

SUBSTANCE EXPOSED NEWBORNS: ADDRESSING SUBSTANCE USE DISORDER

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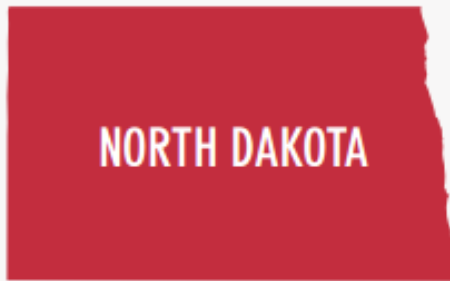
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— NORTH DAKOTA —
**BEHAVIORAL
HEALTH**

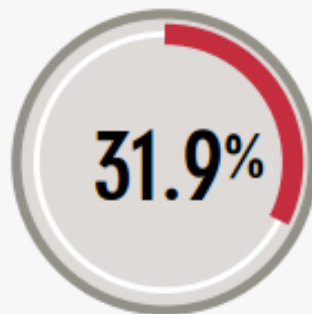
SUBSTANCE USE

ADULTS (AGES 18+)¹²

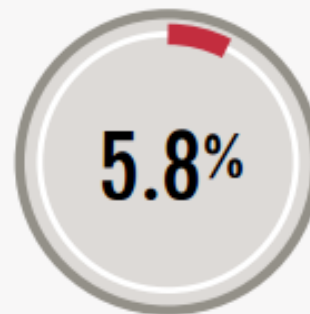
Adults Age 18 and Older Past 30-Day Substance Use



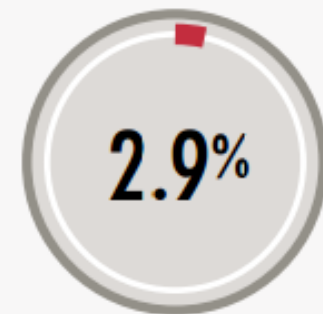
BINGE
ALCOHOL USE



TOBACCO



MARIJUANA



ILLCIT
DRUGS

SUBSTANCE USE



Approximately **6.7%** of ND adults age 26 or older met the criteria for alcohol dependence or abuse in the past year.¹²

SUBSTANCE USE AMONG WOMEN OF CHILDBEARING AGE (*NATIONAL DATA*)

18% of pregnant women **drink alcohol during early pregnancy**, dropping to 4% during late pregnancy.

An estimated annual average of about 21,000 pregnant women **misuse opioids in the past month**.

21,553 female **substance use treatment admissions were pregnant** at treatment entry.

- 22.9 percent reported **heroin** as a substance of misuse, and
- 28.1 percent reported any **non-heroin opioid** as a substance of misuse.

SUBSTANCE EXPOSED NEWBORNS

Nationally each year an estimated 400,000–440,000 infants (10–11% of all births) are affected by prenatal alcohol or illicit drug exposure.

In 2013, 795 children were diagnosed with Fetal Alcohol Spectrum Disorder in North Dakota.

FASD is more prevalent than Down Syndrome, muscular dystrophy, and is as common as autism spectrum disorder.

THE NORTH DAKOTA TASK FORCE ON SUBSTANCE EXPOSED NEWBORNS

The Task Force was comprised of representatives from state agencies, the legislature, medical providers, nonprofit entities focused on children's health and wellbeing, Indian tribes, law enforcement, and the foster care community.

The Task Force developed a report, *“2016 Summary of Recommendations: Report to Legislative Management”*

NORTH DAKOTA TASK FORCE ON SUBSTANCE EXPOSED NEWBORNS
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GOAL ONE
Collect and organize data concerning the nature and extent of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS) from substance use/abuse in the state.

GOAL TWO
Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use/abuse.

GOAL THREE
Identify available federal, state and local programs that provide services to mothers who use/abuse drugs or alcohol and to newborns who have NAS* and evaluate those programs and services to determine if gaps in programs or ineffective policies exist.

GOAL FOUR
Evaluate methods to increase public awareness of the dangers associated with substance use/abuse, particularly to women, expectant mothers and newborns.

PRE-PREGNANCY	PRENATAL	BIRTH	NEONATAL	CHILDHOOD & ADOLESCENCE
This timeframe offers the opportunity to promote awareness of the effects of prenatal substance use among women of child-bearing age and their family members.	This intervention point encourages health care providers to screen pregnant women for substance use as part of routine prenatal care and make referrals that facilitate access to treatment and related services for women who need those services.	Interventions during this timeframe incorporate testing newborns for substance exposure at the time of delivery.	Developmental assessment and the corresponding provision of services for the newborn as well as the family at this intervention point, immediately after the birth event, are the emphasis.	This timeframe calls for ongoing provision of coordinated services for both child and family.

GENERAL CONSIDERATIONS

Addiction and drug abuse during pregnancy should be treated as a health issue since research shows universal criminalization has been ineffective.

Due to current data gaps, the North Dakota State Epidemiological Outcomes Workgroup (SEOW) should determine the best means and methods for developing short- and long-term data on the incidence and cost of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS).

The North Dakota Department of Health should explore mechanisms for recording data on the numbers of newborns born exposed to substances, the substances they are exposed to and the number diagnosed with NAS*.

Medical professionals should follow the current laws for testing, referring, follow-up and reporting pregnant women who are abusing alcohol or using controlled substances and for reporting substance exposed newborns.

State's attorneys and behavioral health professionals should evaluate the pros and cons of having an affirmative defense of periodic drug testing and consent to home visits in cases where criminal child abuse and neglect stems from a parent or caregiver's substance abuse.

*NAS: Neonatal Abstinence Syndrome (also known as Neonatal Withdrawal Syndrome)

POINTS OF INTERVENTION

Pre-Pregnancy

Promote awareness of the effects of prenatal substance use among women of child-bearing age and their family members.

Prenatal

Encourage health care providers to **screen pregnant women for substance use** as part of routine prenatal care and **make referrals that facilitate access to treatment** and related services for women who need those services.

Birth

Testing newborns for substance exposure at the time of delivery.

Neonatal

Developmental assessment and the corresponding **provision of services** for the newborn as well as the family

Childhood & Adolescence

Ongoing provision of coordinated services for both child and family.

**SUBSTANCE USE
DISORDER
TREATMENT BEST
PRACTICES**

EFFECTIVE SUBSTANCE USE DISORDER TREATMENT

1. Addiction is a **complex but treatable disease** that affects brain function and behavior.
2. **No single treatment** is appropriate for everyone.
3. Treatment needs to be **readily available**.
4. Effective treatment attends to **multiple needs** of the individual, not just his or her drug abuse.
5. **Remaining in treatment** for an adequate period of time is critical.

EFFECTIVE SUBSTANCE USE DISORDER TREATMENT

6. **Behavioral therapies**—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.
7. **Medications** are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be **assessed continually and modified** as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other **mental disorders**.

EFFECTIVE SUBSTANCE USE DISORDER TREATMENT

10. Medically assisted **detoxification is only the first stage** of addiction treatment and by itself does little to change long-term drug abuse.
11. Treatment **does not need to be voluntary** to be effective.
12. Drug use during treatment **must be monitored continuously**, as lapses during treatment do occur.
13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other **infectious diseases** as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary

MEDICATION ASSISTED TREATMENT

- Naltrexone
- Buprenorphine
DATA 2000 Waiver
- Methadone
Opioid Treatment Programs

PARENTS LEAD FOR PROFESSIONALS

Using Medication to Treat Opioid Addiction

Medication Assisted Treatment is an effective method for achieving recovery.

- Science has proven medication treatment, when combined with other supportive services, is successful in leading patients to live productive lives in recovery.
- Medications are already used to assist with opioid withdrawal (detoxification); however, opioid withdrawal by itself is NOT treatment—it is merely the first step within the treatment process.
- Opioid addiction is associated with a high rate of relapse. Medication can effectively manage cravings, decreasing potential for relapse.

Myth: Prescribing medication for addiction is substituting one addiction for another.

Fact: When used properly, taking medication to manage the symptoms of addiction is like taking insulin to regulate diabetes.

Medications Used to Treat Opioid Addiction

- Buprenorphine (Suboxone, Suboxone)**
 - Decreases withdrawal symptoms for a longer period of time compared to methadone
 - Prescribed by specialized physicians
- Methadone (Methadose, Dolophine)**
 - Reduces cravings and prevents withdrawal symptoms
 - Monitored in specialized opioid treatment programs
- Naltrexone (Depade, Revia, Vivitrol)**
 - Prevents feeling the effects of a drug
 - Prescribed as an oral medication or by monthly injections

When not treated effectively, opioid abuse can lead to these potential consequences:

- Increase in heroin use
- Increased needle use
- Increased rates of HIV/AIDS
- Increase in crime
- Increased risk of overdose

6.4% in 2007 **TO** **14%** in 2014
Increase in the number of people (18 years or older) receiving treatment at ND Human Service Centers reporting prescription drug abuse (TEDS).

DID YOU KNOW? Opioid treatment is provided by medical professionals in a medical setting.

www.parentslead.org/professionals

OPIOID TREATMENT PROGRAMS

Opioid Treatment Programs use medication and counseling to treat individuals with opioid pain medication and/or heroin addiction.

BISMARCK

- ▶ Heartview began serving patients March 8, 2017. They currently have 9 patients.
- ▶ Premier Care, Inc. withdrew their application.

MANDAN

- ▶ A one year moratorium on OTPs expired in October 2015.
- ▶ Community Medical Services submitted an application, however, has requested the application be placed on hold.

MINOT

- ▶ The one year moratorium on OTPs was lifted September 2015.
- ▶ August 10, 2016 Community Medical Services began serving patients. They currently have 63 patients.

WEST FARGO

- ▶ A one year moratorium on OTPs expired in October 2015.
- ▶ West Fargo City Commission passed city licensing standards to oversee and license programs.
- ▶ Premier Care, Inc. withdrew their application.

FARGO


- ▶ Community Medical Services has received a provisional state license and is proceeding with federal requirements prior to operating. They anticipate opening spring 2017.

**BEST PRACTICES
FOR WOMEN WITH
OPIOID USE
DISORDER**

CURRENT STANDARD OF CARE: MEDICATION ASSISTED TREATMENT

The current standard of care for pregnant women with opioid dependence is:

- Referral for **opioid-assisted therapy with methadone**
- Emerging evidence suggests **buprenorphine** also should be considered.



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION
Number 524 • May 2012 (Reaffirmed 2016)

Committee on Health Care for Underserved Women
and the American Society of Addiction Medicine
This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Opioid Abuse, Dependence, and Addiction in Pregnancy

ABSTRACT: Opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists.

Opioid abuse in pregnancy includes the use of heroin and the misuse of prescription opioid analgesic medications. According to the 2010 National Survey on Drug Use and Health, an estimated 4.4% of pregnant women reported illicit drug use in the past 30 days (1). A second study showed that whereas 0.1% of pregnant women were estimated to have used heroin in the past 30 days, 1% of pregnant women reported nonmedical use of opioid-containing pain medication (2). In this study, the rates of use varied by setting and by mode of assessment. The urine screening of pregnant women in an urban teaching hospital resulted in a detection rate for opioids of 2.6% (2). The prevalence of opioid abuse during pregnancy requires that practicing obstetrician-gynecologists be aware of the implications of opioid abuse by pregnant women and of appropriate management strategies.

Pharmacology and Physiology of Opioid Addiction

Opioid addiction may develop with repetitive use of either prescription opioid analgesics or heroin. Heroin is the most rapidly acting of the opioids and is highly addictive (3). Heroin may be injected, smoked, or nasally inhaled. Heroin has a short half-life, and a heroin user may need to take multiple doses daily to maintain the drug's effects. Prescribed opioids that may be abused include codeine, fentanyl, morphine, opium, methadone, oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene, and buprenorphine (the partial agonist). These products may variously be swallowed, injected, nasally inhaled, smoked, chewed, or used as suppositories (4). The onset and intensity of euphoria will vary based on how the drug was taken and the formulation; however, all have the potential for overdose, physical dependence, abuse, and addiction. Injection of opioids also carries the risk of cellulitis and abscess formation at the injection site, sepsis, endocarditis, osteomyelitis, hepatitis B, hepatitis C, and human immunodeficiency virus (HIV) infection.

Opioids bind to opioid receptors in the brain and produce a pleasurable sensation (3). Opioids also depress respiration, potentially resulting in respiratory arrest and death. Opioid addiction is associated with compulsive drug-seeking behavior, physical dependence, and tolerance that lead to the need for ever higher doses (4). Once physical dependence to an opioid has developed, a withdrawal syndrome occurs if use is discontinued. With short-acting opioids, such as heroin, withdrawal symptoms may develop within 4–6 hours of use, may progress up to 72 hours, and usually subside within a week. For long-acting opioids, such as methadone, withdrawal

OPIOID AGONISTS VS. WITHDRAWAL MANAGEMENT

Pregnant women who are physically dependent on opioids should receive treatment using agonist medications rather than withdrawal management or abstinence as these approaches may pose a risk to the fetus.

*Furthermore, withdrawal management has been found to be **inferior in effectiveness** over pharmacotherapy with opioid agonists and increases the risk of relapse without fetal or maternal benefit.*

SAFEGUARDING AGAINST DISCRIMINATION AND STIGMATIZATION

Interventions should be provided to pregnant and breastfeeding women in ways that **prevent stigmatization, discrimination, criminalization, and marginalization** of women seeking treatment to benefit themselves and their infants.

Prevention and treatment should promote and facilitate family, community and social support as well as social inclusion by fostering strong links with available childcare, economic supports, education, housing, and relevant services.

EVIDENCE-BASED OVERDOSE PREVENTION IN NORTH DAKOTA

www.prevention.nd.gov/stopoverdose

- Flyers
- Posters
- Professional Resources

PROFESSIONAL RESOURCE FOR BEHAVIORAL HEALTH PROFESSIONALS

STOP OVERDOSE

Overdose deaths in North Dakota increased from 20 deaths in 2013 to 43 deaths in 2014.

WHO IS AT RISK?

- People who use or misuse prescription opioids
- People who use opioids in combination with other sedating substances
- People with an opioid use disorder
- People who inject opioids
- People released from incarceration with a history of opioid use disorder
- People who use opioids in an out-of-hospital treatment program
- People with an opioid use disorder in a period of abstinence
- People with an opioid use disorder after a period of abstinence

STRATEGIES TO PREVENT OVERDOSE DEATHS

1. Advise patients to have naloxone on hand. Encourage patients to have naloxone on hand. Encourage patients to have naloxone on hand. Encourage patients to have naloxone on hand.
2. Educate patients on high risk situations. Educate patients on high risk situations. Educate patients on high risk situations. Educate patients on high risk situations.
3. Responding to an overdose. Responding to an overdose. Responding to an overdose. Responding to an overdose.

SIGNS OF AN OVERDOSE

- Face is clammy to touch and has lost color
- Body is limp
- Pinprick or lips have a blue or purple tinge
- Vomiting or making gurgling noises
- Cannot be awakened from sleep or unable to speak
- Breathing is slow or has stopped
- Heartbeat is slow or has stopped

For more information, visit www.prevention.nd.gov/stopoverdose

PREVENTION RESOURCE + MEDIA CENTER

STOP OVERDOSE

Overdose deaths in North Dakota increased from 20 deaths in 2013 to 43 deaths in 2014.

NALOXONE can be a LIFESAVER

Naloxone is a prescription medication that temporarily reverses an opioid overdose. Sold under the brandname Narcan® or Evion®, the medication can be given by intranasal spray or autoinjector.

IF YOU OR SOMEONE CLOSE TO YOU IS AT RISK FOR AN OPIOID OVERDOSE, ASK YOUR DOCTOR OR LOCAL PHARMACIST FOR A NALOXONE PRESCRIPTION.

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IF YOU WITNESS AN OVERDOSE

1. Call 911 and administer naloxone.
2. Do rescue breathing or chest compressions.
3. Remain onsite until assistance arrives and cooperate with first responders.

For more information, visit www.prevention.nd.gov/stopoverdose

PREVENTION RESOURCE + MEDIA CENTER

STOP OVERDOSE

IF YOU WITNESS AN OVERDOSE

The ND Good Samaritan Law protects you so you can protect your friend.

1. CALL 911 AND ADMINISTER NALOXONE
2. DO RESCUE BREATHING OR CHEST COMPRESSIONS FOLLOW 911 DISPATCHER DIRECTIONS
3. REMAIN ONSITE UNTIL ASSISTANCE ARRIVES AND COOPERATE WITH FIRST RESPONDERS

For more information, visit prevention.nd.gov/stopoverdose

PREVENTION RESOURCE + MEDIA CENTER

STOP OVERDOSE

DO YOU KNOW SOMEONE AT RISK OF AN OVERDOSE?

Ask your doctor or local pharmacist for a naloxone prescription.

Naloxone can temporarily reverse the effects of opioid overdose. It can be a lifesaver.

Overdose deaths in North Dakota increased from 20 deaths in 2013 to 43 deaths in 2014.

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PREVENTION RESOURCE + MEDIA CENTER