

Kentucky Department
for Public Health

**Neonatal Abstinence
Syndrome**
2025 Report

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and safety of people in Kentucky through
prevention, promotion, and protection.



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Executive Summary

The Kentucky Public Health Neonatal Abstinence Syndrome (NAS) Reporting Registry reported a decrease in cases of NAS in 2024 compared to the previous year. In 2024, there were 741 cases of babies with signs and symptoms of NAS versus 792 cases reported in 2023; this accounts for a decrease from 15.2 to 14.7 NAS cases per 1,000 live births among Kentucky residents from 2023 to 2024.

Mothers of infants with NAS tend to have less education, be unmarried, and have more children. This may suggest lower socioeconomic status, a lack of social support, or reduced access to services. Although the Appalachian region's rates of NAS remained the highest in the state in 2024, the region also saw a decrease in NAS reports, with 31.2 cases per 1,000 live births in 2024 compared to 49.7 cases per 1,000 live births in 2023. However, the rate of reports in that region remains more than 10 times the most recent national estimate of 5.4 NAS cases per 1,000 live births (HCUP Fast Stats, 2024).

Opioids were the most common type of substance reported in the 2024 registry, with 86% of cases exposed to some type of opioid. The most frequent opioids reported were buprenorphine (55%), fentanyl (28%), and heroin (15%). Other commonly used substances are amphetamines including methamphetamine (37%), cannabinoids (38%), benzodiazepines (13%), cocaine (12%), and gabapentin (10%). Any other substances were reported to have been used by less than 10% of women in the registry. Approximately 72% of cases were exposed to more than one type of substance during pregnancy; for these cases, the average exposure was to two substances, not including tobacco or alcohol.

Prenatal care is critical for these women to address substance use and other co-occurring problems, such as hepatitis C virus (HCV), which was reported in about 29% of mothers of infants with NAS. Compared to women whose infants do not have NAS, mothers of infants with NAS are more likely to utilize Women, Infants, and Children (WIC) services during pregnancy, but much less likely to receive adequate prenatal care. Adequate prenatal care refers to care beginning in the first four months of pregnancy with the appropriate number of visits for the infant's gestational age. Inadequate health insurance may explain part of this disparity, as mothers in the registry were less likely to have insurance of any type to pay for their delivery. Prenatal care should also promote Medication for Opioid Use Disorder (MOUD). About 65% of the women in the registry were estimated to be enrolled in MOUD. Seventy-four percent (74%) of those women were using other drugs not compliant with their treatment; only 26% were compliant with their program.

Infants with NAS are almost twice as likely to have a low birth weight (16%) compared to infants without NAS (9%). These infants are also three times as likely to be admitted to a neonatal intensive care unit (32%) versus infants without NAS (12%). Tobacco use co-occurs with substance use at high rates, which could affect infants' health and development. Forty-one percent (41%) of infants with NAS received pharmacological treatment. Of those treated, 94% received morphine and 37% received clonidine either as a single drug or as an adjunct therapy.

Data from the Kentucky Child Fatality and Near Fatality External Review Panel indicate that NAS is a risk factor for fatal or near-fatal child abuse, including abusive head trauma and Sudden Unexpected Infant Death (JPSC, 2024). About 71% of infants with NAS were referred to the Department for Community-Based Services, and 67% of those referred cases were accepted for investigation.

The Kentucky Department for Public Health currently supports pregnant women and women postpartum through WIC and the Health Access Nurturing Development Services Program (HANDS). The HANDS program provides education to caregivers of babies with NAS. In addressing NAS and the issues of families affected by substance use, the Kentucky Department for Public Health also recommends:

1. Continuing to promote periconceptional and prenatal care;
2. Promoting enrollment and participation in MOUD programs;
3. Implementing a plan of safe care that includes educating parents and medical/childcare providers on safe sleep, abusive head trauma, child abuse, and neglect;
4. Promoting enrollment in services such as WIC and HANDS; and
5. Improving access to long-acting reversible contraception.

Background

The Opioid Epidemic

Opioids are a class of narcotics that bind to receptors in the brain to produce pain relief, anesthesia or euphoria (Hughes et al., 2016). After prolonged use, increasing doses are needed to produce an effect which can lead to drug overdoses (ACOG, “Opioid,” 2017); these overdoses may result in kidney failure, heart problems, nerve damage, anoxic brain injuries and respiratory depression (Zibbell, Howard, Clarke, Ferrell, & Karon, 2019).

The Appalachian region has some of the highest opioid prescription rates in the United States (U.S.) (CDC, “U.S. County Opioid Dispensing Rates,” 2020). Between 1999 and 2015, overdose fatalities quadrupled in the U.S. (O'Donnell, Gladden, & Seth, 2017), driven in part by synthetic opioids and other illicit substances. In 2020, reports of hospitalization, emergency medical services, and deaths due to opioid overdoses increased greatly in various areas of the U.S., including Kentucky (Rodda, West, & LeSaint, 2020; Slavova, Rock, Bush, Quesinberry, & Walsh, 2020). While overdose fatalities continue to be a concern, Kentucky overdose deaths decreased for the last three consecutive years by 30.2% (JPSC, 2024).

Impact on Maternal and Child Health

Infants with prenatal substance exposure, including opioid exposure, may experience effects upon its discontinuation, also known as NAS (Kocherlakota, 2014). Many over the counter or prescription medications can cause NAS (Hudak & Tan, 2012); an infant receiving an NAS diagnosis does not always indicate illicit activity by the mother. NAS presents similarly to withdrawal in adults, with symptoms that include restlessness, tremors, seizure, vomiting, fever, sweating, and apnea (Hudak & Tan, 2012), although symptoms may vary in presentation, duration, and severity. Because symptoms are non-specific, toxicology screenings and maternal history are important in establishing whether there was exposure in utero. As first-line intervention, NAS is treated by comfort care (non-pharmacological intervention), such as swaddling, rocking, and reducing environmental stimuli (Kocherlakota, 2014), but pharmacological intervention is used in severe cases (MacMillan, 2019). Treatment may take place in a Neonatal Intensive Care Unit (NICU) or other special care unit (MacMillan, 2019). Substance use not only affects infant health, but it also contributes to the increasing rate of maternal mortality; in 2021, 56% of Kentucky maternal mortality cases had substance use disorder as an associated factor (CHFS, 2024).

Between 1999 and 2014 in Kentucky, the rate of opioid use disorder (OUD) increased 48-fold to 19 cases per every 1,000 deliveries (Haight, Ko, Tong, Bohm, & Callaghan, 2018). However, women with OUD make up only a fraction of the estimated one in fifteen who use opioids during pregnancy, with most cases utilizing opioids without a prescription (Ko et al., 2020).

Methodology and Limitations

In 2013, KRS 211.676 established NAS as a reportable disease. Mandatory statewide reporting to the Public Health NAS Reporting Registry (from here on, “the NAS Registry”) began on July 15, 2014. The NAS Registry collects information from Kentucky hospitals on Kentucky resident children with NAS and a history of prenatal substance exposure. Case reporting is not tied to the International Classification of Disease codes.

Unless otherwise stated, all figures and tables show preliminary, unduplicated, symptomatic case counts. Any category with less than five (< 5) cases is suppressed and categories with five to nineteen cases should be interpreted with caution, as rare outcomes may lead to unstable estimates.

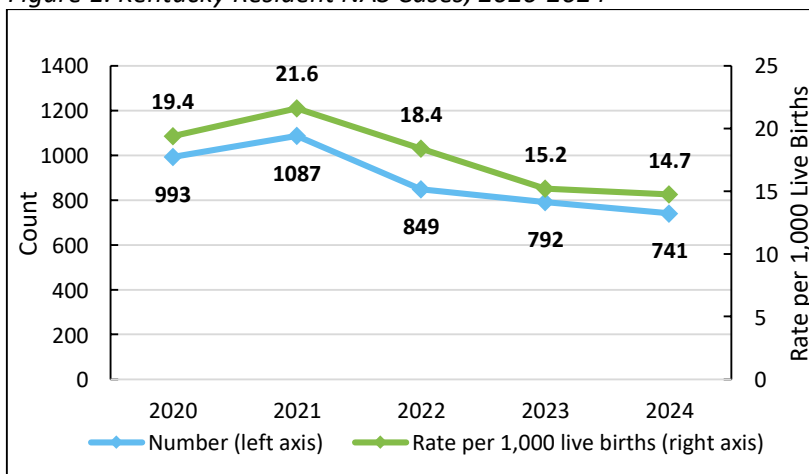
The NAS Registry is a passive surveillance system that poses challenges with data accuracy. Reporting practices of different hospitals or individual hospital employees vary which can lead to inconsistencies that affect the data report as a whole. For birth year 2024, 32 out of 44 Kentucky hospitals reported to the NAS Registry with an average submission time of 45 days after discharge; delayed reporting can negatively affect data quality. The data system does not provide detail on the timing and intent of substance use, which affects reporting on polysubstance use and MOUD. Finally, out-of-state hospitals do not report to the NAS Registry, which could result in underreporting near state borders.

Data and Results

Kentucky Incidence

The rate of NAS cases in Kentucky has decreased over the past two years. However, Kentucky’s NAS rate remains far above the national average, with some areas reaching more than ten times the most recent national estimate (HCUP Fast Stats, 2020). Data from the NAS Registry shows 741 unduplicated cases in 2024, which is a decrease from 792 in 2023 (Figure 1).

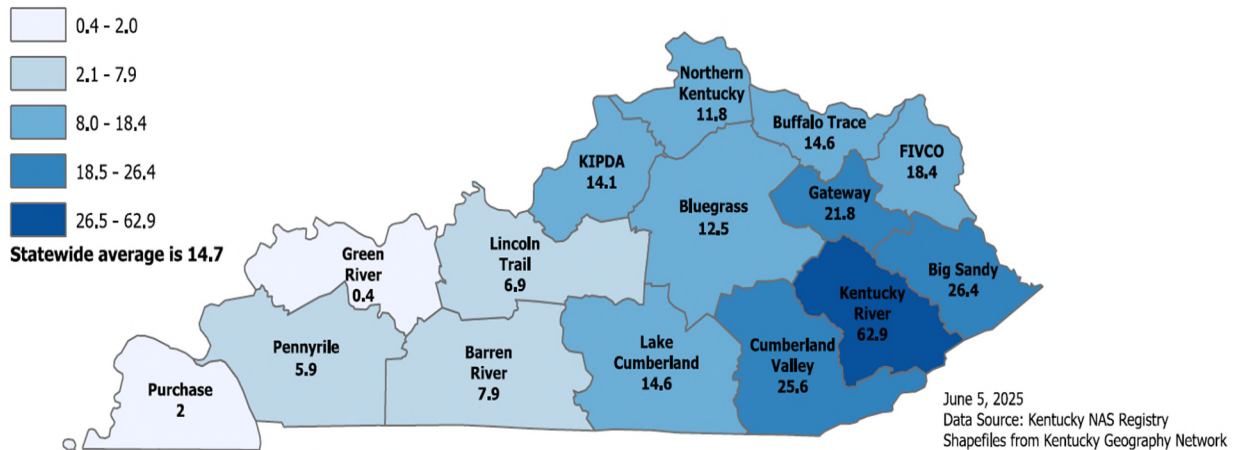
Figure 1. Kentucky Resident NAS Cases, 2020-2024



Data Source: Kentucky Neonatal Abstinence Syndrome Reporting Registry, Office of Vital Statistics birth certificate records 2020-2024

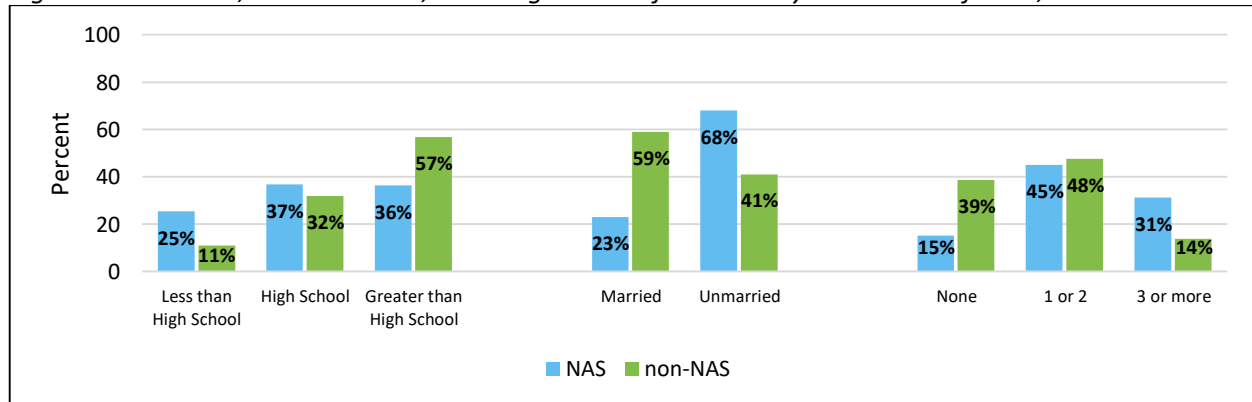
There are large discrepancies within Area Development Districts (ADDs) across Kentucky, with rates ranging from 0.4 to 62.87 cases per 1,000 live births (Figure 2). In Kentucky, the rate of NAS in rural counties is nearly twice the rate in urban counties, with the highest rates in Appalachia.

Figure 2. NAS Rate by ADD of Residence, 2024



Mothers of infants with NAS tended to have less education, be unmarried, and have more children compared to mothers of infants without NAS (Figure 3). These factors may indicate a lower socioeconomic status, less social support, a lack of access to family planning services, or limited health literacy. Identifying demographic patterns and addressing social determinants of health are important steps in developing prevention strategies.

Figure 3. Education, Marital Status, and Pregnancies of Mothers by NAS Status of Child, 2024



Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry, Office of Vital Statistics birth certificate records 2020-2024

Frequently Used Substances

Table 1 includes any substances reported in more than five cases in the NAS Registry (excluding tobacco and alcohol) by category, ranked from most to least commonly reported. This table includes any indication of exposure (maternal history, positive maternal toxicology, and/or positive infant toxicology). Opioids continue to be an issue for Kentucky, with maternal use of opioids reported in 86% of NAS cases.

The second most common substance reported in 2024 was cannabinoids, which were reported in 38% of all NAS cases. Use of cannabinoids has remained high, from 33% in 2023 to 38% in 2024.

Table 1. Frequency of All Substance Groups in the Public Health NAS Reporting Registry, 2024

Frequency of Opioids in the Public Health NAS Reporting Registry		Frequency of Other Substances in the Public Health NAS Reporting Registry	
Any of the below opioids	85.83%	Amphetamines	37.11%
Buprenorphine	54.52%	Cannabinoid	37.79%
Fentanyl	28.07%	Benzodiazepines	12.82%
Heroin	14.57%	Cocaine	12.42%
Methadone	14.30%	Gabapentin	10.26%
Oxycodone	8.64%	Xylazine	3.51%
Hydrocodone	2.16%	SSRI/antagonist	2.16%
Tramadol	1.62%	Barbiturates	2.16%
Unspecified Opioids	30.36%		

Note: Numbers do not add to 100%, as more than one substance can be reported per case and not all substances are shown in the table above. The category “Amphetamines” includes any indication of use of methamphetamine and/or amphetamines. “SSRI” refers to selective serotonin reuptake inhibitors and “SARI” refers to serotonin antagonist and reuptake inhibitors. The category “SSRI/antagonist” includes any indication of use of SSRIs and/or SARIs.

Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry

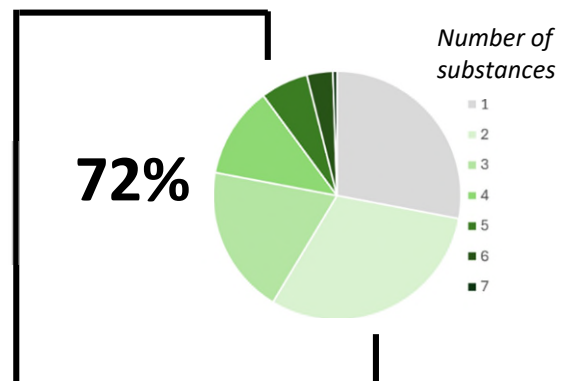
The most common opioid in the NAS Registry is buprenorphine, a partial opioid agonist that is used to reduce withdrawal and cravings (SAMHSA, 2016). While it can be associated with NAS, its use as part of supervised MOUD is preferable to untreated OUD during pregnancy. Increased access to MOUD may explain why buprenorphine is one of the most common substances in the NAS Registry. Approximately 65% of the women in the registry had prescriptions for medications to treat addiction, indicating enrollment in MOUD. Medications for pain treatment and psychiatric treatment were prescribed in 16% and 20%, respectively.

More than one-third of the cases in the NAS Registry were exposed to cannabinoids. The American College of Obstetricians and Gynecologists (ACOG) discourages marijuana use during pregnancy due to a lack of studies on its safety (ACOG, “Marijuana,” 2021). Fentanyl use continues to rise, from 3.86% in 2018 to 28.07% in 2024. Heroin use also remains high, with 14.6% of NAS cases exposed to this substance in 2024.

About 72% of cases had polysubstance use, which in this report means the use of substances from more than one type or category (see Table 1), excluding tobacco and alcohol. About 31% of women used two types of substances, and about 41% used three or more types of substances; on average, cases with polysubstance use had exposures to two types of substances.

Polysubstance use may contribute to prolonged or more severe NAS symptoms, as cocaine, benzodiazepines (Hudak & Tan, 2012), and antidepressants (Kaltenbach et al., 2012) can be associated with worsened NAS symptoms when combined with opiates.

Figure 4. Frequency of Polysubstance Use, 2024



Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry

Prenatal Care

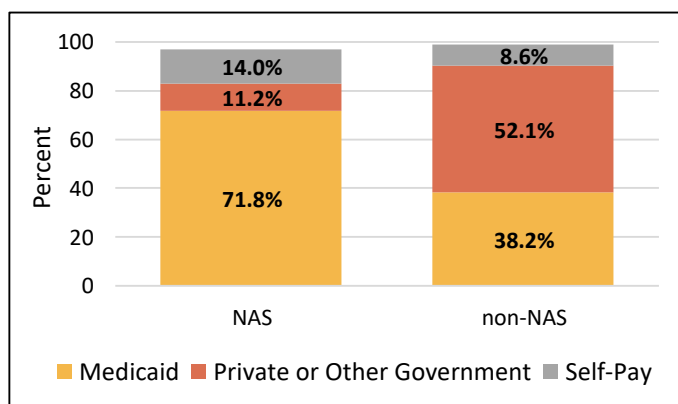
The prenatal period presents a unique window of opportunity for women to make changes in their health and lifestyle, including managing OUD (ACOG, “Opioid,” 2017). Slightly less than half of the mothers in the NAS Registry received at least adequate prenatal care using the Kotelchuck index. By comparison, three out of four mothers who did not have infants with NAS received at least adequate prenatal care.

As part of prenatal care, ACOG recommends that women with OUD be screened for infections, including HCV (ACOG, “Opioid,” 2017). Among women who are HCV positive, perinatal transmission occurs in 5 to 6% of pregnancies (Corcorran, 2021), and injection drug use is one factor that makes transmission more likely. The HCV rate among mothers whose children did not have NAS was 1.2%, compared to 29% among those whose children had NAS. These concerns led to the passage of Senate Bill 250 in April 2018, which added universal screening of pregnant women for HCV to KRS 214.160.

Insurance coverage rates are shown in Figure 5. Approximately 72% of babies with NAS are born to mothers who are enrolled in Medicaid. As a result, Managed Care Organizations have the opportunity to increase their efforts to reach this population and promote periconceptional, prenatal, postpartum, and pediatric care.

In addition to prenatal care, there are other opportunities for preventive services. Just under half of the mothers whose infants had NAS received services through WIC during pregnancy, which can promote nutrition for an infant who is at risk of feeding difficulties, provide assistance with breastfeeding, and refer mothers to additional services. Another opportunity for prevention is MOUD, which uses counseling and mental health therapy approaches in addition to medications such as buprenorphine, methadone, or naltrexone. In this report, MOUD means having a valid prescription for replacement therapy.

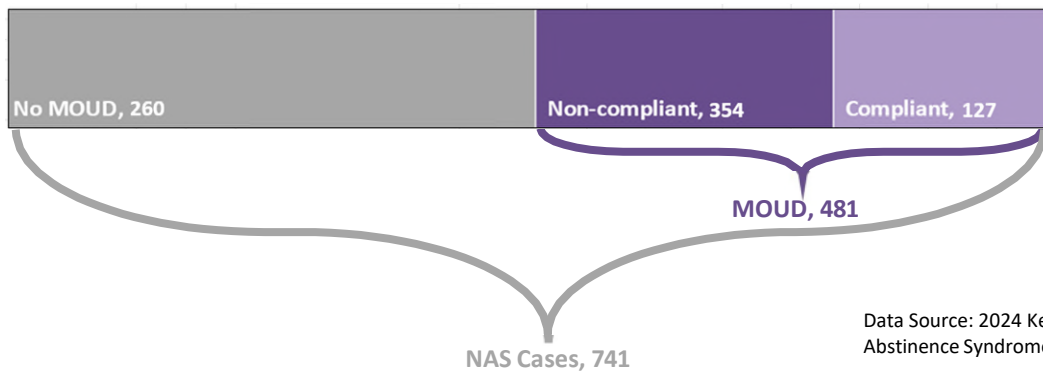
Figure 5. Insurance Type at Time of Delivery, by NAS Status, Kentucky Residents, 2024



Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry

The NAS Registry does not collect compliance with MOUD, so for the purposes of this report, non-compliance is defined as reported prenatal exposure to meth/amphetamines, barbiturates, cannabinoids, cocaine, heroin, or any other opioid. In the 2024 cohort, 65% of the mothers were in MOUD, but only 26% of those mothers were compliant (Figure 6). The low rate of compliance among mothers in MOUD parallels the high frequency of polysubstance use in the NAS Registry.

Figure 6. Number of Cases in NAS Registry, by MOUD Participation and Compliance, 2024



Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry

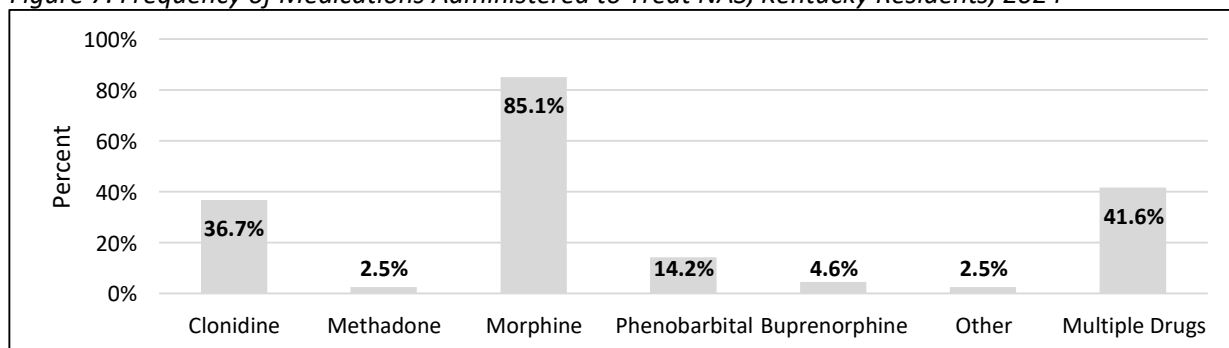
Newborn Outcomes

In the wake of the opioid epidemic, prenatal tobacco exposure is often overlooked, although it is associated with adverse pregnancy outcomes and withdrawal-like symptoms in infants (Hudak & Tan, 2012). Kentucky Office of Vital Statistics data show smoking during pregnancy is over seven times more common among women whose babies have NAS than among women whose babies do not have NAS (52% compared to 6%). Data collected in the NAS Registry mirrors this rate, with 51% of women reporting tobacco use.

Compared to infants without NAS, infants with NAS are nearly twice as likely to be low birth weight (16% compared to 9%), defined as less than 2,500 grams. Infants with NAS can have difficulties feeding and gaining weight (Hudak & Tan, 2012), which further increases the health risks and challenges associated with preterm and low birth weight. These conditions are associated with medical complications that result in a longer duration of hospitalization. In 2024, about 12% of newborns without NAS had NICU stays, compared to 32% of newborns with NAS, and there is a national trend of NICUs dedicating increasing resources to NAS (Tolia et al., 2015).

Overall, 38% of infants with NAS received one or more medications to treat NAS. Eighty-five (85%) of treated infants received morphine, which is consistent with research on prescribing practices (Hudak & Tan, 2012). Clonidine was used in over a third of cases, either as the primary drug or an adjunct therapy in combination with morphine. Phenobarbital was administered to 14% of infants who received treatment. All other medications were administered to fewer than 12% of infants who received medication. Over one-third of infants who received treatment were prescribed more than one medication (41.6%), which would indicate those babies had severe signs of withdrawal.

Figure 7. Frequency of Medications Administered to Treat NAS, Kentucky Residents, 2024



Data Source: 2024 Kentucky Neonatal Abstinence Syndrome Reporting Registry

Breastfeeding may reduce the severity of NAS symptoms (Hudak & Tan 2012; ACOG, “Opioid,” 2017). From birth certificate data, mothers of infants with NAS are much less likely to plan to breastfeed than mothers of infants without NAS (38% vs 75%, respectively); according to the NAS Registry, about 38% of these mothers actually initiate breastfeeding.

Outcomes Beyond Discharge

As part of the Child Abuse Prevention and Treatment Act (CAPTA), states must have policies to notify child welfare agencies about infants with prenatal substance exposure. As stated in the Kentucky Cabinet for Health and Family Services (CHFS) standard of practice manual, reports alleging risk of harm may be accepted if a “caretaker engages in a pattern of conduct that renders him/her incapable of caring for the immediate and ongoing needs of the child” due to substance use (2024). That policy includes the example of infants testing positive or experiencing withdrawal from non-prescribed substances. For that reason, medical providers are expected to document prenatal substance exposure in medical records. Of all infants in the NAS Registry, 71% were referred to the CHFS Department of Community Based Services. Of those 71%, over 67% were accepted. Of the infants in the 2024 NAS Registry, nearly seven out of every ten were discharged to the care of one or both biological parents, and one out of every four is discharged to kinship care, foster care, or an adoptive parent. Nationwide, in fiscal year 2023 over 56,000 children entering foster care had parental drug use as a circumstance of removal from the home (Children’s Bureau, 2025).

The Child Fatality and Near Fatality External Review Panel (the panel) conducts comprehensive, multidisciplinary reviews to discover risk factors and systems issues and recommends prevention measures (2022). During recent reviews, the panel has seen a substantial increase in overdose/ingestion cases. Fifty percent of all cases reviewed by the panel included substance use by a caregiver as a risk factor. Nearly a third of all substance-exposed infants reviewed by the panel were exposed to more than three different types of substances in utero. The panel continues to strongly advocate for more robust plans of safe care for Kentucky. Recommendations from the panel have been incorporated into this report.

Every year, roughly 50,000 U.S. children visit an emergency department because they swallowed something potentially dangerous (AAP, 2023), with some dying from poisoning. Opioids are the most common substance contributing to fatal poisonings among children less than five years old (AAP, 2023). In 2024, there were nine child deaths due to accidental poisoning by various substances in Kentucky (CHFS, 2024). Unintentional injuries are often the most preventable deaths for children.

Data from Kentucky’s Sudden Unexpected Infant Death (SUID) Case Registry shows that in 2018-2023, 33% of cases had a risk factor related to substance use (including NAS and parental/caregiver use). This data could indicate that NAS is a risk factor for SUID. While there is not a known biological mechanism for that relationship, caregiving or co-sleeping while impaired endangers infants.

Concluding Statement

NAS is just one facet of the opioid epidemic and cannot be addressed in isolation from larger systemic issues. Although the problem is daunting, prevention is possible. The following recommendations help address the underlying determinants of health to promote better outcomes for families and children.

Recommendations for Prevention

Promote optimal periconceptional health and prenatal care. Optimal periconceptional status promotes healthy pregnancy. Prenatal care ensures monitoring for any medical or fetal complications and screening for substance use disorder and co-morbidities, so that referral can be made for treatment and counseling. Additionally, the Kentucky Department for Public Health (KDPH) recommends that providers access the Kentucky all schedule prescription electronic report (KASPER) during the first prenatal visit as a standard of care. Women with HCV should have ribonucleic acid (RNA) testing performed at nine to twelve months postpartum to assess for the possibility of spontaneous HCV clearance. KDPH also suggests providers institute a postpartum follow-up within seven to ten days of delivery, especially for high-risk deliveries and for women with SUD, prior to the standard six-week postpartum visit.

Referral and enrollment in MOUD programs. Over half of the women in the NAS Registry report having a prescription for replacement therapy. MOUD programs, especially those that incorporate comprehensive services to address the complex needs of the mother and family, can be very successful in addressing OUD. To support recovery, MOUD should be more accessible for both pregnant and postpartum women. Furthermore, all MOUD providers need training in family-oriented protocols for counseling and behavioral therapy, which are crucial to the success of treatment programs. Regulatory authorities should require MOUD providers to participate in collaborative and holistic services directed to pregnant women or mothers and their infants. Because NAS is a risk factor for SUID and non-intentional injury deaths, strength-based parenting education can be an important part of MOUD treatment and counseling during pregnancy. [Findhelpnowky.org](https://findhelpnowky.org) is a tool providers can use to refer patients for MOUD treatment.

Implement a plan of safe care. Every infant, including those prenatally exposed to drugs or alcohol, should leave the hospital with an appropriate plan of safe care. A plan of safe care should address coordinated and integrated services needed for the impacted child, parent(s), and caregivers. KDPH promotes the creation of a plan of safe care through various programs and education provided at local health departments, through partner agencies including community mental health centers, and through conferences at regional and statewide levels. Interagency collaboration among the Department for Behavioral Health, Developmental and Intellectual Disabilities, Department for Community Based Services, and KDPH should ensure that plans of safe care are implemented for infants with NAS or any substance exposure.

Education for parents on abusive head trauma and safe sleep. Birthing hospitals should provide in-person, evidence-informed education regarding safe sleep and abusive head trauma prevention to parents, both antepartum and postpartum. Continuing this as a universal practice will ensure that all parents of infants with NAS or prenatal substance exposure are reached. To that end, the Kentucky Hospital Association supports this practice. The KDPH continues to promote the [ABCD](#) of safe sleep practice (Babies sleep **A**lone on their **B**ack, in a **C**rib, and attended to without **D**anger from a caretaker who is impaired, tired, or distracted).

Enrollment in services, such as WIC and HANDS. Programs that serve mothers and families prenatally and throughout early childhood have unique opportunities for engagement. Programs that serve this population can take advantage of the support services provided by WIC and HANDS for families affected by substance use.

Improve access to long-acting reversible contraception (LARC). Only 18% of infants with NAS were the first live birth to that mother, compared to 42% of infants without NAS. This demographic trend has been consistent across the past few years, with the additional context that nearly 90% of pregnancies among this population are unintended (Heil et al., 2010). Women of reproductive age who use opioids for any purpose need effective pre-conception counseling and access to family planning. Kentucky Medicaid covers LARCs, and other insurers and providers should work to make LARCs accessible to all interested mothers during the intrapartum period.

Promote breastfeeding for infants with NAS. Breastfeeding may reduce the severity of NAS symptoms (Hudak & Tan 2012; ACOG, “Opioid,” 2017), although mothers of infants with NAS are much less likely to initiate breastfeeding. ACOG also recommends breastfeeding for mothers with HCV infections; breastfeeding is safe for mothers with HCV infections if they do not have damaged, cracked, or bleeding nipples (Corcorran, 2021).

Promote the American Academy of Pediatrics (AAP) well-child visit schedule. Well-child visits have a multitude of benefits, including prevention of adverse health outcomes, tracking of growth and development, and allowing parents to raise concerns to their child’s pediatrician. As part of this schedule, ACOG recommends that all children born to women with HCV infection receive HCV testing at 18 months of age with follow-up at age three for positive tests (Corcorran, 2021).

Education for parents on medication safety. The AAP suggests educating parents on methods for keeping medications out of the hands of children. Some of these methods include storing all medications in a high area out of children’s sight/reach, keeping medicines in their original containers with child-safety caps, promoting the use of lock boxes for extra safety, and disposing of any unused medications, especially opioids, at pharmacies, doctors’ offices, and other drug “take back” programs. The AAP also recommends that clinicians continue to track the source of patient prescriptions and the efficacy of prescribed dosages.

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