Florida Statewide Task Force on Prescription Drug Abuse & Newborns, February 2013 Final Report: An Inadequate Assessment of the Needs of Women, Children, and Families

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Introduction

The Florida Attorney General is to be applauded for having convened a statewide Task Force on Prescription Drug Abuse and Newborns. We also appreciate the bottom line recommendations of the Task Force that include coordinated physical and behavioral health care, collaboration with other service providers, gender specific evidence-based practices, and a "whole family approach."[1] We nevertheless have a number of concerns about the report and the limitations of the information presented to and considered by the Task Force.

Language and Findings in the Task Force Report

While it is clear that the Task Force sought to achieve important public health and policy goals, alarmist language used in the Report suggests problems of both size and severity that are not supported by the Task Force's findings.[2] For example, the Executive Summary states:

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[1] Florida Statewide Task Force on Prescription Drug Abuse & Newborns, February 2013 Final Report (Hereinafter "Report") at 35. Available at: http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf

[2] See generally, Open Letter to the Media and Policy Makers Regarding

> The national prescription drug abuse *epidemic is now afflicting* increasing numbers of pregnant women, fueling *an explosion* in cases of Neonatal Abstinence Syndrome (NAS) in Florida's newborns. Prescription drug abuse during pregnancy creates adverse health effects in newborns termed NAS.[3]

The first sentence of the summary uses the terms "epidemic" and "explosion" both terms that suggest great numbers and terrible damage. The Task Force however does not provide sources that support these characterizations. To the contrary, the report acknowledges, "the numbers of women in Florida giving birth to drug exposed newborns is still thankfully few as a total percentage of pregnancies."[4] While recent research indicates that health care providers are identifying an increase in the number of infants prenatally exposed to prescription opiates,[5] a documented increase that impacts "few as a total percentage" does not support the use of such terms as "explosion" and "epidemic."

Language is important. It affects policy, the direction of resources, and the assignment of stigma. It may also distract attention from greater problems including, as the Report acknowledges, "alcohol and tobacco use [that] occurs more frequently during a pregnancy,"[6] as well as the significant role poverty during pregnancy plays on child health outcomes.[7]

Pregnant Women and Opiate Use

The section of the Report addressing *Women & the Prescription Drug Epidemic*[8] is of particular concern and demonstrates the need for actual diagnoses and a better understanding of women's life and health conditions. This section begins:

> It may be difficult to comprehend why a woman would abuse prescription drugs after finding out she is pregnant. She may not initially disclose to her doctor her use of prescription drugs because she may feel shame or guilt, or, perhaps, she fears she will be reported to a child welfare agency. Other women may believe their use of prescription drugs is safe simply because it was originally prescribed, and therefore may not inform other medical professionals.[9]

Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women ((letter from science and medical leaders urging media to end inaccurate reporting about prescription opiate use by pregnant women) March 13, 2013, available at: http://idhdp.com/media/32950/rnewmanopenexpertletter_-_3.11.13.pdf

[3] *Id*. (Emphasis added).

[4] *Id*.

[5] Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States*, 2000-2009, 307(18) J. Am. Med. Ass'n 1934 (2012).

[6] *Id.* at 16.

[7] *See generally* Charles P. Larson, *Poverty during pregnancy: Its effects on child health outcomes*, 12 PAEDIATR CHILD HEALTH 673 (2007).

[8] Report at 16.

[9] *Id*.

This section of the Report is remarkably and dangerously incomplete. This discussion of pregnant woman fails to list among the reasons why a woman might continue drug use or abuse while pregnant: 1) the need for pain management, 2) addiction that prevents her from simply stopping because she knows she is pregnant, and 3) because of barriers to accessing effective, affordable, sensitive, and appropriate treatment.[10]

This section of the Report fails to acknowledge or address the fact that there are pregnant women who are using (not abusing) prescription drugs for pain management purposes. This is so despite the fact that the Report elsewhere acknowledges the existence of and need for pain management.[11] The failure to recognize this need as a reason why some pregnant women continue drug use is both disturbing and dangerous. Failing to acknowledge that some pregnant women experience health problems that require effective pain management reinforces the stereotype that women should be able to subsume everything for their children (existing and in development), including their need to address severe pain.

Although the Task Force recognizes that addiction is a "brain disease,"[12] this critically important section on pregnant women fails to acknowledge that continued use may be a manifestation of this "disease." Again, failing to recognize that pregnant women no less than other human beings may experience addictions that are difficult to overcome reinforces dangerous stereotypes about pregnant women as people who should somehow be able to manage and overcome health problems other people cannot. To the extent that the Task Force acknowledges that addiction is something pregnant women experience – "Warning women upfront about the potential dangers of prescription drug abuse during pregnancy does have a positive impact on a segment of women who may abuse prescription drugs. However, some women *will ignore* clear warnings and continue to use because they are already addicted"[13] – it is does so in a confusing and seemingly judgmental way. "Ignoring" warnings is very different from being unable, "as a result of addiction," to heed those warnings.

Importantly, this section of the Report also fails to acknowledge the many significant barriers to drug treatment women face as an explanation for their continued use. Many women would love effective treatment but find that it is not accessible, or that what is available or imposed is not helpful and is even, in some cases, counterproductive.

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[10] *See, e.g.,* Harlan Matusow et al., *Medication assisted treatment in US drug courts: Results from a nationwide survey of availability, barriers and attitudes*, 43 J. SUBSTANCE ABUSE TREATMENT 15 (2012).

[11] *See* Report at 8-9 ("The Task Force therefore recommended immediate improvements not only in training on drug screening protocols, but also for cutting edge pain management education in Florida's medical schools"); *See also id.* at 10 ("Develop treatment protocols for drug-exposed newborns as well as recommendations for alternatives to narcotics for pain management in pregnant women*")*; *Id.* at 22 ("In addition, there should be ongoing professional education about what constitutes a safe and appropriate use of opioids for pain treatment that also puts an emphasis on minimizing the risk of addiction and substance abuse.").

[12] *Id*. at 9; *see also id.* at 32 ("the disease of addiction").

[13] *Id.* at 28. (Emphasis added).

"Drug Exposed" v. "Diagnosed with Neonatal Abstinence Syndrome"

We very much appreciate the attention to language and definition that the Task Force used in addressing the term "drug-addicted." As the Report explains "a baby should never be referred to as 'drug-addicted.'" While the mother can be medically defined as addicted to prescription drugs, a fetus or newborn baby cannot be addicted."[14] Other terms used in the Report, however, did not receive the same careful attention.

Rather than use the term "drug-addicted" the Task Force Report urges that, "a baby suffering from NAS should always be referred to as a 'drug exposed' newborn." Drug exposure, however, is not the same as a diagnosis of NAS. In other words, drug exposure may have occurred but not resulted in NAS. Moreover, a positive drug test on the pregnant woman or newborn is not, nor as a matter of science could it be, the same as a clinically determined NAS diagnosis.

According to the Report: "In 2011, there were 1,563 instances of newborns *diagnosed with drug exposure* in Florida, a three-fold increase since 2007 . . ."[15] In another section of the Report, however, drug exposure has been redefined and reported as "1,563 newborn *drug withdrawal cases* reported in Florida."[16] Again, "exposure" is not a diagnosis, nor does it mean that withdrawal has occurred, is occurring, or will occur. Important public health policy needs to be based on accurate numbers, not a conflation of terms that results in a potentially inaccurate inflation of numbers.

Treatment for Pregnant Women

Of particular concern is that the Task Force seems to make "the best" the enemy of "the good" when it comes to clinical management of pregnant women who are dependent on prescription drugs – specifically, on opiate analgesics. While the Task Force acknowledges the benefits of Medication[17] Assisted Treatment (MAT), including methadone and buprenorphine, it concludes that:

> Simply linking a drug abusing woman to a MAT program will not solve her addiction problem. A complete system of care must be instituted to support and improve her chances of sustaining a drug-free lifestyle, and enable her to care for her child.[18]

Peer-reviewed evidence-based research, however, has consistently shown that treatment with the medications methadone and buprenorphine alone often have a profound beneficial effect on the pregnant woman and her baby whether or not accompanied by

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[14] *Id.* at 17. *See also Babies aren't 'addicts,'; mothers should get methadone or buprenorphine*, ALCOHOLISM & DRUG ABUSE WKLY., May 7, 2012, at 1.
[15] *Id*. at 7. (Emphasis added).
[16] *Id*. at 13. (Emphasis added).
[17] Throughout the Report, MAT is referred to, incorrectly as "*Medicated*" Assisted Treatment
[18] Report at 39.

other treatment services.[19] Moreover, medications alone are clearly better when compared to total therapeutic abandonment, a common consequence of mandating that women comply with all treatment demands or be subject to a variety of penalties or dropped from treatment services. In addition, it must also be noted that few behavioral health conditions, especially ones similar to drug dependence, such diabetes and hypertension, lend themselves to being "solved."[20]

Newborns, Children and the Implications and Treatment of NAS

The Report begins with a statement of care and intention. The Executive Summary states: "While society could look the other way and simply focus on the majority of pregnant woman who are not abusing prescription drugs— that is not who we are as Floridians. Floridians want to ensure that the most vulnerable in our society-drug exposed newborns-can grow-up to become healthy, productive citizens."[21]

The concern here is the suggestion that children exposed prenatally to prescription opiates are uniquely vulnerable and that without significant government intervention they will be unable to "become healthy, productive citizens." The Task Force Report however provides no support for this stigmatizing description and indeed contradicts itself when it correctly observes, "Even more fortunately, it is critically important to note that neither NAS nor its treatment is known to produce long-term, negative developmental outcomes."[22]

Another concern is that the Task Force Report suggests a fundamental misunderstanding of the implications and the management of NAS. NAS is an acknowledged possible side effect of methadone and buprenorphine maintenance of the pregnant woman, but also a consequence that is far outweighed by the very well documented benefits of these medications for pregnant woman, mother and child. Thus, for decades the Food and Drug Administration has had regulations that are designed to ensure that pregnant women seeking methadone maintenance will be accommodated immediately, even in the face of long waiting lists for admission.[23] In addition, the Substance Abuse and Mental Health Services Administration ("SAMHSA") has for many years distributed a pamphlet

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[19] *See* Timothy K.S. Christie et al., *Evaluation of Low-Threshold/High-Tolerance Methadone Maintenance Treatment Clinic in Saint John, New Brunswick, Canada: One Year Retention Rate and Illicit Drug Use*, 2013 J. ADDICTION Article ID 753409, *available at* http://dx.doi.org/10.1155/2013/753409; *See also* Stanley R. Yancovitz et al., *A Randomized Trial of an Interim Methadone Maintenance Clinic*, 81 AM. J. PUB. HEALTH 1185 (1991); Robert P. Schwartz et al., *A Randomized Controlled Trial of Interim Methadone Maintenance*, 63 ARCH GEN PSYCHIATRY 102 (2006).

[20] *See e.g.,* Charles Marwick, *Physician Leadership on National Drug Policy Finds Addiction Treatment Works*, 279 J. AM. MED. ASS'N. 1149 (1998) (comparing drug treatment with treatment for other behavioral health problems).

[21] Report at 7.

[22] *Id.* at 17 .

[23] *See, e.g.,* 42 C.F.R. § 8.12(e)(3) (2013) (pregnant women may be exempt from 1-year history of addiction requirement for opioid treatment); *see also* 42 C.F.R. § 8.12(j)(1) (2013) (pregnant women are given preference in transfers from interim to comprehensive treatment programs).

directed to pregnant, opiate-dependent women that states in unusually clear and concise terms: "If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself …"[24]

While medical care providers must always be searching for ever-better therapeutic approaches, guidelines for effective management of the NAS, when it occurs, have been widely disseminated in professional literature for decades. Nevertheless the Task Force recommends that the state "Develop treatment protocols for drug-exposed newborns"[25] and in other ways wrongly suggests that clear, well-established protocols do not already exist.[26]

In addition, the Task Force asserts, "NAS babies *suffer terribly* from withdrawal symptoms such as tremors."[27] To the extent this is true, it is a reflection of woeful and inexcusable lack of knowledge on the part of caregivers. What is especially sad is the statement that neonatal nurses "… can simply feel like drug pushers by having to treat an NAS newborn with narcotics … [and may] resent drug addicted mothers for the harm they have inflicted on their infants."[28] Such attitudes on the part of professional staff should be deemed absolutely intolerable, rather than presented as facts of life that "training can help alleviate … but . . . not eliminate…"[29]

The Task Force also asserts that "NAS *afflicted* newborns impose disproportionately higher costs on our health care and social service systems compared to healthy deliveries."[30] To the extent costs are associated with NAS diagnosed newborns the Task Force failed to explore, much less determine, the extent to which those costs are attributable to poor treatment decisions, including unnecessary medical and social service interventions.

Evidence-based research has shown that the occurrence and severity of NAS is affected by a variety of factors that are unrelated to possible pharmacological effects of prenatal exposure to opiates. For example, a 2006 study demonstrated that babies who stayed in their mothers' room while in hospital (i.e., "rooming in") rather than being placed in neonatal intensive care units (NICU) had less need for treatment of NAS, shorter length

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[24] SUBSTANCE ABUSE & MENTAL HEALTH SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUBLICATION NO. [SMA] 06-4124, METHADONE TREATMENT FOR PREGNANT WOMEN (2006).
[25] Report at 11.
[26] *See id.* at 38 ("After an infant is safely delivered, and assessed, some doctors will treat NAS with methadone or morphine, will (sic) others will use a sedative like Phenobarbital or Clonidine.").
[27] *Id.* at 7. (Emphasis added). *See also id*. (newborns suffering from withdrawal from prescription drugs.)
[28] *Id.* at 39.
[29] *Id.*
[30] *Id*. at 7. (Emphasis added).

of hospital stay, and significantly greater likelihood of being discharged home in the custody of their mothers. Similarly, a 2010 study found that only 11% of babies who boarded with their mothers required treatment of NAS compared to more than four times as many who were placed in an NICU.[31] Indeed these finding are important as the Task Force recognized that "NAS costs are concentrated in Neonatal Intensive Care Unit expenses, and are typically paid by Medicaid."[32]

Finally the Task Force includes highly charged claims about mothers and newborns that are misleading and counterproductive. For example, the Task Force claims that the financial costs pale when compared to the "human costs: a new mother not being able to care for her child because it has to withdraw from prescription opioids in a NICU cannot be calculated." Yet given the research on the value of rooming in and known, effective treatments for NAS it is unclear why most mothers would be unable to care for their newborns and why seeing her newborn would be "a sight no family member should have to endure."[33]

Acknowledging but not Actually Addressing Key Barriers to Care and Treatment

Importantly, the Task Force recognizes that fear of criminal action may deter some pregnant women from care and specifically clarifies that it is not proposing criminal penalties.[34] The Task Force also acknowledges "Some women fear the involvement of child welfare agencies and fail to seek prenatal care."[35] In fact, research confirms that fear of both criminal penalties and of involvement of child welfare agencies deter women from seeking care, and being forthright if they do.[36] This is one of the reasons why

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[31] Ronald R. Abrahams et al., *An Evaluation of Rooming-In Among Substance-exposed Newborns in British Columbia*, 2010 J. OBSTET. GYNAECOL. CAN. 866 (2010); Tolulope et al., 169 EUR. J. PEDS. 95, 95-98 (2010) ("These results suggest caring for infants with NAS on the postnatal ward rather than the neonatal unit reduces the need for treatment and duration of hospital stay.").
[32] Report at 13. *See also id.* at 14 ("More infants are spending longer amounts of time in Neonatal Intensive Care Units (NICU), which exacts significant additional costs for the entire health care system."); *Id.* at 19 ("Most newborns diagnosed with NAS are admitted to a hospital's NICU, and their average length of stay is about three weeks. The length of the NICU stay is what drives the higher cost of treating NAS, and the length of stay for NAS diagnosed newborns did not decline during the last decade.").
[33] *Id.* at 14.
[34] *Id.* at 8.
[35] *Id. See also id.* at 16 ("…or, perhaps, she fears she will be reported to a child welfare agency.").
[36] *See, e.g.*, Sarah C.M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 J. MATERNAL & CHILD HEALTH 333 (2010); Sarah C.M. Roberts & Amani Nuru-Jeter, *Women's Perspectives on Screening For Alcohol and Drug Use in Prenatal Care*, 20 WOMEN'S HEALTH ISSUES 193 (2010); Martha A. Jessup et al., *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2904854/ Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003); Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 DRUG & ALCOHOL DEPENDENCE 199 (1993); Shelly Gehshan, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN ii, 5 (S. Reg'l Project

numerous medical and public health organizations oppose reporting to and involvement of child welfare authorities based on evidence of drug use alone.[37]

The Task Force, however, does not address this issue except to note "Florida's prevention messaging needs to ease those concerns, and get women to seek prenatal care and substance abuse treatment."[38] This is not just a matter of messaging, however. Given the evidence that threats of child welfare interventions deter women from care, the Task Force was remiss in failing to evaluate the effect of its child welfare presumptions and policies that require involvement of child welfare agencies based on evidence of drug use, apparently including use of legally prescribed medications, rather than evidence of harm to children.[39]

In addition, the Task Force Report's statement that the Child Abuse Prevention and Treatment Act (CAPTA) "now requires health care providers to refer all infants identified as drug exposed to child welfare services" is inaccurate. CAPTA does not define or even equate drug exposure alone with a determination that a newborn is "drug affected," has been diagnosed as having withdrawal symptoms (Neonatal Abstinence Syndrome), or has been diagnosed with a Fetal Alcohol Spectrum Disorder [40] Moreover, CAPTA does not require hospitals receiving federal money to report when a baby has a positive toxicology or even if the newborn is "drug affected." The CAPTA requirement about "appropriate referrals to child protection service systems" applies to States, not hospitals.[41] In addition, a State is not required to give their federal funding only to hospitals that abide by any sort of mandatory requirement for reporting a positive toxicology to child welfare authorities.[42]

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on Infant Mortality, 1993); U.S. GOV'T ACCOUNTING OFFICE, GAO/HRD-90-138, DRUG EXPOSED INFANTS: A GENERATION AT RISK 9 (1990).

[37] *See, e.g., Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, Committee Opinion 473 (ACOG/Committee on Health Care for Underserved Women), January 2011; Ctr. for the Future of Child., *Drug Exposed Infants*, 1 Future of Child. 1, 8 (1991) ("An identified drug-exposed infant should be reported to child protective services only if factors in addition to prenatal drug exposure show that the infant is at risk for abuse or neglect.").

[38] Report at 27 ("Under current Florida law, a child will not be removed from a parent if there are reasonable efforts by the parent to ensure their child's safety. For a drug exposed newborn, if the mother voluntarily places the child with the father or another appropriate caretaker until she is well enough to safely care for the child, and does not attempt to secure physical custody of the newborn until she has successfully completed her drug treatment, the mother can retain legal custody while DCF maintains oversight of the child to ensure their safety.").

[39] *Id.* at 24.

[40] *See* 42 U.S.C. §§5106a(b)(4), 5106g; *see also* Ellen M. Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of Non-Public Health Response*, 75 U. MO. KAN. CITY L. REV. 789, 798 (2007) ("Neither the statute nor the legislative history defines what Congress meant by the term 'drug-affected,' an imprecise term that has no basis in medical criteria.").

[41] *See* 42 U.S.C. §5106a(b)(2)(B)(ii) (2012).

[42] *See, e.g.,* 42 U.S.C. §5106a(a) (2012) ("The Secretary shall make grants to the States, from allotments made under subsection (f) for each State that applies for a grant under this section, for

Creating Public Awareness: Prevention Campaign

The Task Force's discussion of public awareness raises particular concerns. While the Task Force embraces the medical model of addiction for curricular improvements, the public educational campaign presents addiction only as a matter of "choice." This is particularly clear in the *Suggested Prevention Campaign Slogans* [43] offered in Appendix B to the Report. A typical slogan is: "You have a choice … your baby doesn't." The emphasis on choice denies the truth that continued use in pregnancy is pathognomonic for those women who are actually addicted. In other words, they cannot, by definition just make a "choice" to stop. Nevertheless, public awareness messaging urged by the Task Force is largely indistinguishable from earlier "just say no" campaigns that have proven to be ineffective.

Moreover, messages that might be understood as urging pregnant women to simply stop their drug use[44] (if they were in fact able to) contradicts medical understanding of pregnancy and opiate addiction. As the SAMHSA pamphlet explains "Withdrawal for pregnant women is especially dangerous because it causes the uterus to contract and may bring on miscarriage or premature birth."[45]

Similarly this ad: "Don't pass down your prescription pill addiction to your baby . . . That pain will never go away"[46] featured by the Task Force conveys misinformation that the Report itself contradicts. As the Task Force correctly notes, newborns are not born addicted and thus pregnant women cannot pass their addiction to their babies.[47] Moreover it is unclear what "pain" the ad refers to. Any pain that a newborn might experience can be alleviated through proper treatment. The alternative meaning is the judgmental and counterproductive suggestion that women should feel a lifetime of pain for what they have done.

Not a single slogan or outreach message is designed to reassure women that they can seek help without fear of loss of medical confidentiality and/or loss of custody of their child once born. And while one of the slogans includes the phrase "get help" a much clearer message posted in prenatal care settings would be: "If you are opiate dependent, effective, non-judgmental treatment is available."

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purposes of assisting the States in improving the child protective services system of each such State…"); *see also, generally*, 42 U.S.C. §5206a(b)(1) (2012).

[43] Report at 48.

[44] *See id*. (messages that advise women to be "be drug-free" and warning them not to "abuse prescription drugs!")

[45] DHHS *supra* note 23; *See also*, Report at 36 ("Whereas illicit use of opioids (i.e. oxycodone, hydrocodone, etc.) subjects a fetus to repeated episodes of painful drug withdrawal and increases the death rate for both mother and child . . ").

[46] Report at 33.

[47] *See also* Slogan 6, Report at 48 ("Give birth to opportunity, not addiction. Protect your newborn from prescription drug abuse.").

Unfortunately, as the Task Force recognizes there are numerous barriers to treatment and appropriate treatment may not be "immediately" or otherwise available to the women urged to seek it.[48] In fact, few places in the United States have sufficient drug treatment services (including MAT services) for those in need, and particularly for pregnant women who need and want services that will actually help them.[49]

Task Force Membership

Finally, we note that the Task Force did not include key actors and informants who could help ensure that the Task Force and its conclusions were fully and fairly informed. Specifically the Task Force did not include a physician with specialized training or experience in treating opioid dependence. Nor did the Task Force membership include women who would be directly affected by their conclusions. Furthermore, while the Task Force apparently heard from women who had experienced some kind of addiction during pregnancy it is not clear that these women or their infants had received the standards of care: Medication Assisted Treatment and proper treatment for the infant after delivery. The failure to include key medical experts and those directly impacted by Task Force recommendations limits the value and clinical relevance of the conclusions reached.

Conclusion

We appreciate the Florida Statewide Task Force on Prescription Drug Abuse and Newborns for its attempt to tackle an important public health issue. We agree that a holistic and evidence-based approach is essential. To that end, however, we question the value of following many of the Task Force Report's recommendations and urge the Task Force to reconvene to ensure that their recommendations are made in light of evidence based research and established polices that were apparently overlooked or given insufficient attention. Part of Florida's response should be to ensure that opioid maintenance is available to all pregnant women. As a recent U.N. Human Rights Council Report observed, "a particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment."[50] We are confident that consideration of these additional sources would lead to revised recommendations including one to remove barriers to Medication Assisted Treatment and to ensure that every person, including every pregnant woman who could benefit from MAT, has access to it.

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[48] Report at 40.

[49] *See e.g.,* Mishka Terplan et. al, *Pregnant and Non-Pregnant Women with Substance Use Disorders: The Gap Between Treatment Need and Receipt*, 31 J. OF ADDICTIVE DISEASES 342 (2012).

[50] U.N. Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶ 73, U.N. Doc A/HRC/22/53 (February 1, 2013) (by Juan E. Méndez) at 17.