4-2016

Opioid Exposed Mothers and Infants in Delaware: Clinical and Legal Considerations

Michele K. Savin, MSN, NNP-BC
School of Nursing, Thomas Jefferson University

David A. Paul, MD
Christiana Care Health System

Opioid Exposed Mothers and Infants in Delaware: Clinical and Legal Considerations

Michele K. Savin, MSN, NNP- BC; David A. Paul, MD

Abstract

Drug use is on the rise in Delaware, as demonstrated by the continued increase in infants born with neonatal abstinence syndrome. Thoughtful, evidence based, and coordinated approaches are necessary to impact this problem. There is solid evidence that mothers and infants who remain together have improved outcomes. Professional medical and nursing societies are unanimous in support of non-punitive approaches to care. Medical professionals, legislators, and society in general would benefit from ongoing education on the addiction disease process in order to best care for the increasing number of mother/baby dyads with neonatal abstinence syndrome.

Introduction

More persons died from drug overdoses in the United States in 2014 than during any previous year on record, with approximately one and a half times as many deaths than in motor vehicle crashes.[1] Drug use in the United States (US), including in pregnant women, is rising – 4.4 percent of pregnant women use illicit drugs, with a much higher rate in women aged 15 to 25 years. Approximately 180,000 infants annually are born with neonatal abstinence syndrome (NAS)[2] which can directly affect infant development. Many of these infants require prolonged hospitalizations and require multifaceted inter-professional skills to guide them and their mothers through the period of withdrawal. Although there are no formal statewide data on NAS in Delaware, the number of infants with the NAS diagnosis has increased from 105 in 2010 to 173 in 2014 at Christiana Care Health System with a concomitant increase in patient days from 1,445 to 3,102 per year.

The American Congress of Obstetricians and Gynecologists (ACOG) states that there are multifactorial reasons for drug use, which is a biologic and behavioral problem with genetic components.[3] Substance abuse affects more people who are living in poverty, who have experienced abuse or trauma, and who are unemployed, or have mental illness. This means that a large percentage of women who deliver opiate exposed infants are uninsured or on Medicaid. In some population-based studies as many as 70 percent or more of infants diagnoses with NAS are on Medicaid.[4] By one estimate Medicaid will pay one trillion dollars for substance abuse over the next 20 years.[5] This translates into problems for families, health care systems, legal systems, and society.

Caring for patients with NAS requires empathy, knowledge, and curiosity. It demands experience and stamina. Due to increased numbers of opiate exposed mother-infant dyads, the stress and challenge of caring for vulnerable families is only increasing. The caregiver, mother, and infant are in a continual feedback loop with the actions of each affecting the reactions of the other.[6,7] Care of the opioid addicted mother is not emphasized in most medical training. It is a specialty area of its own. Nonjudgmental communication that balances needed supports and limits to the actively addicted or recovering is not in most medical professionals' toolbox.[8] Professionals need to expand knowledge and understanding of the addiction process and the evidence based interventions that best serve mothers and infants.

BACKGROUND

Hill defines addiction as a ‘‘chronic, relapsing disease that is characterized by compulsive drug seeking and use, despite harmful consequences.”[9] Addiction is a disease of both brain and behavior, and science has yet to understand the various reasons why people use drugs or how drugs affect the brain to compel addiction.[9] The national increase in NAS has been linked to prescription drug use.[4] Recent Delaware data shows alarming statistics that the top 1 percent of prescribers wrote one in four opioid prescriptions in Delaware. The top 10 percent of prescribers in Delaware wrote two thirds of all opioid prescriptions and wrote for the highest daily dosage among all states.[1]

Medical professionals may be conflicted by the need to advocate for these vulnerable, sick infants whose issues stem directly from maternal actions. Most nurses and physicians are not trained in addiction behaviors and the life experiences of those with addiction.[10,11] This absence of training may impede the relationships, and in turn accentuate negative feelings held by the mother. The lack of a trusting relationship can mean a mother is four times less likely to receive adequate preventive and ongoing health care. This may include how to bond with her infant.[9]

Caregivers without an understanding of the addiction experience may reinforce negative behavior such as non-visitation on the part of the mother.[6,7] Additionally, a paucity of maternal education on the topic of infant cues and signs of withdrawal exhibited by the infant may perpetuate maternal actions that exacerbate infant distress.[12]

CURRENT TRENDS

There is a growing movement nationally to enact punitive approaches to the opioid addicted mother. This may be driven not by evidence, but by a perceived need to intervene in the abuse cycle. Nurses are increasingly raising their voices against the mother, advocating for foster care[13] or legal ramifications for the mother. These ideas seem born of frustration rather than evidence. Evidence suggests that mothers and infants kept together have improved outcomes.[14,15] Indeed, the New Expectations program under the Delaware Department of Corrections is an example of a novel program working to keep mothers and infants together while searching for solutions which break the cycle of incarceration. Studies have also pointed out that mandatory reporting systems create fear of incarceration, fear of removal of the infant from parental care, or require entry into the social service system. Additionally, mandatory reporting can interfere with patient provider relationships.[16] The American

Nurses Association (ANA) believes the threat of prosecution hinders nurses from providing care to women who seek it.[17]

LEGAL PERSPECTIVE

Mandatory reporting of opiate exposed infants can be used as a proxy for local prevalence of maternal opioid use. It may lead to interventions by law enforcement or social services. Legislative action toward maternal opiate use is variable between states, and is creating disparities in care and intervention.[18,19] Some state policies regarding testing and reporting of mothers and infants with opiate exposure are more punitive, focusing primarily on the safety of the child, whereas others are more preventative and consider the health and well-being of the pregnant woman and her newborn. Testing and reporting policies can vary even within states.[20] Mandatory reporting, therefore, exposes women and infants to very disparate outcomes, depending on where they live, and how local and state laws are interpreted and enforced.

A recent report from the Guttmacher Institute gives a national perspective of state laws. Eighteen states consider substance use in pregnancy to be child abuse and three consider it grounds for civil commitment. Eighteen states require health care workers to report suspected abuse to the state and four mandate testing of pregnant women.[18] A myriad of other laws exist in counties and municipalities, and definitions of suspected substance abuse, as well as who is mandated to report and when are not consistent or clear. The potential negative effects that may occur as a result of the legal actions taken against prenatal drug abusers are many. These negative effects may include, but are not limited to avoidance of prenatal care, constitutional infringements, discrimination, poor prison conditions, and ineffectiveness of punitive measures.[5]

The punitive approach is aimed at cost reduction and social well-being. Nationally costs of all infant drug exposure total between $71 million and $113 million per year, but in particular, treatment for infant opiate exposure is extremely costly.[20] However, legal action has many negative unintended consequences. ACOG states "deterring women from seeking care is detrimental to women and infants; seeking care should not expose a woman to civil or criminal proceedings which put her and baby at risk of incarceration and separation."[3] ACOG also points out that it cannot be assumed that a pregnant woman who does not receive treatment does not want it, as availability of targeted substance abuse treatment for pregnant women is limited to 19 states, with only 12 giving pregnant women priority access to treatment.[3,18] Delaware neither gives pregnant women priority access nor protects pregnant women from discrimination in publicly funded programs.[18]

PROFESSIONAL RESPONSE

The National Perinatal Association opposes criminal prosecution of women who abuse substances while pregnant, as there is no evidence that this helps the mother or infant.[21] The American Society of Addiction Medicine (ASAM) supports treatment rather than criminalization as incarceration may hurt the health of the mother and fetus, and may not address efforts toward long-term recovery.[22] In January of 2015 the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) released a position statement, which while endorsing a nurses' responsibility to follow the law, opposes incarceration or punitive legal action against women due to substance abuse in pregnancy.[23]

WORKING TOGETHER

The national extent of maternal opioid abuse and resulting NAS is not clear, and it is variable around the country. Programs aimed at quantifying NAS as a diagnosis, looking at trends in geographic areas, and in differing populations are needed. Young et al. concluded we may be missing an opportunity to increase the impact of policy on the issue of substance use in pregnancy, and that solutions require public and private entities to work together to address how we serve families. Additionally, there is opportunity for partnerships to identify where differences exist in policy goals versus implementation of local laws.[19]

De-identified reporting of infants exposed to opiates has the potential to provide data to drive interventions and to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Programs such as this are underway in Tennessee and Florida, the results of which are pending.[24,25,26] Screening and reporting should be viewed as part of a larger issue of policy and practice interventions for individuals and families. In Tennessee, public health partners in both the public and private sector are using reporting results to enact local prevention strategies.[26] Which mechanism to use for screening, where to collect and house the data, and how the data are used are all questions that need to be addressed. Currently in Delaware screening via urine, meconium, and more recently, umbilical cord tissue has been used based on hospital system policy. All have potential downsides however and cost, sensitivity, and specificity vary. The issue of NAS requires a clear definition of terms, consistent implementation,

and availability of treatment interventions, all of which are challenging.

FAMILY RESPONSE

Parents of children born with NAS perceived themselves to have difficulty being emotionally available and responsive. Additionally, they were often separated from their children by incarceration, hospitalization, or drug seeking behaviors. Health care professionals must target treatment and support at family systems, not just individuals, ensuring continuity of care and caregiving for children.[27] Interventions will need a systematic population health focus. Medicaid will have a role, especially given that these infants are at higher risk of re-hospitalization than their non-exposed peers.[4]

HEALTH CARE CHALLENGES

Professionals need up-to-date education regarding substance abuse care to decrease challenges and stress. Also needed are evidence-based strategies that are shown to aid mother and infant through the crucial early withdrawal and bonding moments. Mothers may struggle to interpret infant cues and provide appropriate care. It is incumbent upon health care professionals to asses maternal and infant interactions, improving maternal confidence in her ability to care for her infant,[12] thereby creating successful mother-infant bonds.

It is increasingly clear that keeping the opioid exposed mother/infant dyad together in the same room and breastfeeding leads to shorter hospital stays and increased bonding.[14,15] Non-pharmacologic intervention and complementary therapies are used in neonates, but they have not been widely studied and use is inconsistent. While things like decreased stimulation and skin to skin care have anecdotal success, they do not have proven efficacy.[14,28] Validating and implementing potential interventions may go a long way toward increased understanding on the part of health care professionals and increased success of the mother/infant dyad.

CONCLUSION

The number of substance abusing mothers in Delaware is increasing. While current national trends may encourage punitive responses to these mothers, ever growing bodies of evidence show treatment and support are better options for families.

Professional organizations are unanimous in calling for non-punitive approaches. De-identified reporting of infants exposed to opiates may provide data to drive interventions, having the potential to reduce physical, emotional, and financial costs of the NAS epidemic to individuals and society. Screening and reporting can be viewed as part of a larger issue of policy and practice interventions for individuals, families, and communities. Policy solutions may include increasing priority for pregnant women in treatment centers, increased funding for research on short term and long term outcome of infants with NAS, and assisting nursing and state agencies to optimize follow up of infants and mothers, to name a few. There is a need to educate health care professionals, legislators, and society about the addiction disease process. Issues such as reasons that lead to opiate abuse should be addressed upstream. Finally, the role of both legislation and health care professionals in the fight against opiate abuse needs structure and clarity. All citizens in Delaware will benefit from a coordinated, thoughtful, evidence based approach to this growing epidemic.

CONTRIBUTING AUTHORS

MICHELE K. SAVIN, MSN, NNP- BC is a Neonatal Nurse Practitioner at Christiana Care Health System and Coordinator of the Neonatal Nurse Practitioner Program at Thomas Jefferson College of Nursing. She has worked with the March of Dimes and the Delaware Healthy Mother and Infant Consortium.

DAVID A. PAUL, MD is a Neonatologist, Chair of the Department of Pediatrics and Clinical Leader of the Women and Children's Service Line at Christiana Care Health System, and a Professor of Pediatrics at Sidney Kimmel Medical College at Thomas Jefferson University.

REFERENCES

1. Paulozzi LJ, Strickler GK, Kreiner PW, Koris CM. Centers for Disease Control and Prevention (CDC). Controlled substance prescribing patterns--prescription behavior surveillance system, eight states, 2013. *MMWR Surveill Summ*. 2015;64:1-14.
2. Caitlin A. Call for improved care for the substance-positive mother. *Adv Neonatal Care*. 2012;12:286-287.
3. American Congress of Obstetricians and Gynecologists Committee on Health Care for Underserved Women. AGOG Committee Opinion No. 473: Substance abuse reporting and pregnancy: The role of the obstetrician-gynecologist. *Obstet Gynecol.* 2011;117:200-201.
4. Patrick SW, Burke JF, Biel TJ, Auger KA, Goyal NK, Cooper WO. Risk of hospital readmission among infants with neonatal abstinence syndrome. *Hosp Pediatr.* 2015;5:513-519.
5. Coleman EE, Miller MK. Assessing legal responses to prenatal drug use: Can therapeutic responses produce more positive outcomes than punitive responses? *J L & Health.* 2006;20:35-67.
6. Cleveland LM, Gill SL. "Try not to judge": Mothers of substance exposed infants. *MCN Am J Matern Child Nurs.* 2013;38:200-205.
7. Cleveland LM, Bonugli R. Experiences of mothers of infants with neonatal abstinence syndrome in the neonatal intensive care unit. *J Obstet Gynecol Neonatal Nurs.* 2014;43:318-329.
8. Whalen BL, Holmes AV. Neonatal abstinence syndrome and the pediatric hospitalist. *Hosp Pediatr.* 2013;3:324-325.
9. Hill PE. Perinatal addiction: Providing compassionate and competent care. *Clin Obstet Gynecol*. 2013;56:178-185.
10. Fraser JA, Barnes M, Biggs HC, Kain VJ. Caring, chaos and the vulnerable family: Experiences in caring for newborns of drug-dependent parents. *Int J Nurs Stud*. 2007;44:1363-1370.
11. Maguire D, Webb M, Passmore D, Cline G. NICU nurses' lived experience: Caring for infants with neonatal abstinence syndrome. *Adv Neonatal Care*. 2012;12:281-285.
12. Velez M, Jansson LM. The opioid dependent mother and newborn dyad: Non-pharmacologic care. *J Addict Med.* 2008;2:113-120.
13. Beal J, Bauer JA, Diedrick LA. Should infants with neonatal abstinence syndrome be discharged with their mothers rather than placed in a foster-care environment? *MCN Am J Matern Child Nurs.* 2014;39:218-219.
14. Isemann B, Meinzen-Derr J, Akinbi H. Maternal and neonatal factors impacting response to methadone therapy in infants treated for neonatal abstinence syndrome. *J Perinatol*. 2011;31:25-29.
15. Saiki T, Lee S, Hannam S, Greenough A. Neonatal abstinence syndrome--postnatal ward versus neonatal unit management. *Eur J Pediatr.* 2010;169:95-98.
16. Kremer ME, Arora KS. Clinical, ethical, and legal considerations in pregnant women with opioid abuse. *Obstet Gynecol.* 2015;126:474-478.
17. American Nurses Association. Non-punitive alcohol and drug treatment for pregnant and breastfeeding women and their exposed children: revised position statement. Available at: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position- Statements/Non-punitive-Alcohol-and-Drug-Treatment-for-Pregnant-and-Breast-feeding-Women-and-the- Exposed-Childr.pdf. Published December 9, 2011. Accessed February 5, 2016.
18. Guttmacher Institute. State policies in brief: Substance abuse during pregnancy. Available at: https://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf. Published December 2015. Accessed February 5, 2016.
19. Young, NK, Gardner, S, Otero, C, et al. Substance-exposed infants: State responses to the problem. *HHS* Pub. No. (SMA) 09-4369. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
20. National Abandoned Infants Assistance Resource Center. Prenatal Substance Exposure Fact Sheet. Available at: http://aia.berkeley.edu/media/pdf/AIAFactSheet_PrenatalSubExposure_2012.pdf. Published March 2012. Accessed February 5, 2016.
21. Advocates for Pregnant Women. Medical and public health statements addressing prosecution and punishment of pregnant women. http://advocatesforpregnantwomen.org/main/publications/fact_ sheets/medical_and_public_health_statements_on_the_prosection_and_punishment_of_pregnant_women.php. Published 2011. Accessed February 5, 2016.
22. Public Policy Statement on Women, Alcohol and Other Drugs, and Pregnancy. American Society of Addiction Medicine (ASAM). http://www.asam.org/docs/publicy-policy-statements/1womenandpregnancy_7-11.pdf. Published 2011. Accessed February 5, 2016.
23. Association of Women's Health, Obstetric and Neonatal Nurses. Criminalization of pregnant women with substance use disorders: position statement. *J Obstet Gynecol Neonatal Nurs.* 2015;44:155-157.
24. Association of State and Territory Health Officials. Neonatal abstinence syndrome: How states can help advance the knowledge base for primary prevention and best practices of care. http://www.astho.org/Prevention/NAS-Neonatal-Abstinence-Report. Published 2014. Accessed February 5, 2016.
25. Bondi P. Statewide Task Force on Prescription Drug Abuse and Newborns. http://myfloridalegal.com/webfiles.nsf/WF/RMAS-9GUKBJ/$file/Progress-Report-Online-2014.pdf. Published 2014. Accessed February 5, 2016.
26. Warren MD, Miller AM, Traylor J, Bauer A, Patrick SW. Centers for Disease Control and Prevention (CDC). Implementation of a Statewide Surveillance System for Neonatal Abstinence Syndrome — Tennessee, 2013. MMWR, 2015;64:125-128.
27. Hogan, DM. The impact of opiate dependence on parenting processes: Contextual, physiological and psychological factors. *Addict Res Theory.* 2007;15:617-635.
28. Sublett J. Neonatal abstinence syndrome: Therapeutic interventions. *MCN Am J Matern Child Nurs.* 2013;38:102-107.