White Paper: Opioid Use, Misuse, and Overdose in Women

Table of Contents

Executive Summary

This reportwas developedas apart ofan initiative supported by the U.S. Department of Health and Human Services (HHS) Office on Women's Health (OWH) to examine the prevention, treatment, and recovery issues for womenwho misuse, have use disorders, and/or overdoseopioids. The White

What Does the Opioid EpidemicMean for Women?

There is growing recognition that the United States is facing epidemicdue to an increase in opioid misuse, use disorderand overdose,and thatdisparitiesexistbetween men and women

What Does the HHS Opioid Initiative Mean for Women?

On March 26, 2015, HHS Secretary Sylvia M. Burwell announced a department-wide initiative focused on combatting the opioid epidemic.[18] The HHS Opioid Initiative focuses on three priority areas:

"Opioid prescribing practices to reduce opioid use disorders and overdose,

The expanded use of naloxone, used to treat opioid overdoses,

Expanded use of Medication

The prevalence of prescription opioid use among women is substantial, and the hazards of opioid use are similarly great. /2015 CDC

Exhibit 2: CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing }• P š} Hñì u}Œ‰ Z]v u]oo]PŒ u ‹µ]À o vš• ~DD •l ÇU v •Z}µo À}]]v Œ • Œ (µooÇ iµ•š](Ç]•]}v š} š]šŒ š }• P š} Hõì DD l ÇX
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history

In February 2016, the American Pain Society released a clinical practice guideline similar to the CDC Guideline, but focused on post-surgical pain management.[37, 38] The American Pain Society's post-surgical guideline includes recommendations to limit use of opioids to manage post-operative pain. The guideline also discusses the need for education aimed at correcting misperceptions including "that opioids are always required for postoperative pain, or that opioid use inevitably leads to addiction."[39] Although the recommendations do not focus specifically on women, they do include guidance around opioid use following cesarean sections, as well as discussion of the need to educate parents and caregivers about issues around post-operative pain management for children, such as assessing pain and concern about OUD

The Surgeon General also recently launched a national campaign called "Turn the Tide Rx" which encourages improved prescribing practices and acknowledges the role of clinicians in addressing the opioid epidemic. The campaign seeks to educate and mobilize prescribers to take immediate action to stem the opioid epidemic, provide patients with information to protect themselves and their families from opioid misuse and overdose, learn from communities around the country that are finding creative ways to tackle the epidemic, and change the cultural perceptions about addiction so that it is not seen as a moral failing but a chronic illness.[40] The website, s.04 TrET /ArtifactTj 0.9(c)1.1(t th)1 Tw -30.435 -1.402 cn 3

Increasing Use of Naloxone for Women

Naloxone is a medication called an "opioid antagonist" used to reverse the physical effects of opioid overdose.

Limitations on the number of patients a provider can treat at one time are designed to ensure that each patient receives high-quality care, appropriate behavioral health services, care coordination, continuity during emergencies, and that risk of diversion is minimized.[53] Additionally, the Comprehensive Addiction and Recovery Act of 2016 includes a provision that, for the first time, allows physician assistants and nurse practitioners to prescribe buprenorphine.[54]

The evidence of the effectiveness of MAT is overwhelmingly positive.[55, 56, 57] However, despite a 2015 Practice Guideline from the American Society of Addiction Medicine that focuses on the use of medications in the treatment of substance use disorder involving opioid use (ASAM National Practice Guideline) [illegible]

has issued guidance about the types of services that should be included in comprehensive MAT for women, such as:

> "Special groups to address problems of pregnant women who are opioid addicted
> Available treatments for women addicted to opioids, including pharmacotherapies
> Education and discussion groups on parenting and childcare
> Special groups and services for children and other family members
> Couples counseling
> Case management and assistance in locating safe, affordable housing."[66]

In future sections, we explore these and other elements of the opioid epidemic and their specific effect on women.

Adverse childhood experiences are limited not only to physical and sexual abuse, but may also include other forms of trauma including emotional abuse, neglect, substance use disorders among family members, mental illness in the home, separation/divorce of parents, an incarcerated household member, or having a mother who was treated violently.[89] The CDC's Adverse Childhood Experiences Study has demonstrated a strong relationship between adverse childhood experiences and a variety of negative health outcomes including smoking, alcohol, and harmful drug use.[90]

Women are also more likely than men to have co-occurring mental and substance use disorders. For women, anxiety disorders and major depression have been associated with substance use disorders and are typically the most common co-occurring diagnoses. In addition to depression and anxiety, studies have identified common comorbidities to also include PTSD, eating disorders, and phobia with or without panic attacks.[91, 92]

Women typically report they use substances more often to cope with negative emotions.[93] Research has demonstrated that trauma followed by PTSD tends to be more commonly seen in drug-using women than men who are seeking treatment.[94] Therefore, health care and other service providers should be aware of and understand trauma theory, and how to provide or refer to trauma-informed services for their clients.[95] In addition, prevention strategies to eliminate exposure to trauma in childhood and adulthood should be considered an important part of a comprehensive approach to substance use disorders.

Social Determinants and Demographics

Factors such as geography, race/ethnicity and socioeconomic status are also determinants for rates of opioid use and misuse in U.S. women. Although these factors are often generally correlated with rates of opioid use and misuse, some differences appear to exist between genders. Understanding trends can help target prevention programming, treatment efforts and monitoring efforts.

Geography

Opioid prescribing rates vary widely across the U.S. When controlling for gender, rates are generally highest in Appalachia, along with counties in Southern and Western states.
hn3.2(e7(s)-4.3(ehs)-4.3(t)-6(a)-)-2.8(n12 72e7(s)-4.3a1.402 Td [(hp(o)-5.3(-)-2act (A)-1.1(p)-h/CS1 cs9(e7(s)-4

eei2 -1.4

Mountains. Similar to the trends for death rates from drug overdose for women, rising to pregnant women is also high (280%) in the Midwest, South, and northern New England. Discussed later in the "Women as Family Caregivers and Parents" section, opioid use during pregnancy is particularly risky as it potentially affecr26c 0.003 Tw 0 11 Tc Access to prescription opioids, overdose deaths, and other factors outbreak0 1 Ts.

98

Source: Desai et a. "Increae in Prescription Opioid Use During Pregnancy-Eoed Wo
http:/www.ncbi.nlm.nih.g12 -1ov/pmc/articles12 -1/PMC4020039/

Reasons for geographic differences cannot be explained by differences in health of the population a there is no significant evidence to show that w.12 -1n- related issues than others. Intead the differences may be accounted for by a lack of conensus of when it is appropriate .12 -1 prescribe opioid pain relievers. A CDC Director, D0 1 Tr. Tom Frieden, tated in 014, "We'0 17

Medicaid 2006-2007

prevention, care, education, and research. In response to the report, the HHS Assistant Secretary for

Adolescents

In 2015, 3.9% (n=969,000) of adolescents age 12 to 17 misused pain relievers in the last year. More than half of those adolescents who misused pain relievers in the last year are female (n=518,000). Further, 122,000 of adolescents age 12 to 17 had a prescription pain reliever substance use disorder in the last year.[152] The rates for prescribing opioids to adolescents age 15 to 19 nearly doubled from 6.4% to 11.2% between 1994 and 2007.[153] Though doctors typically have the ability to prescribe medication as they see

65 and older, 19% of men and 23% of women take at least five prescription drugs.[165] In addition, the use of opioids may be associated with a range of side effects including constipation, nausea, and dizziness. The use of opioids is also known to increase the risk of falls in this population.[166] Health professionals may treat patients for falls, however, rather than exploring the underlying cause of the falls such as OUD. Health professionals need to explore the possibility of opioid use as they assess the reasons for an older adult's fall. In general, OUD often goes unrecognized and untreated in this age group and research on treatment of substance use disorders for this population is limited.[167]

Recently Incarcerated Women

In 2014, 1,508,600 individuals were sentenced to more than one year in state and federal facilities. Of those, 109,200 were women.[168] According to data from the U.S. Department of Justice, approximately half of state and federal prisoners meet the DSM-IV criteria for substance use disorders.[169] Though the need for safe and effective detoxification or continuing medication-assisted treatment for opioid use disorders is appropriate for these individuals, studies have found that these types of services are infrequently available. The majority of jails report that they do not provide medications for opioid detoxification and those that do often do not use evidence-based practices.[170] Failure to provide safe and effective detoxification, treatment and counseling for incarcerated individual's dependence on heroin also puts them at high risk for HIV and viral hepatitis transmission through unsafe injection in prisons and possible loss of tolerance after detoxification that could result in fatal overdoses, and recidivism upon release.[171]

Incarcerated women have additional risk when entering jails and prisons with substance use disorders. At any given time, approximately 6% to 10% of incarcerated women are pregnant, many of these women first learn they are pregnant when they enter into a correctional facility.[172] For these women, as discussed previously, it is especially important that they receive medication-assisted treatment and counseling.[173]

Exploring Issues in Treatment: Research and Promising Practices

Unique Needs to Women in Treatment

In general, there tends to be a lack of substance use disorder treatment to meet overall demand, particularly in rural areas, and this is particularly true for opioid use disorders.[174, 175, 176, 177] Looking at treatment for both men and women, approximately 96% of states, including the District of Columbia, have opioid use or dependent rates higher than their treatment capacity rates.[178] Many states are also already operating at significant capacity; 38 states (77.6%) have at least 75% of their OTPs operating at 80% capacity.[179] According to SAMHSA's 2014 National Survey of Substance Abuse Treatment Services

(N-SSATS), 44% of treatment programs provided special programs or groups for adult women and only 20% offered programs or groups for pregnant or postpartum women.[180] Analysis of data from over 50,000 participants in the National Survey on Drug Use and Health found that among prescription opioid users, men reported significantly higher rates of treatment utilization (11% lifetime, 5% past year) as compared to women (6% lifetime, 3% past year).[181] The reasons are not well understood, although the N-SSATS research suggests a lack of services for women may play a role. When women do enter treatment for substance use disorder, they typically present with medical, behavioral, psychological, and social problems that are generally more severe than for men, suggesting a need for gender-specific treatment approaches.[182]

Women as Caregivers and the Impact on Treatment

Many women who are in caregiving roles often will not seek treatment or do not complete treatment because they are unable to manage their caregiving responsibilities and participate in treatment programs at the same time. Women with children may also fear that their children will be removed from their custody. In addition, t

payment reforms appropriate for a robust SUD system. The goal of the IAP initiative is to help participating states to better identify individuals with SUD, enhance provider capacity to effectively treat individuals with SUD, and expand coverage for promising and evidence-based SUD services, such as

based on the CDC Guideline.[201] Similarly, almost 200 nursing schools and more than 50 pharmacy schools have committed to requiring prescriber training in their educational programs. Beginning in fall 2016, participating schools of nursing will require advanced practice registered nursing students to take some form of prescriber education in line with the CDC guideline by the time they graduate. Colleges and schools of pharmacy will also provide education in their curricula on overdose interventions and how to counsel patients on appropriate use of naloxone.[202]

In addition, CDC is offering a suite of tools and resources to ensure distillation of the information within the CDC Guideline into practical and implementable tools to assist providers. For example, CDC has developed a clinical decision making checklist as well as a webinar series to provide a training opportunity for clinicians to learn about the recommendations within the Guideline and how they can be implemented within practice.

Opportunities for Research and Evaluation

While this paper explores what is known about the opioid epidemic and describes promising practices towards addressing opioid prevention and treatment among women, it also identifies numerous areas that are less well understood and can serve as a platform for further research and evaluation. There is emerging knowledge about the many factors that affect a woman's diagnosis of OUD, including biological and social influences, past experiences, geography, and demographic characteristics, but more needs to be learned about each aspect of this path. As more is learned about factors of opioid misuse that are specific to women, evidence-based successful strategies aimed towards prevention and treatment for women can be evaluated and shared across the numerous stakeholders who have an opportunity to prevent and treat this deadly epidemic. As noted in the introduction, this paper and the September 2016 HHS OWH meeting provide an opportunity to bridge knowledge and gaps among researchers, public health practitioners, and other stakeholders by creating opportunities to share best practices and promising approaches and identify areas for further research and evaluation. Potential key areas for further exploration include:

Studying approaches to best train providers to help prevent and treat, and assess for related health outcomes such as HIV, viral hepatitis, and overdose risk.

Approaches and Opportunities for Moving Forward

Hazardous and deadly opioid misuse, including prescription opioids and heroin, is increasing at alarming rates for both men and women in the United States. While the epidemic is being addressed at many different levels, much still needs to be done, including special efforts designed to address the unique needs of women. As discussed above, the prevalence of prescription opioid use among women is substantial, and the hazards of opioid use are similarly great. Even in areas where differences are

Appendix:HHS Work in Support of the Secretary's Initiative

Many HHS agencies have taken multiple concrete steps this year to support the Secretary's targeted initiative aimed at reducing prescripti

Seek guidance from outside experts in the fields of pain management and drug abuse including the National Academies of Sciences, Engineering, and Medicine, which has been asked to help develop a framework for opioid review, approval and monitoring that balances individual need for pain control with considerations of the broader public health consequences of opioid misuse and abuse.

Convene independent advisory committees composed of physicians and other experts when considering any new opioid drugs for approval that do not contain abuse deterrent properties.

Convene a meeting of the Pediatric Advisory Committee to make recommendations regarding a framework for pediatric opioid labeling and use of opioid pain medications in the pediatric population.

Strengthening the requirements for drug companies to generate post-market data on the long-term impact of using extended release/long acting opioids to create comprehensive data in the field of pain medicine and treatments for OUD. The data will further the understanding of the known serious risks of opioid misuse, overdose and death.

Health Resources and Services Administration (HRSA)

HRSA/Bureau of Health Workforce

HRSA awards grants to academic institutions to increase the number of behavioral health providers in medically underserved areas, which will increase access to substance use treatment. For example, as part of the President's *Now Is The Time* initiative, HRSA is partnering with SAMHSA to expand the behavioral health workforce by supporting clinical training for behavioral health professionals. This activity, the Behavioral Health Workforce Education and Training Program, awarded $44.5 million in 2016. Additionally, the Graduate Psychology Education (GPE) Program supports academic programs to prepare psychologists to provide behavioral health care, including substance abuse prevention and treatment services to underserved and/or rural populations. For 2016, GPE distributed $7.9 million in awards.

National Institutes of Health (NIH)

NIH supports a robust portfolio of research and other programs that align with the three priority areas of the Secretary's Opioid Initiative as described below.

Improved Opioid Prescribing Practices to Reduce Opioid Use Disorders and Overdose:

Improved Pain Treatment

The NIH Pain Consortium was established to enhance pain research and promote collaboration among researchers across the many NIH Institutes and Centers that have programs and activities addressing pain. The Consortium, along with its federal partners on the Interagency Pain Research Coordinating Committee, developed the National Pain Strategy, which was released on March 18, 2016 and outlines actions for improving pain care in America.
NIH is funding the development of the first open-access, no-cost, clinically based, retrospective and prospective chronic pain data registry. The registry will identify pain-management interventions that are most effective for specific patient types with chronic pain.

coordinated care, and evidence-based medication assisted treatment (MAT) and recovery support services to individuals with OUDs seeking or receiving MAT. The goal of the funding is to:

- increase the number of individuals receiving MAT services with pharmacotherapies approved by the FDA for the treatment of OUDs;
- increase the number of individuals receiving integrated care;
- decrease illicit opioid drug use at six-month follow-up; and
- decrease the use of prescription opioids in a non-prescribed manner at six-month follow-up.

SAMHSA expects up to $11 million will be available each year to provide up to 11 grants of up to $1 million each for states using a certified Electronic Health Record (EHR) system or planning to certify their currently non-certified EHR system. States not using a certified EHR system or not planning to certify their EHR system can receive up to $950,000 a year.

In July 2016, SAMHSA also finalized a rule to increase access to buprenorphine to allow a greater number of individuals to be treated for

Other HHS Resources

Fact Sheet: Medication Trea

ASAMCommittee Opinion: Opioid Abuse, Dependence, and Addiction in Pregnancy

[11] Prescription Painkiller Overdoses. (2011). Retrieved from /TJ /TC /LE/Artifact >>ABDC 0 84(e891.0 269. 0 T2 73 W fTC /L /Arr

[22] National Institute on Drug Abuse. Research Report Series "Prescription Opioids and Heroin: A Subset of People who Abuse Prescription Opioids May Progress to Heroin Use." December 2015. Available at https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-abuse-heroin-use/subset-users-may-naturally-progress-rx-opioids-to-heroin

[23] CDC Wonder. Atlanta, GA: Centers for Disease Control and Prevention, 2015. http://wonder.cdc.gov/

[55] Addiction Treatment Forum. MAT with Methadone or Burprenorphine: Assessing the Evidence for Effectiveness. February 01, 2014. http://atforum.com/2014/02/mat-with-methadone-or-buprenorphine-assessing-the-evidence-for-effectiveness/ Accessed October 31, 2016.

[56] Fullerton CA, Kim M, Thomas CP, et al. Medication-assisted treatment with methadone: assessing the evidence. *Psychiatric Services*. 2014 Feb 1;65(2):145-57. doi: 10.1176/appi.ps.201300235.

[57] Thomas CP, Fullerton CA, Kim M, et al. Medication-assis

[66] Center for Substance Abuse Treatment. Chapter 13—Medication-Assisted Treatment for Opioid Addiction During Pregnancy. In: Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville, MD: Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.) http://www.ncbi.nlm.nih.gov/books/NBK64148/#

[67] Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 51.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK83252/

[68] Jones H, Goler N, Werner D. Women's Health, Wellness, and Recovery: An Introduction to Women's Substance Use Disorders and Health [webinar]. May 6, 2015. In the Substance Abuse and Mental Health Services Administration's Women Matter! series. Retrieved from: http://www.samhsa.gov/women-children-families/trainings/women-matter.

[69] Jones H, Goler N, Werner D. Women's Health, Wellness, and Recovery: An Introduction to Women's Substance Use Disorders and Health [webinar]. May 6, 2015. In the Substance Abuse and Mental Health Services Administration's Women Matter! series. Retrieved from: http://www.samhsa.gov/women-children-families/trainings/women-matter.

[70] Brady, KT.; Back, SE.; Greenfield, SF., editors. *Women and Addiction: A Comprehensive Handbook*. New York, NY: Guilford Press; 2009.

[71] Back, SE, Lawson, K, Singleton, L, and Brady, KT. Characteristics and Correlates of Men and Women with Prescription Opioid Dependip5.

[77] Shiffman S, Rathbun SL. Point process analyses of variations in smoking rate by setting, mood, gender, and dependence. *Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors*. 2011;25(3):505-10. doi:10.1037/a0022178.

[78] Back, SE, Lawson, K, Singleton, L, and Brady, KT. Characteristics and Correlates of Men and Women with Prescription Opioid Dep

[101] PDMP Center of Excellence. Brandeis University. Use of PDMP Data by Opioid Addiction Treatment Programs. February 2015. http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Use%20of%20PDMP%20data%20by%20opioid%20treatment%20programs.pdf. Accessed October 31, 2016.

[102] Schrager A.

[112] Lê Cook B, Alegría M. Racial-Ethnic Disparities in Substance Abuse Treatment: The Role of Criminal History and Socioeconomic Status. Psychiatric services (Washington, DC). 2011;62(11):1273-1281. doi:10.1176/appi.ps.62.11.1273.

[113] Substance Abuse and Mental Health Services Administration. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Treatment Improvement Protocol (TIP) Series 54. HHS Publication No. (SMA) 14-4671. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. http://store.samhsa.gov/shin/content/SMA14-4671/TIP54.pdf. Accessed June 9, 2016.

[114] Nahin, RL. Estimates of pain prevalence and severity in adults: United States, 2012. J

[125] Hayden JA, van Tulder MW, Malmivaara A, Koes BW. Exercise therapy for treatment of non-specific low back pain. *Cochrane Database Syst Rev*. 2005;3:CD000335

[126] Weinstock J, Barry D, Petry NM. Exercise-related activities are associated with positive outcome in contingency management treatment for substance use disorders. *Addictive Behaviors*. 2008;33(8), 1072–1075. doi: 10.1016/j.addbeh.2008.03.011

[127] McCracken LM, MacKichan F, Eccleston C. Contextual cognitive-behavioral therapy for severely disabled chronic pain sufferers: Effectiveness and clinically significant change. *European Journal of Pain*. 2007;11(3), 314–322. doi: 10.1016/j.ejpain.2006.05.004

[128] Thorn, BE, Pence LB, Ward LC, et al. A randomized clinical trial of targeted cognitive behavioral treatment to reduce catastrophizing in chronic headache sufferers. *Journal of Pain*. 2007; 8(12), 938 949. doi: 10.1016/j.jpain.2007.06.010

[129] Magill M, Ray LA. Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*. 2009; 70(4), 516–527.

[130] The Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services. National Pain Strategy. The Interagency Pain Research Coordinating Committee Web site. https://iprcc.nih.gov/National_Pain_Strategy/NPS_Main.htm. Published March 2016. Accessed October 31, 2016.

[131] Women and Caregiving: Facts and Figures. Family Caregiver Alliance National Center on Caregiving Web site. www.caregiver.org/women-and-caregiving-facts-and-figures Accessed October 31, 2016.

[132] Jones H, Goler N, Werner D. Women's Health, Wellness, and Recovery: An Introduction to Women's Substance Use Disorders and Health [webinar]. May 6, 2015. In the Substance Abuse and Mental Health Services Administration's Women Matter! series. Retrieved from http://www.samhsa.gov/women-children-families/trainings/women-matter.

[133] Jones H, Goler N, Werner D. Women's Health, Women erf EMC d 133 ferner D. --

136

[149] Final Recommendation Statement: Hepatitis B in Pregnant Women: Screening. U.S. Preventive Services Task Force. October 2014. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-in-pregnant-women-screening

[150] An Opt-Out Approach to HIV Screening. CDC Web site. http://www.cdc.gov/hiv/group/gender/pregnantwomen/opt-out.html. Updated March 23, 2016. Accessed October 3

[161] Research Report Series: Prescription Drug Abuse. NIDA Web site. https://www.drugabuse.gov/sites/default/files/prescriptiondrugrrs_11_14.pdf. Accessed October 31, 2016.

[162] Neumark-Sztainer D. *I'm, Like, SO Fat!: Helping Your Teen Make Healthy Choices about Eating and Exercise in a Weight-obsessed World*. Guilford Press; 2005.

[163] Sullivan MA. Prescription Opioid Addiction and Chronic Pain in Older Adults [webinar]. Providers' Clinic Support System for Opioid Therapies Web site. http://pcss-o.org/wp-content/uploads/2014/10/Prescription

[172] Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion No. 511American College of Obstetricians and Gynecologists

[183] Substance Use in Women. National Institute on Drug Abuse website https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/summary Updated July 2015. Accessed May 27, 2016.

[184] Jones H, Goler N, Werner D. Women's Health, Wellness, and Recovery: An Introduction to Women's Substance Use Disorders and Health [webinar]. May 6, 2015. In the Substance Abuse and Mental Health Services Administration's Women Matter! series. http://www.samhsa.gov/women-children-families/trainings/women-matter

[185] National Drug Control Strategy. Office of National Drug Control Policy website https://www.whitehouse.gov/sites/default/files/ondcp/ndcs2011.pdf. Accessed May 27, 2016.

[186] Women and Treatment. Office of National Drug Control Policy website https://www.whitehouse.gov/ondcp/women-treatment. Accessed May 27, 2016.

[187] Drug courts. County Health Rankings & Roadmaps website http://www.countyhealthrankings.org/policies/drug-courts. Updated October 19, 2016. Accessed October 31, 2016.

[188] Werner, D., Young, N.K., Dennis, K., & Catetti, S. Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007.

[189] Exodus. SHIELDS for Families website. https://www.shieldsforfamilies.org/exodus/ Accessed October 31, 2016.

[190] The Center for Medicaid and CHIP Services. Medication Assisted Treatment for Substance Use Disorders [informational bulletin]. July 11, 2014. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf Accessed October 31, 2016.

[191] Moses K, Klebonis J. Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States [brief]. January 2015. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-for-opiod-dependency.pdf Accessed October 31, 2016.

[192] The Centers for Medicare & Medicaid Services. Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction [CMCS informational bulletin]. January 28, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf. Accessed October 31, 2016.

[193] Substance Abuse and Mental Health Services Administration, *Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders*. HHS Publication No. SMA-14-4854. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. http://store.sa8cooid Use Dial

[204] CMS Finalizes Hospital Outpatient Prospective Payment Changes for 2017 [press release]. November 1, 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2016-Fact-sheets-items/2016-11-01-3.html. Accessed December 16, 2016.

[205] The Centers for Medicare & Medicaid Services. Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction [CMCS informational bulletin]. January 28, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf. Accessed October 31, 2016.

[206] Adler-Milstein J, Lin SC, Jha AK. The number of health information exchange efforts is declining, leaving the viability of broad clinical data exchange uncertain. *Health Affairs*. 2016; 35(7): 1278-1285. doi: 10.1377/hlthaff.2015.1439

[207] Primary Care and Public Health Initiative. CDC Web site. http://www.cdc.gov/primarycare/materials/opoidabuse/index.html. Updated September 16, 2016. Accessed October 31, 2016.