And that maybe for myriad reasons including being unable to access treatment or being not ready for
treatment in a more formal setting or having had a bad experience with access and treatment and so
treating it by a different means.
What are some of the medical consequences of opioid use for women? This is a pretty wordy slides
I'm just going to focus on the highlights here so women's use of heroin and I would say fentanyl as well
has increased over the years. There was a four
opioid use in the 1960s and that progress to a one-to-one ratio. Women have a higher risk of
contracting hepatitis C and HIV with IV heroin use because they are more likely to interact with a
previously used needle or to share needles with a male
partner there are also more likely to be prescribed prescription opioids for pain than are men and they
have a greater likelihood of reporting chronic pain women are less likely to die of prescription
opioid overdose but it is really
important to look at the increases in overdoses over time so for women they had an almost 600
increase and overdose and overdose and men also increased significantly by their overdose amount
by 312 percent but again that was half the rate of women
and also a study from 202016 showed that women who died from an opioid entered overdose were
less likely to receive receive naloxone than men. Are being described less frequently than are men.
This is you can get opioid use disorder among women and
the use of MO ED and and this is among women again and again that 18 to 25-year-old group. Has
significantly Mowery opioid use now on the right-hand side the good news is that the use of
buprenorphine is increasing over time, but not nearly enough
to meet the needs of individuals who have opioid use disorder. Again, it is going on the right direction,
but we are not where we need to be. These members are looking at poly substance use and major
depression episodes and serious mental illness
and women on the left-hand side is looking at people having marijuana use and other substance use
as well as major depression or another serious mental illness. Of the important point to notice here is
that if you have either a serious mental
illness diagnosis or a depression diagnosis, you're more likely to be using any substance and also
when people are using marijuana, they are more likely to use additional substances in addition to
marijuana. On the right-hand side as you looking at
opioid use and substance use in the serious mental illness or depression so again if you have a
serious mental illness or major depression were more likely to use any substance regardless of which
substance we are talking about if we are all using
opioids we are you are more likely to be using another substance in addition to opioids than someone
who is not using opioids serious mental illness is increasing among women and the concerning thing is
that despite the numbers of women who are
accessing treatment for their mental health diagnosis those numbers are better than the numbers of
people for their substance use that says the very significant minority would get no treatment this is
data from data 19 a little more than 40 percent
got no treatment among those age specifically when we think of the pregnant potential potentially pregnant population of 26 to 49-year-olds we have a serious mental illness almost got no treatment this is looking specifically comparing people with no mental health diagnosis and those with any mental health diagnosis and those with a serious mental health diagnosis the more serious your mental health diagnosis is the more significant your comorbid substance use is you have no history of mental health diagnosis than your less likely to use substances and that is across the board this is looking at co-occurring substance use disorder diagnosis and any mental health diagnosis and women. Again, you can see that it is particularly acute in the 18 to 25-year-old range. And this is looking at co-occurring substance use and mental health diagnoses among adult women and as I mentioned on the prior slide, which showed the data a little bit differently, the more significant your mental diagnosis is, the more significant your use of any substance is.

Let's talk a little bit about co-occurring mental health diagnoses and substance use disorder in women. I want to focus particularly on them two most common diagnoses, which are depression and PTSD or trauma history. There certainly are differences between males and females with respect their mental health diagnoses and the relationship with substance use and substance use disorder. Depression increases the risk of substance use and adolescent females and conduct disorder and ADD increase substance use and adolescent males males. Interestingly, is why people use substances so this is from an Australian study that adolescent males drink alcohol to have fun whereas adolescent females drink female to deal with depressed mood. Adult women report using substances to manage negative affective states so that would be primarily associated with depression and adult women with substance use disorder have been shown to have higher prevalence of both depression and anxiety disorders compared to their male counterparts.

Women who are with SU D. treatment are more likely than men to be diagnosed with co-occurring psychiatric disorders or mental health diagnoses. What about PTSD and trauma we were going to talk about trauma and today's presentation, but we are going to give you some high-level facts PTSD and substance use are commonly intersect in women. Women are more likely to figure out history and trauma than men so partly trauma happens more frequently in women but partially that is because women often are more in touch with recognizing they have a trauma history and are more likely to disclose that than are men. For women with substance use or substance use disorder, particularly notable is that they have a history of childhood or preadolescent sexual trauma. PTSD as a result of childhood sexual trauma and other traumas is highly correlated and often precedes the development of a substance use disorder. There was one study that looked to adolescent female truant twins and they showed that women exposed to trauma were almost two times more likely to develop an alcohol use disorder and women exposed to trauma then developed PTS D. had an almost four times more likelihood to
develop substance use disorder. These may lead to other complete complications such as sexual victim and date victimization and risky sexual behaviors. These are the high prevalence of co-occurring disorders in women. On the left-hand side is showing us that substance use disorder is associated with suicidality among adult women older than 18. Less frequently does it lead to a suicide attempt or making a plan but serious thoughts of suicide were very common in those with SUD. If we look at the right-hand side, this is talking about that gap that I mentioned. This is not specific. I'm sorry this is specific to women 12 and above. If we look at women 12 and above with a mental health diagnosis, about 50 percent will never access treatment in their lifetime for their mental health diagnosis. If we look at substance use disorder, though stats or even worse. Only about 11 percent of women above 12 years old with a substance use disorder will ever access to care for their substance use disorder. This is looking particularly at pregnant person's. This is showing past month substance use among pregnant persons. The use of alcohol and tobacco is far more common than the use of illicit substances during pregnancy and if we look at illicit substances, the use of marijuana is far more common than any other illicit substance. I do want to point out that over time, the use of illicit substances has decreased in that persons who are not pregnant are far more likely to be using substances than our pregnant persons. On the left-hand side is looking at daily or almost daily marijuana use by pregnancy status. You can see again among nonpregnant persons, use is more common than among nonpregnant persons. On the right-hand side is looking at past use substance mental health issues and pregnant persons by marijuana status. It reflects similar data. If you have comorbid mental health diagnoses marijuana use is more common to have another substance use. Or part this is looking at the impact of opioid use on pregnant persons. On the left-hand side is the increase in the proportion of pregnant persons who have substance use disorder treatment admissions. Those have remained fairly static over time. At this data is pretty old. There is not more updated data that shows this same information. That was only through 2012. However, there was a significant increase from 1990s through 2010's with respect to pregnant persons who were disclosing opioid use and among pregnant persons reporting prescription opioids as their substance of choice. How has this made an impact on pregnant persons so the rate of overdose deaths rose 20 percent from 2015 to 2016. Opioid use disorder has gone up more than four times among pregnant persons and there have been four times as many infants who were born with newborn opioid withdrawal syndrome so over 1999 and 2014.

If we look at the prevalence of opioid use disorder among hospital deliveries you can see that that also has increased over time unfortunately again this data only goes through 2014. There is not more current data then that. You can see that there
is variable prevalence depending on where you are in the country. Let's talk specifically about substance use among pregnant persons. Important to understand is what typically happens with persons who find out they are pregnant and perhaps so what happens during the pregnancy. There in respect to the use of alcohol cigarettes and illicit substances tends to decrease increasingly you can make it early pregnancy use as more than their first trimester, which is more than their second trimester, which is more than the third trimester so how do you tease out substance use versus a substance use disorder and a pregnant person we as I mentioned the vast these are motivated to maximize their own health and the health of their developing fetus. Those pregnant persons who cannot cut back or quit using likely have a substance use disorder so continued use during pregnancy could indicate a substance use disorder another important topic that I went to address very briefly as maternal mortality in the U.S. So unfortunately the maternal mortality in the person who is pregnant or in the first year after delivery unfortunately maternal mortality in the U.S. is much higher than other developed nations you can see that illustrated on the left-hand side we can see the countries of Europe as well as Canada Australia and high income Asian countries all have much lower maternal mortality rates than does the U.S. Why is that happening? One of the big reasons is due to overdose stats and postpartum persons so this is looking at data out of Massachusetts specifically, and this is looking at rates of opioid stats so these are lowest in the second and third trimesters in the third trimester to the first six weeks postpartum opioid-related overdose deaths increased by four fold and -related overdose was highest in the trimester period postpartum and it is speculated for a variety of reasons so it may be that they have decreased tolerance during that time and it may be that they were and then they got off of it and it may be due to the stress of having an infant and all of the stresses that are put onto parents when they are trying to parent and they have have a substance use disorder. Let's talk about some of the vulnerabilities for developing substance use disorder. This is not an exhaustive list but it is some of the things that I think are very significant and contribute. First and most significant 40 to 50 percent of risk is due to genetic predisposition In other words inherent ability so that accounts for 40 to 60 percent of that risk and that is even slightly higher depending we are talking about for propensity for cocaine use disorder and is more like a 70 percent so this is very, very significant so anybody who has any family history of any substance use disorder and that would include alcohol use disorder tobacco use disorder et cetera that confers a risk on to their offspring we can we talked about the role of concomitant medical health diagnoses but it is not uniform across diagnoses so certain diagnoses confirm more risk than others so particularly notable so bipolar disorder all forms of anxiety so whether we're talking about panic disorder, PTSD, social anxiety et cetera, major depression personality disorder specific
personality disorder and antisocial personality disorder antisocial conduct disorder in adolescents and this is regardless whether it is diagnosed or diagnosed or undiagnosed treated untreated or perhaps treated inappropriately so having that concomitant does confer vulnerability I talked briefly about a history of trauma. And its role. History of Tomo trauma was ubiquitous in the patient population I treated specifically. But again that goes across other substances as well. I mentioned already about preadolescent sexual trauma but also any kind of trauma and that could also be a victim or witness to violence. My clinical experience anecdotally and as I mentioned women are more likely to disclose a trauma history and men may not be as cognizant was a trauma so I often ask men specifically, or experiencing violence Joe generally speaking if somebody is using, they are experiencing violence related to their substance use met many vigils may have had poor coping mechanisms because of their impetus. It may be for escapism. Impulsivity plays of roles in the initiation of substance use and impulsivity is associated with the adolescent brain so our prefrontal quote cortex or prefrontal lobe does not finish developing until approximately 25 years old and many people start using substances much earlier than that. If you do not have the full development of that prefrontal cortex you're not very good at weighing consequences of your actions or having delayed reward. The adolescent brain does coupled with bipolar disorder or borderline personality disorder also which are associated with impulsivity may kind of cause a trifecta of impulsivity leading to substance use. Many people initially may be looking for sensation or novelty seeking but by the time someone meets criteria for diagnosis of a substance use disorder most people tell you they are not having fun anymore. They are basically maintaining particularly opioid use disorder to avoid withdrawal. The role of environment all goals and sensory cues is underrecognized as a trigger to use or to resume use. It may be a song the somebody here is playing or a smell that they associate with substance use or someone showing up to their door with a bag of heroin in hand. The way that the neural pathways work in the brain particularly when they are primed for substance use is that in the brain that returned to use or that trigger to use has occurred on the subconscious level with those environmental or sensual cues before the person even consciously knows that they are about to use. The more formal definition is a lack of homeostatic reward regulation or reward deficiency. When that younger brain is primed toward pleasurable rewards, which all substances are associated with extreme dopamine surges, which is associated with pleasure and the dopamine surges cannot be matched with any physiological dopamine surges that you can get from other pleasurable things like sex or eating something pleasurable et cetera. Once the Prema has been primed to those extreme surges of dopamine what happens is that both on the physiological level so the balance or anatomical level level, neural circuits are actually
recircuited to achieve that constant reward priming of the brain. What about the role of try mom and adverse childhood experiences and what does adverse childhood experiences have effects or outcomes on individuals. When we are talking about adverse childhood experiences, those could include the things that are listed on the left. Physical emotional sexual abuse, physical and emotional neglect and forms of household dysfunction so that may be a parent with a mental health diagnosis, mother specifically treated violently, substance use or in either parent or close nuclear family member or a separation of your parents. These are not benign experiences that happen with they happen in childhood. Not only does personal trauma impact children there may be historical generational trauma in that family there may be social conditions that may contribute to that child's experiences. This combination of generational historical trauma personal trauma and social conditions particularly adverse social conditions, actually leads to disrupted neural development. That means that socially emotionally and cognitively it leads to impairment. That may cause the adoption of what we would think of as risky or unhealthy behaviors that are use to cope with those experiences. That can eventually lead to disease disability or other social problems and may even lead to an early death. What is trauma? Let's look at that briefly and define it. It is exposure to actual or threatened death or serious injury or sexual violence and one or more of a four-way spirit you can directly experience the event yourself. You can witness and person and visualized the event occurring to others. You can learn that such an event happen to a close family member or friend. Or can be experiencing repeated or extreme exposed exposure to aversive details of such events, for example, such as a first responder. How does that trauma or violence translate into a trauma response or PTSD? You get changes that occur in the brain similar to the changes that I talked about with respect to substance use. You get a change in how you respond to things you get a trauma response, which means you get an over release of specific neurotransmitters that as far has been associated with a fight flight or freeze response and that includes epinephrine or norepinephrine. You actually also again get changes at the neural sector circuit level anatomically. What are the effects of trauma on the individual? We talked about some of the behavioral responses so it might be lack of physical activity or smoking. It might be alcohol or substance use or might be absenteeism at work. It leads to specific physical and mental health effects so it could be lead to obesity or disordered eating. Diabetes depression and attempts sexually transmitted infection so risky sexual behavior. Fractures, COPD, stroke, cancer, and heart disease. When we think about trauma, the other thing I think it is important to think about is intersectional identities or how that trauma some of the interact within or at intersect with the world. That trauma may
not be related solely to their specific childhood adverse experiences but they may have multiple layers of trauma on top of that. Perhaps they are a BIPOC person so they have suffered historical generation as well as personal trauma for being a person of color. Perhaps they have a disability, a reading or writing challenge. Perhaps they are unstable he house or homeless. Perhaps they are undocumented. Perhaps they are experiencing stigma in regard to their parenthood. Maybe they are incarcerated or have have criminal justice involvement. Or they are from the LGBTQ plus population. Obviously this is not an exhaustive list.

When we think about pregnant persons with substance use disorder it is up poor deer how complex this population is. Let's talk about the intersectionality with mental health. Approximately two thirds have co-occurring mental health diagnoses in addition to their substance use. Most commonly these are MDD, GAD, PTSD. The majority will suffer with childhood trauma typically preadolescent sexual or physical trauma. There's a high level of intimate partner violence experienced by these individuals in the last year. With respect to reproductive health, the vast majority of pregnancies and substance using persons are unplanned. Eighty to 90 percent. And there are low rates of contraception use. The way I think about it is 170 is actively using substances, there are many hierarchies so, for example, contraception use is going to fall pretty low on hierarchy of needs. They often have other substance use disorders so if they haven't opioid use disorder about 70 percent of them will have another substance use disorder. There is also often limited social functioning. They have in etiquette and adequate social supports, are socially isolated and often have exposure to poor parenting models. Was moving to the next section, which she is going to look at stigma language and barriers there are many barriers to substance use disorder treatment women experience former berries than do men. Social stigma and discrimination are the number 1 reason for women not seeking treatment for their substance use disorder disorder. They are more likely to be screened than men there is a lack of treatment services for pregnant persons. A lack of child services for parenting persons. Economic barriers, lack of insurance lack of transportation or funds significant trauma histories and also intimate partner violence which may be preventing their access to substance use therapy.

I talked briefly about the use of illicit buprenorphine In other words acquired on the street. There been several studies regarding this. On the left-hand side shows people motivation for acquiring diverted buprenorphine in the main reason is to avoid or ease opioid withdrawal and to treat their own OUD. The third most common reason is because they knew they would not have access to their opioid of choice so they acquired
buprenorphine instead, which is a much safer option than other agonists opioids and I would talk about that later. Part of the reason this occurs is that there are barriers to buprenorphine access. Many people who acquire buprenorphine illicitly do so because they had barriers to getting a prescription for it and they would gladly have stopped acquiring it illicitly having been able to find a provider who would prescribe buprenorphine for them.

Stigma is a huge issue for all people who use drugs. A lot of these comments I'm making here are not specific to women who use drugs, but are stigma across the spectrum for men and women. Let's talk about stigma and healthcare settings. Let's define stigma first and foremost. Stigma includes attitudes, beliefs, behaviors and structures at multiple levels. Can be individual group organization or system-level. That can lead to prejudice and discrimination against people with mental health diagnoses and substance use disorders or, for example, a persons with HIV or hepatitis C among other disorders. Stigma perpetuate stereotypes and assigns labels like dangerous, noncompliant, or dirty, asphalt. It can be internalized to make Bill feel they are not deserving of being treated with dignity and respect. That leads to fear and shame and isolation and feeling unwelcome, judged or unworthy of seeking or receiving services. At limits a person's ability to desire services and ultimately it contributes to sub optimal is sometimes traumatic healthcare experiences and health outcomes. There is also a relationship between stigma and trauma. We talked about the ways that people may have experienced trauma. They also may have experienced trauma in the healthcare or pharmacy setting when they go to pick up their buprenorphine. Remember we talked about how trauma impacts people so I'm not going to reiterate that. Again, often people are utilizing behaviors to cope with their trauma. How people have experienced trauma in those many layers of disadvantaged that we talked about affects how they interact with the world at large including healthcare providers support persons pharmacist et cetera. We need to be committed to not repeating trauma or retraumatizing people. Healthcare providers have high feelings of stigma and bad feelings towards people who use drugs and part from derogatory or dehumanizing language that is commonplace. Studies indicate that the language used corresponds with providing poorer treatment.

Here is a study and I'm going to summarize it briefly. The only information that was provided is that one person was referred to as a substance abuser and the same individual was referred to to having a substance use disorder. No other information was given about these individuals. The study found that the substance abuser was less likely to benefit from treatment are more likely to benefit from punishment more likely to be socially threatening, more likely to be blamed for their substance related difficulties and less likely that the problem was the result of an it ain't innate this function over
which they had no control and more able to control their substance use without help. That was just from the way you describe somebody. Language is extraordinarily important when we are talking about individuals with substance use disorder. You can see I am very precise in the language I use and I use nonstigmatizing language. We should always be putting the person first. People or people first and whatever their diagnosis is should not define them. A person who uses heroin, a person with a cocaine use disorder. We should never be using the terms of code dirty or clean” describe these individuals described their time using or not using drugs. We should be factually specific. Their toxicology was expected or unexpected. We would never use those terms to describe somebody with any other condition. Would not describe describe 70 with diabetes with those types of words or depression with those types of words. We should not be with using that language when we're talking about persons with substance use disorder. Link, which around particularly babies who experience physiological withdrawal, things like addicted newborn and born addicted our misnomer's and are not factually correct so we should be describing again, factually with terms like neonatal opioid withdrawal syndrome.

When we are documenting as well as when we are speaking, we should be using strengths-based language and not using stigmatizing terms. My least favorite term is "manipulative "manipulative." We should use a term that a strengths-based like resourceful. That is essentially describing the same behavior. The buttons that pushed with people when they interact with somebody they perceive as manipulative as that they do not appreciate the behavior the person is exhibiting to try to acquire something that they feel like they need. Another way to describe that that is not stigmatizing is resourceful.

Stigma has always existed. It may look a little bit different then as it does now, but really not much difference. The hype in the late '80s and early nineties that the whole press industry around crack babies and the worst threat as Mom herself. Very stigmatizing and particularly stigmatizing towards brown or black individuals.

The visual that we get with opioid use disorder is primarily among white persons those of the individual most often seen in the media and while I am glad the attention is being given to OUD it is unfortunate yet that when he became more of an epidemic for Caucasian individuals, that is what prompted the shift.

What does stigma look like we already mentioned the mystery representation of NOWS so newborn's death sentence, drug addicted baby. This fits the parent versus the child rather than seeing a birth parent and child as a dyad. Despite the fact that these are inflammatory and are not accurate. A baby experiencing NOWS is not fatal. This is wordy, but I wanted to put it here. This is a statement about engagement in care and the role that stigma plays and preventing pregnant persons from access to accessing prenatal care. What we know that is prenatal care mitigates often potential risk of substance use during pregnancy even if the substance use is not being treated. It is
important that we not use stigmatizing practices as stigmatizing behaviors because those will alienate pregnant persons from either seeking prenatal care or substance use disorder care. If someone is engaged in prenatal care that often mitigates the effects of their substance use. Here you can see that if someone is pregnant and they are I am sorry. That is a different slide. The slide is looking at pregnant persons in accessing treatment for their substance use disorder. Unfortunately a very small percentage of pregnant persons access to care for their substance use disorder. More pregnant persons who need treatment or receive it then those that are not pregnant, but unfortunately it is still a minority of pregnant persons who actually received treatment. This is the slide I was referring to. If you look at that outcome for low birth weight in the neonate, you can see that prenatal care mitigates the potential risk for low birth weight and someone who is actively using. If someone is actively using and has no prenatal care they have a 40 percent risk of having a low birth weight baby. If they engage in prenatal care and are still using that mitigates that risk to only 19 percent, which is the same risk as somebody who is not using substances and has no prenatal care. You can see the positive effect that engagement for prenatal care has. We talked about stigma and leading to unfortunately discrimination of punishment of persons of childbearing age. We talked a lot about stigma but the key points with statement or at least to dehumanization, which can lead to discrimination and prejudice and punishment. Unfortunately states across the U.S. handle this issue differently. I'm going to talk about that in just a moment. Three states actually allow civil confinement so they can can find someone for the duration of their pregnancy against their will. Negating their civil liberties. These policies vary by where you live. Twenty-four states and the District of Columbia consider substance use during pregnancy to be child abuse under age civil child welfare statutes and three considerate grounds for civil commitment. They will incarcerate you for the duration of your pregnancy. 25 states and the District of Columbia require healthcare professionals to report suspected prenatal drug use and eight states require them to test for prenatal drug exposure if they suspect drug use. Only 19 states have either created or funded substance use program specifically targeted to those who are pregnant at 70 feet 17 states in the DC provide pregnant people with priority access to state-funded drug treatment programs. 10 states prohibit publicly funded substance use disorder programs. Apart when we think about punishing pregnant persons for substance use is this utilizing best practices squeak first of all it is discriminatory. Persons of color and poor persons are more likely to be prosecuted despite white persons being more likely to use during pregnancy. It is not evidence-based based. The risks of illicit substances, for example, opioids and cocaine are often axing it exaggerated in comparison to the
risks of legal substances such as tobacco and alcohol. Has unintended consequences of punitive policies drive pregnant persons away from SUD treatment and prenatal care. Prenatal care counteracts --

This is New York State Department of Health recordations for improving language and establishing stigma free support of serviced different environments. You will have it available to you on your sites. Going over harm reduction practices.

It is important to understand the evolution of approaches to SUD treatment. I think of this as the stick. What do I mean by that query changes motivated by discomfort. If you make people who use drugs badly enough they will change, people need to hit bottom, all those really stigmatizing and punishing thoughts and processes. What is a better approach to substance use disorder treatment. This is the carrot. When we think about people and change. People are ambivalent about change regardless of what that change is. People who use drugs continue their substance use because of their ambivalence. All change contains an element of ambivalence and resolving ambivalence in the direction of change is a key element in motivation motivational interviewing. Motivation for change can be fostered by an accepting of empowering and safe atmosphere and person centered approach approaches enhance motivation and reduce risk

If you look at the historical view of motivation it was looked at as static meeting the client had it or did not have it. The provider counselor et cetera had no influence on it. This tended to blame clients particularly if there was a discord in the therapeutic relationship. Clients who basically did not adhere to the treatment plants were labeled as difficult, manipulative, resistant.

Part let's think of a modern concept of motivation and what that looks like. Motivation is the key to change but it is multidimensional. It is dynamic and fluctuating. It is influenced by the provider counselor facilitator style. It can be modified. Our task is to elicit and enhance motivation. A lack of motivation is a challenge for the therapeutic facilitator's skills not a fault for which to blame our clients. For the sake of time, I have to be a little quick going through the slides. But our role I see is to build resilience and self-efficacy. These can be built. A lot of individuals will not come to us with good self. That has not been encouraged for them in their lives but often our clients just by getting to us show us that they are resilient. It is important to develop a resiliency and their self-efficacy. And again reminding us about motivation being multi dimensional, it is complex and layered and it involves the clients desires needs and values and has external pressures demands. Is important when we are working on motivational interviewing and our clients that clients associate changes with that they can make In other words building confidence in their ability to make changes.

This is the trans- theoretical model which I am sure you are all familiar with. A little bit more on ambivalence. Depending on where you are in the stages of change, your advice needs to be tailored
to the stage that the individual is in for that particular substance so it is not uniform across substances. If a person has three different substance use disorders, you need to determine which stage of change they are and for each particular substance because that may vary.

This is a reminder that recovery is individualized. This is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. It has several domains including health, home, purpose, and community. I have often found that health is often the easiest to address. For example, a person is actively using and has hepatitis C, treat their hep C and curate that may give them resiliency to address their substance use. If someone does not have a stable home or safe home, that really should be a priority because people are not going to be able to stabilize with their substance use if they do not have a safe and secure place to lay their head at night. Purpose and community are often the hardest concepts and the most important to address with our clients. People need to feel that their lives are meaningful. After coming off those dopamine Russia's daily life and life without substances can feel really mundane. It is important to help people build meaningful activities in their life and help them get the resources they need to participate fully in their life and in their community. And trying to help people build healthy relationships is of key importance.

What is person centered when we think about person centered care it is important to remember that this is not a unilateral relationship that we are in partnership with our client. That means we need to reflect the needs of the individual and those needs change over time and our client gets to prioritize them. Or part when we are working with people it is important not only to have their voice as part of whatever the plan is that you’re going to work on together and also that you are building their resiliency. That fosters recovery.

Harm reduction is employed in person centered care. When we think about motivational interviewing with our clients I’ve highlighted what I think are the most important concepts and principles of person centered care with respect to motivational interviewing. Changes self-change, people have their own strengths motivations and resources that are vital for change to occur, change requires partnership, it is important to understand the person’s perspective, change is not a power struggle, motivation is evoked, and we cannot take away people’s choice about their behavior. People have have volition. We net may not be happy with their choices, but people still have their choices to make.

What are components of patient and family centered care. This also is multilayered and complex with many intersectional components of that care. On the left is looking at patient-centered care particularly for pregnant and parenting persons and the right side is looking at persons.
Reemphasizing why trauma-informed care matters and why trauma is in port for you to be aware of in your work women who are abused are almost three times more likely to use tranquilizers, sleeping pills or sedatives in more than three times more likely to use antidepressants and two in over two times more likely to miss use prescription drugs. The consequences of IPV and many of them are listed there and the word diagram.

What are the components of trauma-informed care? First are the four R.’s. The widespread spread impact of trauma including the patient's their families your own staff, team members responding by fully integrating knowledge about trauma into policies procedures and practices and seeking to actively resist reach from it.

When we think about trauma-informed care, what are some general principles squeak just like we had universal infection control precautions we should have universal trauma precautions meeting that we should expect in anticipate and assume that trauma has happened to everyone we interact with. We need to be flexible and be able to adapt in our clinical situations particularly if we do something unintentionally that we traumatize as our client. One trauma is not all trauma. Even though two individuals may have similar trauma histories that does not mean that they have similar reactions to the trauma. We should also anticipate that our patients have experienced internalized shame and stigma.

What is harm reduction? Here is the

(Reads)

Here I have many harm reduction principles. I'm only going to focus on a couple key ones. They are here for completeness. Substance use exists along a continuing. Absences is one of many possible goals. When you're working with someone and harm reduction format we have talked about that people who use drugs are more than their substance use. Their substance use is just one of their attributes. Excepting people who use drugs as they are and treating them with dignity and compassion.

With is harm reduction mean for people who use drugs. It means meeting people where they are at and not forcing them to be where you want them to be and not leaving them behind. As I mentioned, a harm reduction lies on the treatment continuing with active use at one end and perhaps sustained abstinence from all substances on the other end. It recognizes that change is positive. Embrace any positive change that someone is able to make and encourage self-efficacy and resilience.

Keeping patients alive is harm reduction. Using buprenorphine intermittently to decrease heroin use or fret no use is harm reduction is a decreases the risk of death by overdose. From the Iowa harm reduction coalition. Dead users don't recover.

In the context of primary care, we should be asking about substance use. It depends on how you ask it will elicit a more likely honest response. I assume that substance use is occurring so I normalize it and I got a lot of honest answers. As a clinician, if you are assuming the answer is going to be no, you are less likely to elicit a positive
response. It is important these are asked in a nonjudgmental way with curiosity with your face and
tone of voice. Don't expect people to be honest
with you. You have to earn that trust over time. Most importantly, listen. Everyone has a story. I feel
like empathy for people with substance use disorder increases when you hear someone's story. How
do identify substance use disorder during pregnancy? We should be doing universal not risk-based screening. We should identify risk persons early, utilize motivational interviewing, normalize questions in a bed in the electronic goal electronic medical record. And I listed some examples. Urine toxicology is not recommended for screening. For myriad reasons. Store detection or end window, confirmation testing needed, may not capture intermittent urban juice. Often it is done without the person's consent, which is not acceptable. There are also patient provider barriers to screening. Patients are afraid of discrimination mistreatment and being referred to child welfare services. Providers have lack of training, knowledge on how to address positive results.

What could a clinic visit look like for somebody with substance use disorder. For the sake of I'm going to skip over this slide, but you have the information there. This is a New York State New York State Department of Health resources on building a safety plan. It is intended to go over with individuals who are actively using to decrease their risk for abuse. It is available for free online in both English and Spanish. Or part what about overdose risk for people who use drugs and COVID-19 Creek obviously because people using alone more frequently because of social and physical distance and, that caused an increased risk for overdose because nobody was there with naloxone to reverse an overdose. There are triggers for return to use with increased mental health symptoms symptoms and despair. Virtual virtual naloxone trainings mail order naloxone and harm reduction supplies and an overdose prevention hotline and they can call the hotline it's almost down the line with them. I'm pointing out this resource for you this was put out by the National Harm Reduction Coalition in the Academy of Perinatal Harm Reduction. This is an excellent tool for pregnancy and substance use. The last section MOUD and best practice seas in pregnant and parenting persons. Why is MOUD important it is because it reduces risk for overdose. Overdose deaths decrease when they are placed on methadone or buprenorphine. What is the standard of care for OUD? It is putting people on MOUD bring the persons do not need to the DSM-V for opioid use disorder to receive, MO UD so any opioid use during pregnancy is an education for MOUD. Is endorsed by all professional medical associations and just a reminder that access to behavioral counseling is only needed as an adjunct of treatment if necessary. For example if that pregnant person is only interested in getting methadone or buprenorphine, that is fine. They don't need to have any additional services. My clinical experience is that often people do not win additional supports early in treatment but after they have been stabilized on medication after a while they may recognize on their own if they would benefit from additional
support and then you can refer to those support places. As I mentioned most bring a persons do not access treatment and despite being standard of care do not access pharmacotherapy. This is looking specifically, it is a busy slide and you will have this to refer to, but it is looking at disparities for MOUD a treatment during pregnancy, which is showing that both black and brown persons are less likely to be on MOUD during pregnancy than their Caucasian counterparts.

There is no role for medically assisted or medically managed withdrawal or detox services for opioid use disorder during pregnancy. Withdrawal management has been found to be inferior and effectiveness over pharmacotherapy with opioid agonists and increases the risk of relapse without fetal or maternal benefit. It is extremely important to understand. Again, we talked about overdose mortality being a key factor in the increase of the general mortality in the U.S. When you offer MOUD during pregnancy, it increases treatment retention, increases OB visits and increases the likelihood of in-hospital as opposed to out of hospital delivery.

Benefits of MOUD during pregnancy. 70 percent reduction in maternal overdose deaths, decrease in transmissible infections such as HIV HCV and HBV, increased engagement prenatal care and other maternal outcomes.

Decrease in fetal stress due to stable opioid levels, decrease in intrauterine fetal demise, decrease and in the tree growth restriction and preterm delivery. What are the goals for MOUD number 1 goal is to decrease the risk for fatal and nonfatal overdoses. It eliminates withdrawal symptoms, decreases opioid cravings, increases patient functionality, helps to normalize changes in brain anatomy and physiology, and decreases transmission and acquisition of transmissible infections and also infection complications like abscesses cellulitis and endocarditis. There are three approved method medications methadone which must be dispensed from an OT P. and associated with decreased mortality.

Buprenorphine a partial agonist and requires a waiver to describe prescribe and naltrexone, which is an opioid antagonist and not a controlled substance.

For for time safe I have to be brief about the comparison between methadone and buprenorphine. They are both first-line treatment. Historically methadone was the gold standard, but buprenorphine is more commonly prescribed now during pregnancy. Both are associated with excellent outcomes both maternal and prenatal. Buprenorphine has less severe neonatal withdrawal compared to methadone. I think is important and I touch on this when I talked about diversion of buprenorphine’s understanding that the pharmacology of buprenorphine is different from every other opioid. Fennel heroin oxycodone are all full agonist opioids, which means there is no holds barred. The more you use, the more euphoria until you go into respiratory depression and you will die if it's not reverse with naloxone. In contrast buprenorphine is a partial agonist for people who are opioid tolerant they will not experience euphoria when they take buprenorphine. It also has a ceiling effect with respect to
respiratory depression. What that is is that it means it is a lot safer. The safety profile of buprenorphine if people are using other like alcohol buy out --

The other factor that I think is significant here is that full agonist opioids will block effects that you feel. They will block pain effects and that is physical emotional trauma pain et cetera in a way that buprenorphine will not. Buprenorphine will stop opioid withdrawal and cravings but emotionally it does not block anything. If people have untreated PTSD, trauma depression anxiety et cetera, when someone stops using full agonist opioids and get put on buprenorphine the symptoms may become more obvious. People may feel worse and think that buprenorphine is not working, but what that means is that you may have identified additional supports, for example, mental health services counseling et cetera. It is important when people are put on buprenorphine they are advised of that and they may experience feelings and emotions that have experienced using opioids.

On the bottom is in and antagonist, which is naloxone.

I went to get through these last few slides very quickly so I will be short. This is a New York State oasis and a part of health best practice document on prescribing buprenorphine. Refer to this when you have a chance. It is important on understanding that people are using other substances including by ends of of pain should not be discharged from their group nor because they are using over other substances. The number 1 goal is to decrease a person's risk for overdose. People should not be forced to do counseling or other supports if they are not ready to do that.

When we think about MOUD during pregnancy the dosing may need to change with either methadone or buprenorphine the later you get pregnancy because of increased blood volume and metabolism so that is not unusual that the dosing needs to be increased during the second and third trimester. It is important to educate patients that the dose of methadone and buprenorphine are not associated with an increase risk of NOWS is not operative predictable as to whether a child will develop NOWS so the person should be dosed to comfort level. With respect to intrapartum care continue the methadone or buprenorphine dose throughout the labor and postpartum process. If someone requires pain management for scenes section et cetera that would be dosed in addition to their baseline buprenorphine dose. With respect to postpartum care you continue the dose of buprenorphine if and when remember the stressors in the postpartum period and the vulnerability to overdose in the postpartum period.

Remember the fourth trimester. As I mentioned that postpartum period is a challenging time for postpartum person with substance use issues. There is a lot of pressure on them to be the perfect parent and they may be socially isolated, stigma, have child welfare authorities involved whether appropriately or inappropriately inappropriately and less focus on them. More focus on the baby and often the MOUD provider is the only continuity of care for
that individual. How long should People remain on MOUD? Long enough. If someone is deriving benefit they should remain on it. For some people that may be a lifetime medication. We need to reframe our thinking and think about opioid use disorder is a chronic medical conditions and people may need long-term lifetime lifetime management similar to a person is using insulin for diabetes.

Very briefly about NOWS they studied outcomes at 36 months. These were infants exposed to methadone or buprenorphine during their in utero period. With a found is that there was another difference between methadone or buprenorphine exposure and most significantly that children born exposed to either of those in utero had normal development in terms of growth cognition and psychological development compared to peers not exposed to methadone or buprenorphine.

Methadone and buprenorphine are both safe before breast-feeding. An individual should be encouraged to breast-feed. There are some guidelines around breast-feeding if people are using other substances like alcohol or marijuana. Those guidelines are available online online. I do not have time to go into detail about NOWS, but what I do want to focus on is my summary at the bottom of the slide is that NOWS treatment are not known treatment are not known to have effects interactions between the caregiver and the child can impact resiliency risk with potential long-term effects in some cases if they are separated.

As you can see from this presentation fragments persons with SUD have a unique set of needs across multiple name domains that affect both obstetric health and outcomes and SUD treatment. Care needs to address all those complex needs ideally with co-located and integrated services.

This is from ACOG the it is important that providers have an ethical responsibility to the pregnant parenting patients with SED to discourage separation of parents from the children solely based on SUD either suspected or confirmed.

In conclusion there is a complex mill you factors that underlie substance use disorder in women. Understanding the principles and practical application of person centered care harm reduction trauma-informed care leads to better outcomes and our patients.

For pregnant persons with SED engagement and prenatal care improves outcomes

I will stop sharing my screen and I know we are almost out of time, but I'm happy to answer any questions and whatever questions we don't get too will be sent to me and I will respond and the answers will be shared.

HALEY HARTLE: That was great, thank you so much, very valuable information. I definitely wanted to make sure that we were able to get through all the information so it was great. We have time for one question. I will read the top question that we
had. At looks like there were too pushed to the top of. The first one was from Annie, are the stats that you gave from the hospital or do the overall Dell deaths include jail as well?

KELLY RAMSEY: Most of the data that is reported does not include jails. That is not included in jails.

HALEY HARTLE: Okay. We will try to get through one more. To have any data on the increase in fat no use since 2019 in women?

KELLY RAMSEY: No. As I mentioned early on in the presentation, the survey survey's the data is out, but they have not done then sub analyses yet except for mental health diagnoses. The data that I showed from 2020 is the only data that they have shared thus far. They will do subgroup analyses that will get racial ethnic groups and they will separate women and adolescents, but they have not done that yet. I anticipate that that data will be available within the next few months.

HALEY HARTLE: Thank you so so much. For all that valuable information. I'm going to go ahead and reshare my screen and go through a couple things briefly. Just a reminder, the quiz will be on the webpage where you registered for this webinar. The online CE instructions will be there as well. Here a look at some of our upcoming webinars over the next month or so. Part two of the women in Recovery series will be on March 25th. A few different specialty series that we have in order to expand our educational offerings, you can find all those on our website. You can find the upcoming schedule and upcoming CE information for our six part women in recovery specialty on my training series. Check that out on the webpage and a few reminders of benefits of being a member of NAADAC. If you are a social worker, please stay on for the next two or so minutes. We have a brief video for you for how to access at put your license number on your certificate. Thank you everybody and we will see you at the next one.

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