Pregnant Women, Infants and the Opioid Crisis

Maternity Care Coalition
Fall Public Policy Forum
Welcome

Omar Woodard
Join the conversation

Visit the website Sli.do and enter the code #7011 to ask or answer a question.
When posting to social media, use the event hashtag:

#MCCopioidcrisisPHL
Program

Cathleen Palm
Kellie Phelan
Program Coordinator, Hour Friends in Deed Mentoring Program

“A Real Life Perspective: Opioids and its Impact on Families”
Kellie Phelan’s Story

Kelly Phelan
Hour Children, Coordinator Mentor Program
Mother of Brittany 17 and Savannah 4
Repeat Offender
Kim McLaughlin, LPC
Program Director

MATER Programs
Outline

• Need for Specialized Programming
• MATER
• Admissions/Referrals
• Family Center
• My Sister’s Place
• Incorporating Mindfulness into Treatment
• Barriers to Treatment
Why Services Are Needed

• Opioid Epidemic
• Substance abuse among pregnant/parenting women
  • Physical health
  • Mental health
  • Primary caregivers for children
  • Stigmatized population
Who We Are

• MATER = Maternal Addiction Treatment Education and Research
• Specializing in Pregnant and Parenting opiate dependent woman
  – Family Center – 1233 Locust St.
    • Outpatient and Intensive Outpatient treatment
  – My Sister’s Place – 5601 Kingsessing Ave.
    • Short and Long term Residential treatment
MATER-Maternal Addiction Treatment, Education and Research

- Early 1970s, Dr. Loretta Finnegan established Family Center
  - Neonatal Abstinence Syndrome (NAS) assessment tool commonly used today
- Early 1990s, My Sister’s Place established
- Educating counselors, medical students, residents, fellows, and the public about substance abuse in pregnant/parenting women
- Research funding from NIDA, NICHD, NCI, DHHS, CSAT, among others
How Do Women Connect With Us

- MATER is a known locally, nationally, and internationally
- Referrals from other clinics
- Inpatient stabilization at Thomas Jefferson University Hospital
  - Re-stabilization
- Still, we only see about 20-30% of pregnant opioid-maintained women
Family Center

- Outpatient drug and alcohol treatment clinic
- Opioid Treatment Program (OTP) offering Medication Assisted Treatment (MAT)
  - Methadone
  - 230 treatment slots
- Comprehensive substance abuse treatment, case management, recovery support
Family Center Services

- Individual/group counseling (1hr/wk indiv., up to 6 hrs/wk group)
  - 8 counselors; 5 outpatient, 3 intensive outpatient
- Case management – transportation, insurance, housing assistance
- Peer support
  - 1 peer specialist
- Physical health
  - 4 nurses
  - OB/GYNs
  - Annual physicals
- Mental health
  - 1 psychiatrist
My Sister’s Place Services

- Individual/group counseling (1hr/wk indiv., 15 +hrs/wk group)
  - 3 counselors
- Case management – transportation, insurance, housing assistance
- Physical health
  - 1 nurse on-site
  - OB/GYNs
  - Annual physicals
- Mental health
  - 1 psychiatrist
Mindful Parenting

• 12-week program
• Includes:
  – Mom and child/baby hands on interaction and practice
  – Mindfulness education and practice
  – Tools to use outside of treatment
• Availability to practice on-site throughout the week
• Drop in support groups
Mindful Parenting Continued

- 113 women and their children
- 20 have gone through more than once
- Mindfulness Based Stress Reduction
- Mindful Pregnancy
Glitter Globe Activity
Barriers

- Stigma
- Fear of NAS
- Fear of high dosage
- Child Care
- Support Network
- Housing (stable/safe)

- Out of County
- Funding
- Program at Capacity
- Unemployment
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kimberly.a.mclaughlin@jefferson.edu
David M. Barclay, III, M.D., M.P.H.
Medical Director
Prevention Point Philadelphia
Opioid Use Disorder

• Opioid use disorder is a chronic disease of the brain with both genetic and environmental components.

• The most successful treatment to date is Medically Assisted Treatment.
Agenda

• Barriers to Methadone Treatment
• What I do at Prevention Point Philadelphia and how this helps women
  – STEP (Stabilization Treatment and Engagement Program)
  – Buprenorphine/naloxone, Buprenorphine
  – Buprenorphine and Pregnancy Outcomes
Methadone

- Only available through Federally Qualified Methadone Centers
- Daily Dosing
- Mandatory Attendance at Programmed Activities/Therapy Sessions
- Pharmacology
  Total Mu-Agonist
The STEP (Stabilization, Treatment and Engaging Program)

A needle Exchange based treatment program for injection heroin users at Prevention Point Philadelphia.
STEP

- Program of Prevention Point Philadelphia (PPP)
- Serves Women and Men Who Access PPP services
- Uses Buprenorphine/Naloxone and Buprenorphine
- Provides Case Management Services
Buprenorphine/Naloxone

• Available from qualified physicians in the office settings
  – Allows up to monthly appointments
  – Removes the stigma associated with opioid use disorder
  – May combine with primary care and obstetrical care
• Pharmacology
  – Partial mu-agonist
  – Blocks other opioids
  – Effective for 24-48 hours
• Barriers
  – Insurance companies and price
Urine Drug Screens

October 2008 and December 2014

Heroin - Opiate

POSITIVE
n = 376
18%

NEGATIVE
n = 1692
82%
Urine Drug Screens

October 2008 and December 2014

Cocaine

POSITIVE
n=250
12%

NEGATIVE
n=1814
88%
Urine Drug Screens

October 2008 and December 2014

Benzo

POSITIVE
n=332
16%

NEGATIVE
n = 1727
84%
Urine Drug Screens

October 2008 and December 2014

Buprenorphine

- NEGATIVE
  - n = 149
  - 7%

- POSITIVE
  - n = 1905
  - 93%
Methadone vs Buprenorphine for treatment of opioid use disorder during pregnancy

- **47** pregnancies treated with buprenorphine – Neonatal abstinence (NAS) syndrome occurred in **40.4%** and the majority were mild with only **14.9%** requiring withdrawal treatment.

- **35** pregnancies treated with methadone – Neonatal abstinence syndrome occurred in **77.8%** and **52.8%** needed withdrawal treatment.

- There were significant advantages with buprenorphine treatment:
  - Birth weight was higher, due to longer gestation
  - Length of hospital stay was shorter
  - When buprenorphine treatment started pre-conception, NAS at any level was significantly less frequent than in subjects with post-conception initiated treatment (7/27, 26%; 12/20, 60%, respectively).

Opioid Detox and Relapse

- 27% relapse the day after discharge
- 65% relapse within one month of discharge
- 90% relapse within one year of discharge
- 63% report they want Medication Assisted Treatment (MAT)

(March and June 2011, 186 consecutive English-speaking patients receiving inpatient opioid detoxification at Stanley Street Treatment and Resource, Inc. (SSTAR) in Fall River, Massachusetts)


Perceived relapse risk and desire for medication assisted treatment among persons seeking inpatient opiate detoxification.

- Bailey GL, Herman DS, Stein MD.
Clinical Management of Opioid Use Disorder

Recommendations Published in JAMA, July 2016

• Opioid withdrawal alone is not recommended for treatment of opioid use disorder in most patients because of increased risks of overdose death and infectious disease, particularly HIV through intravenous drug use, following detoxification. **(strong recommendation)**

• In the absence of contraindications, medically supervised opioid agonist treatment should be offered to patients. Buprenorphine/naloxone is the preferred first-line-treatment. Methadone is an alternative in certain patient populations. **(strong recommendation)**

• Psychosocial supports tailored to patient needs may be offered as an adjunct to medical treatment. **(conditional recommendation)**
Roland Lamb, Deputy Commissioner DDBHDS

“A Local Perspective: Philadelphia’s Response to the Opioid Epidemic and its Impact on Pregnant Women and Women with Children”
Cathleen Palm
Founder, The Center for Children’s Justice

The Opioid Epidemic
Leveraging Policy & Advocacy to Impact Culture & Systems Change

Maternity Care Coalition
Policy wonk & advocate **NOT** a clinician, maternal and child health expert, or direct service provider.
REPORT ON THE FATALITY OF:

Brayden Allen Cummings

Date of Birth: 09/05/14
Date of Death: 10/17/14
Date of Report to ChildLine: 01/05/2015

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Photo credit: http://www.reuters.com/investigates/special-report/baby-opioids/
Similar findings and recommendations

- DHS should “amend its policy for mandatory consultation when a report is received with the allegations related to drug-exposed infants. Currently reports regarding drug-exposed infants are assigned to the intake division for investigation. The DHS policy and planning division is in the process of creating an investigation manual that will update the existing policy to reflect the current process.”

- The local review team expressed “the need for local obstetricians and gynecologists to be educated on prevention resources for mothers who abuse drugs during pregnancy.” This team also identified that “illegal drug use” has been a “reoccurring factor in homes with recent deaths of children.”
  http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_201850.pdf

- An amendment was made to the on-call procedure for the assessment of all newborns. Any active or non-active referrals on call, regarding newborn babies are to have two supervisory reviews before determining final safety. An internal discussion was also held with supervisors regarding the weight of a child's removal based on risk, as well as safety.”

- The infant was “known” to the children and youth agency after “a referral was received when the deceased child was born because the mother tested positive for opiates.” Indiana and Westmoreland counties had involvement with the family.
We thought this would be easy!

What do we know about the number of babies diagnosed with NAS each year in PA?

Once we learned that answer, we figured we could move on to other questions about outcomes for the infants (e.g., how many of these babies are able to safely be discharged and remain at home with his/her family?, how many of these babies are referred to/receive early intervention services?, how many of these babies are enrolled in an evidence-based home visiting service?)
7,500+ infants diagnosed with NAS in PA
(Note: Includes only infants born onto Medicaid who were diagnosed with NAS between 2010 and 2014)

Table 1. Infants born onto Medicaid in PA, diagnosed with NAS
2010 - 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Diagnosed with NAS</th>
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<tr>
<td>2010</td>
<td>1,080</td>
</tr>
<tr>
<td>2011</td>
<td>1,283</td>
</tr>
<tr>
<td>2012</td>
<td>1,502</td>
</tr>
<tr>
<td>2013</td>
<td>1,702</td>
</tr>
<tr>
<td>2014</td>
<td>1,970</td>
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Top Three Reasons for Removal by Age FFY 2015

NOTE: not a C4CJ original slide, this slide was presented by the PA Department of Human Services to March 29th Roundtable

![Bar chart showing the top three reasons for removal by age group for FFY 2015. The reasons are Neglect, Substance Abuse (Parent), and Child’s Behavior Problem. The chart displays the percentage of cases for each reason across different age groups.](image-url)
Pennsylvania Infants <1 Year of Age Removed from Home 2014
Source = AFCARS 2010 - 2014 Foster Care Files

Pennsylvania Infants <1 Year of Age Removed from Home 2014
Source = AFCARS 2010 - 2014 Foster Care Files

Infants <1 w/Parental Substance Abuse as Contributing Factor to Placement
Infants <1 Removed from Home

Maternity Care Coalition
“Today, children are born all over this country to mothers who have substance abuse problems.... These babies are born in hospitals, they are frequently underweight, and they are frequently frail. Much money and effort is devoted to bringing them to health. These children do not meet any definition of child abuse, and probably they should not, but what happens is they are sent home from hospitals every day in this country and it is only a matter of time in so many instances until they return back to the hospital abused, bruised, beaten, and sometimes deceased.”

– retired PA Congressman James Greenwood
April 2002

Keeping Children and Families Safe Act of 2003
Public Law 108-36 (June 25, 2003)

• Linked receipt of (very modest) federal Child Abuse Prevention and Treatment Act (CAPTA) funding to a state having “policies and procedures” in place to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

• Required health care providers, involved in the delivery or care of these infants, to notify child protection BUT stipulated this was not an attempt to create a federal definition of child abuse or to require prosecution for any illegal action.

• Required development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms
2010 Reauthorization of CAPTA
Public Law 111-320

• Inserted “or a Fetal Alcohol Spectrum Disorder”
• After the existing language about the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.
A decade later still more questions than answers…

- How and/or who defines “affected by”?
- What is a plan of safe care?
- What entity creates and monitors it?
- How is it paid for?
- How do we promote prevention, avoid punitive responses?

Federal officials in 2011: CAPTA did not specify whether it is the formal child welfare agency or another entity (e.g., hospital, community-based providers) that is to develop and implement this plan of safe care. ACF emphasized the plan “should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety.”

Newborns die after being sent home with mothers struggling to kick drug addictions

By Duff Wilson and John Shiffman | Filed Dec. 7, 2015, 9 p.m. GMT

Part 1: In America, a baby is born dependent on opioids every 19 minutes. But doctors aren’t alerting social services to thousands of these infants, many of whom come to harm in families shattered by narcotics.

LEHIGHTON, Pennsylvania – Brayden Cummings turned 6 weeks old the morning his mother suffocated him.

High on methamphetamine, Xanax and the methadone prescribed to help her kick a heroin habit, 20-year-old Tory Schlier told police that she was “fuzzy” about what happened to her baby boy.

Advocates Urge Action

Require states to amend in a timely way (e.g., within 90 days) their CAPTA state plan to identify how the state is effectively developing inter-disciplinary Plans of Safe Care. Also how the state is working across cabinet-level departments and federal funding streams (e.g., evidence-based home visiting, maternal and child health, substance abuse treatment, child welfare) to support substance-exposed infants and their mothers.

December 16, 2015

The Honorable Robert P. Casey, Jr.
393 Russell Senate Office Building
Washington, DC 20510
ATTENTION: Sara Mabry

Dear Senator Casey:

This month, Reuters unveiled a special investigation – Helpless and Hooked: The most vulnerable victims of America’s opioid epidemic. Reuters identified 110 infants and toddlers who died from preventable deaths after their “mothers used opioids during pregnancy.”
Secretary Sylvia Burwell
January 15, 2016
Page 2

To understand the Department’s process in reviewing and approving state plans under CAPTA, please respond to the following questions.

1. What is the review process for state plans? How often are the state plans reviewed?

2. What steps does the Department take to ensure that each state plan is meeting the basic requirements under CAPTA?

3. How does the Department work with states to address deficiencies if state plans are determined to be out of compliance with the law?

4. If a state plan is determined to be out of compliance and the state does not make efforts to change its plan to comply with the CAPTA requirements, what action does the Department take?

HHS Seeks Insight from States by 6/30/16

1. Identify state’s policies and procedures “to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants.” HHS writes, “We note that such notification should occur in any instance in which an infant is demonstrating withdrawal symptoms due to prenatal drug exposure, whether the drugs were obtained legally or illegally.”

2. Identify “which agency or entity is responsible for developing a plan of safe care, how it is monitored and how follow-up is conducted to ensure the safety of these infants.”

3. Identify “any technical assistance” that is needed “to improve practice and implementation in these areas, including how to support mothers and families, as well as infants, through a plan of safe care.”

“Lack of Teeth” and “Uneven Implementation”

Findings from the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) in March 2016:

“CAPTA requires assurances from states that policies and procedures are in place regarding the development of a Plan of Safe Care for newborn infants identified as being affected by illegal substance abuse, withdrawal symptoms, or fetal alcohol spectrum disorder. The purpose of this requirement is to ensure that the infants do not leave the hospital without supports in place. The Commission heard from issue experts in the field and spoke with officials at HHS who noted the “lack of teeth” in the CAPTA Plan of Safe Care requirement and its uneven implementation across states. Many state agencies are unfamiliar with this requirement, and no state has designated a single accountable agency or person responsible for its implementation. States’ lack of understanding of the policy is reflected in questions submitted to federal officials through the HHS Child Welfare Policy Manual.”

CECANF Full Commission Recommendation:

Expand annual Child Maltreatment Report to include:

1. “The number of births reimbursed by Medicaid in which an infant had a neonatal abstinence syndrome (NAS) diagnosis and the number of NAS-diagnosed infants referred to Part C.
2. The number of infants referred under a Plan of Safe Care who were adjudicated dependent in the first year of life and the number who were victims of child abuse or neglect fatalities in the first year of life.”
CECANF Minority Report Recommendation

States should “develop collaborative plans across cabinet-level departments and funding streams (such as Maternal, Infant & Early Childhood Home Visiting Programs (MIECHV), MCH, SAMHSA, and IV-E and IV-B) to support substance-exposed newborns and their mothers.

PA Congressional Delegation Acts

• S. 2687 introduced by Senator Casey
• H.R. 4843 introduced by PA Congressman Lou Barletta

The Congressional Budget Office (CBO) released a cost estimate for H.R. 4843 and separately for S. 2687. CBO estimated that “implementing the legislation would cost less than $500,000 annually for additional personnel to carry out the new requirements; such spending would be subject to the availability of appropriated funds.” CBO described CAPTA as requiring states that want to be eligible for CAPTA funding to develop “a plan of safe care for any drug dependent infant.”

U.S. House Education and Workforce Committee underscores that while H.R. 4843 amends CAPTA, states “should not limit their efforts to address the needs of substance exposed infants and their families to funds available under CAPTA.”

Infant Plan of Safe Care Improvement Act
S.2687/H.R. 4843 included in the Comprehensive Addiction and Recovery Act (S. 524)

- Amends federal Child Abuse Prevention and Treatment Act (CAPTA)

- Federal guidance/direction on best practices for development of Plans of Safe Care

- Enhanced data collection/reporting on number of substance-exposed infants and then those who a Plan of Safe Care was developed

- Enhanced monitoring by HHS of state plans, actions on behalf of these infants and their families
Obama signs into law opioid addiction bill to protect newborns

An Act

To authorize the Attorney General and Secretary of Health and Human Services to award grants to address the prescription opioid abuse and heroin use crisis, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Comprehensive Addiction and Recovery Act of 2016”.
(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PREVENTION AND EDUCATION

Sec. 101. Task force on pain management.
Sec. 102. Awareness campaigns.
Sec. 103. Community-based coalition enhancement grants to address local drug crises.
Sec. 104. Information materials and resources to prevent addiction related to youth sports injuries.
Sec. 105. Assisting veterans with military emergency medical training to meet requirement for becoming civilian health care professionals.
Sec. 106. FDA opioid action plan.
Sec. 107. Improving access to overdose treatment.
Sec. 108. NIH opioid research.
Sec. 110. Opioid overdose reversal medication access and education grant programs.
Comprehensive Addiction and Recovery Act

- Substance abuse treatment programs are to make available “therapeutic, comprehensive child care for children” when the child’s mother is receiving health and rehabilitative services.
- Creates a competitive pilot grant program to be administered by the Department of Health and Human Services (HHS) to meet the unique needs of pregnant and postpartum women intended, in part, to support family based services within residential and non-residential settings.
- Within the Department of Justice, creates a Comprehensive Opioid Abuse Grant Program to develop or expand treatment alternatives over incarceration, including strategies focused “on parents whose incarceration could result in their children entering the child welfare system.”
- The Government Accountability Office (GAO) will study the prevalence of NAS and identify best practices for treating infants diagnosed with NAS.
CAPTA Amendment included in CARA

(NOTE: text in brackets and highlighted will be deleted, CAPITALIZED text represents new law)

(ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by [illegal] substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants, except that such notification shall not be construed to—

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by [illegal] substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder TO ENSURE THE SAFETY AND WELL-BEING OF SUCH INFANT FOLLOWING RELEASE FROM THE CARE OF HEALTH CARE PROVIDERS, INCLUDING THROUGH ADDRESSING THE HEALTH AND SUBSTANCE USE DISORDER TREATMENT NEEDS OF THE INFANT AND AFFECTED FAMILY OR CAREGIVER; AND

THE DEVELOPMENT AND IMPLEMENTATION BY THE STATE OF MONITORING SYSTEMS REGARDING THE IMPLEMENTATION OF SUCH PLANS TO DETERMINE WHETHER AND IN WHAT MANNER LOCAL ENTITIES ARE PROVIDING, IN ACCORDANCE WITH STATE REQUIREMENTS, REFERRALS TO AND DELIVERY OF APPROPRIATE SERVICES FOR THE INFANT AND AFFECTED FAMILY OR CAREGIVER.
Another law, now what?
$\text{challenge cited in 2003 remains in 2016}$

- (CAPTA) was about $\text{26 million}$ in FY 2016.

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**LETTER IN SUPPORT OF CHILD WELFARE FUNDING**

Dear Chairman Regula and Ranking Member Obey:

We are writing in support of the President’s request to increase funding for the Child Abuse Prevention and Treatment Act (CAPTA) Title I basic state grant funding from $22 million in FY04 to $42 million in FY05 and for CAPTA Title II Community-Based Grants for the Prevention of Child Abuse and Neglect funding from $33 million in FY2004 to $65 million in FY2005.

The nation’s child welfare system has long been stretched beyond capacity to handle the full scope of child maltreatment. While report after report has been issued about a system sorely in need of resources, funds for CAPTA programs have been nearly frozen for a decade. Far too little attention is directed at preventing harm to children from happening in the first place or providing the appropriate services and treatment needed by families and children victimized by abuse or neglect.

In 2002, according to the most recent HHS data, substantiated cases of child abuse and neglect investigated by child protective service agencies in the United States involved an estimated 896,000 children. Unfortunately, many of the victims of child maltreatment get no attention to remediate the negative consequences of maltreatment. States report that the child victims or their families in close to half (41%) of the confirmed cases of child abuse receive no treatment or services after the investigation. Fatalities from child maltreatment remain high: an estimated 1,400 children die of abuse or neglect each year. Nearly 41 percent of those who died were infants under the age of one, and three-quarters of the child abuse fatalities claimed the lives of children under age 4.

CAPTA’s Title I basic state grants help states strengthen their child protection systems. Ninety percent of states report difficulty in recruiting and retaining child welfare workers, because of issues like low salaries, high caseloads, often unsafe working conditions, insufficient training and limited supervision, and the extremely high turnover of child welfare workers. Nationally, average caseloads for child welfare workers are double the recommended caseload.

CAPTA’s Title II community-based prevention grants assist states and communities to develop successful approaches to preventing child abuse and neglect. CAPTA funds support the development of such essential abuse prevention services as support programs for new parents, parenting education classes, crisis nurseries, hotlines, information on community resources, home visiting services, sexual abuse prevention, mutual support groups for parents, respite care for families with disabled children and other family support services.

Billions of dollars are spent every year on foster care - too often the only option for families in crisis. Very little money is spent on the front-end, prevention programs. If we could invest in proven prevention programs and strategies designed at the local level to meet individual family and community needs, we could reduce the expenditure for costly back-end crisis services. Increasing funds for CAPTA’s basic state grants and community-based prevention grants will help in a modest yet constructive manner to begin to address the current imbalance.

According to the Department of Health and Human Services, the additional funds requested for FY05 will fund prevention services, including parent education and home visiting for an additional 55,000 children and families. Additional funding for CAPTA state grants will shorten the time for the delivery of post-investigative services by 40 percent and increase the number of children receiving services by almost 20 percent. It is time to invest additional resources to work in partnership with the states to help families and prevent children from being abused and neglected.

As the passage last year of the legislation reauthorizing CAPTA demonstrates, an overwhelming bipartisan majority of our colleagues already believe that funding to help states

Underpinning all the questions...

What might have been different in 2003 and could be now, if the Plan of Safe Care language was **NOT** within a child abuse law, but instead was within a public health law?
Many issues, disciplines, systems...

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Collaboration</th>
<th>DATA</th>
<th>Information Sharing, Confidentiality</th>
<th>Prevention</th>
<th>Reporting to Child Welfare, CYS Response</th>
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<td>Treatment Options - Pregnancy and Postpartum (e.g., prescription pain pills, Methadone, Buprenorphine, Rapid Conversion)</td>
<td>Behavioral Health</td>
<td>Neonatal Abstinence Syndrome (NAS) - Reportable Health Condition</td>
<td>Child Protective Services Law</td>
<td>Change the Message + Promote Prevention</td>
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<tr>
<td>Treatment of Newborns (e.g., NICU, rooming in)</td>
<td>Child Care</td>
<td></td>
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<td>Family Planning, Reproductive Health Care</td>
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<td>Courts</td>
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<td>Public Health Lens (vs. child welfare)</td>
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<td>Drug &amp; Alcohol Treatment</td>
<td>PA Courts</td>
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<td>Standards, Guidance about CYS response</td>
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Maternity Care Coalition
Plan of Safe Care

- Behavioral Health
- Drug and Alcohol Treatment
- Early Intervention
- Transportation
- Medical Care & Home
- Evidence Based Home Visiting
- Corrections
- Housing
- Child Care
- Family
Call for PA Task Force to:

1. Prioritize prevention of substance-exposed infants,
2. Improve outcomes for pregnant and parenting women striving to recover from addiction; and
3. Promote the health, safety and permanency of substance-exposed infants and other young children at-risk of child abuse and neglect or placement in foster care due to parental alcohol and drug use.
What should guide us...

• Prevention is possible & must be the priority.
• Every substance-exposed infant, not just babies w/NAS.
• Understanding, valuing the mother-baby dyad & extended family.
• Collaboration, coordination, collaboration, coordination.
• Avoid suggesting (or getting distracted by) a single solution or service.
• Improved assessment of needs of/risk for infants and families.
• Be intentional in training, triaging of referrals, & information sharing. Data, data, data and not just to have it but to smartly use it.
• Promote protective factors but value & promote CHILD SAFETY.
None of us are in this alone!

• An overview of the extent of opioid use by pregnant women and the effects on the infant
• Evidence-based recommendations for treatment approaches from leading professional organizations
• An in-depth case study, including ideas that can be adopted and adapted by other jurisdictions
• A guide for collaborative planning, including needs and gaps analysis tools for priority setting and action planning

Contact Information:

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The Center for Children’s Justice
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Bernville, PA 19506
610-488-5059

cpalm@C4CJ.org
Kellie Phelan

“Born In Custody, A Girl Finds Answers With Someone Who Knows Best: Mom”
Discussion

Rosemarie Halt
MCC Director of Health, Policy & Practice
Closing Remarks

JoAnne Fischer
MCC Executive Director

#MCCopiodcrisisPHL

www.maternitycarecoalition.org
Women & Women with Children
Opiate Use & Overdose Issues
Demographic and Socio-Economic Characteristics of Philadelphia County, Pennsylvania, 2009-2013 ACS Five-Year Estimates

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<td>**</td>
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<tr>
<td>Age (%)</td>
<td></td>
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</tr>
<tr>
<td>18 years and over</td>
<td>77.6%</td>
<td>**</td>
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<td>21 years and over</td>
<td>72.1%</td>
<td>+/-0.1</td>
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<td>65 years and over</td>
<td>12.2%</td>
<td>**</td>
</tr>
<tr>
<td>Median Age</td>
<td>33.6</td>
<td></td>
</tr>
<tr>
<td><strong>Race (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, Not Hispanic</td>
<td>36.6%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Black/African American, Not Hispanic</td>
<td>42.0%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>12.7%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>&lt;1%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Asian</td>
<td>6.5%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.0%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>&lt;1%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>1.8%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td><strong>Sex (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>47.2%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td>Female</td>
<td>52.8%</td>
<td>+/-0.1</td>
</tr>
<tr>
<td><strong>Educational Attainment (Among Population Aged 25+ Years) (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School Graduate or Higher</td>
<td>81.2%</td>
<td>+/-0.3</td>
</tr>
<tr>
<td>Bachelor's Degree or Higher</td>
<td>23.9%</td>
<td>+/-0.3</td>
</tr>
<tr>
<td><strong>Unemployment (Among Civilian Labor Force Pop Aged 16+ Years) (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Unemployed</td>
<td>8.9%</td>
<td>+/-0.2</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Household Income (in 2013 inflation-adjusted dollars)</td>
<td>$37,192</td>
<td>+/- $424</td>
</tr>
<tr>
<td><strong>Poverty (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People Whose Income in Past Year is Below Poverty Level</td>
<td>26.5%</td>
<td>+/-0.5</td>
</tr>
</tbody>
</table>

**NOTES:**

Margin of Error: can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value.

**The estimate is controlled; a statistical test for sampling variability is not appropriate.**

**SOURCES:** Adapted by the NDEWS Coordinating Center from data provided by the U.S. Census Bureau, 2009-2013 5-Year American Community Survey (ACS).
Year Substance Use Disorder and Major Depressive Episode for the Philadelphia-Camden-Wilmington Metropolitan Statistical Area (MSA), Pennsylvania, and the United States among Persons Aged 12 or Older (Except as Noted): Annual Averages, 2005 to 2010

Using 9.5% of the 1,31,5154, est. Phila. 2010 census pop 12 and older as well as DEA estimates to determine possible number of people needing D&A Tx ranges from 122,000 to 150,000
Women

- 15.8 million women (or 12.9 percent) ages 18 or older have used illicit* drugs in the past year. (SAMHSA, 2014)
  
  *The term "illicit" refers to the use of illegal drugs, including marijuana according to federal law, and misuse of prescription medications.

- 4.6 million women (or 3.8 percent) ages 18 and older have misused prescription drugs in the past year. (SAMHSA, 2014)

- Every 3 minutes, a woman goes to the emergency room for prescription painkiller misuse or abuse. (CDC Vital Signs, 2013)

- 32 million smoke cigarettes
  
  - Smoking tobacco during pregnancy is estimated to have caused 1,015 infant deaths per year from 2005 through 2009. (CDC, 2014)

- 6 million have alcohol use disorders and alcoholism

The National Center on Addiction and Substance Abuse (CASA) at Columbia University funded by the Bristol-Myers Squibb Foundation, published by The Johns Hopkins University Press.
"Women Under the Influence," the result of 10 years of research

- 15 million girls and women use illicit drugs and misuse prescription drugs,
- 32 million smoke cigarettes and
- 6 million have alcohol use disorders
- Alcoholism and Illicit Drug use increases the woman’s chance of being murdered by her significant other as much as 28 times even if she is not abusing substances at the time of her murder.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University funded by the Bristol-Myers Squibb Foundation, published by The Johns Hopkins University Press.
Women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men.

Women may become dependent on prescription pain relievers more quickly than men.


Heroin overdose deaths among women have tripled in the last few years. From 2010 through 2013, female heroin overdoses increased from 0.4 to 1.2 per 100,000.

Female Alcohol & Drug Use

- Women who are victims of domestic violence are at increased risk of substance use.
- Divorce, loss of child custody, or the death of a partner or child can trigger women's substance use or other mental health disorders.
- Women who use certain substances may be more likely to have panic attacks, anxiety, or depression.
- Women and men appear to differ in their vulnerability to some drugs. Both are equally likely to become addicted to or dependent on cocaine, heroin, hallucinogens, tobacco, and inhalants.
- Women are more likely than men to become addicted to or dependent on sedatives and drugs designed to treat anxiety or sleeplessness, and less likely than men to abuse alcohol and marijuana.
Women use substances differently than men, such as

- Using smaller amounts of certain drugs for less time before they become addicted.
- Women can respond to substances differently. For example, they may have more drug cravings and may be more likely to relapse after treatment. This could be affected by a woman’s menstrual cycle.
- Sex hormones can make women more sensitive than men to the effects of some drugs.
- Women who use drugs may also experience more physical effects on their heart and blood vessels.
- Brain changes in women who use drugs can be different from those in men.
- Women may be more likely to go to the emergency room or die from overdose or other effects of certain substances.
Women:

- Have unique risks of using substances and of becoming addicted.
- Women are more likely than men to experience short- and long-term health consequences from substance abuse and addiction.
- Women become addicted more quickly and develop substance-abuse-related diseases sooner.
- At least 1 in every 5 pregnant women reported using drugs, drinking or smoking.
### Table: Number and rate of drug-induced deaths, by age group, race/ethnicity, and sex — National Vital Statistics System, United States, 2010

| Characteristic | Female | | Male | | Total | | Percentage of total |
|---------------|--------|----------------|--------|----------------|--------|---------------------|
|               | No. of deaths | Rate (95% CI) | No. of deaths | Rate (95% CI) | No. of deaths | Rate (95% CI) | 100.00 |
| **Total**     | 16,017 | 10.2 (10.0–10.4) | 24,376 | 16.1 (15.9–16.3) | 40,393 | 13.1 (13.0–13.2) | 100.00 |
| **Age group** |        |                |        |                |        |                |        |
| 0–9           | 32     | 0.2 (0.1–0.2) | 48     | 0.2 (0.2–0.3) | 80     | 0.2 (0.2–0.2) | 0.0    |
| 10–19         | 258    | 1.2 (1.1–1.4) | 636    | 2.9 (2.7–3.1) | 894    | 2.1 (2.0–2.2) | 2.2    |
| 20–29         | 1,943  | 9.2 (8.8–9.6) | 4,788  | 22.1 (21.5–22.7) | 6,731 | 15.8 (15.4–16.1) | 16.7   |
| 40–49         | 4,620  | 21.0 (20.4–21.6) | 6,333 | 29.3 (28.6–30.0) | 10,953 | 25.1 (24.7–25.6) | 27.1   |
| 50–59         | 4,240  | 19.7 (19.1–20.3) | 5,474 | 26.8 (26.0–27.5) | 9,714 | 23.1 (22.7–23.6) | 24.0   |
| 60–69         | 1,258  | 8.2 (7.8–8.7) | 1,447 | 10.4 (9.9–10.9) | 2,705 | 9.2 (8.9–9.6) | 6.7    |
| 70–79         | 373    | 4.1 (3.7–4.5) | 314    | 4.2 (3.8–4.7) | 687    | 4.1 (3.8–4.4) | 1.7    |
| ≥80           | 314    | 4.4 (3.9–4.9) | 218    | 5.3 (4.6–6.0) | 532    | 4.7 (4.3–5.1) | 1.3    |

**Geographic region**

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of deaths</th>
<th>Rate (95% CI)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Northeast</strong></td>
<td>2,245</td>
<td>7.9 (7.6–8.2)</td>
<td>4,154</td>
<td>15.5 (15.0–15.9)</td>
<td>6,399</td>
</tr>
<tr>
<td><strong>Midwest</strong></td>
<td>3,480</td>
<td>10.2 (9.9–10.6)</td>
<td>5,298</td>
<td>16.1 (15.71–16.5)</td>
<td>8,778</td>
</tr>
<tr>
<td><strong>South</strong></td>
<td>6,243</td>
<td>10.7 (10.4–11.0)</td>
<td>9,202</td>
<td>16.4 (16.1–16.7)</td>
<td>15,445</td>
</tr>
<tr>
<td><strong>West</strong></td>
<td>4,049</td>
<td>11.2 (10.9–11.6)</td>
<td>5,722</td>
<td>16 (15.5–16.4)</td>
<td>9,771</td>
</tr>
</tbody>
</table>

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of deaths</th>
<th>Rate (95% CI)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White, non-Hispanic</strong></td>
<td>13,456</td>
<td>13.2 (13.0–13.4)</td>
<td>19,689</td>
<td>20.0 (19.7–20.3)</td>
<td>33,145</td>
</tr>
<tr>
<td><strong>Black, non-Hispanic</strong></td>
<td>1,332</td>
<td>6.5 (6.1–6.8)</td>
<td>2,170</td>
<td>11.5 (11.0–12.0)</td>
<td>3,502</td>
</tr>
<tr>
<td><strong>American Indian/Alaska</strong></td>
<td>200</td>
<td>15.3 (13.2–17.4)</td>
<td>239</td>
<td>19.0 (16.5–21.4)</td>
<td>439</td>
</tr>
<tr>
<td><strong>Native</strong></td>
<td>129</td>
<td>1.5 (1.3–1.8)</td>
<td>205</td>
<td>2.7 (2.3–3.0)</td>
<td>334</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>844</td>
<td>3.4 (3.2–3.6)</td>
<td>1,944</td>
<td>7.6 (7.3–7.9)</td>
<td>2,788</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>56</td>
<td>— (—)</td>
<td>— (—)</td>
<td>— (—)</td>
<td>185</td>
</tr>
</tbody>
</table>

Abbreviation: 95% CI = 95% confidence interval.

* Unadjusted (crude) death rates per 100,000 population.
† CIs based on ≥10 deaths were calculated using a normal approximation; CIs based on <100 deaths were calculated using a gamma method. (Additional information available from Vital Statistics of The United States: Mortality, 1999 Technical Appendix. Available at: http://wonder.cdc.gov/wonder/sci_data/mort/mcmort/type_txt/mcmort05/techap99.pdf).
¶ Persons of Hispanic ethnicity might be of any race or combination of races.
** Rates for persons with unknown race/ethnicity were not included because population data were unavailable.
The percentage of women dependent on opioids during pregnancy more than doubled during, from 0.17 percent in 1998 to 0.39 percent in 2011.

Women dependent on opioids were twice as likely to go into labor early, with 17 percent experiencing preterm labor versus 7 percent among those without opioid dependency. Women dependent on opioids were also 20 percent more likely to require a C-section and 40 percent more likely to have their water break early.
Opiates and Women

- The percentage of women dependent on opioids during pregnancy more than doubled during, from 0.17 percent in 1998 to 0.39 percent in 2011.
- Women dependent on opioids were twice as likely to go into labor early, with 17 percent experiencing preterm labor versus 7 percent among those without opioid dependency. Women dependent on opioids were also 20 percent more likely to require a C-section and 40 percent more likely to have their water break early.
Prescription Painkiller Overdoses
A growing epidemic, especially among women

About 18 women die every day of a prescription painkiller overdose in the US, more than 6,600 deaths in 2010. Prescription painkiller overdoses are an under-recognized and growing problem for women.

Although men are still more likely to die of prescription painkiller overdoses (more than 10,000 deaths in 2010), the gap between men and women is closing. Deaths from prescription painkiller overdose among women have risen more sharply than among men; since 1999 the percentage increase in deaths was more than 400% among women compared to 265% in men. This rise relates closely to increased prescribing of these drugs during the past decade. Health care providers can help improve the way painkillers are prescribed while making sure women have access to safe, effective pain treatment.

When prescribing painkillers, health care providers can:

- Recognize that women are at risk of prescription painkiller overdose.
- Follow guidelines for responsible prescribing, including screening and monitoring for substance abuse and mental health problems.
- Use prescription drug monitoring programs to identify patients who may be improperly obtaining or using prescription painkillers and other drugs.

**“Prescription painkillers” refers to opioid or narcotic pain relievers, including drugs such as Vicodin (hydrocodone), OxyContin (oxycodeone), Opana (oxymorphone), and methadone.**

See page 4
Want to learn more? Visit www.cdc.gov/vitalsigns
There has been a consistent relationship between the sales of opioid pain relievers (OPRs), treatment admissions and OPR deaths.
### Demographic Profiles of Alcohol and/or Drug Intoxication Deaths, Philadelphia, 2015

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>498</td>
<td>72.4%</td>
</tr>
<tr>
<td>Female</td>
<td>190</td>
<td>27.6%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>378</td>
<td>54.9%</td>
</tr>
<tr>
<td>African American, Non-Hispanic</td>
<td>222</td>
<td>32.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>80</td>
<td>11.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>18-25</td>
<td>54</td>
<td>7.8%</td>
</tr>
<tr>
<td>26-44</td>
<td>314</td>
<td>45.6%</td>
</tr>
<tr>
<td>45+</td>
<td>317</td>
<td>46.1%</td>
</tr>
</tbody>
</table>

Philadelphia Department of Public Health, Medical Examiner's Office
Overdose Risk in Young Children of Women Prescribed Opioids

Y Finkelstein, E Macdonald, A Gonzalea, A Kopp, MLA Sivilotti, MM Mamdani, DN Juurlink
Hospital for Sick Children, University of Toronto, Toronto, ON, Canada, Institute of Clinical Evaluative Sciences, Toronto, ON, Canada, Queen’s University, Kingston, ON, Canada

Background:
The United States is in the midst of a prescription opioid epidemic, resulting in more than 16,000 deaths annually. Whether children of parents prescribed opioids are at increased risk of overdose has not been systematically studied.

Objective:
To explore the risk of overdose in young children of mothers who were prescribed opioids.

Methods:
We conducted a nested case-control study of children younger than 10 years whose mothers’ prescription were insured under the Ontario Drug Benefit program. Cases were children who presented to an emergency department, were hospitalized or died of opioid overdose between 2002 and 2014. Each case was matched with up to 4 controls on age and sex. We linked children with their mothers using birth records. The primary analysis included cases and controls whose mothers filled a prescription for an opioid or a non-steroidal anti-inflammatory drug (NSAID) in the preceding year. We examined the risk of opioid overdose in children of women who received an opioid, with maternal receipt of a prescription NSAID as the reference.

Results:
We identified 560 children treated in hospital and 6 who died of opioid toxicity. Of these, 83 were children of women prescribed an opioid (n=73) or NSAID (n=10). These cases were matched with 331 controls. Maternal opioid prescription was associated with a three-fold increase in the risk of pediatric opioid overdose (odds ratio 2.97; 95% confidence interval 1.95 to 4.52). Among cases, the most commonly implicated opioids were codeine, oxycodone and methadone.

Conclusion:
Young children of women who are prescribed opioids are at increased risk of opioid poisoning.
CDC finds high opioid Rx rates for women of child-bearing age

- More than a third of women enrolled in Medicaid, and more than a quarter of women with private insurance between the ages of 15 and 44 filled a prescription for opioid pain medication annually between 2008 and 2012.
- Researchers found that 39% of women covered under Medicaid filled an opioid prescription at an outpatient pharmacy each year, compared with 28% of reproductive-age women with private health insurance.

(Opioid Prescription Claims Among Women of Reproductive Age — United States, 2008–2012 Weekly, January 23, 2015 / 64(02):37-41, Elizabeth C. Ailes, PhD1, April L. Dawson, MPH1, Jennifer N. Lind, PharmD1, Suzanne M. Gilboa, PhD1, Meghan T. Frey, MPH1, Cheryl S. Broussard, PhD1, Margaret A. Honein, PhD1 (Author affiliations at end of text))

- A 2011 CDC study published in the American Journal of Obstetrics & Gynecology found that women who took opioid medications between one month before pregnancy and the end of their first trimester had higher associated risks of their children developing conditions such as congenital heart defects, spina bifida or gastroschisis, a birth defect in which a baby's intestines stick outside of its body.
### National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population*

#### Demographic Characteristics of Treatment Admissions*, Philadelphia, 2014

<table>
<thead>
<tr>
<th>Substance</th>
<th>SEX</th>
<th>AGE</th>
<th>RACE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Under 26 yrs.</td>
</tr>
<tr>
<td>Alcohol (n=2,476)</td>
<td>80%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Marijuana (n=1,844)</td>
<td>86%</td>
<td>14%</td>
<td>42%</td>
</tr>
<tr>
<td>Heroin (n=1,764)</td>
<td>70%</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Cocaine (n=1,081)</td>
<td>71%</td>
<td>29%</td>
<td>12%</td>
</tr>
<tr>
<td>Rx Opioids (n=311)</td>
<td>64%</td>
<td>36%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Treatment Admissions: Includes admissions for uninsured and underinsured individuals admitted to any licensed treatment programs funded through the Philadelphia Department of Behavioral Health. Percentages may not sum to 100 due to rounding.

**Source:** Data provided by the Philadelphia NDEWS SCE and the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, Office of Addiction Services, Behavioral Health Special Initiative.
### Table 1. Percentage of Primary Heroin and Other Primary Opiate Admissions, by Age, Gender, and Race/Ethnicity: 2007

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Heroin</th>
<th>Other Opiates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 18 Years</td>
<td>&lt;1%</td>
<td>2%</td>
</tr>
<tr>
<td>18 to 24</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>25 to 34</td>
<td>28%</td>
<td>36%</td>
</tr>
<tr>
<td>35 to 44</td>
<td>29%</td>
<td>20%</td>
</tr>
<tr>
<td>45 to 54</td>
<td>21%</td>
<td>13%</td>
</tr>
<tr>
<td>55 or Older</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68%</td>
<td>53%</td>
</tr>
<tr>
<td>Female</td>
<td>32%</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>53%</td>
<td>88%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>22%</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22%</td>
<td>4%</td>
</tr>
<tr>
<td>American Indian/Alaska</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Native</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: 2007 SAMHSA Treatment Episode Data Set (TEDS).
Women with ATOD use disorders tend to:

- Be more likely to seek treatment in non-specialty settings
- Less likely over the lifetime to enter treatment than their male counterparts
- Reflect treatment gaps for men and women is supported by low rates of having ever received treatment, this discrepancy is more pronounced over the lifetime for women than men with substance use disorders
- Women in substance abuse treatment, being diagnosed with drug abuse only and referred by a source other than criminal justice was related to lower retention rates among women in minority racial groups
- 9% of the Philadelphia Prison System population is female. 39% are (self-report) have substance use disorders
Female Alcohol & Drug Use

- Women and men appear to differ in their vulnerability to some drugs. Both are equally likely to become addicted to or dependent on cocaine, heroin, hallucinogens, tobacco, and inhalants.
- Women are more likely than men to become addicted to or dependent on sedatives and drugs designed to treat anxiety or sleeplessness, and less likely than men to abuse alcohol and marijuana.
Study of Opiate Dependent Women

- Women reported a wide range of substance use and other problems including depression.
- Many were heavy and regular drinkers.
- Most of the women were in a relationship with an opiate user:
  - one-third reported that their partner had been physically violent towards them.
- Almost all of these women were living in a state of poverty.
- Many of the mothers were in conflict regarding their dependence upon drugs and their fears about their children being taken into care.
  - The women who were most severely dependent upon both heroin and alcohol felt that if they sought treatment this might help them to avoid having their children taken into care.
  - At the same time they were afraid that, by approaching treatment, this might increase the risk of their children being taken from them.
- Services should seek to reduce the barrier to treatment presented by the anxieties of women with children as well as improving facilities for the care of women with children.

Drug-using mothers: social, psychological and substance use problems of women opiate users with children
BEVERLY POWIS†,*, MICHAEL GOSSOP†, CATHERINE BURY†, KATHERINE PAYNE† and PAUL GRIFFITHS†
Article first published online: 29 MAY 2009
DOI: 10.1080/713659321
2000 Australasian Professional Society on Alcohol and other Drugs
Here are ways in which some key body systems react.

1. **NERVOUS SYSTEM**
   When stressed — physically or psychologically — the body suddenly shifts its energy resources to fighting off the perceived threat. In what is known as the “fight or flight” response, the sympathetic nervous system signals the adrenal glands to release adrenaline and cortisol. These hormones make the heart beat faster, raise blood pressure, change the digestive process and boost glucose levels in the bloodstream. Once the crisis passes, body systems usually return to normal.

2. **MUSCULOSKELETAL SYSTEM**
   Under stress, muscles tense up. The contraction of muscles for extended periods can trigger tension headaches, migraines and various musculoskeletal conditions.

3. **RESPIRATORY SYSTEM**
   Stress can make you breathe harder and cause rapid breathing — or hyperventilation — which can bring on panic attacks in some people.

4. **CARDIOVASCULAR SYSTEM**
   Acute stress — stress that is momentary, such as being stuck in traffic — causes an increase in heart rate and stronger contractions of the heart muscle. Blood vessels that direct blood to the large muscles and to the heart dilate, increasing the amount of blood pumped to these parts of the body. Repeated episodes of acute stress can cause inflammation in the coronary arteries, thought to lead to heart attack.

5. **ENDOCRINE SYSTEM**
   Adrenal glands
   When the body is stressed, the brain sends signals from the hypothalamus, causing the adrenal cortex to produce cortisol and the adrenal medulla to produce epinephrine — sometimes called the “stress hormones.”
   Liver
   When cortisol and epinephrine are released, the liver produces more glucose, a blood sugar that would give you the energy for “fight or flight” in an emergency.

6. **GASTROINTESTINAL SYSTEM**
   Esophagus
   Stress may prompt you to eat much more or much less than you usually do. If you eat more or different foods or increase your use of tobacco or alcohol, you may experience heartburn, or acid reflux.
   Stomach
   Your stomach can react with “butterflies” or even nausea or pain. You may vomit if the stress is severe enough.
   Bowels
   Stress can affect digestion and which nutrients your intestines absorb. It can also affect how quickly food moves through your body. You may find that you have either diarrhea or constipation.

7. **REPRODUCTIVE SYSTEM**
   In men, excess amounts of cortisol, produced under stress, can affect the normal functioning of the reproductive system. Chronic stress can impair testosterone and sperm production and cause impotence.
   In women, stress can cause absent or irregular menstrual cycles or more-painful periods. It can also reduce sexual desire.
Deaths due to Alcohol and/or Drug Intoxication confirmed by the Medical Examiner’s Office 2014- H1 2015

<table>
<thead>
<tr>
<th>Zip code</th>
<th>Count of Intoxication Deaths by Decedent Resident Zip code</th>
<th>Rank</th>
<th>Zip code</th>
<th>Count of Intoxication Deaths by Event Zip code</th>
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Deaths due to Alcohol and/or Drug Intoxication-2014

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<th>Zip code</th>
<th>Count of Intoxication Deaths by Decedent Resident Zip code</th>
<th>Rank</th>
<th>Zip code</th>
<th>Count of Intoxication Deaths by Event Zip code</th>
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Deaths due to Alcohol and/or Drug Intoxication confirmed by the Medical Examiner’s Office 2014 - 2015 H1 by Top 10 Event Zip code

19124 1
19134 2

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<th>Household Type</th>
<th>Number of Households</th>
<th>Percentage</th>
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<tr>
<td>Husband Wife Family</td>
<td>6,470</td>
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<tr>
<td>Single Guardian</td>
<td>9,188</td>
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<tr>
<td>Singles</td>
<td>5,536</td>
<td>25%</td>
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<tr>
<td>Singles With Roommate</td>
<td>1,293</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number of Households</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband Wife Family</td>
<td>5,270</td>
<td>26%</td>
</tr>
<tr>
<td>Single Guardian</td>
<td>8,374</td>
<td>42%</td>
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<tr>
<td>Singles</td>
<td>5,026</td>
<td>25%</td>
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<tr>
<td>Singles With Roommate</td>
<td>1,410</td>
<td>7%</td>
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</table>
Deaths due to Alcohol and/or Drug Intoxication confirmed by the Medical Examiner’s Office 2014 - 2015 H1 by Top 10 Event Zip code

19140  
4

19136  
5

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Husband Wife Family Households</td>
<td>3,754</td>
<td>20%</td>
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<tr>
<td>Single Guardian</td>
<td>8,458</td>
<td>45%</td>
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<tr>
<td>Singles</td>
<td>5,441</td>
<td>29%</td>
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<tr>
<td>Singles With Roommate</td>
<td>1,131</td>
<td>6%</td>
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</table>

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Husband Wife Family Households</td>
<td>5,124</td>
<td>40%</td>
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<tr>
<td>Single Guardian</td>
<td>3,178</td>
<td>25%</td>
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<tr>
<td>Singles</td>
<td>3,941</td>
<td>30%</td>
</tr>
<tr>
<td>Singles With Roommate</td>
<td>714</td>
<td>6%</td>
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Addiction Medicine
Why We Need to Close the Gap between Science and Practice

40 million Americans have the disease of addiction compared to:
- 27 million who have heart conditions
- 26 million who have diabetes
- 19 million who have cancer

Those who need treatment don’t receive it
7 in 10 people with diseases like hypertension, major depression or diabetes receive treatment.
Only about 1 in 10 people who need treatment for addiction involving alcohol, illicit and prescription drugs receive it.

Substance Use and Untreated Addiction result in:
- 20% of deaths
- 1/3 of inpatient hospital costs
- 70 other diseases requiring medical care

Addiction is a complex brain disease that can and should be treated within the medical system.
Treatment works, but:
- Doctors are not trained to treat addiction
- Addiction Counselors are not trained in medicine

For every dollar we spend on addiction and risky substance use:
- .02 per $1 goes toward prevention and treatment
- .98 per $1 goes toward consequences of addiction and substance use

Source: CASAColumbia™ (2011): Addiction Medicine: Closing the Gap between Science and Practice
www.casacolumbia.org
Some simple tips to avoid opiate overdose’s

- **Avoid using alone**: if you overdose, you want someone around to help.
- **Know your tolerance**: Know when it might be lower than usual (for example, when you have not been using for a while).
- **Avoid using different drugs** at the same time and mixing drugs with alcohol.
- You’re less likely to overdose from snorting or smoking drugs than injecting them.
- If you have a new dealer, always use a small amount first to see how strong it is.
- “**Know about Naloxone** (a drug used to counter the effects of opiate overdose)”
- In the event of an overdose **ALWAYS** call the emergency services!
Questions? More Information?

- Office of Addiction Services
  - Roland.lamb@phila.gov
- 1101 Market Street
  8th Fl

Department of Behavioral Health Intellectual disAbility Services (DBHIDS)