PENNSYLVANIA
SECTION
OF ACOG
District III

SUBMITTED FOR THE 8/31/16 HEARING RECORD

Dear Representatives:

On behalf of the Pennsylvania Section of the American Congress of Obstetricians and Gynecologist (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 drug epidemic.

As an organization vested in the well-being of pregnant and postpartum women and neonates, we agree this public health issue is deserving of wider attention. We recognize the growing, tragic reality of opioid use disorders and its impact on Pennsylvania mothers, infants and families. We welcome the opportunity to work with you and other stakeholders to respond appropriately to this public health issue. Our shared goal must be positive health outcomes for both mother and baby. Healthy babies need healthy moms. 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.

The standard of care for pregnant women with opioid addiction is opioid-assisted therapy, which includes methadone and buprenorphine. It is much safer for women with opioid use disorders to be on prescribed and supervised use of opioid-based medications, known as opioid agonist therapy (OAT), than ongoing use of illicit opioids or medication-assisted withdrawal. Unlike illicit opioid use, OAT provides a known quantity of a known medication and has been demonstrated to be a safe and effective treatment for opioid addiction during pregnancy.

Withdrawal and detoxification is discouraged during pregnancy. It is not an effective, appropriate, or evidence-based treatment. More notably, detoxification during pregnancy 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, abruptio placentae, 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. After pregnancy, women should continue in their treatment and addiction support.

Some newborns exposed prenatally to opiates experience an abstinence (withdrawal) syndrome at birth. Neonatal Abstinence Syndrome (NAS) is an expected, readily diagnosed and treatable condition that follows prenatal exposure to opioid agonists. Most women using OAT have uncomplicated pregnancies and babies with average birth weights and high APGAR scores. While NAS is understandably concerning, there is no evidence to indicate that, with effective modern treatment, NAS itself is life threatening or results in permanent harm. There is safe, evidence-based treatment protocols endorsed by the American Academy of Pediatrics being used today. Unlike neonatal exposure to maternal alcohol and tobacco use, there have been no reported long-term effects of maternal opioid use.

Although pregnant women and women who have custody of their children are more likely to complete substance abuse treatment at a higher rate, there are multiple barriers to accessing treatment, including stigma, fear of prosecution or losing custody of children. Additionally, existing treatment programs are scarce and many reject pregnant women, fail to provide child care, or do not account for a woman's family responsibilities or accommodate women and children. 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 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, before it becomes a newborn's substance exposure 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. 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 consent.*

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 does nothing to 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 detox is not a safe or medically recommended approach for pregnant women and their fetuses.

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 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, especially 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 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. 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.