Understanding Opiate Use Disorders, Medication Assisted Treatment and Family Recovery

2017 Annual CRB
Every Day Counts Conference

"The increase of opioid misuse has been described by long-time child welfare professionals as having the worst effects on child welfare systems that they have seen."

Written Testimony of:

Nancy K. Young, Ph.D.
Director, Children and Family Futures, Inc.
Before the United States Senate Committee on Homeland Security and Governmental Affairs
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Objectives

- Describe the pharmacology of heroin and other opiods.
- Understand treatment options for clients with Opioid Use Disorder.
- Discover how collaboration and coordinated care can improve treatment engagement and outcomes.

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Difference Between Opiates And Opioids

Opiates: A Natural Pain Remedy

- *Opiates are alkaloids derived from the opium poppy. Opium is a strong pain relieving medication, and a number of drugs are also made from this source.*

- **Types Of Opiates**
- Morphine
- Codeine
- Heroin
- Opium

Opioids: Synthetic Pain Medications

- *Opioids are synthetic or partly-synthetic drugs that are manufactured to work in a similar way to opiates. Their active ingredients are made via chemical synthesis. Opioids may act like opiates when taken for pain because they have similar molecules.*

- **Types Of Opioids**
- Methadone
- Percocet, Percodan, OxyContin (oxycodone)
- Vicodin, Lorcet, Lortab (hydrocodone)
- Demerol (pethidine)
- Dilaudid (hydromorphone)
- Duragesic (fentanyl)

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Heroin and Other Opiates

What is heroin?

- Heroin is an opioid drug made from morphine, a natural substance taken from the seed pod of the Asian opium poppy plant. Heroin can be a white or brown powder, or a black sticky substance known as black tar heroin. Other common names for heroin include *dope*, *horse*, *junk*, and *smack*.

How do people use heroin?

- People inject, snort, or smoke heroin. Some people mix heroin with crack cocaine, called a *speedball*.

How does heroin affect the brain?

- Heroin enters the brain rapidly and changes back into morphine. It binds to opioid receptors on cells located in many areas of the brain, especially those involved in feelings of pain and pleasure. Opioid receptors are also located in the brain stem, which controls important processes, such as blood pressure, arousal, and breathing.

Prescription Opioids and Heroin

- Prescription opioid pain medicines such as OxyContin® and Vicodin® have effects similar to heroin. Research suggests that misuse of these drugs may open the door to heroin use.
- Nearly 80 percent of Americans using heroin (including those in treatment) reported misusing prescription opioids prior to using heroin.
- While prescription opioid misuse is a risk factor for starting heroin use, only a small fraction of people who misuse pain relievers switch to heroin. According to a national survey, less than 4 percent of people who had misused prescription pain medicines started using heroin within 5 years.
- *This suggests that prescription opioid misuse is just one factor leading to heroin use.*

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Short-Term Effects

People who use heroin report feeling a "rush" (euphoria) accompanied by effects that include:

- Dry mouth
- Flushing of the skin
- Heavy feelings in the hands and feet
- Clouded mental functioning
- Going "on the nod," A back-and-forth state of being conscious and semi-conscious

Other Health Effects Of Heroin

People who use heroin over the long term may develop:

- Collapsed veins
- Infection of the heart lining and valves
- Abscesses (swollen tissue filled with pus)
- Constipation and stomach cramping
- Liver or kidney disease
- Lung complications, including various types of pneumonia

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Heroin Cont.

- In addition to the effects of the drug itself, street heroin often contains dangerous chemicals that can clog blood vessels leading to the lungs, liver, kidneys, or brain, causing permanent damage. Also, sharing drug injection equipment and having impaired judgment from drug use can increase the risk of contracting infectious diseases such as HIV and hepatitis (see "Injection Drug Use, HIV, and Hepatitis.")

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Heroin Overdose

- An overdose occurs when the person uses too much of a drug and has a toxic reaction that results in serious, harmful symptoms or death.
- When people overdose on heroin, their breathing often slows or stops. This can decrease the amount of oxygen that reaches the brain, a condition called hypoxia.
- Hypoxia can have short- and long-term mental effects and effects on the nervous system, including coma and permanent brain damage.

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Heroin Addiction, A Form Of Substance Use Disorder (SUD)

- Heroin is highly addictive. People who regularly use heroin often develop a tolerance, which means that they need higher and/or more frequent doses of the drug to get the desired effects.
- A substance use disorder (SUD) develops when continued use of the drug causes issues, such as health problems and failure to meet responsibilities at work, school, or home.
- An SUD can range from mild to severe, the most severe form being addiction.

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Those who have become addicted to Heroin, and stop using the drug abruptly may have severe withdrawal

Withdrawal symptoms—which can begin as early as a few hours after the drug was last taken include:

- muscle and bone pain
- sleep problems
- diarrhea and vomiting
- cold flashes with goose bumps ("cold turkey")
- uncontrollable leg movements ("kicking the habit")
- severe heroin cravings
- Researchers are studying the long-term effects of opioid addiction on the brain. Studies have shown some loss of the brain's white matter associated with heroin addiction, which may affect decision-making, behavior control, and responses to stressful situations

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Challenges/Barriers for Parents with Opioid Use Disorders involved with Child Welfare

- Medication stabilization may take up to 90-days.
- There is a high rate of relapse for opiate users.
- Stigma and bias associated with Medication Assisted Treatment (MAT).
- Access to residential treatment for MAT clients.
- Safe and stable housing.
- The child's developmental timetable. (Bonding and attachment)
- The child welfare timetable may move too quickly to give parents sufficient time to complete treatment or to demonstrate sufficient stability to care for their children.
- Other barriers include transportation and affordable childcare.

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The Substance Abuse Treatment Timetable

- The substance abuse treatment timetable relates to the substance abusing parent's timetable for treatment and recovery. Some parents may have timetables that are incompatible with the child welfare and welfare reform deadlines.
- This includes parents who are not ready for treatment.
- It includes parents who have co-occurring disorders (e.g., parents with substance use disorders who also have mental health disorders, past traumatic experiences, or a history of domestic violence.)
- It also includes parents who have relapsed but are still working at their recovery.

The Child Welfare/Court Timetable

- The child welfare/court timetable relates to the time limits parents with children in the foster care system have to develop a safe and nurturing family environment to which their children can be returned, before losing permanent custody.
- The Adoption and Safe Families Act gives parents about 15 months to address the issues leading to placement of a child and allow them to safely return home.

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Engagement and Stabilization

- Addicted parents in the child welfare system need assistance with motivation to engage in and maintain treatment because the requirements of Federal and State statutes do not allow for much time to be lost in relapse.
- Assist clients in accessing treatment
  - Arrange medical transportation to treatment with the client
  - Utilize Addiction Recovery Team (ART) and recovery mentors to assist with initial appointments
- Collaboration
  - Improves family engagement
  - Enhances family outcomes
  - Reduces family stress
  - Helps families meet requirements
  - Improves information sharing and treatment outcomes

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Relapse

- Many clients will not immediately sustain new changes they are attempting to make.
- Substance use after a period of abstinence may be common in early recovery.
- Clients may go through several cycles of the stages of change to achieve long-term recovery.
- Relapse should not be interpreted as treatment failure or that the client has abandoned a commitment to change.
- With support, these experiences can provide information that can facilitate subsequent progression through the stages of change, and identify new areas in which treatment and case plans can be enhanced. When parents lapse or relapse, child welfare professionals have an especially important role helping parents to reengage in treatment.

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Stigma

- One of the most misunderstood issues about methadone is that many people will say that methadone is just another addiction. Both heroin and methadone create a dose dependent physical dependence and tolerance (i.e., there are physical withdrawal symptoms upon reduction), However, methadone is not associated with the behavioral syndrome of addiction which is characterized by the repeated, compulsive seeking or use of a substance, despite adverse consequences.

- *Methadone does not produce the behaviors associated with addiction and compulsive use.*

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How Opiates And Opioids Work

- Both of these types of drugs alter the way that pain is perceived, as opposed to making the pain go away. They attach onto molecules that protrude from certain nerve cells in the brain called opioid receptors.
- Once they are attached, the nerve cells send messages to the brain that are not accurate measures of the severity of the pain that the body is experiencing. Thus the person who has taken the drug experiences less pain.
- Drugs in these classes also affect how the brain feels pleasure. A person who takes them who is not in pain will experience a feeling of elation, followed by deep relaxation and/or sleepiness

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Opioid Treatment Programs (OTPs)

- Opioid treatment programs (OTPs) provide MAT for individuals diagnosed with an Opioid Use Disorder (SUD).
- OTPs also provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and/or the spread of infectious disease. OTPs focus on improving the quality of life of those receiving treatment.
- OTPs must be accredited by a SAMHSA approved accrediting body, and certified by SAMHSA.
- The Division of Pharmacologic Therapies (DPT), part of the SAMHSA Center for Substance Abuse Treatment (CSAT), oversees accreditation standards and certification processes for OTPs.

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OTP's Cont.

- Federal law requires patients who receive treatment in an OTP to receive medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication.
- The law allows MAT professionals to provide treatment and services in a range of settings, including hospitals, correctional facilities, offices, and remote clinics.
- As of 2015, OTPs were located in every U.S. state except North Dakota and Wyoming.
- The District of Columbia and the territories of Puerto Rico and the Virgin Islands also had OTPs in operation.

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Medication Assisted Treatment

- Few people with opiate addiction recover permanently without Medication Assisted Treatment (MAT). In fact, opiate addiction treatment without MAT results in relapse rates of 80 to 95 percent, according to the Federal Center for Substance Abuse Treatment.
- ***It is important to note that these medications are designed to be prescribed in conjunction with behavioral therapy, not as stand-alone treatment.***

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Effective medication-assisted treatment has the following desired outcomes

- Prevention of the onset of subjective and/or objective signs of opioid abstinence syndrome for at least 24 hours (opioid agonists).
- Reduction or elimination of drug craving routinely experienced by the patient (opioid agonists or antagonists).
- Blockage of the euphoric effects of any illicitly acquired, self-administered drug without the patient experiencing or observers noticing undesirable effects (opioid agonists or antagonists).

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MAT Effectiveness

- In 2013, an estimated 1.8 million people had an Opioid Use Disorder related to prescription pain relievers, and about 517,000 had an Opioid Use Disorder related to heroin use.
- MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy.
- MAT also includes support services that address the needs of most patients.
- The ultimate goal of MAT is full recovery, including the ability to live a self-directed life.

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This treatment approach has been shown to:

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant
- Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis- C by reducing the potential for relapse

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Counseling and Behavioral Therapies

- Under federal law, MAT patients must receive counseling, which could include different forms of behavioral therapy
- These services are required along with medical, vocational, educational, and other assessment and treatment services.

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Medications Used in MAT

- FDA has approved several different medications to treat opioid addiction and alcohol dependence.
- A common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body.
- MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid.
- Research has shown that when provided at the proper dose, medications used in MAT have no adverse effects on a person's intelligence, mental capability, physical functioning, or employability.
- Medications used in MAT for opioid treatment can only be dispensed through a SAMHSA-certified OTP .

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Opioid Dependency Medications

- Methadone, Buprenorphine, and Naltrexone are used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.
- People may safely take medications used in MAT for months, years, several years, or even a lifetime.
- Plans to stop a medication must always be discussed with a doctor.

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Methadone

- Methadone tricks the brain into thinking it's still getting the abused drug. In fact, the person is not getting high from it and feels normal, so withdrawal doesn't occur. Learn more about methadone.
- Pregnant or breastfeeding women must inform their treatment provider before taking methadone.
- It is the only drug used in MAT approved for women who are pregnant or breastfeeding .

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Buprenorphine and Naltrexone

- **Buprenorphine** suppresses and reduces cravings for the abused drug.
- It can come in a pill form or sublingual tablet that is placed under the tongue.

- **Naltrexone** works differently than methadone and buprenorphine in the treatment of opioid dependency.
- If a person using naltrexone relapses and uses the abused drug, naltrexone blocks the euphoric and sedative effects of the abused drug and prevents feelings of euphoria.

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Treatment with Buprenorphine

The ideal candidates for opioid dependency treatment with buprenorphine:

- Have been objectively diagnosed with an opioid dependency.
- Are willing to follow safety precautions for the treatment.
- Have been cleared of any health conflicts with using buprenorphine.
- Have reviewed other treatment options before agreeing to buprenorphine treatment.

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Buprenorphine treatment happens in three phases

1. **The Induction Phase** is the medically monitored startup of buprenorphine treatment performed in a qualified physician's office or certified OTP using approved buprenorphine products. The medication is administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal. ***It is important to note that buprenorphine can bring on acute withdrawal for patents who are not in the early stages of withdrawal and who have other opioids in their bloodstream.***
2. **The Stabilization Phase** begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, side effects. The buprenorphine dose may need to be adjusted during this phase. Because of the long-acting agent of buprenorphine, once patients have been stabilized, they can sometimes switch to alternate-day dosing instead of dosing every day.

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Buprenorphine treatment happens in three phases

1. **The Maintenance Phase** occurs when a patient is doing well on a steady dose of buprenorphine. The length of time of the maintenance phase is tailored to each patient and could be indefinite. Once an individual is stabilized, an alternative approach would be to go into a medically supervised withdrawal, which makes the transition from a physically dependent state smoother. People then can engage in further rehabilitation—with or without MAT—to prevent a possible relapse.
   - ***Treatment of opioid dependency with buprenorphine is most effective in combination with counseling services, which can include different forms of behavioral therapy and self-help programs.***

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Switch from Methadone to Buprenorphine

- Patients can possibly switch from methadone to buprenorphine treatment, but because the two medications are so different, patients may not always be satisfied with the results.
- Studies indicate that buprenorphine is equally as effective as moderate doses of methadone.
- *However, because buprenorphine is unlikely to be as effective as more optimal-dose methadone, it may not be the treatment of choice for patients with high levels of physical dependency.*
- A number of factors affect whether buprenorphine is a good choice for someone who is currently receiving methadone. Therefore, patients receiving buprenorphine can possibly be switched to methadone
- Patients interested in learning more about switching their treatment should discuss this with their doctor

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Unsupervised Approved Use (Take-home) Of Medication

- Federal and state regulations limit the potential for diversion of Opioid agonist treatment medications to the illicit market, opioid agonist treatment medications dispensed to patients for unsupervised use.

For more information see:

- Federal Guidelines for Opioid Treatment Programs

www.samhsa.gov

- OAR 415-020 Standards for Outpatient Synthetic Opiate Treatment Programs

www.oregon.gov

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- ***Medication Assisted Treatment should continue as long as the patient desires and derives benefit from treatment. There should be no fixed length of time in treatment. For some patients, indefinite medication-assisted treatment may be clinically indicated.***

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Summary

- Heroin and other opioid use is straining child welfare agencies.
- For people with Opioid Use Disorders, Opioid Treatment Programs (OTP's) providing Medication Assisted Treatment (MAT) in combination with counseling and behavioral therapies is the most successful form of treatment for opioid addiction.
- A collaborative approach between Child Welfare professionals and treatment providers can help to improve treatment engagement, retention and outcomes for families.

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Practical application

- Please complete the work sheet regarding parental progress in cases with parents undergoing treatment for heroin/opiate use.

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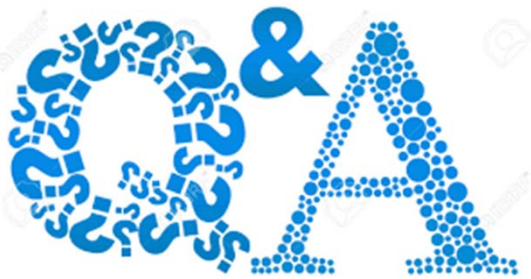

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Thank you for Participating!

Teri Morgan, CADC-II
Clinical Supervisor,
Marion County Alcohol &Drug Treatment Services
503-361-2643
thmorgan@co.marion.or.us

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Children exposed prenatally to heroin/opiates

Issues to consider when addressing a child's safety, health and well-being during CRB review

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Immediate risks at birth for children exposed to Heroin/Opiates prenatally include the following:

- preterm delivery
- HIV and Hepatitis B and C
- withdrawal symptoms

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NAS – Neonatal Abstinence Syndrome

- CNS symptoms: hyperirritability, tremors, convulsions, gastrointestinal distress, respiratory distress, autonomic disturbances.
- Infants of methadone addicted mothers experience more severe symptoms for a longer time.
- Treatment for infants generally consists of providing children with a tapering schedule of tincture or opium, morphine or phenobarbital while monitoring clinical symptoms.
- During withdrawal period infants may dramatically influence caretaker interactions because they are often resistant to cuddling or soothing and have a decreased ability to respond to normally to auditory or visual stimuli.
- Onset of withdrawal symptoms is usually between 48 and 72 hours after birth.

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Short and long term risks

There have been few long term studies and some contradictory conclusions. However, research is ongoing and some results have been confirmed.

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- Children born to mothers partaking in opioid and poly-substance use during pregnancy often have lower birthweight. Low birthweight has been found to be a predictor of later cognitive abilities, socio-emotional functioning, executive functioning, and academic achievement.
- The few studies of young children indicate the likelihood of problems within fields related to executive control, attention and emotional and behavior regulation.
- Fine motor abilities, which are often related to executive control have also been found to be worse among young children born to mothers with opioid and poly-drug use during pregnancy than among other children. Some studies find that motor abilities are the most affected functional area.

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- It has been postulated that optimization of the postnatal environment may compensate for the biological vulnerability of these children. The children may have a positive trajectory over time if they were brought up in good foster or adoptive homes which compensated for their prenatal vulnerabilities. Several changes of caregivers instead of an early change to stable foster or adoptive care may also be related to worse outcomes in youth.
- The few longitudinal studies of children exposed to opioids and multiple illegal drugs who were brought up in foster or adoptive homes do not indicate that the children catch up but instead that they have continuous problems or more clearly manifested symptoms throughout infancy, early childhood and adolescence.

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- In youth, the results of neuropsychological tests did not indicate specific problems with executive functions but rather a mild general feature.
- The problems identified cannot be explained by perinatal factors, even though it is probable that birthweight and gestational age are important for this group of vulnerable children.
- However, the knowledge that these youths have worse outcomes on basic cognitive abilities tests than other comparable youths should, in itself, be important knowledge for policymakers and health or school personnel who come into contact with these vulnerable youths.

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- The biological vulnerabilities of prenatally drug-exposed children may influence early cognitive abilities which again are highly related to later cognitive abilities. However, the prenatal vulnerabilities may also have a continuous direct effect on the ability to acquire new skills.
- Effects of maternal opioid use on complex cognition and self-regulation, such as executive functions, can only be observed when these behaviors develop, i.e., during school age years and beyond.
- This may be especially true at the age when young adults normally move away from their parents and other support systems that have followed them through their upbringing. The scarce data on the adult offspring of opioid-dependent parents indicate a high risk of criminal behavior, substance abuse and unemployment.

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One long term study completed interviews with 30 subjects born to heroin-addicted mothers between 1985 and 1990

- One third of the subjects had been diagnosed with some psychiatric disorder in childhood, most of them presented attention deficit disorder and hyperactivity and major depression, and 66.7% of subjects were found susceptible to have personality disorders.
- Drug consumption was very high across the sample; 70% of subjects had consumed cannabis in the previous year, 30% of people consumed cocaine in the last 12 months, 20% amphetamine, 13.3% of them had consumed ecstasy, 13.3% used hallucinogens and 2 people referred consumption of heroine. The use of alcohol also seemed to be high, as 5 people were classified as hazardous drinkers.

Conclusion:

Subjects born to heroin-addicted mothers may be at risk of having social problems, psychiatric problems and illicit substance use disorders, therefore they could therefore benefit from close monitoring after birth to minimize and control the risks.

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What can we do at the CRB review?

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At the first CRB review for infants prenatally exposed to heroin/opiates

- Determine if the child received appropriate medical care to address medical issues and withdrawal symptoms at birth
- Determine if the child was tested for HIV (but do not ask the outcome), and Hepatitis B and C
- Determine if the child has received appropriate developmental assessments and recommended services in a timely manner
- Inquire if the foster parent is informed and trained regarding issues likely to manifest such as eating/feeding, resistant to cuddling or soothing and have a decreased ability to respond normally to auditory or visual stimuli

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At subsequent reviews

- Monitor a child's academic performance and development and inquire if the child's school staff and treatment providers have been provided information regarding the child's prenatal exposure and associated risks.
- Recommend further testing and assessment incorporating known prenatal exposure if a child is having unexplained difficulties with emotions and/or behaviors
- Ensure that older youth and those nearing a transition out of foster care receive support to address their higher risk of criminal behavior, substance abuse and unemployment

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Practical Application

Please complete the worksheet provided regarding ensuring a child's safety, health and well-being

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THANK YOU!!!

For participating in this training and for your efforts on behalf of children and families