



WHITE PAPER ON IMPLEMENTATION  
OF CHAPTER 820

# OPPORTUNITIES TO ADDRESS PREGNANCY, DRUG USE AND THE LAW

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## Introduction

Even the earliest of Biblical stories records excessive drug use in the form of alcohol. Early American history records the use of “sober houses” and “inebriate asylums”. In 1919 with the adoption of the 18th Amendment, the country tried the Noble Experiment of Prohibition without success. In 1944 the National Committee for Education on Alcoholism noted that alcoholism is a disease, and the alcoholic is a sick person. In 1956 the American Medical Association noted that alcoholism is a disease. In 1973, U.S. researchers first described fetal alcohol syndrome (FAS), a pattern of birth defects in children born to alcoholic mothers. In 1981, First Lady Nancy Reagan announced the “Just Say No” campaign, and President Ronald Reagan then followed with the War on Drugs that led to increased incarceration of drug offenders.

Tennessee has not been immune to historical trends. Even with the lively lyrics of one of our state songs, “Rocky Top” extolling the virtues of corn in a jar, prescription drugs have recently overtaken alcohol as our number one drug of choice. In 2013, the General Assembly enacted Public Chapter 398, the Safe Harbor Act, which encourages pregnant women to seek treatment services knowing that they will not be at risk of losing their parental rights. In 2014, the General Assembly enacted Public Chapter 820, the Fetal Assault law, which makes addicted pregnant women subject to criminal prosecution under Tennessee’s assault statutes. Among the 50 states, this legislative approach makes Tennessee unique.

In 2016, The Tennessee Association for Alcohol, Drug & other Addiction Services (TAADAS), a membership organization for the prevention and treatment community has drafted this white paper to assist policy makers and the public in understanding the issues surrounding Pregnancy, Drug Use, and the Law. TAADAS hopes this effort will assist policy makers as they discuss whether to wind down the temporary fetal assault law which is set to expire in 2016.

TAADAS welcomes your questions, comments, and observations about this white paper.

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## Opportunities to Address Pregnancy,

### Drug Use and the Law

#### EXECUTIVE SUMMARY

TAADAS is concerned that the recent enactment of Chapter 820 of the Public Acts of 2014 did not adequately address access to care while criminalizing women who did not receive care. The focus of our recommendations regarding Chapter 820 are to promote access to care for pregnant drug-using women and enable women to have healthy pregnancies and healthy babies while receiving addiction treatment. Any barriers to accessing treatment will reduce the potential for healthy outcomes for these babies. The data presented shows the ramifications for women seeking care after Chapter 820 was passed as well as the shortage of addiction treatment options for this population.

Opioids are the primary substance of abuse in Tennessee. The Opioid Prescription Reporting Database operated by TN Department of Health (TDOH) significantly increased physician awareness of this issue. Still there were 25% more controlled substances dispensed in Tennessee in 2012 than in 2010. (Prescription for Success) It should be noted that offering treatment to women will not necessarily reduce the number of Neonatal Abstinence Syndrome (NAS) births. The evidence based practice recommended treatment for pregnant drug using women is Medication Assisted Treatment (MAT) which results in nearly the same or slightly reduced rate of NAS births. Increasing access to care is appropriate for these women, but the premise of this bill was to reduce NAS babies. In other studies, MAT was found to maintain or even increase the number of NAS babies. As of October 31, 2015, just over 80% of the cases of NAS were attributed to opiate use taken under the supervision of a physician. The number of NAS cases appears to be leveling off, and the rate is no longer increasing to the same degree. But NAS will not be eliminated as long as the safest and most preferred treatment during pregnancy continues to be medication assisted therapy.

Body functioning, thinking and automatic responses are all controlled by chemical reactions in the brain. Taking an opioid alters those chemical reactions. Opiates, in particular, destroy the pleasure cells in the brain which leads to an increasing need for more substance to feel anything or to recreate the 'high' that first occurred. Because these cells are destroyed, the user will keep trying even though the original 'high' is never recreated. The person becomes dependent on the substance in an effort to feel better. Any degree of use can trigger this reaction – there is no predicting the length of use or amount of use that cause a person to become addicted. This is the disease of addiction – a brain disease.

There are many chronic diseases such as hypertension, asthma, diabetes and addiction that require long term management approaches. Treatment for these kinds of chronic diseases during pregnancy may require adaptations of patient treatment plans to keep the fetus from undergoing any harm. Many of these conditions pose a higher risk to a developing fetus than do opioids. Addiction is not illegal. Possession of certain drugs and drug paraphernalia as well as selling drugs are illegal. Criminalizing addiction in any manner would make reporting your condition and accessing the health care system risky.

TAADAS does not endorse additional criminal penalties for pregnant drug-using women because our data shows that criminal sanctions drive women away from care. Many studies have cited pregnancy and the need to care for children and families to be a primary motivation for women to enter addiction treatment. A study of drug-using women between 2000 and 2007 found that pregnant women were more than four times as likely as non-pregnant women to express greater motivation for treatment. Family care issues are also cited as one of the chief reasons that women leave treatment – often due to the problems with long term absence and need to provide direct care for their children and families.

The following issues were found to be barriers to care for pregnant drug-using women:

1. Lack of treatment facilities that will admit pregnant women – including poor access to Methadone and Subutex providers;
2. Lack of high-risk OB-GYNs who will affiliate with treatment providers and these women to provide care while they are in addiction treatment;
3. Lack of treatment facilities that provide recovery support for women through their pregnancies and post-partum – especially ones that provide family residential care;
4. Lack of childcare for women in treatment during pregnancy and post-partum;
5. Lack of funding for treatment – access to care is further limited for those without insurance, state/Federal funding for indigent care only treats a few hundred pregnant women each year
6. Lack of insurance parity enforcement keeps some women from accessing care even when they have insurance; and
7. Lack of transportation for women to get to treatment - especially in rural areas

TAADAS does endorse and recommend ways to develop and provide appropriate care that follows best practice guidelines.

TAADAS Recommendations:

1. Allow Chapter 820 to sunset.
2. Provide additional specialized treatment options for mothers with opioid addiction whose babies have been born with Neonatal Abstinence Syndrome or who are at risk of losing their children – including the potential for family residential care.
3. Continue TennCare coverage for new mothers of babies born with opioids and other substances in their systems for at least 6 months postpartum.
4. Develop Recovery Courts throughout the state to ensure access for women charged under pre-existing criminal statutes.
5. Develop best practices for the treatment of opioid dependent pregnant women.
6. Provide specialized training to treatment providers on the new best practices for serving people with opioid addiction.
7. Increase the availability of and refine training for time-limited substance abuse case management services.
8. Ensure the state's enforcement of parity regulations to insure that these women have access to addiction services within their health plans.

## CHAPTER 820 OF THE PUBLIC ACTS OF 2014

Chapter 820 of the Public Acts of 2014 amends Tennessee’s fetal assault law (codified in Tenn. Code. Ann. §§ 39-13-107) to allow a woman to be prosecuted for the illegal use of a narcotic while pregnant, if her child is born addicted to or harmed by a narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant. Chapter 820 allows a woman to be charged with assault, which is a Class A Misdemeanor, punishable by up to one year in jail. The implications for the treatment of pregnant drug-using women were heavily debated at the bill’s inception. The bill was set to sunset in 2016 in order to assess the ramifications and outcomes before becoming permanent.

Chapter 820 also creates an affirmative defense for a woman who is actively enrolled in a long-term addiction recovery program before the child was born, remained in the program after delivery, and successfully completed the program, regardless of whether the child is born addicted to, dependent upon, or harmed by the narcotic drug. The bill’s sponsors state that the intent of the bill is to prevent and reduce the number of babies born with opiates in their systems or a diagnosis of Neonatal Abstinence Syndrome (NAS).

## PREVALENCE OF ADDICTION IN TENNESSEE - PREVALENCE IN WOMEN

Tennessee ranks second per capita in the United States for its rate of opioid abuse. When people get a prescription from a doctor for these substances their perception is that they are safe –commonly believing they are not addictive, especially if taken as prescribed. In Tennessee, people who are educated, married or successful with their careers are three times more likely to use prescription drugs than others and thus find themselves addicted, according to TDMHSAS Division of Alcohol and Drug Abuse Services. (28) Adolescents who are prescribed opioids are more likely to become abusers later in life. (4) Yet, according to the 2013 National Survey on Drug Use and Health (NSDUH), almost 5 million Americans aged 12 or older used opioids during the past month. Opioids are the primary substance of abuse in Tennessee. The Opioid Prescription Reporting Database operated by TDOH significantly increased physician awareness of this issue. Still there were 25% more controlled substances dispensed in Tennessee in 2012 than in 2010. (22)

*Opiates in particular destroy the pleasure cells in the brain which leads to an increasing need for more substance to feel anything or to recreate the ‘high’ that first occurred.*

Body functioning, thinking and automatic responses are all controlled by chemical reactions in the brain. Taking an opioid alters those chemical reactions. These altered reactions change a person’s sensitivity to pain and increase the likelihood that the person’s perceptions will be altered as well. Opiates, in particular, destroy the functioning of pleasure cells in the brain which leads to an increasing need for more substance to feel anything or to recreate the ‘high’ that first occurred. Because these cells are destroyed, the user will keep trying even though the ‘high’ is never recreated. Their brain will send messages seeking that substance. Those cravings can lead to use where the person becomes dependent on the substance in an effort to feel better. Any degree of use can trigger this reaction – there is no predicting the length or amount of use that cause a



person to become addicted. This is the disease of addiction – a brain disease. In this case, a disease caused by a medication intended to ease suffering. It can take at least a year of abstinence for a person’s brain to recover enough to return to baseline – essentially fully functioning, able to feel emotions and sensations again.

Addiction can occur by simply taking the prescribed dose of opioids. Cravings can cause the person to seek more and more of the substance to get the same ‘high’ and to switch to other more available substances. People also abuse opioids just like abusing alcohol or other drugs, if they are available, to inappropriately deal with stress and find themselves addicted. 46,471 Americans died from drug overdoses in 2013, the most recent year of data available. More than half of these were specifically attributable to prescription painkillers and heroin. A DEA report notes that this is more than the 35,369 who died in car crashes and 33,636 who died from guns. (29)

Tennessee ties with Alabama for the most painkiller prescriptions per 100 people, at 143 prescriptions. (30) A controlled substance database report presented to the Tennessee General Assembly in 2012 stated that in 2011, 275 million Hydrocodone pills were dispensed in Tennessee, 117 million Xanax pills and 113 million Oxycodone pills. That adds up to 22 Xanax pills, 51 Hydrocodone pills and 21 Oxycodone pills for every Tennessee resident over 12 years old.

Women are more likely than men to receive prescriptions for opioids, perhaps because they are more likely to suffer from chronic pain conditions, such as fibromyalgia (2). They tend to progress more quickly from using an addictive substance to dependence. They also develop medical or social consequences of addiction faster than men, often finding it harder to quit using addictive substances, and are more susceptible to relapse (2). This is also likely due to the higher prevalence of systemic and multiple psychological trauma for women. Masking traumatic issues and responses with substances is more common for women. “Nearly two decades of epidemiological and clinical studies have documented the staggering rates of interpersonal violence in the lives of women with substance use disorders.” (11) Another study found that, “although men are, overall, more likely to be exposed to trauma in their lives, women are more often exposed to chronic high-impact trauma such as childhood sexual violence, physical abuse and neglect.” (25) This has increased the need to have substance abuse programs trained in trauma-informed care and to promote programs that are capable of providing co-occurring mental health and substance abuse care for women in order to be most effective. More complex treatment needs and multiple disorders require more intensive and focused long-term management of this chronic disease for women. Addiction treatment for a pregnant woman is a complex issue which is not determined by the amount drugs taken or the period of time taken for example – but should be based on individual treatment needs assessed by a treatment professional.

With 79,954 live births to women in TN in 2013 and an expected rate of opiate use at 5.4% of those women (among pregnant women aged 15 to 44, 5.4 percent were current illicit drug users based on data averaged across 2012 and 2013 - SAMHSA) - 4318 pregnant women will need access to addiction treatment each year in Tennessee.

Recovery Courts have been under the jurisdiction of TDMHSAS since 2012 and data has been collected from the courts since that time. This data shows no significant increase in the number of pregnant women taken



into the jurisdiction of these courts since that time. A pregnant woman would most likely have been referred to a Recovery Court, whenever possible, before and after Chapter 820 was enacted into law.

There have been just over 30 arrests of women using this new statute identified in the Department of Safety and Homeland Security survey of District Attorneys about their use of the Chapter 820. Twenty-eight prosecuted cases were cited in that report in April of 2015. 17 of those cases were referred to Recovery Court with most of the remaining cases pending, one case dismissed and two cases otherwise adjudicated. When you compare the number of those charged to the number of NAS cases in a year to the number of women one would expect to need drug treatment – the need to prosecute women on this specific charge outside of a Recovery Court would seem negligible.

## PREVALENCE OF NAS

Each year, about 50 to 60 percent of opioid-exposed infants develop symptoms of Neonatal Abstinence Syndrome (NAS). NAS does not occur in every pregnancy when a woman uses opiates. Why some babies are born with NAS and others are not while having the same fetal exposure to opiates remains a question.

Tennessee saw an explosion of the rate of NAS starting in 2008 with the Eastern grand division experiencing the highest incidences of babies born diagnosed with NAS. In 2013, the TDOH established a reporting system for hospitals diagnosing newborns with NAS to more accurately track and monitor one of the most devastating outcomes of the prescription drug epidemic, with 921 babies being reported. In 2014, that number rose to 972. As of October 31, 2015 the number of NAS cases for the year is 812 and the source of the mother’s use is reported in the table below:

Source of Maternal Substance (if known)	# Cases <sup>1</sup>	% Cases
Supervised replacement therapy	502	61.8
Supervised pain therapy	83	10.2
Therapy for psychiatric or neurological condition	71	8.7
Prescription substance obtained WITHOUT a prescription	274	33.7
Non-prescription substance	181	22.3
No known exposure but clinical signs consistent with NAS	4	0.5
No response	15	1.9

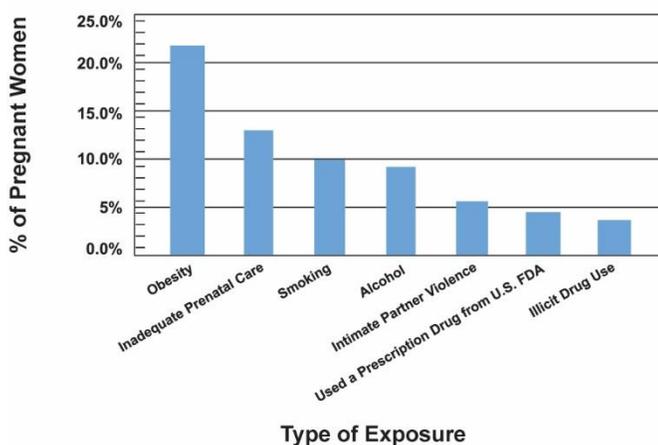
<sup>1</sup> –Multiple maternal substances may be reported; therefore the total number of cases in this table may not match the total number of cases reported.

This report shows that just over 80% of the cases of NAS can be partially attributed to opioid use that was prescribed and taken under the supervision of a physician. Pregnant women in addiction treatment would most commonly be prescribed an opiate replacement therapy. The number of NAS cases appears to be leveling off and the rate is no longer increasing to the same degree. But NAS will not be eliminated as long as the safest and most preferred treatment during pregnancy continues to be medication assisted therapy.

## TREATMENT OPTIONS

Many chronic diseases such as hypertension, asthma, diabetes and addiction require long-term maintenance and management approaches. Treatment for these chronic diseases during pregnancy may require adaptations of patient treatment plans to keep the fetus from undergoing any harm. Treatment initiation during pregnancy can be done successfully as well using protocols that minimize the risk to the fetus and allow for ongoing management post-partum. Many of these conditions pose a higher risk to a developing fetus than do opioids – see chart below:

### Prevalence of Risk Factors During Pregnancy in the U.S.



*Many of these conditions pose a higher risk to a developing fetus than do opioids.*

NAPW ©

Fetuses of pregnant women who are overweight or obese are at increased risk of prematurity, stillbirth, congenital anomalies, macrosomia with possible birth injury, and childhood obesity. Women who were severely obese had twice the risk of stillbirth in comparison to lean women; risk was just slightly less in obese women. Previous studies have not shown an increase in risks of birth defects after prenatal exposure to oxycodone, propoxyphene, or meperidine. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise.

Addiction is not illegal. Possession of certain drugs and drug paraphernalia, as well as selling drugs, are illegal acts. Criminalizing a chronic health condition such as addiction would make reporting your condition and accessing the health care system for treatment a potential criminal act. 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. Whether increased risks to pregnancy come from smoking cigarettes, using alcohol or using any of the criminalized drugs, including heroin, accessing health care is vital for healthy pregnancies and pregnancy outcomes. Access to health care is essential for opioid using women and any barriers to accessing treatment will reduce the potential for healthy outcomes for their babies.

U.S. Department of Health and Human Services Treatment Improvement Protocol (TIP 2) and the Substance Abuse and Mental Health Service Agency (SAMHSA) both recommend methadone maintenance treatment for

pregnant women using opiates. SAMHSA guidelines (TIP 51) cite literature that recommends Methadone treatment to reduce maternal and fetal complications. For example, Jarvis and Schnoll published a widely cited study that found methadone treatment to be safely used for opiate addiction during pregnancy and urges clinicians to send women to these programs. Another study by Kalterback in 1998 called Opioid Dependence During Pregnancy: Effects and Management found that the fetus is at risk for injury and death from circumstances of maternal withdrawal. Methadone treatment is an opiate replacement therapy that typically has the same risks for the fetus to be born with NAS. In some studies, a reduced risk of NAS was found when compared to continued street drug or heroin use. Women in medication assisted or replacement therapy programs with Methadone or Subutex are slightly less likely to give birth to babies with NAS than women who are not in treatment. SAMHSA issued Opioid Treatment Guidelines in March of 2015 that updated protocols for the first time since the 1970's. Those guidelines now recommend both Methadone treatment and Subutex for the treatment of pregnant drug-using women. Research with pregnant women has always been limited and more research is definitely needed to verify current best practice guidelines.

A 2011 study of engagement of pregnant substance using women in addiction recovery found that, "contrary to existing stereotypes, we found that women are highly motivated to engage in recovery programs but are prevented from doing so by current CPS policies and practices." The same study found that the "... women indicated they gained strength from their children, who became their motivation for change. Conversely, removal of their children was associated with relapse and long-term addiction." (15)

Poor cognition in infants and children as well as poor health outcomes are problems strongly associated with perinatal and childhood trauma and stress and the lack of contact with a maternal caretaker. (1, 3) Healthy babies are sustained in environments that are supportive, not stressful. A jail environment or one that removes the mother from her child does not promote healthy attachment and good cognitive development in children. Treatment programs that are specific to women and are supportive of their pregnancy and post-partum needs are vital to promote health outcomes for children, as well as their mothers. (5, 7, 8, 10, 23, 31)

Many studies have cited pregnancy and the need to care for children and families to be a primary motivation for women to enter addiction treatment. A study of drug-using women between 2000 and 2007 found that pregnant women were more than four times as likely as non-pregnant women to express greater motivation for treatment. SAMHSA's TIP 51 cites dozens of studies concerning women's motivations for treatment and the finding that women's primary motivation to seek treatment is often related to child care concerns.

*"I would move mountains for my kids. I don't think I ever let ... that's one thing I don't think I ever did was let my addiction come in the middle of my parenting, 'cause I mean I think that's the only thing that's getting me through now is that I'm fighting for them."*

A 2015 Centerstone Study on Parental Substance Abuse and Mothering stated that, "During all their interviews, it was when mothers spoke of their children that they seemed the happiest. "One mother in a program was quoted as saying, "I would move mountains for my kids. I don't think I ever let ... that's one thing I don't think I ever did was let my addiction come in the middle of my parenting, 'cause I mean I think that's the only thing that's getting me through now is that I'm fighting for them."



Family care issues are also cited as one of the chief reasons that women leave treatment – often due to the problems with long-term absence and need to provide direct care for their children and families. This is why SAMHSA released a program model for Family Centered Treatment for Women with Substance Use Disorders. Family residential care that includes the woman and her children in treatment allow families to remain intact and for as many members as possible of the family to receive treatment together. Tennessee currently has no licensure category or standards for family residential care issued by TDMHSAS. TAADAS has located three family residential care type programs in three locations in Tennessee. These three programs have used different means to group together services in such a way as to resemble residential care for families. One of the most successful is Renewal House in Nashville, which utilizes an Intensive Outpatient Program in tandem with HUD housing to provide a family residential care type option.

Tennessee currently has no standards or protocol for the appropriate care for pregnant drug-using women. The Department of Mental Health and Substance Abuse Services publishes a Best Practice Manual. That manual has no protocol for treating pregnant drug-using women. Without such a protocol, treatment programs are left to formulate their own program practices using the broad guidelines offered by SAMHSA and the work of colleagues. Many program boards of directors are hesitant to undertake the liability of endangering a woman and her pregnancy so program development and implementation suffer.

The primary emotions for pregnant drug-using women are guilt and shame. These emotions can be a barrier for women to access treatment and must be put aside in order for the women to process treatment with the proper motivation and belief in change. Punishing women for their drug taking is seen as counter-therapeutic. (6,21)

## ACCESS TO TREATMENT

Clinical interventions to treat addiction for the best possible outcomes must include four basic elements: detoxification, rehabilitative counseling, continuing care, and MAT (when indicated) (16). Opiate addicts who try to manage their addiction with “willpower” rarely have more than 60-90 days of sobriety. The majority of these individuals relapse in less than 30 days. Detoxification services are essential in assisting patients to achieve a state of abstinence, but the ultimate goal of sustained abstinence cannot be obtained by detoxification only. In a study published in the Journal of the American Medical Association (11), it was learned that when patients receive the aforementioned four essentials of addiction, their treatment outcomes were equal to or better than treatment outcomes of other chronic medical illnesses (diabetes, hypertension, and asthma). Surprising to many, opiate dependent patients recovered at a rate of nearly 80% at one year compared with a 50% recovery rate for diabetics. Most of those successful opiate dependent patients underwent inpatient detoxification and residential rehabilitation stays.

It should be noted that offering treatment to women will not necessarily reduce the number of NAS births. In fact, a study by the National Institutes of Health titled “NAS, Treatment and Pediatric Outcomes” from March 2013, stated, the “Recent rise in rates of opiate replacement therapy among pregnant women have resulted in increasing number of infants requiring treatment for neonatal abstinence syndrome.” Increasing access to care is appropriate for these women, but the premise of Chapter 820 will not necessarily be realized. Treatment was found to maintain or even increase the number of NAS babies. Access to care remains a



problem throughout Tennessee, including our larger cities. Nationwide this is also true – USA Today surveyed drug treatment facilities and found that fewer than 2000 of the 11,000 listed drug treatment facilities nationwide include services for pregnant women. (32) A recent Vanderbilt study on NAS was featured in this article and Professor Stephen Patrick, the author, stated, “In many communities, women are left with very few options.”

Methadone and Subutex are both forms of medication assisted treatment for addiction endorsed by SAMHSA for pregnant women. There are only 12 licensed methadone centers throughout Tennessee. Methadone treatment is available to women who can pay cash for this service – it is a cash-only business in Tennessee. Methadone services are not a TennCare benefit and are not part of indigent care funding. Methadone treatment in Tennessee typically costs \$12.50 a day or more than \$4,500 a year if taken daily.

Subutex is a covered benefit under TennCare. This medication is prescribed for addiction treatment subject to strict caseload guidelines for physicians set by CMS. Subutex treatment is predominantly a cash only business because most physicians do not want the hassle of taking insurance for this service. Access to a Subutex prescriber for a pregnant woman can be difficult to find as the patient management is more tedious and costly for the physician and the out-of-pocket cost can be a barrier. Managed care companies have also put limitations on the amount of Subutex that can be prescribed, which can be a barrier to the appropriate management of a pregnant woman.

There are certified Subutex physicians who can provide MAT as well as hospital based detoxification. There are also 39 licensed residential detoxification programs in TN – often as part of a continuum of care that provides ongoing residential services. Only 11 of those licensed residential detox programs will accept pregnant women for detoxification. Consequently, the maximum amount of these treatment beds available at those 11 facilities (some beds swing between male and female slots) is 132. There will be an expected 4318 pregnant drug-using women each year needing access to treatment. The average minimum amount of time for opioid detoxification is 5 days. 4318 women would need 21,590 residential bed days for treatment each year. The 132 available beds in Tennessee can only provide 9636 of the treatment days needed to address opioid addiction for Tennessee’s pregnant drug-using women.

Medicare coverage is available for addiction services for some young women who are disabled or with survivor’s benefits. Medicare does not cover the full continuum of care for addiction treatment and does not cover long-term rehabilitation or residential treatment. Medicare covers hospital based detoxification and residential care as well as out-patient therapy. Methadone may be covered, if provided to hospital inpatients, but not provided in outpatient clinics. Medicare does cover Subutex in Medicare Part D plans.

Many of these pregnant drug-using women will have medical insurance. But until our country’s parity laws are fully implemented, benefit limitations, spend downs, deductibles and lack of network providers will keep many with insurance from accessing addiction care because of the cost and distance to access providers. The Mental Health Parity and Addiction Equity Act was passed by Congress in 2010 and, as of this year, final rules for implementation were issued by CMS for private insurance plans. The final rules for Medicaid and Medicare plans will likely be issued in 2016. This law generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations



on those benefits than on medical/surgical benefits. Enforcement of the Parity Law will close gaps in coverage and enable providers to use indigent care funds for those who are truly uninsured.

Temporary TennCare is available for pregnant women through TennCare presumptive eligibility. Pregnant women are directed to their local health department for a pregnancy test and, if positive, receive presumptive eligibility, which covers doctor visits and other medically necessary services during their pregnancy. Women can enroll if their income is under the TennCare income limit for pregnant women. Even if the woman receives presumptive eligibility, you must still complete and submit an on-line Marketplace application to be covered after the 45-day presumptive eligibility grace period. Otherwise, a woman can lose temporary presumptive eligibility TennCare coverage. A woman can complete this application by going to [healthcare.gov](http://healthcare.gov) before the pregnancy test at the health department or afterwards. Access to a computer and eligibility documents are needed to enroll. This too can be a barrier to access treatment in a timely manner. The TennCare application process can be confusing and DHS offices in any of Tennessee's 95 counties should have a trained staff person available to assist all applicants. Presumptive TennCare benefits end at 7 weeks postpartum. Access to continued coverage of addiction treatment for at least 6 months postpartum will ensure that these mothers have adequate support to maintain recovery and keep their families intact.

TDMHSAS funding to access addiction treatment for the uninsured in 2013 helped serve just over 13,000 Tennesseans - less than 200 of them were pregnant women. Tennessee mandates that state funded treatment centers give priority for alcohol and drug abuse treatment to women who are pregnant. While every provider abides by this mandate, it would be typical that a pregnant woman will still be on a waiting list for services. On any given day, there are very few state funded beds available in Tennessee for men or women and a long waiting list is the norm. The residential detoxification treatment programs that serve pregnant women have a wide range of admissions criteria. Most programs state that they take pregnant women on a case by case basis and if they accept pregnant women, most only serve women between the 8th and 34th week of pregnancy. The women accepted must be medically stable and most detoxification programs insist on having the women accepted by a high-risk OB-GYN before admission to detox.

Women who are pregnant and using opioids typically require monitoring by a high-risk OB-GYN and a facility that has an addiction physician that is comfortable with prescribing a MAT or withdrawal protocol for the patient. Physicians will typically only take women at certain stages of pregnancy into addiction treatment. Finding an addiction treatment facility in Tennessee that also has access to a high-risk OB-GYN further limits the available treatment sites for these women. Rural areas would have even lower access to this kind of expertise. Additionally, a Centerstone Research Institute study of this population in 2015 found that "for mothers living in rural areas, concrete needs were described as especially salient. All the providers described that rural families struggled with basic needs." (16) The same study also found that transportation in rural areas greatly affected access to treatment.

TAADAS staffs a 24/7 hotline for treatment referrals called the Tennessee REDLINE. TAADAS receives calls from pregnant women, their OB-GYNs and family members seeking assistance with finding addiction treatment. TAADAS regularly receive calls from pregnant women who are on multiple waiting lists for services all across Tennessee. TAADAS tries to find them available resources but a wait for services is common. Two addiction treatment programs in Tennessee were polled just before this paper was published to determine the status of their waiting lists. One addiction program had 1098 on their list and one non-TAADAS member who is



a Community Mental Health Center had 1175 people on a waiting list for its 5 detoxification beds. It is typical for A&D programs in Tennessee to have hundreds on waiting lists each day. Women are calling and asking for faith based care at facilities that do not need a license to provide addiction care. The women have told TAADAS staff they want care where there is no medical or insurance record maintained and where they will not be reported – even though the services are limited in scope and typically do not provide MAT.

Many barriers prevent women from seeking treatment for their opiate use. Lack of access to care is one issue – but Chapter 820 seems to also be inhibiting women from accessing care. TDMHSAS data from state funded programs has found that substance abuse treatment admissions of pregnant women increased in the first 3-month period after Chapter 820 went into effect in April 2014, then decreased. Successful treatment outcomes for pregnant women were lower than previous periods prior to the new law, and further declined after the new law. More pregnant women using opioids or cocaine did enter treatment (6.9%) than women using other substances (3.5%) immediately after the law was enacted. The percentage of pregnant women admitted to Recovery Courts remained constant after the law change. Additionally, the Centerstone Research Institute study in 2015 cited that the pregnant drug-using mothers in their study reported, “there was a war being waged against them” (16) and that many mothers had not sought treatment due to fear of criminal prosecution or loss of child custody.

This TDMHSAS data will continue to be compiled and analyzed throughout the Summer and Fall. As this bill was enacted, many theorized that criminalizing women for fetal assault would prevent women from seeking treatment and this appears to be a valid concern. TAADAS would like to see access to treatment become a focus of the debate related to this.

Several statements were released with the results of the Attorneys General survey of the use of Chapter 820. One District Attorney stated that in his rural district, “I intend to use this statute sparingly but it is an important tool in our toolbox.” District Attorneys primarily see people when they are arrested and don't often have the opportunity to see the success stories of women in treatment who were not prosecuted. They may assume that criminalization is what works to help these women but actually it more likely limits access to treatment. However, women should not have to go to jail to get access to treatment. Providing access to treatment, without having to criminalize women to do so, is an important goal because it helps keep families intact in the long term. Criminal records for these women serve as a barrier to higher education, jobs, housing and other resources. We already have the tools to assist women with access to treatment who've been arrested through Recovery Courts. Recovery Court programs already exist around the state and they intervene when needed. Recovery Courts have the ability to defer charges so that these women and their families can remain intact while in treatment and so that a criminal record is less likely and will not inhibit the woman and her family from accessing housing or employment. Recovery Courts, generally, do not provide direct services but must access services for their court participants in the community.

An advocate working with the rural west TN drug courts responded to these access issues by saying, “As a women in recovery myself and having gone through a pregnancy during my addiction, I would be completely torn if presented with the choices under the current law. I work on a project to help people get into treatment and over the past year the number of pregnant women referred to me needing treatment has at least tripled. If the woman decides to go to treatment they are supposed to have top pick of any treatment facility and automatically have the next available bed. But this is where the problem starts as I can't seem to find anyone



who will detoxify a pregnant woman. MAT programs are available which I agree with totally since it is the safest. Once they are on these MAT programs NO rehabilitation facilities will accept them so basically they are back at square one. I have yet to find one rehabilitation program or recovery home in my region that will allow women to come that are on MAT. I know a few faith-based treatment centers will randomly allow them, but then they have to have someone either pay for them to go or sponsor them... And most of the faith based centers cost anywhere from \$500-\$750 a month! This was not a well thought out law, and there needs to be some kind of change that looks at the problems that it's causing."

Another important tool is Chapter 398 of the Public Acts of 2013, sponsored by Senator Ken Yager (R-Harriman) and Representative Bill Dunn (R-Knoxville). This statute encourages pregnant women who misuse prescription opioids to access early prenatal care and drug rehabilitation. In exchange, they would be given a safe harbor from having their parental rights terminated through a petition filed by the Department of Children's Services due to prenatal drug abuse. The safe harbor only applies if the mother meets certain requirements set out in the bill to protect the health of the fetus. "The Safe Harbor Act of 2013 provides a woman with a strong incentive to do the right thing for her baby," said Sen. Yager. "Children are the innocent victims of the prescription drug epidemic. Early prenatal intervention can help stabilize the mother and hopefully curb the number of premature births or deaths and a host of other severe symptoms the drugs can have on the baby." (24) Tennessee's Department of Children's Services (DCS) offices in the state continue to use this statute to encourage women to seek treatment. As of May 1, 2015 DCS had taken only one child into state custody due to issues related to an NAS birth and the mother's parenting ability.

Ohio recently studied barriers to treatment that were affecting their NAS rates. Their findings were consistent with the issues cited above. Their report cites, "Barriers to pregnant women obtaining substance abuse treatment include capacity and resources, personal challenges and inadequate medical assistance. Capacity issues were reported by treatment professionals and their clients. Pregnant women also have trouble with insurance coverage, as well as finding transportation, housing, childcare and employment assistance.... All the while these women feel stigmatized and try to stay under the radar. Community professionals report a lack of interconnectedness among facilities and agencies and many women fear Children's Services involvement." (19)

Vermont has one of the most comprehensive and successful addiction treatment systems in the United States. What sets Vermont apart is the scale of its effort to reorganize its health system as well as expanding access to care and shifting its criminal justice system toward treatment. The number of people seeking treatment for opioid addiction has surged 770 percent since 2000 in Vermont. Vermont passed a statewide system of mandatory pre-trial assessments that evaluate the risk of releasing a prisoner -- something only a handful of states have done system-wide. This system also allows judges to use that assessment to require treatment for drug offenders before they're even charged, establishing drug addiction as a condition to avoid prosecution. They have implemented a "Hub and Spoke" System to provide appropriate care. A "HUB" is a specialty treatment center responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care. A "SPOKE" is the ongoing care system comprised of a prescribing physician and collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. This system



provides comprehensive addiction treatment, mental health care and physical health care in a coordinated and integrated approach that mimics a care managed system.

## PRESCRIPTION FOR SUCCESS

In June of 2014, Governor Haslam revealed a three-year plan to reduce the impact of prescription drug abuse, *Prescription for Success*. This strategy also illustrated the need to coordinate responses to the state's drug addiction crisis throughout state agencies. These goals and recommendations are key to the success of any coordinated approach to address addiction and NAS issues in Tennessee. The goals of this plan are also the key to addressing access to treatment for pregnant drug-using women. *Prescription for Success* recognizes the need to address these issues in a strong, coordinated and meaningful way. The research presented and goals identified are comprehensive and impactful. The goals presented in this plan include:

1. Completion of the development of guidelines for prescribing opioids and encourage adoption.
2. Licensing bodies should continue to review their own policies and procedures around unsafe opioid prescribing practices and enact new rules that allow better self-regulation of licensees including tougher and timelier consequences for physicians who overprescribe.
3. Review and revise the Tennessee Intractable Pain Treatment Act and the Tennessee Code related to pain management clinics in order to address current opioid prescribing practices.
4. Provide additional specialized treatment options for mothers with opioid addiction whose babies have been born with Neonatal Abstinence Syndrome or who are at risk of losing their children.
5. Provide additional low budget/high-impact services such as Oxford Houses, Lifeline, 12-Step Meetings, and Faith-Based initiatives.
6. Develop additional Recovery Courts throughout the state.
7. Create up to three additional Residential Recovery Courts.
8. Develop best practices for opioid detoxification of pregnant women.
9. Provide specialized training to treatment providers on best practices for serving people with opioid addiction.
10. Increase the availability of and refine training for time-limited substance abuse case management services.

## RECOMMENDATIONS:

TAADAS supports the goals of the Prescription for Success Plan and would encourage prompt focus on the recommendations that have been identified to help prevent NAS and to provide access to treatment for pregnant drug-using women. In particular, the following recommendations would successfully impact this issue:

1. Allow Chapter 820 to sunset.
2. Provide additional specialized treatment options for mothers with opioid addiction whose babies have been born with Neonatal Abstinence Syndrome or who are at risk of losing their children – including the potential for recovery support homes for after care and family residential care. Please consider creating two or more Family Residential Treatment pilots for the TennCare population so that this model of treatment (allowing women to bring children to care with them) can be tested and modeled. This will allow TDMHSAS to consider adding this level of care to the list of substance abuse treatment program licenses in TN. As illustrated by the Vermont model, Tennessee and most other states are changing from an acute care model of treatment to a more residential support model of treatment. This kind of model programming needs to be included in the system of care in Tennessee.
3. Continue TennCare coverage for new mothers of babies born with opioids and other substances in their systems to cover the mother's addiction treatment for at least 6 months postpartum to ensure that these mothers have adequate support to maintain recovery and keep their families intact.
4. Develop additional Recovery Courts throughout the state to ensure all pregnant women in Tennessee have access to a recovery court program if charged under pre-existing criminal statutes. When charged, women need access to treatment and not jail. Recommend that Recovery court contracts and relationships with treatment providers include long-term residential support for women during pregnancy, post-partum and intermittent support when needed. Ensure that Recovery Courts are trained in protocols for pregnant drug-using women.
5. Develop best practices for opioid detoxification of pregnant women.
6. Provide specialized training to treatment providers on the new best practices for serving people with opioid addiction.
7. Increase the availability of and refine training for time-limited substance abuse case management services – especially those targeted for women who are pregnant and those who are post-partum with a baby diagnosed with NAS. Support for recovery for pregnant or new mothers is crucial to their continued success in sobriety and to keep families intact.
8. Ensure the state's enforcement of parity regulations secure access for these women to addiction services within their health plans.

TAADAS' recommendation overall is that increased access to health care is what is needed, not punishment for women unable to access health care. Addiction treatment for a pregnant woman is a complex issue which should be based on individual treatment needs determined by a treatment professional. Control of treatment should be in the hands of a health care provider, not managed by a criminal court.

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#### Prevalence of Risk Factors During Pregnancy CHART

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