB

Reduces the burden of monitoring medication compliance, which is challenging in remote locations with limited to access facilities for medication counts and urinalysis

Reduces risk of withdrawal and relapse related to Rx interruption

Bush mail delivery frequently interrupted

weather / road and airport closures → delayed Rx refills → withdrawal → relapse / overdose

Flexible dosing q4-6 weeks, slow reduction in serum levels reduces withdrawal sx's

Excellent and long-lasting opioid blockade

Provides protection from overdose, including for patients with interrupted access (fishermen, slope workers, incarcerated) reducing risk of overdose in this remote population

Is Low-Threshold Treatment for Patients with OUD Effective?

Treatment as usual for patients with OUD too often includes high-threshold practices and rigid protocols, processes, and workflows that decrease retention in care. These approaches have served as barriers to treatment initiation and led to high rates of treatment discontinuation. Over a decade of research on low-threshold treatment for patients with OUD has demonstrated how this approach to care can improve equity and access to buprenorphine, especially for people of color, justice-involved individuals, and people experiencing homelessness, and can have more successful outcomes.

- Prompt **(same-day) treatment** initiation of buprenorphine improves enrollment rates compared to treatment as usual (i.e., delaying initiation of MOUD).
- **Removal of abstinence requirements** in OUD treatment has produced similar outcomes to treatment as usual (i.e., discontinuing MOUD due to drug tests finding non-prescribed substances)

- Increased flexibility in regulations related to the use of **telehealth for buprenorphine** prescribing (initiated in response to the COVID-19 pandemic) has increased access to buprenorphine and may have comparable retention rates and outcomes as face-to-face treatment.
- **Optional psychosocial services** during buprenorphine therapy can have similar or better outcomes to treatment as usual (i.e., requiring counseling and other behavioral interventions).
- Provision of buprenorphine therapy **in non-traditional settings** such as syringe exchange programs, mobile health clinics, shelters, and on the street can improve patient engagement in treatment and may have comparable retention rates and outcomes as treatment as usual
- Compared with treatment as usual **buprenorphine treatment along with safer injection** and wound care equipment kits, reduced mortality, extended life expectancy, and was cost-effective.



Low Threshold XR-BUP

- Given regardless of active drug/alcohol use
- No required drug testing
- Flexible schedule
- Walk-in appointments for injections
- Single day medication start for opioid tolerant patients
- Flexible dose
- SL supplementation available
- Available in pregnancy (2nd/3rd trimester)

The Intersection Child Welfare and Substance use in Alaska

Class-action lawsuit says state is failing Alaska foster kids

By Wesley Early, Alaska Public Media - Anchorage - May 20, 2022

“Alaska is fifth-worst in returning kids to their family homes and seventh-worst in the country on the frequency with which children are visited, which is a federal mandate,” Lowry said.

It says the system is causing particular harm to Alaska Native children, who make up roughly two-thirds of all Alaska children in foster care, despite being (20%) of the state’s population.

Failure of Systems

The person is never the problem, the problem is the problem

The way we define problems determine how we solve them, and once defined it is hard to replace these existing definitions because they are rooted in belief systems and values.

Rather than attempting to change oppressing and stigmatizing systems, we view people themselves as the problem.



Alaska child removal statistics

From 2004 to 2015, **38.7% of Medicaid-enrolled infants with NOWS in Alaska were temporarily or permanently placed in protective custody by OCS** within 28 days of birth [33]. In 2015–2016, among infants admitted into Alaska Regional Hospital's Neonatal Abstinence Evaluation Support Treatment (NEST) Unit: **50% were discharged into OCS custody**; 24% had OCS review with a safety plan outlined before discharge to the parents; 20% had OCS notification without action and 6% had no OCS referral.

Native Alaskan children under 10 years old

- 38% (1 in every 2.6 births) of NA children born in Alaska will be reported to Child Welfare
- 31% (1 in every 3.2 births) of NA children born in Alaska will be screened in by Child Welfare
- 13% (1 in every 7.7 births) of NA children born in Alaska will be substantiated by Child Welfare
- 7% (1 in every 14.3 births) of NA children born in Alaska will be removed by Child Welfare

American Indian/Alaska Natives Disproportionality in Child Welfare Nationally

AI/AN children are 14 times more likely to be in state foster care than the general population

https://www.nicwa.org/wp-content/uploads/2021/12/NICWA_11_2021-Disproportionality-Fact-Sheet.pdf

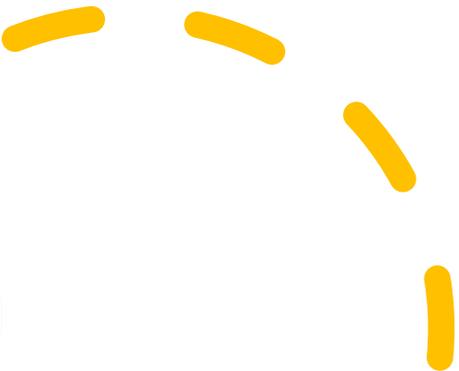
56% of adopted AI/AN children are adopted outside of their families and communities

<https://friendsnrc.org/prevention/working-with-ai-an-communities/#:~:text=American%20Indian/American%20Native%20children,Indian%20and%20Alaskan%20Native%20communities.>

From 2017 to 2021, more than 700 AI/AN children experienced the termination of their parents' rights, which is nearly 13 times the rate for white children (in SD)

<https://www.propublica.org/article/native-american-parental-rights-termination-icwa-scotus#:~:text=There%2C%20more%20than%20700%20Native%20American%20children,rate%20for%20white%20children%20in%20the%20state.>

It is difficult to overstate the amount of disruption and harm that this scale of child removal can have on a community or a family.

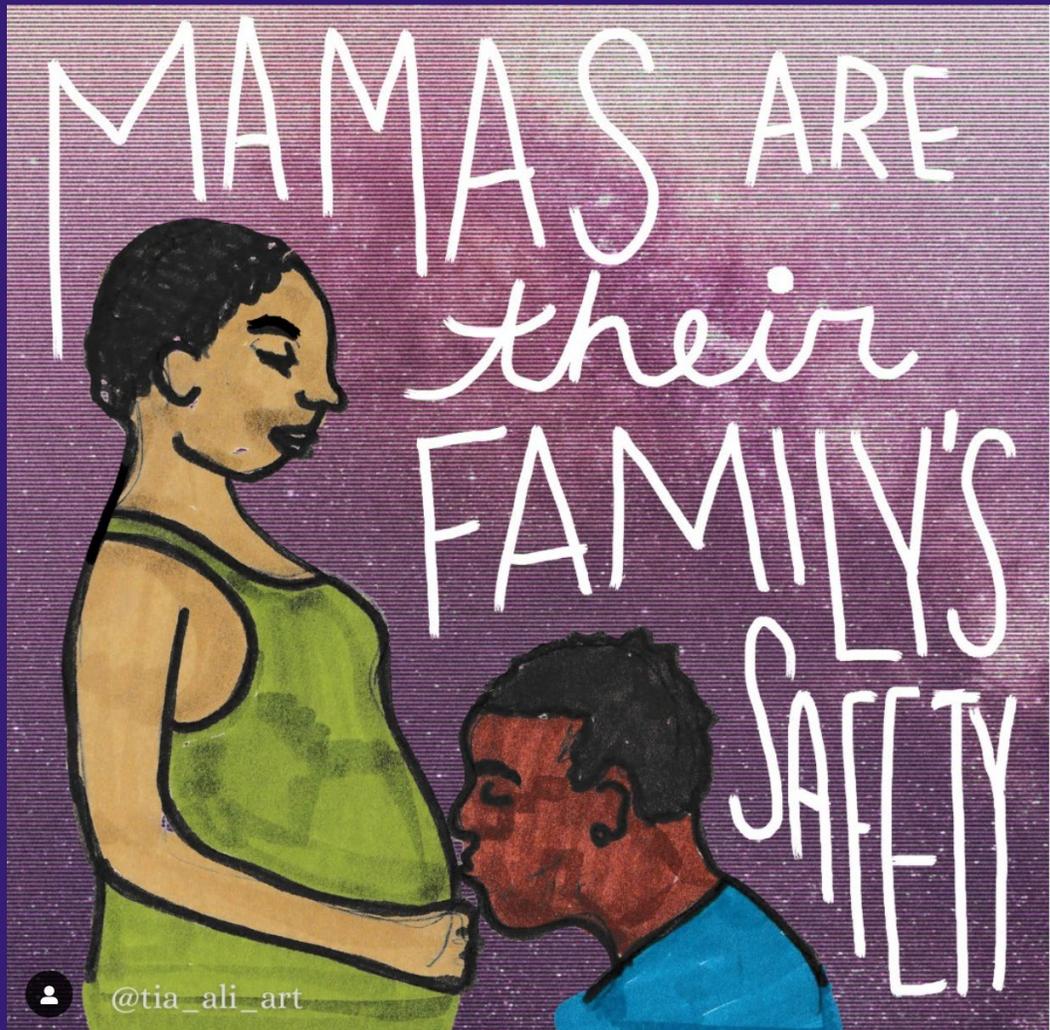


As recently as a generation ago, at least one-third of American Indian children were removed from their households
(Mannes, 1995).

Factors Associated with Child Removal Among American Indian and Alaska Native People in an Alcohol Intervention Study

Abram J Lyons^{1 2 3}, Katherine A Hirchak^{1 2}, Gordon Kordas^{1 2}, Jalene L Herron^{4 5},

In our adjusted multivariable model, those participants who reported attending a boarding school as children were 93% more likely (OR = 1.9; 95% CI = 1.1-3.4; $p = .03$) to have experienced removal of a child from their care as an adult...Results may provide evidence of multigenerational child removal impacts of boarding schools on AI/AN adults receiving an alcohol use disorder intervention. Assessment of parental history of child removal by practitioners, strategies to prevent alcohol-related separation and to support reunification should be integrated into addiction treatment in AI/AN communities.



Virtually all families in the child welfare system are low income or poor.

<https://www.hrw.org/report/2022/11/17/if-i-wasnt-poor-i-wouldnt-be-unfit/family-separation-crisis-us-child-welfare>

<https://www.childwelfare.gov/resources/separating-poverty-neglect-child-welfare/>

An Iatrogenic Injustice: Child Welfare and Substance Use

Mishka Terplan MD MPH
Medical Director, Friends Research Institute
Substance Use Warmline Clinician, UCSF



Assumptions

Addiction is a chronic condition, treatment works, and recovery happens all the time

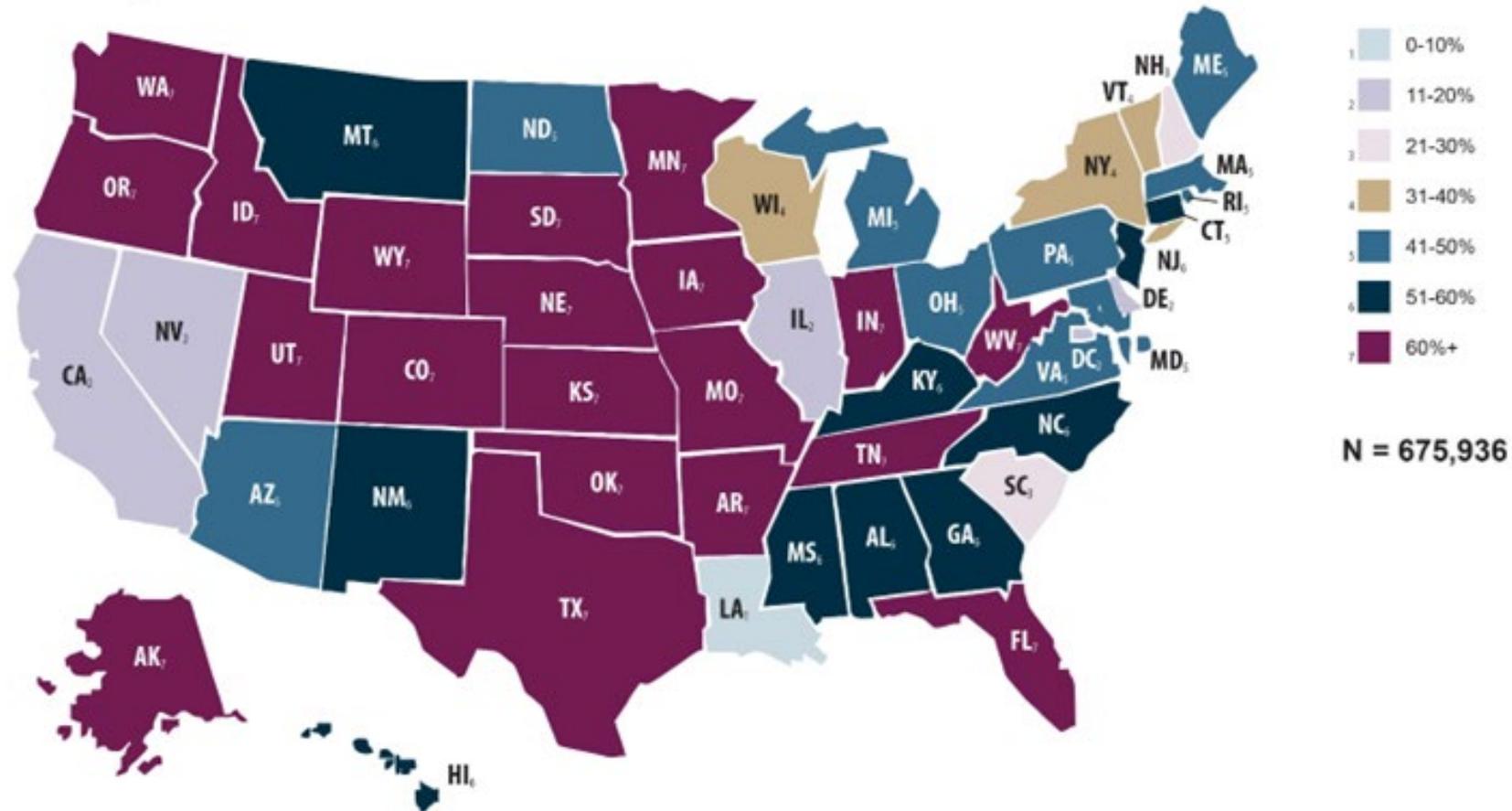
Child abuse (physical, sexual, emotional) is real, rare, and within health professional responsibility to assess and respond

Substance exposure is not in-and-of-itself child abuse

Percent of Children Removed with Parental Alcohol or Drug Abuse as an Identified Condition of Removal by Age, 2019

Under Age 1

National Average 50.7%



“Test and Report” -- Provider Culpability

Most child welfare reports (<1yr) are from medical professionals during birthing hospitalization

Health Professional Reporting increased 400% in past decade

Driven by (misuse of) urine drug testing

Compounds racial inequities

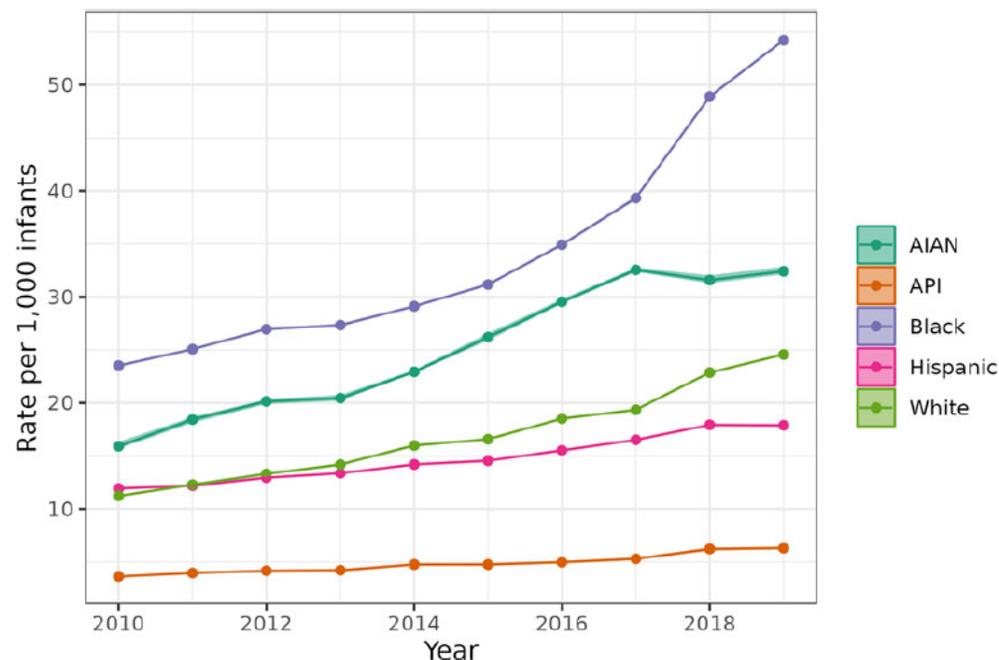


FIG. 2. U.S. child welfare investigations of infants (age < 1 year) initiated following a medical professional report, 2010–2019 by child race/ethnicity. Intervals indicate uncertainty from missing race/ethnicity data.

Health Equity V7.1, 2023 <https://www.liebertpub.com/doi/10.1089/heq.2023.0136>

HHS 2020 <https://www.childwelfare.gov/pubs/factsheets/cpswork/>

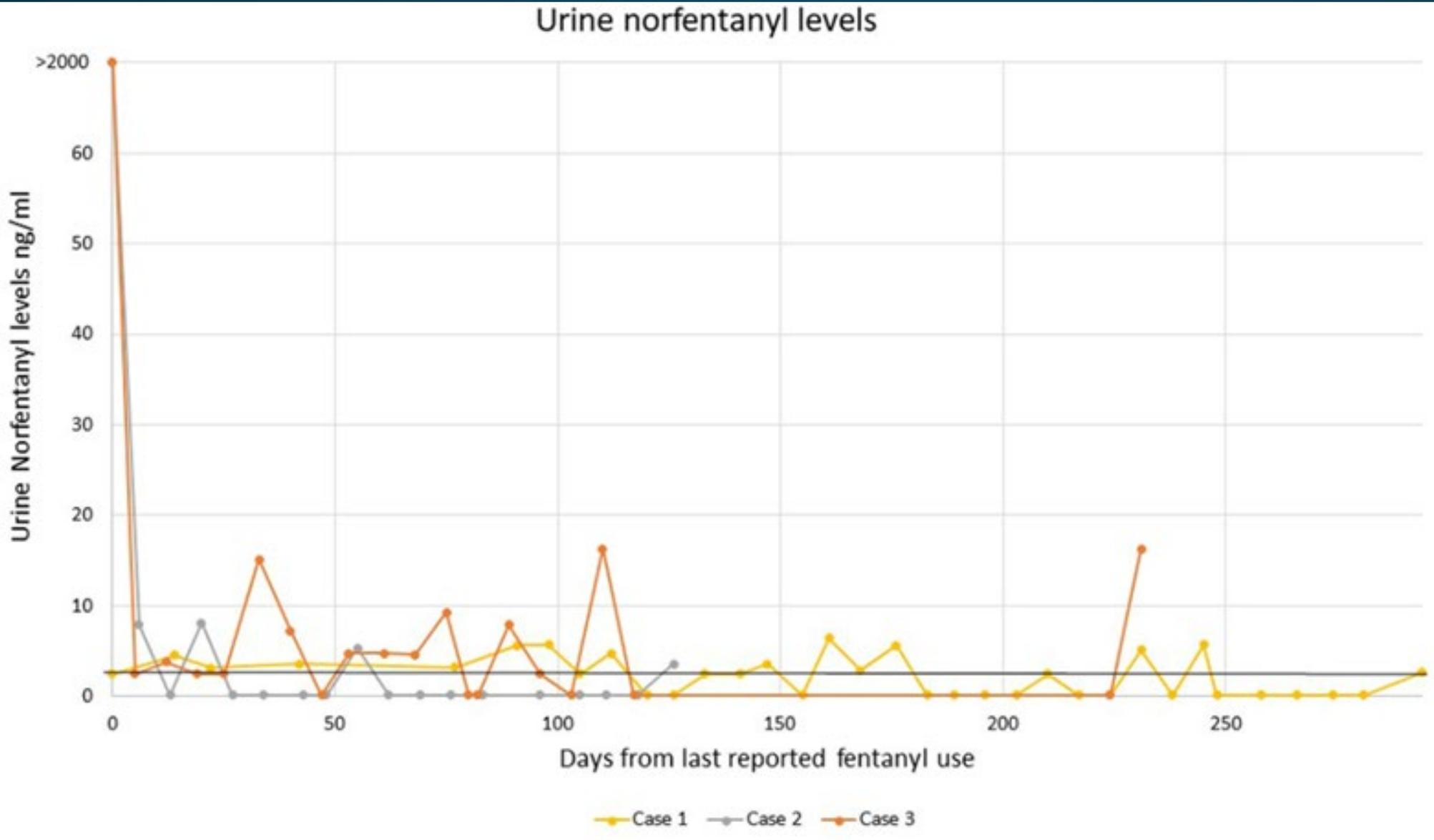
AAP 2015 <https://pediatrics.aappublications.org/content/135/5/948>

Drug tests DON'T tell you...

- When the substance was taken
- By what route the substance was taken
- How much substance was taken
- How often the substance was taken
- What was the motivation to take the substance
- What was the effect of the substance use
- What was the situation/setting of the use
- If a use disorder exists
- If the use was intentional
- If patients are taking their medication as Rx
- If the substance use will negatively affect the newborn

Drug testing is not proven to improve patient outcomes

Prolonged detection of urine norfentanyl in individuals enrolled in a MOUD in pregnancy and postpartum program

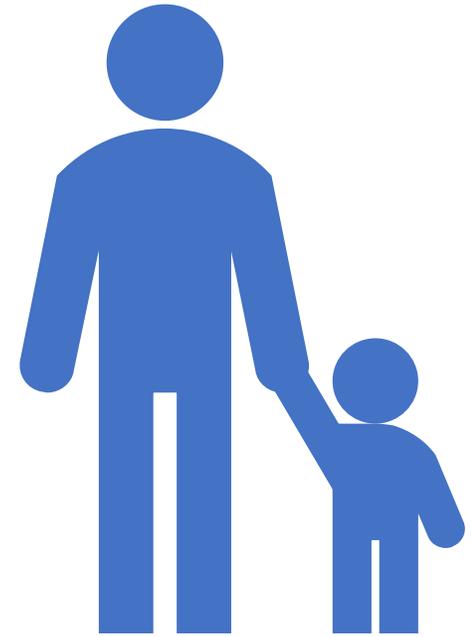


Low levels of norfentanyl (<16.3 ng/mL) were detected in urine 294 days, 126 days, and 231 days after the last fentanyl use. Patient self-reported abstinence was supported by consistently negative urine fentanyl levels throughout the collection period, compliant weekly urine drug tests that were otherwise only positive for buprenorphine, and negative fentanyl and norfentanyl in umbilical cord toxicology

While the Department of Health & Human Services emphasizes that a diagnosis of NOWS should not be used to assess a child's social welfare risk, it often is. Positive drug screens during pregnancy are considered child abuse in almost half of the US, with healthcare reporting obligations. These states consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and healthcare providers often obtain drug tests without a mother's consent. Although a positive drug screen during pregnancy should not be ignored, it is not in itself a diagnosis of a substance use disorder, nor does it determine the likelihood of a parent to abuse or neglect their child.

“Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons’ engagement with healthcare services.”

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022



“Better Safe Than Sorry”? Child Welfare Report and Consequence for Drug Exposure

20% children experience abuse or neglect in out-of-home placement

Mental health and somatic conditions greater among children in foster care compared to general population

Toxic stress: The physiologic result of physical or dangerous, recurrent, or prolonged experience of trauma caused by the initiation of the stress response without the protective existence of a compassionate adult

Non-death Loss and Grief in Foster Care

EVIDENCE BASE FOR AVOIDING FAMILY SEPARATION IN CHILD WELFARE

1. What is the impact of out-of-home placement on the wellbeing of children who have been maltreated?

From the current limited research available that attempts to isolate the impact of out-of-home placement from the impact of maltreatment on maltreated children, the following **preliminary conclusions** can be drawn:

- » **Out-of-home placement provides little to no measurable benefits to children who have experienced maltreatment, in terms of:**
 - Cognitive and language outcomes
 - Academic achievement
 - Mental health outcomes
 - Behavior problems
 - Suicide risk

- » **Out-of-home placement may cause additional harm to children who have experienced maltreatment in terms of:**
 - Increased risk of juvenile and adult criminal behavior
 - Increased risk of Reactive Attachment Disorder
 - Increased risk of early mortality

Child Maltreatment 2020



Child Fatalities due to Maltreatment are
Tragic and Rare

1713 fatalities in 2020 (rate 2/100,000)

Each Death is Preventable

But there is no evidence that removing
children for substance exposure protects
them from fatality due to maltreatment



U.S. Department of Health & Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



State Policies on Drugs and Pregnancy have Increased and are Increasingly Punitive

Punitive Policies Associated with:

- No Improvement in Birth Outcomes
- Increased Odds of Neonatal Abstinence Syndrome
- Increased Odds of Low Birth Weight
- Increased Odds of Preterm Delivery
- Decreased Odds of any Prenatal Care
- Decreased Odds of APGAR 7+

Mandatory Reporting Does Not Improve Population Health Outcomes

FAHERTY, ET AL., ASSOCIATION BETWEEN PUNITIVE POLICIES AND NEONATAL ABSTINENCE SYNDROME AMONG MEDICAID-INSURED INFANTS IN COMPLEX POLICY ENVIRONMENTS. ADDICTION, 2022

THOMAS, ET AL., DRUG USE DURING PREGNANCY POLICIES IN THE UNITED STATES FROM 1970 TO 2016. CONTEMPORARY DRUG PROBLEMS, 2018

CARROLL, THE HARMS OF PUNISHING SUBSTANCE USE DURING PREGNANCY. IJDP, 2021

ROBERTS, ET AL., FORTY YEARS OF STATE ALCOHOL AND PREGNANCY POLICIES IN THE USA: BEST PRACTICES FOR PUBLIC HEALTH OR EFFORTS TO RESTRICT WOMEN'S REPRODUCTIVE RIGHTS? ALCOHOL AND ALCOHOLISM, 2017

Researchers Call for Changes to State Law Requiring Child Protective Services to Be Notified When Medications for Opioid Use Disorder Are Used During Pregnancy

<https://www.massgeneral.org/news/press-release/research-calls-for-changes-to-state-law-requiring-child-protective-services-to-be-notified-when-medications-for-opioid-use-disorder>

THE NEGATIVE IMPACT OF MANDATED REPORTING POLICIES FOR PRENATAL SUBSTANCE USE

MEDICATIONS FOR OPIOID USE DISORDER ARE PRESCRIBED & DISPENSED TO SUPPORT RECOVERY



WANTING THE BEST FOR ME AND MY BABY

IN SOME STATES, INCLUDING MASSACHUSETTS, POLICIES REQUIRE AUTOMATIC FILING OF CHILD ABUSE & NEGLECT CHARGES FOR SUBSTANCE-EXPOSED NEWBORNS INCLUDING INFANTS EXPOSED IN-UTERO TO MEDICATIONS TO TREAT OPIOID USE DISORDER BECAUSE IN-UTERO EXPOSURE TO THESE MEDICATIONS CAN RESULT IN NEONATAL WITHDRAWAL -- A TEMPORARY & TREATABLE CONDITION

26 WOMEN WITH OPIOID USE DISORDER IN MASSACHUSETTS WERE INTERVIEWED ABOUT THEIR EXPERIENCES DURING PREGNANCY AND DELIVERY

CHILD PROTECTIVE SERVICES (CPS) FILINGS ARE NOT MADE AGAINST FATHERS WHO USE THESE SAME ADDICTION RECOVERY MEDICATIONS WHICH CONSTITUTES

- GENDER DISCRIMINATION

- FRUSTRATION THAT MEDICALLY INDICATED TREATMENT TRIGGERS CPS SURVEILLANCE

- INTENSE ANXIETY EXPERIENCED DURING PREGNANCY KNOWING A CPS REPORT WOULD BE FILED AT DELIVERY

STRESS STIGMA FEAR

- DISCRIMINATORY LANGUAGE LIKE "UNFIT" & "NEGLECT," USED IN CPS FILINGS INCREASE STIGMA IN THE HEALTHCARE SETTING

- LOSS OF PRIVACY AND AUTONOMY AROUND MEDICAL DECISIONS

POTENTIAL FOR:

- NEGATIVE HEALTH IMPACTS FOR MATERNAL-INFANT DYAD
- TREATMENT NON-ADHERENCE DUE TO FEAR AND ANXIETY
- CPS INVOLVEMENT AFFECTING THE MEDICAL CARE MOTHERS RECEIVE

VS

WE CAN CREATE A BETTER PATH to SUPPORT FAMILIES

- UNCOUPLE TREATMENT DECISIONS FROM CPS REPORTING

- FOCUS ON SERVICE DELIVERY, NOT SURVEILLANCE

- SUPPORT SERVICES LIKE COMMUNITY HEALTH PROGRAMS & CHILDCARE

INFORMED BY THOSE WITH LIVED EXPERIENCE

IMPROVED MATERNAL-INFANT HEALTH OUTCOMES

MEDICAL DECISIONS SHOULD BE MADE AUTONOMOUSLY WITH A KNOWLEDGEABLE HEALTHCARE PROVIDER - WITHOUT FEAR OF POLICIES REQUIRING CPS INVOLVEMENT

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 PRESCRIBED AND PENALIZED: THE DETRIMENTAL IMPACT OF MANDATED REPORTING FOR PRENATAL UTILIZATION OF MEDICATION FOR OPIOID USE DISORDER. *MATERNAL CHILD HEALTH JOURNAL*. 2023

Mass General Brigham
 Mass General for Children

seeyourwords.com

ACOG statement on SUD reporting in pregnancy

The use of the legal system to address perinatal alcohol and substance abuse is inappropriate. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. In states that mandate reporting, policy makers, legislators, and **physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system** to address the needs of women with addictions. These approaches should include **the development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women**, especially pregnant women, and their families.

Alaska SUD reporting statute

Sec. 47.17.024. Duties of practitioners of the healing arts.

a. A practitioner of the healing arts **involved in the delivery or care of an infant who the practitioner determines has been adversely affected by, or is withdrawing from exposure to, a controlled substance or alcohol shall immediately notify** the nearest office of the department of the infant's condition.

b. In this section,

1. "controlled substance" has the meaning given in AS 11.71.900, but does **not include a substance lawfully taken under a prescription** from a health care provider who is authorized to prescribe the substance...

i. This section **does not require a person required to report** child abuse or neglect under (a)(7) of this section to report **the resumption of use of an intoxicant** as described in AS 47.10.011(10) so long as **the person does not have reasonable cause to suspect that a child has suffered harm** as a result of the resumption.

https://dfcs.alaska.gov/ocs/Pages/childrensjustice/reporting/references_law.aspx

https://dfcs.alaska.gov/ocs/Pages/childrensjustice/reporting/references_law.aspx#47.17.020

doingrightbybirth.org

**DOING RIGHT AT BIRTH**

A self-paced, online course for healthcare professionals intended to guide learners in the legal, scientific, and ethical aspects of child welfare reporting

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- ✓ Case studies and reflection questions

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Welcome to Doing Right By Birth

We're shifting the discussion from drugs in pregnancy and parenting to an emphasis on family and child wellbeing and development.



EQUITY DRIVEN **+50 YEARS EXPERIENCE** **EMBRACING DISSENT**

 **CLINICIAN CONSULTATION CENTER**
National rapid response for HIV management and bloodborne pathogen exposures.

Substance Use Warmline
Peer-to-Peer Consultation and Decision Support
10 am – 6 pm EST Monday - Friday
855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

Treating women with opioid use disorders during pregnancy requires integrated, collaborative care

CONSISTENT PRENATAL CARE PROVIDER



INTEGRATION OF MEDICATION ASSISTED TREATMENT WITH BUPRENORPHINE



MULTIDISCIPLINARY CARE WITH PRENATAL PROVIDER AND BEHAVIORAL HEALTH CARE PROFESSIONALS

MORE FREQUENT PRENATAL CARE VISITS



TRAUMA-INFORMED CARE



INTEGRATION OF OR COLLABORATION WITH PSYCHIATRIC PROVIDER

PREGNANCY AND SUBSTANCE USE:

A HARM REDUCTION TOOLKIT

NATIONAL
HARM REDUCTION
COALITION



**PREGNANT PEOPLE WHO USE
DRUGS DESERVE ACCESS TO
SERVICES AND HIGH-QUALITY,
EVIDENCE-BASED CARE.**

Know your rights and learn
how to find quality care in
this toolkit.

<https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/>

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