



# **CARING FOR WOMEN & FAMILIES AFFECTED BY ADDICTION**

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Gynecology  
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University School of Medicine

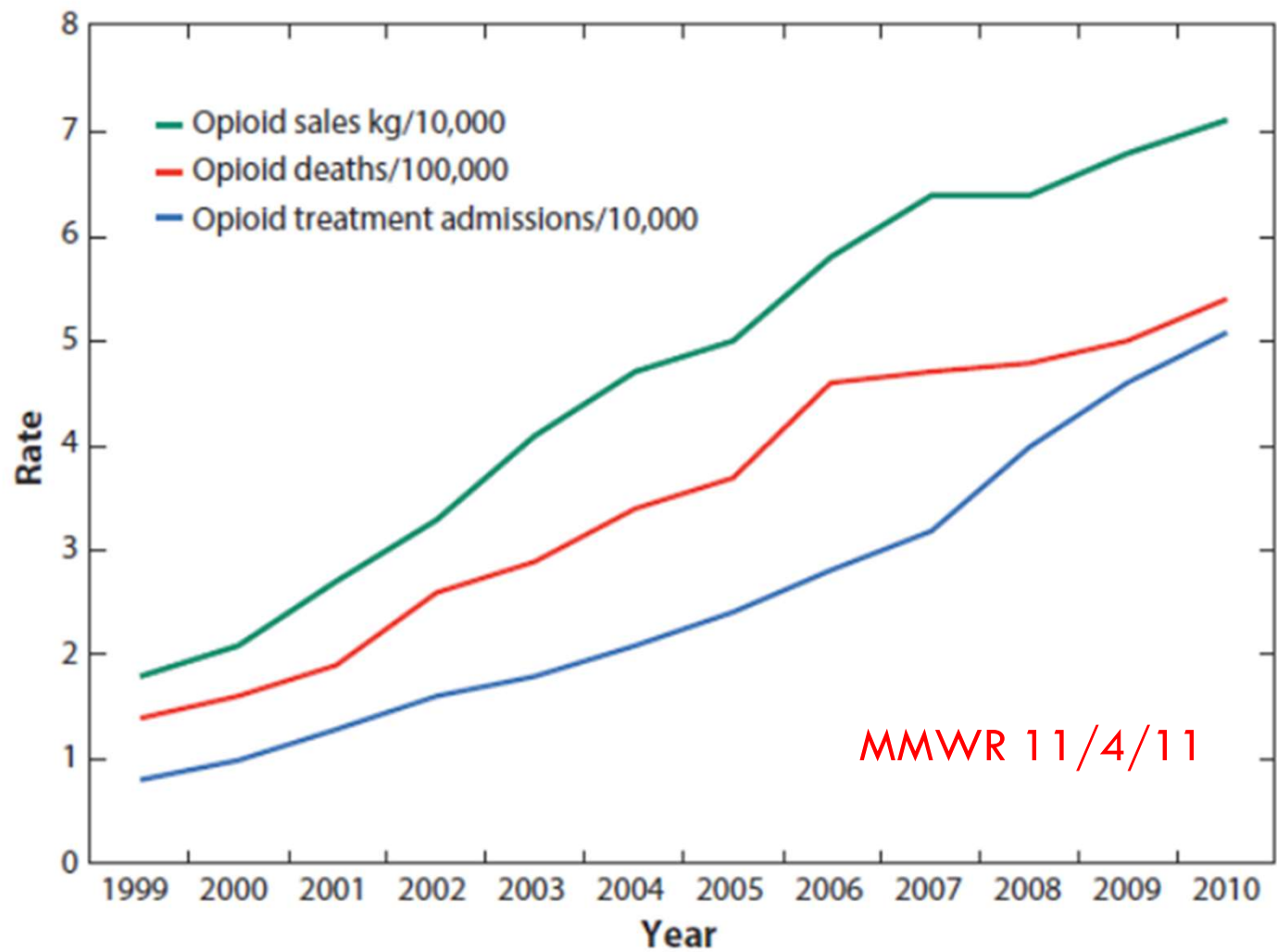
# OBJECTIVES

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

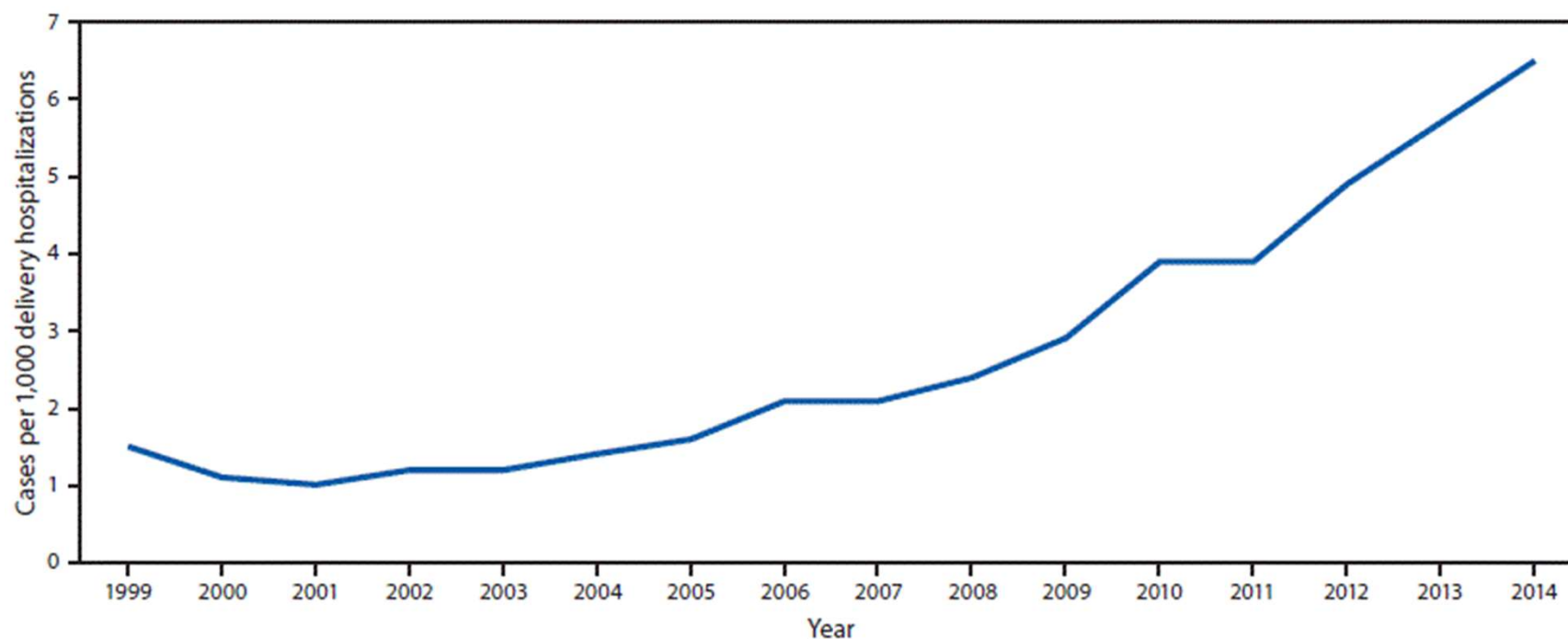


# **SUBSTANCE USE AND THE OPIOID CRISIS DISPROPORTIONATELY HARM WOMEN**

# THE CURRENT OPIOID CRISIS

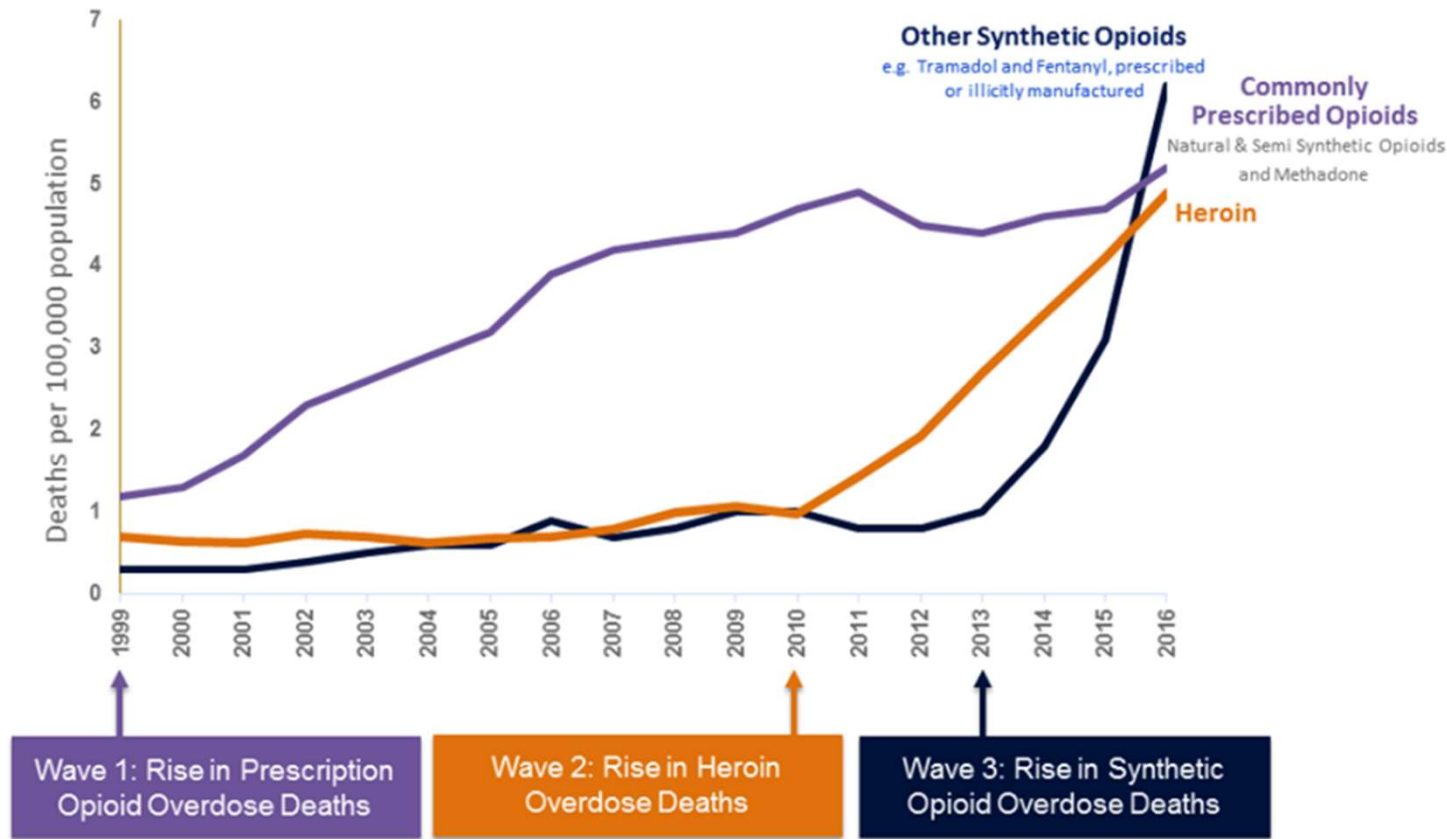


**National prevalence of opioid use disorder per 1,000 delivery hospitalizations —  
National Inpatient Sample (NIS), Healthcare Cost and Utilization Project (HCUP),  
United States, 1999–2014**



MMWR 8/10/2018

### 3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

# THE OPIOID CRISIS: A TRIPLE WAVE EPIDEMIC

Thanks to Dan Cicarrone

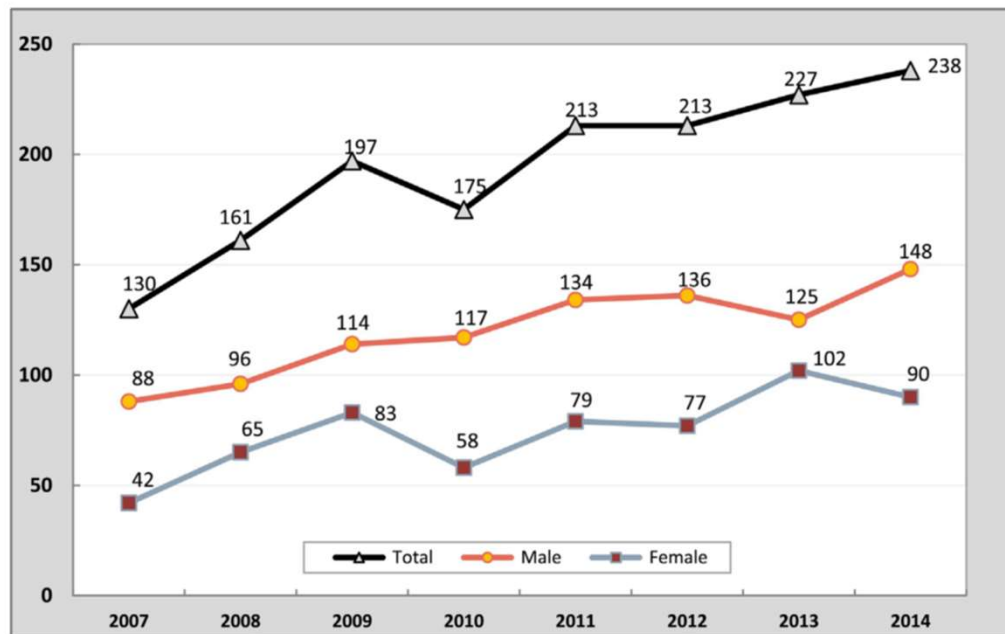


## Gender differences in trends for heroin use and nonmedical prescription opioid use, 2007–2014

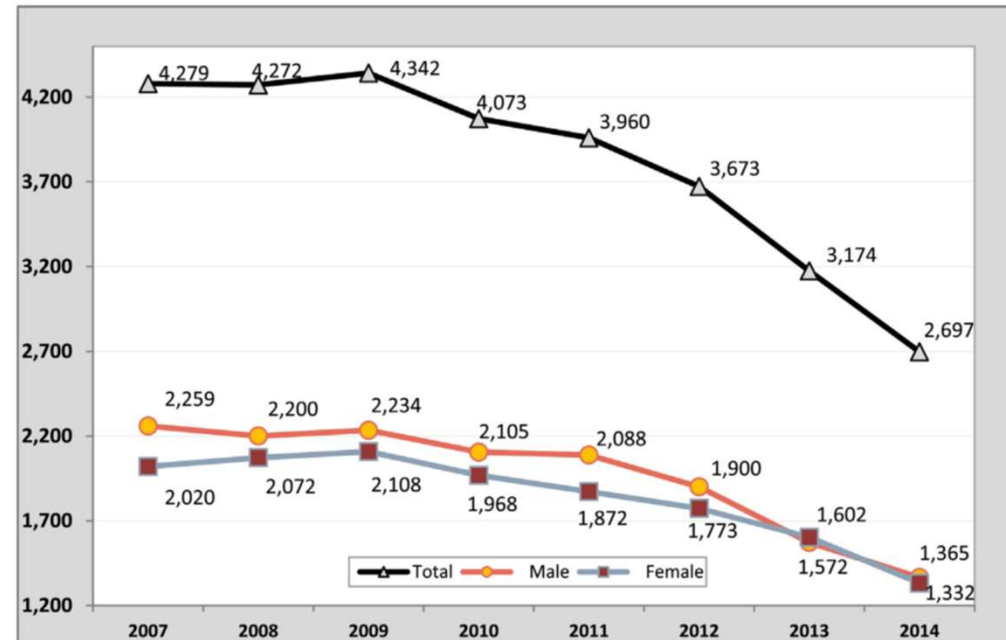
Jeanne C. Marsh \*, Keunhye Park, Yu-An Lin, Cliff Bersamira



### Heroin use increasing faster among women than men



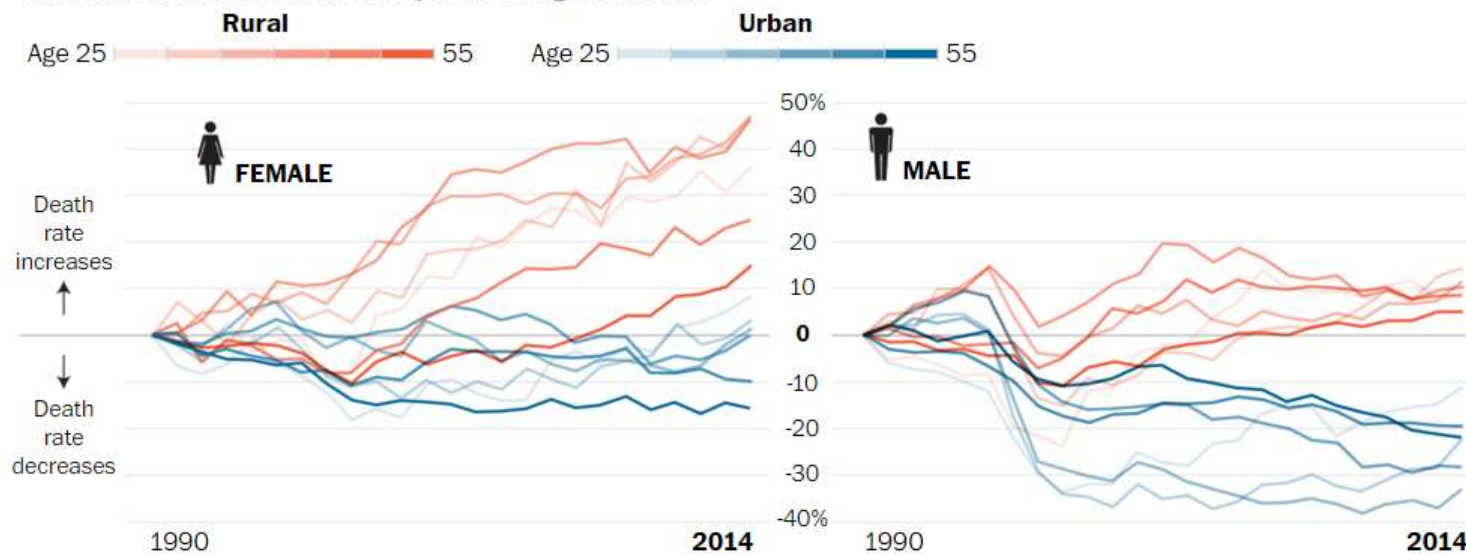
### Use of prescription opioids decreasing more slowly among women than men



# The Washington Post A new divide in American death

## Change in mortality rate, urban vs. rural

White women and men in small cities and rural areas are dying at much higher rates than in 1990, while whites in the largest cities and their suburbs have steady or declining death rates.



Source: Washington Post analysis of Centers for Disease Control and Prevention mortality data

Since 2010, prescription opioid overdose deaths have increased 237% for men & 400% for women (CDC)

[https://www.washingtonpost.com/sf/national/2016/04/10/a-new-divide-in-american-death/?hpid=hp\\_hp-top-table-main-obesity-divide%3Ahomepage%2Fstory&hpid=hp\\_hp-top-table-main-obesity-divide%3Ahomepage%2Fstory](https://www.washingtonpost.com/sf/national/2016/04/10/a-new-divide-in-american-death/?hpid=hp_hp-top-table-main-obesity-divide%3Ahomepage%2Fstory&hpid=hp_hp-top-table-main-obesity-divide%3Ahomepage%2Fstory)  
Adverse consequence = overdose

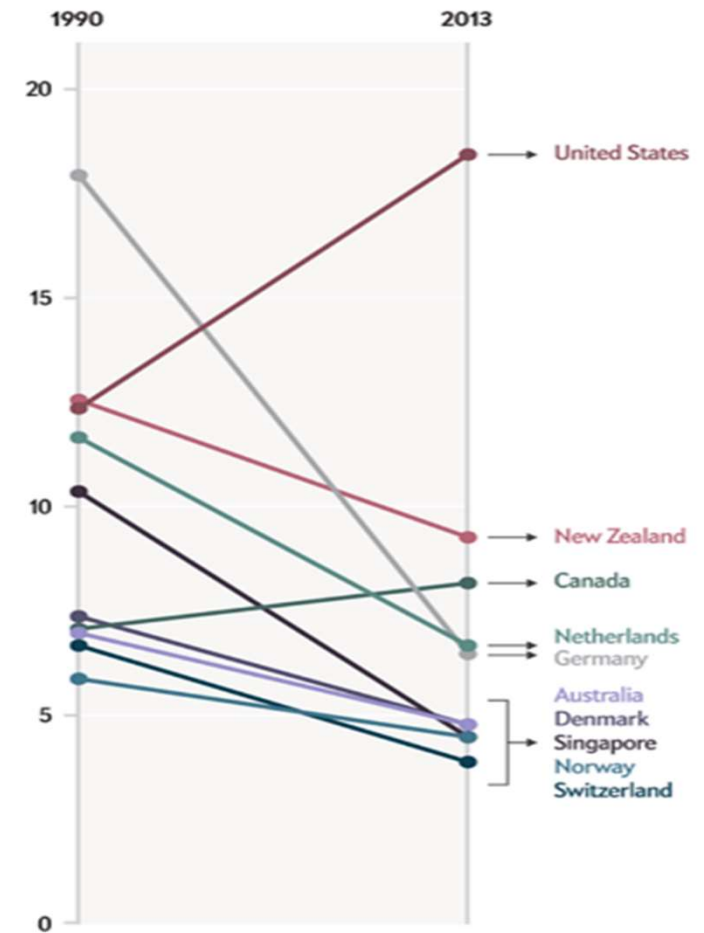


# MATERNAL MORTALITY



Maternal mortality in the past and its relevance to developing countries today  
 Am J Clin Nutr. 2000;72(1):241S-246S. doi:10.1093/ajcn/72.1.241S

**Maternal Mortality Ratio (MMR) by Developed Country**  
 Maternal deaths per 100,000 live births

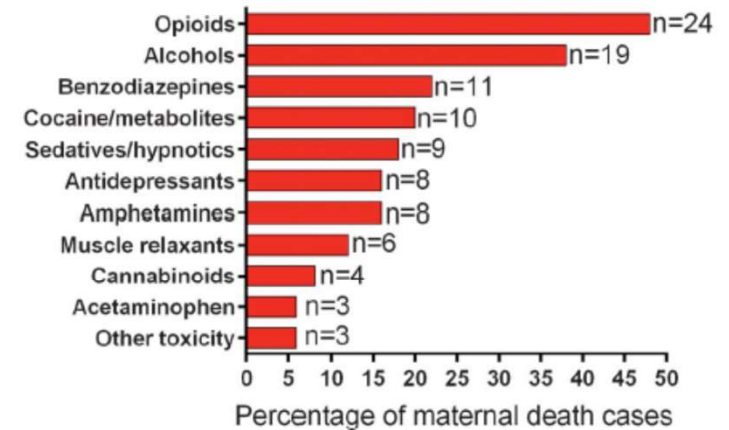
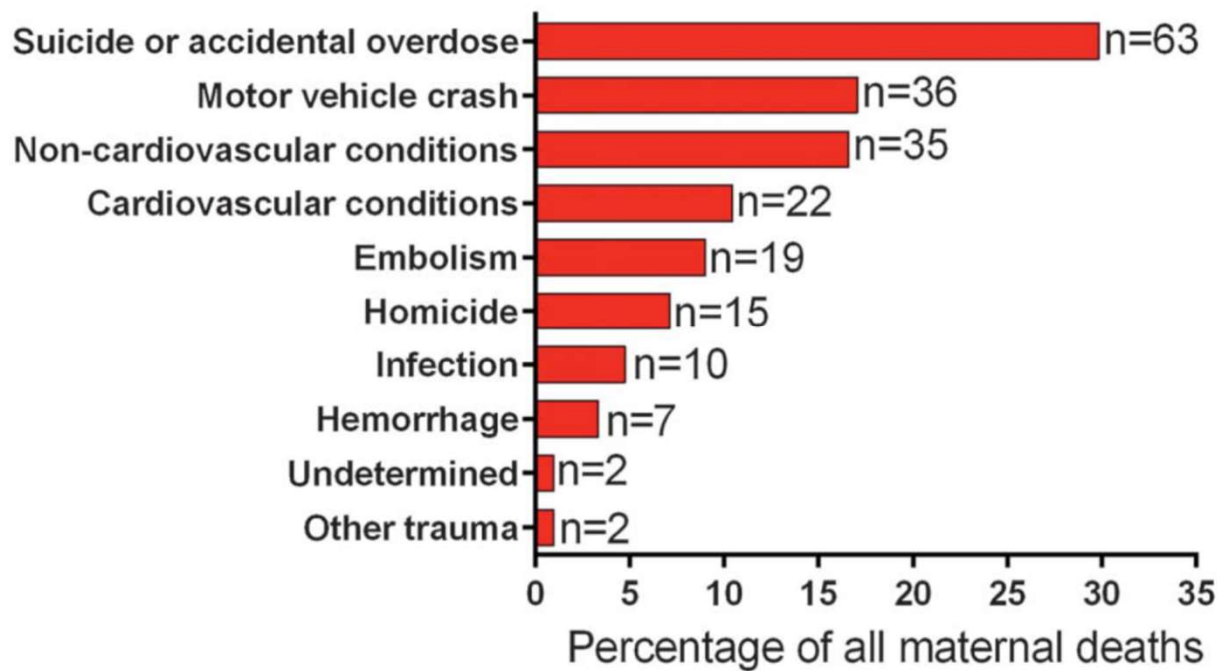


Source: Institute for Health Metrics and Evaluation

Graphic by Tiffany Farrant-Gonzalez, for **SCIENTIFIC AMERICAN**

# Maternal Deaths From Suicide and Overdose in Colorado, 2004–2012

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



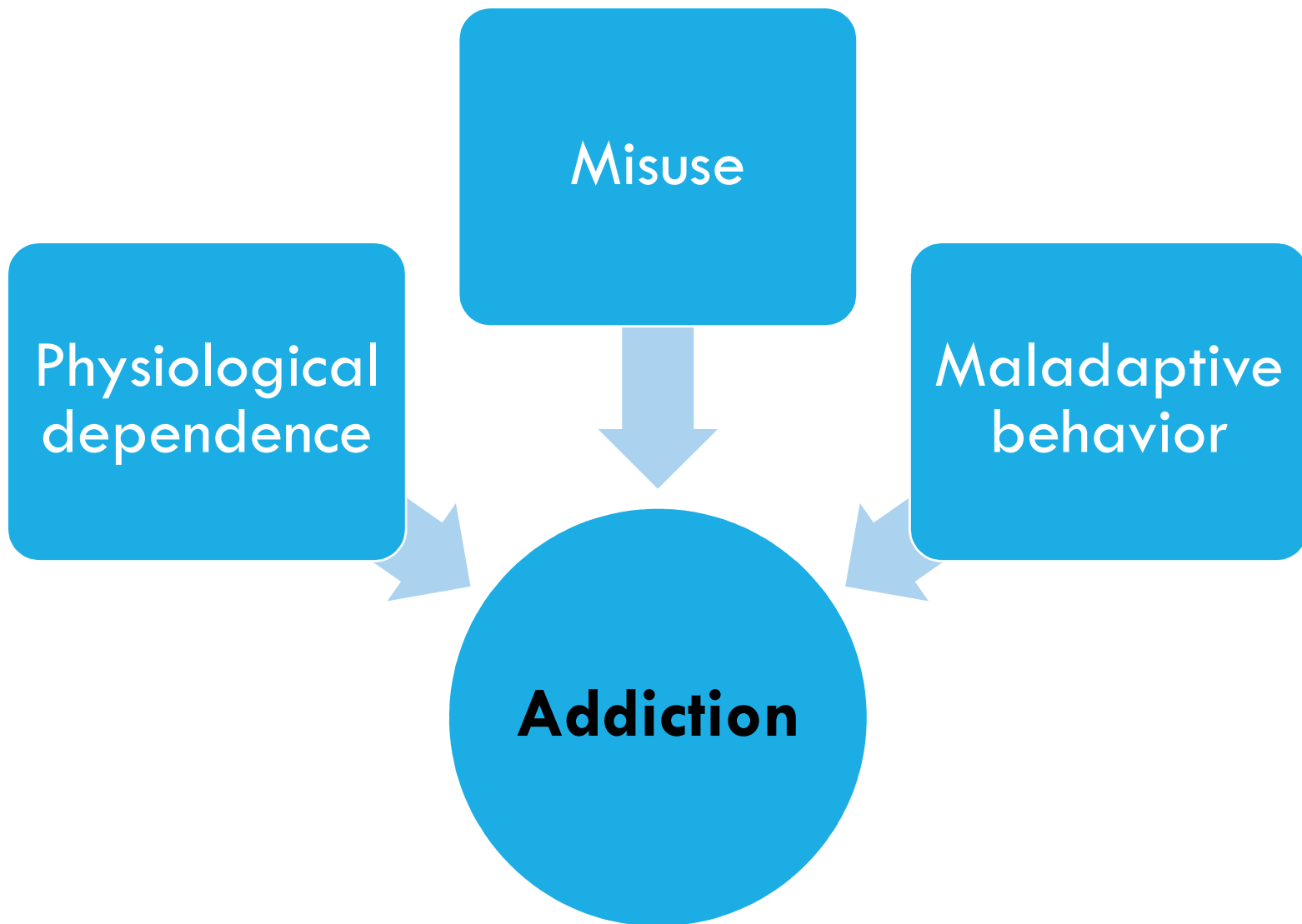
**ADDICTION IS A CHRONIC DISEASE OF THE BRAIN**

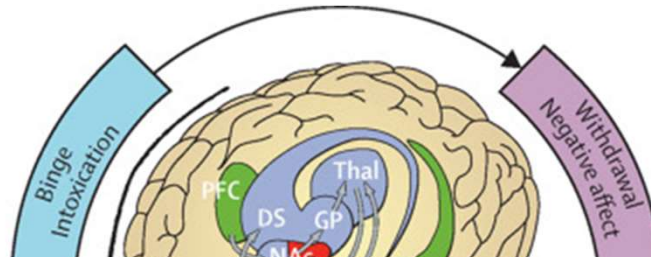
# SUBSTANCE USE VS. SUBSTANCE USE DISORDER

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

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

\*Weighted prevalence/%



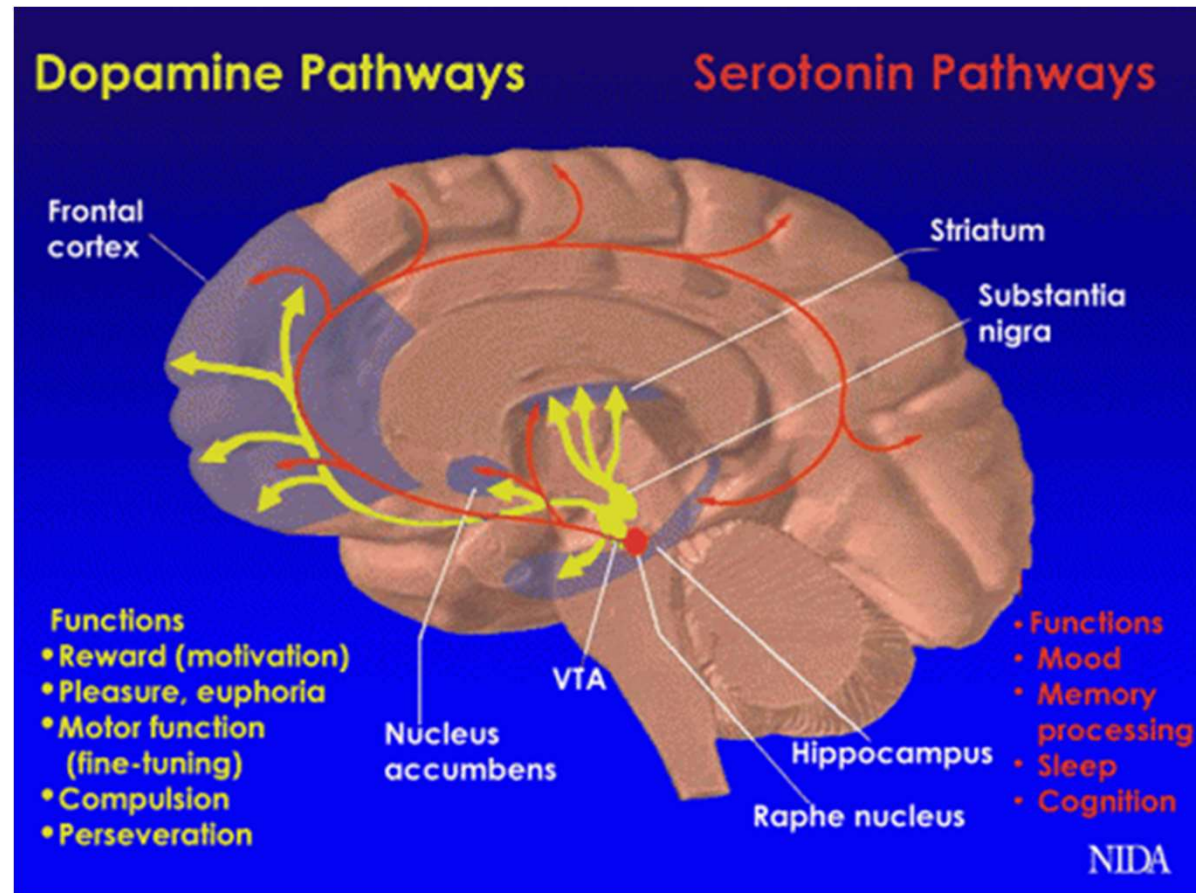


Addiction: A Brain-Centered Condition  
Whose Symptoms are Behaviors  
Salient feature: Continued use despite  
adverse consequences



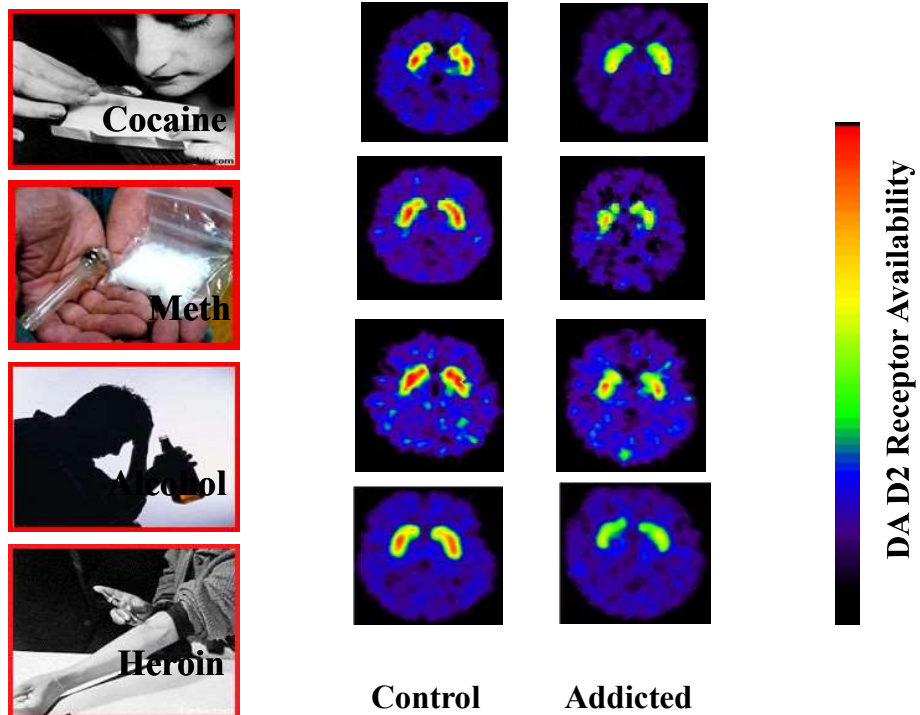
**A chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain (NIDA)**

# DOPAMINE AND THE HIJACKED BRAIN HYPOTHESIS



## *Functionally...*

**Dopamine D2 Receptors are Decreased by Addiction**



NIDA



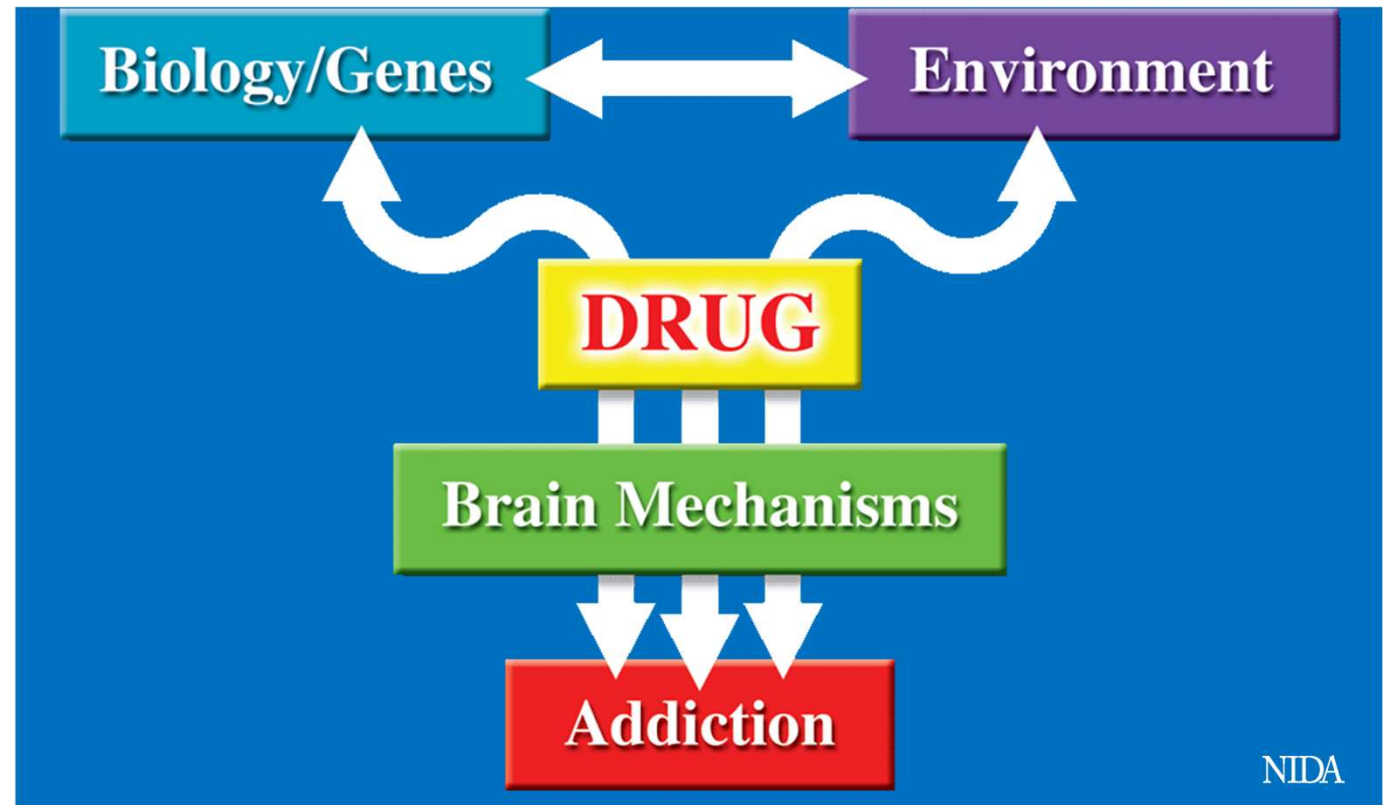


**ASAM** American Society of  
Addiction Medicine

# 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.”*

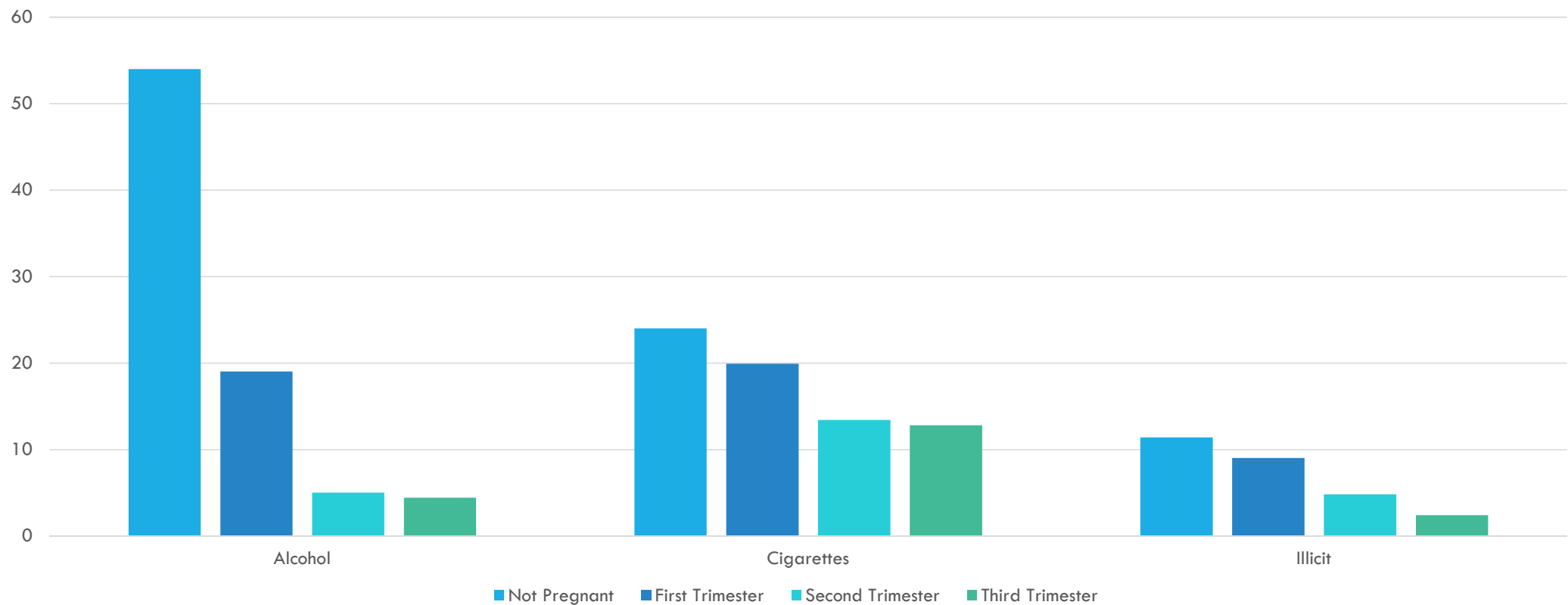
# WHY DO SOME PEOPLE BECOME ADDICTED AND NOT OTHERS?





**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

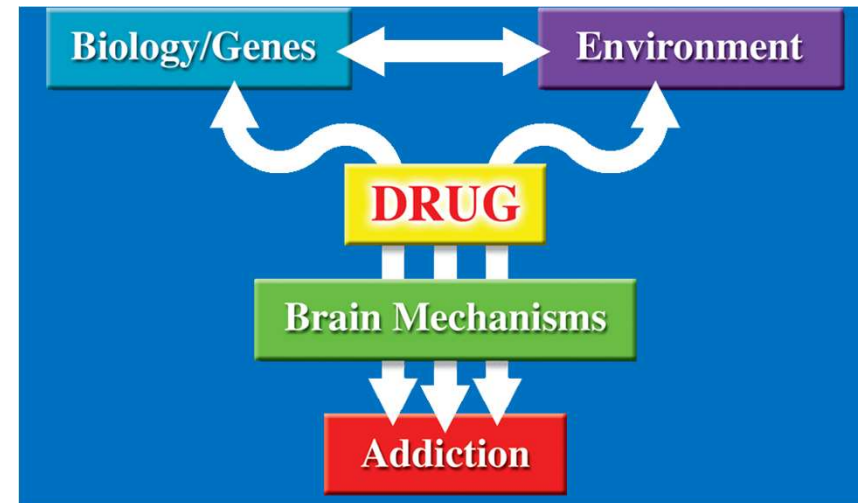
- 50-90% with history of childhood physical or sexual abuse

## Violence

- 60-80% past year intimate partner violence

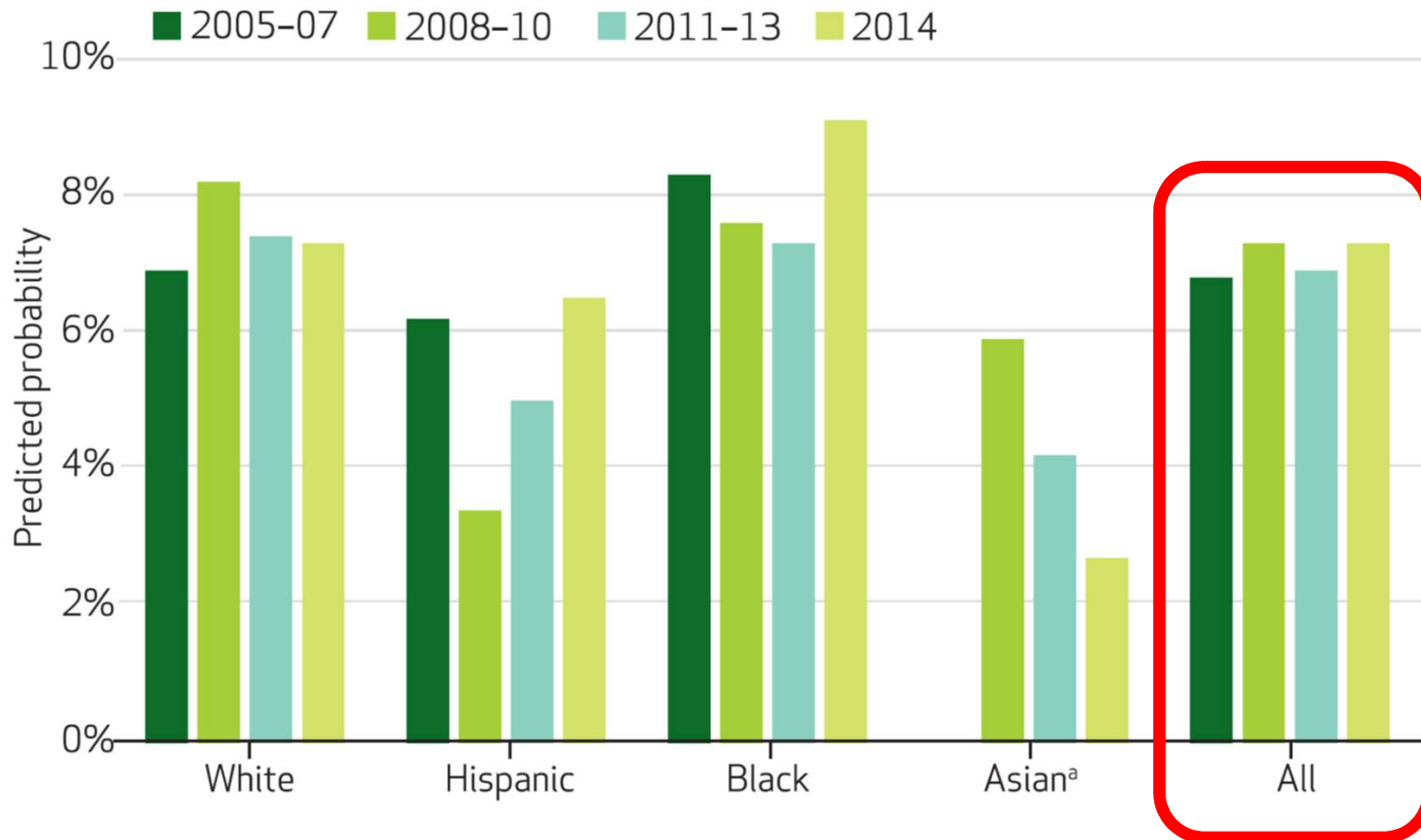
## Low social support

- 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**

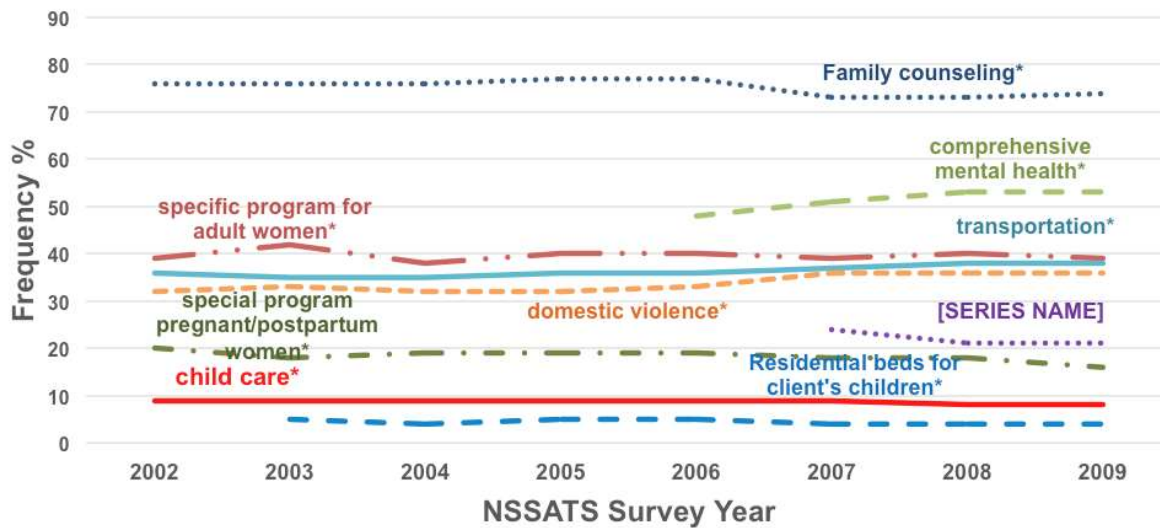


Creedon Health Aff (Millwood) 2016



# SUBSTANCE USE DISORDER TREATMENT NEED AND RECEIPT AMONG WOMEN, 2007-2014 NSDUH

	TOTAL	NOT PREGNANT, NOT PARENTING (%)	PREGNANT (%)			PARENTING (OWN CHILD <18 IN HOUSEHOLD) (%)	P
			1ST TRIMESTER	2ND TRIMESTER	3RD TRIMESTER		
PAST YEAR SUBSTANCE USE DISORDER TREATMENT NEED	9.4	13.9	7.6			5.8	<.0001
			9.5	7.7	5.7		0.0060
RECEIVED PAST YEAR TREATMENT (% OF NEED MET)	9.3	8.8	12.8			9.9	0.0634
			12.5	9.4	18.7		0.2459



Overall provision of women-centered services in drug treatment facilities declined 2002-2009 (43%-40%,  $p < 0.001$ )

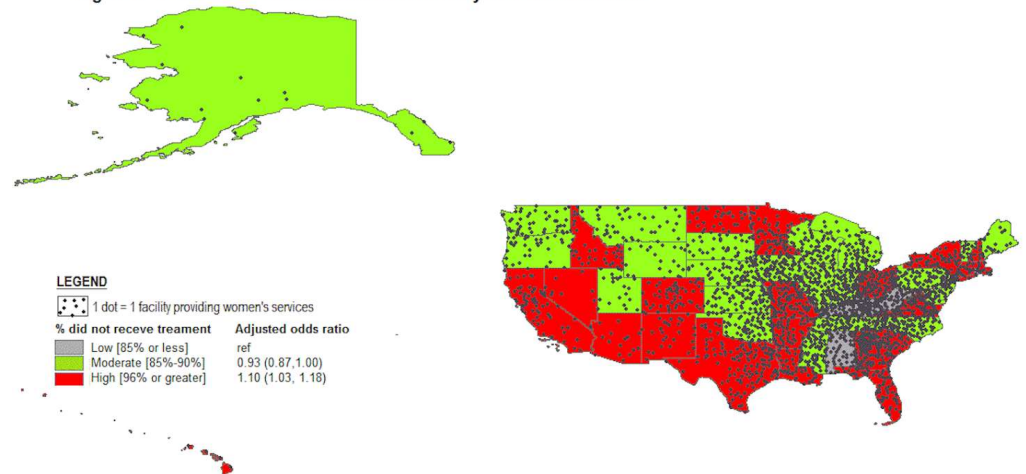
AJPH 2015

## Women-Centered Drug Treatment Services and Need in the United States, 2002–2009

Mishka Terplan, MD, MPH, Nyaradzo Longinaker, MS, and Lindsay Appel, MD

# Treatment Gap Greater for Women

Figure 2. Facilities that offer women's services by State treatment need



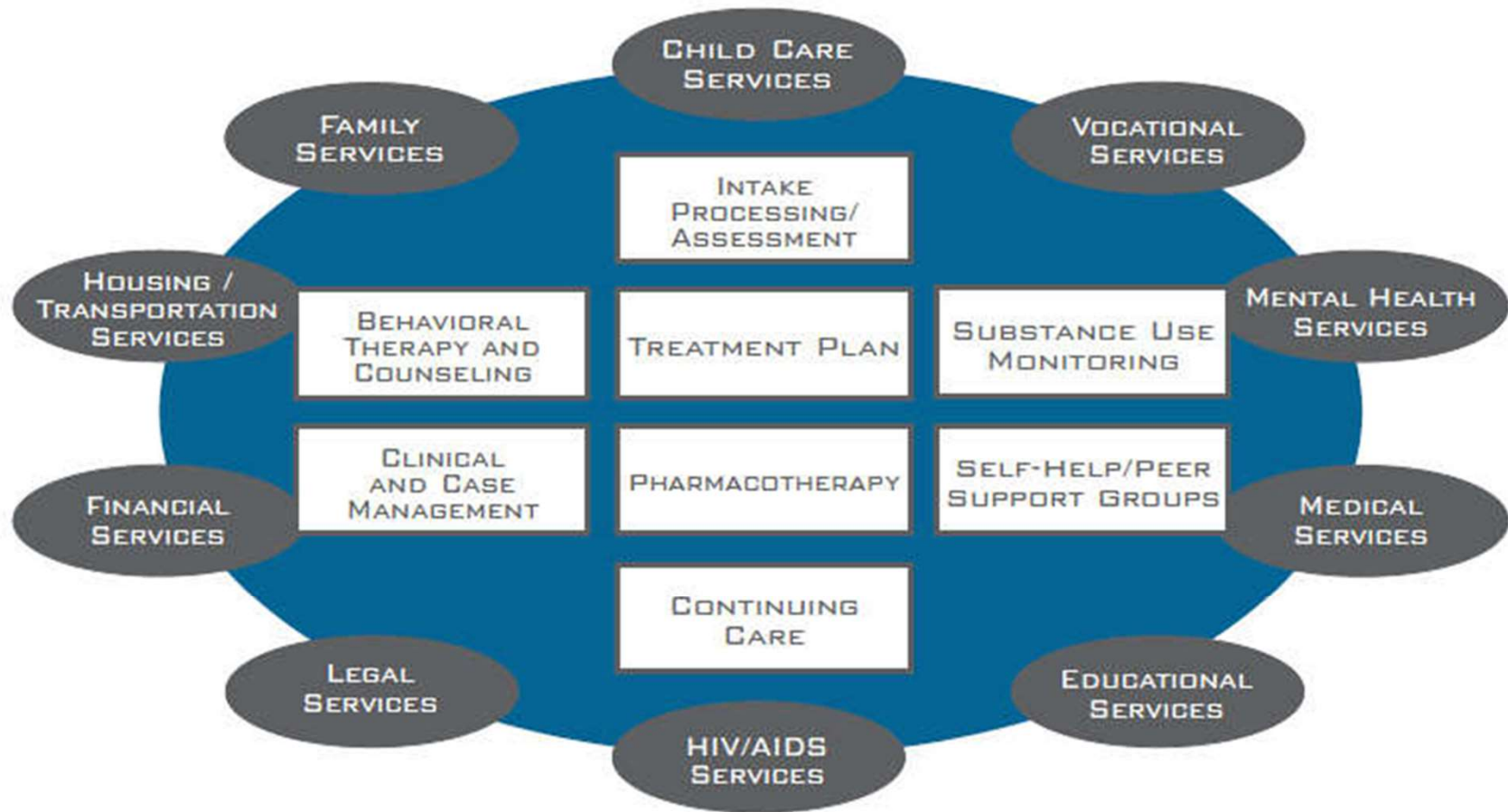
## Barriers encountered receiving past year substance use disorder treatment among those with current need: 2015-2017 NSDUH

	Total	Women 34.2% (32.5, 36.0)	Men 65.8% (32.5, 36.0)	P <.0001
Couldn't afford/ no insurance; insurance didn't cover cost	4.2% (3.4, 5.0)	5.6% (4.0, 7.1)	3.5% (2.6, 4.3)	0.0074
No transportation; didn't have time	1.8% (1.4, 2.3)	3.2% (2.1, 4.4)	1.1% (0.7, 1.5)	<.0001
Desired treatment not offered; no openings in program	1.6% (1.1, 2.1)	2.3% (1.3, 3.3)	1.2% (0.5, 1.8)	0.0521
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	6.9% (5.9, 7.8)	8.1% (6.1, 10.1)	6.2% (6.1, 7.3)	0.0829
Felt treatment would have negative effect on job; didn't want others to find out	2.0% (1.6, 2.5)	2.9% (1.9, 4.0)	1.6% (1.0, 2.2)	0.0461
Didn't know where to go / Other	2.5% (1.8, 3.1)	3.9% (2.5, 5.3)	1.7% (1.1, 2.3)	0.0007



# EVIDENCE BASED TREATMENT FOR SUBSTANCE USE DISORDER

## *Components of Comprehensive Drug Abuse Treatment*

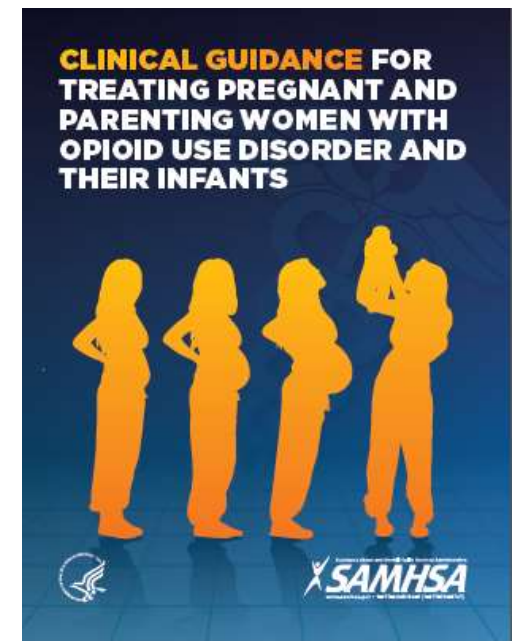


*The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.*

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



**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*

140

Annals New York Academy of Sciences

TABLE 2  
 OBSTETRICAL COMPLICATIONS IN 367 DRUG-DEPENDENT WOMEN  
 AND 215 CONTROLS; FAMILY CENTER PROGRAM, 1969-1976

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

LOW BIRTH WEIGHT	Prenatal Care	No Prenatal Care
No drug use	14%	19%
Drug Use	19%	48%



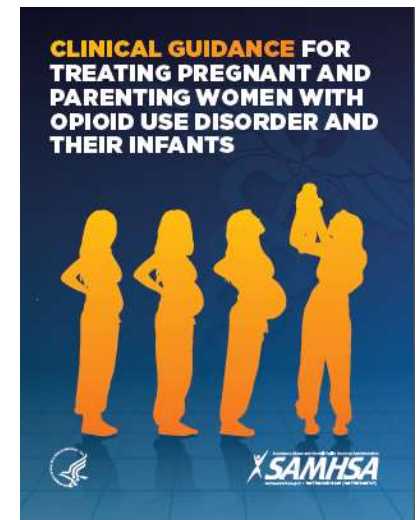
## The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck<sup>1</sup> · Erika R. Cheng<sup>2</sup> · Candice Belanoff<sup>3</sup> · Howard J. Cabral<sup>3</sup> ·  
Hermik Babakhanlou-Chase<sup>4</sup> · Taletha M. Derrington<sup>5</sup> · Hafsatou Diop<sup>6</sup> ·  
Stephen R. Evans<sup>3</sup> · Judith Bernstein<sup>3</sup>

	No Addiction	Treated Addiction	Untreated Addiction
Preterm Birth	8.7%	10.1%	19.0%
Low Birthweight	5.5%	7.8%	18.0
Fetal Death	0.4%	0.5%	0.8%
Neonatal Mortality	0.4%	0.4%	1.2%
Post Neonatal Mortality	0.05%	0.03%	0.1%

# OPIOID USE DISORDER (OUD) SAMHSA CLINICAL GUIDE RECOMMENDATIONS

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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

# 2018 SYSTEMATIC REVIEW: TERPLAN ET AL.

*“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”*

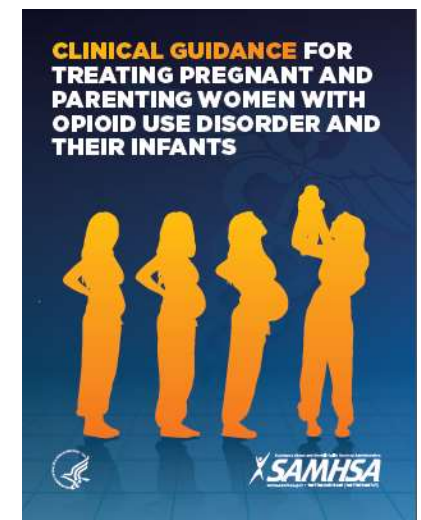
Detoxification leads to:

- 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

Terplan M, Laird HJ, Hand DJ, Wright TE, Premkumar A, Martin CE, Meyer MC, Jones HE, Krans EE. Opioid Detoxification During Pregnancy: A Systematic Review. *Obstet Gynecol.* 2018 May;131(5):803-814.

# OPIOID USE DISORDER (OUD) SAMHSA CLINICAL GUIDE RECOMMENDATIONS

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<http://store.samhsa.gov/product/SMA18-5054>

# PHARMACOTHERAPY FOR OPIOID USE DISORDER

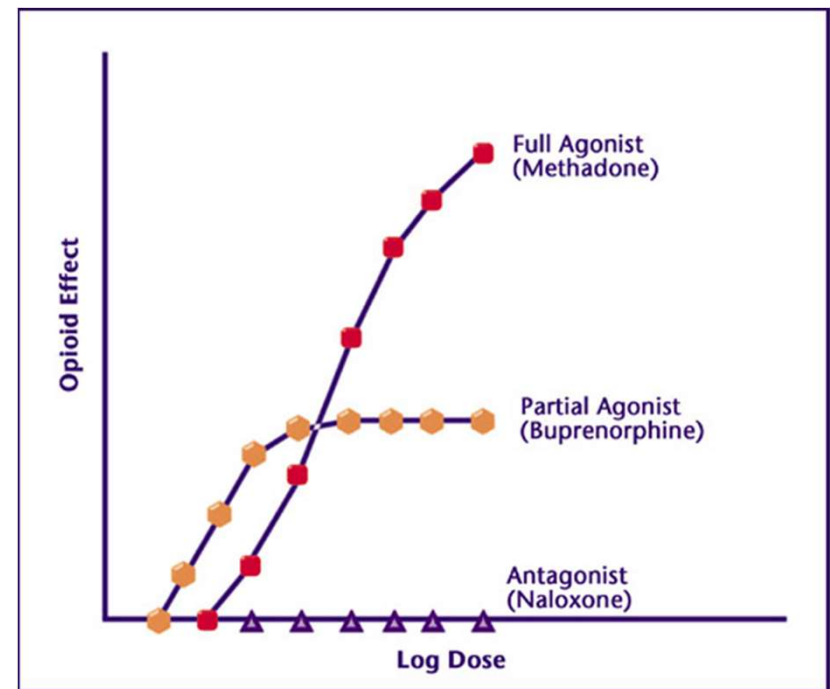
## Opioid Receptor Activation

### Medication

Methadone

Buprenorphine  
(Subutex/Suboxone)

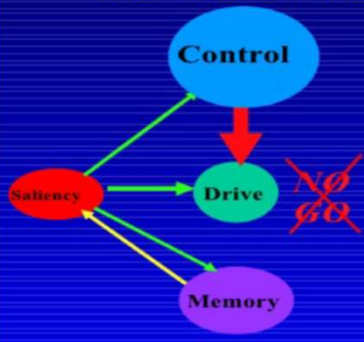
Naltrexone (Vivitrol)



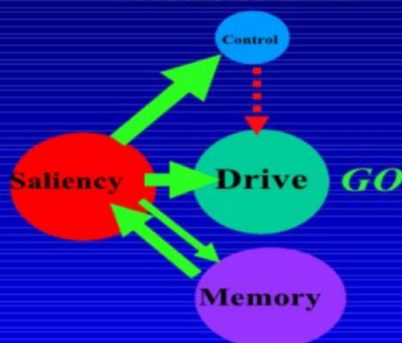
# TREATMENT & PHARMACOTHERAPY TREAT THE BRAIN DISEASE OF ADDICTION

## Why Can't Addicts Just Quit?

Non-Addicted Brain



Addicted Brain



*Because Addiction Changes Brain Circuits*

Adapted from Volkow et al., Neuropharmacology.

NIDA

## Basic Research → Medication

Opiate agonists stabilize brain function in heroin addicts

**Agonist Therapy**  
Methadone  
Buprenorphine

CB1 KO mice have decreased responses to multiple drugs of abuse

**CB1 Antagonists**

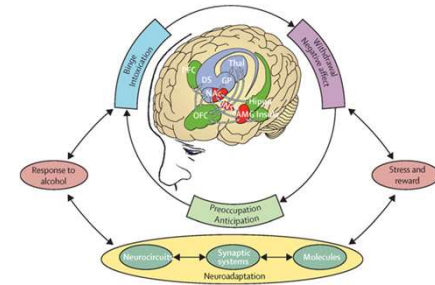
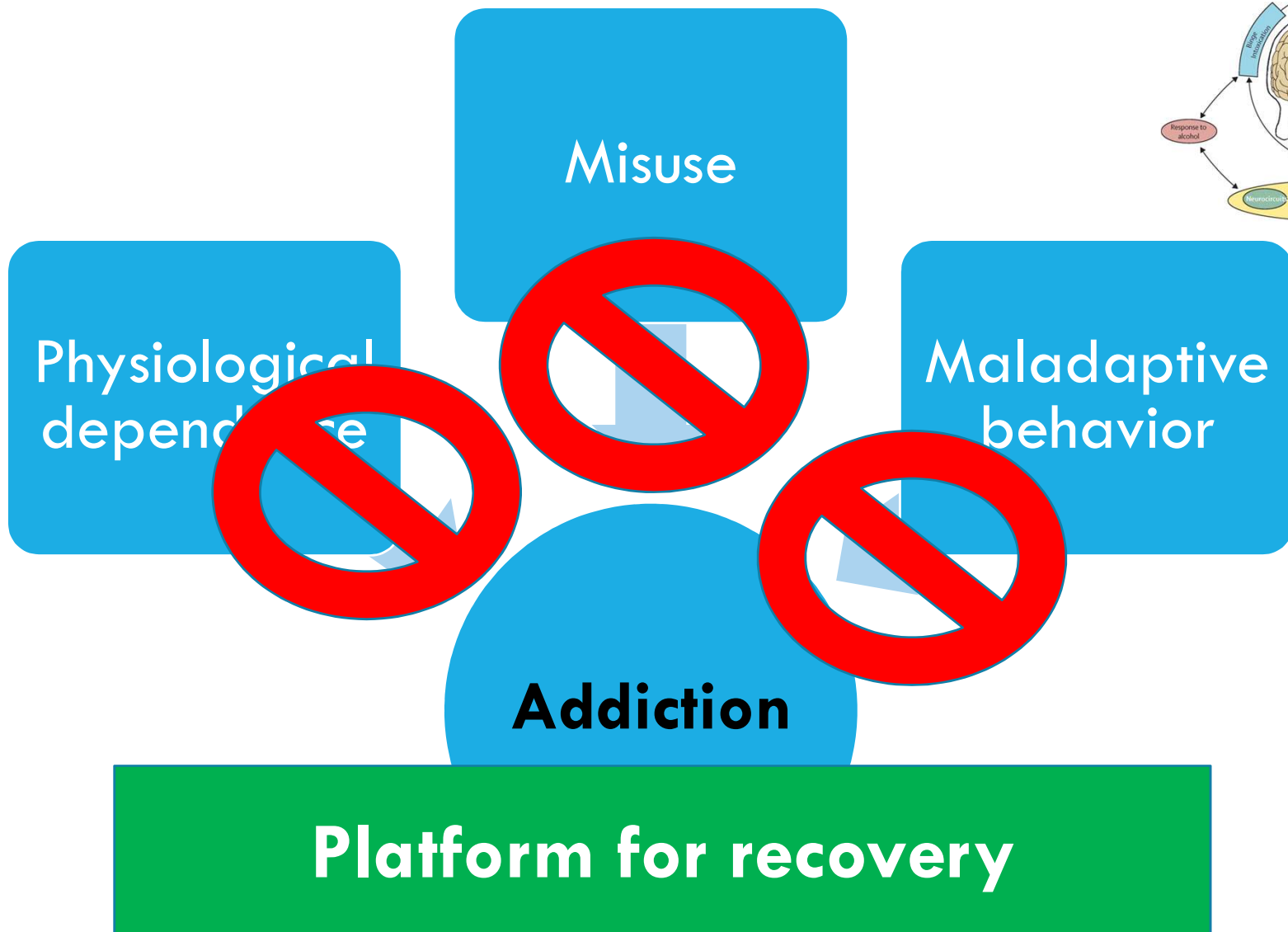
Smokers who are poor nicotine metabolizers smoke less

**Inhibitors of metabolizing enzymes**

Stress triggers relapse in animal models of addiction and CRF antagonists interfere with the response to stress

**CRF Antagonists**

NIDA





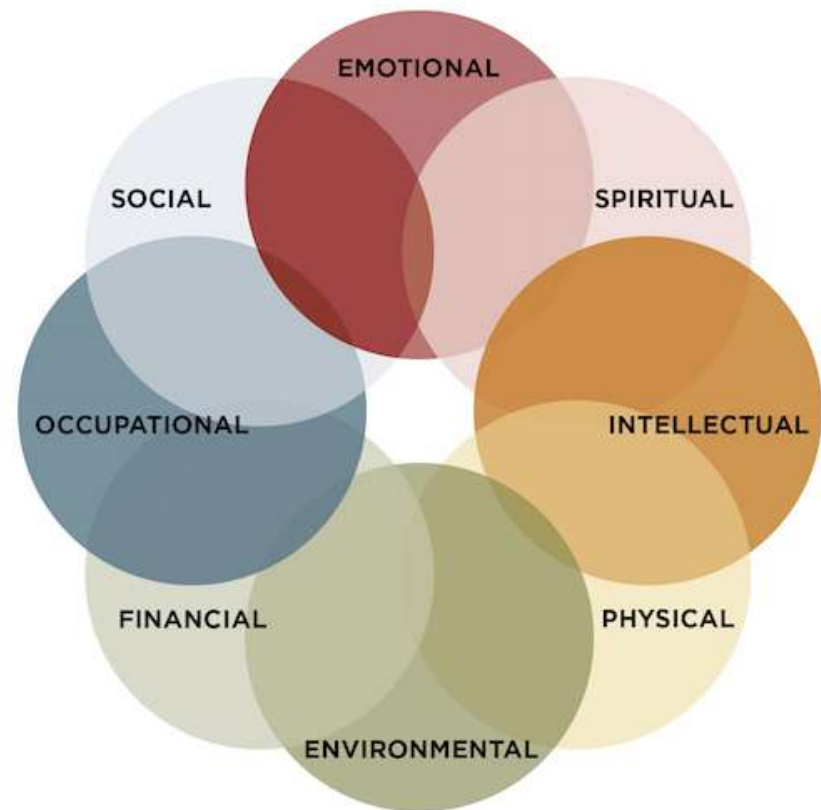


**THE GOAL OF TREATMENT IS RECOVERY NOT  
MORE TREATMENT**

# SAMHSA's WORKING DEFINITION OF RECOVERY



10 GUIDING PRINCIPLES OF RECOVERY

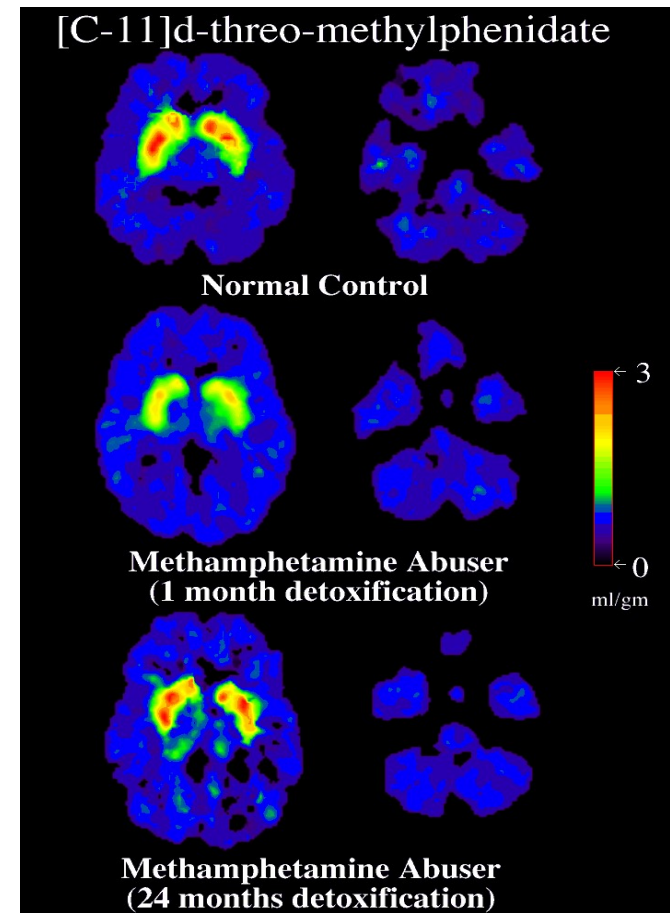


WELLNESS

# RECOVERY LEADS TO RETURN OF NORMAL BRAIN STRUCTURE AND FUNCTION

*DAT Recovery  
with prolonged  
abstinence from  
methamphetamine*

*Volkow et al., J. Neuroscience, 2001.*



# RECOVERY CAN BE ACHIEVED WITH THE USE OF MEDICATIONS



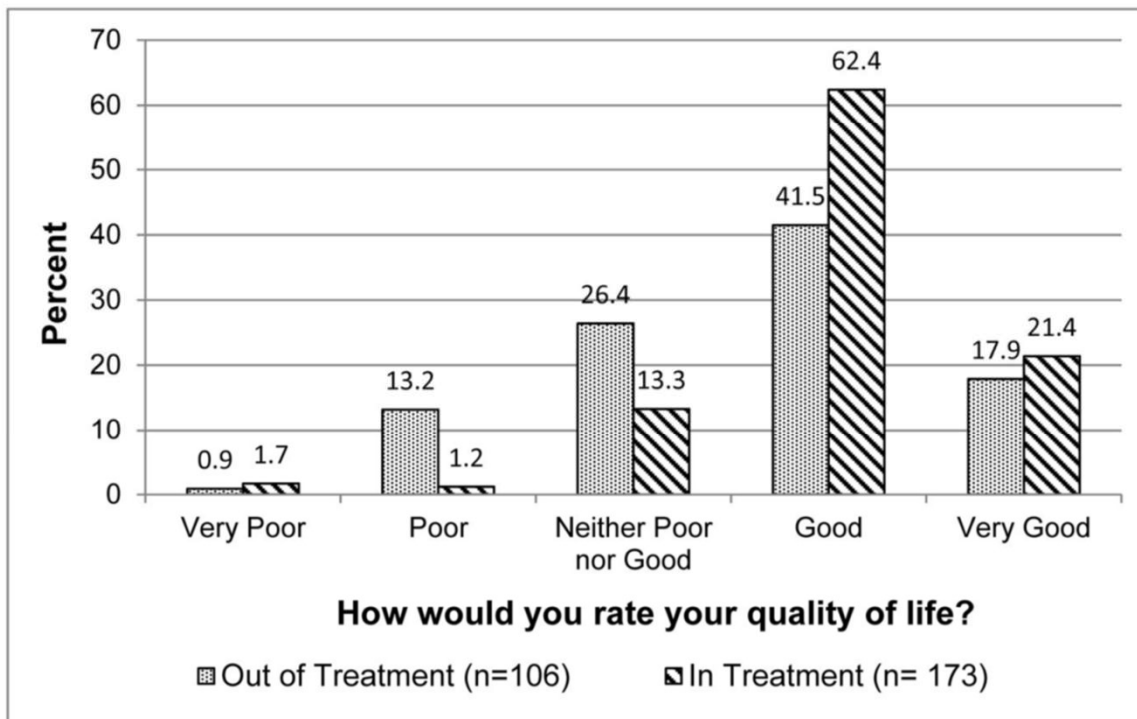
**HHS Public Access**

Author manuscript

*J Psychoactive Drugs*. Author manuscript; available in PMC 2015 May 08.

Published in final edited form as:

*J Psychoactive Drugs*. 2015 ; 47(2): 149–157. doi:10.1080/02791072.2015.1014948.

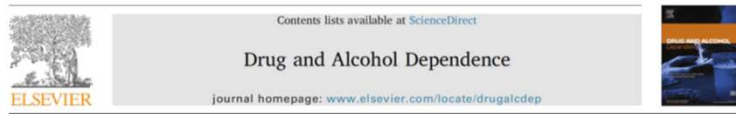
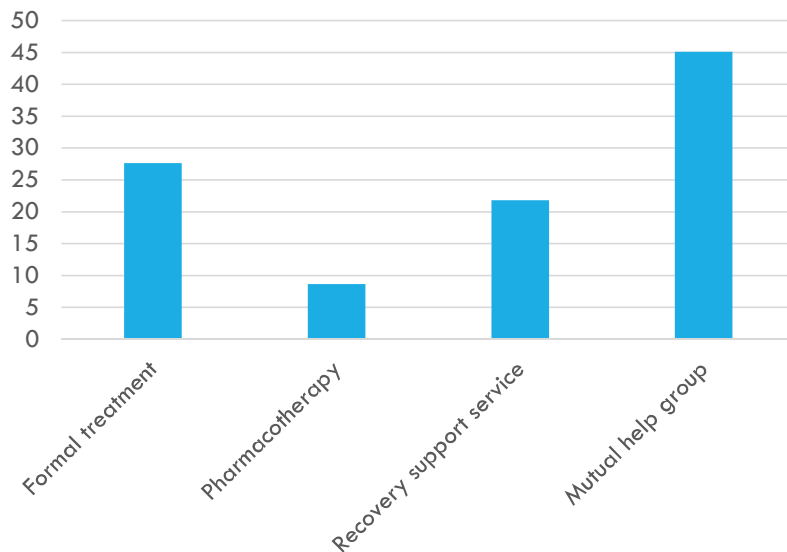


## Changes in Quality of Life following Buprenorphine Treatment: Relationship with Treatment Retention and Illicit Opioid Use

Shannon Gwin Mitchell, Ph.D.<sup>a</sup>, Jan Gryczynski, Ph.D.<sup>b</sup>, Robert P. Schwartz, M.D.<sup>c</sup>, C. Patrick Myers, M.A.<sup>e</sup>, Kevin E. O'Grady, Ph.D.<sup>f</sup>, Yngvild K. Olsen, M.D.<sup>g</sup>, and Jerome H. Jaffe, M.D.<sup>d</sup>

# THERE ARE MANY PATHWAYS TO RECOVERY

National Recovery Survey (N=25,229)



Full length article

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

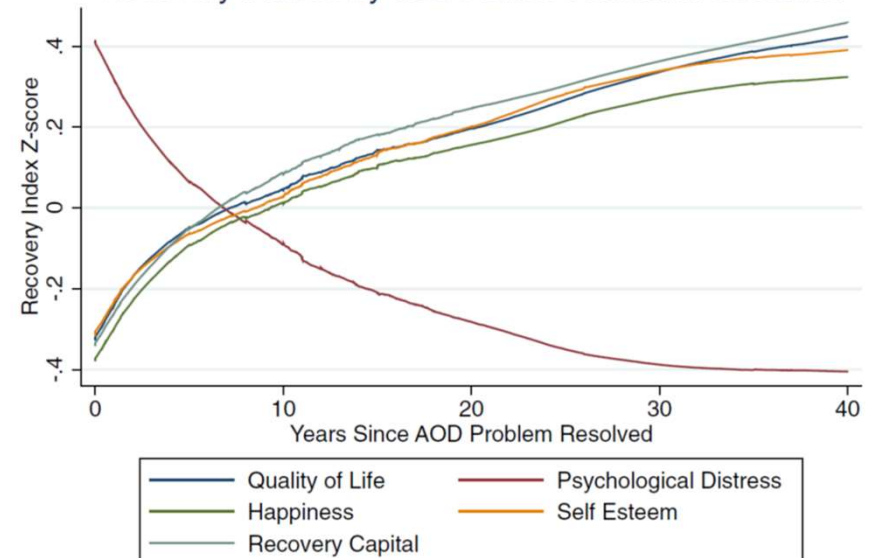
John F. Kelly<sup>a,\*</sup>, Brandon Bergman<sup>a</sup>, Bettina B. Hoepfner<sup>a</sup>, Corrie Vilsaint<sup>a</sup>, William L. White<sup>b</sup>



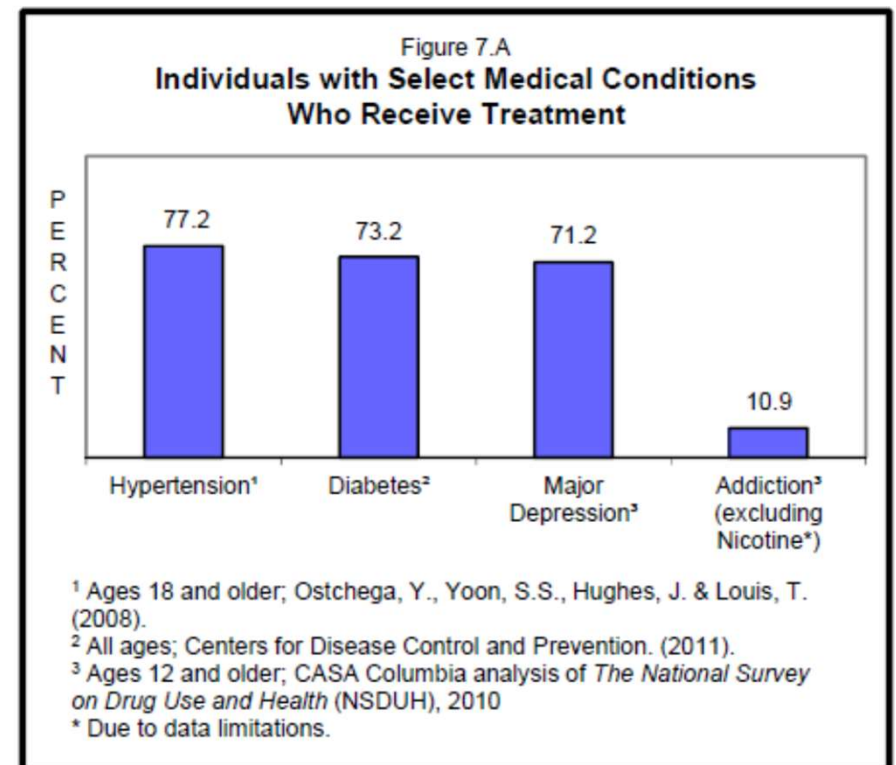
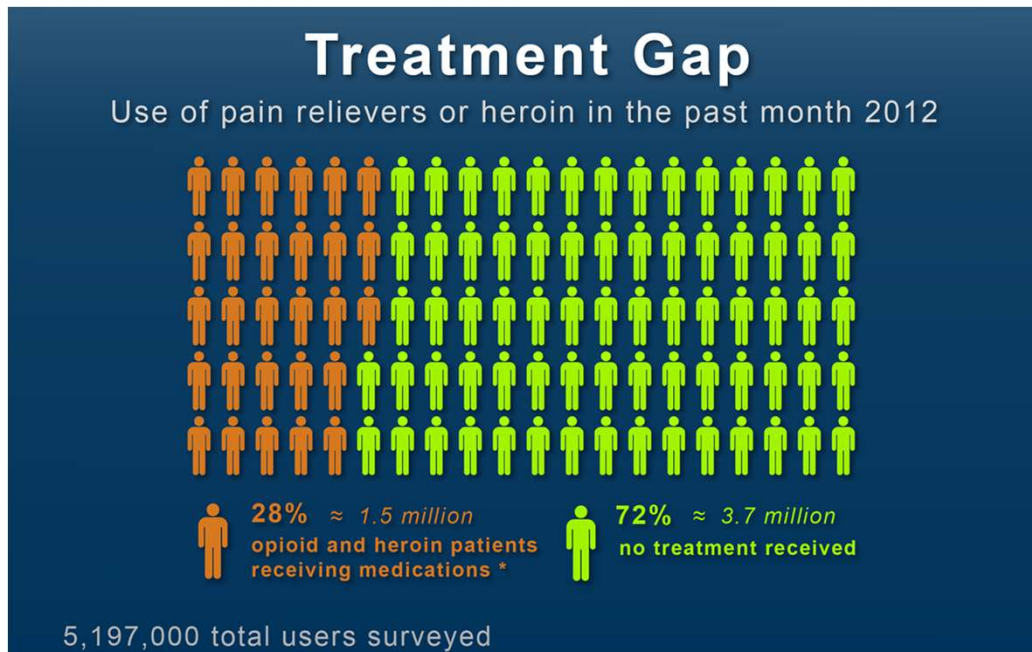
## Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults

John F. Kelly , M. Claire Greene, and Brandon G. Bergman

### Recovery Indices by Years Since Problem Resolution

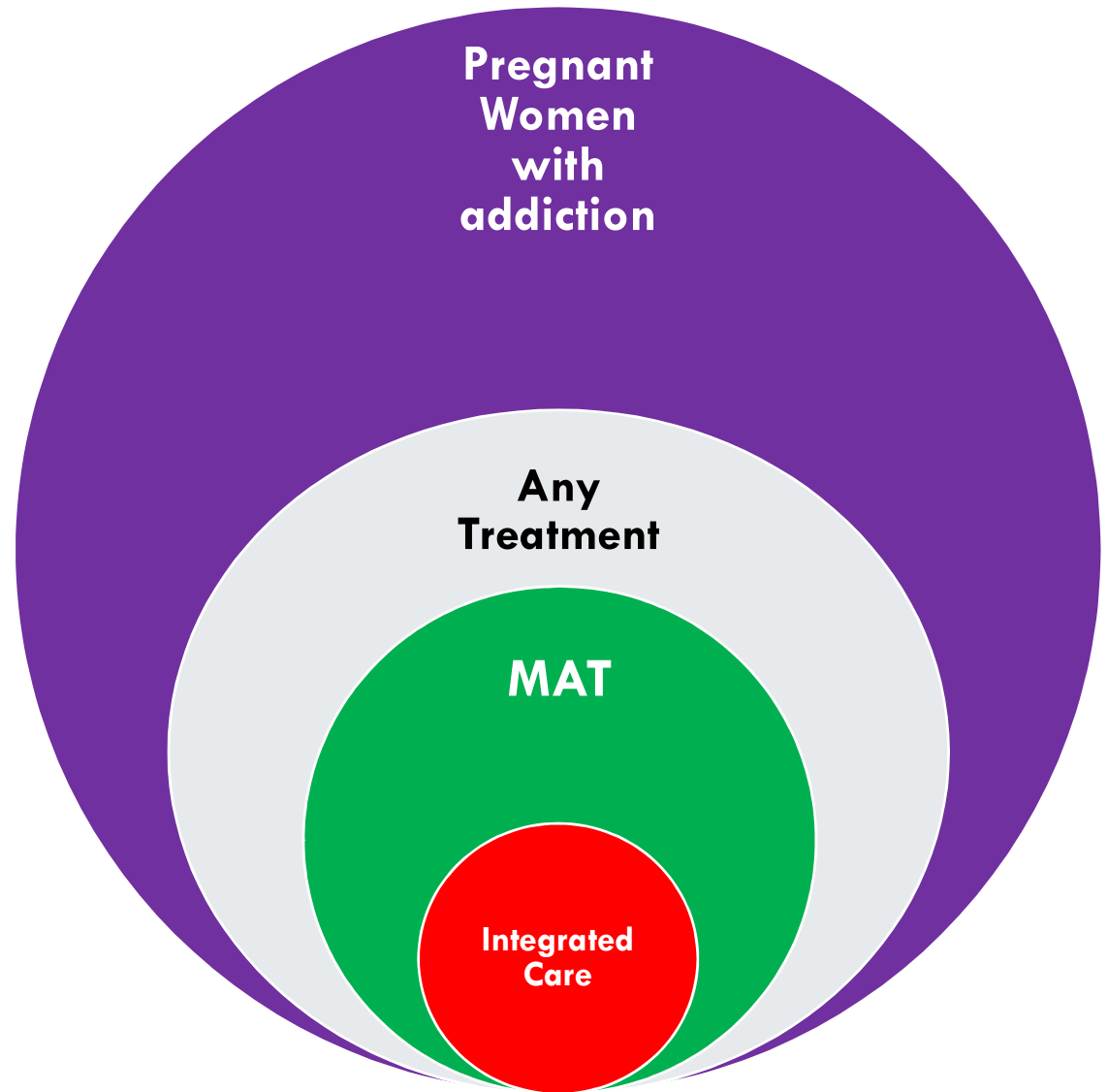


# TREATMENT WORKS BUT MOST INDIVIDUALS WITH ADDICTION DON'T RECEIVE ANY FORMAL TREATMENT



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)**



# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

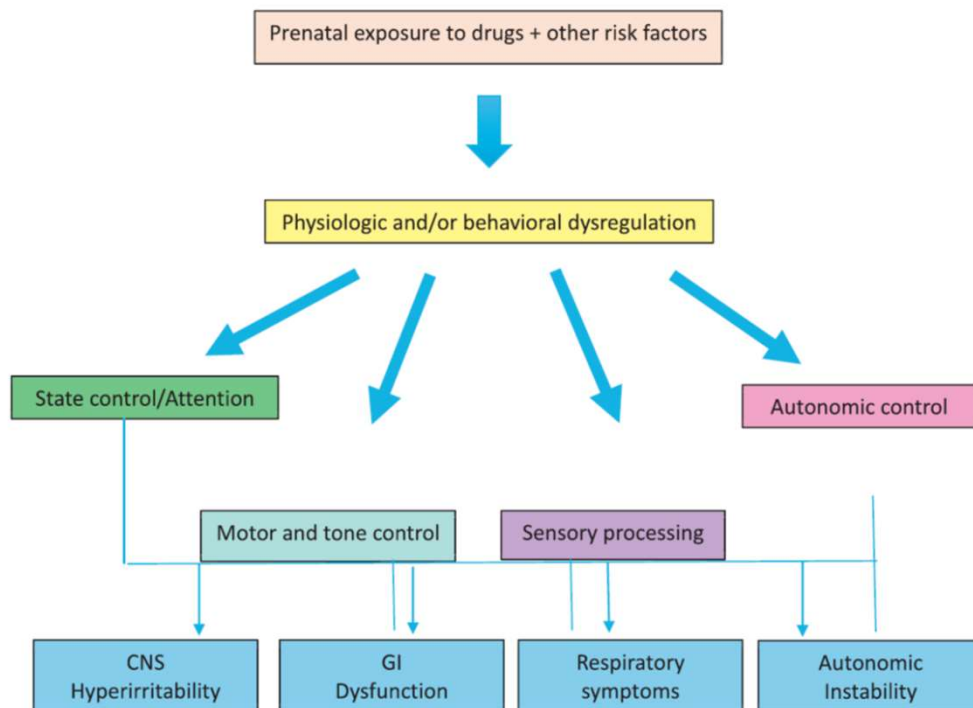
*“Neonatal abstinence syndrome includes a combination of physiologic and neurobehavioral signs that include such things as sweating, irritability, increased muscle tone and activity, feeding problems, diarrhea, and seizures. Infants with neonatal abstinence syndrome often require prolonged hospitalization 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



Jansson & Patrick. *Pediatr Clin N Am* 66 (2019) 353–367

Table 1

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

## Maternal Factors

Illicit substance use:  
heroin, cocaine,  
marijuana

In general, polysubstance exposure alters NAS expression by increasing its severity, or causes neurobehavioral signs consistent with a withdrawal phenomenon.<sup>10</sup>

Licit substance  
use/misuse: oxycodone,  
benzodiazepines,  
gabapentin, nicotine

Oxycodone and benzodiazepines increase NAS expression.<sup>11–13</sup> Gabapentin produces an atypical NAS display.<sup>14</sup> Cigarette smoking can increase NAS severity.<sup>15,16</sup>

Licit medications:  
psychotropics, OUD  
treatment medications  
(eg, methadone,  
buprenorphine)

Psychotropic exposure can alter or increase NAS display.<sup>17</sup> 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.

Genetics/epigenetics

Infants with particular genotypes (SNPs) at the OPRM1 and COMT gene sites had less severe NAS expression.<sup>18</sup> Hypermethylation at the same sites was associated with more severe NAS, consistent with gene silencing.<sup>19</sup>

Breastfeeding

Can reduce NAS severity.<sup>20</sup>

## Infant factors

Sex

Male infants have been reported to have more severe NAS expression.<sup>21,22</sup>

Gestational age

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).<sup>23</sup>

Fetal programming

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.<sup>22</sup> Alterations from these changes may not be evident until the affected neurosystem matures, potentially later in life.<sup>24</sup>

## Environmental factors

Physical environment

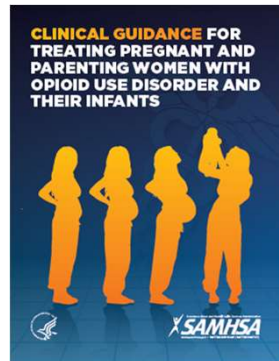
NICU care can exacerbate NAS severity, while maternal rooming-in can reduce NAS severity.<sup>25,26</sup>

Caregiver (parent or  
medical staff) handling  
and communication

Misinterpretation of or inappropriate responses to infant cues or insensitive handling can exacerbate NAS expression.<sup>27</sup>

# 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

Jones & Fielder, *Preventive Medicine*, 2015.



# THE FOURTH TRIMESTER

# SUBSTANCE USE RECURRENCE OCCURS OFTEN POSTPARTUM

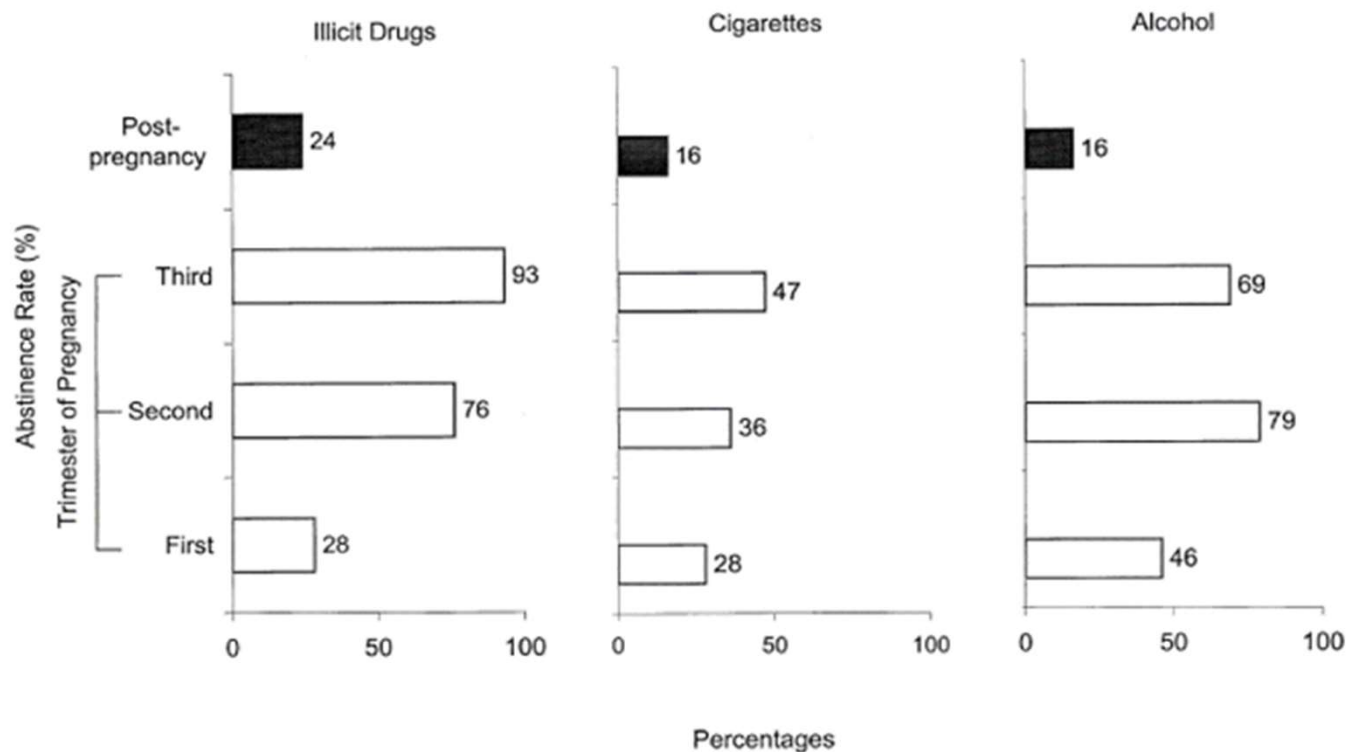
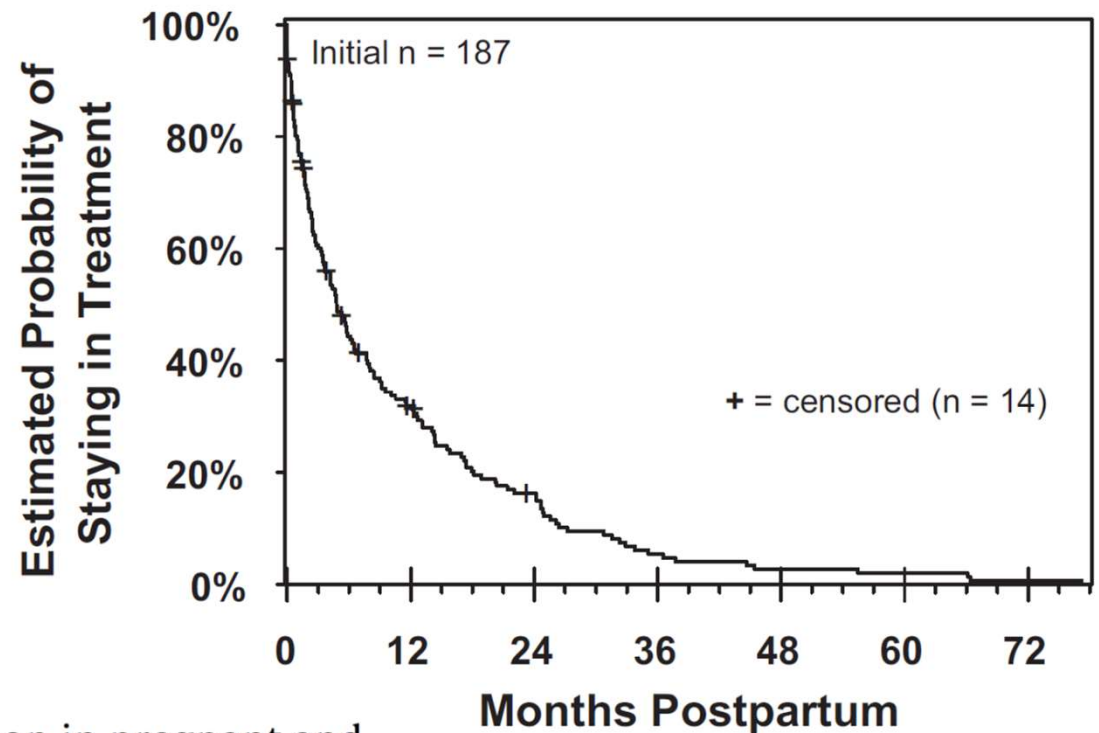


Figure 1. Relative proportion of substance-using women who abstained during and after pregnancy.

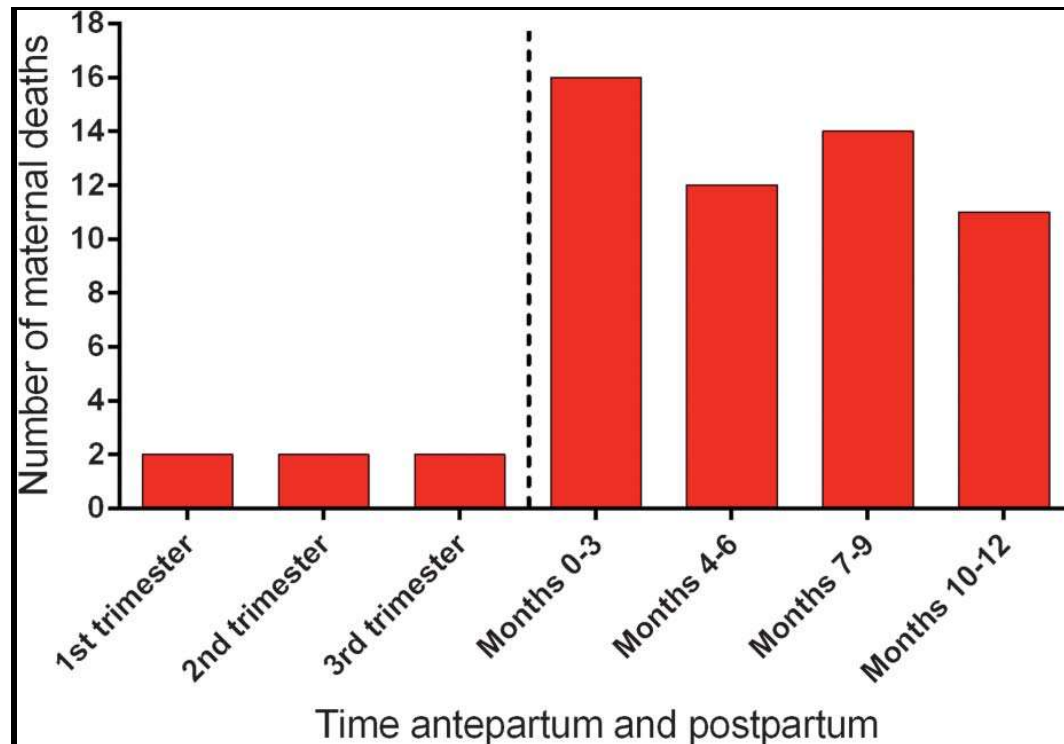
# MANY WOMEN ARE LOST TO ADDICTION CARE POSTPARTUM



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

Christine Wilder<sup>a,b,\*</sup>, Daniel Lewis<sup>a</sup>, Theresa Winhusen<sup>a</sup>





## TIMING OF MATERNAL DEATHS POSTPARTUM

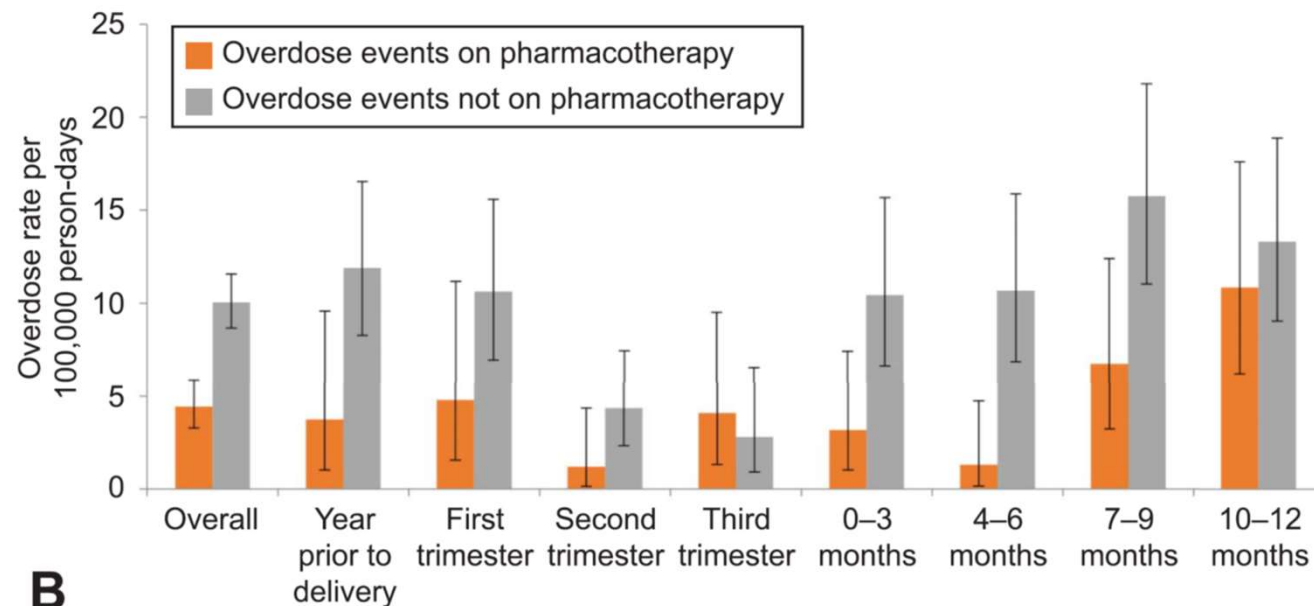
COLORADO MMR DUE TO OVERDOSE =  
5/100000  
(42% PRESCRIPTION OPIOIDS)

>50% did not attend  
postpartum visit

Only 6 had documented  
treatment

# Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

*David 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*

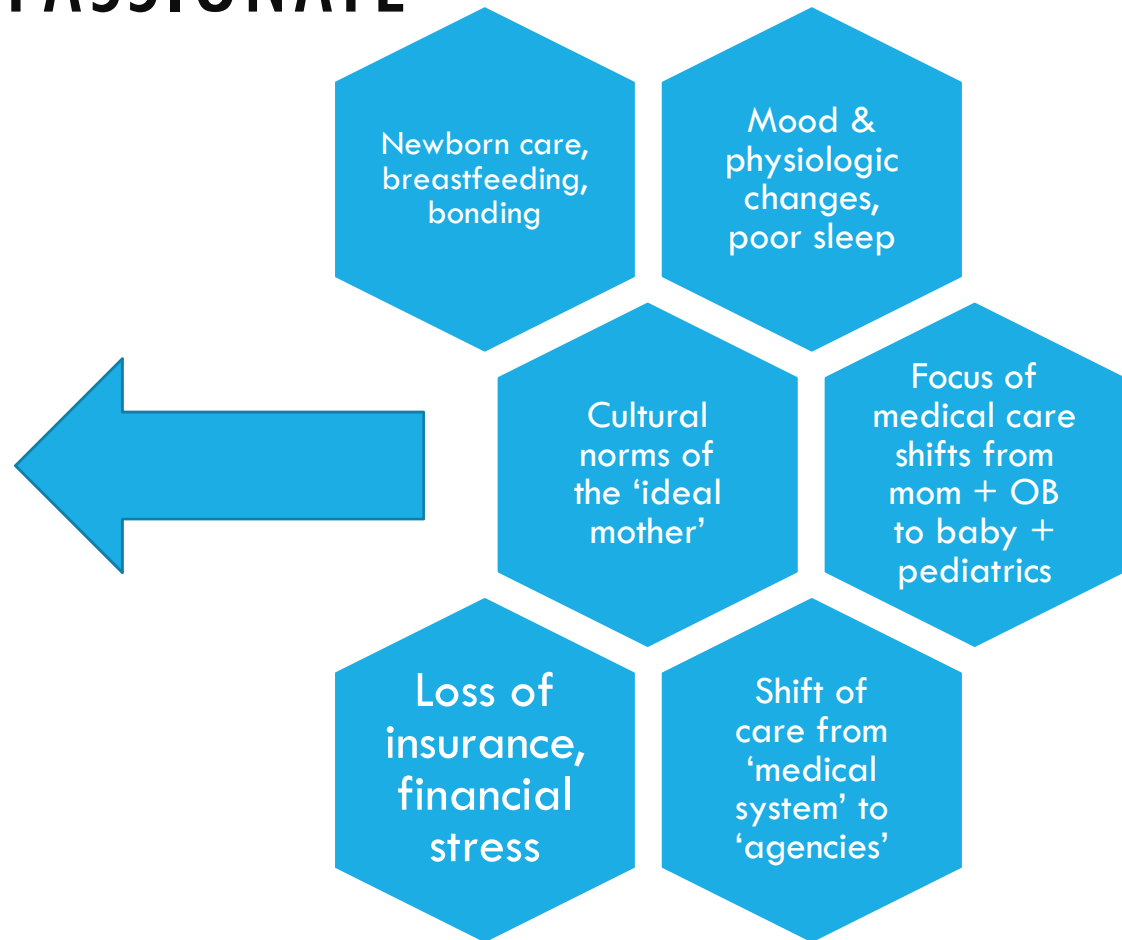


Schiff (Obstetrics & Gynecology) 2018

# CONTINUOUS COMPASSIONATE CARE IS KEY



**Gaps in substance  
use disorder  
treatment**





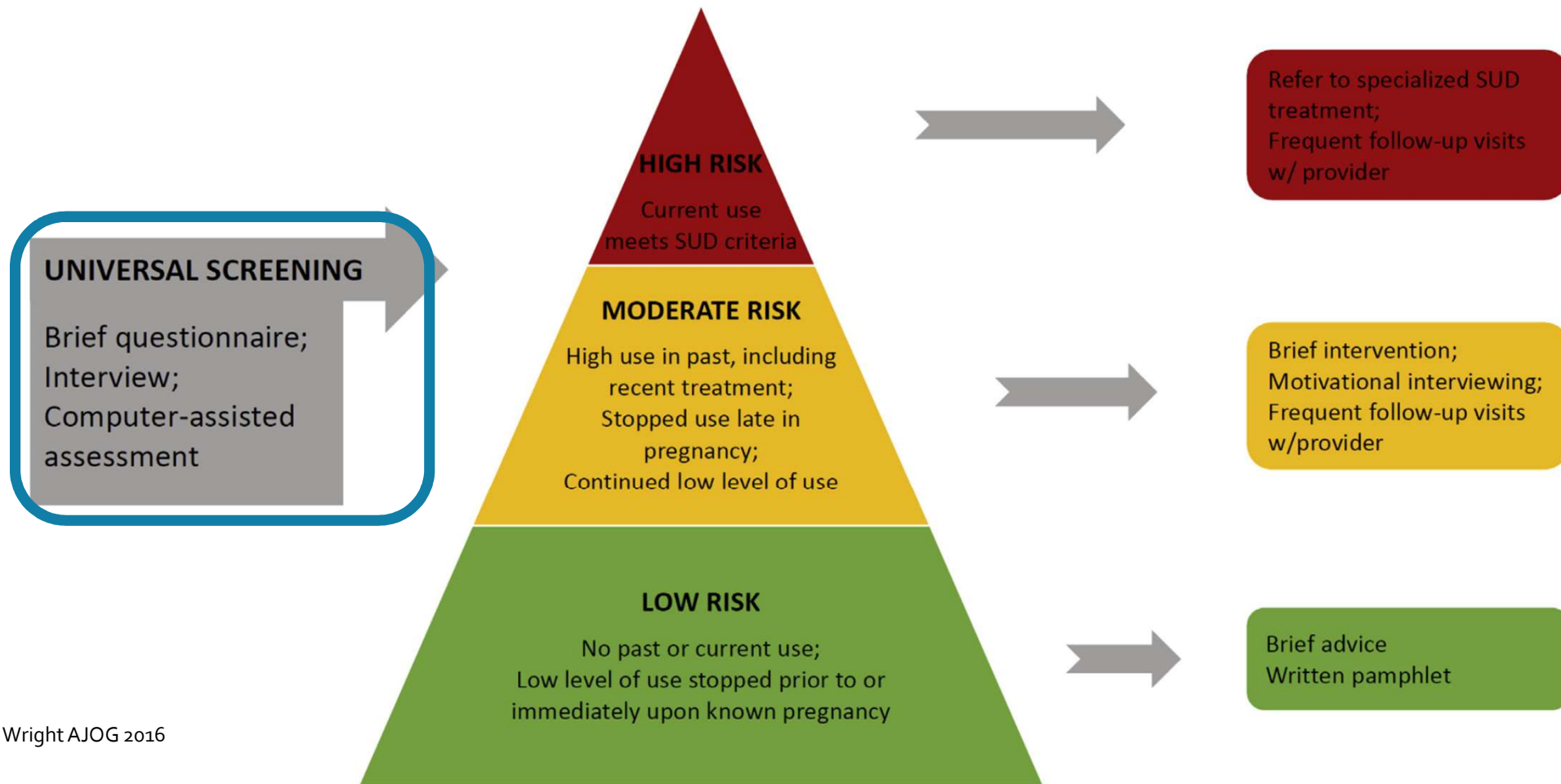
# SOLUTIONS



## **SOLUTION #1: FACILITATE EARLY LINKAGE TO TREATMENT**

**FIGURE 1**

**Risk pyramid for assessment of substance use during pregnancy**



# SCREENING INVOLVES A CONVERSATION, NOT A TEST

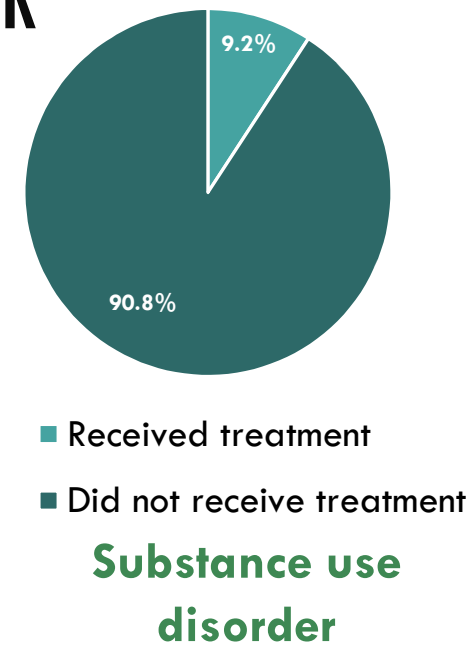
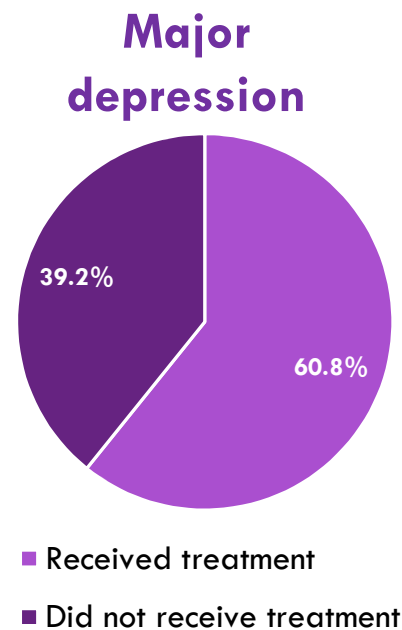
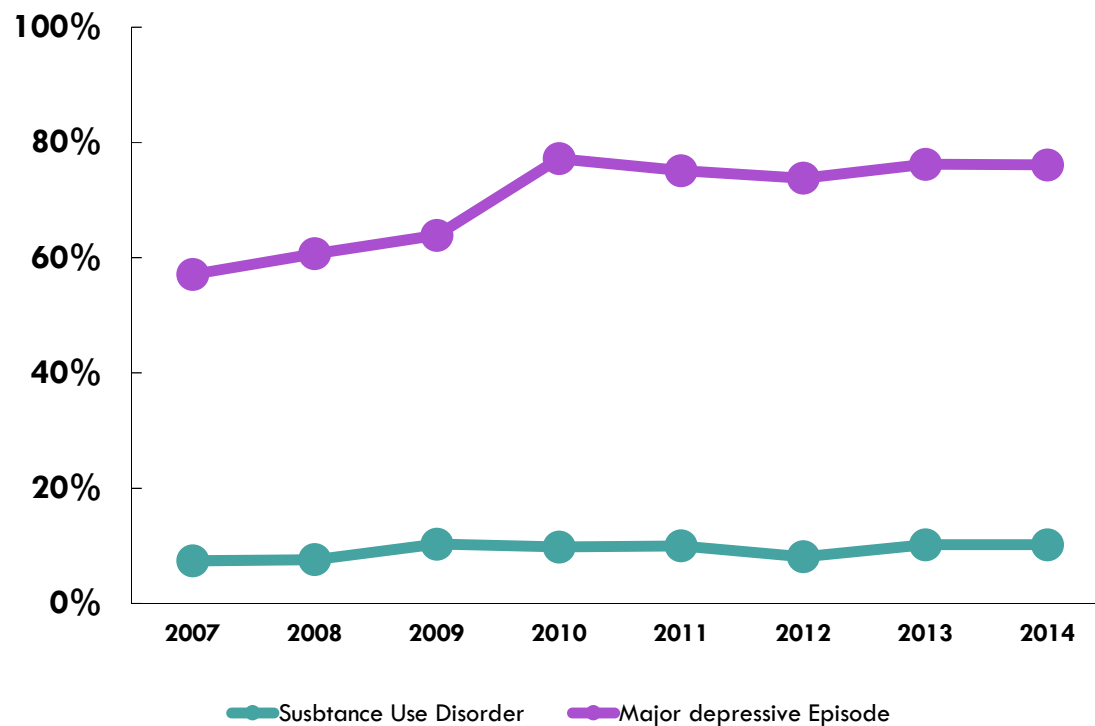
- It is not a parenting test
- Toxicology tests for drugs are not sufficient for a diagnosis of a substance use disorder
- Having a substance use disorder is only one of many other factors in determining child safety



- 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.**

# DEPRESSION AND SUBSTANCE USE DISORDER TREATMENT RECEIPT, 2007-2014 NSDUH





Vox



## 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](mailto:german.lopez@vox.com) | May 10, 2018, 6:00am EDT

Photographs by Julia Rendleman | Charts by Christina Animashaun

Fawn Ricciuti, 33, plays with her son Aiden, 5, in the yard of her home outside of Richmond, Virginia.

## **SOLUTION #2: FIGHT STIGMA, DISCRIMINATION AND PREJUDICE**

## A parent's heroin addiction, a newborn's death sentence



Nicole Beltrame with her 18-month-old daughter, Nevaeh, with whom she was recently reunited. Beltrame became addicted to painkillers after a bad car accident, but she's off the drugs now and pregnant again, with her baby due this month.

Mike De Sisti

By Crocker Stephenson of the Journal Sentinel

Nov. 14, 2014

Tweet 24

Recommend 222

+1 2

EMAIL PRINT (0) COMMENTS

### Photo Gallery



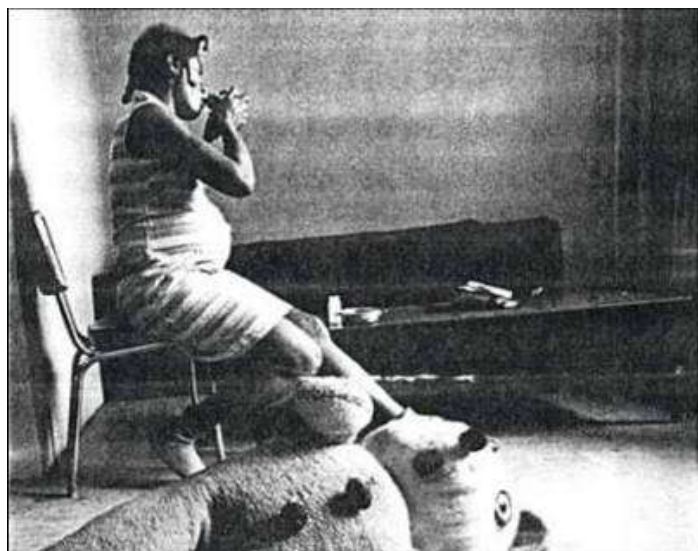
No bystander could be more innocent. No damage so helplessly collateral.

Trysten Jacob Powell, delivered by C-section at Wheaton Franciscan-St. Joseph hospital on March 28, 2013, lived three months.

f of his life was spent in St. Joe's neonatal intensive care unit,

No bystander could be more innocent. No damage so helplessly collateral.





# Crack Babies: The Worst Threat Is Mom Herself

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By Douglas J. Besharov

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**L**AST 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

Stigmatizing Words	Preferred Words
Addict, Abuser, Junkie	Person in active addiction, person with a substance misuse disorder, person experiencing an alcohol/drug problem, patient
User	person who misuses alcohol/ Drugs or person engaged in risky use of substances
Abuse	Misuse, harmful use, inappropriate use, hazardous use, problem use, risky use
Clean, Dirty	Negative, positive, substance-free
Habit or Drug Habit	Substance misuse disorder, alcohol and drug disorder, alcohol and drug disease, active addiction
Replacement or Substitution Therapy	Treatment, medication-assisted treatment, medication

The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L. White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04



## **SOLUTION #3: ADVOCATE FOR COMPASSIONATE CARE FOR FAMILIES WITH ADDICTION**



# Obstetric Care for Women with Opioid Use Disorder

# 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.





[Caitlin.Martin@VCUhealth.org](mailto:Caitlin.Martin@VCUhealth.org)

<https://women.smokefree.gov/>

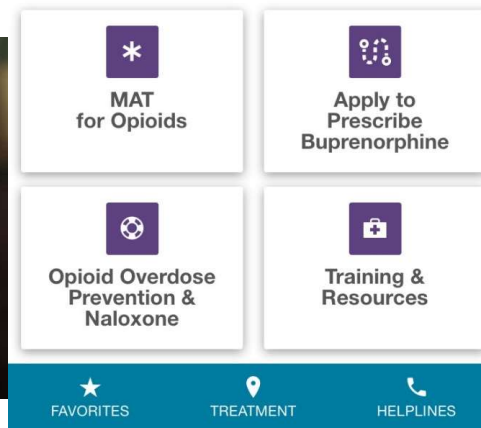


<https://www.rethinkingdrinking.niaaa.nih.gov/>

# THANK YOU!



Clinical resources for health care practitioners to use in medication-assisted treatment (MAT) for substance use disorders.



Search



quitSTART -  
Quit Smoking  
ICF International

GET

4.0 ★★★★★  
21 Ratings

12+  
Age

