Understanding Medication Assisted Treatment (MAT) for Families Affected by Parental Substance Use Disorders

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Medication Assisted Treatment The Basics: How It Works

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GOALS FOR PHARMACOTHERAPY

- Prevention or reduction of withdrawal symptoms
- Prevention or reduction of drug craving
- Prevention of relapse to use of addictive drug
- Restoration to or toward normalcy of any physiological function disrupted by drug abuse
- Blockade of euphoric effects of illicit self-administered opiates

Source: MJ Kreek, Rationale for Maintenance Pharmacotherapy of Opiate Dependence, 1992

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PROFILE FOR POTENTIAL PSYCHOTHERAPEUTIC AGENT

- Effective after oral administration
- Long biological half-life (>24 hours)
- Minimal side effects during chronic administration
- Safe, no true toxic or serious adverse effects
- Efficacious for a substantial % of persons with the disorder

Source: MJ Kreek, Rationale for Maintenance Pharmacotherapy of Opiate Dependence, 1992

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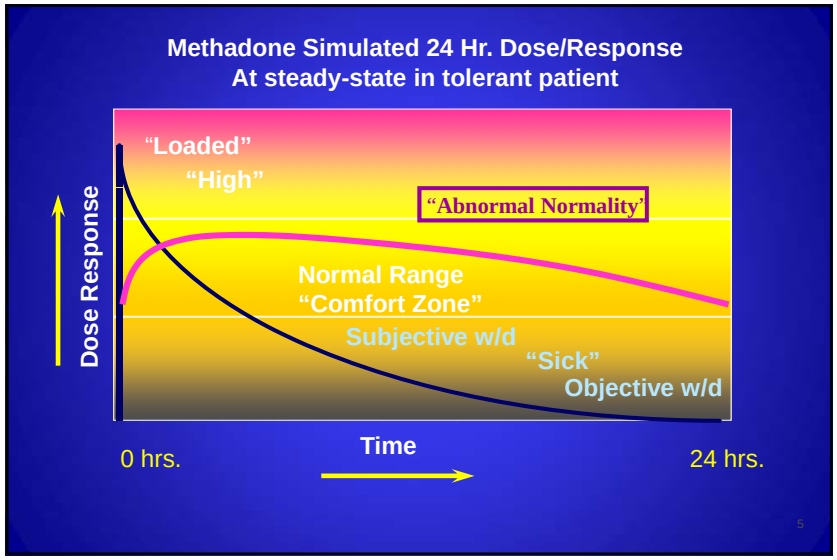


Impact of Maintenance Treatment

- Reduction death rates (Grondblah, '90)
- Reduction IVDU and relapse to IVDU (Ball & Ross, '91)
- Reduction crime days (Ball & Ross)
- Reduction rate of HIV seroconversion (Bourne, '88; Novick '90,; Metzger '93)
- Improved employment, health, & social function

The Statistics

- TIP 43 from SAMSHA says, "risk of relapse during and after tapering is significant and because of the physical and emotional stress of attempting to end treatment, its encouraged clients stay in treatment for at least 2 years. The highest risk of relapse is 3-12 months after ending Medication Assisted Treatment.
- Less than 25% of opiate addicts can be successful in the first year when quitting use "cold turkey".
- Studies show 70% of patients that participate in OTPs for at least 1 year no longer abuse opiates.

Nature of the Prescription Drug Crisis

Deaths from Opiate Addiction

- Based on the Medical Examiner's Report (2007) of drug related deaths in Florida, 56% occurred as a result of opioid toxicity (Bohs & Sayed, 2009)
- Methadone related deaths are connected to pain management clinics and not MAT clinics (Bohs & Sayed, 2009)

The Florida Experience

- In 2007, average of 9 daily lethal overdoses (11 daily as of end of 2008)
- 3317 of prescription overdose deaths were 70% of total drug deaths in 2007
- Over 700,000 Floridians misuse prescription pain meds yearly
- Top 25 US dispensing practitioners of Oxycodone are all in Florida
- Florida was one of the largest states without a Prescription Drug Monitoring Program (PDMP), recently implemented
- Florida has become a major distribution center for opioids and benzodiazepines

Source: Broward County Commission on Substance Abuse, United Way, 2008.

Healers or Dealers?

- From 2005 to 2009, Florida tallied 5,887 deaths from prescription drugs. That's three times the number of deaths from heroin, cocaine and other illegal drugs combined.

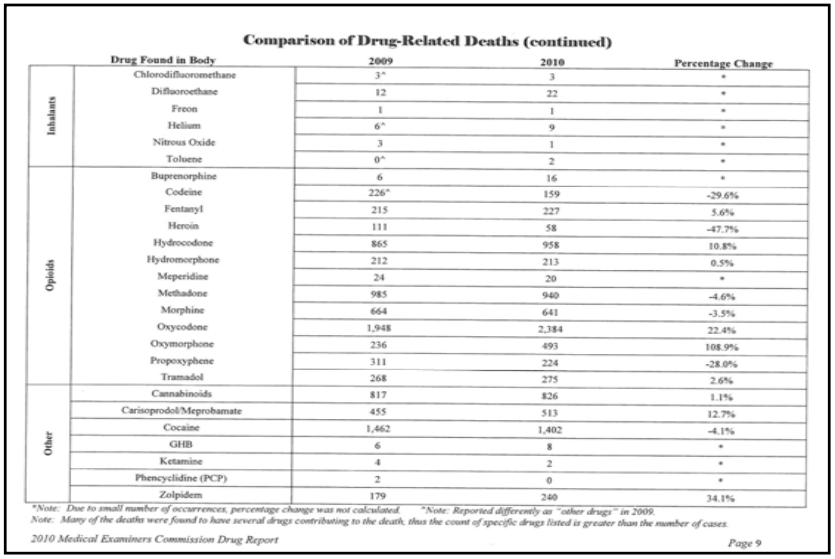
Florida is now home to 98 of the top 100 doctors in the United States who dispense Oxycodone right out of their offices. This is one reason Florida is known as the epicenter of the nation's prescription drug abuse crisis.

USA Today

- "Prescriptions Now Biggest Cause of Fatal Drug Overdoses"
- Prescription drugs account for most of 26,000 fatal overdoses yearly – CDC
- Prescription Opioids account for 13,800 deaths in 2006-triple the number in 1999
- 120,000 ER visits are due to Opioid Overdoses

2010 Florida Medical Examiners Report

- In 2009 there were 1,948 oxycodone related deaths and in 2010 there were 2,384 oxycodone deaths, an increase of 22.4%.
- Also increases from 2009 to 2010 in deaths from other prescription opiates like hydrocodone (10.8%), fentanyl (5.6%), and oxymorphone (109%).
- Decrease from 2009 to 2010 by 48% in heroin related deaths.



Comparison of Drug-Related Deaths (continued)

	Drug Found in Body	2009	2010	Percentage Change
Inhalants	Chlorodifluoromethane	3*	3	*
	Difluoroethane	12	22	*
	Freon	1	1	*
	Helium	6*	9	*
	Nitrous Oxide	3	1	*
	Toluene	0*	2	*
Opioids	Buprenorphine	6	16	*
	Codeine	226*	159	-29.6%
	Fentanyl	215	227	5.6%
	Heroin	111	58	-47.7%
	Hydrocodone	865	958	10.8%
	Hydromorphone	212	213	0.5%
	Meperidine	24	20	*
	Methadone	985	940	-4.6%
	Morphine	664	641	-3.5%
	Oxycodone	1,948	2,384	22.4%
	Oxymorphone	236	493	108.9%
	Propoxyphene	311	224	-28.0%
	Tramadol	268	275	2.6%
Other	Cannabinoids	817	826	1.1%
	Carisoprodol/Meprobamate	455	513	12.7%
	Cocaine	1,462	1,402	-4.1%
	GHB	6	8	*
	Ketamine	4	2	*
	Phencyclidine (PCP)	2	0	*
	Zolpidem	179	240	34.1%

*Note: Due to small number of occurrences, percentage change was not calculated. *Note: Reported differently as "other drugs" in 2009.
Note: Many of the deaths were found to have several drugs contributing to the death, thus the count of specific drugs listed is greater than the number of cases.

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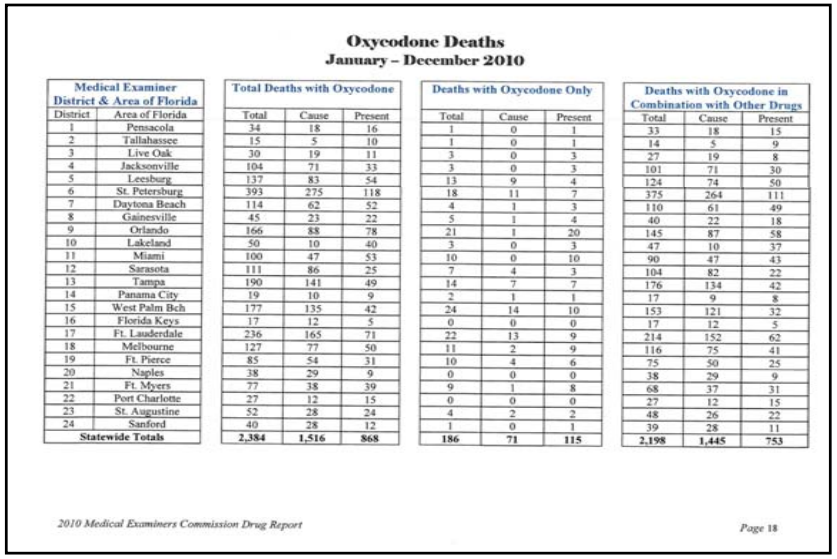

Oxycodone Deaths
January – December 2010

Medical Examiner District	Area of Florida	Total Deaths with Oxycodone			Deaths with Oxycodone Only			Deaths with Oxycodone in Combination with Other Drugs		
		Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	34	18	16	1	0	1	33	18	15
2	Tallahassee	15	5	10	1	0	1	14	5	9
3	Live Oak	30	19	11	3	0	3	27	19	8
4	Jacksonville	104	71	33	3	0	3	101	71	30
5	Leesburg	137	83	54	13	9	4	124	74	50
6	St. Petersburg	393	275	118	18	11	7	375	264	111
7	Daytona Beach	114	62	52	4	1	3	110	61	49
8	Gainesville	45	23	22	5	1	4	40	22	18
9	Orlando	166	88	78	21	1	20	145	87	58
10	Lakeland	50	10	40	3	0	3	47	10	37
11	Miami	100	47	53	10	0	10	90	47	43
12	Sarasota	111	86	25	7	4	3	104	82	22
13	Tampa	190	141	49	14	7	7	176	134	42
14	Panama City	19	10	9	2	1	1	17	9	8
15	West Palm Bch	177	135	42	24	14	10	153	121	32
16	Florida Keys	17	12	5	0	0	0	17	12	5
17	Ft. Lauderdale	236	165	71	22	13	9	214	152	62
18	Melbourne	127	77	50	11	2	9	116	75	41
19	Ft. Pierce	85	54	31	10	4	6	75	50	25
20	Naples	38	29	9	0	0	0	38	29	9
21	Ft. Myers	77	38	39	9	1	8	68	37	31
22	Port Charlotte	27	12	15	0	0	0	27	12	15
23	St. Augustine	52	28	24	4	2	2	48	26	22
24	Sanford	40	28	12	1	0	1	39	28	11
Statewide Totals		**2,384**	**1,516**	**868**	**186**	**71**	**115**	**2,198**	**1,445**	**753**

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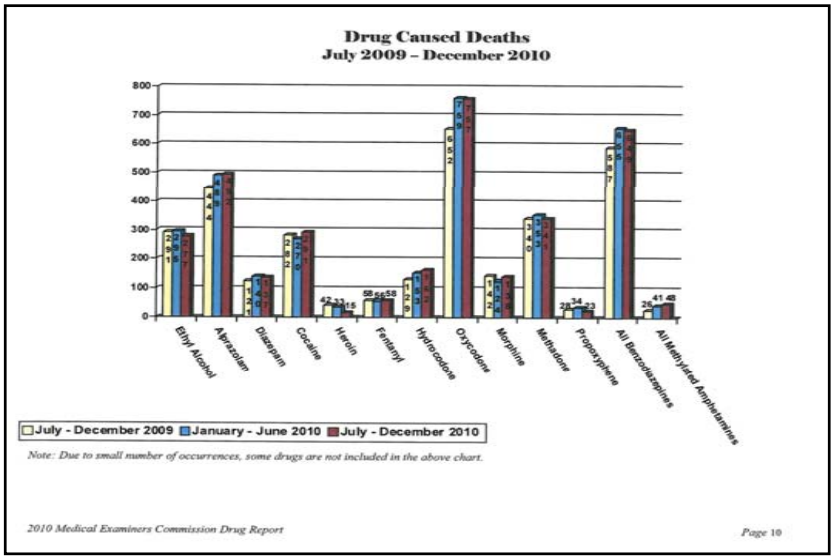

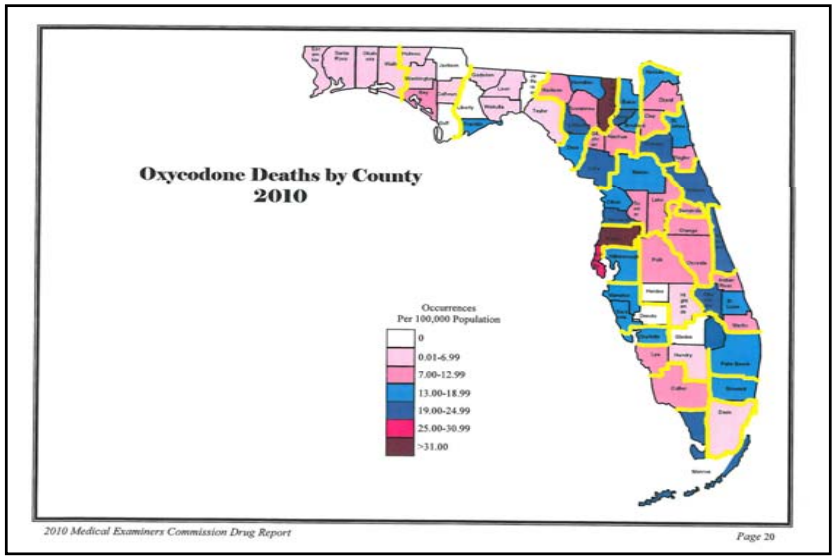

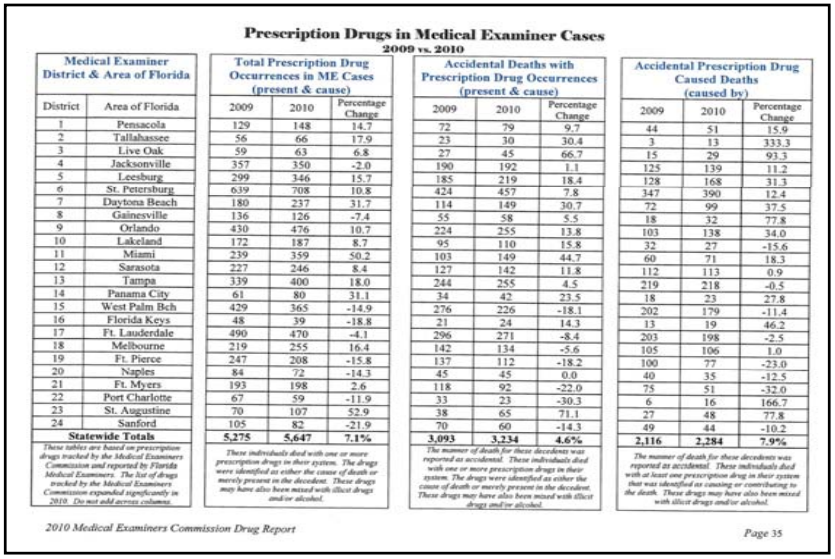

Prescription Drugs in Medical Examiner Cases
2009 vs. 2010

Medical Examiner District & Area of Florida		Total Prescription Drug Occurrences in ME Cases (present & cause)			Accidental Deaths with Prescription Drug Occurrences (present & cause)			Accidental Prescription Drug Caused Deaths (caused by)		
District	Area of Florida	2009	2010	Percentage Change	2009	2010	Percentage Change	2009	2010	Percentage Change
1	Pensacola	129	148	14.7	72	79	9.7	44	51	15.9
2	Tallahassee	56	66	17.9	23	30	30.4	3	13	333.3
3	Live Oak	59	63	6.8	27	45	66.7	15	29	93.3
4	Jacksonville	357	350	-2.0	190	192	1.1	125	139	11.2
5	Leesburg	299	346	15.7	185	219	18.4	128	168	31.3
6	St. Petersburg	639	708	10.8	424	457	7.8	347	390	12.4
7	Daytona Beach	180	237	31.7	114	149	30.7	72	99	37.5
8	Gainesville	136	126	-7.4	55	58	5.5	18	32	77.8
9	Orlando	430	476	10.7	224	255	13.8	103	138	34.0
10	Lakeland	172	187	8.7	95	110	15.8	32	27	-15.6
11	Miami	239	359	50.2	103	149	44.7	60	71	18.3
12	Sarasota	227	246	8.4	127	142	11.8	112	113	0.9
13	Tampa	339	400	18.0	244	255	4.5	219	218	-0.5
14	Panama City	61	80	31.1	34	42	23.5	18	23	27.8
15	West Palm Bch	429	365	-14.9	276	226	-18.1	202	179	-11.4
16	Florida Keys	48	39	-18.8	21	24	14.3	13	19	46.2
17	Ft. Lauderdale	490	470	-4.1	296	271	-8.4	203	198	-2.5
18	Melbourne	219	255	16.4	142	134	-5.6	105	106	1.0
19	Ft. Pierce	247	208	-15.8	137	112	-18.2	100	77	-23.0
20	Naples	84	72	-14.3	45	45	0.0	40	35	-12.5
21	Ft. Myers	193	198	2.6	118	92	-22.0	75	51	-32.0
22	Port Charlotte	67	59	-11.9	33	23	-30.3	6	16	166.7
23	St. Augustine	70	107	52.9	38	65	71.1	27	48	77.8
24	Sanford	105	82	-21.9	70	60	-14.3	49	44	-10.2
Statewide Totals		**5,275**	**5,647**	**7.1%**	**3,093**	**3,234**	**4.6%**	**2,116**	**2,284**	**7.9%**

These tables are based on prescription drugs tracked by the Medical Examiners Commission and reported by Florida Medical Examiners. The list of drugs tracked by the Medical Examiners Commission expanded significantly in 2010. Do not add across columns.

These individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol.

The manner of death for these decedents was reported as accidental. These individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol.

The manner of death for these decedents was reported as accidental. These individuals died with at least one prescription drug in their system that was identified as causing or contributing to the death. These drugs may have also been mixed with illicit drugs and/or alcohol.

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Why MAT as a solution?

- Not addressing the addiction leaves the individual ill and no closer to recovering and gaining pro-social behaviors, proactive instead of reactive.
- Chasing answers to the adverse events associated with opiate addiction such as ER expenses does not get to the solution.
- Treatment adapted from the biopsychosocial model of addiction which shows opiate addicts do recover.
- Over 35 years of research justifying MAT as the standard of practice in the medical community for the opiate dependent individual.

Benefits of MAT to the Individual and Community

- Reduces Deaths
- Reduces Crime
- Promotes healthier lifestyle
- Reduces economic impact
- Allows client to return to normal activities of daily living including parenting
- Promotes pro-social behaviors

Reduced Crime

- Criminal activities are decreased as individuals are being treated for their addiction and do not have to rob, steal or sell drugs to maintain their habit.
- A nationwide study showed 82% of clients in MAT were arrested at least once before starting treatment and this arrest rate decreased to 19% after one year of treatment (O'Connor & Carillo, 2006).
- Three to five years post-treatment arrests were still down 50% (O'Connor & Carillo, 2006).
- A study by NIDA found that methadone treatment reduced illicit opiate use by 70%, criminal activity by 57% (O'Connor & Carillo).

Promotes Healthier Lifestyle

- Research shows long-term MMT is medically safe, over 35 years of research
- Long term treatment causes no negative effects to the heart, lungs, liver, kidneys, bones, blood, brain, or other vital organs
- Reduction rate of HIV seroconversion (Bourne, '88; Novick '90,; Metzger '93).
- Reduction of intravenous drug use and its complications.
- Participants can maintain a relationship with primary care provider with continuity of care and address mental health concerns.

Reduced Economic Impact

- Bohs and Sayed (2009) analyzed economic costs of drug use in Florida and reported $22,867,843,781 was spent on adverse events due to drug use, Billions spent on reactive measures.
- The same study showed about 3% of Florida's GDP is spent on consequences of drug use.
- Out of every $100 it was reported $96.80 is spent on burden public programs (i.e. criminal justice) with only 0.2% of costs spent on treatment programs with zero dollars spent on research to enhance proactive efforts on these economic issues.

Reduced Economic Impact

- Prescription diversion is costly. Bohys & Sayed (2009) stated $266,510 was spent every hour on drug related crimes.
- Clients must dose with Methadone in MAT daily, promoting diversion control.
- In viewing the economic costs spent in Florida on drug issues, 23 billion spent overall and 2.3 billion on crime alone.
- For every $1 spent on methadone allows $4 to be saved in social and health costs (O'Connor & Carillo, 2006).

Return to Normal Activities of Daily Living

- Individual can focus on daily activities with attention to short and long term goals
- Methadone does not produce euphoria as the medicine fills opiate receptors in the brain eliminating physical withdrawal (O'Connor & Carillo, 2006).
- While on the medication the brain returns to normal physiological functioning, no negative effects on mental function (O'Connor & Carillo, 2006).
- A NIDA study found increased full-time employment by 24% (O'Connor & Carillo, 2006).
- Participants may again participate in their family and return to parenting.

Research Demonstrates Three Major Messages

- Opioid addiction is a brain disease.
- Supervised treatment works when tailored to the individual.
- When patients are effectively treated society benefits

From the publication Countering Opioid Stigma for AATOD, 2006

Opioid Addiction is a Brain Disease

- Use of drugs starts off as voluntary behavior, but once continued, use of an addictive drug brings about structural and functional changes in the brain that cause compulsive drug-seeking and use (Leshner 1997)
- The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain activity, receptor availability, gene expression and responsiveness to environmental cues (Leshner 1997).
- Research shows that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. The drug induced changes in brain function have behavioral consequences, including the compulsion to use drugs despite adverse consequences – the defining characteristic of addiction (NIDA 1999).

Supervised Treatment Works Well When Individualized

- MMT is "not substituting one drug for another" (COMPA 1997)
  - Opiate euphoria is absent and opiate withdrawal symptoms are eliminated
  - Cravings for opiates is effectively diminished
  - The ability to focus on daily life activities and goals is restored.
  - Methadone blocks the effects of heroin and other opiate drugs, rendering ineffective attempts to take them to achieve euphoria
- Dependence is a medical disorder that can be treated effectively. Of the various treatments available, MMT combined with individual attention to medical, psychiatric and socioeconomic issues, as well as drug counseling, has the highest probability of being effective (NIH Consensus Statement 1997).
- Similar to other diseases of the brain (depression) and other diseases of the body (hypertension, diabetes) opioid addiction is a chronic, relapsing disease. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate amount of time depends on the individual's problems and needs (NIDA).

When Patients Are Treated Effectively Society Benefits

- Methadone therapy….is one of the longest established, most thoroughly evaluated forms of drug treatment…Methadone therapy helps keep more than 100,000 addicts off heroin, off welfare, and on the tax rolls as law-abiding, productive citizens (National Drug Control Strategy, 1999).
- The financial cost of untreated opiate dependence to the individual, the family, and society are estimated to be approximately $20 billion/year (NIH Consensus Statement, 1997)
- A three-city field study of methadone treatment patients in NYC, Baltimore and Philadelphia found significant reductions in criminality across 14 types of crimes, most categories declining over 80% (NIDA 1999).
- Lifetime arrest rates of 151 male patients in Baltimore demonstrated a substantial reduction after admission to methadone treatment – an 85% decrease in the annual arrest rate in comparison to the addiction years (Ball et al. 1994)

Methadone and Pregnancy

Opioid misuse during pregnancy is a serious and growing concern:

- High rates of infection
- Premature delivery
- Low birth weight, which is an important risk factor for later developmental delay.
- Comprehensive methadone maintenance treatment that includes prenatal care reduces the risk of obstetrical and fetal complications, in utero growth retardation, and neonatal morbidity and mortality.

Obstetrical Complications Opiate Abuse

- Remember the polysubstance abuse is the norm…..
  - Increased spontaneous Abortion, especially first trimester
  - Increased 3rd trimester premature delivery, premature rupture of membranes
  - Intrauterine Growth Retardation
  - Amnionitis
  - Placental Insufficiency
  - Postpartum Hemorrhage
  - Pre-eclampsia and Eclampsia
  - Septic thrombophlebitis

Acceptance as the Standard of Care

- Methadone has been accepted since the late 1970s to treat opioid addiction during pregnancy
- In 1998, a National Institutes of Health consensus panel recommended methadone maintenance as the standard of care for pregnant women with opioid addiction
- Recent literature supports Buprenorphine as another option for safe medication-assisted treatment for opioid addiction (MAT) in pregnant patients.

Standard of Care

- Methadone maintenance has been the recommended standard of care over no treatment or Medication Assisted Withdrawal (MAW) based on:
  - Longer durations of maternal drug abstinence
  - Better obstetrical care compliance
  - Avoidance of associated risk behaviors
  - Reductions in fetal illicit drug exposure
  - Enhanced neonatal outcomes-heavier birth weight (Kaltenbach 1998).

Standard of Care

- Methadone is the oldest, most widely used medication prescribed during pregnancy, and in comparison to infants born to heroin-abusing mothers, infants from methadone-treated mothers have:
  - Increased fetal growth
  - Reduced fetal mortality
  - Decreased risk of HIV infection
  - Decreased risk of pre-eclampsia
  - Less fetal exposure to rapid and unpredictable cycles of heroin-induced highs and withdrawal
  - Increased likelihood of the infants being discharged to their parents (Finnegan 1991).

Pregnancy Specific Benefits of Opioid Maintenance Therapy

- Methadone Maintenance Therapy (MMT) is regarded as an established treatment with birth outcomes comparable to a general obstetrical population (Kreek MJ, 2000)
  - Fewer Pre-term Births
  - Less Intrauterine Growth Restriction
  - Fewer Low Birth Weight Infants
- Less Maternal Drug Use
  - Greater reduction with higher dose of methadone
- Improved Prenatal Care Compliance (Burns L, 2004; Goler NC, 2008)
- There appears "to be no differential effect of either treatment (methadone or Buprenorphine)—it was exposure to stable treatment that was important (Gibson 2008).

Common Medical Complications Among Pregnant Women Who Are Opiate Addicted

(many of these from intravenous drug use)

- Anemia
- Bacteremia/septicemia
- Cardiac disease, especially endocarditis
- Cellulitis
- Depression and other mental disorders
- Edema
- Gestational Diabetes
- Hepatitis A, B, and C
- Hypertension/tachycardia
- Phlebitis
- Pneumonia
- Poor dental hygiene
- STDs
  - Chlamydia
  - Condyloma acuminatum
  - Gonorrhea
  - Herpes
  - HIV/AIDS
  - Syphilis
- Tetanus
- Tuberculosis
- UTIs
  - Cystitis
  - Pyelonephritis
  - Urethritis

Common Obstetrical Complications Among Women Addicted to Opioids

(The fetus is at risk for morbidity and mortality because of episodes of maternal withdrawal compounded by a lack of prenatal care)

- Abruptio placentae
- Chorioamnionitis
- Intrauterine death
- IUGR
- Intrauterine passage of meconium
- Low Apgar Scores
- Placental insufficiency
- Amnionitis
- Postpartum hemorrhage
- Preeclampsia
- Premature labor/delivery
- PROM
- Septic thrombophlebitis
- Spontaneous abortion, especially first trimester

Neonatal Abstinence Syndrome

METHADONE AND BUPRENORPHINE: PRESENTATION AND MANAGEMENT

Methadone and Pregnancy

- There is no evidence that higher doses are harmful to the fetus.
- The neonate has a high probability of having NAS (Neonatal Abstinence Syndrome)
- Delivery should be arranged for a hospital where the neonate can be appropriately managed for NAS, if necessary.

Dosages relative to Neonatal Abstinence Syndrome

- Historically, treatment providers have based dosing decisions on the need to avoid or reduce the incidence of NAS (Kaltenbach et al. 1998).
- This low-dose approach emerged from several 1970s studies (Harper et al. 1977) and has been contradicted by more recent studies (Brown et al. 1998).
- There is no compelling evidence supporting reduced methadone dosages to avoid NAS.

On the contrary, higher doses of Methadone have been associated with:

- Increased weight gain
- Decreased illegal drug use
- Improved compliance with prenatal care by pregnant women in MAT
- Increased birth weight
- Increased head circumference
- Prolonged gestation
- Improved growth of infants born to women in MAT (De Petrillo and Rice 1995)

Reduced methadone dosages may result in continued substance use and increased risks to both expectant mothers and their fetuses

Initial Neonatal Work-up

- First urine-will only detect very recent substance use
- First meconium-will detect substances used after 20 weeks gestation
- Standardized NAS scoring should begin within 2 to 4 hours of birth and repeated every 2 hours
- Finnegan Scores
  - **Easy to learn/administer**
  - **Promotes standardization/consistent management**
- Assess for other diagnoses as indicated particularly for persistent diarrhea

Substance Exposed Infants

- May be full term and look healthy
- Symptoms occur 60% of time and to varying degrees within a few days of birth and include:
  - Tensed Muscles
  - Frequent Diarrhea
  - High Respiratory Rates
  - Loss of Appetite
  - Vomiting
  - Marble like appearance
  - Increased risk of SIDS
  - Long hospital stays which can cause clashes with families

Infant Withdrawal

Opioids (heroin, codeine, morphine, Oxycodone)

- Withdrawal occurs in 42-94% exposed infants
- Occurs **24 hours after birth and as long as 6 days** after birth

Methadone (synthetic opiod)

- Best medical option for opioid-addicted pregnant women
  - does not cause birth defects
  - blocks the euphoric and sedating effects of other opioids
  - decreases illicit behaviors, improves prenatal care and outcomes
  - prevents acute maternal withdrawal that is associated with fetal death
- Withdrawal usually occurs within **1-4 weeks**.

Treatment for Babies

- Withdrawal can last weeks or months
- No universal standard for pharmacologically treating babies
- Finnegan scale helps determine treatment
- Tiny doses of morphine, methadone, phenobarbital or clonidine used to relieve symptoms and wean newborns of addiction
- Doctor may attempt to treat baby without drugs
- Long-term effects remain unknown

Discharge Planning

- Integrate the mother/family into the treatment team
- Establish and maintain communication with other providers – methadone or Buprenorphine providers, early intervention, visiting nurses, child protective services, pediatric care, school programs, community support programs – regarding treatment plans for the child, the mother and the family
- Confirm follow up appointments and activities and review with mother/family, provide written instructions
- Monitor status of follow up on the plans developed with providers and document this in file
- Reduce the barriers to treatment – transportation, child care, attitudes and behaviors, resources

Developmental Sequelae

- Research findings on developmental sequelae associated with in utero methadone exposure are diverse but most studies suggest that infants through 2 year-olds function well within the normal developmental range. They do not differ in cognitive function from a population that was not drug exposed and was of comparable socioeconomic and racial background (Kaltenbach 1996).
- Other data have suggested that maternal drug use is not the most important factor in how opioid-exposed infants and children develop but that family characteristics and functioning play a significant role (Johnson et al. 1987).

Developmental Sequelae

- One long-term follow-up study of 27 children who had been exposed to methadone in utero found no cognitive impairment in preschool years (Kaltenbach et al. 1998).
- Overall, prenatal exposure to methadone provided as part of comprehensive treatment does not appear to be associated with developmental or cognitive impairments (Kaltenbach 1996).

Buprenorphine

- There have been 31 published reports of Buprenorphine, a partial-mu opioid agonist, exposure during pregnancy that were reviewed and summarized (Jones et al. 2008).
- Overall, the studies report approximately 522 neonates prenatally exposed to Buprenorphine, with a wide range of therapeutic doses from 0.4 to 24 mg sublingual tablets/day.
- Generally, the pregnancies were uneventful, without physical teratogenic effects, and with low rates of prematurity, suggesting that Buprenorphine is relatively safe and effective for this population.

Methadone vs. Buprenorphine

- Opioid maintained patients who become pregnant should be maintained on the current agent
- Suboxone can be changed directly to Subutex
- Even though it is a category C drug, Buprenorphine may be used with pregnant patients in the US under certain circumstances
- Buprenorphine should only be initiated when
  - **Patient cannot tolerate methadone**
  - **Methadone program is not accessible**
  - **Patient is adamant about avoiding methadone**
  - **Patient is capable of informed consent**

New Study!

- Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure, Jones et. Al 2010, New England Journal of Medicine.
- A double blind, double dummy, flexible-dosing, randomized, controlled study in which Buprenorphine and methadone were compared for use in the comprehensive care of 175 pregnant women with opioid dependency at 8 international sites.
- Primary outcomes were:
  - The number of neonates requiring treatment for NAS
  - The peak NAS score
  - The total amount of morphine needed to treat NAS
  - The length of the hospital stay for neonates
  - Neonatal head circumference
- Secondary outcomes were:
  - Number of days during which medication was given for NAS
  - Weight and length at birth
  - Preterm birth (<37 weeks gestation)
  - Gestational age at delivery
  - 1 and 5 minute APGAR scores

Results:

- A comparison of the 131 neonates whose mothers were followed to the end of pregnancy according to treatment group (with 58 exposed to Buprenorphine and 73 exposed to methadone) showed the Buprenorphine group
  - Required significantly less morphine (mean dose, 1.1 mg vs. 10.4 mg)
  - Had a significantly shorter hospital stay (10.0 days vs. 17.5 days)
  - Had a significantly shorter duration of treatment for the NAS (4.1 days vs. 9.9 days)
- There were no significant differences between the groups in other primary or secondary outcomes or in the rates of maternal or neonatal adverse events.

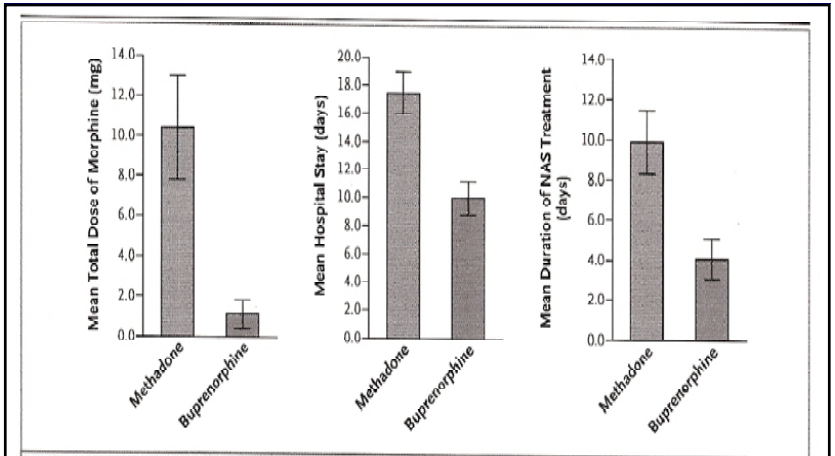


Figure 2. Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome.

Pregnant Clients in OATS

- Current Number Served: 30
- Fiscal Year from July 2010 to June 2011:
  - Deliveries: 45
  - Average Weight: 6lbs 3.5oz
  - Withdrawals:
    - None: 15'
    - Mild, Minor, Slight, Moderate, Some: 19
    - Not Reported: 11
- 2009: 30 of 31 total deliveries reported as full term.
- 2010: 39 or 44 total deliveries reported as full term
- 2011: To date, 26 of 28 total deliveries reported as full term

Measurable Outcomes

- UDS Compliance
- Drug-Free Delivery
- Infant birth weight and gestation at delivery (Full term defined as greater than or equal to 37 weeks)
- Presence of NAS and outcome (How long were infants treated?)
- Did client utilize ZEP services?
- Was infant discharged to mother?
- Was client dually enrolled in another DACCO's Program, such as WOS or Residential?
- Developmental Milestones WNL?

Services Involved in Comprehensive, Coordinated Care

- OBGYNs/Primary Care (Genesis/Exodus)
- OATS (Physician/Nursing/Counselor)
- Zero Exposure Services
- Women's Outpatient Services
- Women's Residential
- Social Workers
- Hospital Delivery Service
- NICU
- Pediatrician

Revised Policy for Pregnant Clients in OATS

- Purpose: To set standards for the medical monitoring of pregnant population dosing with Methadone or Buprenorphine
- Policy: Pregnant clients enrolled in MAT will be prescribed Methadone or Buprenorphine and will be expected to sign a consent to release information between OATS and their OB/GYN provider. The physician staff at OATS will communicate with outside providers regarding the patients' progress, use of other medications and any education that can be done with the provider.

Revised Policy for Pregnant Clients in OATS

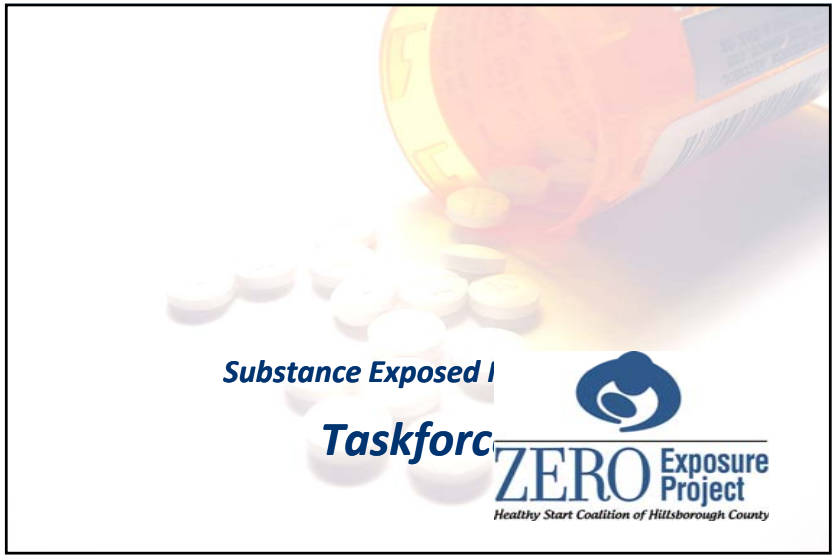
1. Upon admission, staff will obtain consent to release information to/from the client's OBGYN, primary careprovider. Consent will need to be obtained for established pregnant clients that do not have a release in their chart yet.
2. A letter explaining coordinated care will be faxed to the OB/GYN provider or primary care provider once the release is in place. This letter invites the OBGYN/ primary care provider to contact physician staff at OATS to promote coordinated care.
3. At the initial visit, the client will be educated on MAT as the standard of care for pregnant client's expectations of MAT will be reviewed and clients will be given a handout on MAT for Pregnant clients.

Revised Policy for Pregnant Clients in OATS

4. With respect to pharmacotherapy for women who are pregnant, the program will maintain the same dosing principles and protocols for all other persons served in OATS.
5. Follow-up visits with our physicians will be offered weekly until the client is on a stable dose, and will be scheduled at a minimum of monthly intervals while they are pregnant. There will be a mandatory post-delivery follow-up for education and promotion of the client weaning down to their pre-pregnancy methadone dose.
6. Clients are expected to meet all of the requirements of MAT with the exception of those clients with medical exceptions, such as bed rest. When such exceptions exist, the physician will determine whether the client meets criteria to receive special take homes.

Revised Policy for Pregnant Clients in OATS

7. Clients will not be weaned off of their Methadone or Buprenorphine during their pregnancy with the exception that clients decide on medically supervised withdrawal despite education.
8. Clients will be assessed to see if they fulfill criteria to be dually enrolled in another program with a higher level of care, such as intensive outpatient or residential. A referral to Zero Exposure services will also be made.
9. All psychiatric evaluations, psychiatric follow-ups, and monthly visits will be performed in OATS. If clients are dually enrolled in OATS and other services, such as Women's Residential Programs or Women's Outpatient Services, care will be coordinated with that service.



Taskforce Members

- Healthy Start Coalition and Healthy Start
- Hospital social workers
- Hospital Administration, nurses, neonatologists
- DACCO
- Hillsborough Kids, Inc.
- CPI's, Hillsborough County Sheriff's Office
- Office of Attorney General

Epidemic

- Reviewed Discharge Records from 109 Florida Hospitals and found the following:
  - From 2005-2009, births dropped by 2.3% while reported NAS cases increased 274%
  - There are no standard NAS tracking policies so many may not be counted
  - Prenatal drug testing is not mandatory so many babies may be sent home before symptoms become obvious
  - A month of treatment for these babies adds an average of $18,000 to the hospital bill
  - About 63% of these cases are on Medicaid

Florida

- 2010: 1,100 babies born in FL treated for NAS (4x the number from 5 years ago)
- 3 times a day, a Florida baby is treated for withdrawal
- Oxycodone #1 drug

Agency for Health Care Administration

Moms

- Drug Abusers who don't seek treatment are a majority of the birth moms
- Some mothers have prescriptions or are on methadone for medicated assisted drug treatment
- Florida law does NOT require reporting pregnant women with drugs in their system
- Pregnancy screening is not required prior to receiving prescription for addictive drugs

Recognizing the Opioid Dependent Client and Screening

Clues in the Medical History

- No prenatal care –
  - May be because of fear of discovery of addiction
  - May be secondary to general chaos in her life
- Tattoos or self scarring
  - Secondary to IVDU or skin popping
- Burns on hands and clothing
- Nicotine abuse
- Hep C
- Physical dependence = addiction
- Tolerance = addiction

Screening for Substance Use During Pregnancy

- Most effective way to determine risk
  - Lab tests and toxicology are ineffective
  - Quick, brief questionnaires are most effective in assessing drug and alcohol use
  - Pregnant women follow their provider's advice

Using a Screening Tool

- Be non-judgmental and supportive
- Stress benefits of abstinence and offer to help patient achieve it
- Know where to refer a patient for assistance
- Screen every patient

Screening Tools

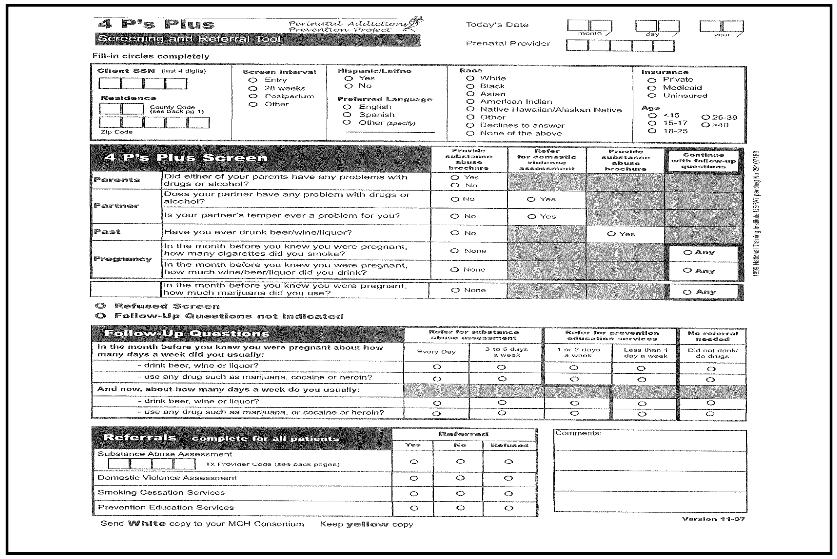
- Substance use by pregnant remains a frequently missed diagnosis.
- T-ACE (Tolerance, Annoyed by Criticism, Cut down, Eye-opener)
- TWEAK (Tolerance, Worry about drinking, Eye-opener, Amnesia, K/Cut down)
- CAGE (Cut down, Annoyed by criticism, Guilty about drinking, Eye-opener)
  - These questionnaires are more suited for heavy, alcoholic drinking and do not identify more moderate or light drinkers or users of illicit drugs

4 P's Plus

- The 4P's Plus Screen for Substance Use in Pregnancy: Clinical Application and Outcomes, Chasnoff et al. 2005
- Evaluated the performance of the screening instrument in five diverse populations.
- 4 P's Plus (Parents, Partner, Past, Pregnancy) is a easy to use five question screen specifically designed to quickly identify obstetrical patients in need of in-depth assessment or follow-up monitoring for risk of alcohol, tobacco, and/or illicit drug use.
- Takes less than one-minute and is easily integrated into the initial pre-natal visit and used for follow-up screening through the pregnancy.

4P's Plus Questions

- Parents: Did either of your parents ever have a problem with alcohol or drugs?
- Partner: Does your partner have a problem with alcohol or drugs?
- Past: Have you ever drunk beer, wine, or liquor?
- Pregnancy: In the month before you knew you were pregnant, how many cigarettes did you smoke?
- Pregnancy: In the month before you knew you were pregnant, how many beers/how much wine/how much liquor did you drink?



4 P's Plus — *Perinatal Addictions Prevention Project*

Screening and Referral Tool

Today's Date: month / day / year

Prenatal Provider

Fill-in circles completely

Client SSN (last 4 digits)

Residence — County Code (see back pg 1); Zip Code

Screen Interval: O Entry O 28 weeks O Postpartum O Other

Hispanic/Latino: O Yes O No

Preferred Language: O English O Spanish O Other *(specify)*

Race: O White O Black O Asian O American Indian O Native Hawaiian/Alaskan Native O Other O Declines to answer O None of the above

Insurance: O Private O Medicaid O Uninsured

Age: O <15 O 15-17 O 18-25 O 26-39 O >40

4 P's Plus Screen		Provide substance abuse brochure	Refer for domestic violence assessment	Provide substance abuse brochure	Continue with follow-up questions
Parents	Did either of your parents have any problems with drugs or alcohol?	O Yes O No			
Partner	Does your partner have any problem with drugs or alcohol?	O No	O Yes		
	Is your partner's temper ever a problem for you?	O No	O Yes		
Past	Have you ever drunk beer/wine/liquor?	O No		O Yes	
Pregnancy	In the month before you knew you were pregnant, how many cigarettes did you smoke?	O None			O Any
	In the month before you knew you were pregnant, how much wine/beer/liquor did you drink?	O None			O Any
	In the month before you knew you were pregnant, how much marijuana did you use?	O None			O Any

O **Refused Screen**

O **Follow-Up Questions not indicated**

Follow-Up Questions	Refer for substance abuse assessment		Refer for prevention education services		No referral needed
In the month before you knew you were pregnant about how many days a week did you usually:	Every Day	3 to 6 days a week	1 or 2 days a week	Less than 1 day a week	Did not drink/ do drugs
- drink beer, wine or liquor?	O	O	O	O	O
- use any drug such as marijuana, cocaine or heroin?	O	O	O	O	O
And now, about how many days a week do you usually:					
- drink beer, wine or liquor?	O	O	O	O	O
- use any drug such as marijuana, or cocaine or heroin?	O	O	O	O	O

Referrals complete for all patients	Referred: Yes	No	Refused
Substance Abuse Assessment — Tx Provider Code (see back pages)	O	O	O
Domestic Violence Assessment	O	O	O
Smoking Cessation Services	O	O	O
Prevention Education Services	O	O	O

Comments:

Send **White** copy to your MCH Consortium Keep **yellow** copy

Version 11-07

1999 National Training Institute USPAT pending No 29107188

Treatment Barriers

- Fear, shame, and guilt about use
  - Will she lose other children if in treatment?
  - Does she have family support?
  - Attitudes of medical providers
- Lack of comprehensive clinical care services for all the problems of pregnancy AND addiction
  - Can she get to treatment? Transportation problems?
  - Lack of childcare while in treatment
  - Basic needs must be met for her to engage in treatment
- Co-morbid diagnosis impacting ability to access services
  - Difficulty addressing many issues simultaneously
  - Depression, anxiety
  - Personality Disorder
  - Immaturity/lack of coping skills

Methadone & Pregnancy Fact Sheet

- Pregnant women on methadone need to be on doses that alleviate withdrawal symptoms. If your baby is becoming hyperactive in utero as the methadone dose wears off, you may need to go up on your dose.
- Pregnant women on methadone are candidates for split dosing. Dosing twice a day delivers more steady methadone levels to your baby. You will be returning to once a day dosing after the baby is born.
- All pregnant women must see the medical provider once a month.
- During the third trimester, you may need to go up on your methadone dose due to increased blood volume that dilutes the methadone.
- After delivery, reduction in methadone dose is often needed. It you are feeling drowsy, let the nurse know so that we can decrease your methadone dose.

Methadone & Pregnancy Fact Sheet

- Breast feeding in methadone maintained mothers is encouraged and safe for the baby. The amount of methadone in breast milk is negligible. (Mothers who are HIV positive should not breast feed). Breast feeding decreases withdrawal symptoms in the baby due to maternal bonding, not from methadone in the breast milk.
- Most babies born to methadone maintained mother have some withdrawal symptoms. Your baby may require opiates for a few days in order to treat the withdrawal symptoms. There are no know long term negative effects from this in the baby.
- While you are in the hospital after delivery, your maintenance dose of methadone should be continued. This will be provided to you by the hospital. If you require pain medications after a C-section or vaginal delivery, you should still get your maintenance methadone dose as well as the pain medication.

Methadone & Pregnancy Fact Sheet

- **When you go to the hospital to deliver your baby, do not let the staff give you any of the following medications because these drugs will cause immediate and severe withdrawal in you and your baby:**
  - **Stadol (butorphanol)**
  - **Nubain (nalbuphine)**
  - **Talwin (pentazocine)**
  - **Buprenex (Buprenorphine)**

These drugs are contraindicated in the methadone maintained patient!

WWW Resources

Medications in Pregnancy and Lactation:

- **Toxnet**- www.toxnet.nlm.nih.gov
  A free, regularly updated information on medications in pregnancy and lactation, select "Lactmed" for safety in lactation.
- **Reprotox** - www.reprotox.org – subscription . Free for trainees.
- **TerisWeb** - http://depts.washington.edu/terisweb

Toxicology and Teratology:

- **Motherrisk -** http://www.motherisk.org/prof/index.jsp
- **Organization of Teratology Information Specialists -** www.otispregnancy.org

Addiction and Pregnancy:

- **Drug Policy Alliance Lindesmith Library** - http://www.drugpolicy.org/library/

WWW Resources

Psychiatric Disorders and Pregnancy - Clinical Research Centers

- UPMC - **www.womensbehavioralhealth.org**
- MGH – **www.womensmentalhealth.org**

Postpartum Psychiatric Disorders

- MedEdPPD - **www.mededppd.org**
  A professional education, peer-reviewed Web site developed with NIMH support.
- Postpartum Support International – **www.postpartum.net**

Questions?

Addressing Resistance to Medication Assisted Treatment in The Child Welfare System

Addressing MAT in Child Welfare System: The Core Challengers

- Family and friends
- Child welfare workers
- State/local child safety administrators
- Dependency judges & court administrators
- Criminal Judges & Probation Officers

Commonly Heard MAT Myths in the Child Welfare System

- "Methadone clients are 'still using' (continuing drug use) and not really engaged in recovery."

  MAT is a medical intervention used to treat symptoms of opioid addiction, similar to a SSRI treating depression, also a brain disorder.

- "They're just substituting one drug for another."

  Belief that clients should be free of all chemicals regardless of medical validity.

Commonly Heard MAT Myths in the Child Welfare System

- Drug use including Methadone treatment is a "choice," not a disease process. "Just quit!"

  Addiction is not a moral choice but a disease process of the brain that creates intense craving and distressing, painful withdrawal symptoms.

- "Clients get high on Methadone & Suboxone."

  With correct dosing MAT clients' withdrawal symptoms are ameliorated and no high is produced.

Countering Family & Friends Challenges to MAT

- Comprehensively educate MAT client themselves so they can discuss factually with family/friends.
- Provide MAT education to family & friends via: 1) "Info Sheets" in non-technical terms; 2) family meetings or sessions; and 3) participation in Methadone Anonymous meetings.
- Co-enrollment between MAT and SA/co-occurring disorders treatment programs with the counseling staff knowledgeable & supportive of MAT.

Responding to Child Welfare Workers and Administrators

- Dissemination of current research & practice information on multiple levels.
- *Whenever and wherever* prescription drug abuse is mentioned also discuss MAT as an option.
- Sharing of case information and SA/CW cross-system, reciprocal staffings.
- Cross-system trainings with case managers and supervisors.

Responding to Child Welfare Workers and Administrators

- Presentations to key community stakeholders - DACCO physician provided MAT training to the Hillsborough County Community Alliance 9/10/10.
- Tours of medically monitored, licensed Methadone programs to dispel myths to Judges, court administration, CBC and CPI leaders, case managers, etc..

Responding to Dependency Judges & Court Administrators

- Accurate program, research & practice information distributed to judges & court administrators.
- 1:1 meetings with judges to facilitate communication & strengthen collaboration.
- MAT trainings with court staff.
- Develop MAT progress reports to courts, as needed, to assist and indirectly educate court staff.
- SA case managers in courts to communicate accurate client & program information.

Addressing MAT in Child Welfare System Timeline: 2006- 2008

- The prescription drug problem in Hillsborough County increasing.
- Hillsborough County Family Dependency Treatment Court funded & implemented.
- Parents on MAT initially excluded from FDTC participation.

Addressing MAT in Child Welfare System Timeline: 2007-2008

- Emergence of parents on MAT in the dependency system grows simultaneously with county prescription drug abuse.
- MAT discouraged by Judges & CW workers, thereby creating confusion for clients and issues with SA TX providers.
- Parents are frequently required to discontinue MAT as a prerequisite to reunification.

Addressing MAT in Child Welfare System Timeline: 2007-2008

Locally, resistance to MAT initially addressed via:

- SA trainings for HKI & HCSO CPI's that includes information regarding opioid abuse and MAT.
- Informal discussions with Judges and case managers.
- Whenever the prescription drug problem is mentioned, DACCO discussing MAT as an treatment option.

Addressing MAT in Child Welfare System Timeline: 2007-2008

- At the state level, FADAA (Florida Alcohol & Drug Abuse Assoc) discussing value of establishing stronger connections with other systems of care.
- Several FADAA members recommend that the DCF Family Safety office be at the table to discuss recurring issues between the SA and CW systems.

Addressing MAT in Child Welfare System Timeline: 2009

- Locally, as more FDTC and dependency clients are opioid addicted, more engage in MAT. Court resistance increases concurrently.
- HKI workers continue to report to Judge that parents need to discontinue Methadone w/in 2 or 4 weeks in order to be reunified.
- Judge continues to confront clients when their dose is increased and asks for plan to reduce dose & discontinue MAT.

Addressing MAT in Child Welfare System Timeline: 2009

- Another meeting scheduled with FTDC Judge and substance abuse provider wherein current & accurate MAT information presented and discussed.
- A specific FDTC MAT Review form is subsequently developed to provide the Judge with data he deems crucial to the court to make informed decisions. A DACCO physician signs-off on the reviews.

Addressing MAT in Child Welfare System Timeline: 2009

- At the state level, FADAA reaches out to DCF Office of Family Safety.
- Alan Abramowitz, Office of Family Safety Director, attends March 2009 FADAA board meeting wherein he provides an overview of the state child welfare system.
- FADAA board members voice concerns to Director Abramowitz about disconnect between CW workers/ leadership and the SA TX community.

Addressing MAT in Child Welfare System Timeline: 2009

- Discussion includes the particular challenges posed by the dependency system regarding clients receiving Medication Assisted Treatment.
- Highlighted areas of concern:

1) If clients pushed to abandon their MAT protocol destabilization of a family could occur.

2) Dose reduction is a medical decision, not a CW caseworker call.

Addressing MAT in Child Welfare System Timeline: 2009

- Director Abramowitz offers to write a letter in support of MAT to circuit administrators, CBC lead agencies, supervisors and all related staff across the state.
- MAT DCF Memorandum subsequently drafted with assist of DACCO & FADAA board members.
- Draft document highlights MAT as an EBP and medically managed intervention.

Addressing MAT in Child Welfare System Timeline: 2009

- Director Abramowitz expresses dedication in releasing MAT Memorandum.
- Both the DCF Assistant Secretaries of Operations and Programs review and subsequently sign off, thereby empowering the message.
- Memorandum released Sept. 9, 2009.

Bridging the GAP: Child Welfare & SA Treatment Systems 2009

- FADAA Child Welfare Strategic Plan workgroup convenes in Summer 2009 to address:

  FADAA strategic plan goal #5: "promote alcohol & drug prevention and treatment as part of the solution to national and state problems."

  Task 1: "develop a policy paper for DCF that promotes a statewide, unified system of response for preventing child abuse & neglect and promoting safe family reunification as a result of alcohol & drug prevention and treatment."

2010: Hillsborough County FDTC Changing Client Profile

2010: Hillsborough County Child Protections Investigations Client Profile

- 61% (1624/2653) of the UDS screens facilitated by HCSO Child Protection Investigators were positive.
- Of the 1624 positive screens by CPI's:

  373 (23%) Oxycodone & Opiates

  299 (19%) Benzodiazepines

  664 (41%) THC- clearly the most prevalent

HCSO CPI UDS RESULTS 10/11

HCSO CPI UDS RESULTS 10-11

Month	Total tests	Negative	Positive	AMP	BZO	COC	MAD	MDMA	MAMP	OPI	OXY	THC	OTHER	
07/2010	242	70	172	5	29	5	4	11	9	2	27	79	1	172
08/2010	253	93	160	3	25	10	10	4	2	2	31	72	1	160
09/2010	176	62	114	6	17	8	2	7	7	6	25	36	0	114
10/2010	226	93	133	3	24	7	3	3	3	5	18	67	0	133
11/2010	224	94	130	6	27	6	5	6	8	3	26	43	0	130
12/2010	170	82	88	1	19	7	0	2	2	2	13	40	2	88
01/2011	279	92	187	5	29	7	9	4	5	6	45	77	0	187
02/2011	211	88	123	2	24	15	7	0	1	3	24	46	1	123
03/2011	194	82	112	2	21	9	2	2	1	6	24	45	0	112
04/2011	228	81	147	3	31	9	9	2	2	4	32	55	0	147
05/2011	201	90	111	2	16	5	2	2	5	2	27	49	1	111
06/2011	249	102	147	1	37	8	1	1	3	5	35	55	1	147
TOTAL	2653	1029	1624	39	299	96	54	44	48	46	327	664	7	1624

2010: Hillsborough County FDTC Changing Client Profile

- Hillsborough FDTC enrolls 91 parents in FY10 - 74% female.
- While our community is culturally diverse, the majority of clients are Caucasian, non-Hispanic.
- Of the 394 positive UDS detected by Drug Court Specialists across all dependency courts last year, Oxycodone most prevalent at 24.6%, while other opiates accounted for additional 10%.
- Of the 60 clients DACCO treats under FDTC funding, 41% are addicted to opiates. Court data indicates prescription drugs as the substances of choice in the FDTC.

FDTC PRESUMPTIVE UDS 2010

FDTC UDS 2010	TOTAL	Qtr. I	Qtr. 2	Qtr. 3	Qtr. 4
Drugs Detected	394	146	100	68	80
AMP (Amphetamines)	23	13	7	3	0
BZD (Benzodiazepines)	67	20	19	10	18
COC (Cocaine)	22	11	2	5	4
MAD (Methadone)	46	20	11	7	8
MDMA (Ecstasy)	14	6	5	3	0
MET (Methamphetamine)	11	3	3	4	1
OPI (Opiates)	41	11	6	7	17
OXY (Oxycodone)	97	30	29	17	21
THC (Marijuana)	73	32	18	12	11
Adulteration Detected	0	0	0	0	0

DACCO Opioid Assisted Treatment Services (OATS) Data

- **OATS Child Welfare unduplicated clients for past 3 FY's:**

  2008/2009 - 36

  2009/2010 - 45

  2010/2011- 78

Felony Drug Court Assistance: MADCT

- A three-year federally funded SAMHSA grant was awarded to Hillsborough County, FL to expand substance abuse treatment for felony offenders with prescription drug dependency. The *Medication Assisted Drug Court Treatment* program partnered by:
  - Administrative Office of the Court
  - DACCO, a not-for-profit substance abuse treatment agency
  - University of South Florida's Florida Mental Health Institute

Felony Drug Court Assistance: MADCT

- The purpose of the *Medication Assisted Drug Court Treatment (MADCT)* program is to offer opiate-addicted offenders a harm-reduction based outpatient treatment option, as an alternative to abstinence-based programs or jail/prison – with the ultimate goal of enabling clients to achieve sobriety and stability.
- Coincidentally, MADCT Judge also the FDTC Judge, thereby reinforcing the value of MAT in the courts.

DACCO CHILD WELFARE/MAT CONTINUUM OF CARE

- Dependency MAT clients typically co-enrolled in OATS and SA treatment program
- A continuum of gender specific, comprehensive care. “One Stop Shop”
- Evidenced based curriculums
- F/T RN & medical case management
- Women’s Health Education groups including prenatal effects of alcohol & drugs
- Intensive case management for pregnant women and DOULA classes with delivery support

DACCO CHILD WELFARE/MAT CONTINUUM OF CARE

- Tampa Family Health Center satellite office on site 5 days/wk
- Mental health services (psychiatric evals, medication mgmt. & psycho-educational COD groups)
- Science-based Nurturing Parenting Program
- Extensive substance abuse case management in FDTC
- Supported Employment services
- On-site, full day developmental Childcare Center
- GED classroom on-site
- Transportation

Additional MAT Challenges

- Cost - Medicaid & private insurance will pay for Methadone, otherwise client must self-pay.
- Medicaid currently pays for Methadone but not Suboxone. Buprenorphine requires extensive pre-authorization process.
- Appropriate MAT training to child welfare and court staff due to time & cost restraints.
- Maintaining current level of FTDC substance abuse case management.
- Coordination of internal services.
- Other SA TX providers not embracing MAT.

RESOURCES

Florida Alcohol & Drug Abuse Association
www.fadaa.org

Hazelden
www.hazelden.org

National Center on Substance Abuse & Child Welfare
http://ncsacw.samhsa.gov/tutorials/tutorialMenu.asp

National Institute on Drug Abuse (NIDA)
www.drugabuse.gov

Treatment Improvement Exchange
www. treatment.org

US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment
csat.samsha.gov

US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration
www.samsha.gov