



Responding to the Effects of Opioid Abuse on Children and Families

October 18, 2017



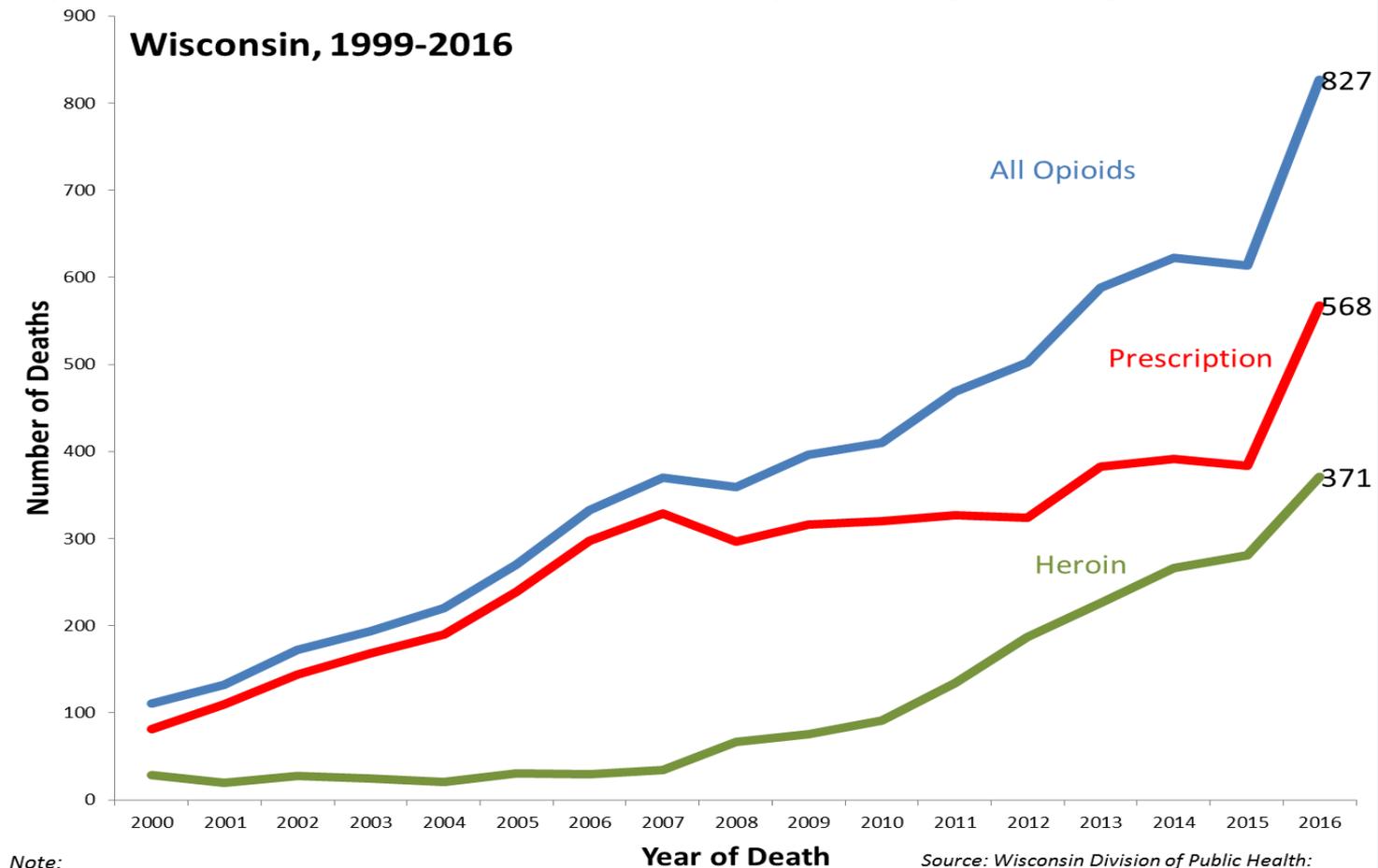
WISCONSIN DEPARTMENT OF
CHILDREN AND FAMILIES

Presentation

- Opioid Use and Child Welfare Trends in Wisconsin
- Best Practice for Care of the Mother and Fetus during Pregnancy and Beyond
- Services for Individuals with Substance Use Disorders: United Community Center
- DCF Opioid Steering Committee
 - Background
 - Guiding Principles
 - Preliminary Recommendations

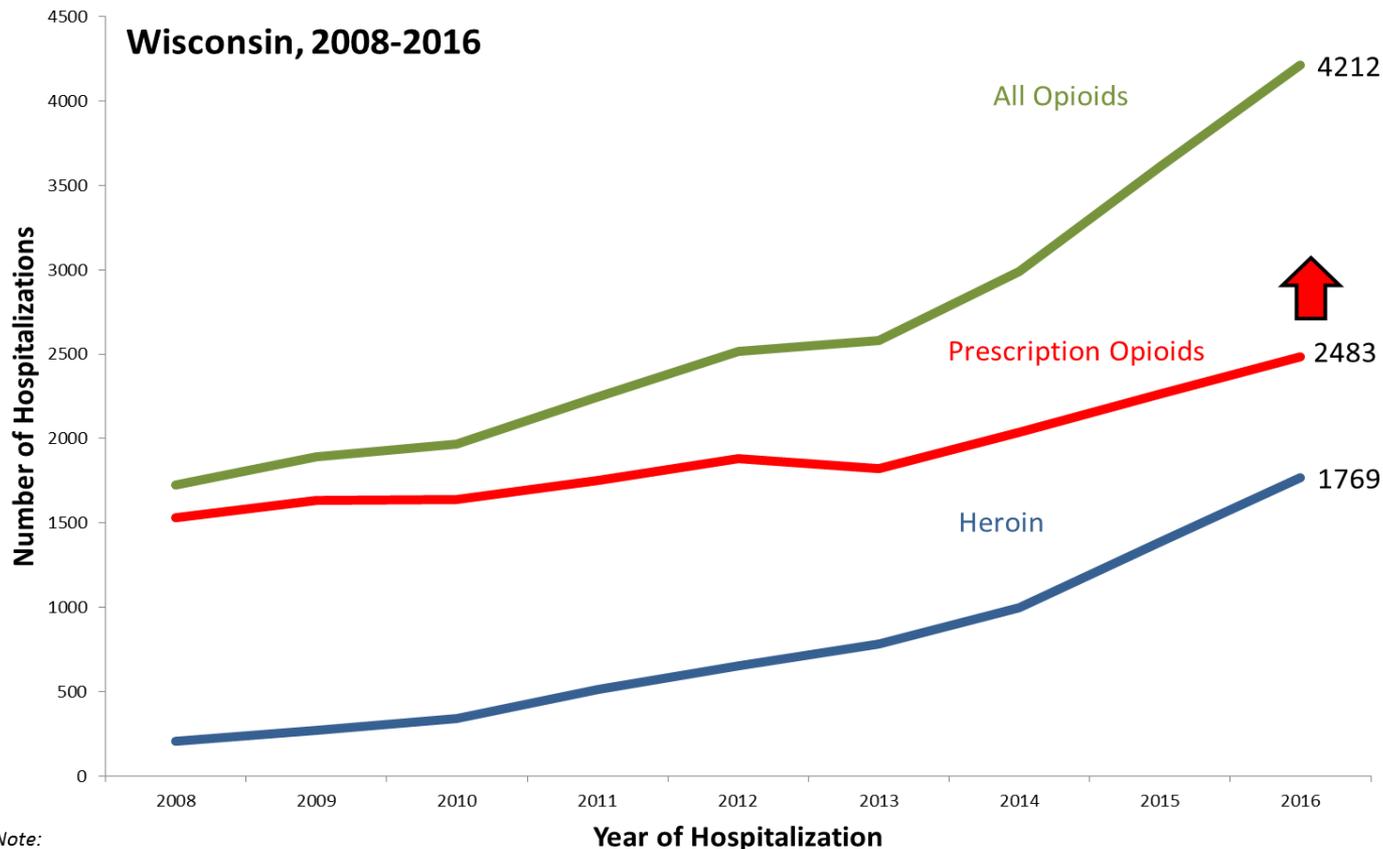
Opioid Trends in WI: Opioid-related Deaths

Opioid-Related Deaths Are Driven by Prescription Opioids.



Opioid Trends in WI: Opioid-Related Hospitalizations

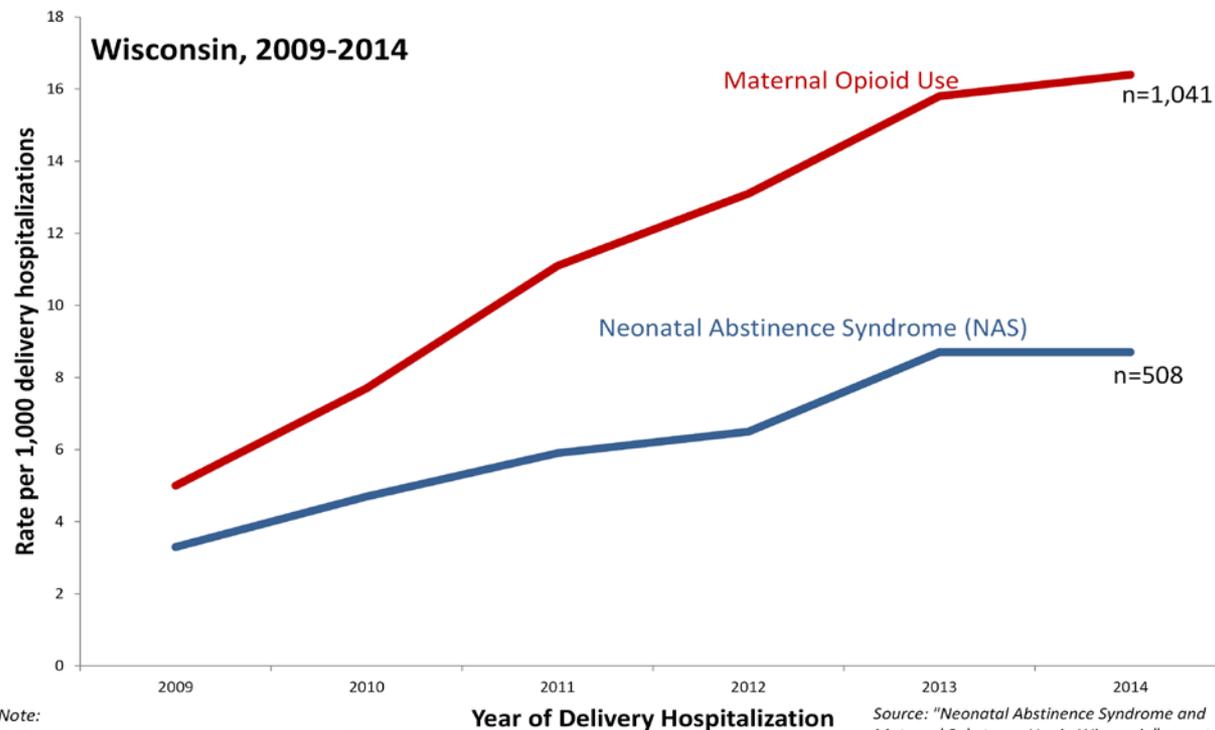
Opioid-Related Hospitalizations Are Driven by **Prescription Opioids**.



Note:
Drug overdose death numbers may include more than one type of drug.

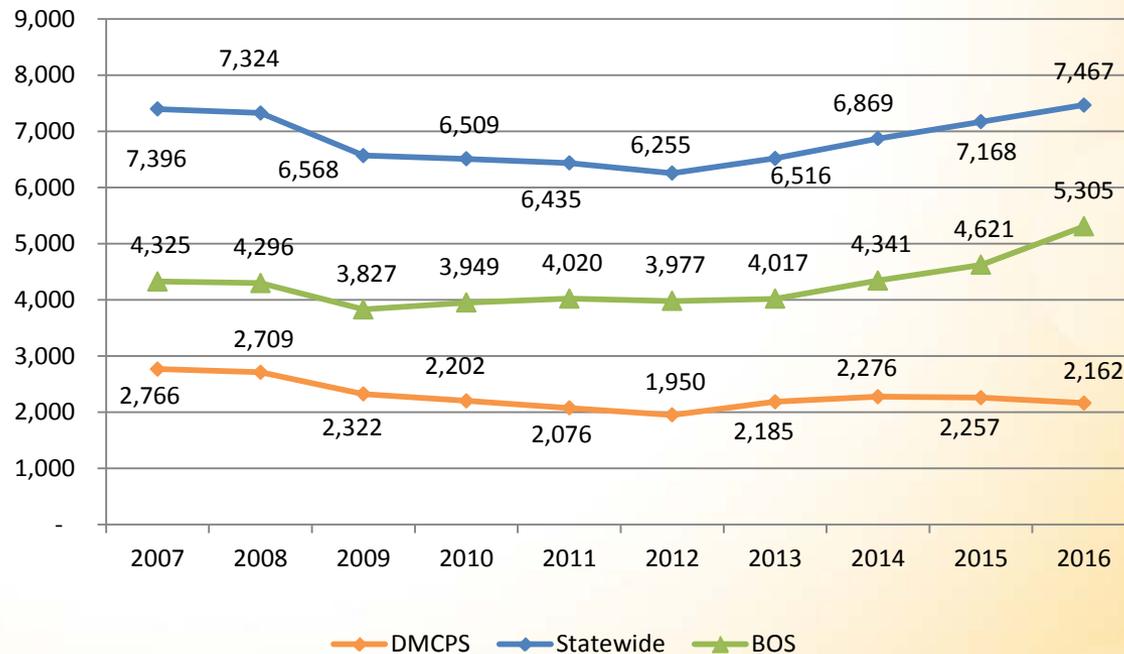
Opioid Trends in WI: Maternal Use and Neonatal Abstinence Syndrome (NAS)

As **Opioid Use Identified at the Time of Delivery** Increased Among Mothers, the **Rate of Neonatal Abstinence Syndrome** also Increased.



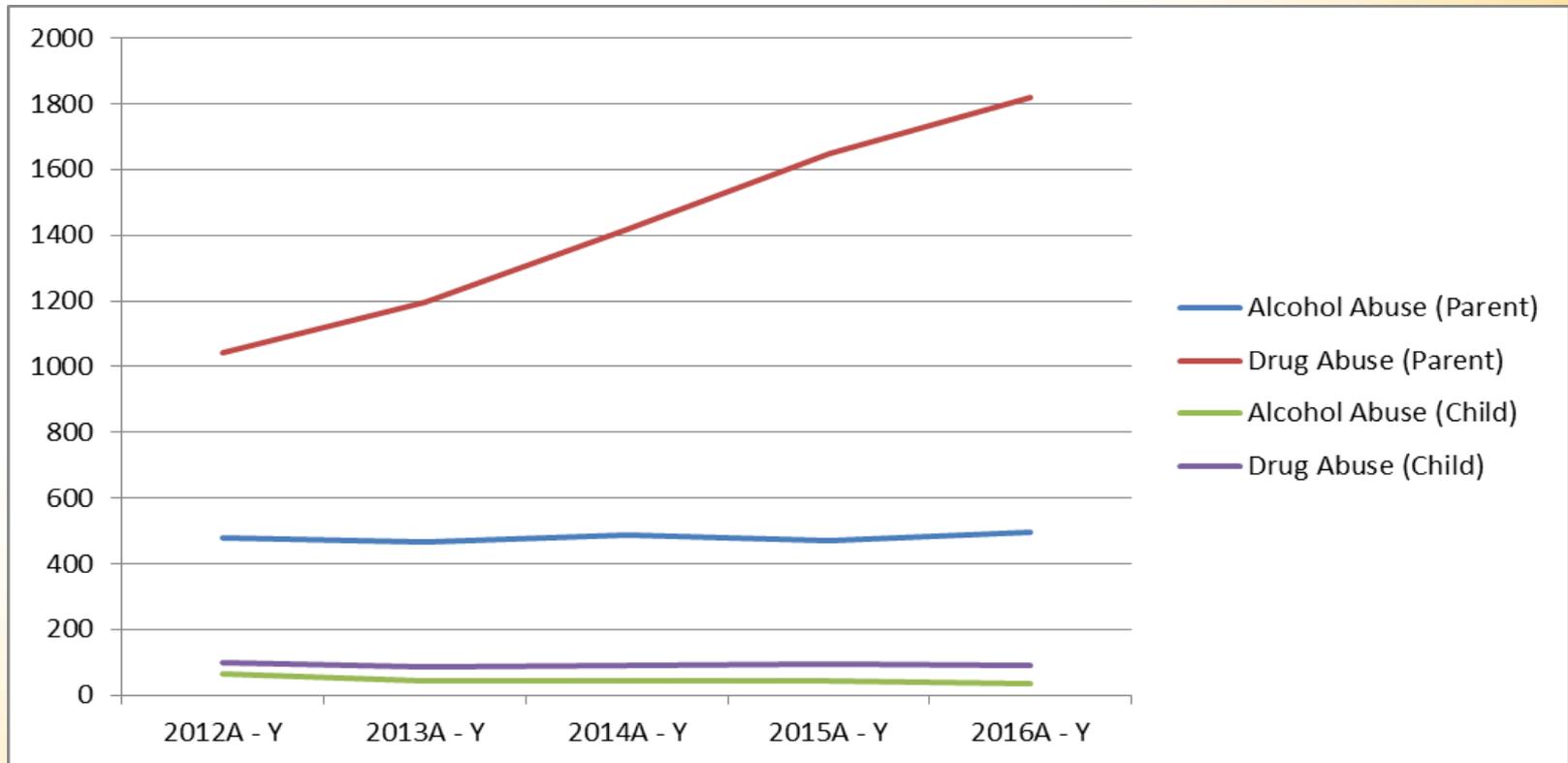
Wisconsin Child Welfare Overview

Children in Out-of-Home Placements on December 31, 2007-2016



- Since 2012, the number of children in out-of-home care statewide has increased each year. Since 2013, in non-Milwaukee counties, the number of children in out-of-home care has increased significantly each year, while in Milwaukee the number has remained relatively flat.

Opioid Trends in WI: Child Welfare Removals due to Parental Drug Abuse



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Wisconsin Section

BEST PRACTICES for CARE of the MOTHER and FETUS DURING PREGNANCY and BEYOND

Kathy D. Hartke, MD

WI ACOG Legislative Co-Chair and Immediate Past Chair

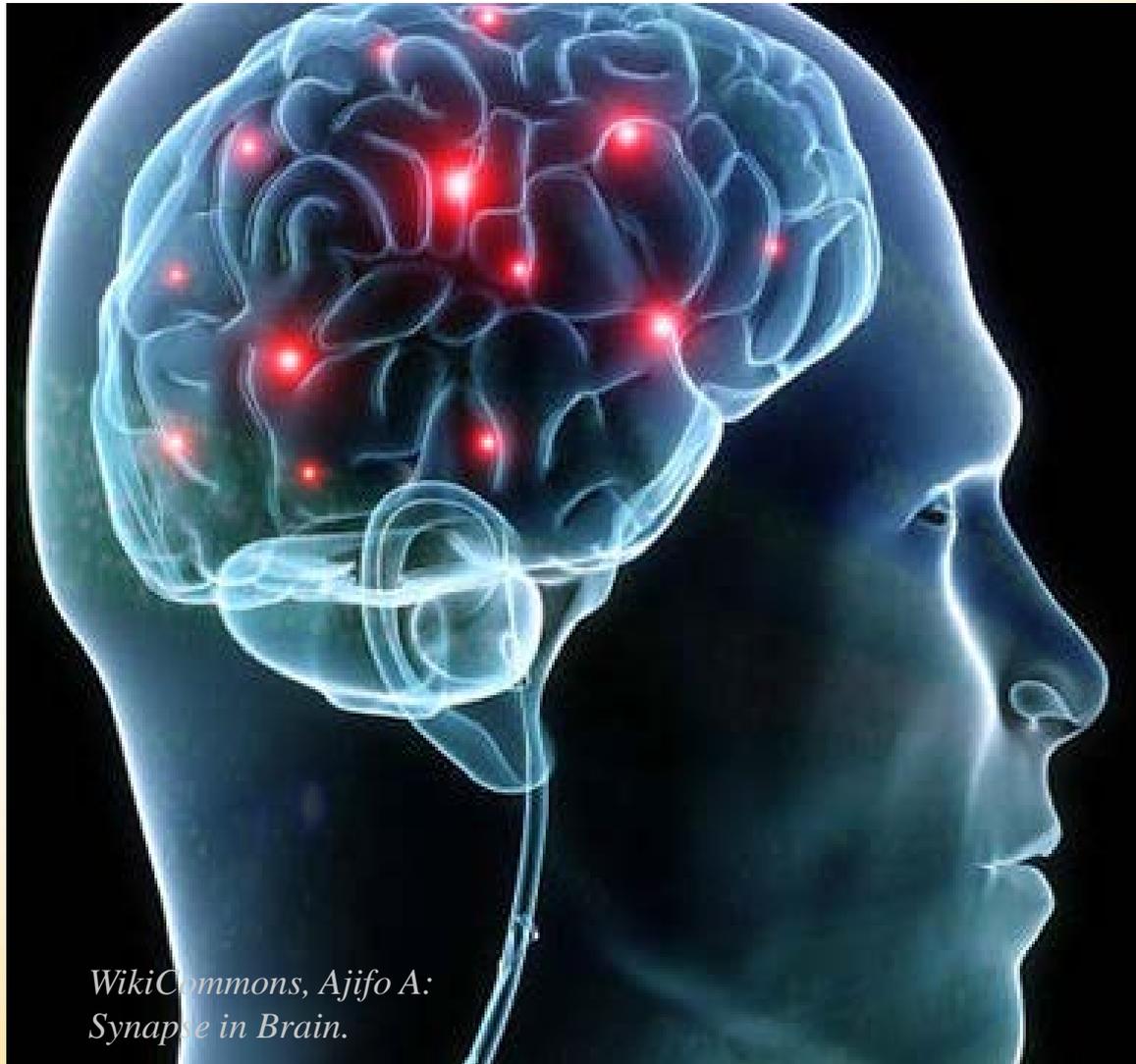
Disclosures

- No financial disclosures
- Expert witness in the in the United States District Court for the Western District of Wisconsin Tamara M. Loertscher v. Eloise Anderson, Brad Schimel, Taylor County
- Testified in Racine County Court 1996

Objectives

- Discuss addiction as a chronic medical disease
- Understand stigma and treatment of OUD
- Best practices for pregnancy and new research

Addiction is a primary chronic brain disease



*WikiCommons, Ajifo A:
Synapse in Brain.*

Addiction



- Primary chronic disease of brain reward, motivation, memory and related circuitry.
 - Dysfunction in these circuits leads to psychological, social and spiritual manifestations.
- Reflected in pathologically pursuing reward and/or relief by substance use and other behaviors.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment, addiction is progressive and can result in disability or death.

Addiction can affect anyone....



https://commons.wikimedia.org/wiki/File:People_on_Grafton_Street,_Dublin,_Ireland.jpg

MISCONCEPTIONS

Opioid Abuse in Chronic Pain —
Misconceptions and Mitigation Strategies
Nora D. Volkow, M.D., and A. Thomas
McLellan, Ph.D.
N Engl J Med 2016; 374:1253-1263
March 31, 2016

Table 1. Misconceptions Regarding Opioids and Addiction.*

Addiction is the same as physical dependence and tolerance. This misconception leads some clinicians to avoid prescribing opioids to patients who would benefit from them and many patients to be afraid of taking opioids as prescribed.

Addiction is simply a set of bad choices. This misconception contributes to the discrimination against patients with addiction and to the willful ignorance by many in the health care system about modern treatment methods. It also promotes mistrust of patients by clinicians and prevents affected patients from seeking help for their addiction.

Pain protects patients from addiction to their opioid medications. This misconception can lead to overconfidence and overprescribing among clinicians as well as failure to monitor and recognize addictive behaviors or to intervene properly when they emerge. Research has shown that patients who are prescribed opioid medications for pain can become addicted to them even when the drugs are taken as prescribed.

Only long-term use of certain opioids produces addiction. The misconception that addiction is simply the property of certain opioid drugs promotes overprescribing of certain types of opioids that may be as risky as types that are well known to be associated with addiction. An improved prescribing practice in the management of acute pain is a necessary step in the control of opioid diversion and overdose, since the overprescription of opioids for acute pain is the main source of drug diversion.

Only patients with certain characteristics are vulnerable to addiction. Certain conditions do increase the vulnerability to addiction. These include substance-use disorder (including abuse of alcohol, nicotine, and illicit drugs), developmental stage (adolescents are more vulnerable than adults), and certain mental illnesses (e.g., attention deficit–hyperactivity disorder and major depressive disorder). Although some patients are more vulnerable than others, no patient is immune to addiction.

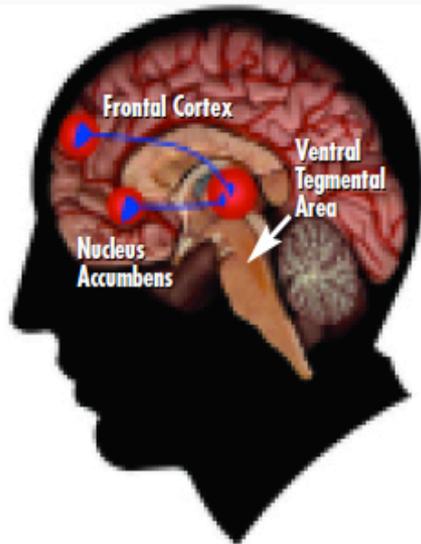
Medication-assisted therapies are just substitutes for heroin or opioids. The use of opioid-agonist medications such as methadone and buprenorphine for opioid addiction has led to the misconception that such drugs are just substitutes for the opioid being abused. Although these medications are opioid agonists, their slower brain pharmacokinetics along with their more stable concentrations help to stabilize physiologic processes that are disrupted by intermittent abuse of opioids. The use of these drugs also protects against risks associated with opioid abuse while facilitating recovery.¹⁸⁻²⁰

* These misconceptions were drawn directly from questions submitted by physicians to two major websites for pain-management specialists (the American Academy of Pain Management and the American Pain Society).

Brain: Drugs Affect Dopamine Pathways

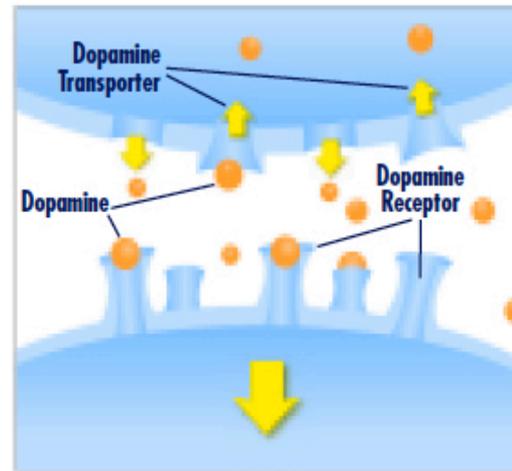
DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

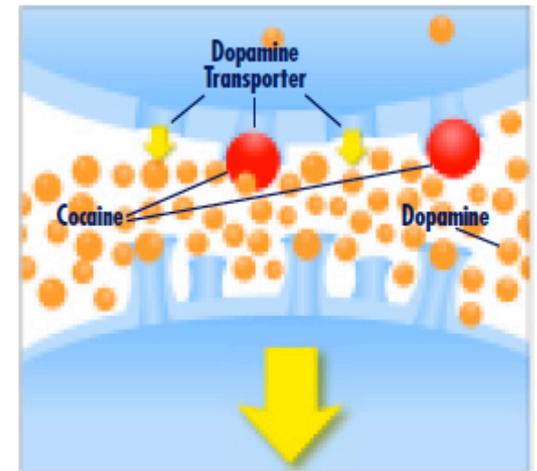


These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



FOOD



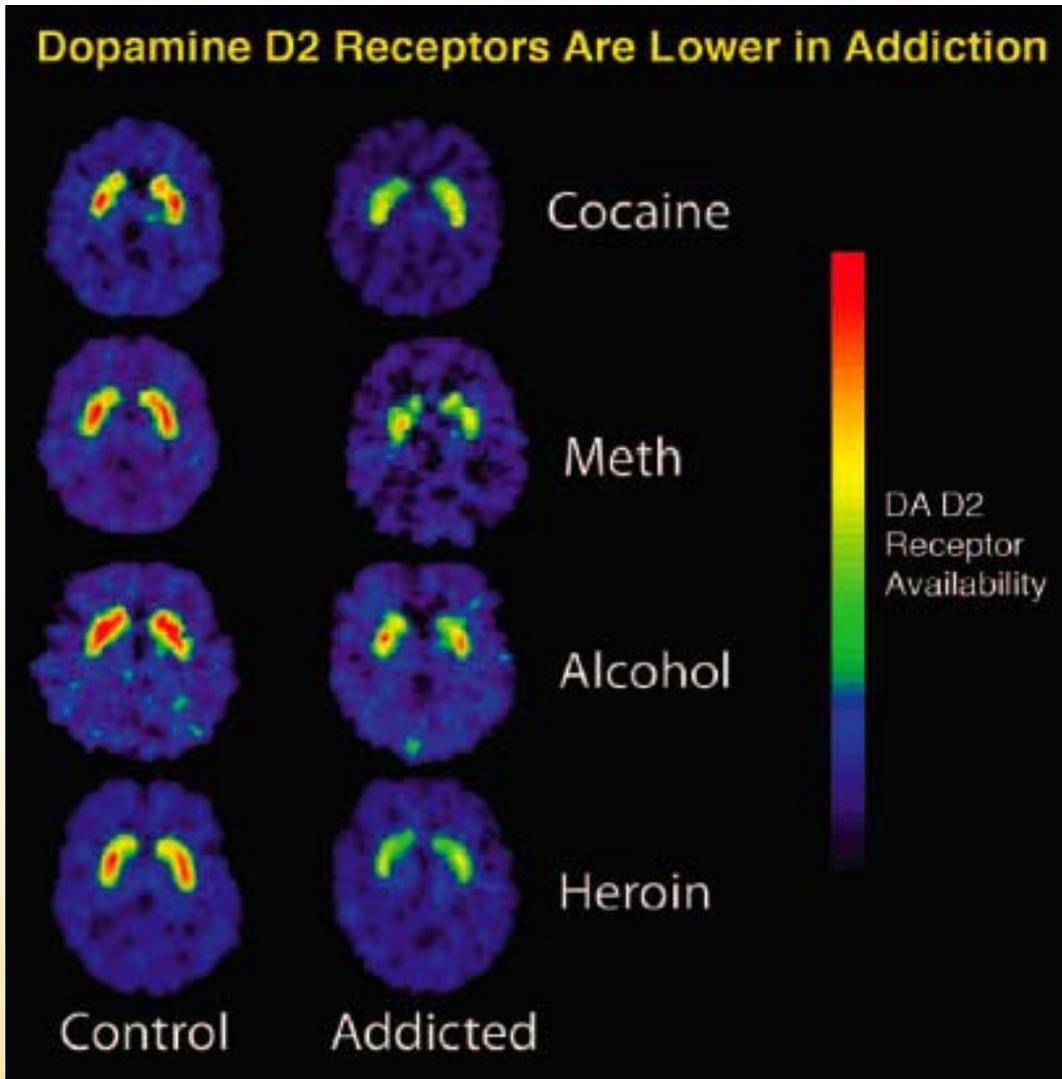
COCAINE

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

Creative Commons, National Institute on Drug Abuse

<http://www.drugabuse.gov/publications/science-addiction/drugs-brain>

Dopamine Receptors: Reward Pathways

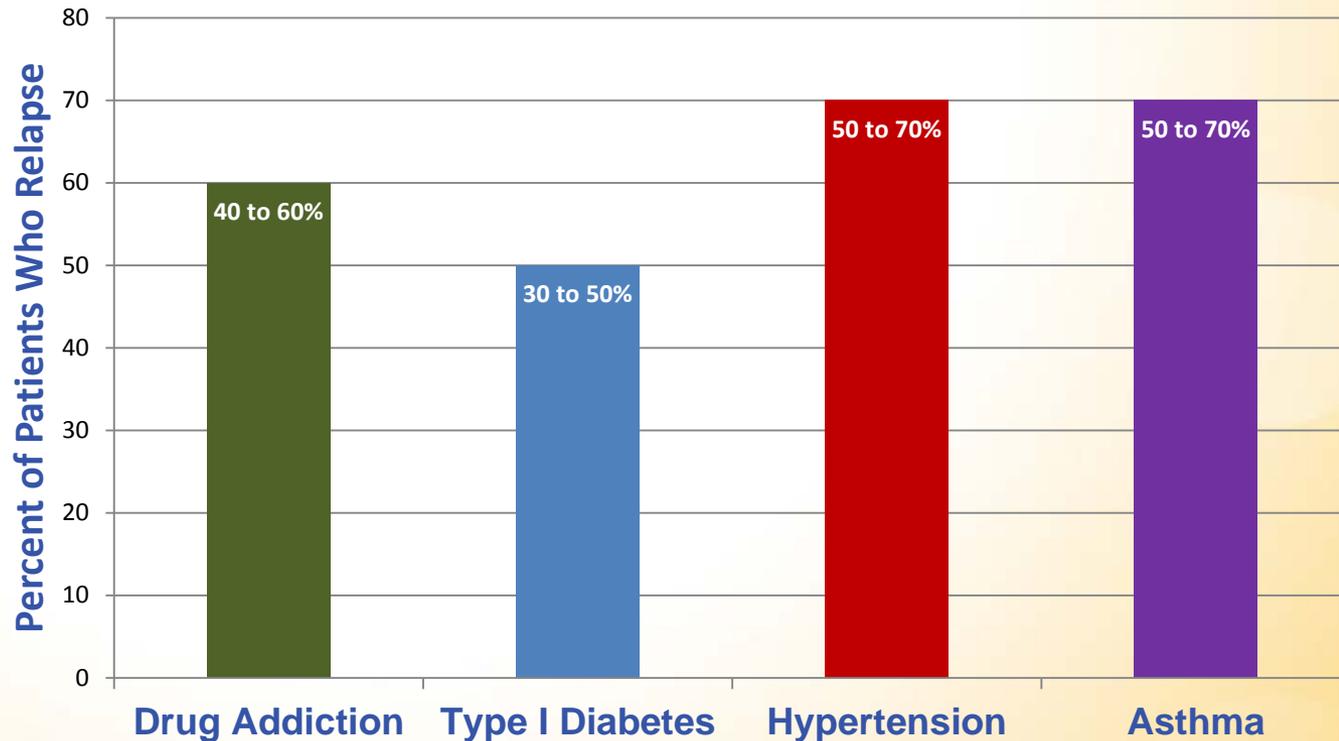


- PET images: depletion of the brain's DA receptors by drugs of abuse
- Normalize with long-term recovery

Treatment: Chronic Disease Model



Comparison of Relapse Rates between Drug Addiction and Other Chronic Illnesses



Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

Source: JAMA 284:1689—1695, 2000.

Addiction is Treatable!

- Strong relationship between treatment duration and intensity and success
- Chronic, complex disease model
 - Long-term treatment
 - Multi-modal approach to address both addiction and its consequences
 - Individualized approach is crucial

Saitz R et al. J Addict Med 2008; 2:55–65

NIDA 2012, Principles of Drug Addiction Treatment

Stigma of Addiction and its Treatment is a Major Barrier to Seeking Help

BREAKING THE
STIGMA

Addiction: The Disease

Barry CL et al., Psychiatr Serv 2014, 65(10): 1269-72
Clement S, Psychological Medicine, 2015, 45(1): 11-27

Benefits of Treatment

- Improved prenatal care
- Improved birthweight
- Decreased preterm birth
- Improved treatment retention
- Improved engagement in parenting
- Improved maternal custody



Fullerton et al.2014; Jones HE et al., 2012, 2008

MAT for Opioid Addiction

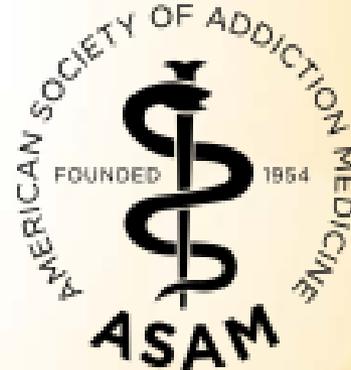
- Medications block opioid receptors
 - ↓ Craving
 - ↓ Illicit opioid use and its consequences
- Buprenorphine and Methadone:
Crucial for the treatment of pregnant women
- Naltrexone:
No diversion, non-addictive

Medication-Assisted Treatment (MAT) for Opioid Dependence

- Methadone (only licensed programs)
 - Oral to take daily
- Buprenorphine (any certified physician)
 - Known as Suboxone[®], Subutex[®]
 - Sublingual to take daily
- Naltrexone (any clinician)
 - Antagonist
 - Oral-Revia[®] (daily); Injectable-Vivitrol[®] (monthly)

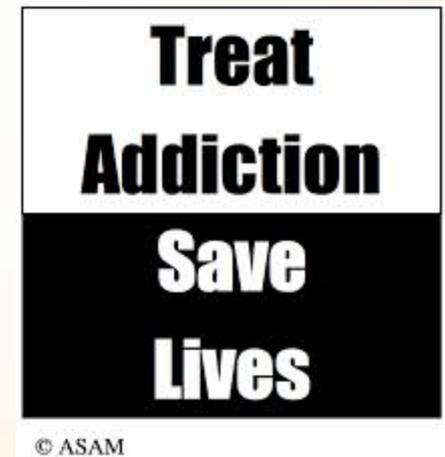
Medications for Opioid Addiction = *Treatment* Not a 'New Addiction'

- Patient is...
 - Not in withdrawal
 - Not intoxicated
 - Not craving
 - Not seeking / using
- Many experience ↑ mood and ↓ anxiety
- *Most report feeling 'normal' again and having their lives back!*



Medications TREAT Opioid Addiction

- Decreased drug use
 - Decreased number of deaths
 - Decreased criminal activity
 - Decreased risk/spread of HIV
 - Decreased cost
- Increased retention-in-treatment
 - Increased engagement in work/social roles
 - Improved pregnancy/child outcomes



Methadone and Buprenorphine Improve Outcomes in Pregnancy

- Neonatal Abstinence Syndrome:
 - Expected and treatable condition that follows maternal opioid use
 - No long term harm in children
 - Less severe, with shorter hospital stay, for newborns born to mothers treated with buprenorphine, compared to methadone

MOTHER Study, Jones HE et al. Addiction, 2012, 107, 28-35

Reduce Barriers to Treatment

- Reduce the stigma of addiction
 - Education; treat addiction like other chronic diseases
 - Treat instead of criminalizing addiction
- Improve patient readiness to treatment
 - Education
 - Primary care-based screening and interventions

Reduce Barriers to Treatment

- Increase treatment capacity
 - Decrease insurance-based barriers
 - Increase number of treatment providers
 - Increase primary care-based interventions:
 - Screening/education
 - Buprenorphine (licensed physicians)
 - Naltrexone (any prescriber)

Optimal Pregnancy Care for Opioid Use Disorder

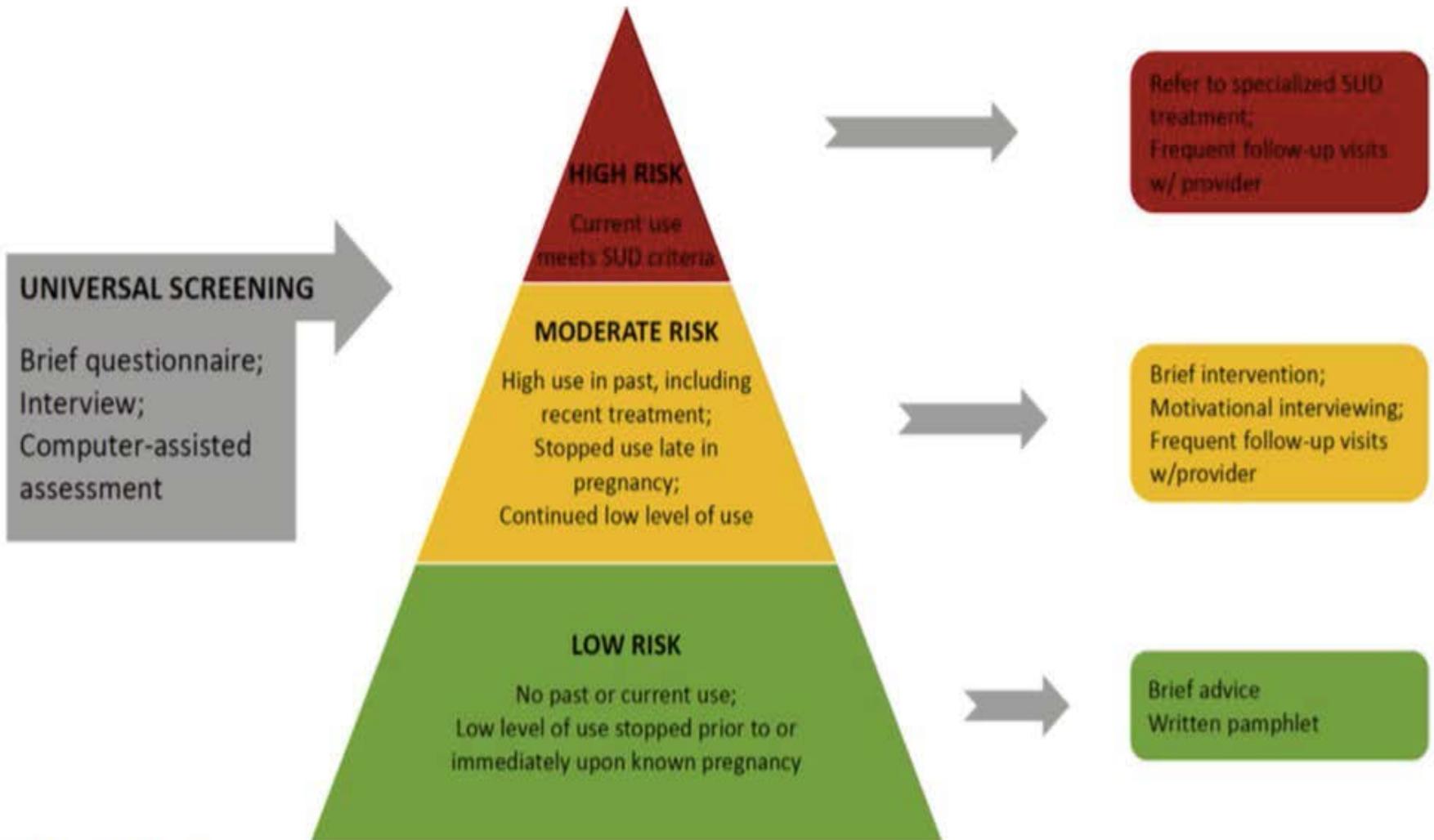
- Universal screening
- Antepartum care
- Peripartum care
- Postnatal care
- Contraceptive counseling

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Component	Goal
Screening	Assess substance use and its severity
Brief intervention	Increase intrinsic motivation to affect behavioral change (ie, reduce or abstain from use)
Referral to treatment	Provide those identified as needing more treatment access to specialty care

Wright. SBIRT in pregnancy. Am J Obstet Gynecol 2016.

Risk pyramid for assessment of substance use during pregnancy



SUD, substance use disorder.

Wright. SBIRT in pregnancy. *Am J Obstet Gynecol* 2016.

Referral to Treatment

- Know what is out there
- Local resources
- SAMHSA website
- 211
- The Periscope Project MCW
- MCH Hotline
- Wisconsin Association of Perinatal Care



MEDICATION-ASSISTED TREATMENT (MAT)

Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders.

Medications to Treat OPIOID ADDICTION

- [Buprenorphine](#)
- [Methadone](#)
- [Naltrexone](#)

Medication for OPIOID OVERDOSE Naloxone

Certifications of OTPs

Find directions to:

- » [Apply for OTP certification](#)
- » [Notify SAMHSA of program changes](#)
- » [Submit an opioid treatment exception request](#)

Regional [OTP Compliance Officers](#) within SAMHSA's [Division of Pharmacologic Therapies \(DPT\)](#) determine whether an OTP is qualified to

NPs and PAs Waivers

Nurse practitioners (NPs) and physician assistants (PAs) can now train and apply to become DATA-Waiver practitioners. [Learn more and sign up for training.](#)

Review SAMHSA's proposed learning objectives for the [NP and PA waiver training.](#)

Buprenorphine Waiver Management

To prescribe or dispense buprenorphine


FREE TRAINING
 PROVIDERS' CLINICAL SUPPORT SYSTEM
[PCSS-Opioid](#)
[Medication Assisted Treatment](#)


BUPRENORPHINE TREATMENT PRACTITIONER LOCATOR


OPIOID TREATMENT PROGRAM DIRECTORY

HELP STARTS HERE

FIND YOUR
LOCAL 2-1-1

ZIP CODE

OR

CITY

AND

STATE



SEARCH

2-1-1 is a free and confidential service that helps people across the U.S. and in many parts of Canada find the local resources they need. We're here for you 24 hours a day, seven days a week.

Antepartum Care

- Other screening:
 - Infection – STIs, HIV, hepatitis, Tb
 - Additional medication/substance use
 - Tobacco
 - Intimate partner violence
 - Comprehensive mental health
 - Comprehensive social assessment

Reddy 2017, Akerman 2012, Winkelbaur
2009

Antepartum Care

- Evaluation of fetal growth
- If antepartum surveillance, 4-6 hours after treatment
- Prenatal consultations
 - Anesthesia, social work, lactation

Reddy 2017

Peripartum Care

- Staff preparation
- Continue with substance treatment
- Early regional anesthesia
 - Avoid nubain and stadol
- Alternative pain management

Reddy 2017

Postpartum Care

- Cesarean section – 50-70% opioid increase
- Encourage lactation and rooming-in
- Coordination with discharge medications
- Coordination with social services
- Follow up – relapse, depression
- Contraception

Reddy 2017



Wednesday, September 6, 2017

1:30 p.m. Eastern

Dial In: 888.863.0985

Conference ID: 49390125

Safety Action Series

Obstetric Care for Women with Opioid Use Disorder Patient Safety Bundle



#3. Do Non-narcotics Really Work? Cochrane Review Results

NNT* to get 50% postop pain relief from one dose:

<u>Medication</u>	<u>NNT*</u>
Oxycodone 15 mg	4.6
Naproxen	2.7
Percocet 5/325	2.7
Ibuprofen 200/APAP 500	1.6

*Number needed to treat

So 1 Advil® + 1 Tylenol® ES is 3 times as likely to give 50% pain relief as OxyIR 15 mg!

<http://www.nsc.org/RxDrugOverdoseDocuments/evidence-summary-NSAIDs-are-stronger-pain-medications-than-opioids-with-IFP.pdf>



Wisconsin Medical Society

Opioid Epidemic: Original Research

Patterns of Opioid Prescription and Use After Cesarean Delivery

Brian Bateman et al. Massachusetts General, Harvard Medical School
VOL. 130, NO. 1, JULY 2017 OBSTETRICS & GYNECOLOGY

720 women enrolled 615 (85.4%) filled an opioid prescription

Median Number of pills dispensed **40** (interquartile range 30-40)

Median Number of pills consumed **20** (interquartile range 8-30)

Median Number of leftover pills **15** (interquartile range 3-26)

Of those with leftovers pills 95% had not disposed of them at 2 weeks post-op

Correlation between the larger of number pills dispensed and larger number consumed independent of patient characteristics

Number of pills dispensed did NOT correlate with patient satisfaction, pain control, or need to refill prescription

Responsible Prescribing

Cesarean Delivery is the most commonly performed inpatient surgical procedure in the United States

Shared Decision Making - A Promising Strategy

- 10 minutes, one day before discharge
- Expected use
- Patterns of pain
- 50% decrease in number of opioids
- Low refill rate
- Risks and benefits of opioid and non-opioid analgesics
- Information on opioid disposal and access to refills

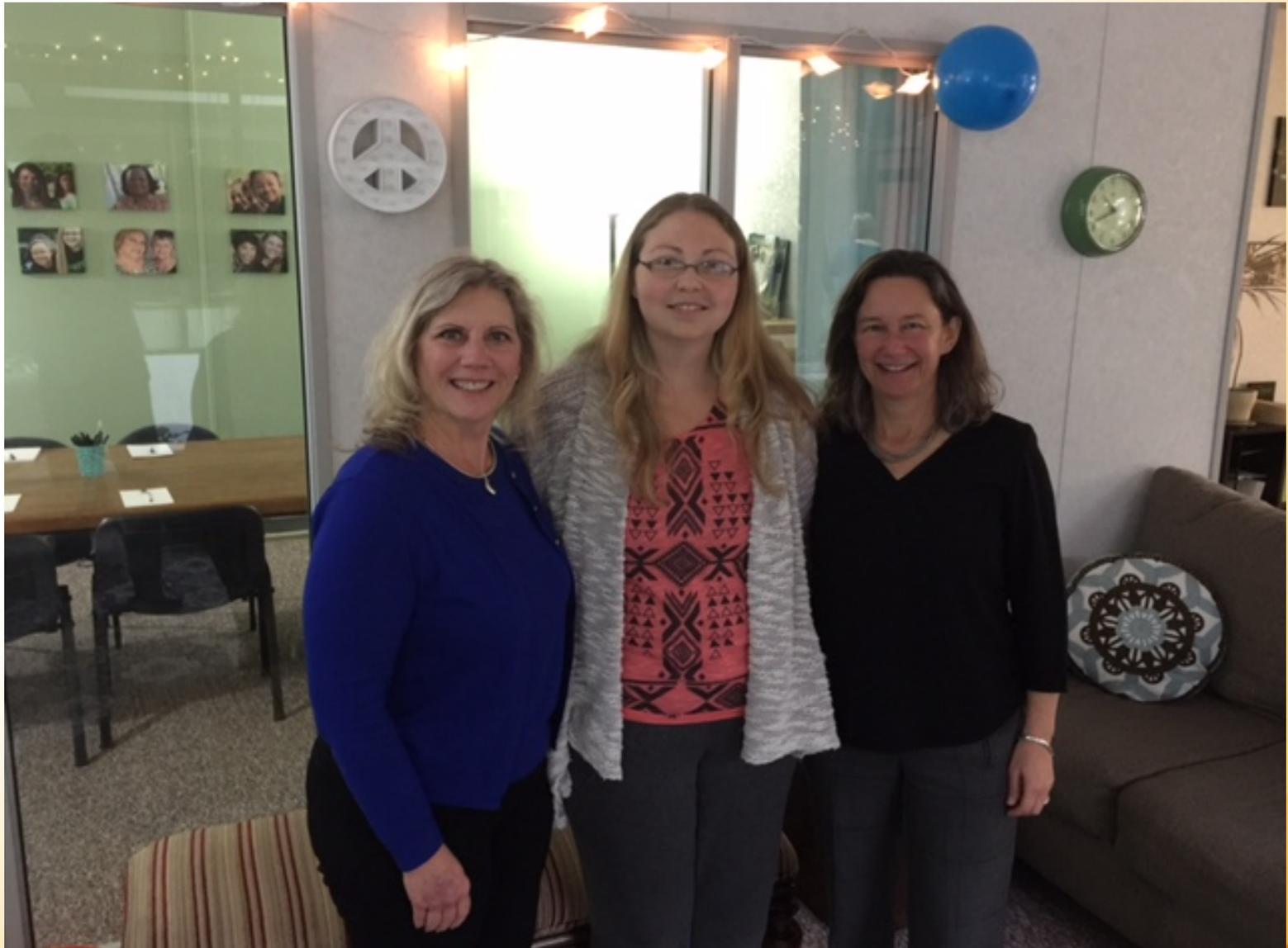


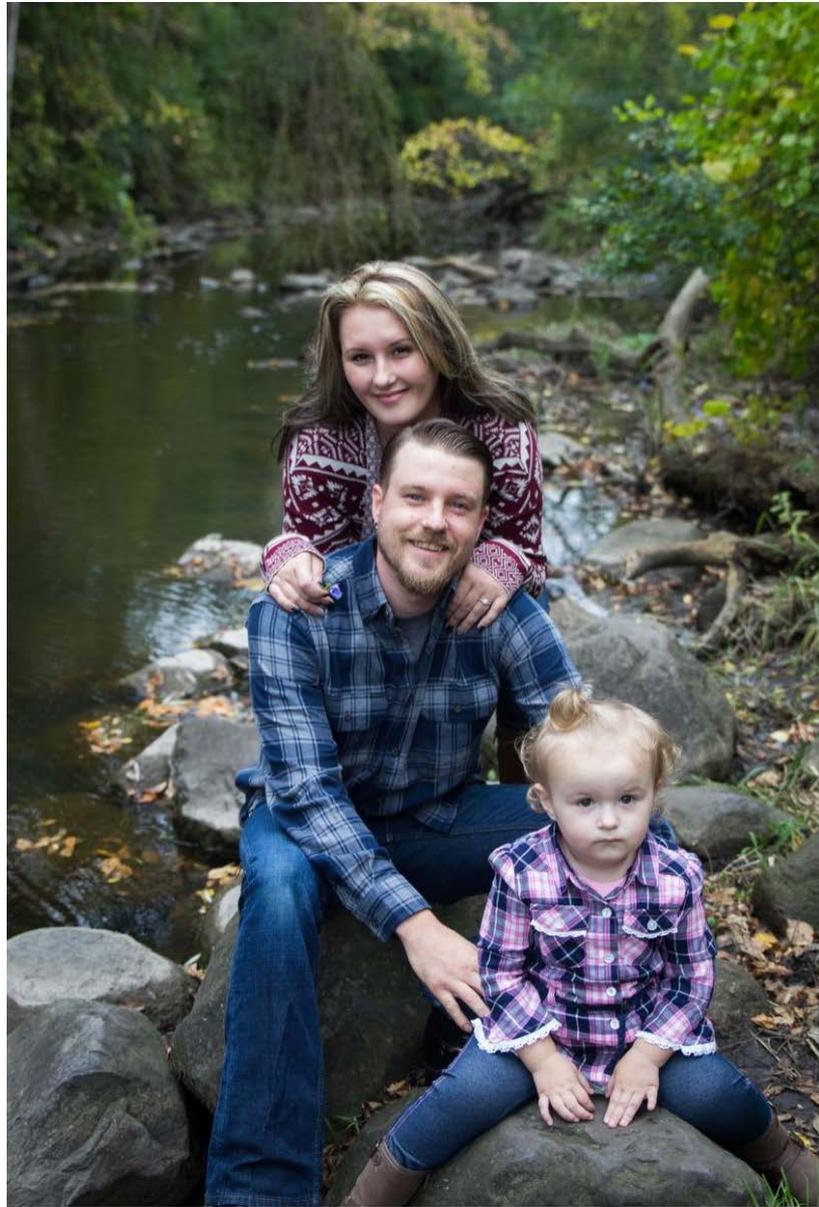
A Blueprint for Action Improving Care for Women and Infants Affected by Opioids

Improving care for women and infants affected by opioids centers on six areas for change:

1. Community engagement to improve care for women and infants affected by opioids
2. Identification and implementation of best practices for care of women and their infants
3. Education and educational resources for women and health care providers
4. Diagnostic and treatment resources for women and their partners
5. Public policies that support women and families
6. Data to support continuous improvement of care for women, infants, and families

2016 Live Births in Wisconsin 66,572
CDC Grant \$1 Million over 5 Years





We can make a substantial public health impact by investing in the prevention and treatment of substance use disorders.

THANK YOU!

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OF OBSTETRICIANS
AND GYNECOLOGISTS
Wisconsin Section



United Community Center Human Service Department

Marcia Villa, MS, LPC-IT, SAC-IT

Laura Haas, Certified Peer Specialist

Levels of Care

- Residential
- Day treatment
- Outpatient

Residential

- 24 hour community based residential facility
- Men's House and Women's House
 - Minor children are allowed to reside with their mothers up to 10 years of age
 - A family suite to accommodate multiple children
- Clients attend approximately 40 hours of programming a week
- Minimum of weekly individual therapy session with Substance Abuse Counselor
- Random urine drug screens

Services

- Family and Child Specialist that provides group therapy sessions and individual sessions
- Case Manager
- Medical Case Manager
- Certified Peer Specialist

Day Treatment

- 5 days a week / 3 Hours each day
- Weekly individual therapy sessions with a Substance Abuse Counselor
- 15 hours of programming a week
- Random urine drug screens

Outpatient

- Weekly individual sessions with Substance Abuse Counselor
- Weekly group therapy sessions
- Random drug screens
- Family sessions if needed

DCF Opioid Steering Committee

DCF Opioid Steering Committee

- Established in response to Governor's Executive Orders #214 in September 2016
- Chaired by DCF and composed of a broad range of stakeholders, including DCF, Department of Health Services (DHS), Children's Court Improvement Project (CCIP), counties, tribes, local law enforcement agencies, health care professionals, and providers.
- Charge: Develop an understanding of and strategies to address opioid addiction and other drug abuse issues in families that affect child safety.
- Monthly meetings since January 2017
- Using the framework recommended by the National Center on Substance Abuse and Child Welfare, which examines the following five points of intervention: Pre-pregnancy, Prenatal, Birth, Neonatal, and throughout Childhood and Adolescence.

DCF Opioid Steering Committee: Guiding Principles

- Recommendations will not create or perpetuate stigma and will seek to mitigate it.
- Recommendations will be strengths-based, trauma-informed, culturally responsive, and focused on preserving children safely in their family homes whenever possible.
- Recommendations will be focused on serving the family and will be respectful and inclusive of roles within family.
- Recommendations should be lasting and scalable and incorporate tenets of primary prevention when applicable and ensure family and child safety is the focus.
- Recommendations will promote and facilitate family, community, and social support as well as social inclusion.

DCF Opioid Steering Committee: Guiding Principles

- Recommendations will be informed by the science of addiction and the role of trauma and attachment on child development and family health.
- Recommendations will be measurable, based on data from reputable sources, and be informed by state and national evidence-based models and best practice.
- Recommendations will recognize the importance of leveraging private, as well as public, funding, particularly for prevention.
- Recommendations, whether based on local or state-level change, will promote coordination and a systemic response and be implemented at the systems level.
- Recommendations must be sensitive to and should recognize when there are barriers to timely access to related or needed services within or across the state.

DCF Opioid Steering Committee: Recommendations under Consideration

Prevention

- Subject to funding availability, expand use of evidence-based programs such as “Celebrating Families!” and “Strengthening Families” prevention program, designed to break intergenerational cycle of addiction within families

Child Welfare Response

- Evaluate and revise as appropriate the State CPS Standards and Chapter 48 to reflect and align with an understanding of the cycle of addiction
- Review curriculum in the child welfare training system and social work schools related to substance use and families/parenting to ensure it reflects the science of addiction and the unique relationship to child safety
- Improve data collection on drug/alcohol use in child welfare and youth justice cases

DCF Opioid Steering Committee: Recommendations under Consideration

Cross-system Collaboration and Education

- Develop a shared language and practice model among professionals in the different systems assisting families with addiction, including trauma informed principles, and support pilot program.
- Strengthen cross-system education/collaboration/peer learning among CPS, local and national law enforcement, health care providers, workforce system, education partners (schools and child care), and legal partners (courts and attorneys), specifically including voices of individuals with lived experience

Legal

- Shift focus in legal system from criminal charges to establishing Substance Use Disorder (SUD) treatment for caregivers involved in the system due to SUD
- Subject to funding availability, expand Family Drug Treatment Courts

DCF Opioid Steering Committee: Recommendations under Consideration

Substance Use Disorder (SUD) Service Capacity

- Expand and promote treatment programs for parents with children that are tailored to the individual's needs and the needs of the children; such as providing living spaces and/or child care and services for children as needed.
- Increase workforce capacity of professionals treating SUD using evidence based approaches by (subject to funding availability):
 - Increasing the Medicaid reimbursement rate for clinicians, therapists, and counselors to help support expansion of service capacity and avoid financial burdens on other systems.
 - Reducing barriers to AODA clinician licensing.
- Integration of peer support services into clinical care.
- Provide 24/7 availability of emergency services such as community recovery specialists (as in Sauk County program) to improve safety planning and to immediately link services for the individual.

Comments/Questions?