

Fetal Assault Law Update

In the Spring of 2014, the Tennessee Legislature adopted Chapter 820 of the Public Acts of 2014 allowing a woman to be prosecuted for the illegal use of a narcotic while pregnant, if her child was born addicted to or harmed by a narcotic drug and the addiction or harm was a result of her illegal use of a narcotic drug taken while pregnant. 820 allowed a woman to be charged with assault, which is a Class A Misdemeanor, punishable by up to one year in jail. This bill was only adopted for 2 years in order to study its effects. Concern was expressed that the bill did not adequately address access to care while criminalizing women who did not receive care. Treatment advocates focused on access to care for pregnant drug-using women; enabling women to have healthy pregnancies and healthy babies while receiving addiction treatment. Any barriers to accessing treatment could reduce the potential for healthy outcomes for these babies.

**Fetal Assault Law
Expires July 1, 2016**

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The House Criminal Justice Subcommittee killed HB 1660 by Representative Weaver to extend the fetal assault law after the testimony showed a lack of access to prenatal care, particularly in rural areas, and that and that the threats of prosecution were reducing access to prenatal care for pregnant, drug using women. The data presented showed the ramifications for women seeking care after the law was passed and the shortage of addiction treatment options for this population. New legislation is likely to be introduced in the next legislative session to address these issues and our hope is that it will address the lack of access to treatment.

Opioid Abuse

Opioids continue to be the primary substance of abuse in Tennessee. Offering treatment to women will not necessarily reduce the number of Neonatal Abstinence Syndrome (NAS) births. The evidence based treatment for pregnant, drug using women is Medication Assisted Treatment (MAT) which results in nearly the same or slightly reduced rate of NAS births. MAT is the treatment endorsed by medical professional societies and is endorsed by SAMHSA. MAT reduces the possibility of seizures and other withdrawal symptoms that endanger a pregnancy. As of June 1, 2016, just over 86% of the NAS cases were attributed in some part to prescribed opiates. The number of NAS cases appears to be leveling off statewide. Increasing access to MAT and recovery support is appropriate for these women, but unless the rate of prescription of Opioids is reduced, the rate of addiction and the rate of NAS cannot be reduced.

Treatment

Access to treatment is difficult but the Tennessee REDLINE tracks programs for pregnant women. Tennessee REDLINE is a 24/7 treatment referral hotline: **1-800-889-9789**

Many studies cite that pregnancy and the need to care for children and families is 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 a chief reasons that women leave treatment – often due to the problems with long term absence and a need to provide direct care for their children and families.



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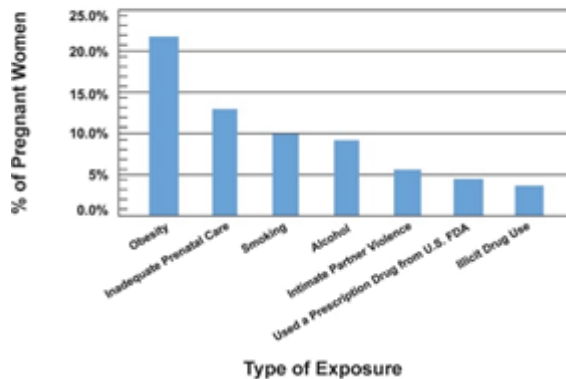
Many chronic diseases, such as hypertension, asthma, diabetes and addiction, require long term management approaches. Many of these diseases have higher relapse rates than that of addiction. Treatment for these types of chronic diseases during pregnancy may require adaptations of patient treatment plans to keep the fetus from harm. Many of these chronic conditions pose a higher risk to a developing fetus than do opioids. Addiction should be managed as a chronic long term disease with long term support for recovery.

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Barriers to care for pregnant drug-using women:

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



- Lack of treatment facilities that admit pregnant women – resulting in poor access to Methadone and Subutex /MAT providers;
- Lack of high-risk OB-GYNs who will affiliate with treatment providers and these women to provide care while they are in addiction treatment;
- Lack of treatment facilities that provide recovery support for women through pregnancy and postpartum – especially ones that provide family residential care;
- Lack of childcare for women in treatment during pregnancy and post-partum;



- 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
- Lack of insurance parity enforcement keeps some women from accessing care even when they have insurance; and
- Lack of transportation for women to get to treatment, especially in rural areas

TAADAS/Coalition Recommendations:

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.

Develop best practices for opioid detoxification of pregnant women.

Provide specialized training to treatment providers on the new best practices³ for serving people with opioid addiction.

Increase the availability of and refine training for time-limited substance abuse case management services for pregnant and post partum women.

Ensure Tennessee's enforcement of parity regulations to insure that these women have access to addiction services within their health care plans.