OBJECTIVES

1. Define addiction and describe the current epidemiology of substance use disorder among women
2. Describe how comprehensive treatment can help families achieve recovery and long term health
3. Outline best use of opioid use disorder pharmacotherapies in the context of the mother child dyad
4. Define neonatal abstinence syndrome and identify at least one factor that affects its course
5. Recognize the unique biopsychosocial needs of pregnant and postpartum women and how support systems can meet them
SUBSTANCE USE AND THE OPIOID CRISIS DISPROPORTIONATELY HARM WOMEN
THE CURRENT OPIOID CRISIS

MMWR 11/4/11
National prevalence of opioid use disorder per 1,000 delivery hospitalizations — National Inpatient Sample (NIS), Healthcare Cost and Utilization Project (HCUP), United States, 1999–2014
THE OPIOID CRISIS: A TRIPLE WAVE EPIDEMIC

Thanks to Dan Cicarrone
Heroin use increasing faster among women than men

Use of prescription opioids decreasing more slowly among women than men
Since 2010, prescription opioid overdose deaths have increased 237% for men & 400% for women (CDC)
Maternal mortality in the past and its relevance to developing countries today
Maternal Deaths From Suicide and Overdose in Colorado, 2004–2012

Torri D. Metz, MD, MS, Polina Rovner, MD, M. Camille Hoffman, MD, MS, Amanda A. Allshouse, MS, Krista M. Beckwith, MSPH, and Ingrid A. Binswanger, MD, MPH, MS

Suicide or accidental overdose: n=63
Motor vehicle crash: n=36
Non-cardiovascular conditions: n=35
Cardiovascular conditions: n=22
Embolism: n=19
Homicide: n=15
Infection: n=10
Hemorrhage: n=7
Undetermined: n=2
Other trauma: n=2

Percentage of all maternal deaths

Percentage of maternal death cases

Opioids: n=24
Alcohols: n=20
Benzodiazepines: n=11
Cocaine/metabolites: n=9
Sedatives/hypnotics: n=8
Antidepressants: n=8
Amphetamines: n=6
Muscle relaxants: n=4
Cannabinoids: n=4
Acetaminophen: n=3
Other toxicity: n=3
ADDICTION IS A CHRONIC DISEASE OF THE BRAIN
# Substance Use vs. Substance Use Disorder

**Past year substance use among women, 2016 National Survey of Drug Use and Health**

<table>
<thead>
<tr>
<th></th>
<th>Any past year use</th>
<th>Past year use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit drugs</td>
<td>21,454,672 (15%)</td>
<td>2,904,354 (2%)</td>
</tr>
<tr>
<td>Illicit drugs other than cannabis</td>
<td>11,142,423 (8%)</td>
<td>1,914,400 (1.4%)</td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription opioid:</td>
<td>50,572,462 (36%)</td>
<td>986,627 (0.71%)</td>
</tr>
<tr>
<td>Heroin:</td>
<td>335,326 (0.24%)</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>86,735,490 (62%)</td>
<td>5,805,559 (4.2%)</td>
</tr>
</tbody>
</table>

*Weighted prevalence/%
Addiction

Physiological dependence

Misuse

Maladaptive behavior
Addiction: A Brain-Centered Condition Whose Symptoms are Behaviors

Salient feature: Continued use despite adverse consequences

A chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain (NIDA)
DOPAMINE AND THE HIJACKED BRAIN HYPOTHESIS
Functionally…

Dopamine D2 Receptors are Decreased by Addiction

Cocaine

Meth

Heroin

Control

Addicted

NIDA
DEFINITION OF ADDICTION

“Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”
WHY DO SOME PEOPLE BECOME ADDICTED AND NOT OTHERS?
Addiction is a chronic disease that extends into pregnancy like many others.
What happens when women who use drugs get pregnant?

National Survey Drug Use and Health 2013/2014 Past Month Use Data
All pregnant women are motivated to maximize their health and that of their baby-to-be.

Pregnant women who can’t quit or cut back – They likely have a substance use disorder.

Continued use in pregnancy is pathognomonic for addiction.
MANY RISK FACTORS FOR ADDICTION ARE COMMON AMONG WOMEN

Psychiatric co-morbidities
• > 60% women with addiction have a mental health disorder (PTSD, depression, etc.)

Trauma
• 50-90% with history of childhood physical or sexual abuse

Violence
• 60-80% past year intimate partner violence

Low social support
• 67% with parents with substance use histories
Addiction is a chronic disease in need of long term treatment but few receive it.
Any past-year specialty substance use disorder treatment among people with past-year substance use disorders

Predicted probability

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Black</td>
<td>8%</td>
<td>7%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian(^a)</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>All</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Creedon Health Aff (Millwood) 2016
## Substance Use Disorder Treatment Need and Receipt Among Women, 2007-2014 NSDUH

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>NOT PREGNANT, NOT PARENTING (%)</th>
<th>PREGNANT (%)</th>
<th>PARENTING (OWN CHILD &lt;18 IN HOUSEHOLD) (%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1ST TRIMESTER</td>
<td>2ND TRIMESTER</td>
<td>3RD TRIMESTER</td>
</tr>
<tr>
<td>Past Year Substance Use Disorder Treatment Need</td>
<td>9.4</td>
<td>13.9</td>
<td>7.6</td>
<td>9.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Received Past Year Treatment (% of Need Met)</td>
<td>9.3</td>
<td>8.8</td>
<td>12.8</td>
<td>12.5</td>
<td>9.4</td>
</tr>
</tbody>
</table>
Overall provision of women-centered services in drug treatment facilities declined 2002-2009 (43%-40%, p<0.001)

AJPH 2015
### Barriers encountered receiving past year substance use disorder treatment among those with current need: 2015-2017 NSDUH

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Total</th>
<th>Women</th>
<th>Men</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couldn’t afford/ no insurance; insurance didn’t cover cost</td>
<td>4.2% (3.4, 5.0)</td>
<td>5.6% (4.0, 7.1)</td>
<td>3.5% (2.6, 4.3)</td>
<td>0.0074</td>
</tr>
<tr>
<td>No transportation; didn’t have time</td>
<td>1.8% (1.4, 2.3)</td>
<td>3.2% (2.1, 4.4)</td>
<td>1.1% (0.7, 1.5)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Desired treatment not offered; no openings in program</td>
<td>1.6% (1.1, 2.1)</td>
<td>2.3% (1.3, 3.3)</td>
<td>1.2% (0.5, 1.8)</td>
<td>0.0521</td>
</tr>
<tr>
<td>Not ready to stop use; negative opinion of treatment, didn’t feel need for treatment, could handle problem without program; didn’t think treatment would help</td>
<td>6.9% (5.9, 7.8)</td>
<td>8.1% (6.1, 10.1)</td>
<td>6.2% (6.1, 7.3)</td>
<td>0.0829</td>
</tr>
<tr>
<td>Felt treatment would have negative effect on job; didn’t want others to find out</td>
<td>2.0% (1.6, 2.5)</td>
<td>2.9% (1.9, 4.0)</td>
<td>1.6% (1.0, 2.2)</td>
<td>0.0461</td>
</tr>
<tr>
<td>Didn’t know where to go / Other</td>
<td>2.5% (1.8, 3.1)</td>
<td>3.9% (2.5, 5.3)</td>
<td>1.7% (1.1, 2.3)</td>
<td>0.0007</td>
</tr>
</tbody>
</table>
EVIDENCE BASED TREATMENT FOR SUBSTANCE USE DISORDER
Components of Comprehensive Drug Abuse Treatment

NIDA: Principles of Drug Addiction Treatment
OPIOID USE DISORDER (OUD)
SAMHSA CLINICAL GUIDE RECOMMENDATIONS

• Collaborative approach to treatment

• Medically supervised withdrawal is not recommended during pregnancy

• Buprenorphine and methadone are the safest medications for managing OUD during pregnancy

• Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended

https://store.samhsa.gov/product/SMA18-5054
COMPREHENSIVE RECOVERY CARE DURING PREGNANCY

- Prenatal Care
- Medication assisted treatment
- Behavioral counseling, psychiatry, social work, etc.

Comprehensive co-located service delivery
TREATING ADDICTION LEADS TO MATERNAL-CHILD OUTCOMES SIMILAR TO WOMEN WITHOUT ADDICTION

MANAGEMENT OF PREGNANT DRUG-DEPENDENT WOMEN

Loretta P. Finnegan

Department of Pediatrics
Thomas Jefferson University
Philadelphia, Pennsylvania 19107

Annals New York Academy of Sciences

Table 2
Obstetrical Complications in 367 Drug-Dependent Women and 215 Controls; Family Center Program, 1969-1976

<table>
<thead>
<tr>
<th>Groups</th>
<th>No. of Patients</th>
<th>Average no. of Prenatal Visits</th>
<th>Obstetrical Complications %</th>
<th>LBW Incidence %</th>
<th>Pre-eclampsia %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>65</td>
<td>0</td>
<td>36.9</td>
<td>47.7</td>
<td>9.2</td>
</tr>
<tr>
<td>B</td>
<td>109</td>
<td>1.9</td>
<td>32.1</td>
<td>35.5</td>
<td>2.8</td>
</tr>
<tr>
<td>C</td>
<td>193</td>
<td>8.2</td>
<td>33.7</td>
<td>19.7</td>
<td>4.7</td>
</tr>
<tr>
<td>D</td>
<td>93</td>
<td>0</td>
<td>32.3</td>
<td>19.4</td>
<td>8.6</td>
</tr>
<tr>
<td>E</td>
<td>122</td>
<td>9.2</td>
<td>32.0</td>
<td>13.9</td>
<td>8.2</td>
</tr>
</tbody>
</table>

LOW BIRTH WEIGHT

<table>
<thead>
<tr>
<th>Prenatal Care</th>
<th>No Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>No drug use</td>
<td>14%</td>
</tr>
<tr>
<td>Drug Use</td>
<td>19%</td>
</tr>
</tbody>
</table>

Finnegan New York Acad Sci 1978
The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck¹ · Erika R. Cheng² · Candice Belanoff³ · Howard J. Cabral³ · Hermik Babakhanlou-Chase⁴ · Taletha M. Derrington⁵ · Hafsaton Diop⁶ · Stephen R. Evans³ · Judith Bernstein³

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No Addiction</th>
<th>Treated Addiction</th>
<th>Untreated Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Birth</td>
<td>8.7%</td>
<td>10.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>5.5%</td>
<td>7.8%</td>
<td>18.0</td>
</tr>
<tr>
<td>Fetal Death</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>0.4%</td>
<td>0.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Post Neonatal Mortality</td>
<td>0.05%</td>
<td>0.03%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
OPIOID USE DISORDER (OUD)
SAMHSA CLINICAL GUIDE RECOMMENDATIONS

• Collaborative approach to treatment

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https://store.samhsa.gov/product/SMA18-5054
WHO GUIDELINES (2014)

“Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification. Opioid maintenance treatment in this context refers to either methadone maintenance treatment or buprenorphine maintenance treatment.”

- Medication followed by no medication treatment frequently have high attrition and a rapid returns to illicit opioid use

- Maintenance medication facilitates treatment retention and reduces substance use compared to no medication

- Biggest concern with pharmacotherapy during pregnancy is the potential for neonatal abstinence syndrome (NAS) – a treatable condition
“Evidence does not support detoxification as a recommended treatment intervention as a result of low detoxification completion rates, high rates of relapse, and limited data regarding the effect of detoxification on maternal and neonatal outcomes beyond delivery”

Detoxification leads to:
- High disease recurrence (17% to 96% - average 48%)
- No reduction in NAS with detoxification relative to pharmacotherapy
- Increases risk of maternal substance use and poor treatment engagement and does not improve newborn health
- Treatment of chronic maternal disease, including opioid use disorder, should be directed toward optimal long-term outcomes

OPIOID USE DISORDER (OUD)  
SAMHSA CLINICAL GUIDE RECOMMENDATIONS

• Collaborative approach to treatment

• Medically supervised withdrawal is not recommended during pregnancy

• Buprenorphine and methadone are the safest medications for managing OUD during pregnancy

• Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended
PHARMACOTHERAPY FOR OPIOID USE DISORDER

Medication

Methadone

Buprenorphine (Subutex/Suboxone)

Naltrexone (Vivitrol)
TREATMENT & PHARMACOTHERAPY TREAT THE BRAIN DISEASE OF ADDICTION

**Why Can’t Addicts Just Quit?**

- **Non-Addicted Brain**: Control, Saliency, Memory
- **Addicted Brain**: Control, Saliency, Drive, GO

**Because Addiction Changes Brain Circuits**

Adapted from Volkow et al., Neuropharmacology.

---

**Basic Research**

- Opiate agonists stabilize brain function in heroin addicts
- CB1 KO mice have decreased responses to multiple drugs of abuse
- Smokers who are poor nicotine metabolizers smoke less
- Stress triggers relapse in animal models of addiction and CRF antagonists interfere with the response to stress

**Medication**

- Agonist Therapy: Methadone, Buprenorphine
- CB1 Antagonists
- Inhibitors of metabolizing enzymes
- CRF Antagonists

**NIDA**
Addiction

- Physiological dependence
- Misuse
- Maladaptive behavior

Platform for recovery
THE GOAL OF TREATMENT IS RECOVERY NOT MORE TREATMENT
SAMHSA’s Working Definition of Recovery

10 Guiding Principles of Recovery

SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-2627)
RECOVERY LEADS TO RETURN OF NORMAL BRAIN STRUCTURE AND FUNCTION

DAT Recovery with prolonged abstinence from methamphetamine

Recovery can be achieved with the use of medications.
THERE ARE MANY PATHWAYS TO RECOVERY

National Recovery Survey (N=25,229)

Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults

Recovery Indices by Years Since Problem Resolution

Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy

John F. Kelly*, Brandon Bergman*, Bettina B. Hoeppner*, Corrie Vilsaint*, William L. White*
TREATMENT WORKS BUT MOST INDIVIDUALS WITH ADDICTION DON’T RECEIVE ANY FORMAL TREATMENT
Comprehensive treatment and pharmacotherapy are rare and unavailable for most pregnant women with addiction.

Nationally pregnant women are not receiving priority services for substance use disorder.
NEONATAL ABSTINENCE SYNDROME (NAS/NOWS)
Neonatal abstinence syndrome includes a combination of physiologic and neurobehavioral signs that include such things as sweating, irritability, increased muscle tone and activity, feeding problems, diarrhea, and seizures. Infants with neonatal abstinence syndrome often require prolonged hospitalization and treatment with medication."
SALIENT MATERNAL CATEGORIES RELATED TO OPIOID EXPOSURE/NAS

1. Women using opioid analgesics for a medical condition(s) who do not have a substance use disorder

2. Women receiving pharmacotherapy for the treatment of an opioid use disorder

3. Women with an (unrecognized) untreated opioid use disorder

(Borrowed from the National Center of Substance Abuse and Child Welfare)
PREDICTING NAS COURSE IS DIFFICULT

Table 1
Maternal, infant, and/or environmental factors that can alter infant neonatal abstinence syndrome expression

<table>
<thead>
<tr>
<th>Maternal Factors</th>
<th>Infants with particular genotypes (SNPs) at the OPRM1 and COMT gene sites had less severe NAS expression.\textsuperscript{18} Hypermethylation at the same sites was associated with more severe NAS, consistent with gene silencing.\textsuperscript{19}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licit medications: psychotropic, OUD treatment medications (eg, methadone, buprenorphine)</td>
<td>Psychotropic exposure can alter or increase NAS display.\textsuperscript{17} OUD treatment medications can predispose the exposed infant to NAS, but benefits associated with maternal comprehensive treatment that includes medications for OUD are paramount for the dyad.</td>
</tr>
<tr>
<td>Genetics/epigenetics</td>
<td>Table 1</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Can reduce NAS severity.\textsuperscript{20}</td>
</tr>
<tr>
<td>Infant factors</td>
<td>Sex: Male infants have been reported to have more severe NAS expression.\textsuperscript{21,22}</td>
</tr>
<tr>
<td>Gestational age</td>
<td>Preterm infants have less severe expression of NAS (notably, NAS measurement tools were designed for term infants. As such, NAS may not be adequately assessed in preterm infants).\textsuperscript{23}</td>
</tr>
<tr>
<td>Fetal programming</td>
<td>The fetus adapts to an unfavorable intrauterine environment by altering ANS set points. These changes can be adaptive in utero and maladaptive ex utero and may be expressed as NAS.\textsuperscript{24} Alterations from these changes may not be evident until the affected neurosystem matures, potentially later in life.\textsuperscript{24}</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>NCU can exacerbate NAS severity, while maternal rooming-in can reduce NAS severity.\textsuperscript{25,26}</td>
</tr>
<tr>
<td>Caregiver (parent or medical staff) handling and communication</td>
<td>Misinterpretation of or inappropriate responses to infant cues or insensitive handling can exacerbate NAS expression.\textsuperscript{27}</td>
</tr>
</tbody>
</table>

FAMILY EDUCATION ON NAS

• No long term effects of NAS for infants
• Moms CAN take steps to improve her & her infant’s health:
  • Breastfeeding!
  • Smoking cessation
  • Decrease benzodiazepine, gabapentin use
  • Maternal-infant bonding (e.g., rooming in, skin-to-skin)
  • Other non-pharmacological treatments (e.g., quiet environment, swaddling, waterbeds)

• Reducing dose of pharmacotherapy does NOT reduce incidence or severity
  • Dose should be maximized to suppress withdrawal, cravings and maintain recovery
NAS IS NOT ADDICTION

• Newborns can’t be “born addicted”
• NAS is withdrawal – due to physical dependence
• Physical dependence is not addiction
• Addiction is brain illness whose visible signs are behaviors
• Newborn do not have the life duration or experience to meet the addiction definition
• Addiction is chronic disease – chronic illness can’t be present at birth

THE FOURTH TRIMESTER
SUBSTANCE USE RECURRENCE OCCURS OFTEN POSTPARTUM

Figure 1. Relative proportion of substance-using women who abstained during and after pregnancy.
MANY WOMEN ARE LOST TO ADDICTION CARE POSTPARTUM

Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder

Christine Wilder\textsuperscript{a,b,*}, Daniel Lewis\textsuperscript{a}, Theresa Winhusen\textsuperscript{a}
TIMING OF MATERNAL DEATHS POSTPARTUM
COLORADO MMR DUE TO OVERDOSE = 5/100000
(42% PRESCRIPTION OPIOIDS)

>50% did not attend postpartum visit
Only 6 had documented treatment

Metz, Obstetrics & Gynecology 2016
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Davida M. Schiff, MD, MSc, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Bernson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MSc, and Thomas Land, PhD

Schiff (Obstetrics & Gynecology) 2018
CONTINUOUS COMPASSIONATE CARE IS KEY

- Newborn care, breastfeeding, bonding
- Mood & physiologic changes, poor sleep
- Cultural norms of the 'ideal mother'
- Loss of insurance, financial stress
- Shift of care from 'medical system' to 'agencies'
- Focus of medical care shifts from mom + OB to baby + pediatrics

Gaps in substance use disorder treatment
SOLUTIONS
SOLUTION #1: FACILITATE EARLY LINKAGE TO TREATMENT
FIGURE 1
Risk pyramid for assessment of substance use during pregnancy

HIGH RISK
Current use meets SUD criteria

MODERATE RISK
High use in past, including recent treatment; Stopped use late in pregnancy; Continued low level of use

LOW RISK
No past or current use; Low level of use stopped prior to or immediately upon known pregnancy

UNIVERSAL SCREENING
Brief questionnaire; Interview; Computer-assisted assessment

Refer to specialized SUD treatment; Frequent follow-up visits w/ provider

Brief intervention; Motivational interviewing; Frequent follow-up visits w/ provider

Brief advice Written pamphlet

Wright AJOG 2016
• It is not a parenting test

• Toxicology tests for drugs are not sufficient for a diagnosis of a substance use disorder

• Having a substance use disorder is only one of many other factors in determining child safety

• Urine toxicology screening and confirmatory testing

• Patient consent required before specimen collection

Toxicology screens are not a substitute for verbal, interactive questioning and screening of patients about their drug and alcohol use.

https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing
DEPRESSION AND SUBSTANCE USE DISORDER TREATMENT RECEIPT, 2007-2014 NSDUH

- Substance Use Disorder: 60.8% received treatment, 39.2% did not receive treatment.
- Major depressive Episode: 90.8% received treatment, 9.2% did not receive treatment.

Chart showing trends in treatment receipt from 2007 to 2014.
We really do have a solution to the opioid epidemic — and one state is showing it works

Virginia shows how Medicaid can help end the opioid crisis.

By German Lopez | @germanlopez | german.lopez@vox.com | May 10, 2018, 6:00am EDT
Photographs by Julia Rendleman | Charts by Christina Animashaun
SOLUTION #2: FIGHT STIGMA, DISCRIMINATION AND PREJUDICE
No bystander could be more innocent. No damage so helplessly collateral.
Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: “Because [the mother] demanded that the baby be released.”

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend’s house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother’s drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.
## The Power of Words to Hurt or Heal

<table>
<thead>
<tr>
<th>Stigmatizing Words</th>
<th>Preferred Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict, Abuser, Junkie</td>
<td>Person in active addiction, person with a substance misuse disorder, person experiencing an alcohol/drug problem, patient</td>
</tr>
<tr>
<td>User</td>
<td>person who misuses alcohol/Drugs or person engaged in risky use of substances</td>
</tr>
<tr>
<td>Abuse</td>
<td>Misuse, harmful use, inappropriate use, hazardous use, problem use, risky use</td>
</tr>
<tr>
<td>Clean, Dirty</td>
<td>Negative, positive, substance-free</td>
</tr>
<tr>
<td>Habit or Drug Habit</td>
<td>Substance misuse disorder, alcohol and drug disorder, alcohol and drug disease, active addiction</td>
</tr>
<tr>
<td>Replacement or Substitution Therapy</td>
<td>Treatment, medication-assisted treatment, medication</td>
</tr>
</tbody>
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SOLUTION #3: ADVOCATE FOR COMPASSIONATE CARE FOR FAMILIES WITH ADDICTION
Obstetric Care for Women with Opioid Use Disorder

**RESPONSE**

Every provider/clinical setting/health system

- Ensure that all patients with OUD are enrolled in a woman-centered OUD treatment program.
  - Establish communication with OUD treatment providers and obtain consents for sharing patient information.
  - Assist in linking to local resources (e.g., peer navigator programs, narcotics anonymous (NA), support groups) that support recovery.
- Incorporate family planning, breastfeeding, pain management, and infant care counseling, education, and resources into prenatal, intrapartum, and postpartum clinical pathways.
  - Provide breastfeeding and lactation support for all postpartum women on pharmacotherapy.
  - Provide immediate postpartum contraceptive options (e.g., long-acting reversible contraception (LARC)) prior to hospital discharge.
- Ensure coordination among providers during pregnancy, postpartum, and the inter-conception period.
  - Provide referrals to providers (e.g., social workers, psychiatry, and infectious disease) for identified co-morbid conditions.
  - Identify a lead provider responsible for care coordination, specify the duration of coordination, and assure a “warm handoff” with any change in the lead provider.
  - Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff (i.e., inpatient maternity staff, social services) and child welfare services.
- Engage child welfare services in developing safe care protocols tailored to the patient and family's OUD treatment and resource needs.
- Ensure priority access to quality home visiting services for families affected by SUDs.
TAKE HOME POINTS

1. Addiction is a brain disease with behavioral symptoms that require long term treatment like other chronic conditions.

2. Opioid and other substance use disorders (SUDs) are common among women across the lifespan including during pregnancy.

3. Behavioral and medical treatments are effective to treat substance use disorders and improve outcomes in multiple dimensions.

4. In pregnancy, pharmacotherapy is recommended to treat OUD as it improves maternal and neonatal outcomes.

5. Neonatal abstinence syndrome (NAS), or opioid withdrawal of the neonate, is a temporary, treatable condition.

6. Medical and psychosocial co-morbidities are common with SUDs and are best addressed with comprehensive, compassionate care.

7. There are many pathways to recovery, and families in recovery can achieve long term health of mothers and their children.