Minnesota Summit on Prenatal Substance Use and Infant Exposure

St. Cloud, MN – May 21, 2015

Welcome!

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Department of Human Services

Great Lakes (HHS Region 5) ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

march of dimes®

Minnesota Prematurity Coalition

Acknowledgements

Summit Planning Committee

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*Served on Summit Steering Committee.

Partner Organizations

March of Dimes
Minnesota Prematurity Coalition

The Health and Well Being of the Mother and the Health and Well Being of the Child Are Bound Together

Minnesota Department of Health Great Lakes ATTC Minnesota Department of Human Services

"2015 Minnesota Summit on Prenatal Substance Use and Infant Exposure"

May 21, 2015, St. Cloud, Minnesota

Santa Clara University

The Health and Well Being of the Mother and the Health and Well Being of the Child Are Bound Together

H. WESTLEY CLARK, MD, JD, MPH
DEAN'S EXECUTIVE PROFESSOR
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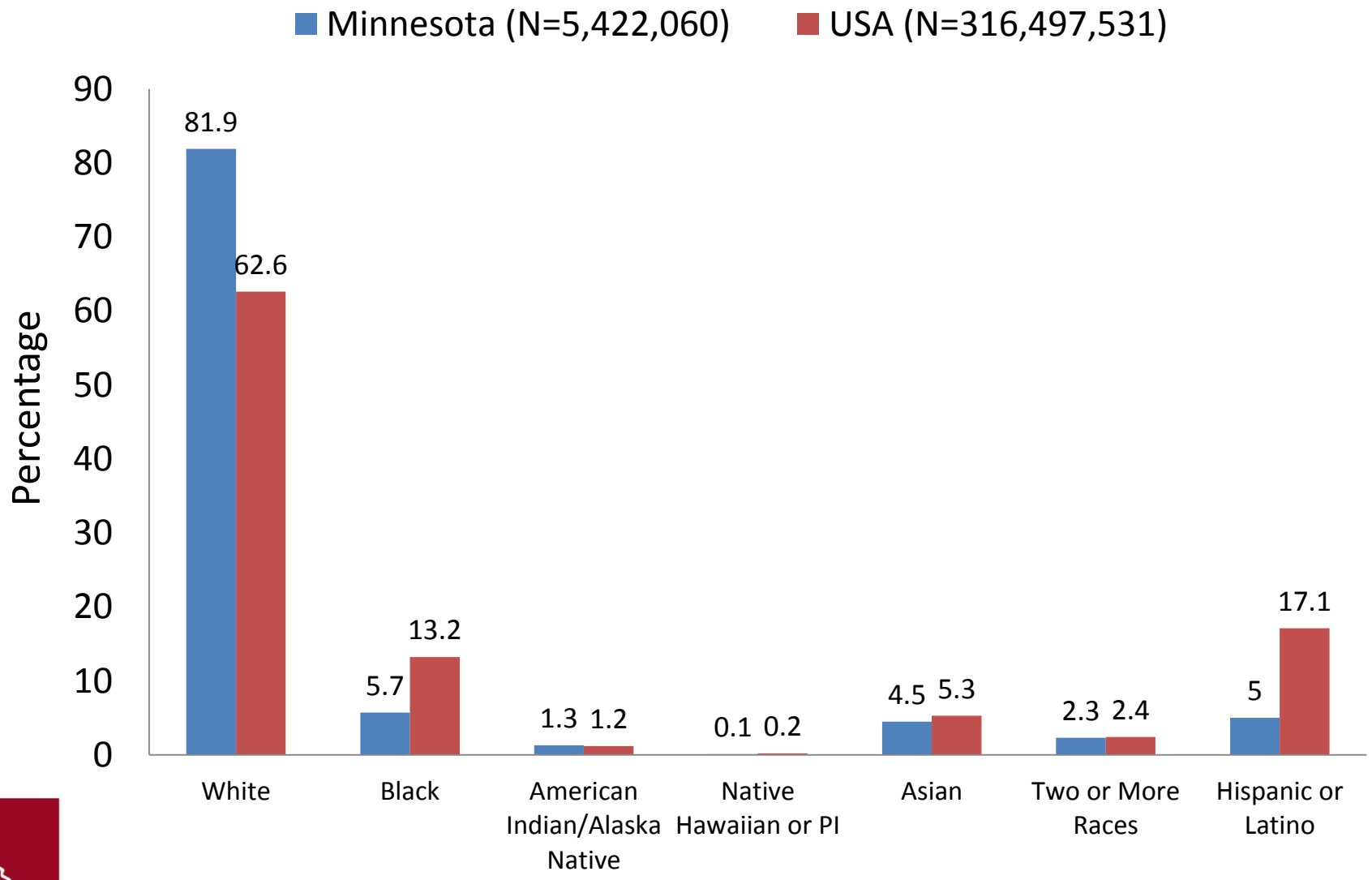
SANTA CLARA UNIVERSITY
Santa Clara, California

Santa Clara University

Overall Population of Minnesota by Race & Ethnicity: Percentages, Based on 2013 US CENSUS.



US Census, 2013

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Estimated Female Population of Minnesota between the Ages of 15 and 44, Based on 2013 US CENSUS.

15 to 19 years	179,235
20 to 24 years	174,926
25 to 29 years	185,124
30 to 34 years	168,351
35 to 39 years	162,375
40 to 44 years	175,670
Total 15-44 years of age	1,045,681

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

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Estimated Number of Women in Minnesota between Ages of 15 and 44 who identify themselves by Race or Ethnicity Alone from the American Community Survey 5-Year Estimates 2009-2013

	White	Black	American Indian/Alaska Native	Hispanic	Asian
15 to 17 years	85,515	7,121	1,353	6,412	5,442
18 to 19 years	57,904	4,720	917	4,509	4,249
20 to 24 years	138,610	12,477	2,730	9,687	10,633
25 to 29 years	145,093	12,542	2,266	10,690	12,115
30 to 34 years	142,341	11,183	1,901	10,627	11,041
35 to 44 years	276,032	18,933	3,667	17,140	17,746

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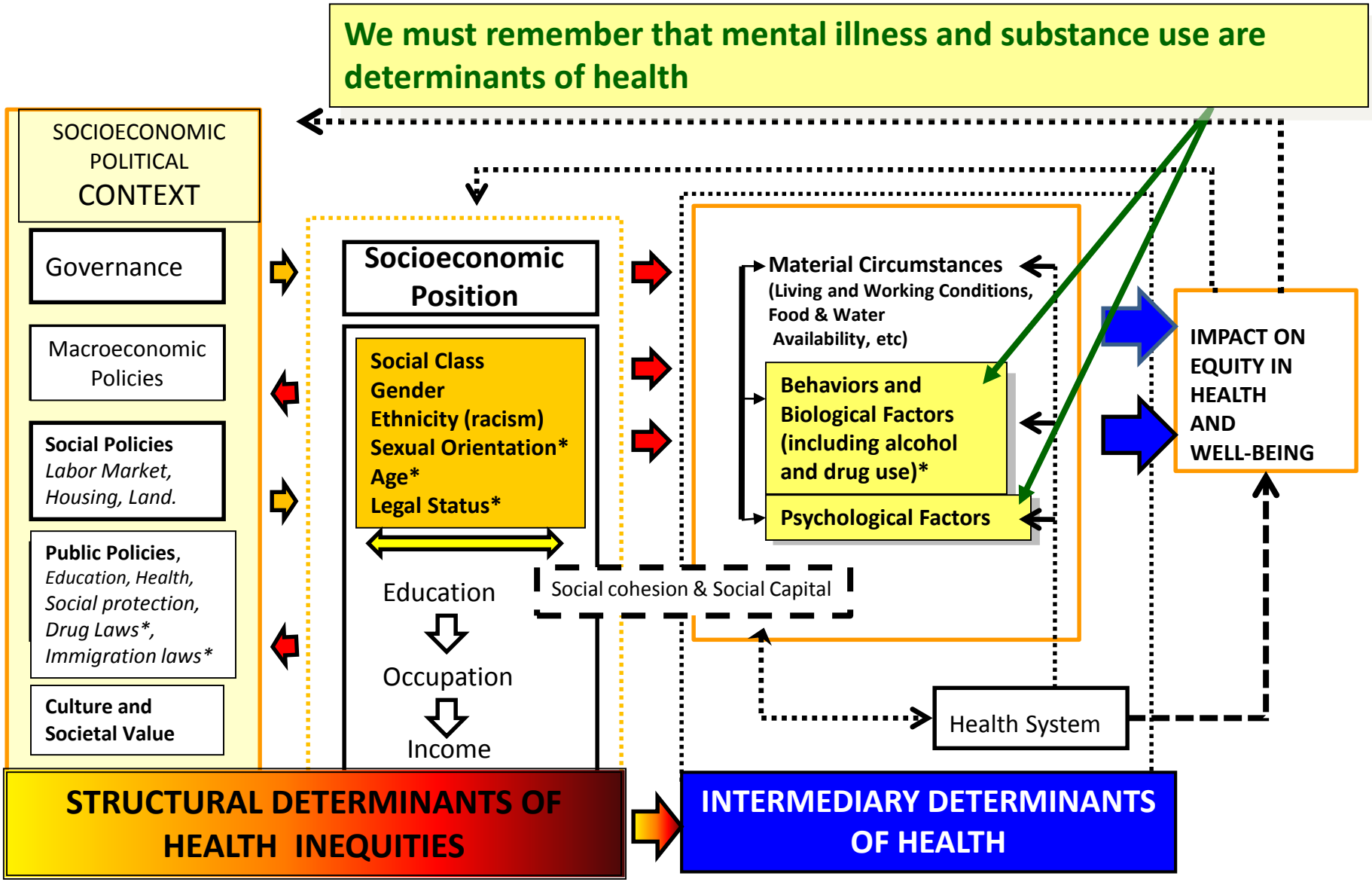
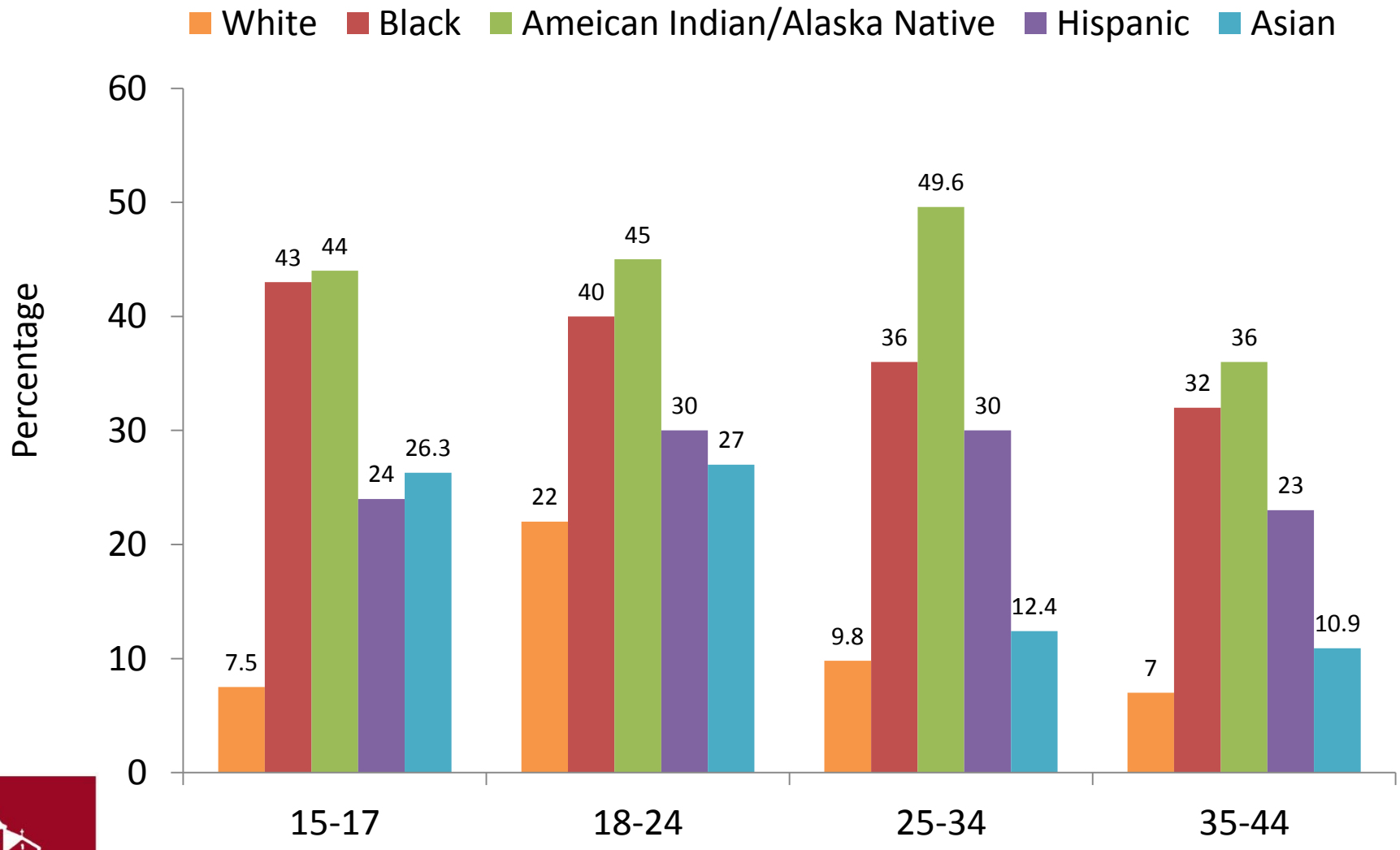
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_B01001B&prodType=table

The Social Determinants of Health*



* Adapted from the World Health Organization

Estimated Percentage of Minnesota Women, by Race Alone or Ethnicity Alone Whose Income is Below Poverty Level in the Past Year



2009-2013 American Community Survey 5-Year Estimate

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Infant Mortality Reduction Plan for Minnesota (IMRPM)

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Infant Mortality Reduction Plan for Minnesota (IMRPM): Recommendations

- Improve health equity and address the social determinants of health that most significantly impact disparities in birth outcomes
- Reduce the rate of Sudden Unexpected Infant Deaths (SUID), which includes SIDS and sleep-related infant deaths in Minnesota
- Assure a comprehensive statewide system that monitors infant mortality
- Provide comprehensive, culturally appropriate, coordinated health care to all women during the preconception, pregnancy and post-partum period
- Reduce the rate of preterm births in Minnesota
- Improve the rate of pregnancies that are planned, including reducing the rate of teen pregnancies
- Establish an ongoing task force of stakeholders to oversee implementation of recommendations and action steps.

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Infant Mortality Reduction Plan for Minnesota (IMRPM)
Appendix C: Alcohol & Drug Use & Abuse Recommendations

- Increase funding directed to prevent drug and alcohol use/abuse. For example, outreach and awareness activities, afterschool programs that support asset building for youth should be available in the community.
- Provide education and services related to alcohol, tobacco, and other drugs during pregnancy and in homes with children
- Educate and support pregnant and parenting women to stop smoking and to not use alcohol or other drugs
- Screen pregnant women for alcohol use at every prenatal visit. Provide referrals for services and support as needed.
- Screen and refer to programs as appropriate to reduce substance use/abuse for women of childbearing age. For pregnant and parenting women, screen refer to every visit. This includes alcohol, tobacco, and other drugs
- Provide intensive, holistic, wrap-around services and support for both parents and children dealing with the effects of fetal alcohol exposure.
- Educate families not to give over-the-counter medicine to infants.

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626.5561 REPORTING OF PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES.

§ Subdivision 1.Reports required.

(a) Except as provided in paragraph (b), a person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

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MINNESOTA STATUTES 2014

(b) A health care professional or a social service professional who is mandated to report under section 626.556, subdivision 3, **is exempt from reporting** under paragraph (a) a woman's use or consumption of **tetrahydrocannabinol or alcoholic beverages** during pregnancy **if the professional is providing the woman with prenatal care or other healthcare services**.

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MINNESOTA STATUTES 2014

§ **Subd. 2.Local welfare agency.**

Upon receipt of a report required under subdivision 1, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include, but are not limited to, a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action under chapter 253B, including seeking an emergency admission under section 253B.05. The local welfare agency shall seek an emergency admission under section 253B.05 if the pregnant woman refuses recommended voluntary services or fails recommended treatment.

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§ **Subd. 5.Immunity.**

(a) A person making a voluntary or mandated report under subdivision 1 or assisting in an assessment under subdivision 2 is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith.

(b) This subdivision does not provide immunity to any person for failure to make a required report or for committing neglect, physical abuse, or sexual abuse of a child.

History:

1989 c 290 art 5 s 5; 1990 c 542 s 27-30; 2007 c 69 s 3,4; 2010 c 348 s 1; 2014 c 291 art 11 s 38

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State and Federal Action Against Pregnant Women with Substance Use Disorders

- In 18 States Substance Abuse during Pregnancy is considered Child Abuse. In one State (Tennessee, it is considered a criminal act.) Three States (MN, WI, S.D.) authorize civil commitment to an inpatient treatment program if the pregnant woman uses substances. Fifteen states require health care professionals to report suspected prenatal drug abuse, and four states require the testing for suspected prenatal drug exposure [IA, KY, MN and N.D.).
- In order to receive federal child abuse prevention funds, states must require health care providers to notify child protective services when the provider cares for an infant affected by illegal substance abuse.

http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf

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Some states are committed to accessible substance abuse treatment for pregnant women

19 states, including Minnesota, have either created or funded drug treatment programs specifically targeted to pregnant women, and 11 provide pregnant women with priority access to state-funded drug treatment programs.

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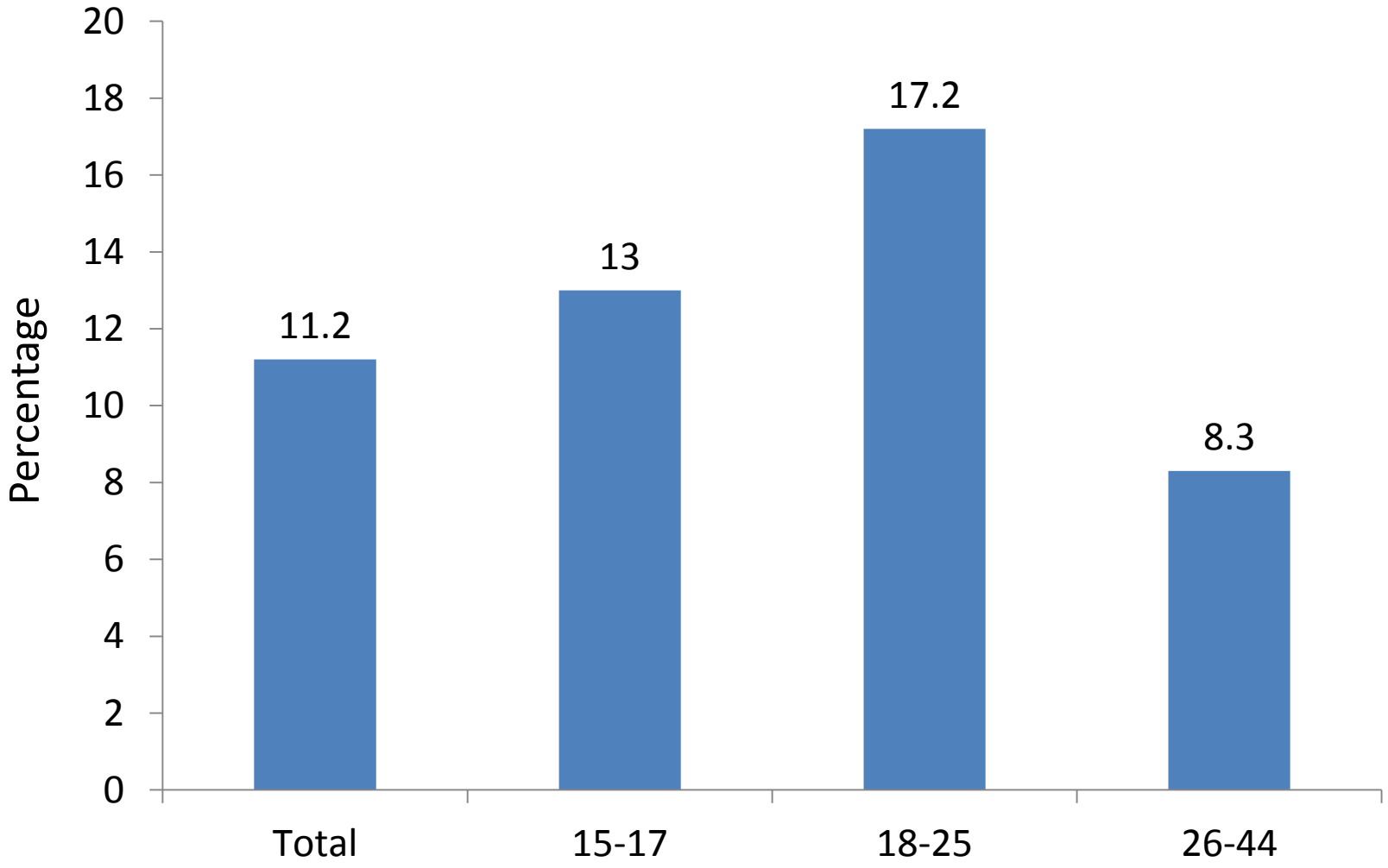
Illicit Drug Use in the Past Month among Females Aged 15 to 44 by Age: Percentages, Annual Averages Based on 2012-2013



National Survey on Drug Use and Health, 2014

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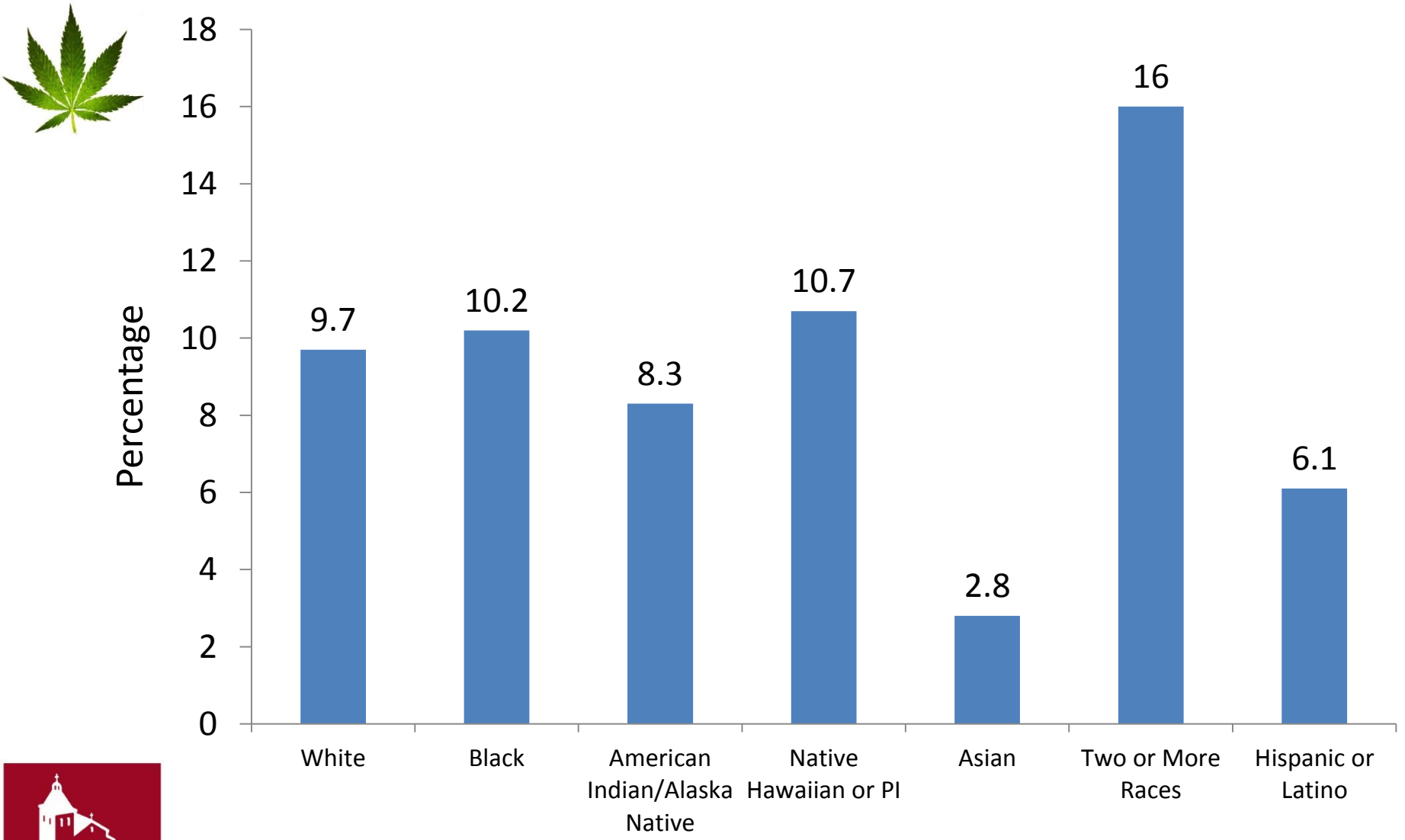
Marijuana Use in the Past Month among Females Aged 15 to 44 by Age, Race & Ethnicity: Percentages, Based on 2012-2013



National Survey on Drug Use and Health, 2014

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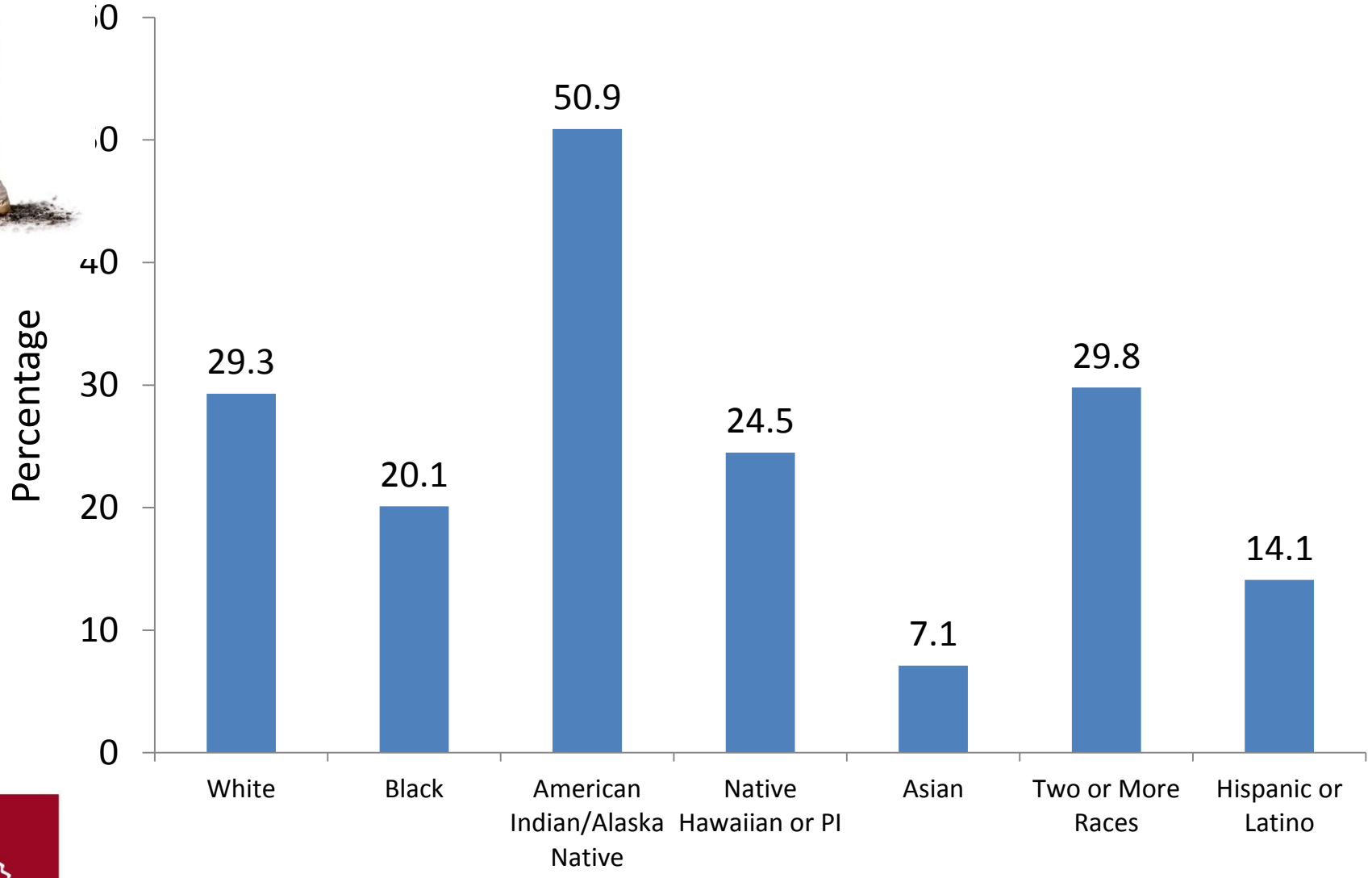
Cigarette Use in the Past Month among Females Aged 15 to 44 by Age, Race & Ethnicity: Percentages, Based on 2012-2013



National Survey on Drug Use and Health, 2014

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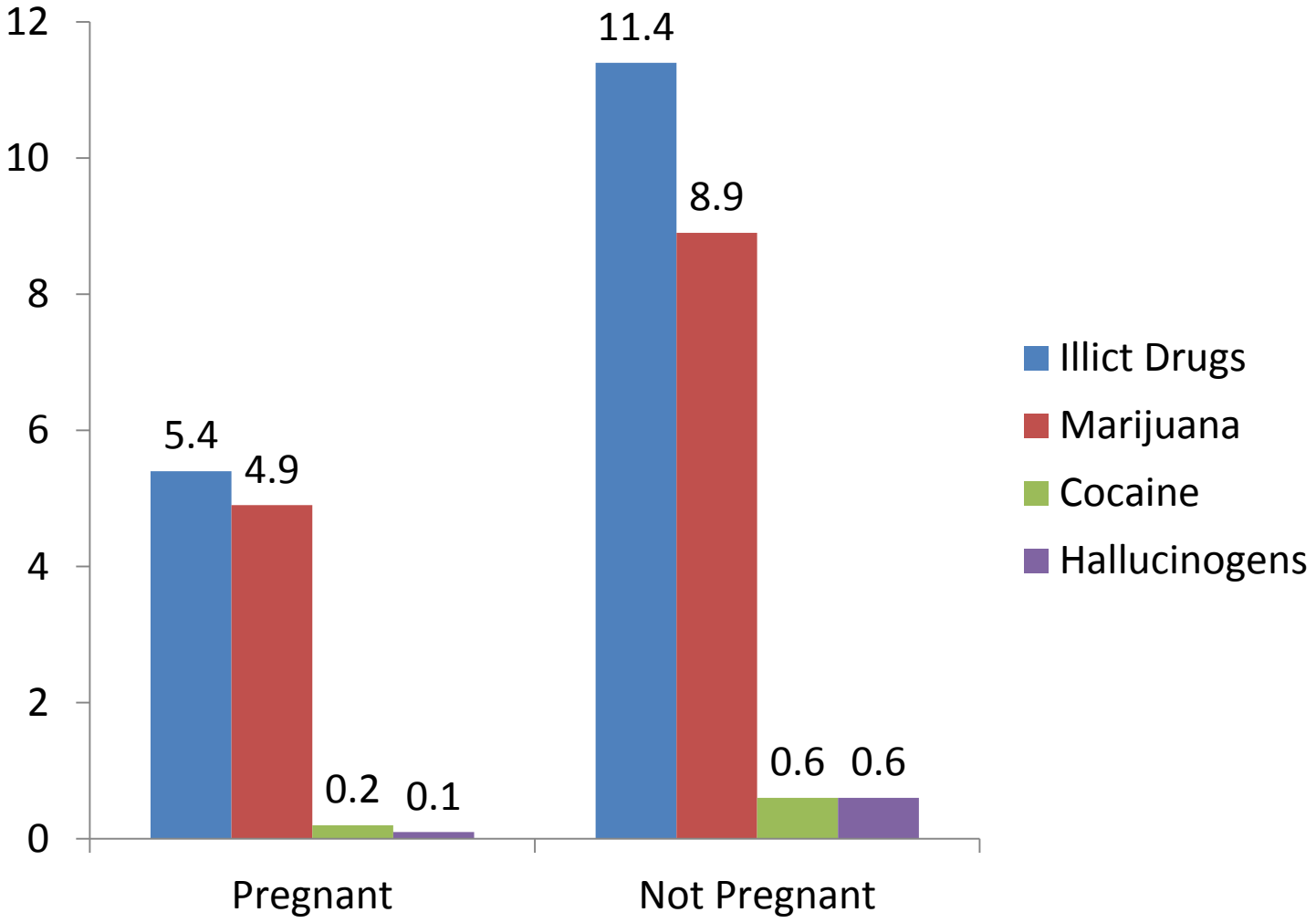
Types of Illicit Drug Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status: Percentages, Annual Average Based on 2012-2013



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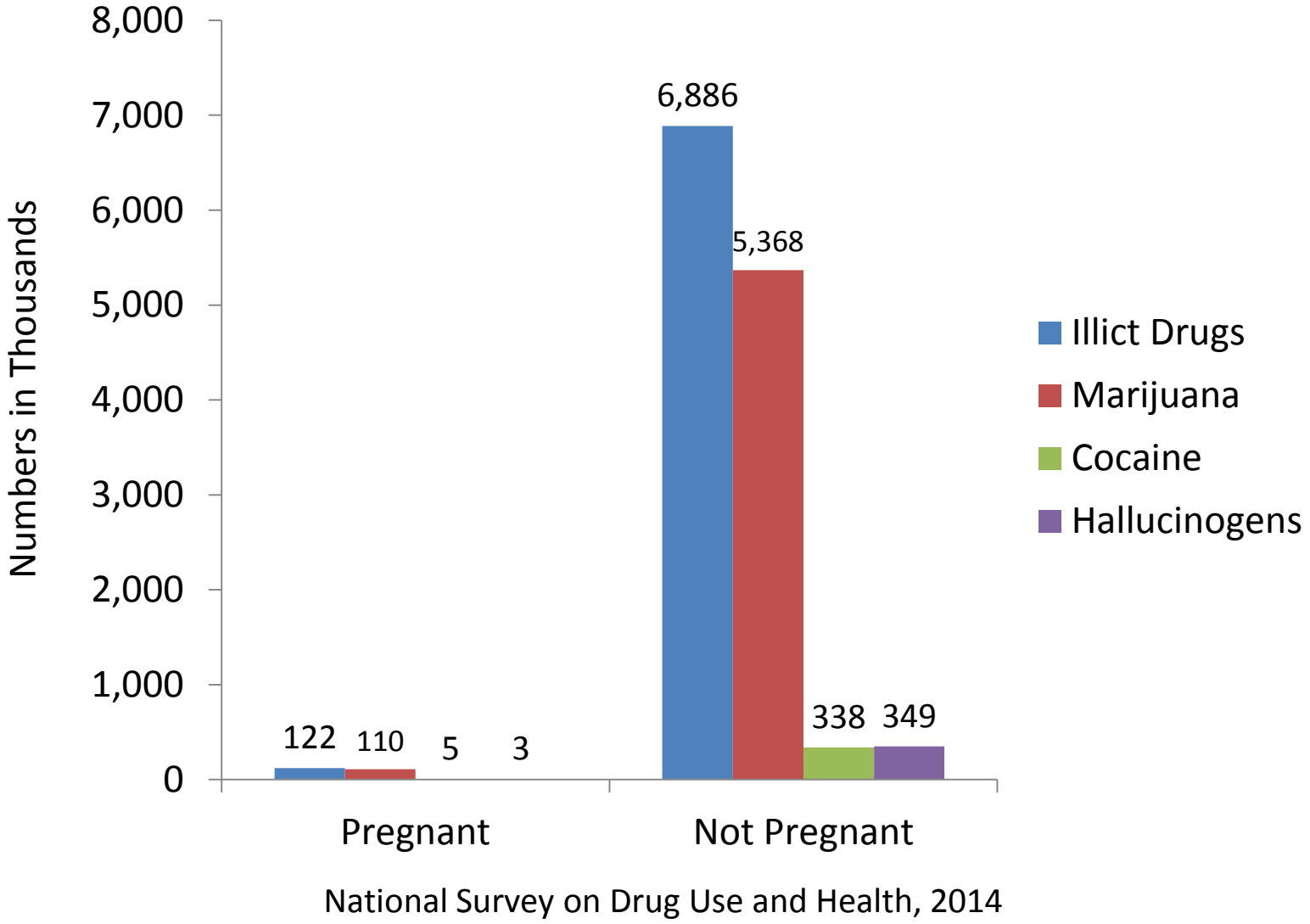
Types of Illicit Drug Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status: Numbers in Thousands, Annual Average Based on 2012-2013



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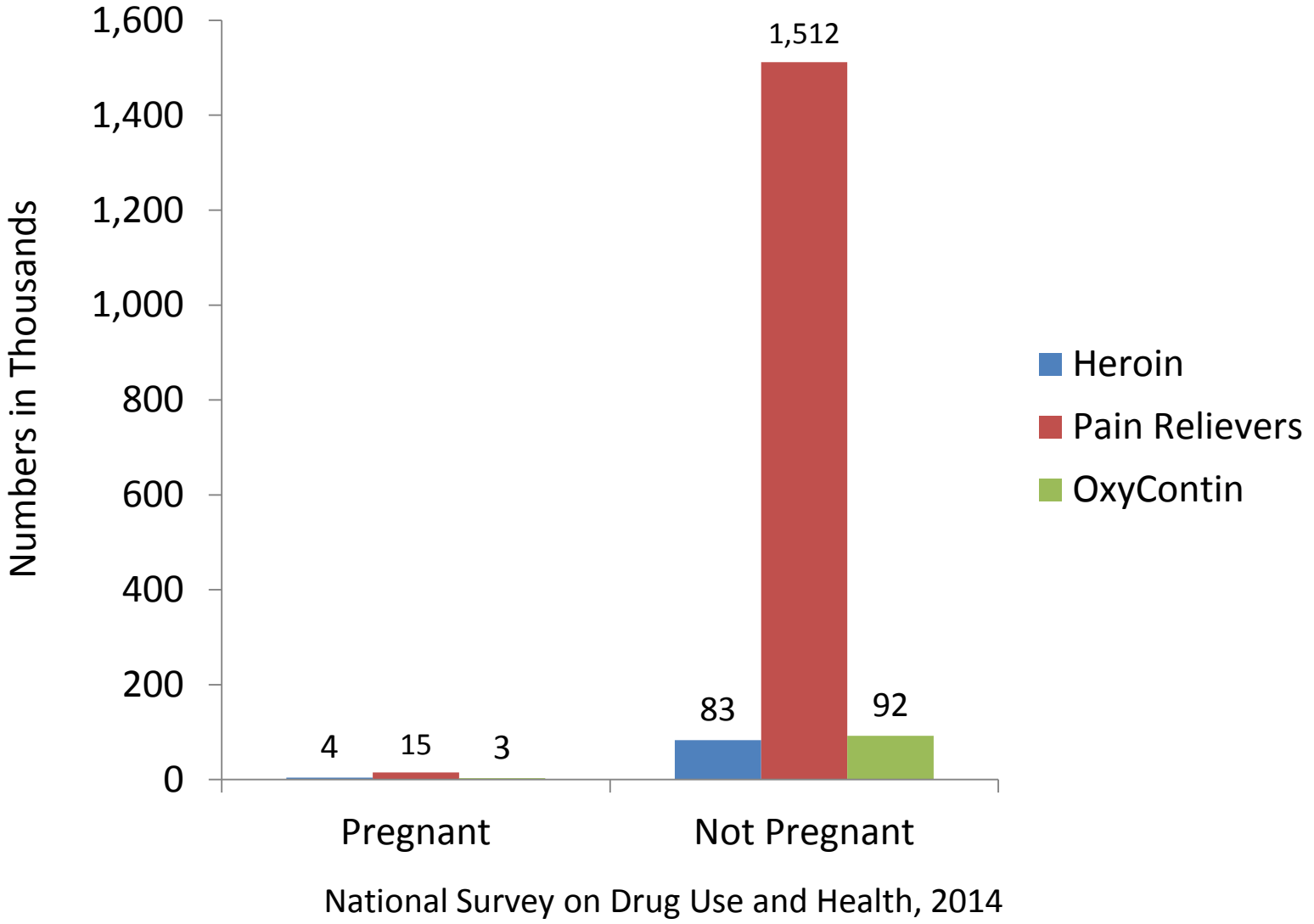

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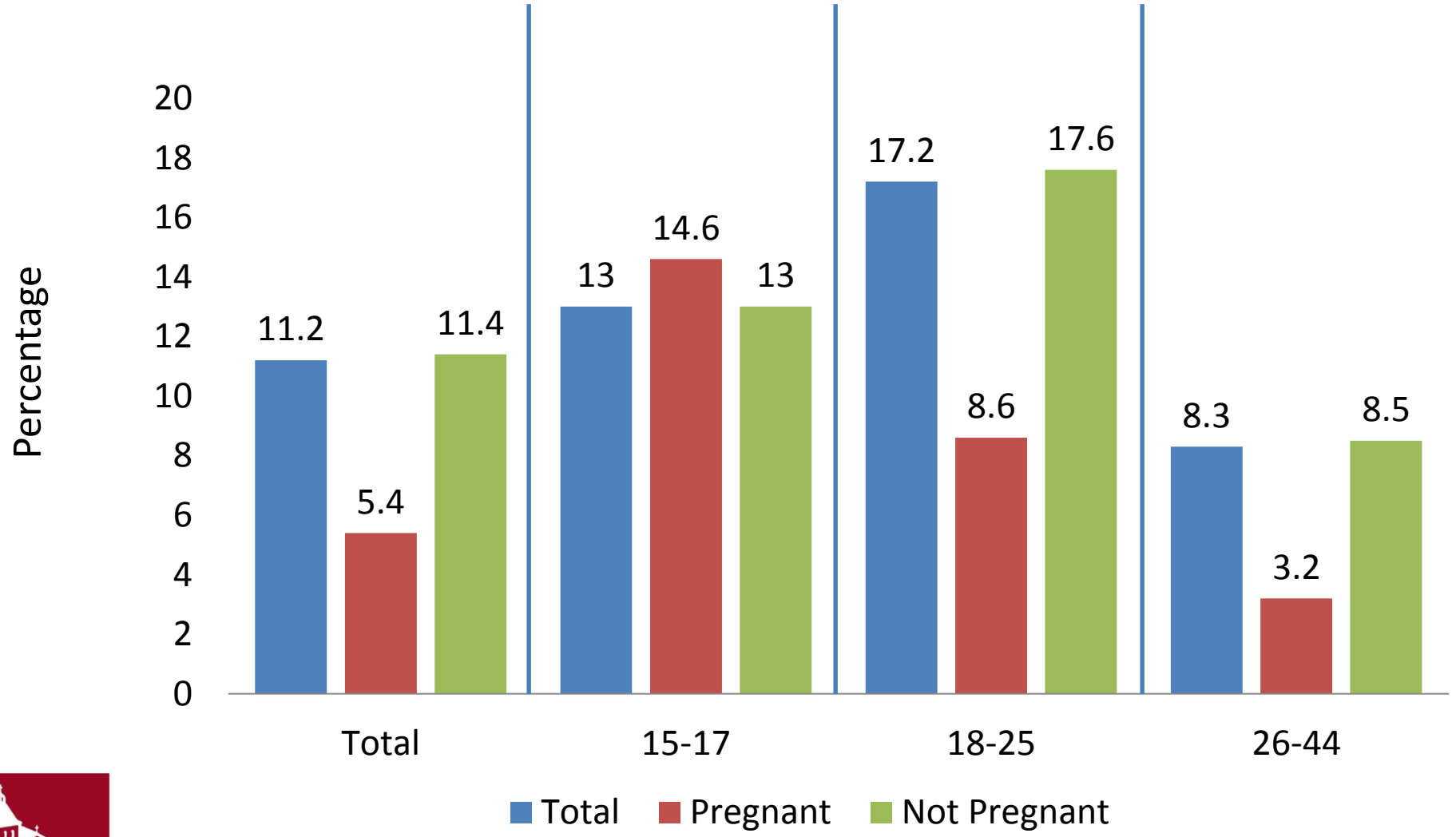
Illicit Drug Use in the Past Month among Females Aged 15 to 44 by Pregnancy & Age: Percentages, Annual Averages Based on 2012-2013



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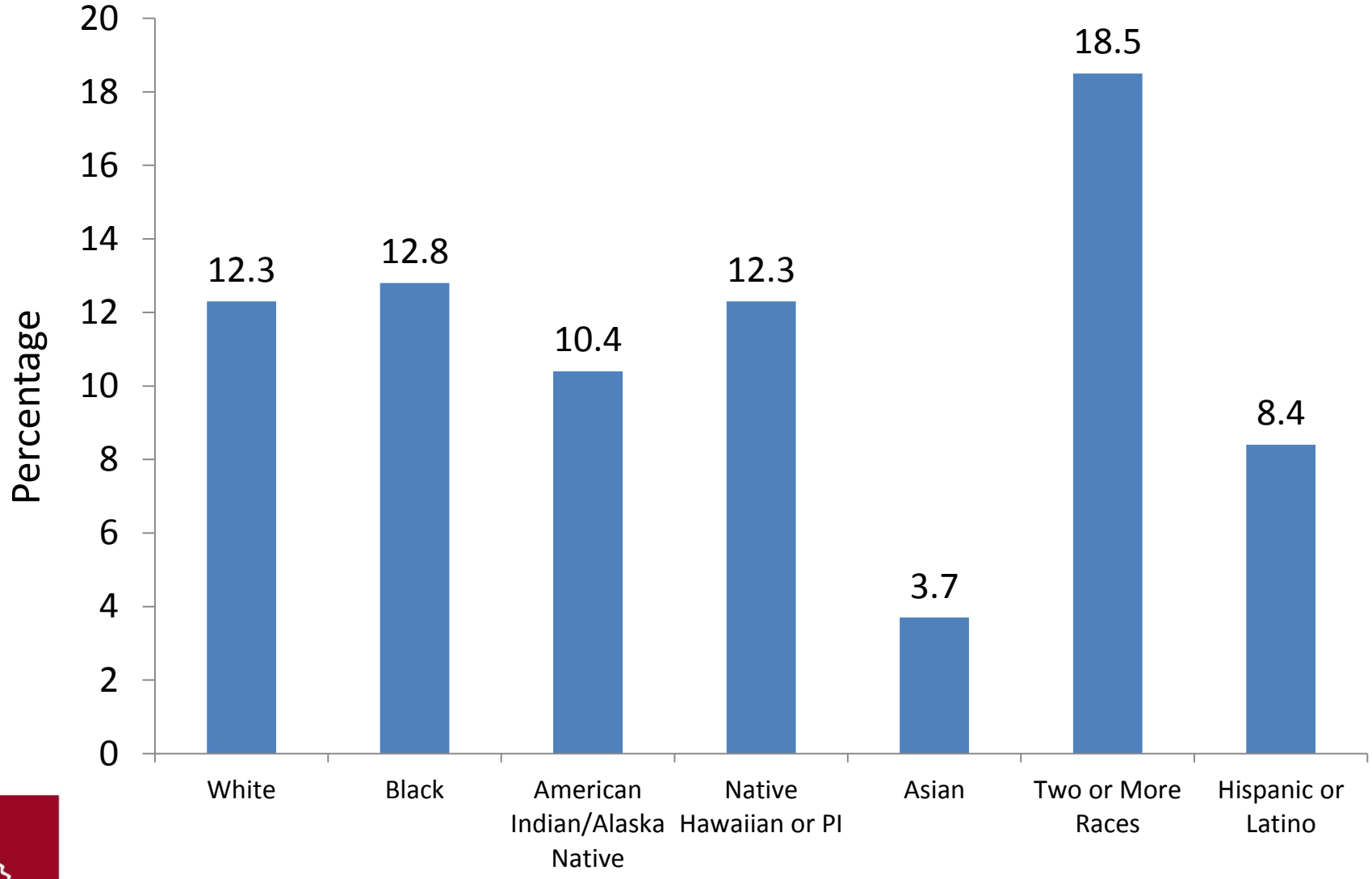
Illicit Drug Use in the Past Month among Females Aged 15 to 44 by Age, Race & Ethnicity: Percentages, Based on 2012-2013



National Survey on Drug Use and Health, 2014

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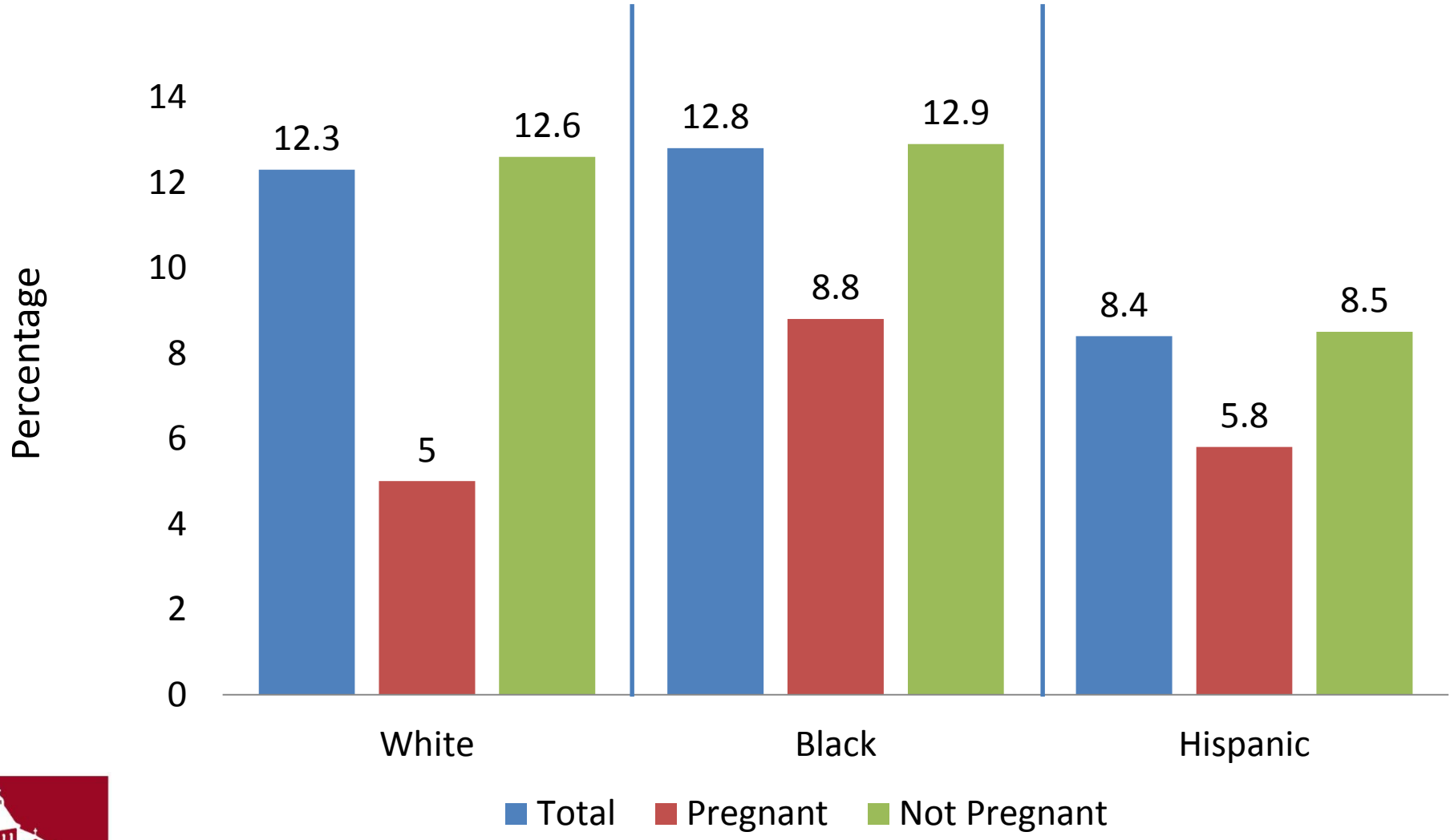
Illicit Drug Use, Past Month, among Females Aged 15-44 by Pregnancy, Race or Ethnicity : Percentages, Annual Averages:2012-2013



National Survey on Drug Use and Health, 2014

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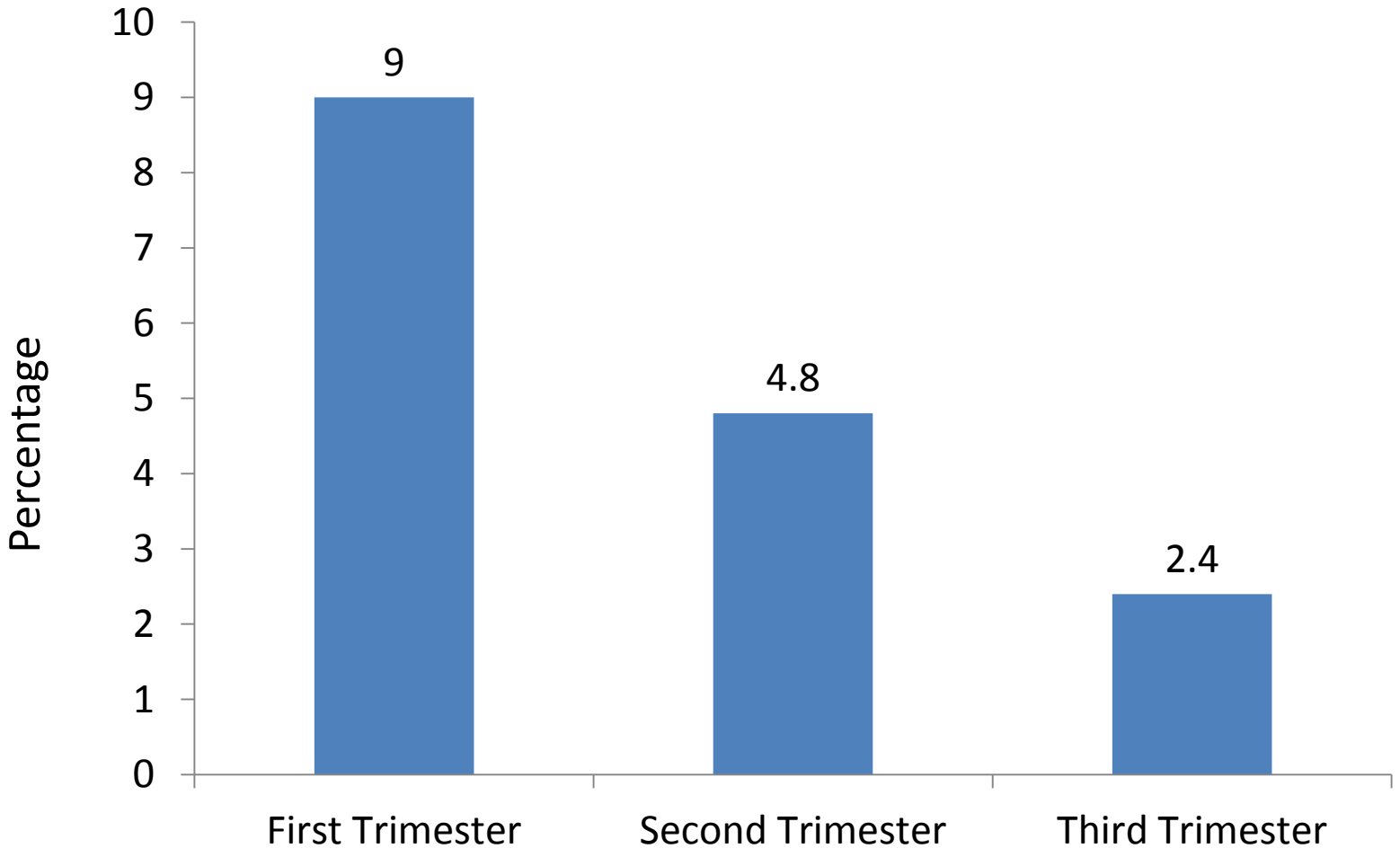
Illicit Drug use in the Past Month among Females Aged 15-44 by Pregnancy Trimester, Percentages, Based on 2012-2013



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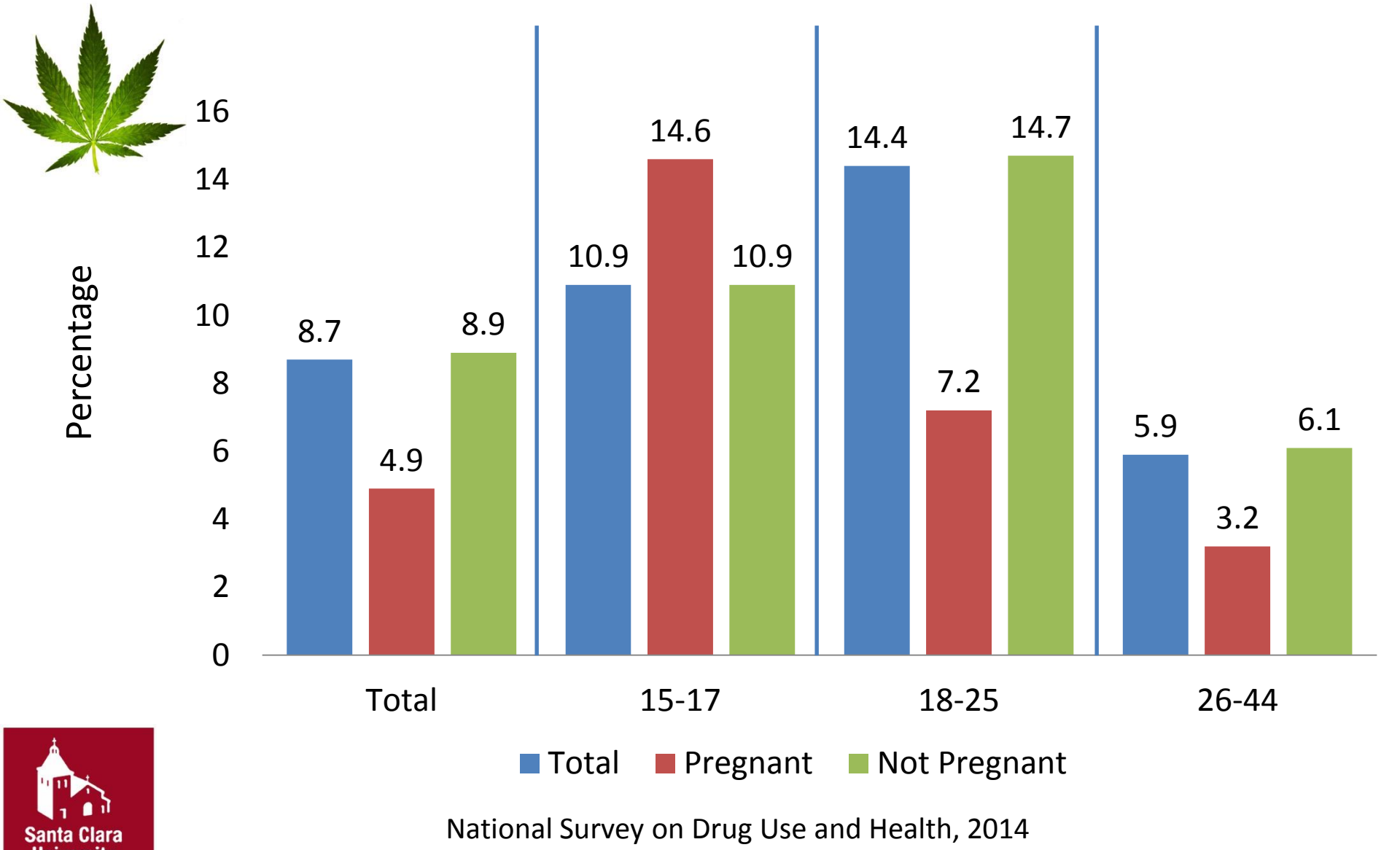
Marijuana Use in the Past Month among Females Aged 15 to 44 by Pregnancy & Age: Percentages, Annual Averages Based on 2012-2013



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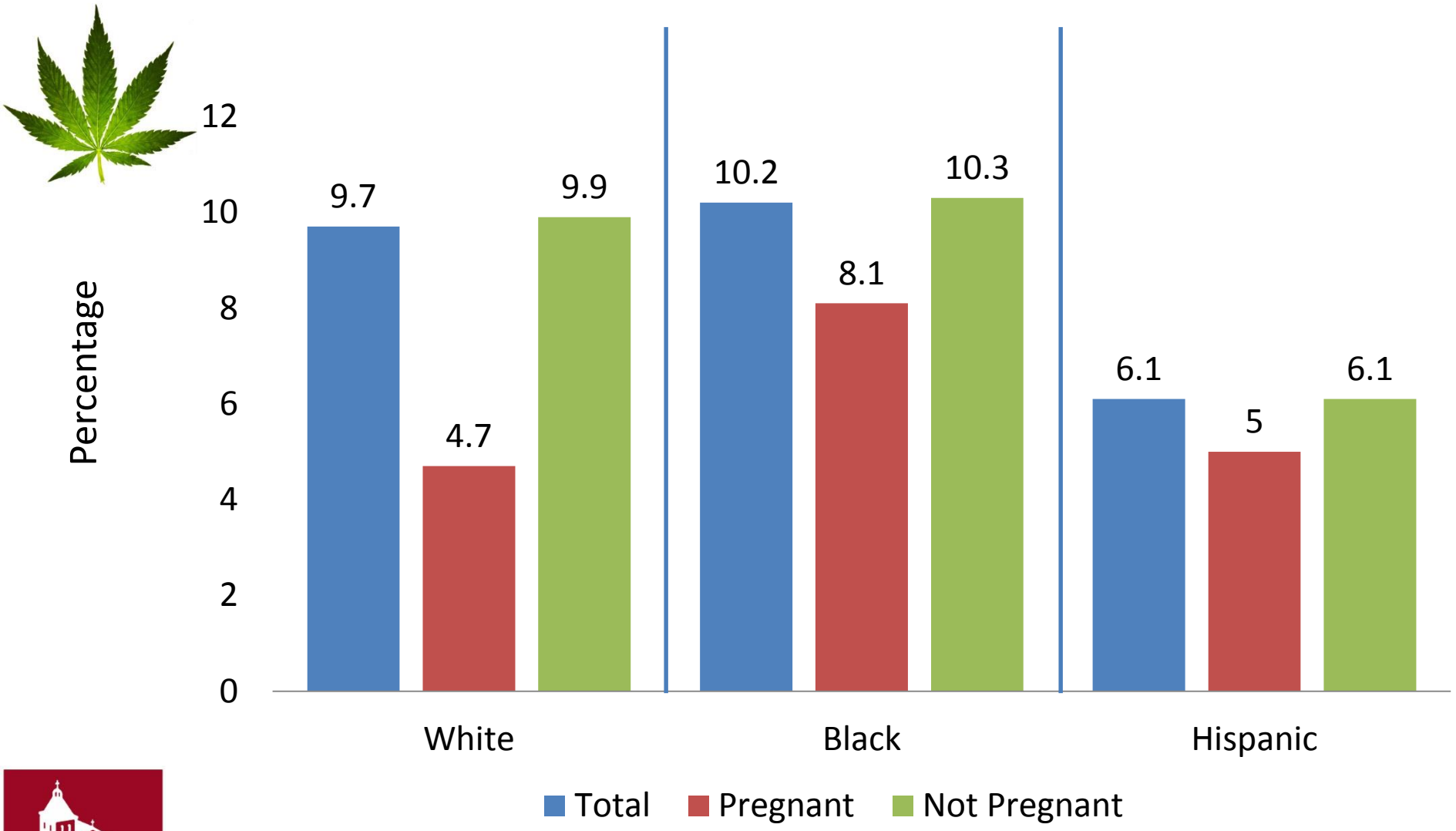
Marijuana Use, Past Month, among Females Aged 15-44 by Pregnancy, Race or Ethnicity : Percentages, Annual Averages:2012-2013



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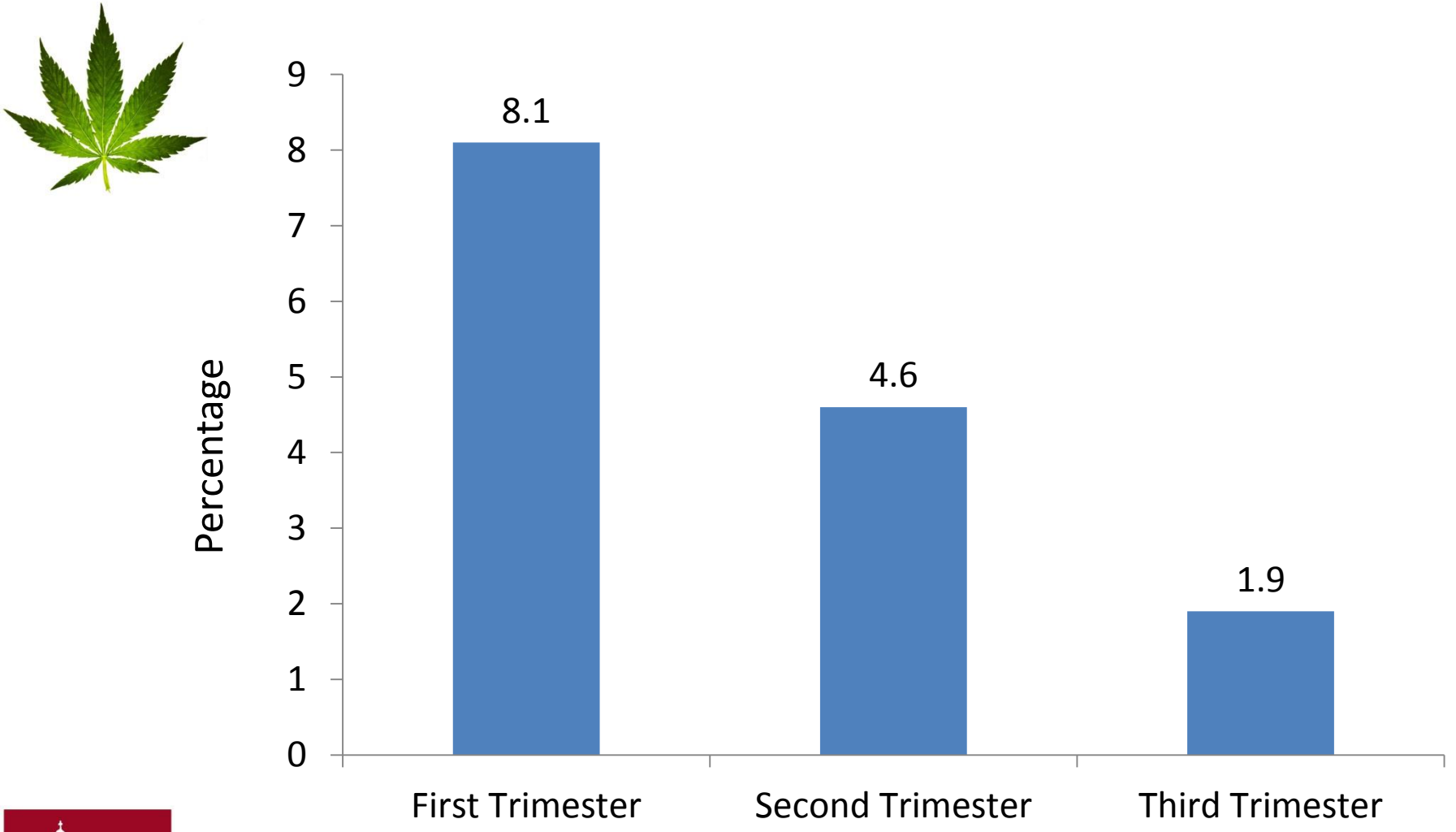

National Survey on Drug Use and Health, 2014

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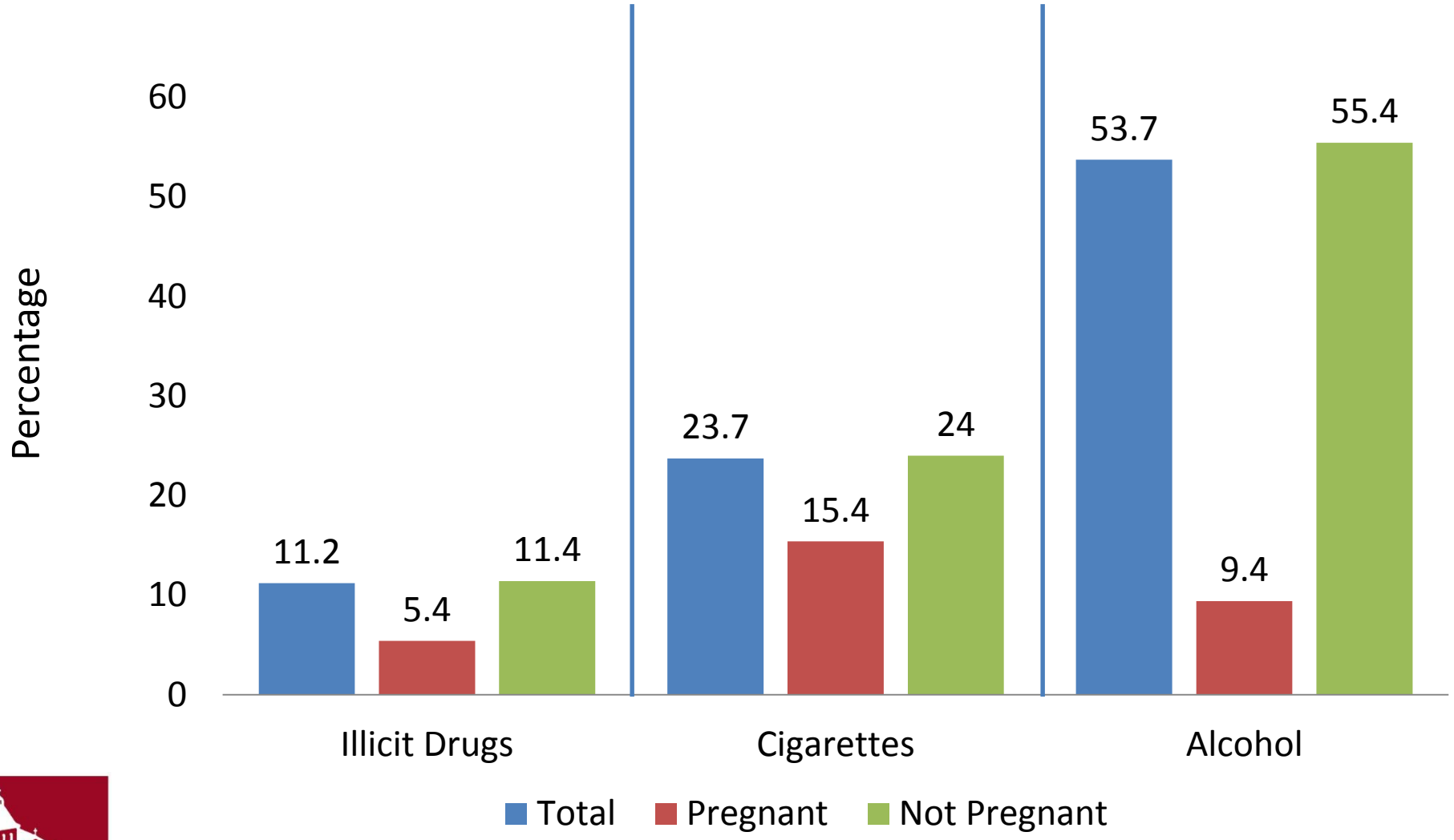
Illicit Drugs, Cigarettes, & Alcohol Use, Past Month, among Females Aged 15-44 by Pregnancy: Percentages, Annual Averages:2012-2013



National Survey on Drug Use and Health, 2014

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Any Alcohol Use, Binge Alcohol Use & Heavy Alcohol Use, Past Month, among Females Aged 15-44 by Pregnancy: Percentages, Annual Averages: 2012-2013

National Survey on Drug Use and Health, 2014

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Cigarette Use in the Past Month among Females Aged 15 to 44 by Pregnancy & Age: Percentages, Annual Averages Based on 2012-2013

* Low Precision; no estimate reported

National Survey on Drug Use and Health, 2014

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Cigarette Use, Past Month, among Females Aged 15-44 by Pregnancy, Race or Ethnicity : Percentages, Annual Averages:2012-2013

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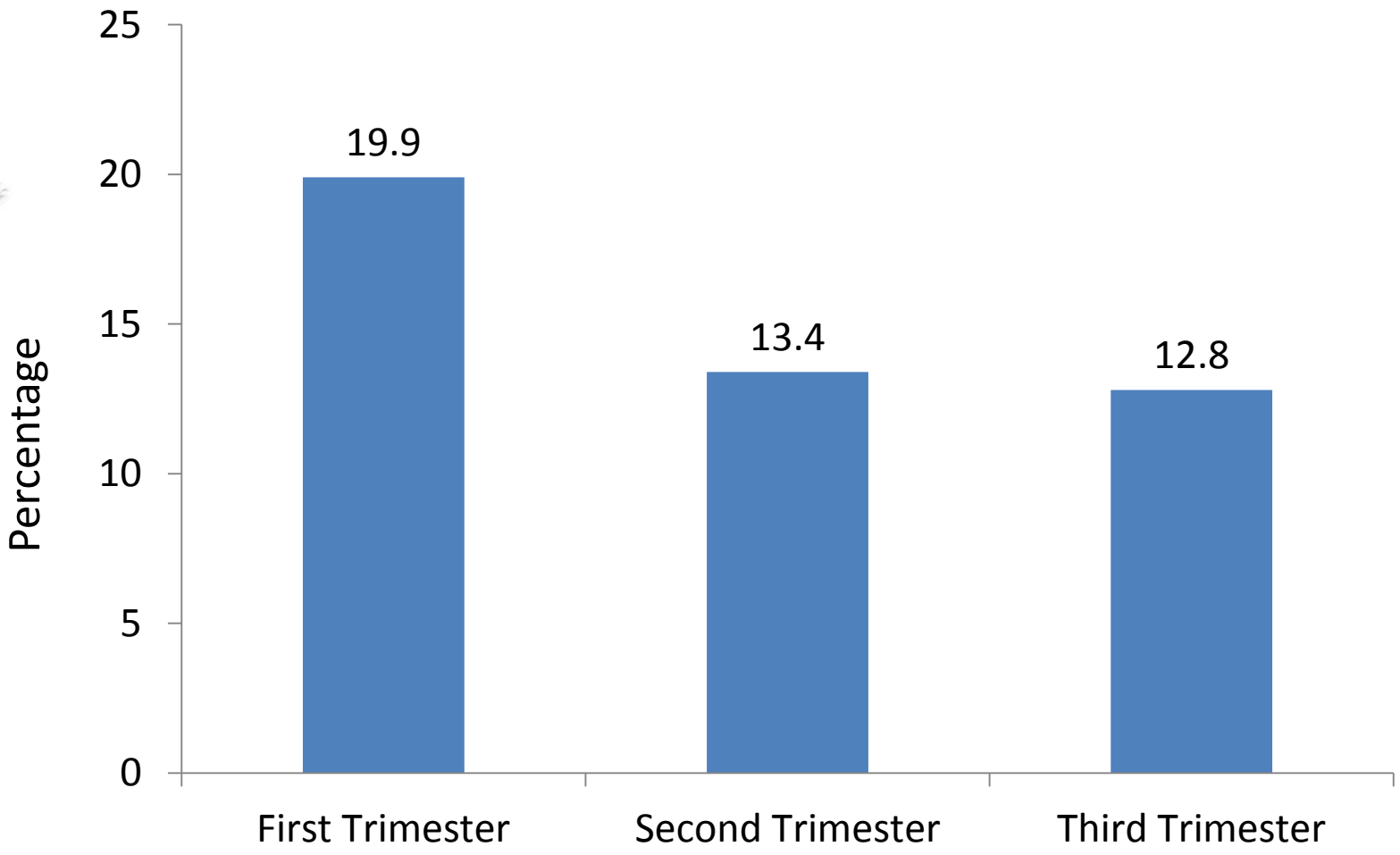

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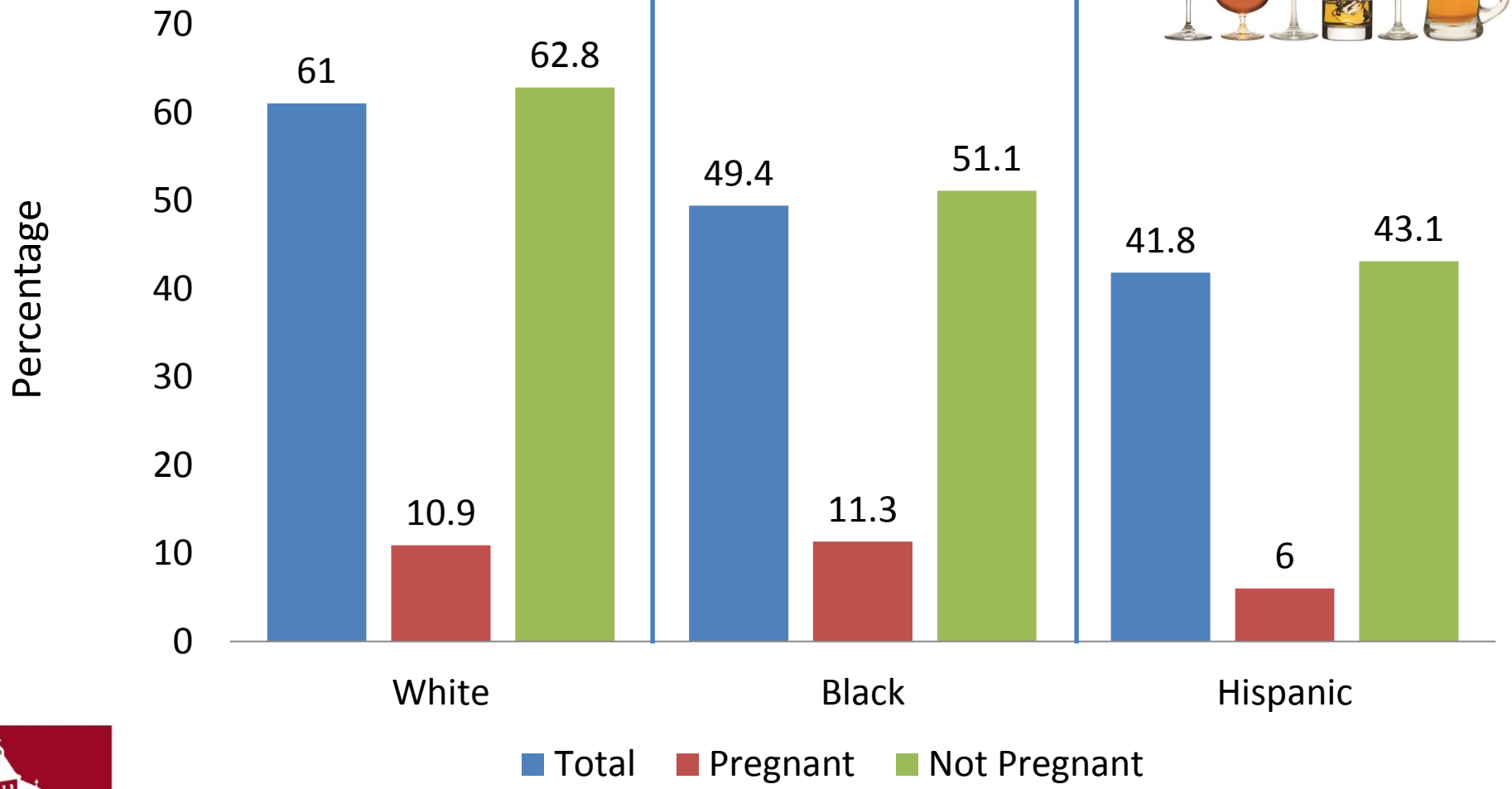

National Survey on Drug Use and Health, 2014

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Alcohol use in the Past Month among Females Aged 15-44 by Pregnancy Trimester, Percentages, Based on 2012-2013

National Survey on Drug Use and Health, 2014

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Binge Alcohol Use in the Past Month among Females Aged 15 to 44 by Age, Race & Ethnicity: Percentages, Based on 2012-2013

National Survey on Drug Use and Health, 2014

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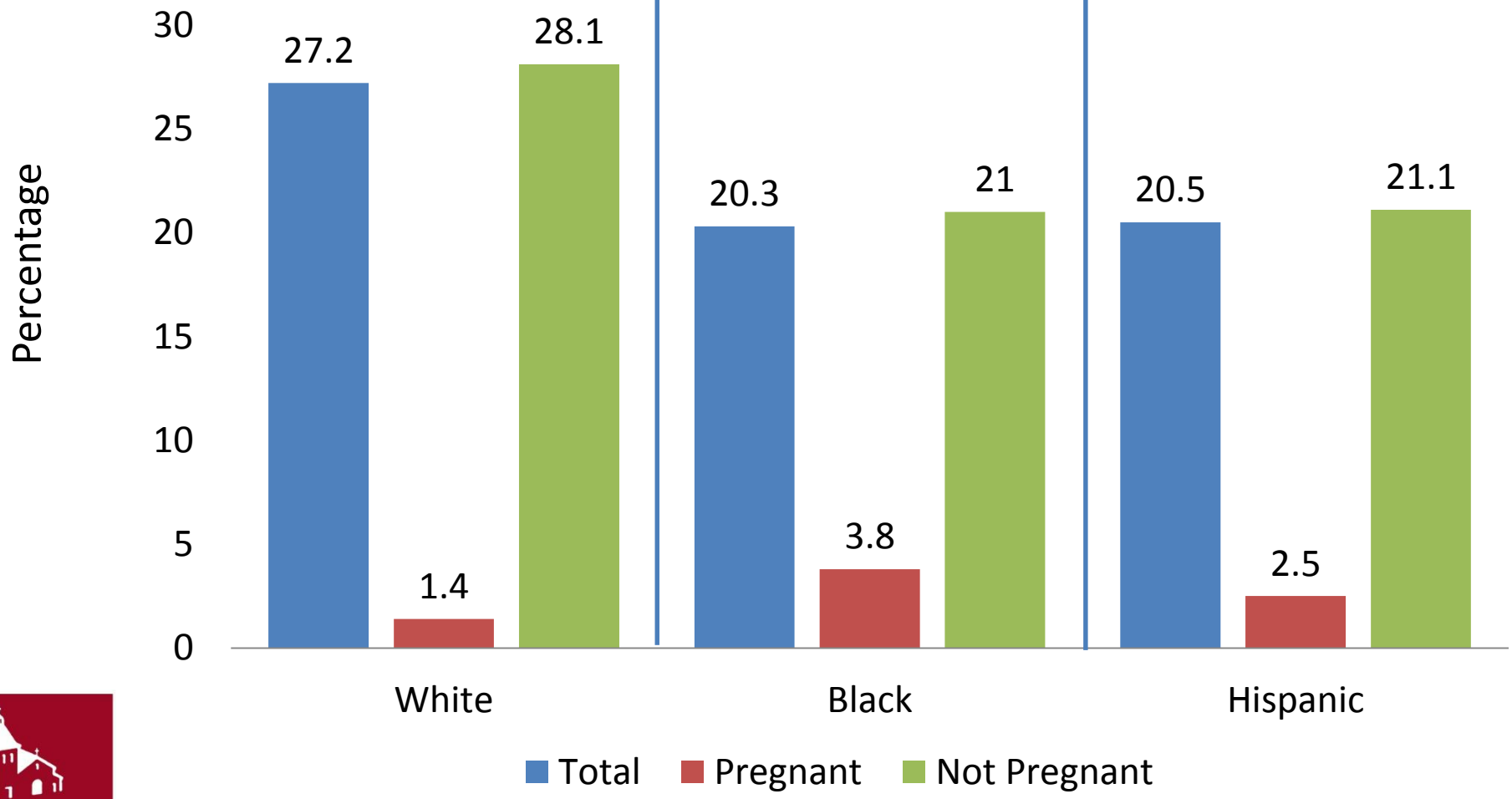

National Survey on Drug Use and Health, 2014

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Binge Alcohol use in the Past Month among Females Aged 15-44 by Pregnancy Trimester, Percentages, Based on 2012-2013

National Survey on Drug Use and Health, 2014

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Heavy Alcohol Use in the Past Month among Females Aged 15 to 44 by Age, Race & Ethnicity: Percentages, Based on 2012-2013

National Survey on Drug Use and Health, 2014

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Heavy Alcohol Use in the Past Month among Females Aged 15 to 44 by Pregnancy & Age: Percentages, Annual Averages Based on 2012-2013

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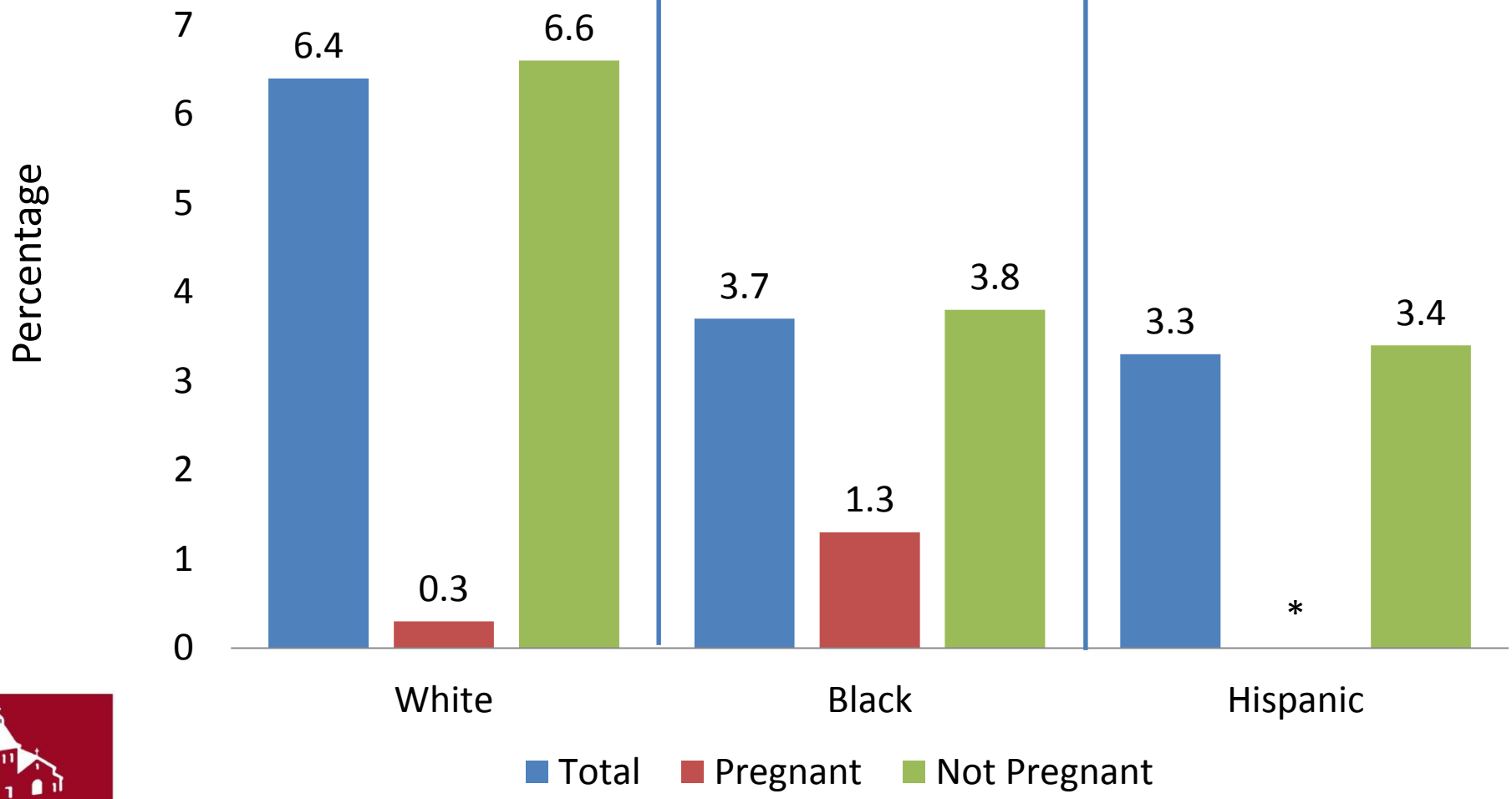
Heavy Alcohol Use, Past Month, among Females Aged 15-44 by Pregnancy, Race or Ethnicity : Percentages, Annual Averages:2012-2013



National Survey on Drug Use and Health, 2014

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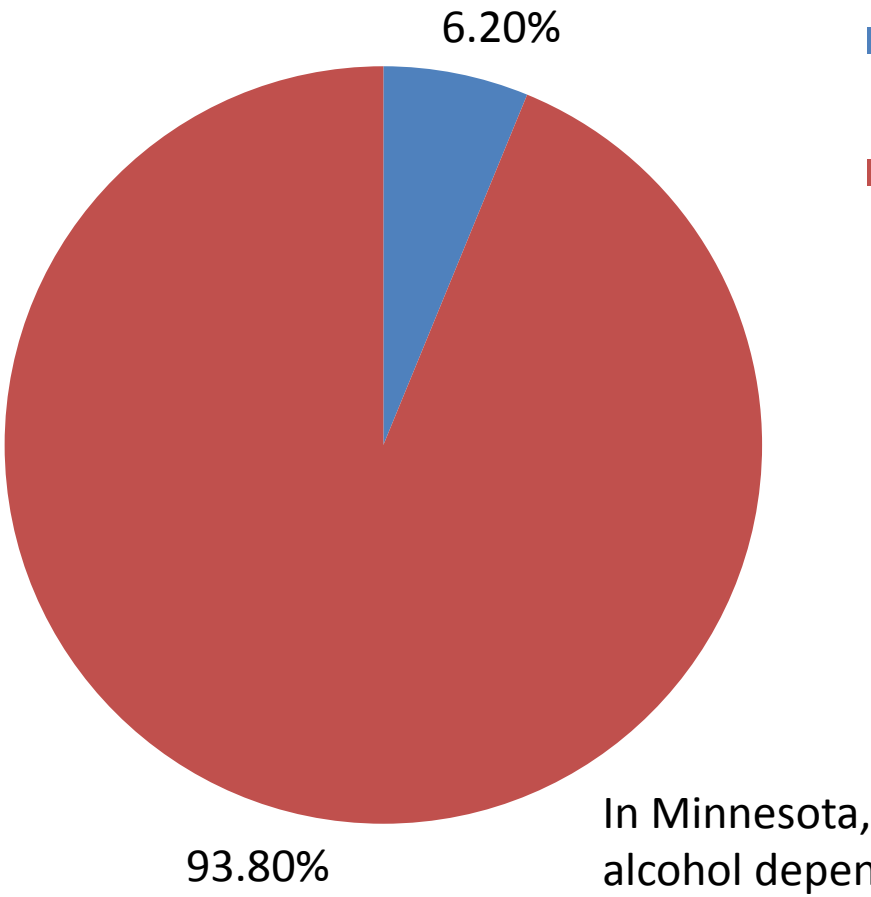
Past-Year Alcohol Use Treatment among Persons Aged 12 or Older with Alcohol Dependence of Abuse in Minnesota (2009-2013))



In Minnesota, among persons aged 12 or older with alcohol dependence or abuse, about 20,000 persons (6.2%) per year in 2009-2013 received treatment for their alcohol use within the year prior to being surveyed

http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-MN.pdf

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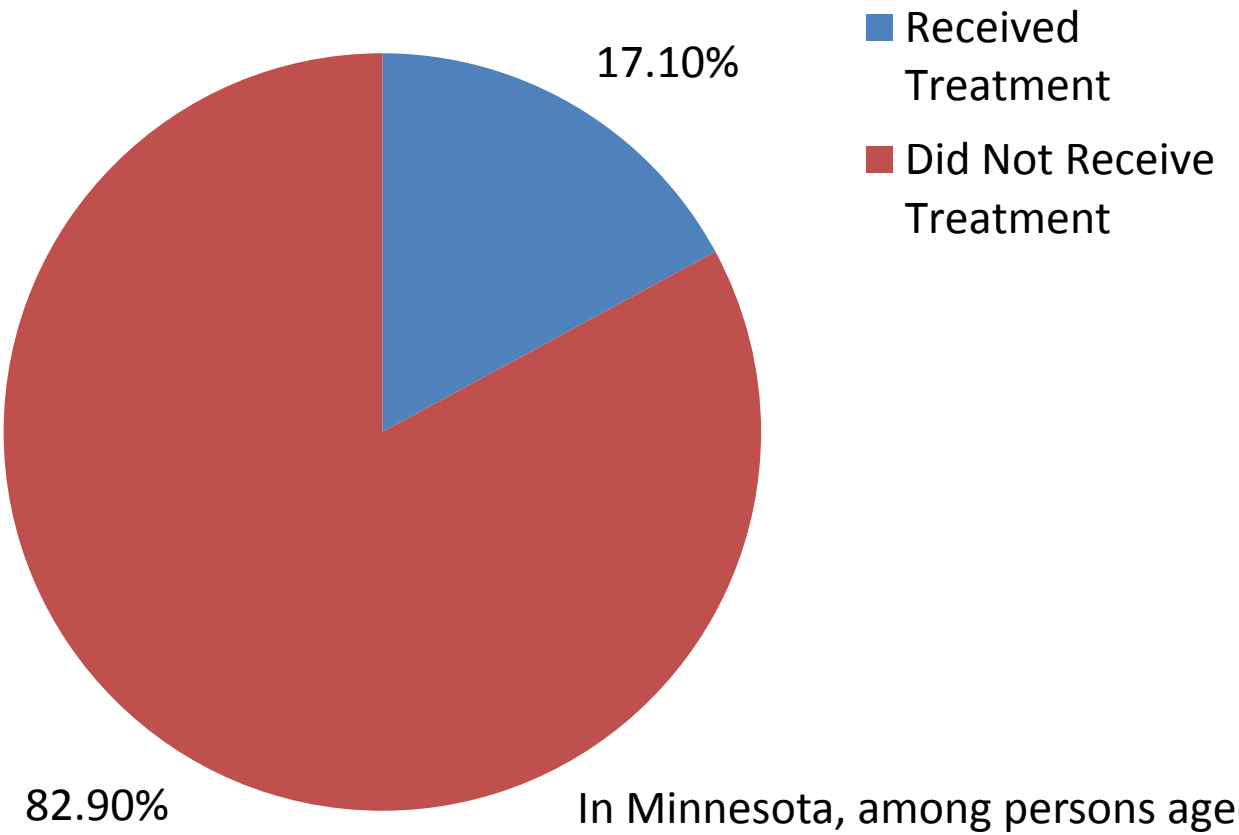
Past-Year Drug Use Treatment among Persons Aged 12 or Older with Drug Dependence of Abuse in Minnesota (2005-2013))



In Minnesota, among persons aged 12 or older with illicit drug dependence or abuse, about 17,000 persons (17.1%) per year in 2005-2013 received treatment for their illicit drug use within the year prior to being surveyed

http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-MN.pdf

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SAMHSA TREATMENT EPISODE DATA SET: MINNESOTA

In 2012, there were 52,829 admissions to Minnesota Substance Use Disorder programs.

65.5 percent of those admissions were male, and 34.4 percent were female.

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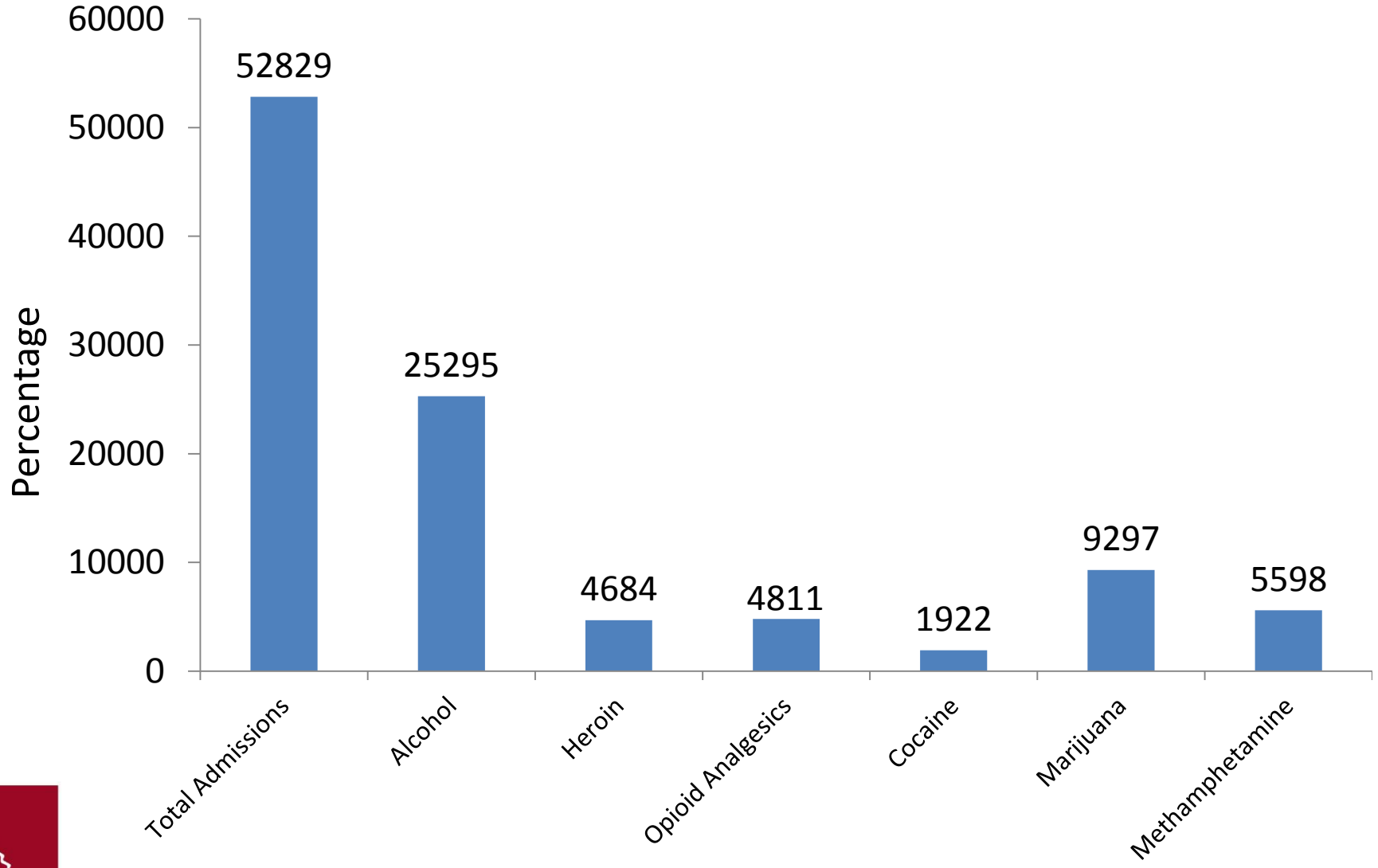
http://www.samhsa.gov/data/sites/default/files/2002-2012_TEDS_State/2002_2012_Treatment_Episode_Data_Set_State.pdf

Minnesota Admissions aged 12 and Older by Primary Substance: 2012



SAMHSA Treatment Episode Data Set (TEDS), 2014

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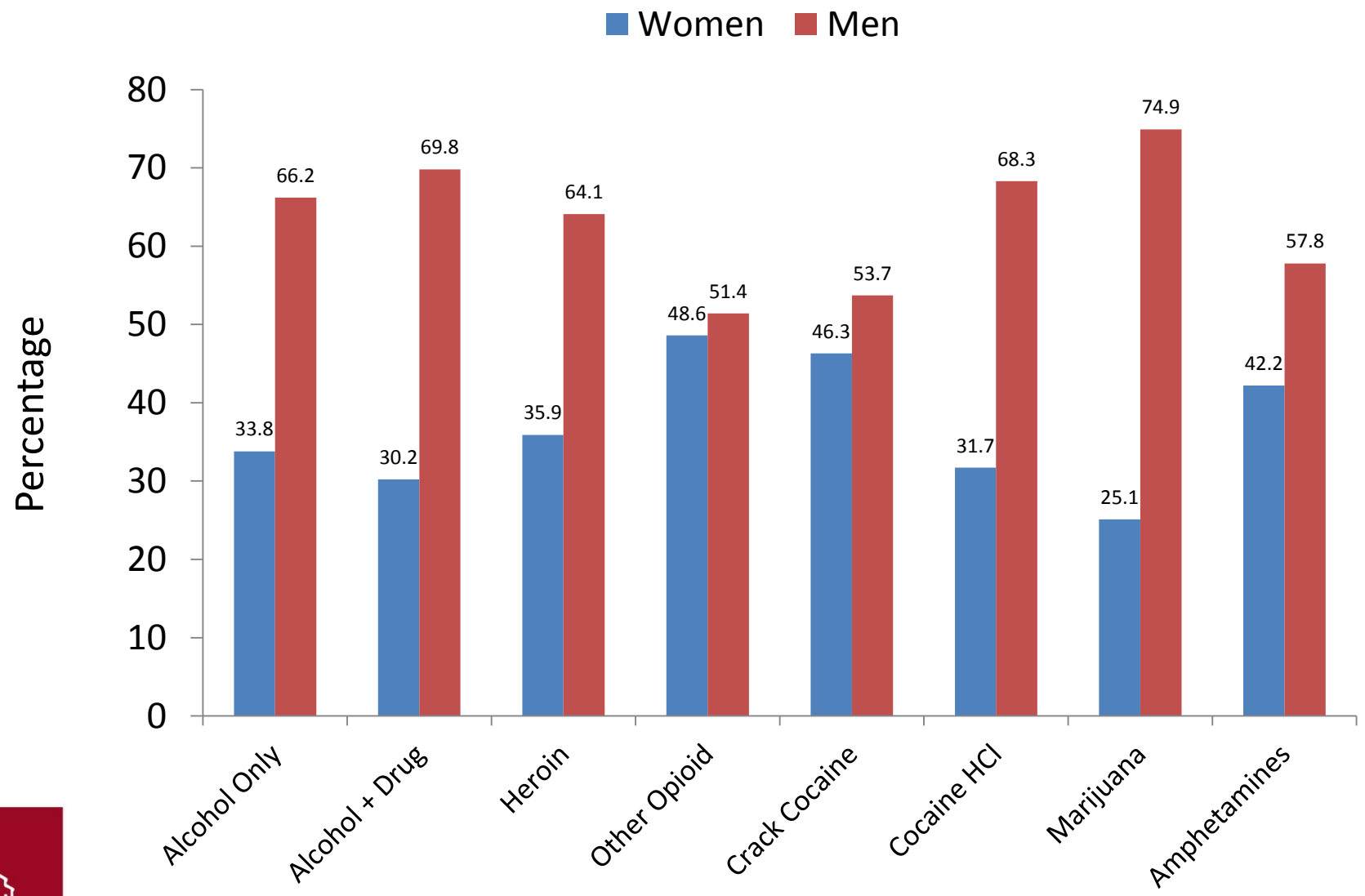
Minnesota Admissions aged 12 and Older by Gender and by Primary Substance: 2012



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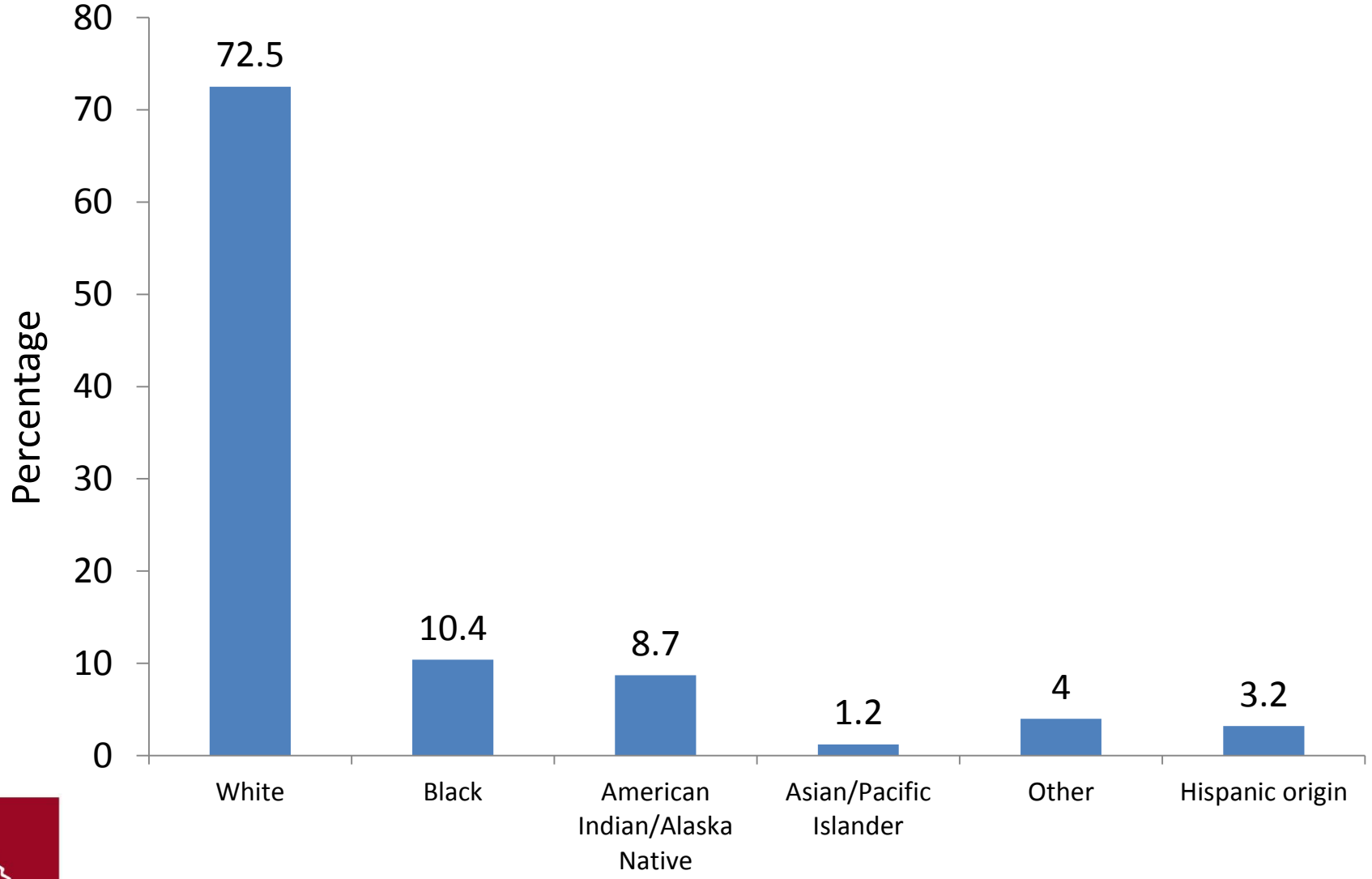
http://www.samhsa.gov/data/sites/default/files/2002-2012_TEDS_State/2002_2012_Treatment_Episode_Data_Set_State.pdf

Minnesota Admissions to Substance Abuse Treatment, aged 12 and Older by race/ethnicity: 2012



SAMHSA Treatment Episode Data Set (TEDS), 2014

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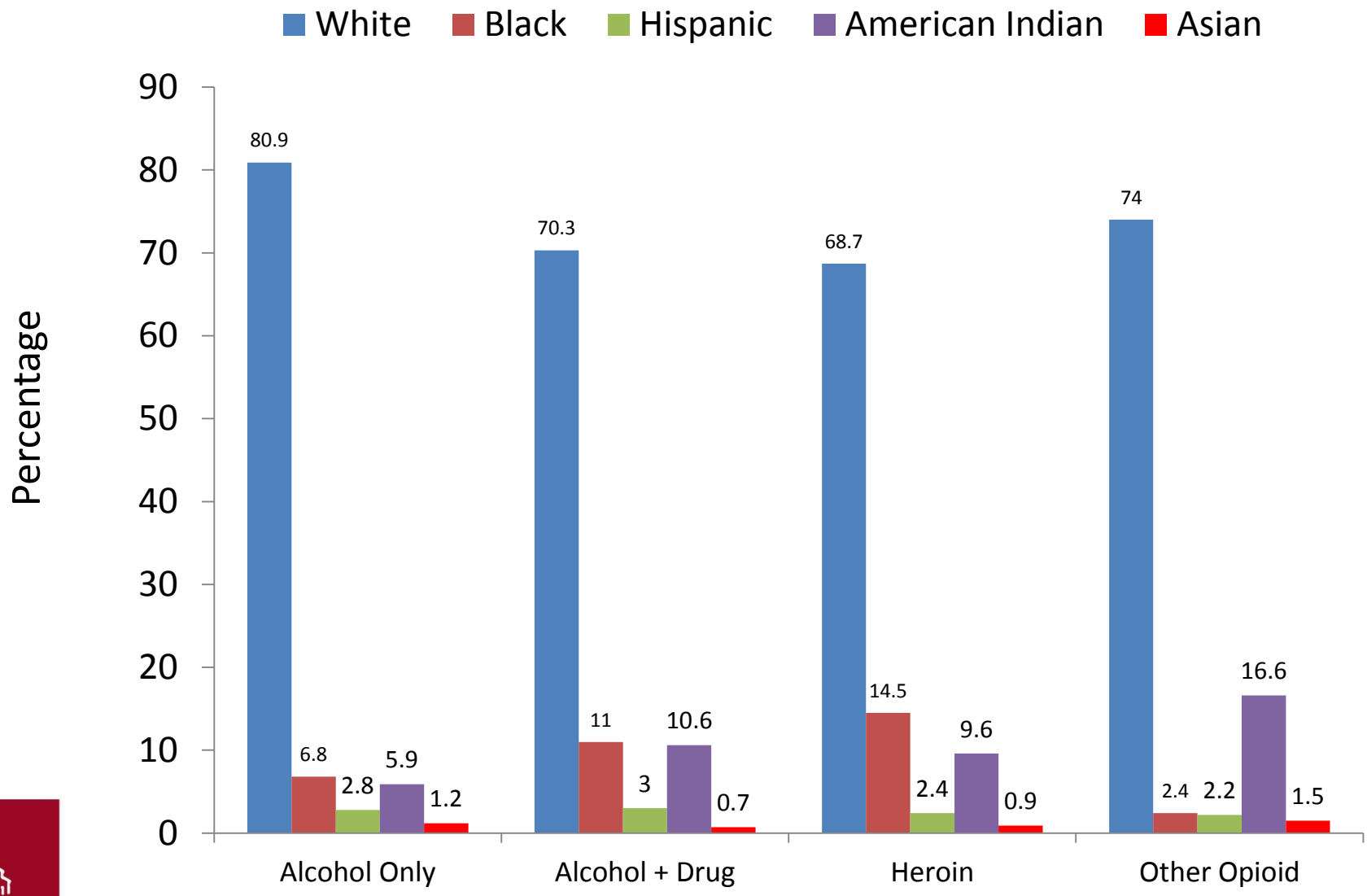
Percent Distribution of Minnesota Admissions aged 12 and Older by Race/Ethnicity and by Primary Substance: 2012



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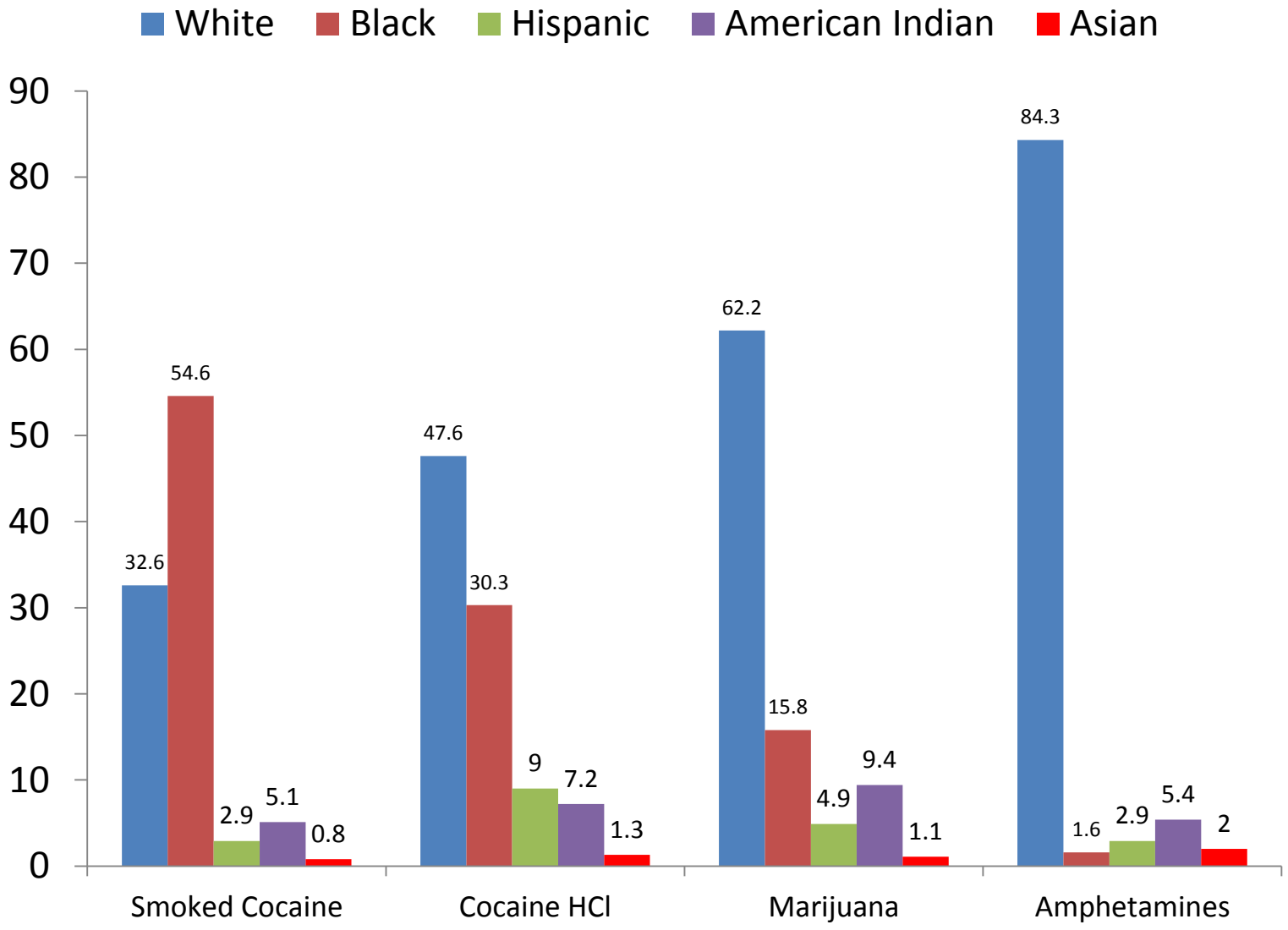

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The Health and Well Being of the Mother and the Health and Well Being of the Child Are Bound Together

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Federal Funding to Minnesota from the Substance Abuse and Mental Health Services Administration 2014/2015

Formula Funding	
Substance Abuse Prevention and Treatment Block Grant	$24,521,274
Community Mental Health Services Block Grant	$7,127,318
Projects for Assistance in Transition from Homelessness (PATH)	$811,000
Protection and Advocacy for Individuals with Mental Illness	$445,048
Subtotal of Formula Funding	$32,904,640
Discretionary Funding	
Mental Health	$848,592
Substance Abuse Prevention	$4,250,l973
Substance Abuse Treatment	$500,551
Subtotal Discretionary Funding	$5,600,116

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Wayside House ‘s Center for Substance Abuse Treatment’ Pregnant/Post-Partum Women Grant

FY 2014 Funding: $500,551
Project Period: 09/30/2014 - 09/29/2017

The Wayside Whole Family Treatment project will provide evidence-based residential family treatment services to assist women, their children, and their families to recover from addiction, reunify, and build stable lives. Located in Minneapolis, Minnesota, the project will serve a total of 100 women and their children and family members annually, prioritizing women who are pregnant, intravenous drug users with minor children, and women involved with child protection. Over three years, the project will serve 300 low-income women, 600 children, and 300 family members, including high numbers of African-American participants. Women who combine chemical dependency with pregnancy, parenting, and child protection issues typically have very complex needs that also impact their children and families. Through the Wayside Whole Family Treatment project, women with these intensive needs will be able to access on-site chemical dependency treatment, individual and family therapy, psychiatric consults, STEP parenting groups, individual Triple P (RAP) parent coaching sessions, and 24-hour parenting support and supervision.

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http://www.samhsa.gov/grants-awards-by-state/details/Minnesota

Services Grant Program for Residential Treatment for Pregnant and Postpartum Women (PPW)

The PPW program supports evidence-based parenting and treatment models including trauma-specific services in a trauma-informed context, which will:

- Decrease the use and/or abuse of prescription drugs, alcohol, tobacco, illicit and other harmful drugs (e.g., inhalants) among pregnant and postpartum women;
- Increase safe and healthy pregnancies;
- Improve birth outcomes;
- Reduce perinatal and environmentally related effects of maternal and/or paternal drug abuse on infants and children;
- Improve the mental and physical health of the women and children;
- Prevent mental, emotional, and behavioral disorders among the children;
- Improve parenting skills, family functioning, economic stability, and quality of life;
- Decrease involvement in and exposure to crime, violence, and neglect; and
- Decrease physical, emotional, and sexual abuse for all family members.

http://www.samhsa.gov/grants/grant-announcements/ti-14-005

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Minnesota Maternal and Child Health Title V Funding 2013

Source	Dollar Amount	Percent of Total
Federal Allocation	$8,799,085	29.5%
Total State Fund (Match and Overmatch)	$6,599,313	22.1%
Local MCH Funds	$3,524,012	11.8%
Other Funds	$10,845,373	36.4%
Program income	$66,728	0.2%
Total	$29,834,510	100%

Title V funding seeks to assure access to quality care, especially for those with low incomes, to reduce infant mortality, to provide comprehensive prenatal and postnatal care to women, to increase the number of children receiving health assessments and follow-up diagnostic and treatment services, to provide access to preventive and child cre services and to implement family-centered, community-based care.

https://mchdata.hrsa.gov/tvisreports/special/BlockGrantExpenditureHistorySearch.aspx

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Minnesota Family Home Visiting Program

- Receives $1, 3 Million in formula grants and $9.4 Million in discretionary grants through the Health Resources and Services Administration (HRSA)'s Maternal, Infant, and Early Childhood Home Visiting Program to provide voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children.

- The Tribal Maternal, Infant, and Early Childhood Home Visiting program provides grants to tribal organizations to develop, implement, and evaluate home visiting programs in American Indian and Alaska Native communities. The Tribal Home Visiting program is funded by a 3 percent set-aside from the larger Federal Home Visiting (MIECHV) program. Tribal Home Visiting grants are awarded to Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations

https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=D89&rs:Format=HTML4.0

https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=X02&rs:Format=HTML4.0

http://mchb.hrsa.gov/programs/homevisiting/grants.htm

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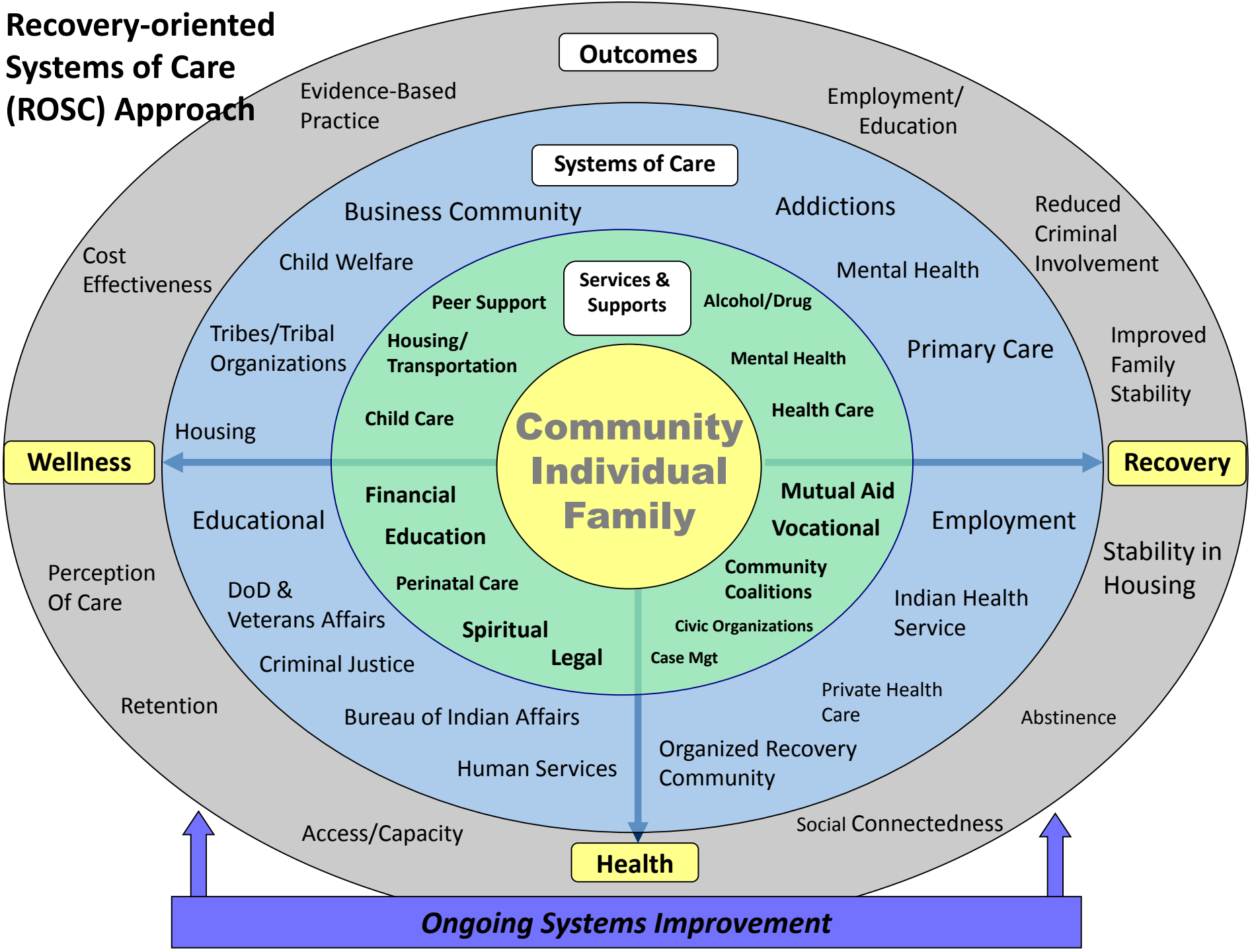
Recovery-oriented Systems of Care (ROSC) Approach
Outcomes
Evidence-Based Practice
Employment/ Education
Systems of Care
Business Community
Addictions
Reduced Criminal Involvement
Cost Effectiveness
Child Welfare
Mental Health
Services & Supports
Peer Support
Alcohol/Drug
Tribes/Tribal Organizations
Housing/ Transportation
Primary Care
Improved Family Stability
Mental Health
Child Care
Health Care
Housing
Wellness
Community Individual Family
Recovery
Financial
Mutual Aid
Educational
Education
Vocational
Employment
Stability in Housing
Perception Of Care
Perinatal Care
Community Coalitions
DoD & Veterans Affairs
Spiritual
Civic Organizations
Indian Health Service
Criminal Justice
Legal
Case Mgt
Retention
Private Health Care
Bureau of Indian Affairs
Abstinence
Organized Recovery Community
Human Services
Access/Capacity
Social Connectedness
Health
Ongoing Systems Improvement

ROSC and the Infant Mortality Reduction Plan for Minnesota

INTEGRATED STRATEGIES FOR THE COMMON GOOD

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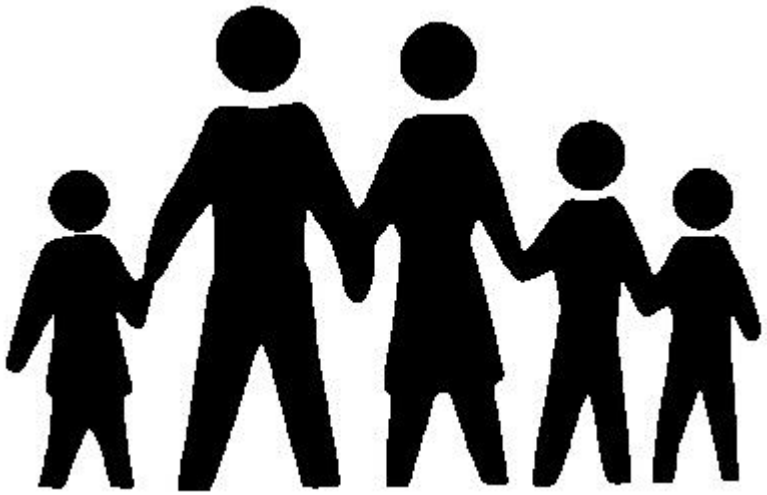
SAMHSA's 10 Guiding Principles of Recovery



- Hope
- Person-Driven
- Many Pathways
- Holistic
- Peer Support
- Relational
- Culture
- Addresses Trauma
- Strengths/Responsibility
- Respect

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Dispelling the Myths

ROSC **is not:**

- Just about Substance Use Disorders
- A Model
- Primarily focused on the integration of recovery support services
- Dependent on new dollars for development
- A new initiative
- A group of providers that increase their collaboration to improve coordination
- An infusion of evidence-based practices
- An organizational entity, group of people or committee
- A closed network of service and supports

ROSC **is:**

- A Value-driven APPROACH to structuring behavioral health systems and a network of clinical and non-clinical services and supports
- A Framework to guide systems transformation

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Healthy Mom = Healthy Baby

The American Congress of Obstetricians and Gynecologists (ACOG) has worked with ethicists and the American Society of Addiction Medicine to assist physicians who feel torn between fetal and maternal rights.

ACOG endorses the same basic ethical tenets used for medical care exist for the treatment of unhealthy behavior during pregnancy:

Beneficence: We have an ethical obligation to treat addiction as a medical disease rather than moral failing. Effective treatments are available and should be provided during pregnancy.

Nonmaleficence: We have an ethical obligation to do no harm. We can harm pregnant women by using humiliation or shame, as it creates a barrier to treatment and recovery.

Justice: This principle governs access to care and distribution of resources. Pregnant women should have access to addiction treatment, including referral to appropriate resources and medication.

Respect for Autonomy: The issue of autonomy is particularly difficult during pregnancy. While patients may have a moral obligation to act in a manner that is to the benefit of the fetus, as health care providers, our ethical obligation is to develop a trusting relationship with the patient and assist her in achieving this goal. Patients who fear repercussion of admitting to an addiction problem will not seek help.

Majorie Meyer, MD, University of Vermont Medical Center,
http://www.basisonline.org/2015/05/addiction-during-pregnacy-how-can-specialists-balance-maternal-autonomy-and-fetal-health-.htm

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Pregnant Women with Substance Use Disorders Deserve Treatment

"Addiction is a treatable disease. Health care providers have a professional and ethical obligation for the best treatment for the mother, recognizing this approach is congruent with the best treatment of the fetus. All women deserve treatment for substance abuse with the same evidenced-based treatment as non-pregnant women (and men), which may include no treatment until they are ready."

Majorie Meyer, MD, University of Vermont Medical Center,
http://www.basisonline.org/2015/05/addiction-during-pregnacy-how-can-specialists-balance-maternal-autonomy-and-fetal-health-.htm

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Who Are These Women with SUDs Who Can't Stop Using Substances While Pregnant?

- High Rates of Previous Physical Abuse
- Have More Children in Out-of-Home Placement
- Lack family Support
- Need More social Services
- Often unemployed
- Have High Rates of Mental Health Problems
- Have Histories of Traumatic Life Events
- Increased Rate of Low Incomes or Poverty
- Shame and Fear

Katherine Davis & Kimberly Yonkers, J Clin Psychiatry 2012

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MEDIA FRENZY AND HOSTILE ATTITUDES TOWARD PREGNANT WOMENT WITH SUBSTANCE USE DISORDERS

Demonizing pregnant women who have a substance use disorder scares them away from both prenatal care and substance use treatment. Further, it may result in separating mothers from their babies just when mother-child bonding is critical.

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"Women who cannot afford private treatment for their addiction and who fear arrest and separation from children they already have may feel as though abortion is the only way to keep their current families together"

Farah Diaz-Tello, Staff Attorney with National Advocates for Pregnant Women.

http://rhrealitycheck.org/wp-content/uploads/2014/04/TN-SB1391-Pregnancy-Criminalization-Law-Press-Packet.pdf#page=6

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Medication Assisted Treatment in Pregnant and Postpartum Women with Opioid Use Disorders

Pregnant opiate users and addicts say they sometimes hear one thing from health professionals, who may recommend they be put on a maintenance program like methadone or buprenorphine , and another thing from law enforcement or child welfare agents, who may say that mothers who use any drug, even physician prescribed methadone or buprenorphine, should be investigated. This puts many women in the Catch-22 of either trying to go off a drug completely while pregnant, knowing it could result in a miscarriage, or following their doctor's orders and fearing that their baby could be taken away at birth.

Ada Calhoun

http://www.nbcnews.com/news/us-news/pregnant-opiates-when-following-doctors-orders-breaks-law-n100781

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MEDIA DRIVEN PSEUDO-SCIENCE STIMATIZES BOTH THE PREGNANT WOMAN WITH SUD'S AND HER BABY

"Bad Science Leads to Bad Public Policy"

Deborah Frank, MD, Professor of Pediatrics, Boston University School of Medicine

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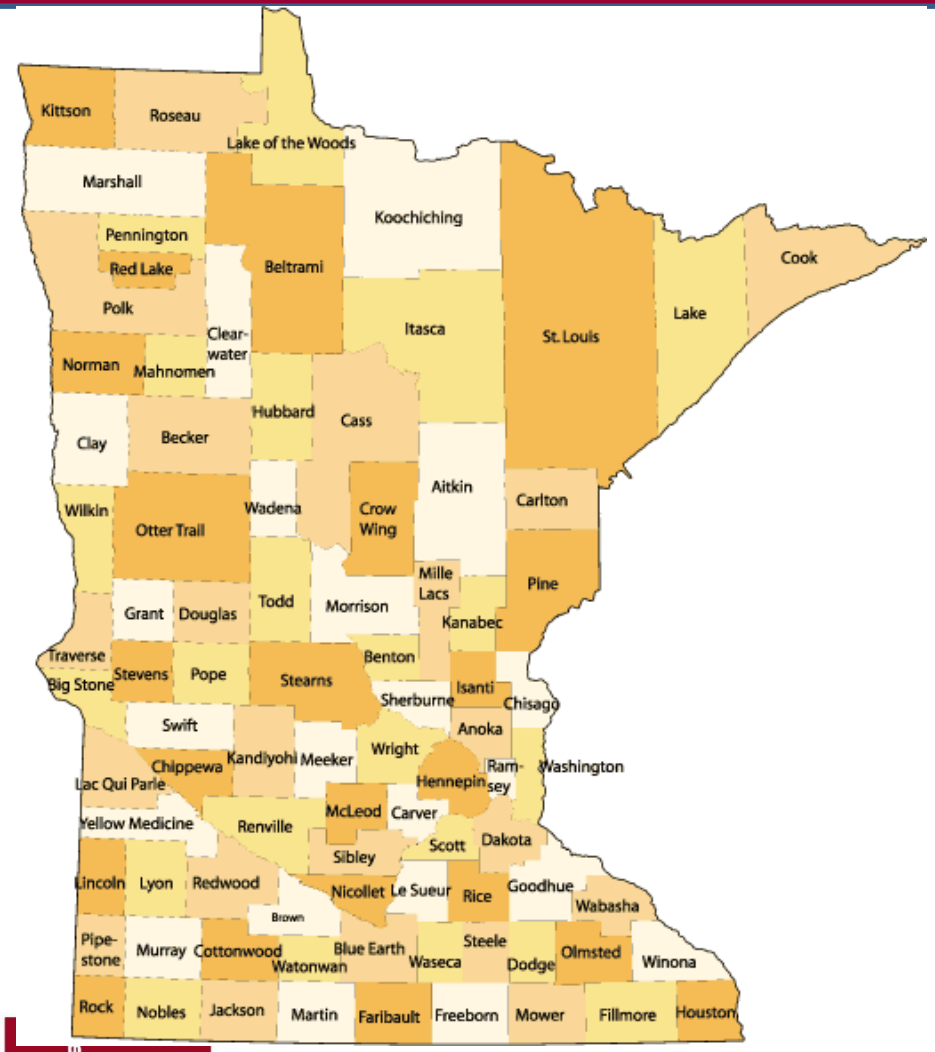
Minnesota County Variations in Demographics



Hennepin, Ramsey, Dakota, Rice, Scott,and Anoka Counties have larger Black populations by number or proportions compared to St. Louis, Lake, Beltrami or Kittson Counties.

Mahnomen, Cook, Beltrami, Cass, Itasca, Clearwater, Becker, and Carlton Counties have larger American Indian populations by number or proportion than Kittson, Cottonwood, or Rock Counties.

- There are more American Indians in Hennepin County than in Beltrami or Mahnomen Counties
- There are more American Indians in Beltrami County than in St. Louis County

There are similar variations for Asians and Hispanics

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ARE THERE REGIONAL VARIATIONS IN CULTURE AND ATTITUDES IN MINNESOTA?

- Geographic variations may give rise to variations in resources and attitudes about vulnerable populations from racial or ethnic groups, including access to social supports, arrests for alcohol or drugs, access to health care, in general, access to behavioral health services, in specific, and reports to child protection services
- Women, in general, Women of child bearing age, in specific, and Pregnant Women will be affected by the cultural, attitudinal, and resource variations

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Abstinence is Achievable

Forray et al recently published the results of a randomized controlled study that followed 152 women who received either Brief Advice or CBT in prenatal clinics during their pregnancy and then 3-months, 12-months and 24- months after delivery. Looking only at cigarettes, alcohol, marijuana, and cocaine they found:

- During pregnancy, 83% of the women achieved abstinence to at least one substance. The majority achieved abstinence in the second trimester.
- The average time to abstinence was approximately 5 months for cigarettes, marijuana and cocaine; for alcohol it was 4.4 months.
- Among women who used two substances, only 23% achieved abstinence from cigarettes, compared to 100% from alcohol, 76% from marijuana, and 73% from cocaine.
- Among women who used three substances, 37% achieved abstinence from cigarettes, 96% from alcohol, 76% from marijuana, and 71% from cocaine.

Forray et al, Drug and Alcohol Dependence 150 (2015) 147-155

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BUT RELAPSE HAPPENS

Forray et al recently published the results of a randomized controlled study that followed 152 women who received either Brief Advice or CBT in prenatal clinics during their pregnancy and then 3-months, 12-months and 24- months after delivery. Looking only at cigarettes, alcohol, marijuana, and cocaine they ALSO found:

- By three months postpartum, 58% of abstinent smokers relapsed
- 51% of abstinent women who used alcohol relapsed
- 41% of abstinent women who used marijuana relapsed
- 27% of abstinent women who used cocaine relapsed
- Women older than 21 years were less likely to relapse than younger women
- Women with a diagnosis of major depressive disorder were more likely to relapse than women without a diagnosis of depression

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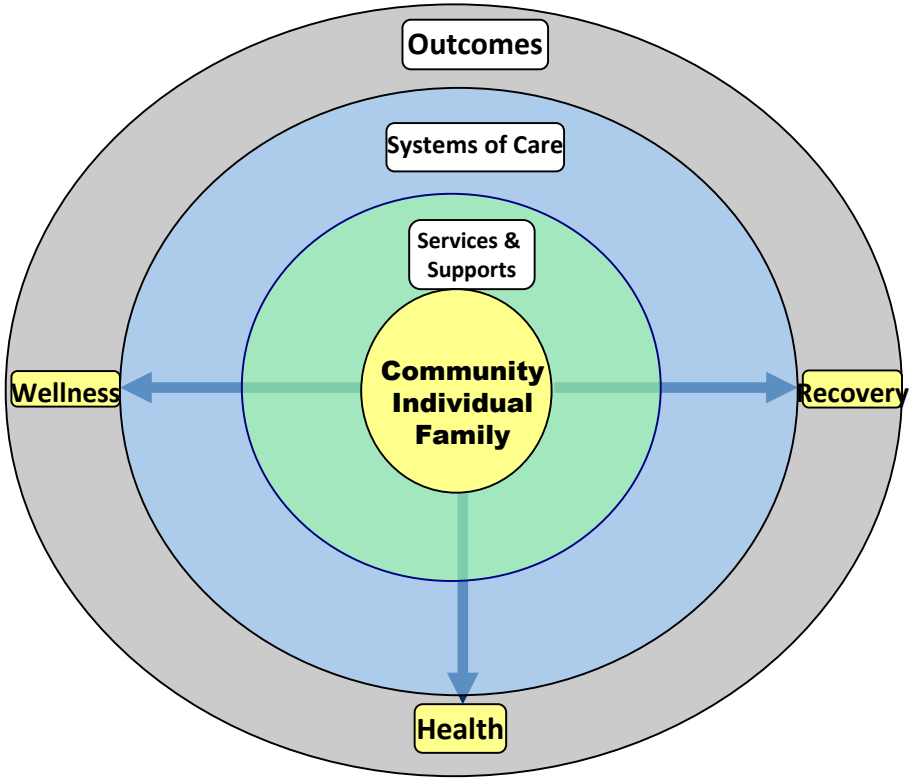
Forray et al, Drug and Alcohol Dependence 150 (2015) 147-155

MOVING FROM ROSC and IMRPM TO ACTION and RESULTS

Recovery-oriented Systems of Care (ROSC) Approach



Infant Mortality Reduction Plan for Minnesota (IMRPM)

Healthy Moms, Healthy Babies, Healthy Families & Healthy Communities

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It's Not Just about Moms and Babies

Don't forget we want healthy babies to grow into healthy children who grow into healthy adolescents who grow into healthy adults who mature into healthy seniors.

> "A large volume of high-quality research shows that unhealthy children grow up to be unhealthy adults, that poor health and low income go hand in hand, and that the consequences of both poverty and poor health make large demands on public coffers."

Janet Currie and Nancy Reichman in "The Future of Children" 2015

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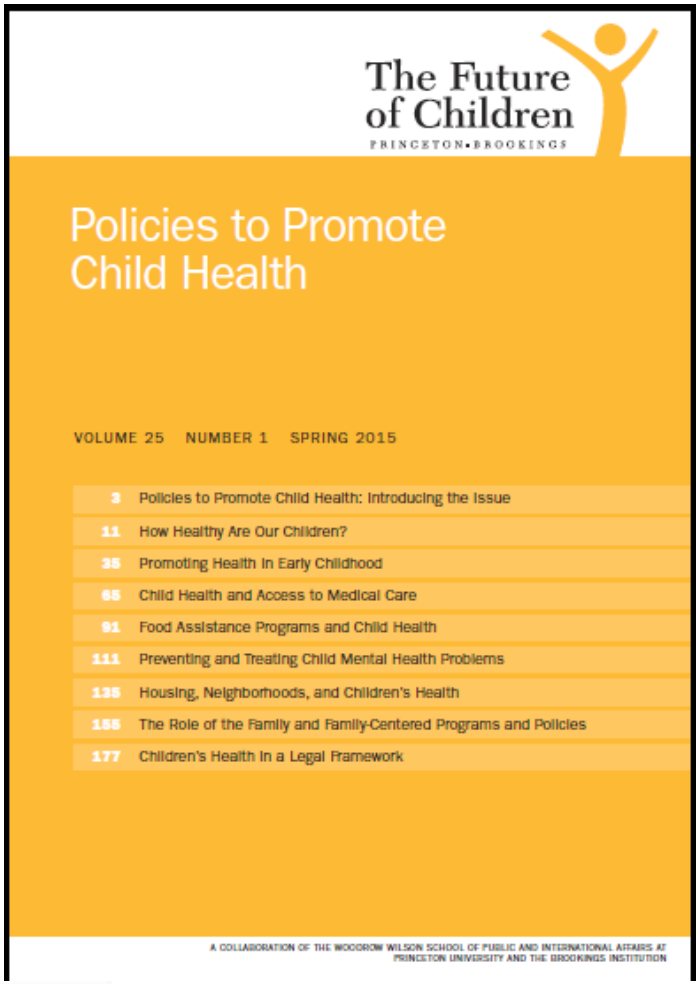
CONCERNS ABOUT CHILDREN HAVE ALSO BEEN RAISED



VOLUME 25 NUMBER 1 SPRING 2015

Policies to Promote Child Health

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http://www.princeton.edu/futureofchildren/publications/journals/journal_details/index.xml?journalid=83

SAFETY NET FOR THE POOR

- SSI
- Unemployment Insurance
- Child Support
- Temporary Assistance for Needy Families (TANF)
  - Minnesota Family Investment Program (MFIP)
- General Assistance
- Supplemental Nutrition Assistance Program (SNAP)
- School Lunch
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Housing Vouchers
- Earned Income Tax Credits for the under employed
- Medical Assistance

Healthy: Moms, Babies, Families & Communities

- You cannot bemoan the problem of perinatal substance abuse in Minnesota and remain inert.
- You cannot lament the social determinants of health of people of color in Minnesota and remain unmoved.
- You must act to improve the situation.
- The politics of action will yield a divided community, but solutions are necessary.
- There must be new experiments, solutions and measures, even if they are slow to take effect.
- Use this Summit as your springboard to action and results.

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The Health and Well Being of the Mother and the Health and Well Being of the Child Are Bound Together

THANK YOU!

H. Westley Clark, MD, JD, MPH
hclark@scu.edu

Santa Clara University

Break

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Department of Human Services

Great Lakes (HHS Region 5) ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

march of dimes®

Minnesota Prematurity Coalition

Women and Addiction: Considerations in Gender-Specific Treatment

Jessica Schmoll, MS, LPC, CPCS

Director, MARR Women's Recovery Center

Why are we here?

- Rates of addiction/alcoholism females 12-17 mirror rates for males
- Mid-life/older women largest consumers of prescription benzos, pain meds, antidepressants
- Shame kills and stigma still more prevalent for female addicts/alcoholics
- Barriers to treatment – lack of childcare/transportation/health insurance/finances; drug-abusing partner; lack of support

Objectives

- Assess the gender landscape of addiction
- Examine the "biology of relationships" – dissect the benefits and risks
- Identify challenging physiological factors and added dangers
- Review treatment considerations

The Female Brain*

- All fetal brains look female until 8 weeks
  - Female = sprouts connections in communication/emotion centers
  - Male = Testosterone surge kills off cells in communication center, grows cells in aggression center and sex center
- Female brain centers for language / hearing have 11% more neurons

  (**women: _____ words per day vs. ____ for men**)

*Louann Brizendine, M.D., 2006

The Female Brain*

- Larger Hippocampus (hub for emotion/ memory formation - words)
- 1st 3 months of life for girls: skills in eye contact/facial gazing increases 400%; boys = no increase in skills at all (boys: move, draw and track things- better at spacial skills and navigation)
- Better at reading facial expressions / hearing vocal tones – use to discover meaning about themselves/worthiness ("touchstone for reality")

*Louann Brizendine, M.D., 2006

Major Hormones

- **Estrogen:**
  - Promotes social interest
  - Provides a sense of well-being
  - Causes one to feel more socially relaxed
  - Causes one to seek intimacy with others
- **Testosterone:**
  - Is a trigger for sexual desire
  - Males have on avg. _____ x more testosterone than females

Hormonal Shifts

Oxytocin:

- Neurohormone that triggers / Is triggered by intimacy (reduces stress)
- (+) Chemical reaction mimics being "**In Love**"
- **INTENSE** – shares neural circuits/reward pathway with states of obsession, mania, intoxication, thirst, hunger
- **REJECTION** = Drop in Oxytocin / Dopamine / Estrogen
- (-) chemical reaction mimics **withdrawal symptoms**
- **Relationships** are a huge relapse risk factor in early recovery

Biology

- **Telescoping** – term used to describe an accelerated progression from the initiation of substance use to the onset of dependence and first admission to treatment.
  - Women may require medical help up to 4 years sooner (avg)

Biology

- Become intoxicated faster – less water and more fatty tissue – Increases absorption
- Lower activity level of enzyme alcohol dehydrogenase which breaks down alcohol
- One drink, twice the impact – addicted faster

Biology

- Contributes to heart damage, osteoporosis, cirrhosis, chronic pain, thyroid issues, GI symptoms, brain atrophy sooner than men (etc.)
- Hurts chances of pregnancy; impacts prenatal care
- HIV/AIDS/Hepatitis/HPV – diseases that are more easily transmitted male to female

Relationship Factors for Female Addicts

- Failing to provide financial / parenting support / go to jail
- Being violent / abusive
- Providing minimal / conditional support for females in treatment

"When are you coming home?"

Relationship Factors for Female Addicts

- Unhealthy partners contribute to women's addiction…
  - By introducing them to drugs / alcohol (and supplying) - women want to belong and not hurt feelings / trouble saying "no"
    - Women most likely to use IV for 1st time with sex partner (mirrors intimacy)
    - Women: speak in terms of relationships – "Alcohol was my love"

Other Reasons for Using

- Weight control = body image issues
- Relieve stress or boredom
- Improve mood = diagnosed or undiagnosed mental health issues/ self-medicate
- Reduce sexual inhibitions = desire for intimacy/connection, trauma management
- Increase confidence = self-esteem issues

Women-Centered Treatment Key Components

1. Relationship Focused
   - Consider Family of Origin Issues
2. Trauma-informed
3. Addresses Shame Resilience
4. Provides Safety
5. Considers co-occurring issues

Key Component #1

Relationship Focused

- Healthy connections help build identity and self-esteem
- Provide support for decision-making and day-to-day living and growth
- *Family
- Romantic – Healthy v Unhealthy Partners
- Higher Power – Spirituality
- Social Support/Peers, Friends and 12-Step Community
- Therapy/Treatment Team

*Family of Origin

- Explore dysfunctional dynamics that are being recreated in adulthood
- Draw Healthy Boundaries
- Stop enabling/rescuing/controlling cycle
- Improve communication
- Family of Creation

*Family of Origin (cont)

ACOA (Adult Child of Alcoholic)

Alcoholic/Addict parents create homes that:

- discourage feelings;
- Foster a loss of identity and overdeveloped sense of responsibility and guilt
- create low self-esteem and a fear of abandonment

Key Component #2

Trauma-informed

- 50%-90% of women in treatment have trauma history (often by those who said "I love you")
- Trauma = ruptures in primary relationships; history of abuse; lack of safety
- Trauma breeds more trauma: Untreated symptoms of PTSD lead to self-medication/high risk behaviors, continued victimization

  (anxiety, learned helplessness, hypervigilance, isolation)

Key Component #2

Trauma-informed

- Research shows that there is twice the rate of abuse in women as found in men among those seeking treatment

* This may be due to there being more perpetrators, more frequent trauma, and for longer periods of time

- Trauma can be due to stigma, poverty, gender, race, disability, etc.
- Normalize grief, develop coping skills, teach boundaries and communication skills, address codependency

"You'll never be good enough."

- Unworthy, unlovable, incapable, inadequate, broken, weak, flawed…
- Hide your faults by pretending to be perfect or to be what others expect of you.

Key Component #3

Addresses Shame Resilience

- De-mystify disease with education
- De-stigmatize disease by sharing stories and participating in gender-specific groups
- Find emotional authenticity
- Discover internal sense of belonging
- Honor imperfections
- Combat Stigma – "good moms;" "crackhead" v "crackwhore"

Key Component #4

Safety

- Secure and stable physical surroundings
- Predictable and nonjudgmental staff
- Single gender groups v mixed gender provides even playing field
  - Women take up less than 1/3 group time, even if more than ½ of group

Key Component #5

Co-occurring Issues- PTSD

- PTSD, panic disorders, generalized anxiety more common among women
- Women are twice as likely as men to develop PTSD after exposure to trauma

*Department of VA Affairs studies suggest that women experience PTSD at two to three times the rate that men do

Key Component #5

Co-occurring Issues - Depression

- Women are **2x** as likely as men to experience major depressive episodes and/or dysthymia in lifetime
- Depression is 70% more likely to predate the substance dependence and persist into sobriety in women
  - PMS/PMDD, Pregnancy, Peri/Menopause contribute
  - Stressors like unequal power and status, work overload and relationship issues, abuse histories contribute

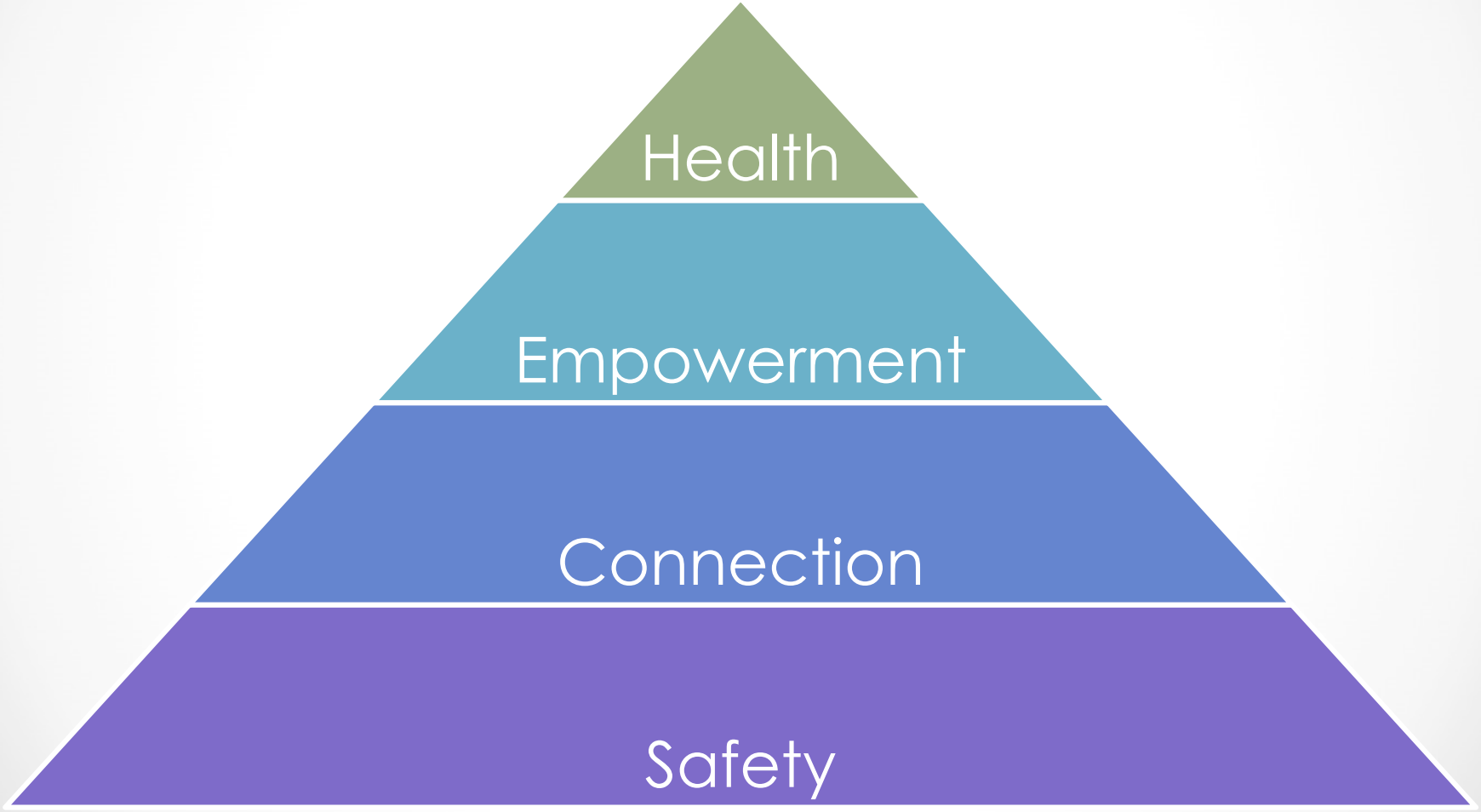
Key Component #5

Co-occurring Issues – Disordered Eating

- Approx. 90% of those diagnosed with an eating disorder are women (NIH)
- Eating Disorders: Over 1/3 of women seeking treatment have ED/DE issues

Treating the Addicted Woman:

Establish a Healing Environment



"Accurate Empathy"

"Entering accurately into a client's world, allowing her to be fully seen and heard."

- Carl Rogers

References

- Brizendine, L. 2006. *The Female Brain.* New York, NY: Broadway Books.
- Covington, S. 1997, *Helping Women Recovery Curriculum, A Program for Treating Addiction,* Hazelden, Center City, MN.
- DASIS Report, 2005
- Najavits, L.M., Weiss, R.D., Shaw, S.R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. The *American Journal on Addictions.*
- NSDUH report, 2006
- Priyadarsini, S. (1986). Gender-role dynamics in an alcohol therapy group. In D.L. Strug, S. Priyadarsini, & M.M. Hyman (Eds.) *Alcohol interventions: Historical and sociocultural approaches* (pp. 179-196). Binghamton, NY: Haworth.
- Vander Kolk, B. 1996 . *Psychological Trauma.* Washington, D.C.: American Psychiatric Press, Inc.
- Weiss, R.B., Kung, H.C., Pearson, J.L. (2003). Emerging Issues in Gender and Ethnic Differences in Substance Abuse and Treatment. *Current Women's Health Reports,* 3, 245-253.
- Wetherington, C.L. (2007). Sex-Gender differences in drug abuse: A shift in the burden of proof. *Experimental and Clinical Psychopharmacology,* 15(5), 411- 417.
- The National Center of Addiction and Substance Abuse at Columbia University (CASA). Women under the Influence, John Hopkins University Press. 2006

Cultural Perspectives on Prenatal Substance Use

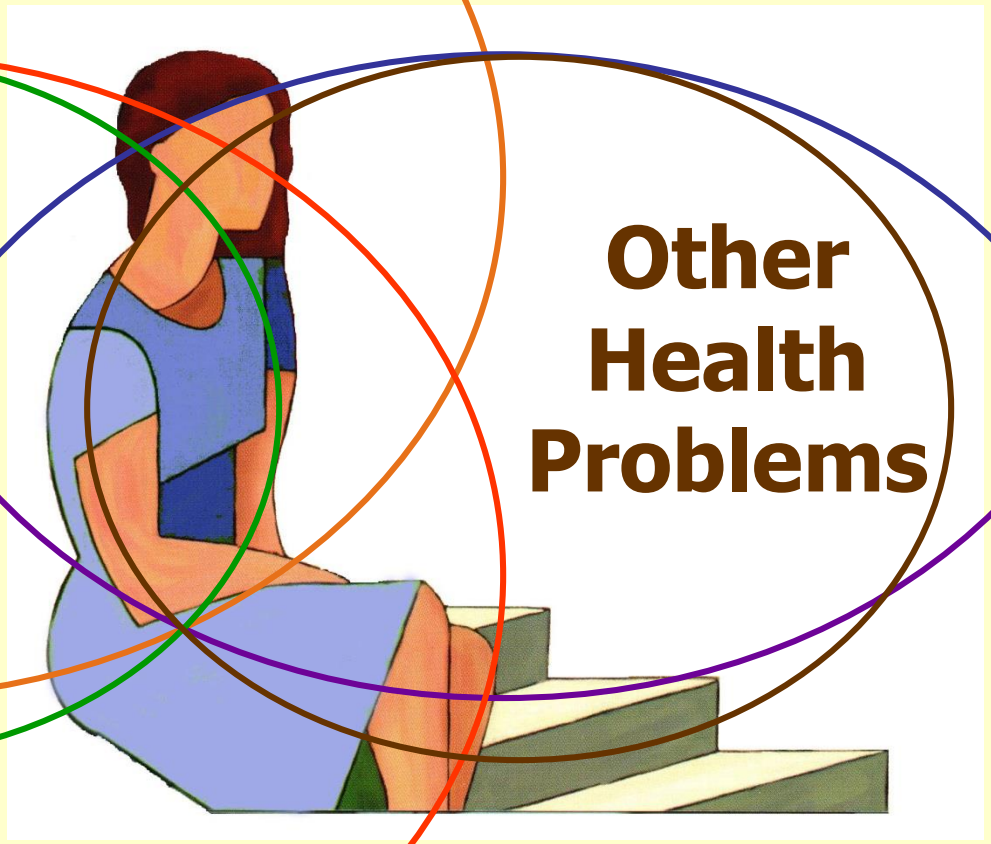
50 Shades of Brown: Providing Co-occurring treatment to African American and other women of color

Rashida Fisher, MS, LGSW, LADC

Mental Illness

Substance Abuse

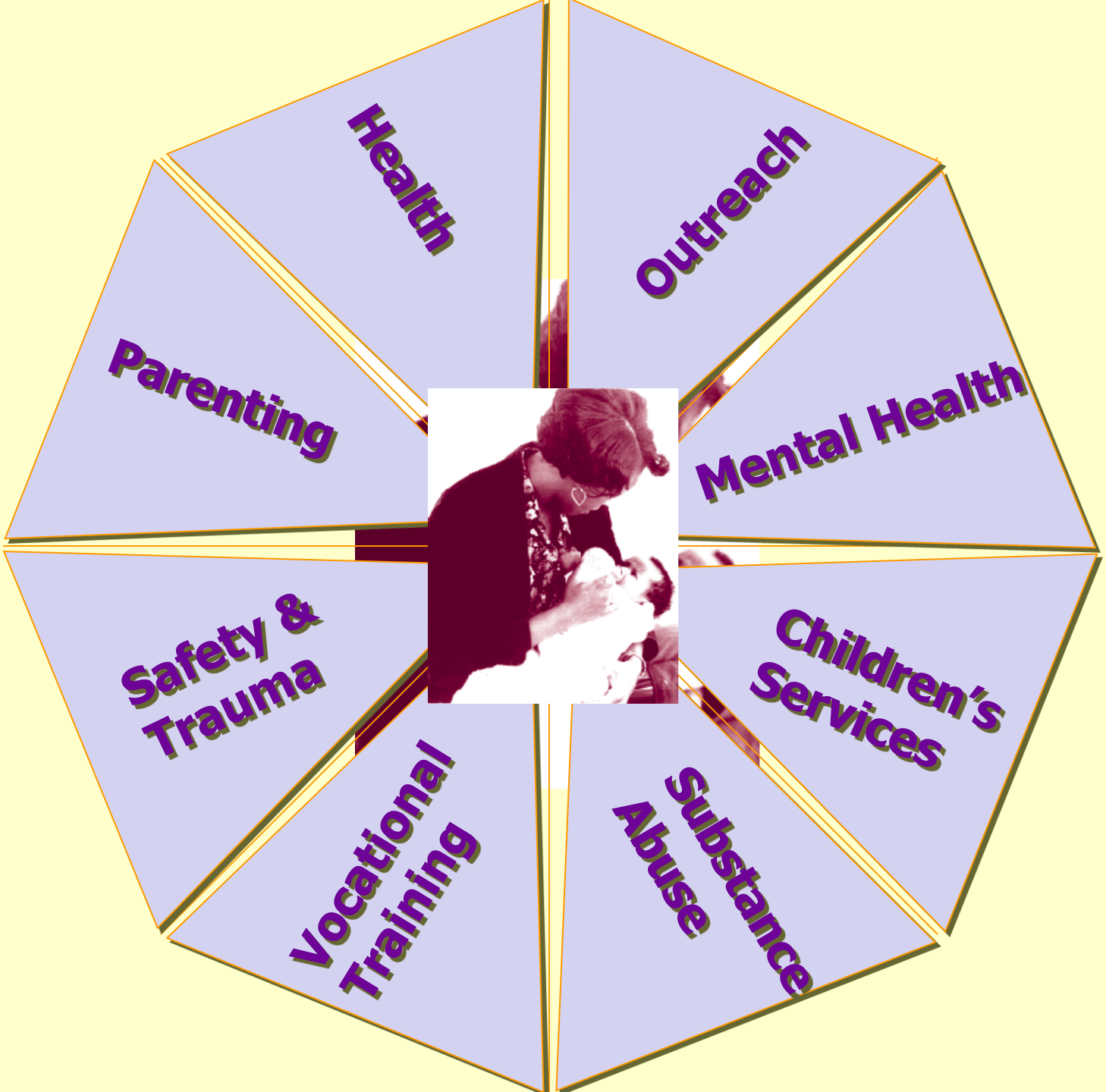
HIV/ AIDS



Other Health Problems

Trauma

Homelessness


Health
Outreach
Parenting
Mental Health
Safety & Trauma
Children's Services
Vocational Training
Substance Abuse

African Americans

- **Are just over 12% of population.**

- **Substance abuse and addiction rate is 8.8%. 24% report binge drinking. Illicit drug abuse 9.6%. About 24% of treatment population but drug use is not much more than that of general population.**

- **In prison are 44% of inmates sentenced for illicit drug involvement.**
- **Of those who gamble, high addiction rate.**
- **45% of all new HIV cases are African American.**

African Americans continued

- **Higher social class and church attendance are protective factors.**
- **Older African American women— over 85% abstain.**
- **Twice as many are in poverty as whites. Higher social class a protective factor.**
- **Almost half of advertising budget targets blacks.**
- **Recovery relates to spirituality and family support.**
- **David Goodson quote: “ deals with cultural pain.” Harm reduction techniques recommended.**
- **Treatment barriers—paper work for Medicaid, waiting period, wanting to conceal problem, waiting period.**

The New Jim Crow

Michelle Alexander (2010): *The New Jim Crow: Mass Incarceration in the Age of Color-Blindness*

1 in 9 young black men/ Women behind bars.

Many children without fathers or both parents.

Gender Issues

- **Shame factor for women in treatment.**
- **Women in treatment more likely than men to have a substance-dependent partner.**
- **Escape gamblers (women). Women start gambling later in life than men do.**
- **Treatment less accessible for mothers than fathers due to child care responsibilities.**
- **Many women lose custody of children over substance misuse.**
- **Lack of treatment availability for pregnant women.**
- **Good results with recovery coaches and family courts.**

Cultural Responsiveness

- Need to know social political context of being minority.
- Treatment must take into account ethnoculture norms.
- The Council on Social Work Education (CSWE) lists the ability to “engage diversity and difference in practice” as one of the ten core competencies.
- We need to know something about norms of particular groups to enhance treatment.

Social Class

Importance of class—bell hooks-

Class affects adolescents access to drugs.

Drug use affected by unemployment and low income status.

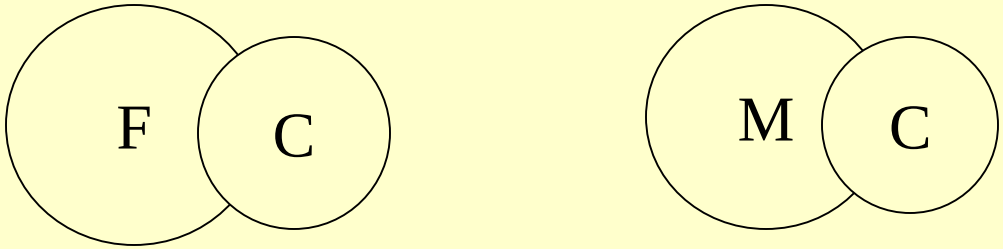
Often as acculturation increases, so does substance misuse

Family Risks and Resilience

- **Addiction is a family disease…pain and stigma.**
- ***Des Moines Register*** **"Children of Addicts"—meth labs, family fights, and child neglect in Iowa**
- **Classic Family Structure:**
  - **Addict as symptom of carrier.**
  - **Faulty communication in family >anorexia**
- **Confusion of cause and effect**
- **Family therapy field, little attention to addiction problems except as symptoms**
- **Little attention to cultural diversity as well. See McGoldrick et al's *Ethnicity and Family Therapy* (2005)**

Family Forms

***Enmeshed family*: Spouses are estranged: one child here is enmeshed with father, one with mother**



Other Cultural Considerations

McGoldrick et al's book on different ethnicities. Describes work with:

- **African American families—reciprocity a strength here**
- **Latino families—avoid a businesslike approach**
- **Asian and Asian American families—engage most powerful person in the family**
- **Native American families—engage the women who will teach health care practices**

Treatment Needs

- 1. Address barriers to treatment that many women experience, such as lack of transportation, child care, and treatment availability.
  2. Changing program goals and processes to accommodate women's needs for more support, less confrontation, job skill training, and parenting skills.
  3. Embracing an empowerment model of change.
  4. Female counselors who can attend to shame and stigma issues.
  5. Need to celebrate any significant decrease in substance use.

Two Approaches to Treatment

Traditional	**Strengths-based**
Bio	**Bio**
Dichotomy	Continuum
Psycho	**Psycho**
Problems mandate—one size fits all	Strengths-motivation
Social	**Social**
Identify family dysfunction	Holistic family as resource

Spiritual Healing

Today, social work education stresses importance of helping clients find spiritual meaning.

Older adults often change their outlook as they look back on their lives. Seek for the meaning of life.

Higher Power as nature in Norway, Native American traditions.

Search for forgiveness and renewal.

12 Steps as guide to self knowledge

A need for Multicultural Counseling

- By 2050, White (52.8%), Hispanic (24.3%), African Americans (14.7%), Asian Americans (9.3%), and American Indians (1.1%)

- Disparities in access to mental health services
  - Availability of mental health services
  - Appropriateness of services
  - Affordability of mental health service

Group differences:

- Between Group Differences
  - Knowledge of each ethnic group's cultural background
- Within Group Differences
  - Acculturation
  - Racial identity development
  - Socioeconomic factors
  - Cultural mistrust

Alternative therapist roles

- An advocate
  - Speak on behalf of the client
- A change agent
  - Change the social environment to one that is free of oppression
- A consultant and a advisor
  - Help to prevent the problems from developing in the first place
  - Teach skills needed to interact successfully with the dominant society

Common Factors in therapy

- Therapeutic relationship (most important)
- A debate: Empirically Supported Treatment (EST) VS. Empirically Supported Relationship (ESR)
- Common factors are more effective than specific ingredients in counseling
- Others: client expectations, the characteristics of therapist, shared beliefs about the causes of and solutions for the problems

Common Factors in a cultural context

- Utilize knowledge of the client's culture to build relationship
- Develop shared worldviews
- Raise the client's expectations that therapy will be helpful
- Implement interventions that make sense to the clients

Multicultural counseling Competence

- Awareness of one's own assumptions, values, and biases (awareness of self)
- Understanding the worldview of culturally diverse clients (understand others)
- Developing appropriate intervention strategies and techniques (appropriate Skills)

Attitude in Multicultural Counseling

- Become **aware** of your **biases and values**
- Attempt to understand the world **from your client's standpoint**
- Gain a **knowledge** of the **dynamics of oppression, racism, discrimination, and stereotyping**
- Study the historical **background**, traditions, and **values** of **your client**
- Be **open** to learning from your client

Lunch

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A Mother's Journey

FROM ST. PAUL - WHAT WE KNOW, HOW WE ARE WORKING TO HELP

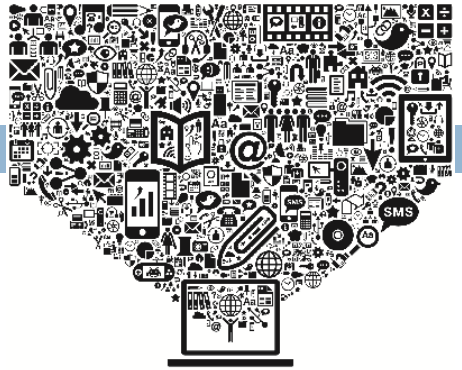
Minnesota Summit on Prenatal Substance Use and Infant Exposure

Jeff Schiff, MD MBA
Medical Director
Minnesota Department of Human Services
May 21, 2015

Today

- Data
- State opioid efforts
- More on NAS

Stories and data



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Data

Community Stories

- Data mirrors concerns that have been highlighted by community leaders and health practitioners.

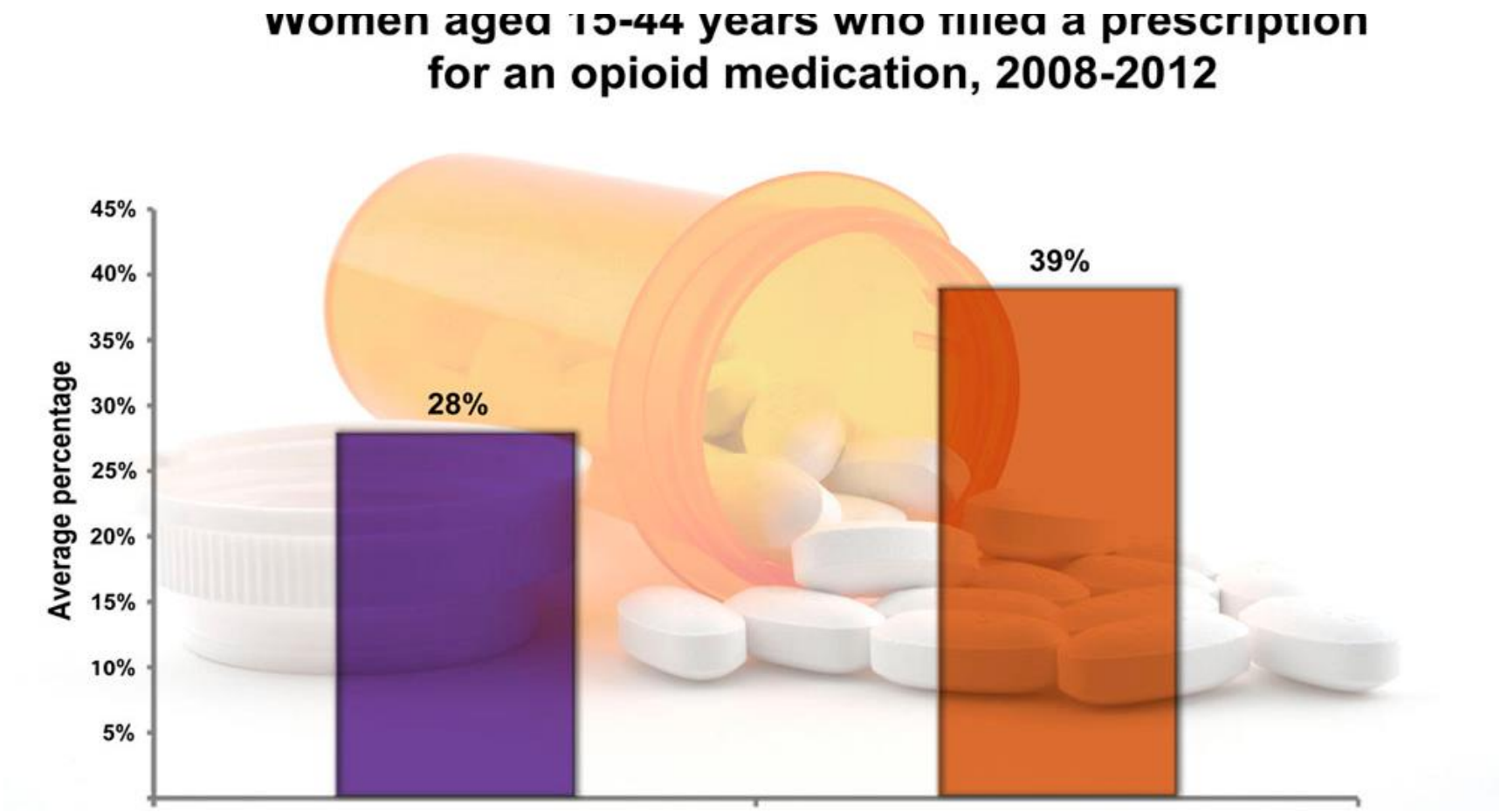
Data mirrors the story

Story of the data

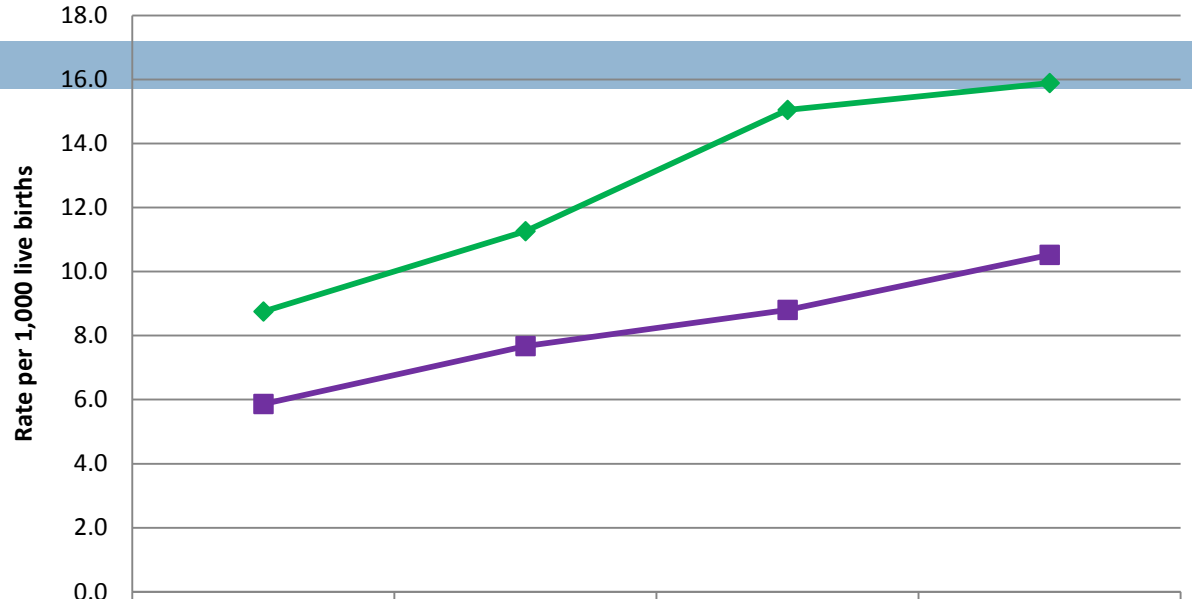
- We heard from the tribal communities
- Involved in developing data request
- Presented the data first
- Breaking the cycle of being "done to"
  - Our internal perception vs. external
    - Internal – we don't have much control
    - External - we control all the funding

Data by the numbers

- 30,000
- 8x
- 50%
- 3600
- 0


Women aged 15-44 years who filled a prescription for an opioid medication, 2008-2012
Average percentage
45%
40%
35%
30%
25%
20%
15%
10%
5%
28%
39%

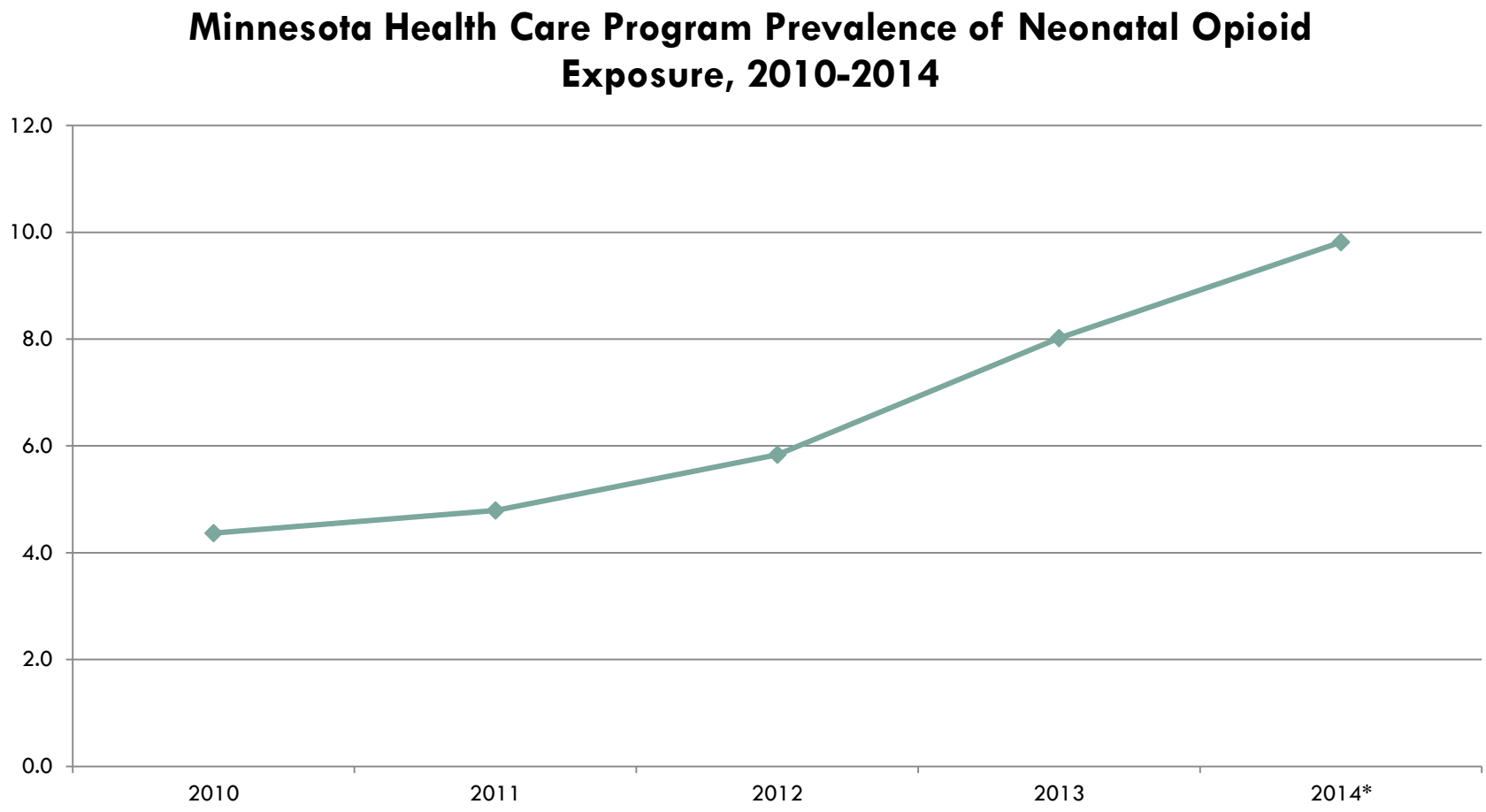
MHCP Prevalence Maternal Opioid Abuse and NAS, 2009-2012



	2009	2010	2011	2012
Maternal Opioid Abuse	8.8	11.3	15.0	15.9
NAS	5.9	7.7	8.8	10.5

- From 2009 to 2012 both maternal opioid abuse diagnosis and infant NAS diagnosis has almost doubled.
- Maternal diagnosed opiate abuse has risen from 0.9% of all births in 2009, to 1.6% in 2012.
- Of those diagnosed with maternal opiate abuse, 80% had the first diagnosis noted 0-10 months prior to delivery, while in 20% the first diagnosis occurred at the time of delivery or in the first two months postpartum.

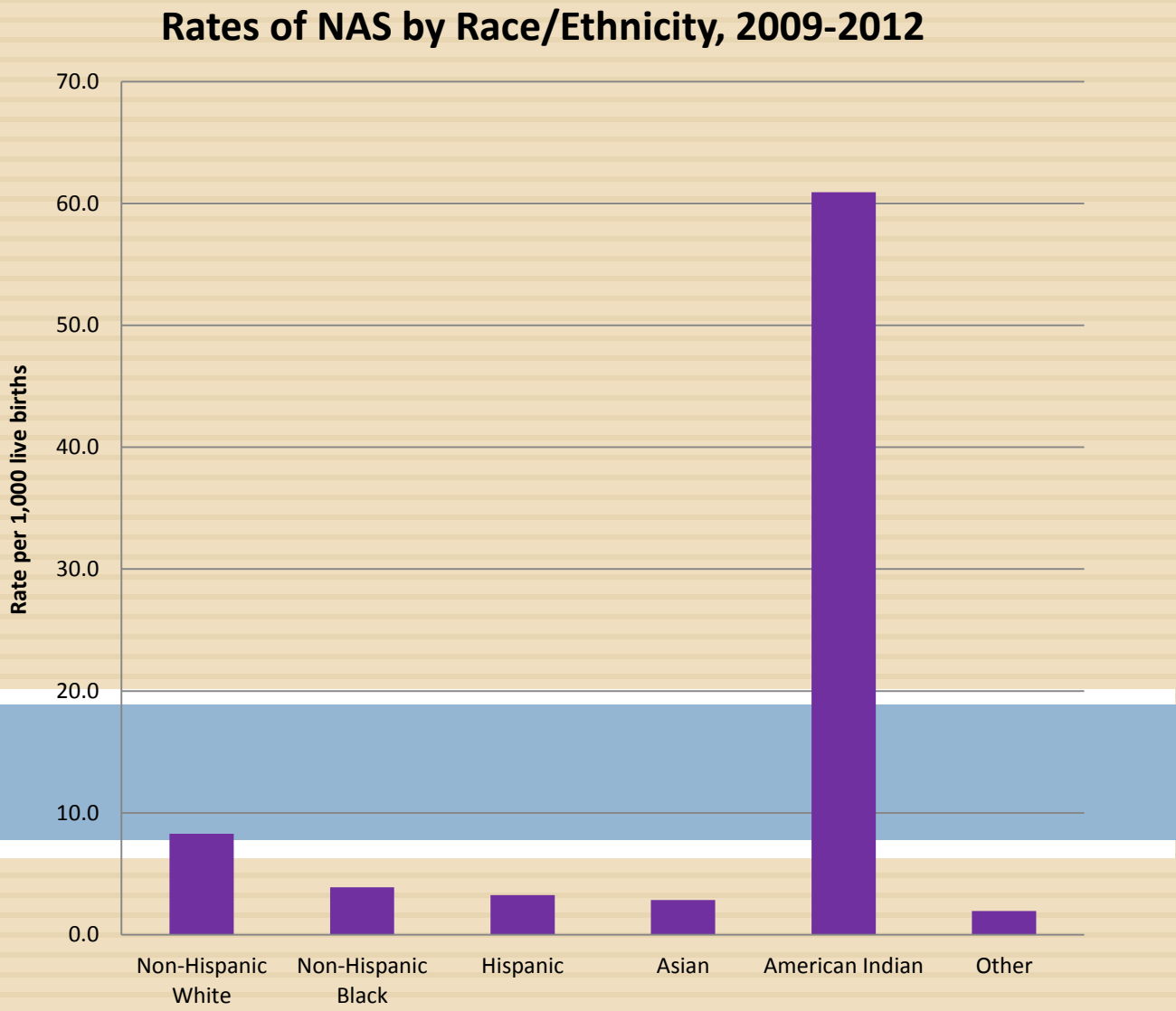
Data


Minnesota Health Care Program Prevalence of Neonatal Opioid Exposure, 2010-2014
12.0
10.0
8.0
6.0
4.0
2.0
0.0
2010
2011
2012
2013
2014*

NAS Infants

Compared to non-Hispanic whites, American Indian Infants are 7.4 times more likely to be born with NAS.

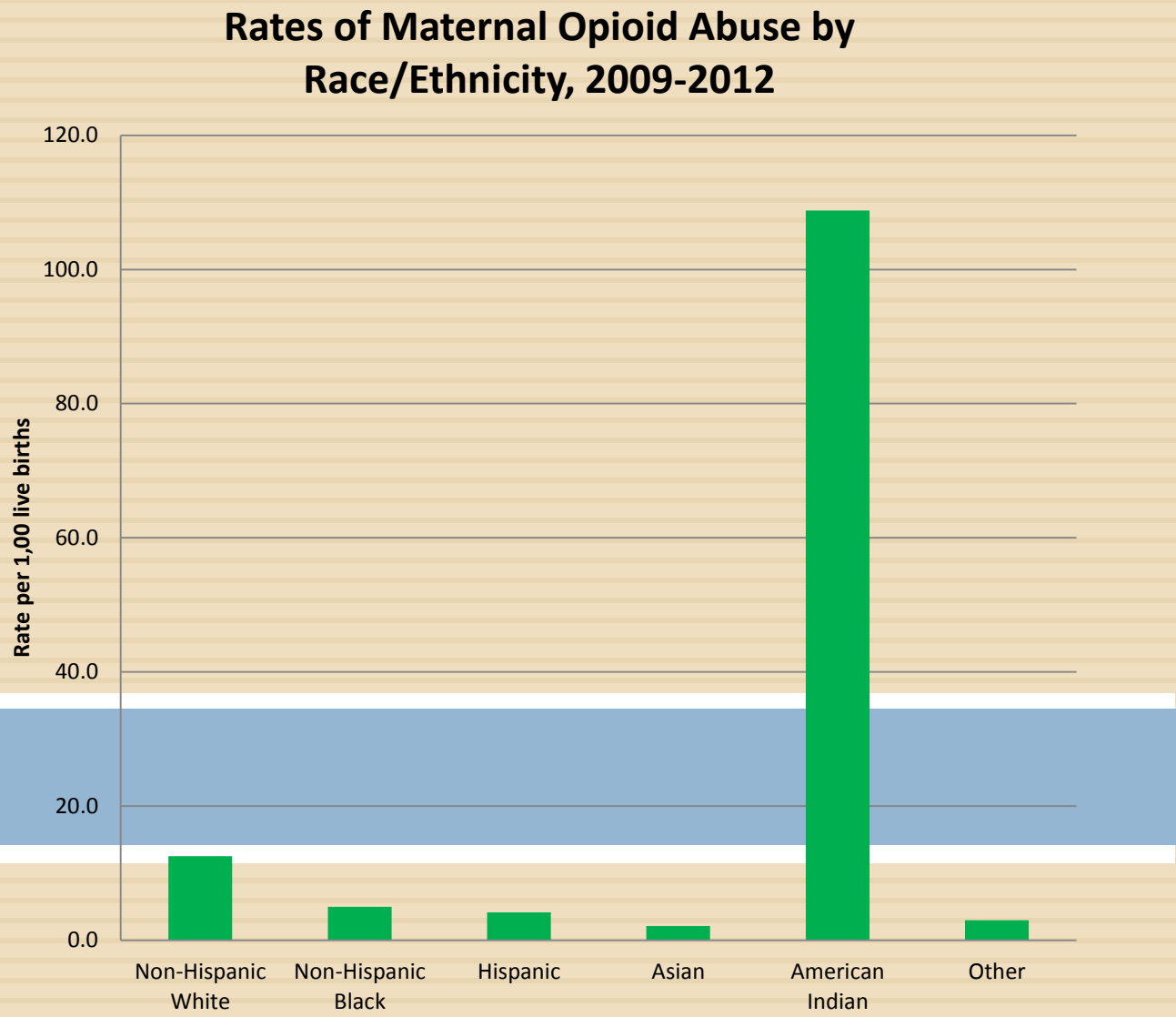
Over half of all NAS newborns are white, and over a quarter are American Indian.



Maternal Diagnosis of Opioid Abuse

Compared to non-Hispanic whites, American Indian women are 8.7 times more likely to be diagnosed with maternal opiate dependency or abuse during pregnancy.

More than one in ten pregnancies among American Indian women have a diagnosis of opiate dependency or abuse.



NAS infants

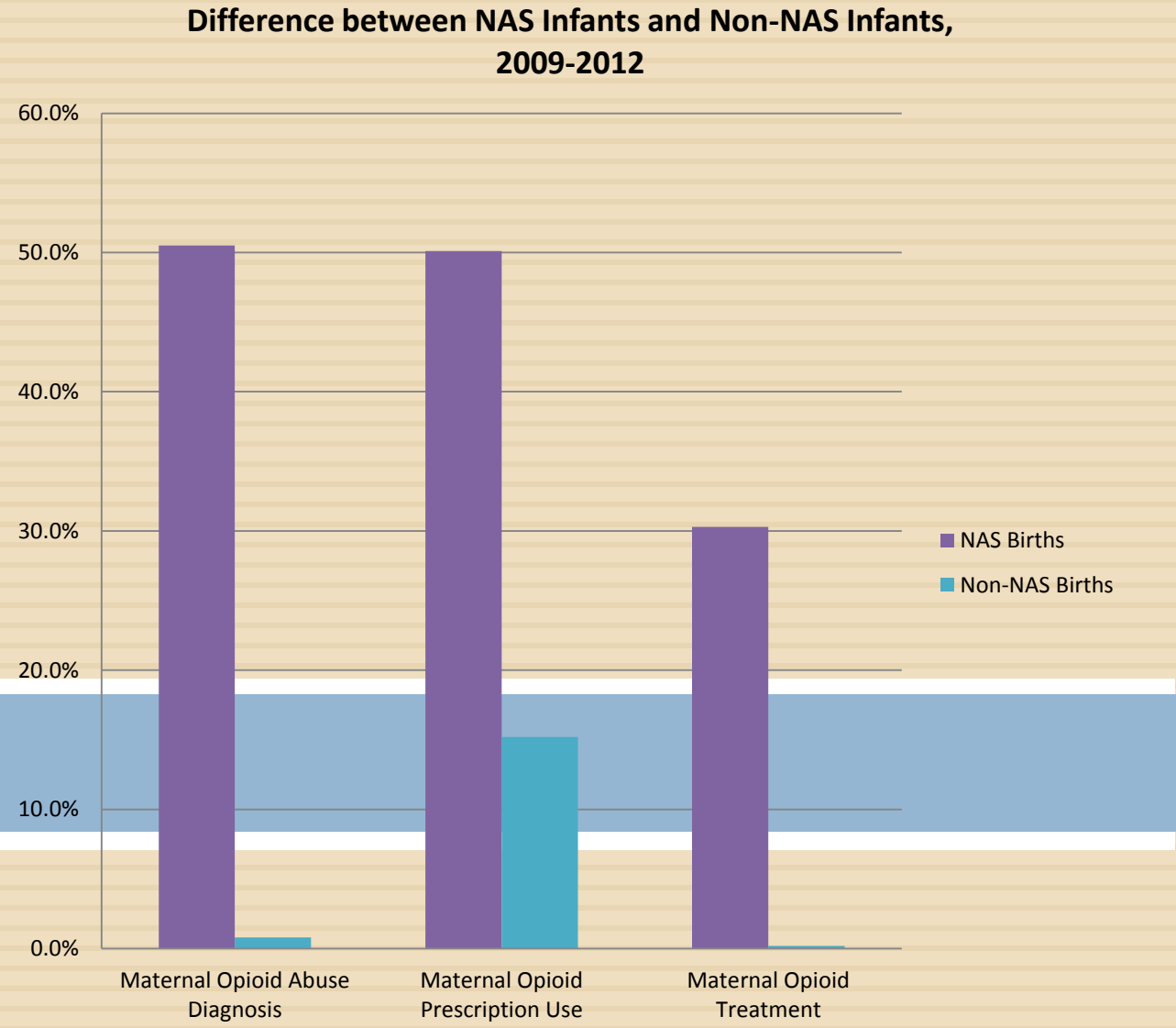
- Only half of NAS babies are born to a mom with a diagnosis of SUD for opioids
  - Only 30% of NAS babies had a mom on MAT
- 26% of NAS babies are preterm

Maternal Opioid Use

58 percent of moms on Methadone or Buprenorphine treatment had a NAS infant

During pregnancy of a mother with a diagnosis of Opioid Substance Abuse

- 32 percent were on Opioid Treatment
- 54 percent had an opioid prescription



Comparison data

How many mom's of NAS babies get an opioid prescription?

50%

Versus

15% of other moms

Comparison data

How many moms of NAS babies get inadequate or no prenatal care?

34%

Versus

14% of other moms

NAS Economic Data

- 23 Days
- Hospital charges (2012) = $93,400
- 80% to Medicaid
- Primary prevention: $1 on short-acting opioids = $50 in NAS treatment

Patrick SW, Davis MM, Lehman CU, Cooper WO. Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. J Perinatol. Apr 30 2015

What about Other Drugs?

- Illicit drug use in pregnancy (averaged across 2011-2012)
  - 18.3% - pregnant girls 15 to 17 years old
  - 9.0% - pregnant women 18 to 25 years old
  - 5.9% - 15-44 years (less than non-pregnant 10.7%)
- Legal drugs in pregnancy
  - 17.6% smoke cigarettes
  - 9.4% use alcohol

Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings. Rockville, MD: Substance Abuse and Mental Health Services Administration;2013.

Other drugs- Minnesota DANNES data

Treatment admissions 2010 vs. 2014

Opiates besides heroin

121 to 141

Heroin

52 to 172

Methamphetamine

96 to 256

Alcohol

248 to 130

What about opioids for pain?

- Evidence for use for chronic pain?
- Biology of pain/ genetic variation in receptors
- Early changes in opioid receptors
- Avoiding new chronic users

Data by the numbers

- 30,000
  - Birth in Minnesota Health Care Programs/ year
- 8x
  - Risk of NAS in Native American babies
- 50%
  - Percent of NAS babies where mom's use was know before birth
- 3600
  - Number of new chronic users of opioids each year
- 0
  - Amount of evidence that chronic opioids are effective for chronic pain

So what have we been doing?

SOOP

- State Opioid Oversight Project
  - All state agencies/ National Governor's Association sponsored
  - Collaborate and coordinate
  - Report up to the State Substance Abuse Strategy leadership – Commissioners and Governor's office

SOOP areas of work

- Neonatal exposure
- Prescribing
- Medication Assisted Treatment
- Prescription Monitoring Program
- Primary prevention
- Narcan for overdose
- Disposal

SOOP

- Some state legislation
  - INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN
  - Prescribing

INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN

"Qualified integrated perinatal care collaborative" or "collaborative" means
a combination of (1) members of community-based organizations that represent
communities within the identified targeted populations, and (2) local or tribally based
service entities, including health care, public health, social services, mental health,
chemical dependency treatment, and community-based providers, determined by the
commissioner to meet the criteria for the provision of integrated care and enhanced
services for enrollees within targeted populations.

INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN

- Early identification
- Enhanced access and effective use of services
- Education
- Integration with child welfare
- Effectively systematize activities
- Facilitate post partum continuity
- On-going quality improvement

Looking at models

- Three legs of a stool
  - Screening
  - Treatment
  - Community support

Tell our stories

Break

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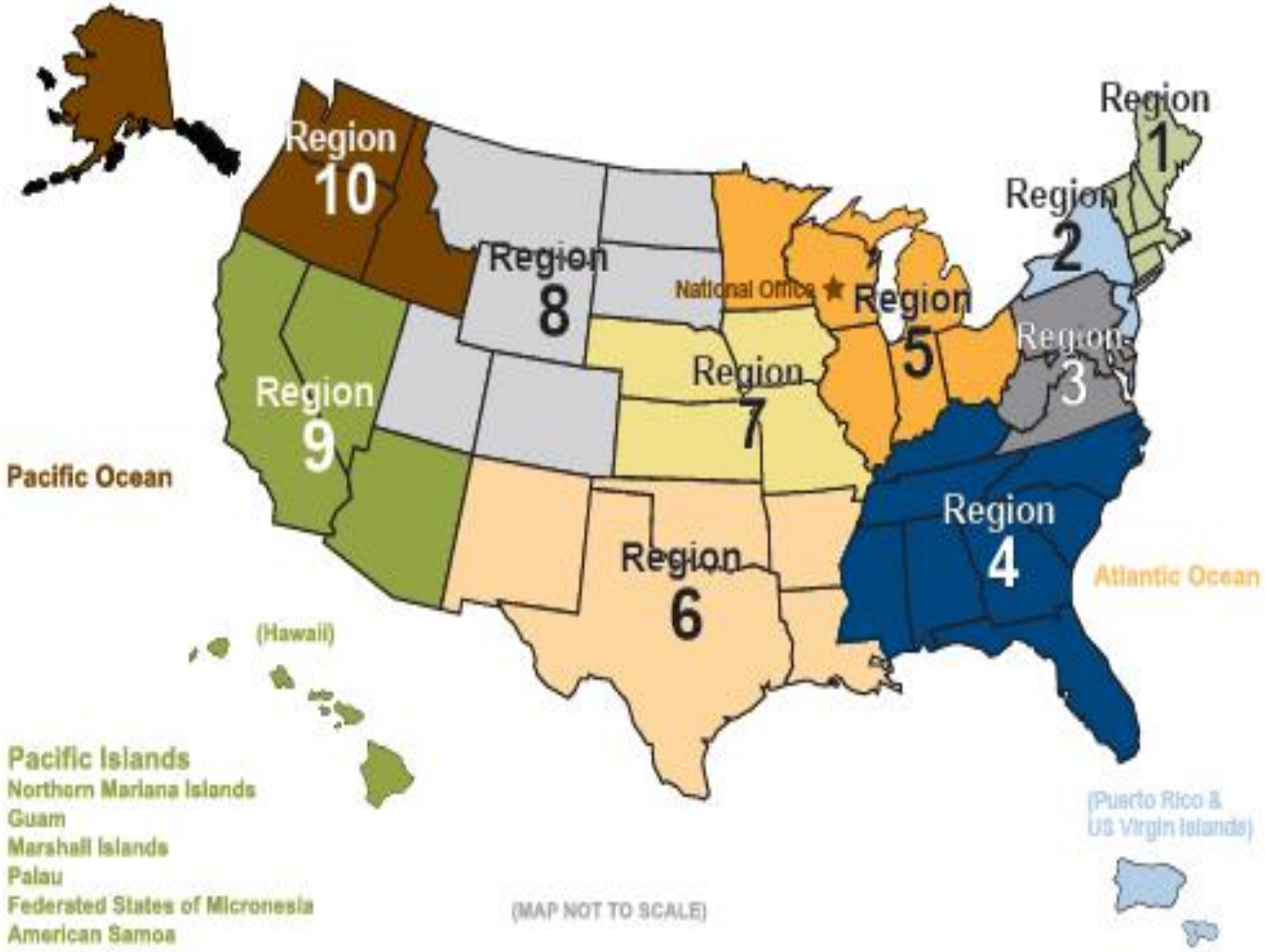
Building Community Collaborations

2012 – 2017 ATTC Network Map



National Focus ATTC's

National Frontier and Rural ATTC

National Hispanic and Latino ATTC

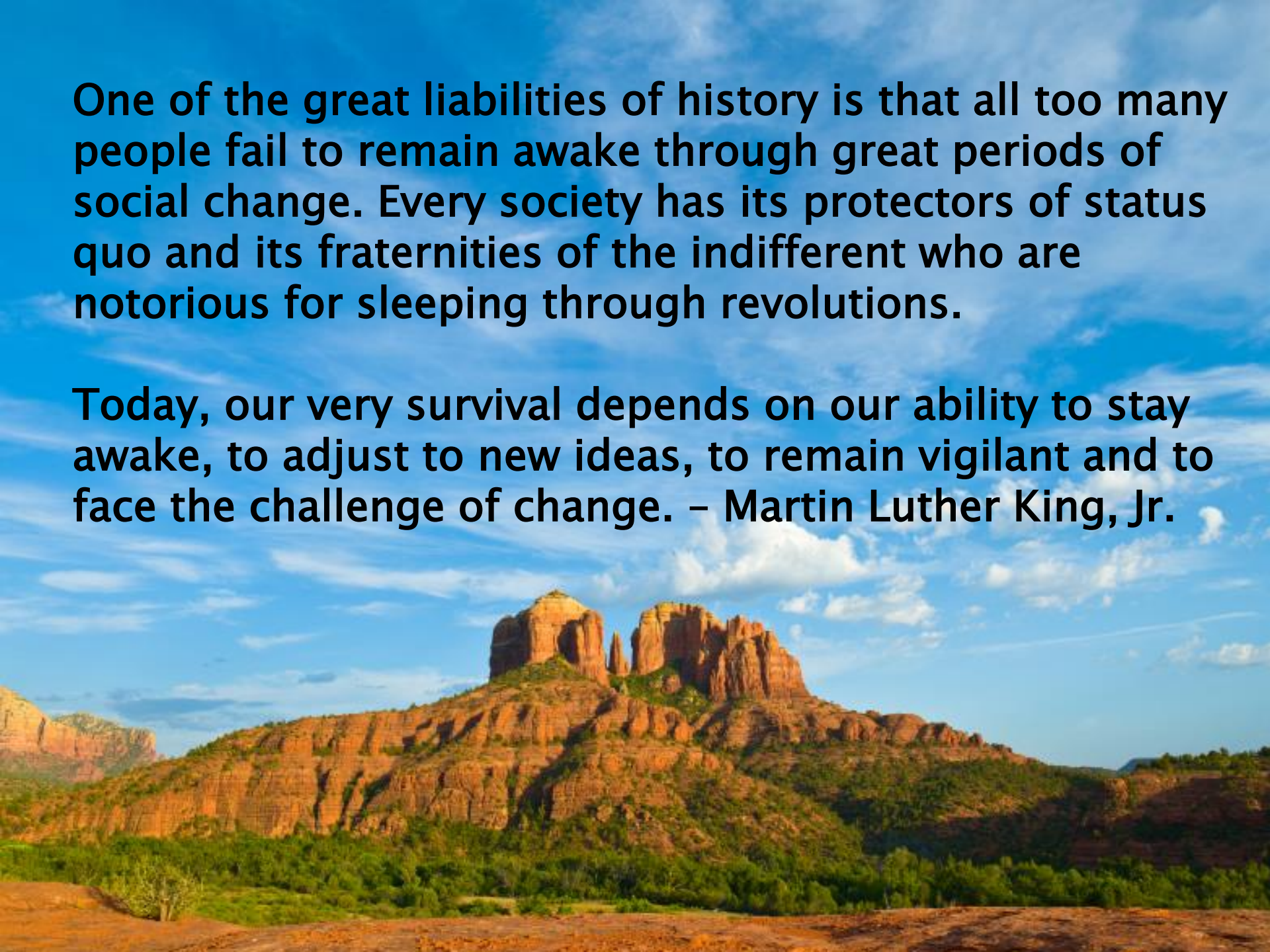
National American Indian and Alaska Native ATTC

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

Visit us at: www.attcnetwork.org

One of the great liabilities of history is that all too many people fail to remain awake through great periods of social change. Every society has its protectors of status quo and its fraternities of the indifferent who are notorious for sleeping through revolutions.

Today, our very survival depends on our ability to stay awake, to adjust to new ideas, to remain vigilant and to face the challenge of change. – Martin Luther King, Jr.



Recovery-Oriented Systems of Care shifts the question from

"How do we get the client into treatment?"

to

"How do we support the process of recovery within the person's life and environment?"

ROSC as a Conceptual Framework & Road Map

SOCIAL SUPPORT

NAMI

Peer Support

Housing Improvements

Treatment and Medication Support

Employment Opportunities

AA and NA

Family Education

Faith-based Support

Physical Health

RCOs

Healthy relationships

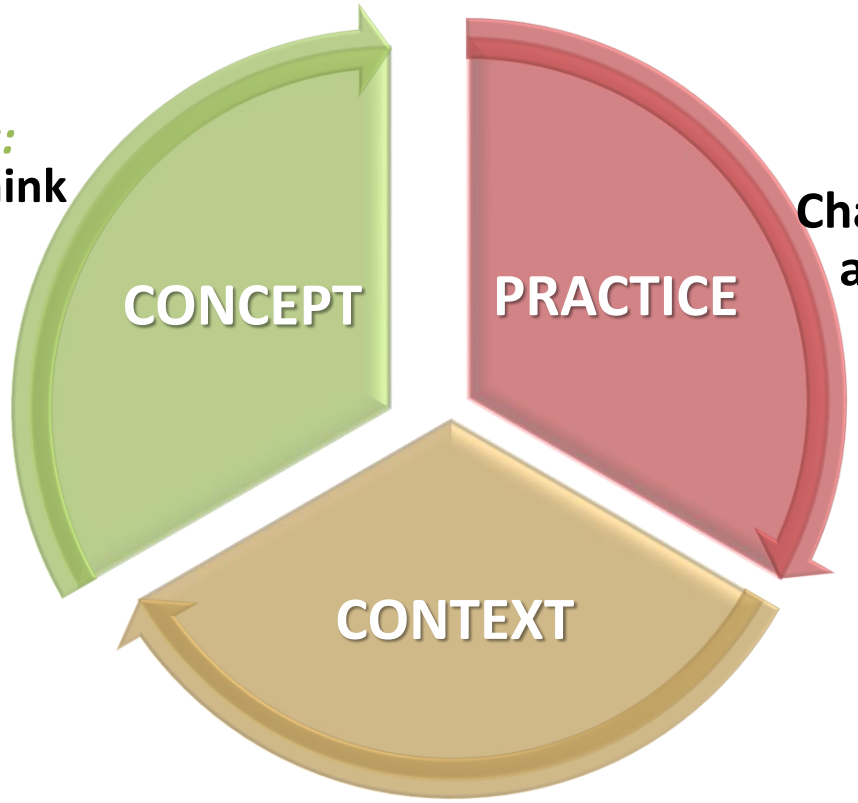
Life skills training

3 Approaches to Recovery/Resilience Focused CHANGE PROCESSES

ADDITIVE	SELECTIVE	TRANSFORMATIONAL
Adding peer and community based recovery supports to the existing treatment system.	Practice and Administrative alignment in selected parts of the system – e.g. pilot projects.	Cultural, values based change drives practice, community, policy and fiscal changes in all parts and levels of the system. Everything is viewed through the lens of and aligned with recovery oriented care.

A FRAMEWORK FOR LEADING CULTURE CHANGE

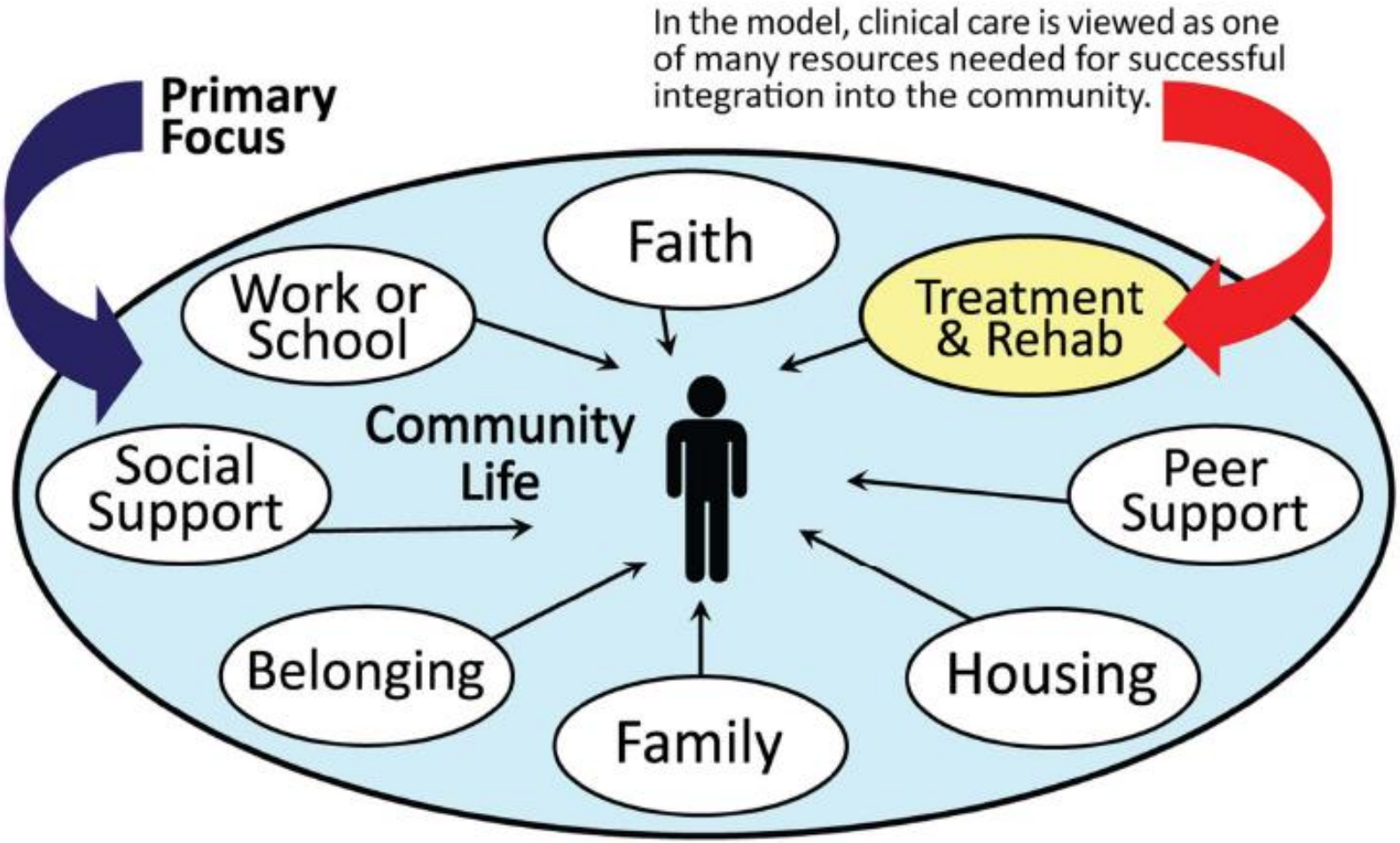
Aligning Concepts:
Changing how we think



Aligning Practice:
Changing language, behavior and practices at all levels

Aligning Context:
Changing regulatory/physical environment, policies and procedures, enlisting community support

Recovery and Resilience Oriented System of Care



ROSC as a Conceptual Framework & Road Map

Activity

Wrap-Up and Next Steps

Next steps

- Continue great work in local areas
- Focus group trainings (Training of Trainers)
  - June 25, 2015 10:00 AM – 12:00 PM (CDT)
  - June 30, 2015 1:00 – 3:00 PM (CDT)
- Post-webinars
- Better and increased collaboration w/Law Enforcement
- Website http://tinyurl.com/2015MN-Summit
- Evaluations

Circle Send-Off

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