Women's Commission on Alcohol and Drug Issues of Oregon

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SPECIAL EDITION

"Women and the Opioid Crisis"

SUMMER 2018

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To increase public awareness of women's alcohol and drug abuse issues and to promote services related to women throughout the state of Oregon. This means ALL women who are affected by their own alcohol or drug use or that of their family or friends.

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It's Time to Talk About the Opioid Crisis as a Women's Health Issue

By Ivana Rihter
Reprinted from www.vogue.com.

At the beginning of the Oscar-nominated short documentary Heroin (e), centered on the town of Huntington, West Virginia, deputy fire chief Jan Rader speeds to a local pub, sirens blaring. By the time she arrives, a woman is already being wheeled out on a stretcher after overdosing in the bathroom. Not a minute passes before another call comes over the scanner: a second overdose, this time a 23-year-old who didn't make it. This is an everyday reality for Rader, and she's not alone. Across the country, as the opioid crisis continues to worm its way into rural outposts and cities alike, fatality rates are staggering: The epidemic claims as many as 115 Americans lives daily, according to recent statistics from the Centers for Disease Control and Prevention, with a newly published study recording a 30% increase in emergency visits for overdoses across all states between 2016 and 2017.

The 39-minute Netflix Original, directed by Peabody Award–winning filmmaker Elaine McMillion Sheldon, tracks the issue on an intimate scale, following three women as they confront the scourge of addiction in their hometown. Judge Patricia Keller presides over drug court, Necia Freeman supplies meals to local sex workers through the town's ministry, and Rader patrols the streets. Their front-lines perspective shines a light on an overlooked truth: While the majority of such fatalities are men, the toll on women is grim, with an 850% increase in opioid-related deaths between 1999 and 2015, almost double the rate for men, according to Linda Richter, Ph.D., director of policy research and analysis at the National Center for Addiction and Substance Abuse. Digging into the reasons for this disparity reveals a patchwork of factors tied to opioid-use disorder, ranging from gender-biased biological data to treatment centers without child care. The point, as outlined below, is that this national crisis is just as much a women's health one, and treating it as such is crucial.

Chronic Pain

Beginning in the mid-'90s, the medical community embraced long-term painkillers as the holy grail of relief: Efficient and effective, the pills were also widely thought to be addiction-proof. Prescriptions soared among post-operative patients and chronic-pain sufferers, but dependency often kicked in, leading to the current crisis. The fact that women have a greater predisposition for chronic conditions like arthritis, endometriosis, and multiple sclerosis—all of which require long-term treatment and daily pain management—

(Continued on page 2)

means that addiction can come as an unintended side effect.

"A lot of patients start out with a legitimate injury or legitimate complaint," says Sharon L. Walsh, Ph.D., who advises the FDA and sits on the board of FORCE (Female Opioid Research Clinical Experts), referring to the slippery slope that follows prolonged use. "If you had some accident and were in the hospital and took an opioid for seven straight days around the clock, you would develop a physical dependence where your body needs that drug in order to feel normal."

That is a strikingly short timeline, roping in another at-risk group: new mothers recovering from cesarean sections, who encounter pain medications at a time when they're already grappling with new pressures and ravaged sleep. For them and other patients, the medical industry has taken note, steering away from default opioid prescriptions when designing pain-management treatments.

Physiological Differences

The effects of any substance on a human body are far from universal, with biological makeup—gender included—shaping the response. "Women experience something called telescoping," says Andrea Grubb Barthwell, M.D., a founding chairwoman on the board of FORCE and director of the North Carolina substance-use treatment center called Two Dreams. The phenomenon she describes entails a rapid spiral into addiction as well as an inflated set of medical, social, and psychological problems. "Even with later onset use [of a substance], we [as women] advance faster and have consequences earlier" than men, she continues. One reason is basic physiological differences: Compared with men—taking into account variations in body size, fat-to-lean body-mass ratio, metabolic rate, and hormones—women tend to be more susceptible to opioid addiction.

It's dismaying, then, that studies investigating opioid's effect on the body—both by drug manufacturers and independent labs—have historically involved male participants, resulting in a lack of data that reflects women's experiences with addiction. One-sided research has led doctors to prescribe opioid medication with gender-neutral doses. Systematic misunderstanding around women and opioids can also mean life or death: A recent review of overdose deaths in Rhode Island showed that women were three times less likely than men to get Naloxone, the life-saving drug administered during resuscitation efforts. This is due, in part, to a misreading of signs of overdose among women, who may be more likely to top out on prescription drugs (and therefore fail to present telltale red flags of addiction to first responders).

Shame and Stigma

Opioid-use disorder is a medical diagnosis, not a moral failing. But too often, especially for mothers and pregnant women, there is a net of shame cast over their dependence and treatment choices. Instead of discussing the condition as one would address diabetes—as a long-term, treatable disease that affects our bodies and lifestyle choices—the court system and general public routinely cast judgment. This only raises the already-high bar to getting help; mothers often avoid treatment out of fear that admitting a need for assistance could mean losing custody of their children.

"You'll have women who get in trouble with the law, lose their children, and get into treatment with a physician and are doing well—and then go into court to obtain custody, [only] to have a judge tell them they can't have custody unless they come off of their medication," says Walsh. "That's illegal. In what other condition would a judge or a lawyer or a social worker be giving someone a medical dictum? That just doesn't happen anywhere else."

More and more, the stigma surrounding opioid-use disorder and the treatments available today are shifting, offering up new opportunities for timely intervention, such as when soon-to-be mothers come to emergency rooms seeking prenatal care. "It would be a thing of beauty if we could wrap our arms around all those people and immediately get them into care someplace—care that was individualized to meet patient needs," says Walsh.

Trauma and Motherhood

As Heroin(e) follows Freeman on her night drives, delivering food and hygiene kits to local sex workers, she encounters a woman whose recent relapse has landed her back on the streets—"the only place [she] could turn to" after losing her job. Selling one's body to feed an addiction sits at one end of the extreme when considering gendered trauma, but experiences of rape, domestic abuse, and even childbirth are also risk factors. "Not all sexual violence ends up in a woman with substance-use disorder," says Barthwell, "but it's rare to find a woman with a substance-use disorder who wasn't attacked prior to the onset of the disease—or certainly attacked during the expression of her disease."

Insurance coverage, socioeconomic status, and lack of education often put high-cost treatment out of reach, yet women have added barriers, especially when they are caretakers. There's the aforementioned stigma; of those who do seek addiction treatment, about 70% of those women have children, yet most residential programs do not allow them, according to Richter. Alternative child care and missed work days are seldom an option, and

recovery plans—and attendant withdrawal symptoms—are not just physically grueling but time-consuming. Implementing legislation that gives women and families greater access to health care and resources across the board might enable more women to find support in long-term recovery.

The Way Forward

"Everyone is talking about doing something," says Walsh. "There is not a day that goes by where someone doesn't send me a link to this new program or that new program." Organizations like FORCE are changing the stigma around opioid-use disorder; their all-female board of specialists and academics is dedicated to putting inclusivity at the forefront of the national conversation. Through fundraising, research, and education, like-minded groups are using their platforms to bring awareness to how this crisis affects women. State legislation is following suit.

www.forcefoundation.org

Maryland is launching coalitions to help women in recovery by providing supportive housing that welcomes children. New Jersey has allocated funding for gender-specific addiction plans that include family-centered treatment and trauma-informed care. "Aside from the programs and initiatives that focus specifically on the needs of women, it is important to note that any progress made to address the lack of access to prevention and affordable treatment for the larger population benefits women and families," adds Richter. And on a micro-level, persistent community efforts matter, as seen in Heroin(e). As Rader says in the film, "I don't care if I save somebody 50 times. That's 50 chances to get into long-term recovery." ❖

WCADIO Announces Counselors of the Year for 2017 & 2018

The board of the Women's Commission on Alcohol and Drug Issues of Oregon is pleased to recognize the WCADIO Counselor of the Year for 2017 and 2018. These two counselors were chosen from amongst their peers for their contributions, competence, and commitment to serving women with addictions.

Annie Kalama and **Peggy Williams** will be honored at the *Spirit of Giving* conference on August 8 in Portland. The conference is sponsored each year by the Native American Rehabilitation Association (NARA).

Annie Kalama

I started on November 13, 1996 as the intake coordinator for alcohol, drug and mental health services on the Warm Springs Reservations. Over the years, the job has been sometimes tough for me but I really want my people to be free of addictions to alcohol and drugs, especially the methamphetamine. I have lost many relatives to alcohol addiction and I would like to continue working in the field to help my people for as long as I can. Women are the backbone of our community; they care for the children, the home, and the culture and traditions. My relatives are counted among these women and sobriety is necessary for our people.

One of my groups is done in the tribal jail and I use this time to approach the women about their lifestyle and choices. I consider this a crucial time to catch them. They are clean and sober and can focus on the A & D free idea.

When I was notified about this honor, I was shocked. I didn't know anyone would honor me for doing my job. I am deeply touched by the fact that someone noticed what I do on a daily basis. I am humbled by this and will continue to do my work to the best of my ability.

Peggy Williams

I was born and raised on the Warm Springs Reservation. In 1989 I entered the field of alcohol and drug treatment. I work with the adult females and males of the Warm Springs Community. Over the past few years I have encouraged and supported females to enter treatment with their children. Many of the females want change to become better mothers, leave abusive relationships and even find positive ways of developing a better relationship. Not to overlook the males, I encourage them to enter treatment. Like the females they have things they want to work on. Those are the good things in my life up to now.

Over the years my life has been full of hurt/pain. I lived through physical and emotional abuse. I tried to cover it by falling in the bottle of alcohol. That was not a help, it destroyed my self-esteem.

Today I have maybe 36 or 37 years sobriety. In those years I lost three sons with my youngest leaving April 7, 2018. I've leaned on the Creator for support so that I would not fall back to alcohol use. Another big support was raising three grandchildren. Two other grandchildren lived in my home over the years.

No Surprise Here: Best Care For Babies May Be Mom's Recovery

By Fran Smith

Reprinted from National Geographic Magazine, September 2017.

A handful of researchers around the country are revamping treatment for neonatal abstinence syndrome to rely less on medication and more on parental bonding. Instead of using score sheets for assessing babies, staff at Boston Medical Center evaluate them on just three measures: eating, sleeping, and being consoled. Rather than transfer babies to an ICU or a specialty unit, Boston Medical Center keeps them with their moms throughout their stay. The women are encouraged to breastfeed and clutch their babies skin to skin. One hundred fifty volunteers—most of them medical students and hospital employees—put in two-hour shifts as cuddlers. The waiting list to hold babies has 200 names.

Before the hospital changed its approach, 86 percent of the babies with NAS it treated received medication. Now it's 30 percent. The babies generally spend nine days in the hospital, down from 19 days under the old protocol. The average cost of a hospital stay for a baby with NAS is $19,655 at Boston Medical Center, compared to a national average of $67,000.

Sound treatment for the babies must go hand in hand with compassionate, comprehensive care for their mothers. The medical center runs a prenatal clinic for women with addiction. The obstetricians prescribe buprenorphine and prepare women for the possibility that their babies will have NAS. The clinic also offers counseling, social services, psychiatric help, peer support, and education about infant care. When the moms come in to deliver, they're in the best shape they can be. In July the medical center opened a clinic that provides pediatric care for babies born with NAS and addiction services for their mothers.

"We keep hearing about the babies, and that it is important, but there needs to be much more of a focus on women and making sure they're taken care of well," says Uma Reddy, a maternal-fetal medicine expert at the Eunice Kennedy Shriver National Institute of Child Health and Human Development. ❖

Residential Treatment Options for Women and Their Children in Oregon

- OnTrack Rogue Valley, Medford
- CODA Inc - Gresham Recovery Center, Portland
- Lifeworks NW - Mountaindale Recovery Center, Portland
- Native American Rehabilitation - Association of The Northwest Inc, Portland
- New Directions - Recovery Village, Baker City
- Eastern Oregon Alcoholism Foundation, Pendleton
- LifeWorks NW - Project Network, Portland
- Milestones Family Recovery Program - Womens Residential, Corvallis
- ADAPT/Crossroads, Roseburg
- Unio Recovery Center - Mommy and Me, Ontario
- Willamette Family Treatment Services - Womens Residential, Eugene

For additional information, please see directory: https://www.oregon.gov/oha/HSD/AMH/Publications/provider-directory.pdf

What is Neonatal Abstinence Syndrome?

Neonatal abstinence syndrome is a drug withdrawal syndrome that may result from chronic maternal opioid use during pregnancy and is an expected and treatable condition seen in 30–80% of infants born to women taking opioid agonist therapies.

Neonatal abstinence syndrome is characterized by disturbances in gastrointestinal, autonomic, and central nervous systems, leading to a range of symptoms including irritability, high-pitched cry, poor sleep, and uncoordinated sucking reflexes that lead to poor feeding. In infants exposed to methadone, symptoms of withdrawal may begin anytime in the first 2 weeks of life, but usually appear within 72 hours of birth and may last several days to weeks. Infants exposed to buprenorphine who develop neonatal abstinence syndrome generally develop symptoms within 12–48 hours of birth that peak at 72–96 hours and resolve by 7 days . Recent evidence indicates that other substances such as nicotine, selective serotonin re-

uptake inhibitors, and benzodiazepines may increase the incidence and severity of neonatal abstinence syndrome.

Use of validated screening assessments such as the Finnegan Scale to diagnose neonatal abstinence syndrome and protocols that standardize treatment using methadone or morphine have been associated with improved outcomes for these infants. Families should be encouraged to visit and care for their infants and women should be supported in their effort to breast feed their infants, if appropriate.

Long-Term Infant Outcome

Long-term outcomes of infants with in utero opioid exposure have been evaluated in several observational studies. A major challenge in assessing these outcomes is isolating the effects of opioid agonists from other confounding factors such as use of other substances (tobacco, alcohol, nonmedical drugs) and exposure to environmental and other medical risk factors (eg, low socioeconomic status, poor prenatal care). For the most part, studies have not found significant differences in cognitive development between children up to 5 years of age exposed to methadone in utero and control groups matched for age, race, and socioeconomic status, although scores were often lower in both groups compared with population data. Preventive interventions that focus on supporting the woman and other caregivers in the early and ongoing parenting years, enriching the early experiences of children and improving the quality of the home environment are likely to be beneficial. ❖

Source: The American College of Obstetricians and Gynecologists, Committee on Obstetric Practice.

Contributions to WCADIO are being accepted for 2018. Please support the work we do by making a tax deductible donation. See last page.

Women and Opioid Use: Did You Know?

Research has shown that women often use drugs differently, respond to drugs differently, and can have unique obstacles to effective treatment as simple as not being able to find child care or being prescribed treatment that has not been adequately tested on women.

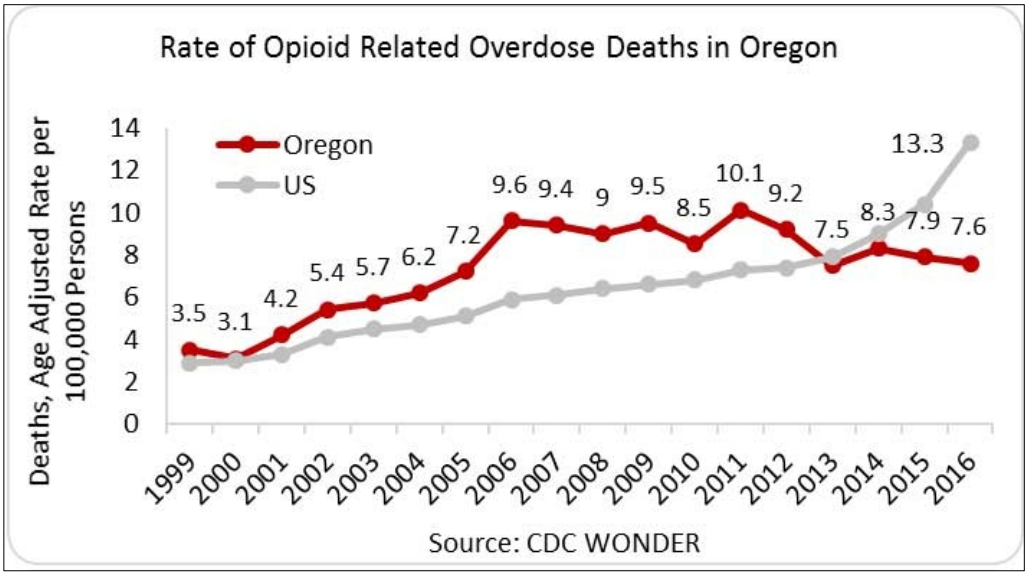
- Women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men.
- Women may become dependent on prescription pain relievers more quickly than men.
- 48,000 women died of prescription pain reliever overdoses between 1999 and 2010.
- Prescription pain reliever overdose deaths among women increased more than 400% from 1999 to 2010, compared to 237% among men.
- Heroin overdose deaths among women have tripled in the last few years. From 2010 through 2013, female heroin overdoses increased from 0.4 to 1.2 per 100,000.
- Compared with men, women who use heroin are:
  - Younger
  - Likely to use smaller amounts for a shorter time
  - More likely to combine heroin with prescription drugs
  - Less likely to inject the drug
  - More influenced by drug-using sexual partners
- Compared with men, women who use prescription opioids are:
  - More sensitive to pain and more likely to have chronic pain
  - More likely to take prescription opioids to deal with pain
  - More likely to misuse prescription opioids to self-treat for other problems such as anxiety or tension
- More pregnant women in rural areas are using opioids and there has been a disproportionately higher increase in neonatal abstinence syndrome (NAS) in rural areas compared to urban areas. Between 2004 and 2013, the number of newborns with NAS in rural areas increased from 1.2 to 7.5 per 1,000 in rural areas compared with 1.4 to 4.8 in cities.
- For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes.

Source: 2016 Facts & Figures, American Society of Addiction Medicine; National Institute on Drug Abuse web site, Substance Use in Women; The American Journal of Nursing, March 2017; and The American College of Obstetricians and Gynecologists.

Opioid-Related Overdose Deaths - Oregon

In 2016, there were 312 opioid-related overdose deaths--- in Oregon—a rate of 7.6 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000. The number of heroin- and synthetic opioid-related overdose deaths has remained relatively unchanged since 2013.

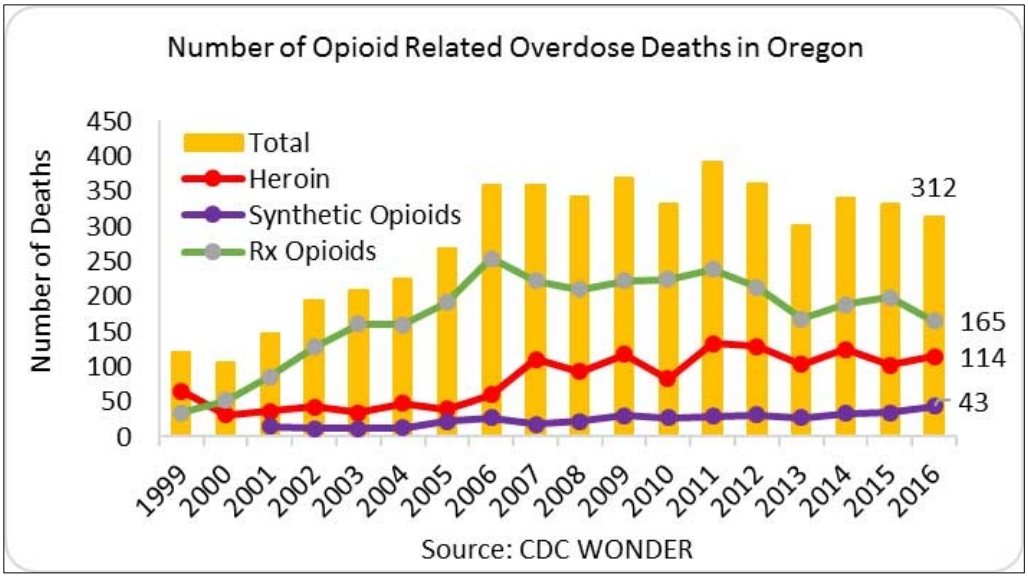
The graph at right shows the rate of opioid-related overdose deaths in Oregon compared to the United States from 1999-2016. In 2016, the opioid overdose death rate was 7.6 deaths per 100,000 persons in Oregon, versus 13.3 deaths per 100,000 persons in the United States.



Opioid Pain Reliever Prescriptions

In 2015, Oregon providers wrote 78.1 opioid prescriptions per 100 persons (3.1 million prescriptions). In the same year, the average U.S. rate was 70 opioid prescriptions per 100 persons (IMS Health, 2016).

This graph at right shows the number of opioid-related overdose deaths in Oregon from 1999-2016. In 2016, there were 312 opioid-related overdose deaths: 43 involved synthetic opioids, 114 involved heroin, and 165 involved prescription opioids. Categories are not mutually exclusive because deaths may involve more than one drug.



Neonatal Abstinence Syndrome (NAS)

The incidence of NAS in Oregon increased from 1.0 case per 1,000 births in 1999 to 5.0 cases per 1,000 in 2013—a fivefold increase. The average across the 28 states included in the 2013 analysis was 6.0 cases per 1,000 births.

Source: National Institute on Drug Abuse

Of the estimated 2.1 million Americans currently in the grip of opioid addiction, many are women of childbearing age. The young-adult population has been hardest hit, proportionately, with nearly 400,000 adults ages 18 to 25 suffering from addiction to prescription painkillers (the vast majority) or heroin. Strict adherence to a birth-control regimen — or any regimen at all — is difficult for someone whose body and mind have been hijacked by drug dependence, which may help to explain why, according to the largest recent study, nearly 90 percent of pregnancies among women who abuse opioid medications are unintended. The number of pregnant women using opioids grew significantly between 2004 and 2013, according to recent research published in JAMA Pediatrics, with the increase disproportionately high — more than 600 percent — in rural areas. Another decade-long study found a fivefold increase in the number of newborns who experienced the opioid-withdrawal condition known as neonatal abstinence syndrome, or NAS: to eight per 1,000 hospital births from one and a half. Experts estimate that a baby with NAS is born in America every 15 minutes.

But the tally of babies born into withdrawal also includes the offspring of a great many mothers who go into treatment in the course of their pregnancies. The standard of care for a pregnant women addicted to opioids is medication-assisted treatment: a long-acting opioid substitute — traditionally methadone — that binds to the body's opioid receptors to prevent withdrawal symptoms, usually without causing the euphoric sensations that commandeer the brain's dopamine system into a relentless quest for more. Pregnant women on methadone or buprenorphine (a newer opioid-replacement drug) are more likely to bring their pregnancies to term, ensuring higher birth weights and better health for their babies. Federal standards mandate that methadone clinics require pregnant clients to receive prenatal care in order to get their medication. Women stabilized on medication-assisted treatment are in far less danger of relapsing, overdosing or contracting H.I.V., hepatitis C or other infections common among those who inject drugs. They experience less maternal stress, which has been shown to negatively impact the fetus's epigenetics, or gene expression.

But because methadone and buprenorphine are still opioids, a fetus adapted to them is still at risk for withdrawal after birth. Most experts feel that this risk is justified. "As a society, if we're thinking about the trade-off, it is much better to get Mom into treatment, for her health and her infant's health, and then have some risk of neonatal abstinence syndrome," said Dr. Stephen Patrick, a neonatologist at Vanderbilt University Medical Center. Compared with other babies in the neonatal intensive-care unit, "for the most part, infants with neonatal abstinence syndrome are just not that sick."

Symptoms of withdrawal in newborns range from relatively benign indicators like yawning, sneezing, mottled skin and a high-pitched cry to more serious problems like diarrhea, difficulty feeding and, very rarely, seizures. Doctors can't predict which babies will develop the syndrome, although factors like maternal smoking, anti-anxiety drugs and antidepressants have been shown to increase the likelihood. Although there are common practices, there is no uniform protocol on how to diagnose or treat NAS; morphine, methadone and buprenorphine are all currently given to newborns, while some doctors believe that, except in extreme cases, swaddling and skin-to-skin contact with the mother are sufficient. Nor has it been determined what, if any, long-term effects NAS might have on a child; the first longitudinal study, a multisite N.I.H. study begun in 2014, in which 117 babies treated for NAS will receive developmental tests at 18 months, is still underway.

Addiction is now widely recognized as a medical disorder, and the medical establishment and communities are more likely to treat people with drug dependency as victims of an illness. But this more generous spirit rarely extends to pregnant women in the grip of addiction, who are still widely seen as perpetrators. In 24 states and the District of Columbia, the use of any illegal substance during pregnancy constitutes child abuse, and in Minnesota, South Dakota and Wisconsin, it is grounds for civil commitment: court-ordered institutionalization — say, to a drug-treatment program — regardless of the woman's wishes or needs (using a drug once doesn't mean she is addicted to it). In just the past few months, authorities in Oklahoma and Montana have announced new initiatives to prosecute pregnant women who use drugs or alcohol. In Alabama, according to a report by ProPublica and AL.com, at least 479 pregnant women were prosecuted — and some imprisoned — between 2006 and 2015 under the "chemical endangerment" law originally aimed at parents who risked their children's lives by cooking methamphetamine at home.

This results in a crazy quilt of punitive approaches to

pregnant women with drug problems, which vary arbitrarily by region, county and local politics. In New Jersey, a woman on methadone was charged with child abuse in 2011 because her baby had NAS — an entirely predictable outcome of following the standard of care. In Wisconsin, a pregnant woman who told her doctor she had successfully weaned herself off painkillers was forced onto methadone in 2013 by a skeptical judge who decided she still needed treatment — thus needlessly putting her baby at risk for NAS.

Widespread horror at the thought of newborns in withdrawal has led, some experts feel, to a cultural overreaction reminiscent of the "crack baby" hysteria of the late 1980s and early 1990s, which wildly overstated the negative effects cocaine would have on the children of pregnant women who smoked it. "Crack moms" were nearly always represented as African-American, adding racism to the mix of distortions at play in that perceived crisis. Race has worked the opposite way in our current epidemic — indeed, the perception of our opioid crisis as an epidemic, rather than a racial pathology, owes much to the fact that white Americans have been hard hit. But pregnant women are often treated especially harshly. As Lynn Paltrow, executive director of National Advocates for Pregnant Women, put it, "Pregnant women are perceived as their own special class of persons, entitled to fewer constitutional and human rights." Race and class biases may be active here, too. In a 2013 study by Paltrow and a co-author, low-income and African-American women were more likely than other women to be arrested for possibly causing harm to their fetuses during their pregnancies.

Health experts deplore the societal impulse to blame and punish drug-dependent women who find themselves pregnant because it discourages them from seeking treatment — even in the 19 states where a publicly funded drug-treatment program specifically for pregnant women exists. Not only does inhibiting a woman from treatment harm both fetus and mother, they say, it also squanders a rare opportunity to intervene constructively in a woman's addiction. "Sometimes a pregnancy is when women see past their own traumas to have that clarity to move forward," Dr. Lauren Jansson, director of pediatrics at the Center for Addiction and Pregnancy at Johns Hopkins, told me. "Treatment works, and especially for this population. They have a lot to gain." ❖

Source: Children of the Opioid Epidemic by Jennifer Egan; New York Times Magazine, May 9, 2018.

Fighting for Our Communities: Overcoming the Opioid Crisis

Highlights from a report issued by U.S. Representative Suzanne Bonamici, April 2018.

For the full report go to:

https://bonamici.house.gov/sites/bonamici.house.gov/files/documents/FightingforOurCommunities_OvercomingtheOpioidCrisis.pdf

Across the country and here in Northwest Oregon, communities are experiencing the tragic and often deadly emergency of opioid abuse. During the past few months, I have met with parents, health care professionals, community leaders, veterans, and people from all walks of life who have shared heart-wrenching stories about how the opioid crisis is taking lives and inflicting pain on Oregon families.

The Oregon Health Authority found that Oregon has one of the highest rates of opioid misuse in the nation; about three Oregonians die each week from prescription opioid overdose. The heartbreak and suffering behind these numbers is staggering.

Many factors have contributed to this crisis, and it will take significant efforts to overcome it. Local, state, and federal officials must cooperate to address this epidemic and stem the loss of lives. The private sector, non-profits, and our health care system also have a role to play, and in some cases are already leading the way.

In this report I outline my priorities moving forward. One thing is clear: changing policy alone won't stop the crisis. We also need more resources for prevention, treatment, and innovative solutions.

This report addresses five topics that we discussed in the listening sessions and in which policy changes and funding can make a significant difference: Prevention; Treatment and Recovery; Pain Management; Innovation; and Disposal.

• Prevention: Raising Awareness and Stopping Addiction Before It Begins

More education and awareness are needed regarding the effects of opioid use and abuse on adolescent brain development, and a promising study at OHSU should help us better understand this issue.

• Treatment and Recovery: Expanding Treatment to Serve Everyone in Need

The opioid crisis continues to grow, and we are already failing to offer treatment to everyone who needs it. Medicaid reimbursement and even some private insurance reimbursement rates are too low to cover the true costs of running a safe, supportive, 24-hour-a-day facility.

Medication-assisted treatment with medications like methadone, buprenorphine, or naltrexone can be a critical part of the treatment and recovery puzzle. Unfortunately, there have been unnecessary limits on the kind of providers who can offer this treatment and the number of patients they can treat at one time. More must be done to increase the availability of medication-assisted treatment.

Sometimes in the depths of crisis we are given the opportunity to improve as a society. In listening to people in recovery and those working on the front lines, it's clear that our country's punitive approach to addiction has failed, and in many cases even inflicted more harm. We must commit to developing a more compassionate approach to addiction and to recognizing the humanity and dignity of every person, including those struggling with substance abuse.

To fully take on and overcome the opioid crisis, we must address the provider shortage. We need more providers serving in addiction medicine, and more providers in primary care who will help meet the needs of people struggling with addiction.

• Pain Management: Treating Pain More Effectively and Reducing Pills in Circulation

Although opiates are still necessary for treating pain in some circumstances, they were overprescribed for too long and to too many patients. Studies demonstrate that alternative pain treatments like physical therapy, acupuncture, massage, and mindfulness are effective treatments for some patients, yet many insurance plans do not cover these services or adequately reimburse for them.

• Innovation: Developing New Solutions

Every day researchers and scientists are expanding on our knowledge of opioid addiction and developing new solutions. We must apply emerging knowledge to address the crisis.

•Disposal: Addressing the Opioid Crisis by Increasing Safe Disposal Options

One issue came up repeatedly at my community discussions: the lack of available disposal options for opioids and other prescription drugs. We must make it easy to safely dispose of unused medications. ❖

Open Invitation to Contribute

WCADIO's Mission is to increase public awareness of women's alcohol and drug abuse issues and to promote services related to women throughout the State of Oregon. This means to **ALL** women who are affected by their own alcohol or drug use or that of their family or friends.

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