Statewide Drug Policy Advisory Council (DPAC)

Public Meeting

Public Meeting Book

August 28, 2024

Statewide Drug Policy Advisory Council (DPAC) Meeting

Wednesday, August 28, 2024
2:00 p.m. EST

Location: 4052 Bald Cypress Way, Conference Room 301, Tallahassee, FL 32311

Meeting details can be found at
http://floridahealth.gov/DPACMeeting

AGENDA

Topic	Topic Facilitator / Presenter
Welcome/Opening Remarks	Joseph A. Ladapo, MD, PhD State Surgeon General Florida Department of Health
Approval of May 22, 2024, Meeting Minutes	DPAC Members
Drugs Identified in Deceased Persons 2023 Interim Report	Brett Kirkland, PhD Chief of Policy and Special Programs Medical Examiners Commission Florida Department of Law Enforcement
Treatment of Opioid Use Disorder in Pregnancy Presentation	Kay Roussos-Ross, MD Professor and Chief Departments of OBGYN and Psychiatry University of Florida
Break	
Review and Updates of Recommendations 7-10	Jon Conley Strategic Initiatives Manager Florida Department of Health
Agency and Member Updates	DPAC Members
Public Comment	
Next Steps Adjournment	Joseph A. Ladapo, MD, PhD

Statewide Drug Policy Advisory Council
Meeting Minutes
May 22, 2024

Meeting Location:
Florida Department of Health
4052 Bald Cypress Way, Room 301
Tallahassee, FL 32399, and

Meeting Time:
3:00 – 5:00 p.m
Virtual Meeting via Microsoft Teams

Welcome/Introductions

Melissa Jordan, MS, MPH, Assistant Deputy Secretary for Health, Florida Department of Health, served as Chair, as the Designee of State Surgeon General Joseph Ladapo.

Staff proceeded with roll call.

The following members or designees were in attendance:

Melissa Jordan, MS, MPH, Florida Department of Health (DOH)
Joe Spataro for Ashley Moody, Office of the Attorney General (OAG)
Kristen Shipp Brennan for Mark Glass, Department of Law Enforcement (FDLE)
Jeffrey Cece, MS, CPM for Shevaun Harris, Department of Children and Families (DCF)
Maggie Agerton for Ricky Dixon, Department of Corrections (DOC)
Joy Bennink for Eric Hall, Ed.D., Department of Juvenile Justice (DJJ)
Jonathan Stephens for Manny Diaz, Jr., Department of Education (DOE)
Captain Derrick Rahming for Dave Kerner, Department of Highway Safety and Motor Vehicles (DHSMV)
Major David Rodriguez for Major General John Haas, Department of Military Affairs (DMA)
Doug Simon, Governor's Office of Policy and Budget (OPB)
Sheriff Peyton Grinnell, Governor Appointee: Drug Enforcement, Lake County Sheriff's Office (LCSO)
Ramon Maury for Peggy Sapp (Governor Appointee: Substance Abuse Prevention, Informed Families)
Melanie Brown-Woofter (Governor Appointee: Substance Abuse Treatment, Florida Behavioral Health Association (FBHA)
Colonel Chris Rule for Sheriff Chad Chronister, Governor Appointee: Expertise in Drug Enforcement and Substance Abuse Programs and Services, Hillsborough County Sheriff's Office (HCSO)
Sheriff Chris Nocco, Governor Appointee: Expertise in Drug Enforcement and Substance Abuse Services, Pasco Sheriff's Office (PSO)
Aaron Gerson for Judge Steve Leifman, 11th Judicial Circuit Court of Florida

Guests and Staff:

Yolanda Bonds, DOH
Deborah Babin
Nancy Castillo
Ashley Chern, DOH
Jeanette Cherubini, DCF
Jon Conley, DOH
David Devries, DCF
Maggie Dilger, DOH
Jesseka Forbes, ACHA
Ala Orr
Thomas Palacio
Nathan Hipps
Jennifer Johnson, FBHA
Lynnora Elaine Planter Longley
Tina Pettingill (Groups Recover Together)
Mary Prim, DOH
Lisa Rawlins
Scott Tucker, Advent Health

Opening Remarks
The Chair reviewed the agenda, noting there would be no presentations due to a scheduling change. She highlighted that the week before the May 22, 2024, meeting was SAMHSA's National Prevention Week, promoting substance use prevention and mental health.

She also shared the following updates:

- June 6, 2024, is Revive Awareness Day, raising awareness about opioid antagonists like naloxone.
- Emergency response agencies can enroll at FLoridaHealth.gov/HEROS to receive naloxone through the HEROS program.
- The CORE Network (FLCORENetwork.com) treats substance use disorder with continuous care, similar to other diseases.

Business

1. **Review and Approval of Meeting Minutes from February 29, 2024:**
   - The Council approved the Minutes with no opposition.

2. **Review and Updates of Recommendation 1-6:**
   - DOH staff led the discussion for 2023 Recommendations 1-6 and invited revisions for 2024. Here is a high-level summary of the discussion:

Recommendation	Details
Recommendation 1: Strengthening the Workforce for Mental Health and Substance Abuse Disorder Services	Suggested collaboration with the Physicians Workforce Advisory Council to address workforce issues. **Noted initiatives in support of the workforce issues:** • The Live Healthy Act for social work and behavioral health staffing. • Coordination with the Mental Health Commission. • Creation of behavioral health teaching hospitals partnering with state university medical schools. • Increased interest in the Drug Demand Reduction Outreach program.
Recommendation 2: Develop ongoing Substance-Use Prevention Strategy for Youth 12-17	Chair proposed a presentation from The Facts. Your Future. Campaign. Requested feedback on trauma-related programs from agencies. Council member offered to contact mental health specialists.
Recommendation 3: Engage in an evidence-based substance use prevention program designed to reduce drug use among youth 12–17 years of age	Highlighted similarities to Recommendation 2. Staff is streamlining language for the Annual Report, to combine recommendations 2 and 3.
Recommendation 4: Regulation of Kratom-Based Products	Discussed goals related to kratom-based products and planned future presentations.
Recommendation 5: Transfer of Care and Naloxone Provision	DCF explained new guidelines for direct dispensing of naloxone, along with proposed technical assistance for hospitals on safe distribution of medications.

	ACHA offered to research existing programs on warm handoff or education. There was mention of the FOCUS program, which is a public health initiative that enables partners to develop and share best practices in routine blood-borne virus and mention of recent pharmacy expansions for HIV screening and treatment. Suggesting providing Medication Assisted Treatment (MAT) bridge programs through pharmacies.
Recommendation 6: Support equal Coverage for Mental Health and Substance Use Disorders in Medical Insurance Policies	No additional feedback provided.

3. Agency and Member Updates:

Key Themes	Details
Combating Illegal Drug Activity:	• FDLE, FDOT, and DHSMV collaborating on Operation Lone Star and Vigilant Century to curb the influx of illegal drugs, particularly fentanyl, into Florida. • HCSO continues to succeed in opioid overdose prosecutions and is launching a new interdiction unit to target fentanyl trafficking. • PCSO highlighted the success of its partnership with federal agencies to enhance interdiction efforts.
Enhanced Resources and Support:	• DMA received increased funding for its Counterdrug program, significantly boosting recovery resources and equipment. • DJJ ensures naloxone availability across detention centers and other juvenile facilities, with trained staff to administer it. They also provide Medication-Assisted Treatment (MAT) as needed.
Mental Health and Awareness:	• FBHA celebrated Mental Health Awareness Month with various activities, emphasizing the importance of housing in healthcare for those in recovery. • Upcoming Behavior Health conference aims to continue raising awareness and provide extensive educational opportunities.
Collaborative Efforts:	• Multiple agencies highlight the importance of collaboration at both state and local levels, working together to enhance drug interdiction and recovery programs. • Informed Families and DCF are focusing on prevention messaging, with updates on fund allocations for campaigns like The Facts. Your Future.

Notable Agency Activities:

- FDLE: Engaged in investigations and operations to combat illegal fentanyl activity.
- DHSMV: Partnering with various agencies for border control and executing operations focused on drug confiscation.
- DMA: Received funding boost for Counterdrug program and provided substantial resources to support recovery efforts.

- FBHA: Highlighted Mental Health Awareness Month activities and announced the Behavior Health Conference.
- HCSO: Success in opioid overdose prosecutions and launching a new fentanyl interdiction unit.
- PSO: Noted the importance of long-term recovery plans and partnerships with federal teams for effective drug interdiction.
- DJJ: Noted naloxone availability in all juvenile centers and provided access to MAT.

4. Public Comments/Open Discussion:
No public comments were received.

5. Adjournment:
The Chair announced that the date for the next Council meeting will be announced and publicly posted soon.

The meeting was adjourned at 4:02 p.m.

Drugs Identified in Deceased Persons by Florida Medical Examiners

2023 Interim Report

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

PUBLISHED JULY 2024

Medical Examiners Commission Members

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Chairman
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Joshua Stephany, M.D.
District 9/25 Medical Examiner

Honorable Charlie Cofer, J.D.
Public Defender, Fourth Judicial Circuit

Robin Giddens Sheppard, L.F.D.
Vice President/Funeral Director, Hardage-Giddens Funeral Home

Kenneth T. Jones
State Registrar, Department of Health

Nick Cox, J.D.
Office of the Attorney General

Amira Fox, J.D.
State Attorney, 20th Judicial Circuit

Honorable Robert "Bob" Johnson
Sheriff, Santa Rosa County

Honorable Michael A. Barnett
County Commissioner, Palm Beach

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January – June 2023

- **117,361** deaths occurred in Florida during the first six months of 2023.
- Of the deaths investigated by medical examiners, toxicology results determined that one or more of the drugs listed below were present at the time of death in **7,412** cases. **6.3%** of Overall Deaths
- Medical Examiners measure deaths in two ways:
  - Drug death- the drug **caused** the death
  - Drug occurrence-at least once drug is **present** in the decedent
- **The vast majority of the 7,412 cases (decedents) had more than one drug occurrence.**

Data were collected on the following 42 drugs:

Amphetamines
- Amphetamine
- Methamphetamine

Benzodiazepines
- Alprazolam
- Chlordiazepoxide
- Clonazepam
- Diazepam
- Lorazepam
- Midazolam
- Nordiazepam
- Oxazepam
- Temazepam

Ethanol
- Ethyl Alcohol

Hallucinogenics
- Phencyclidine (PCP)/ PCP Analogs
- Phenethylamines/ Piperazines
- Tryptamines

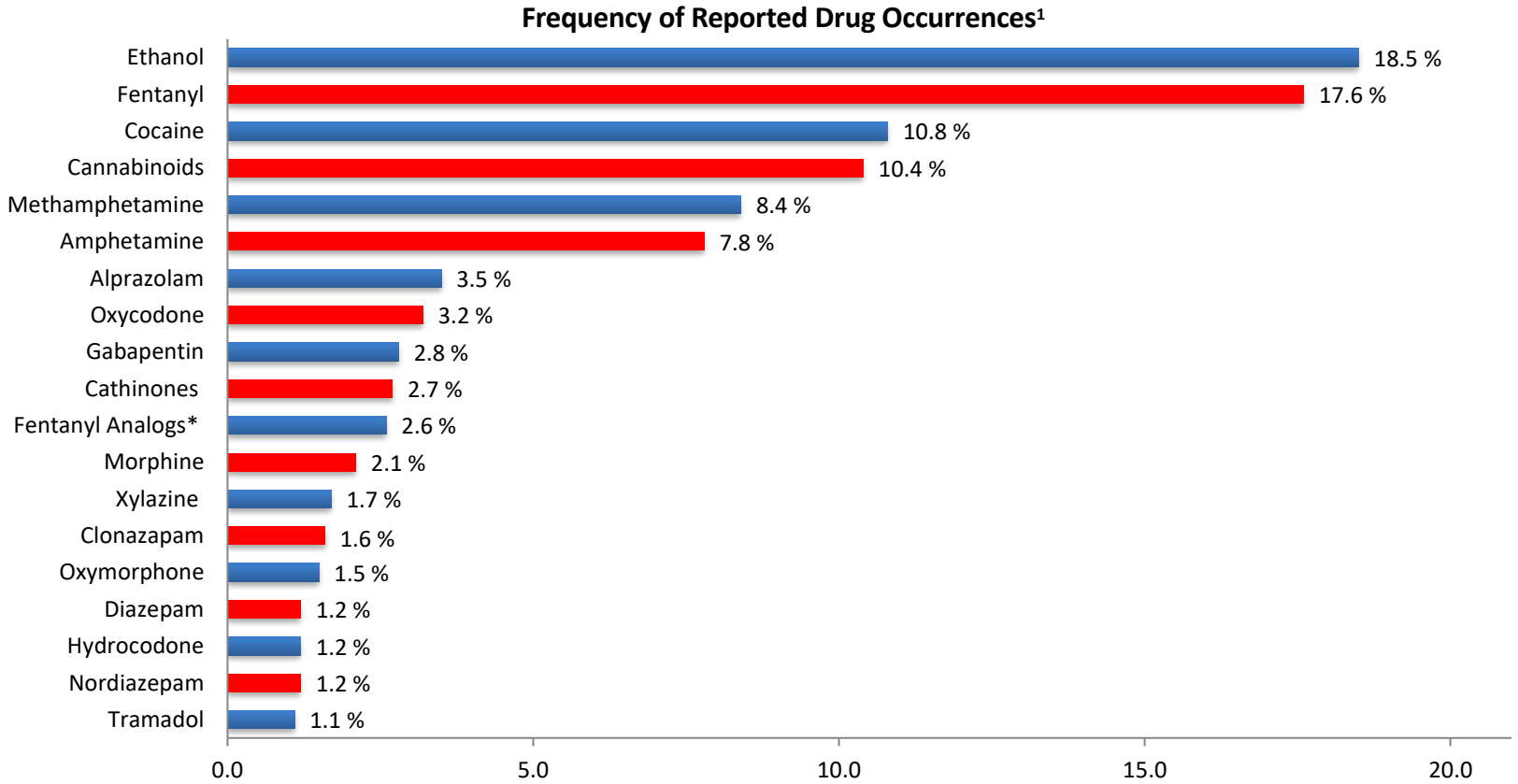
Inhalants
- Halogenated
- Hydrocarbon

Opioids
- Buprenorphine
- Codeine
- Fentanyl
- Fentanyl Analogs
- Heroin
- Hydrocodone
- Hydromorphone
- Methadone
- Morphine
- Oxycodone
- Oxymorphone
- Tramadol
- U-47700

Other
- Cannabinoids
- Carisprodol/Meprobamate
- Cathinones
- Cocaine
- GHB
- Gabapentin
- Ketamine
- Mitragynine
- Sympathomimetic Amines
- Synthetic Cannabinoids
- Xylazine
- Zolpidem

General Statewide Trends

- Total drug-related deaths decreased by **7%** (533 less) when compared with the first six months of 2022.
- **3,640 opioid-related** deaths were reported, which is a **11% decrease** (470 less).
- **2,783 opioid-caused** deaths were reported, which is a **10% decrease** (321 less).
- **4,241** individuals (**10% decrease**, 485 less) died with one or more prescription drugs in their system.
- **3,836** individuals (**10% decrease**, 301 less) died with at least one prescription drug in their system that was identified as the cause of death.

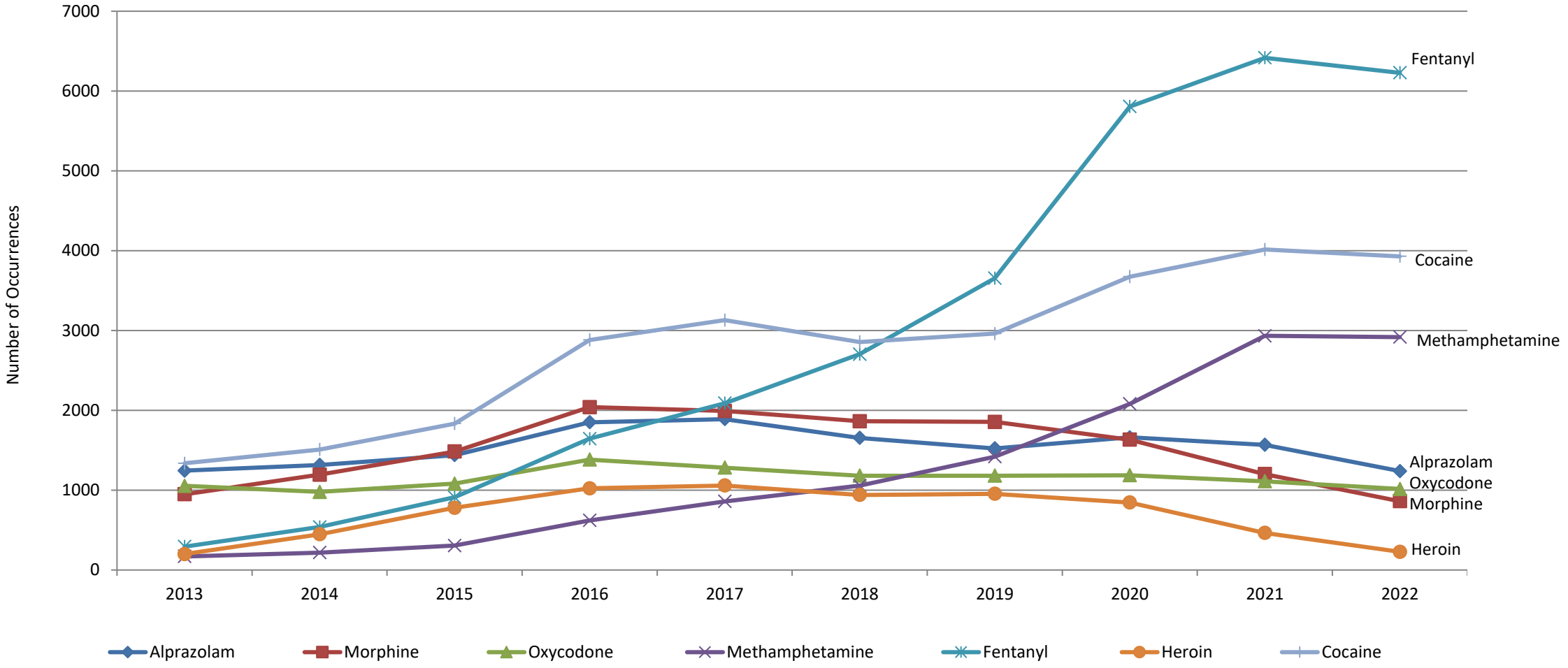


[1]The following drugs individually constituted less than one percent of drug frequencies and are not included: chlordiazepoxide, lorazepam, midazolam, oxazepam, temazepam, all hallucinogenics, all inhalants, buprenorphine, carisoprodol/meprobamate, codeine, GHB, heroin, ketamine, methadone, mitragynine, sympathomimetic amines, synthetic cannabinoids, U-47700 and zolpidem. Note: Percentages may not sum to 100 percent because of rounding.

*Does not include 4-ANPP.

Historical Overview of Alprazolam, Morphine, Oxycodone, Methamphetamine, Fentanyl, Heroin, and Cocaine Occurrences

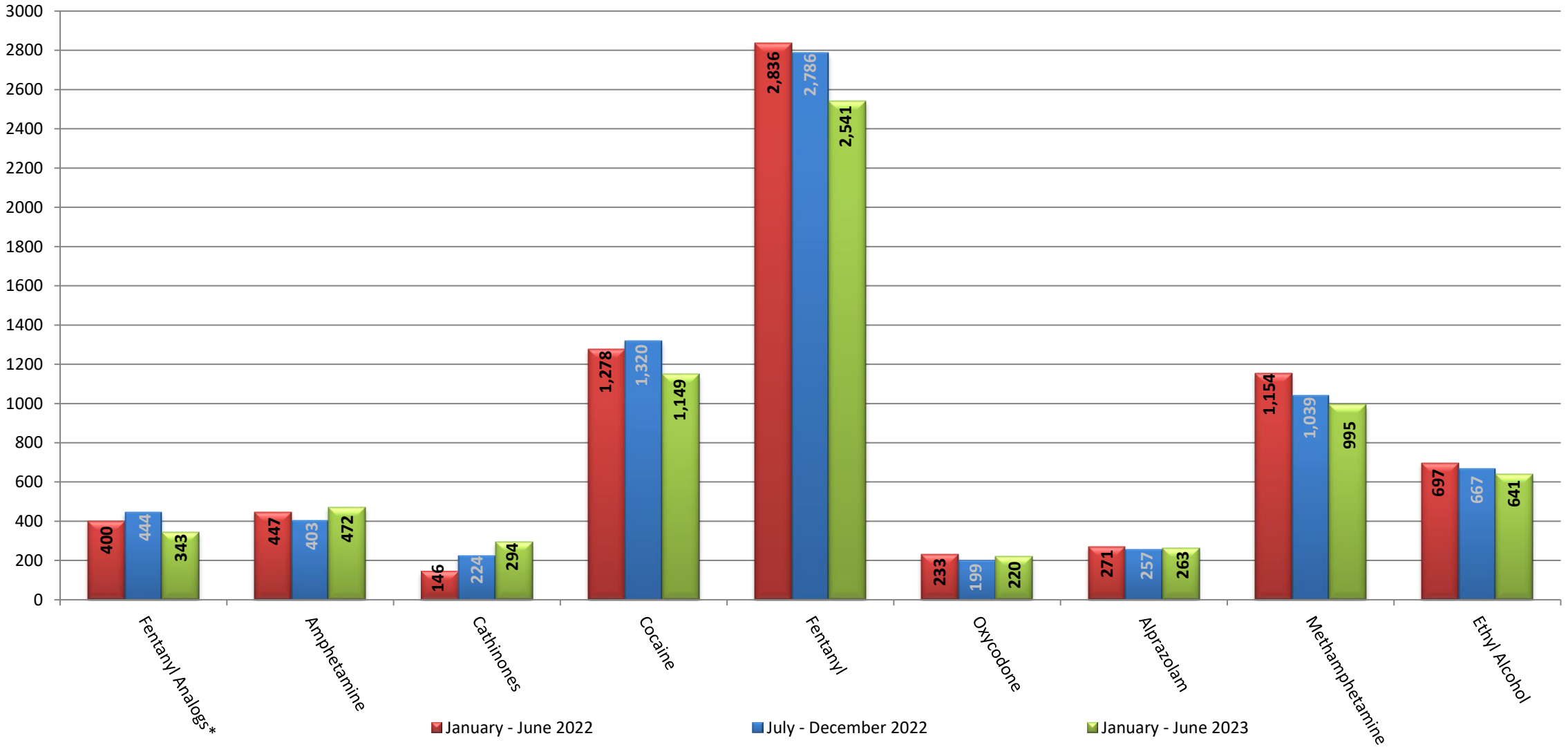
(Present and Cause)
2013 to 2022



Drug Caused Deaths

The drugs that caused the most deaths were fentanyl (2,541), cocaine (1,149), methamphetamine (995), ethyl alcohol (641), benzodiazepines (437, including 263 alprazolam deaths), amphetamine (472), fentanyl analogs (343) and cathinones (294).

* Does not include 4-ANPP

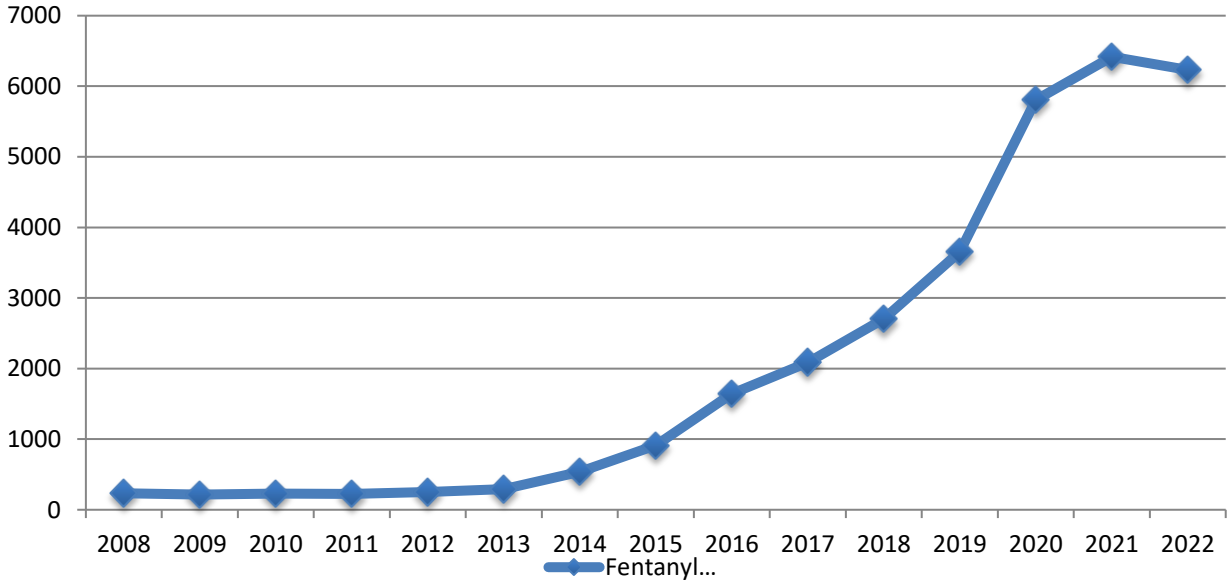


Fentanyl Deaths

Occurrences of ↓ **10%** and deaths caused by ↓ **10%**.

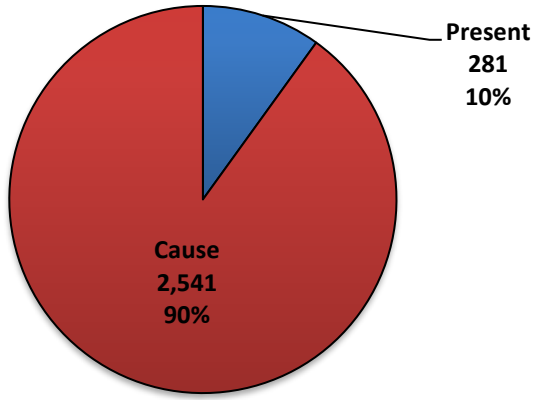
Historical Overview of Fentanyl Occurrences[1]

(Present and Cause)
2008 to 2022



[1]Prior to 2016, the number of fentanyl occurrences indicated includes occurrences of fentanyl analogs. Starting in 2016, fentanyl analogs were tracked separately.

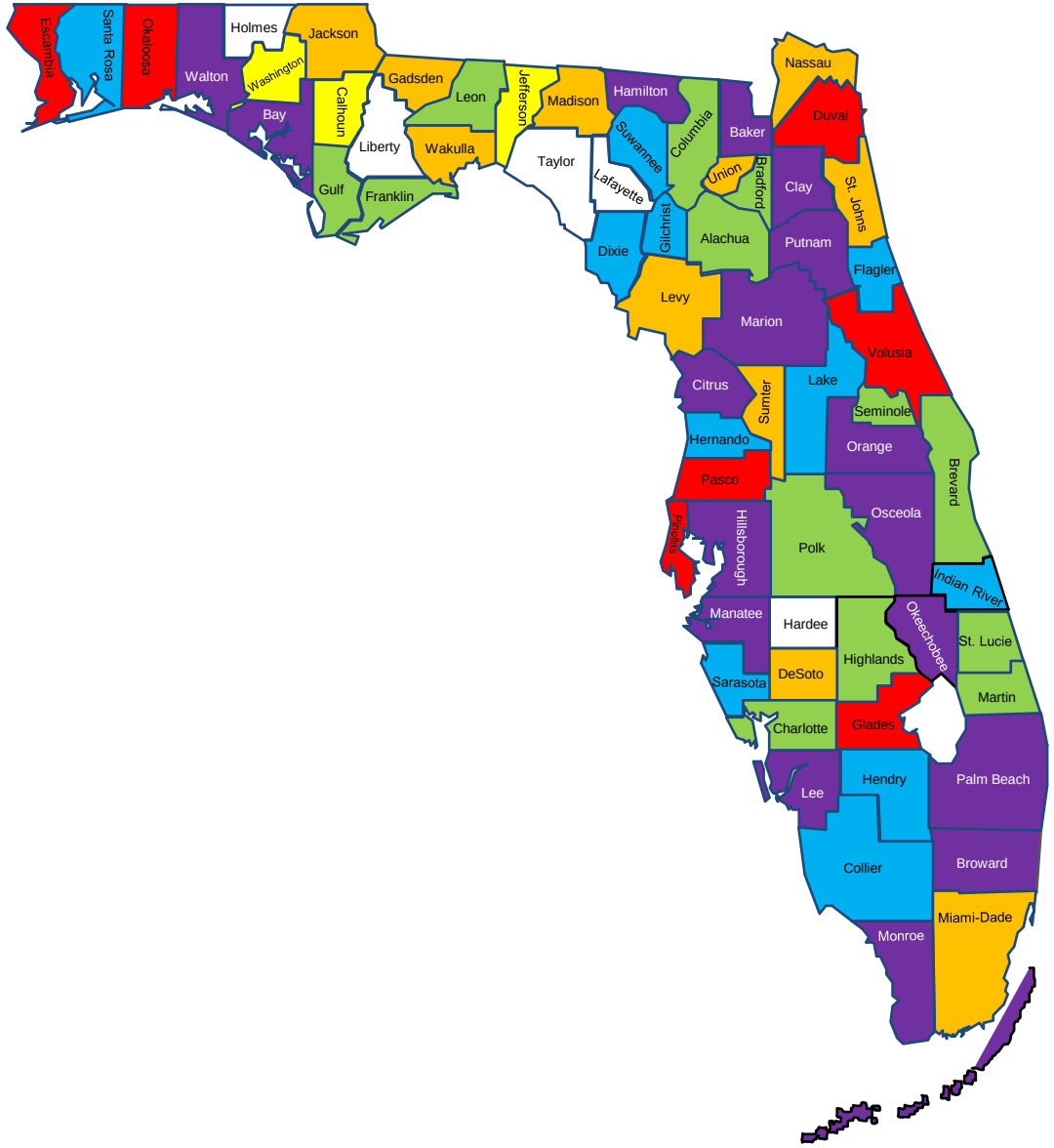
Fentanyl Deaths
Total Occurrences = 2,822



While fentanyl is a prescription drug, data indicates that at least **86%** of fentanyl occurrences were illicitly obtained.

Fentanyl Deaths by County

2022



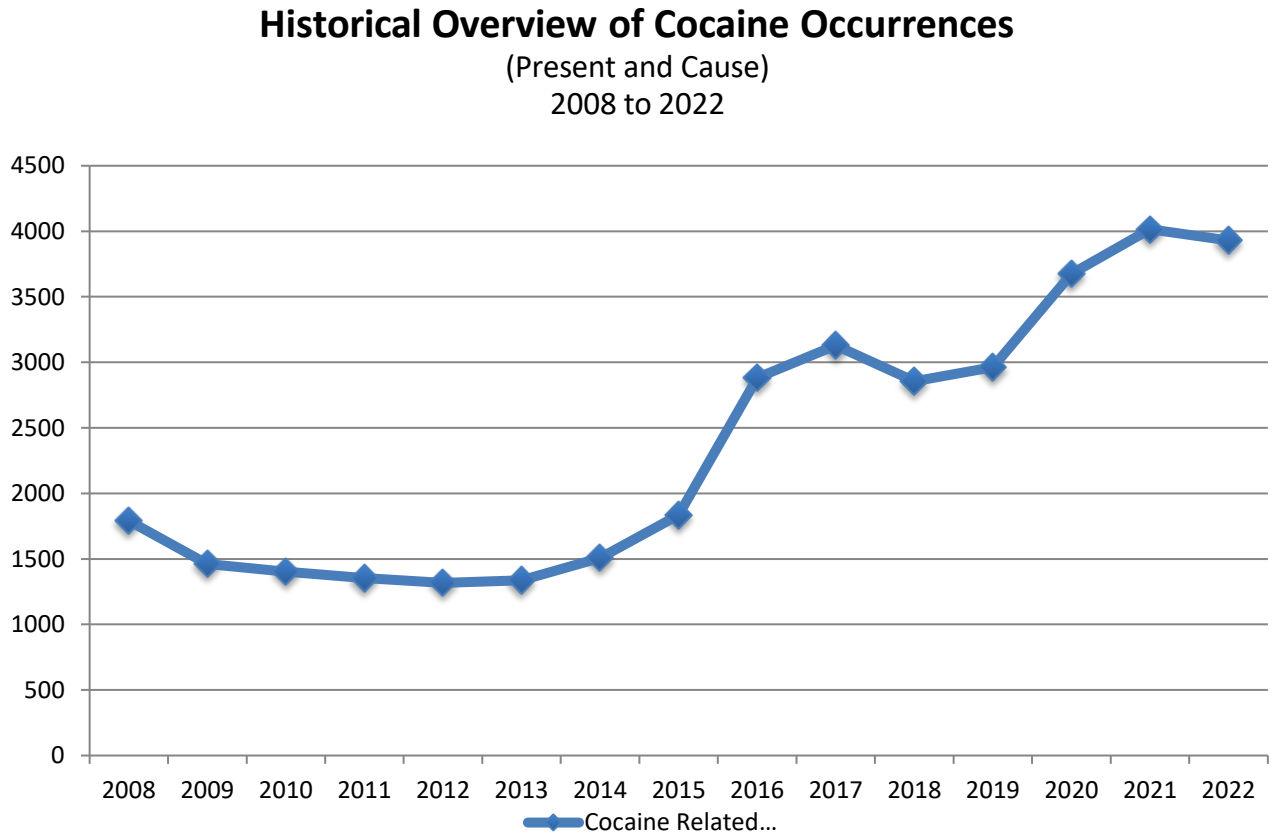
Occurrences
Per 100,000 Population

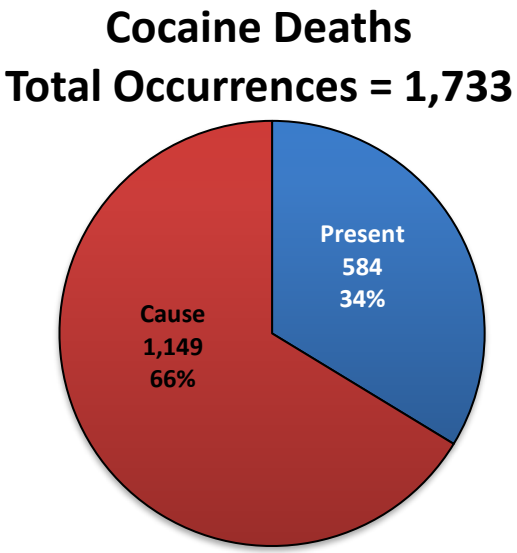
- 0 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- 25.00 - 39.99
- > 40.00

Due to the amount of cases the number ranges were altered.

Cocaine Deaths

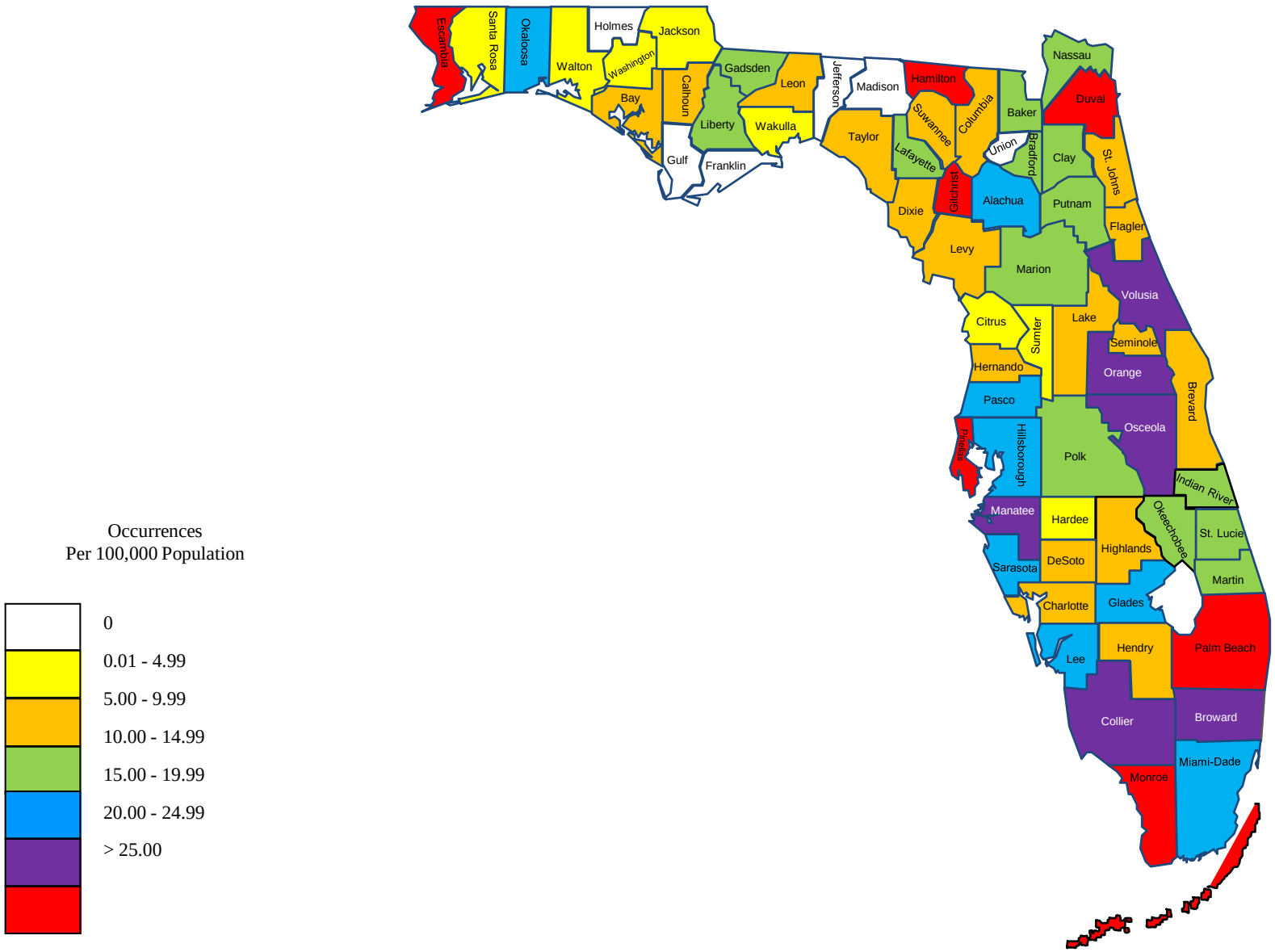
Occurrences of ↓ 12% and deaths caused by ↓ 10%.





Cocaine Deaths by County

2022



Occurrences
Per 100,000 Population

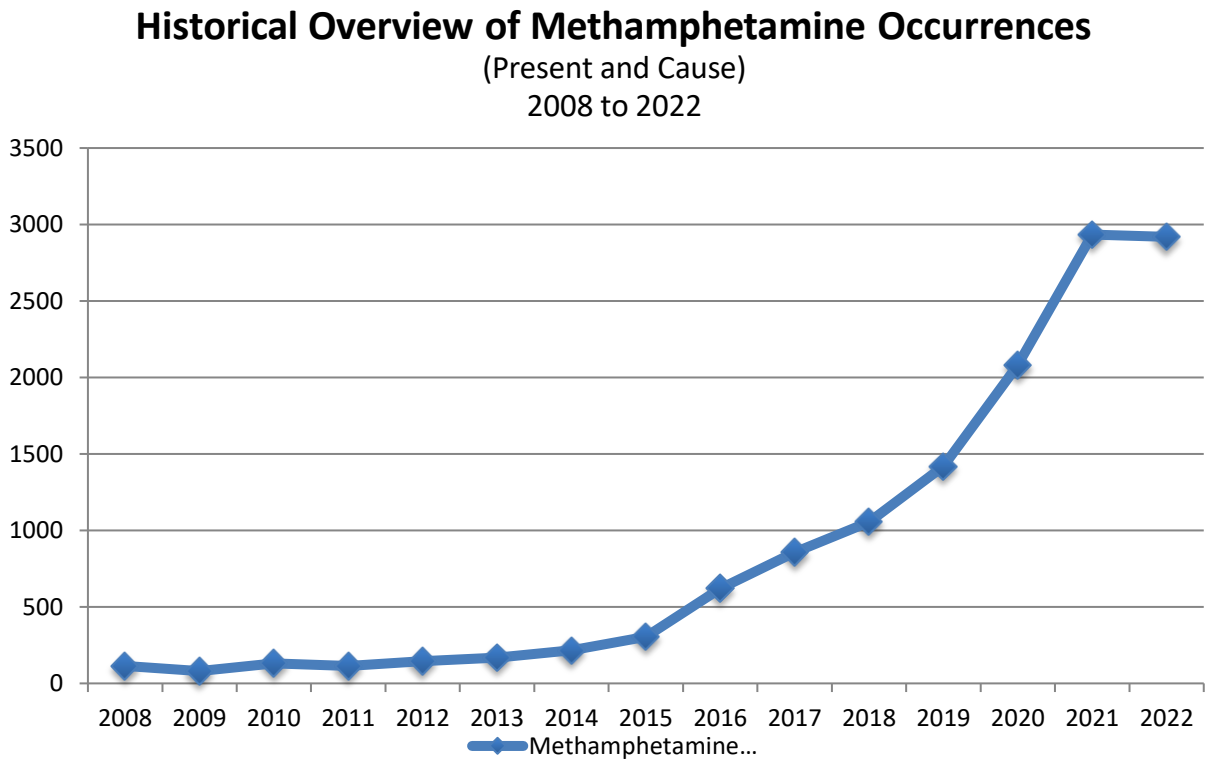
- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

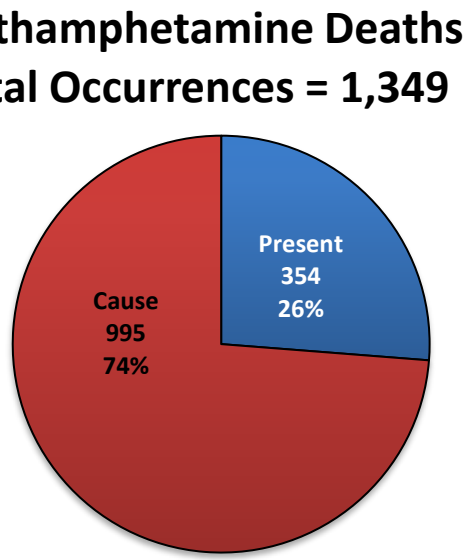
A

Methamphetamine Deaths

Occurrences of ⬇ **11.5%** and

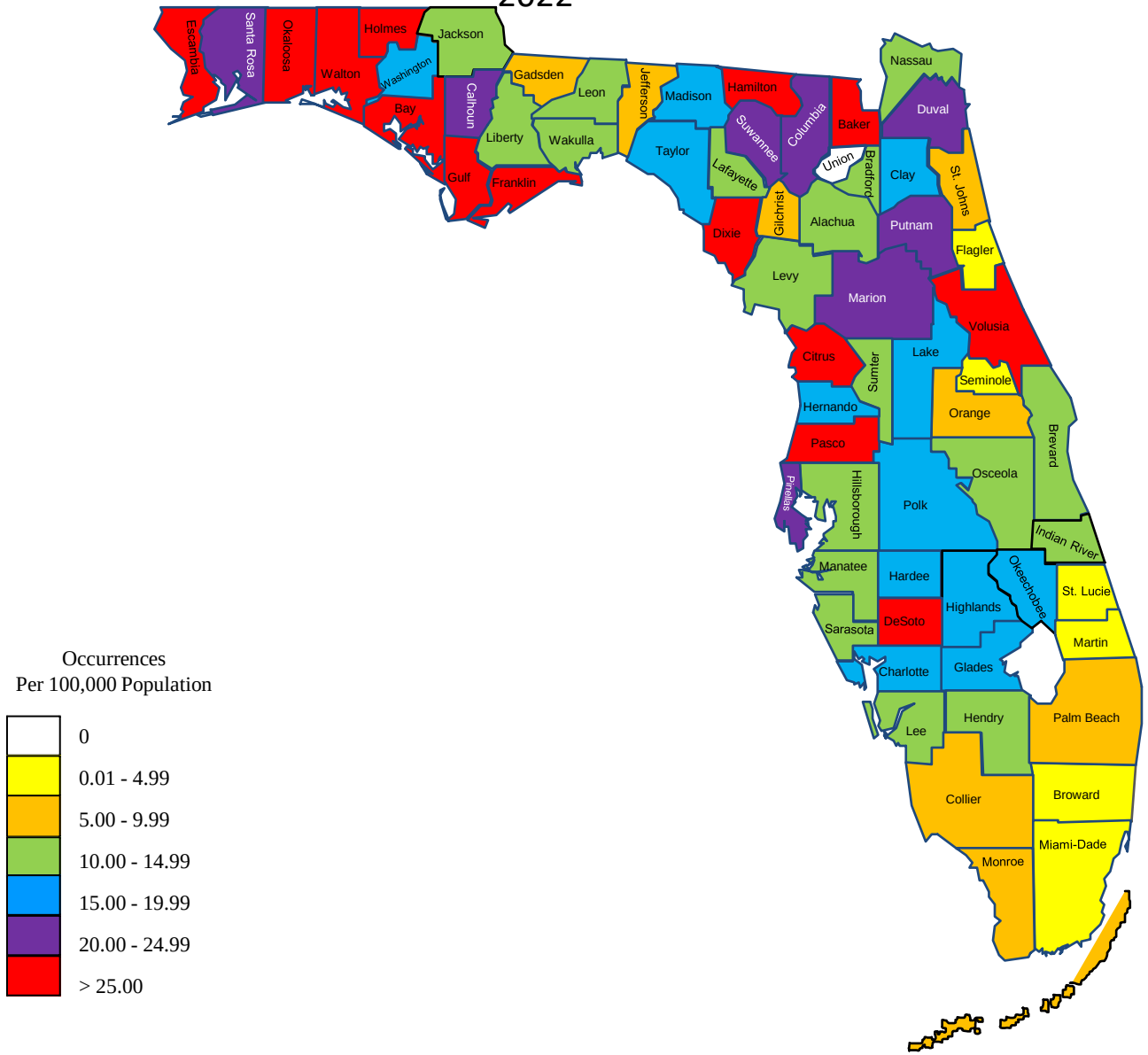
deaths caused by ⬇ **14%.**





Methamphetamine Deaths by County

2022



Occurrences
Per 100,000 Population

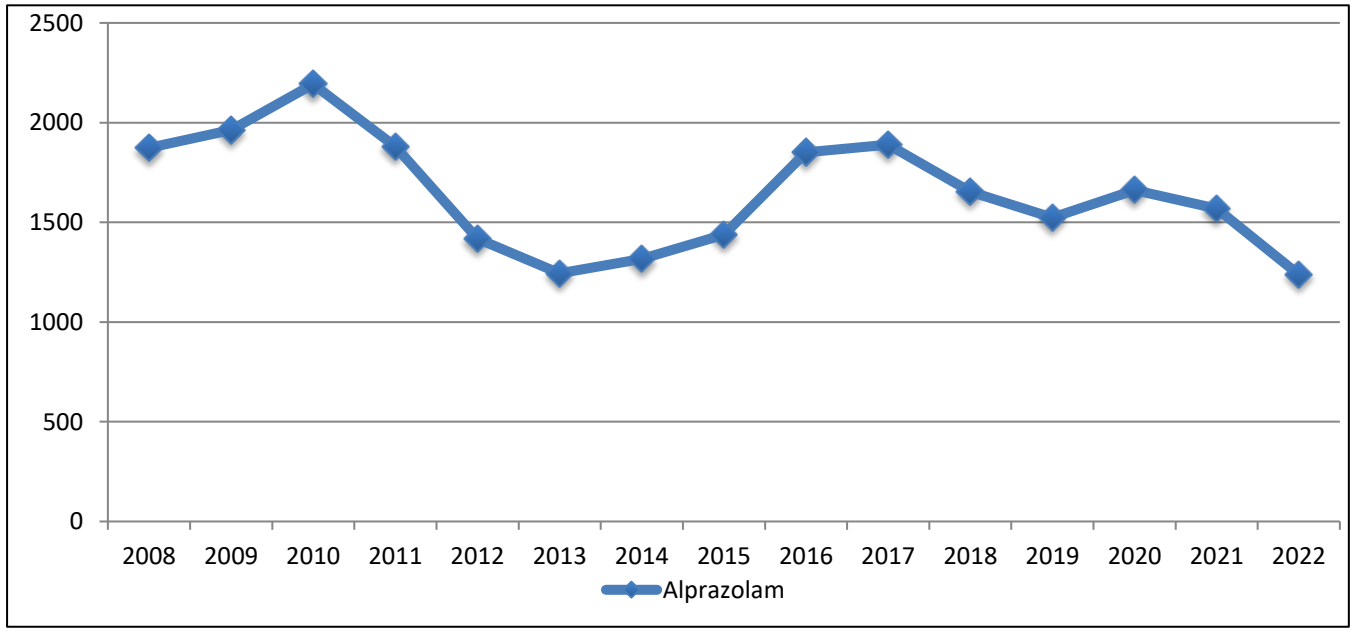
- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

B

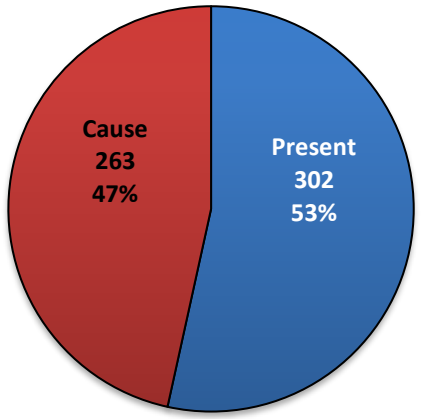
Alprazolam Deaths

Alprazolam (Xanax) continues to dominate the category of benzodiazepines even though occurrences ↓ 16%

Historical Overview of Alprazolam Occurrences
(Present and Cause)
2008 to 2022

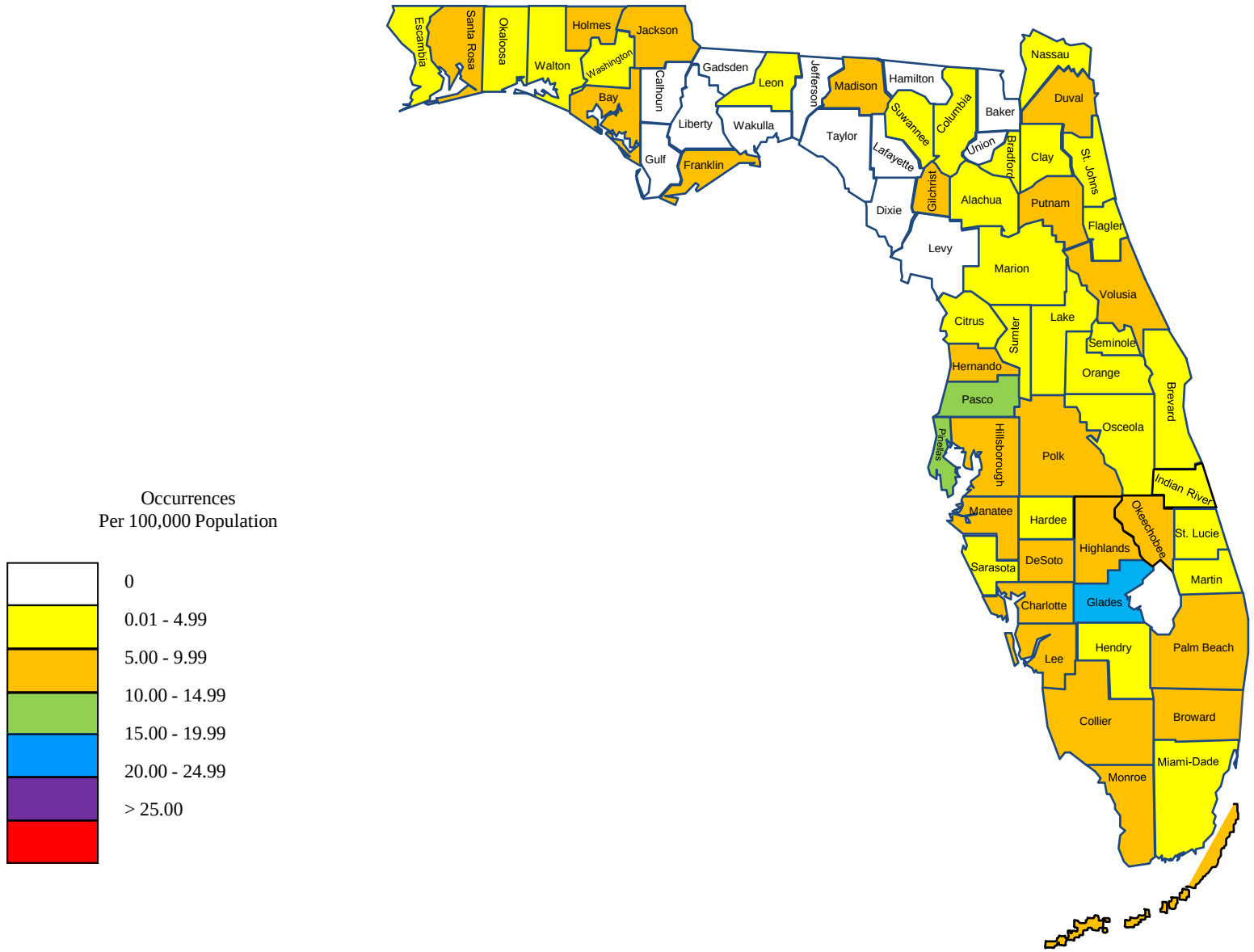


Alprazolam Deaths
Total Occurrences = 565



Alprazolam Deaths by County

2022



Occurrences
Per 100,000 Population

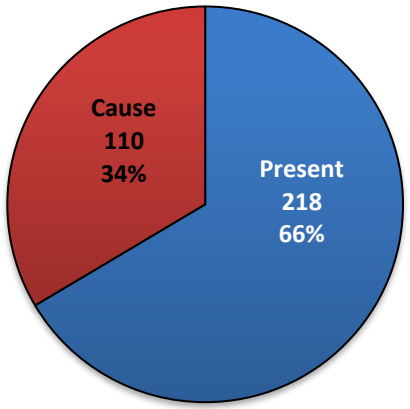
- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

O

Morphine Deaths

Morphine was the fourth most occurring opioid with 328 occurrences, a **31%** decrease.

Morphine Deaths
Total Occurrences = 328

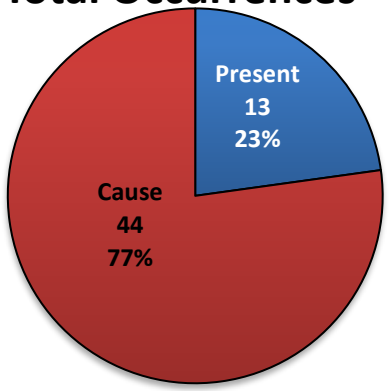


*Since heroin is rapidly metabolized to morphine, this may lead to a substantial over-reporting of morphine-related deaths as well as significant under-reporting of heroin-related deaths.

Heroin Deaths

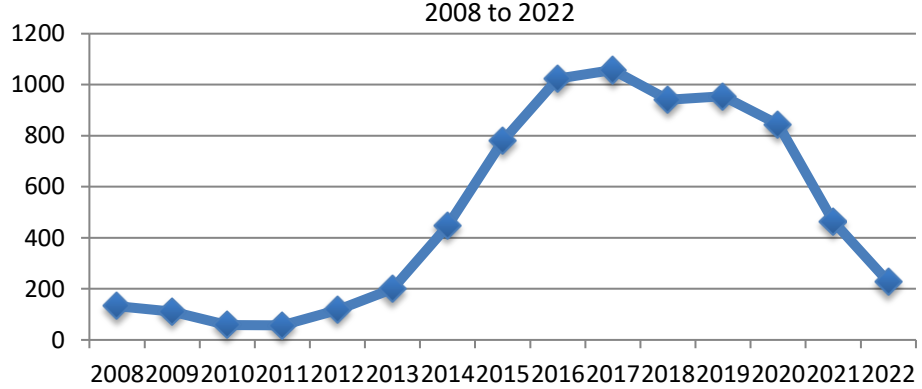
Occurrences of heroin decreased by **54%** and deaths caused by heroin decreased by **53%.**

Heroin Deaths
Total Occurrences = 57



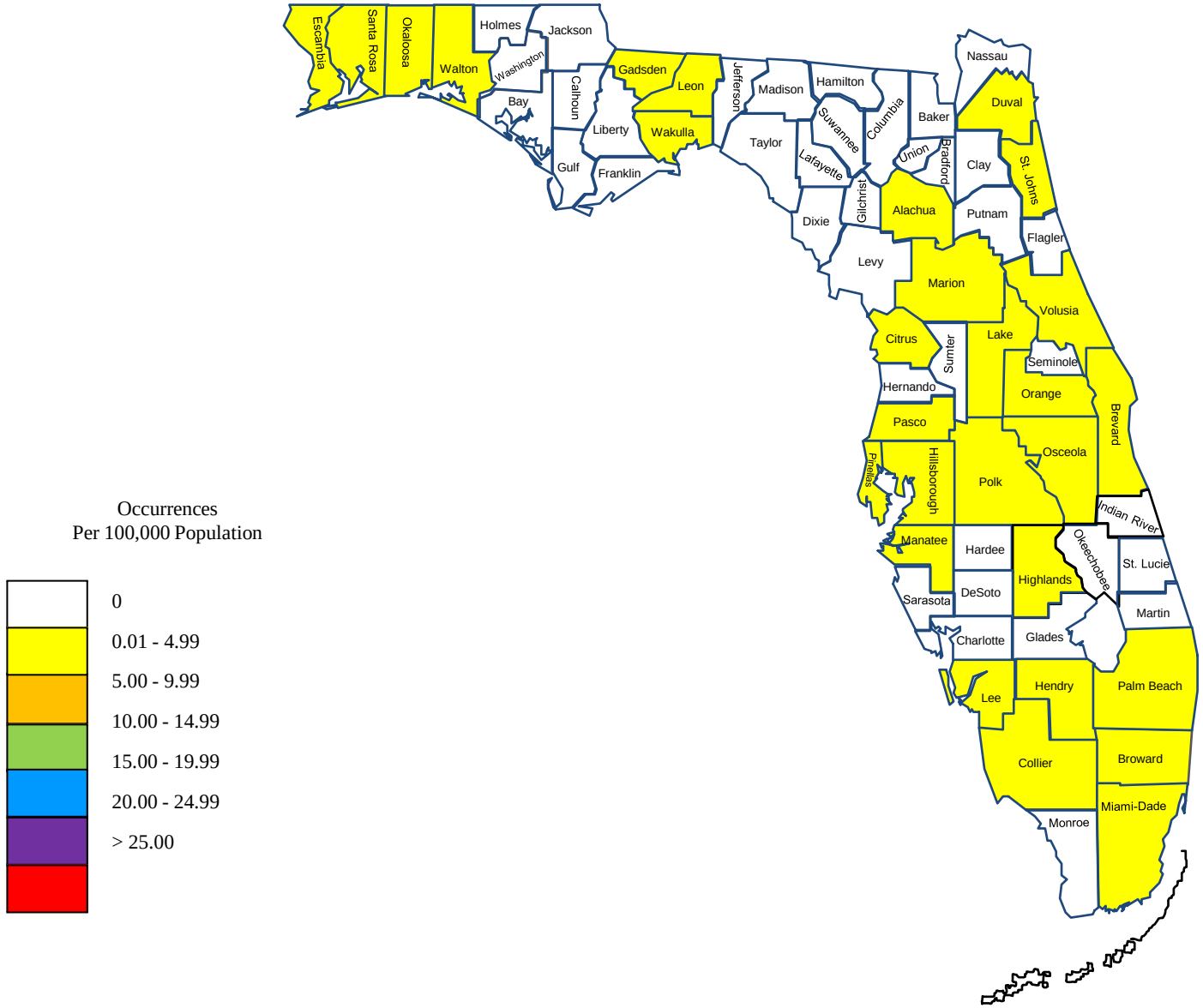
Historical Overview of Heroin Occurrences

(Present and Cause)
2008 to 2022



Heroin Deaths by County

2022

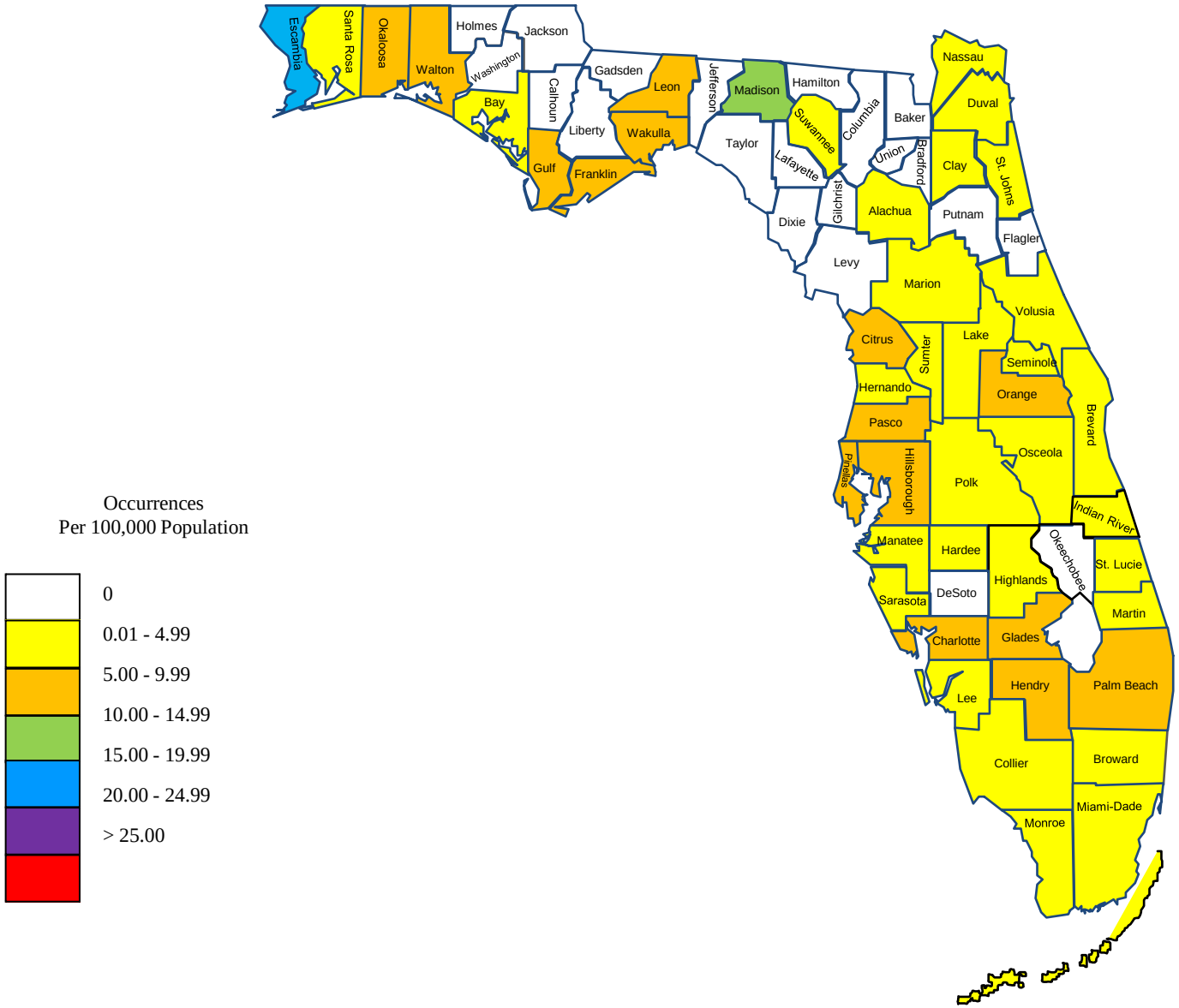


Occurrences
Per 100,000 Population

- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

Morphine Deaths by County

2022



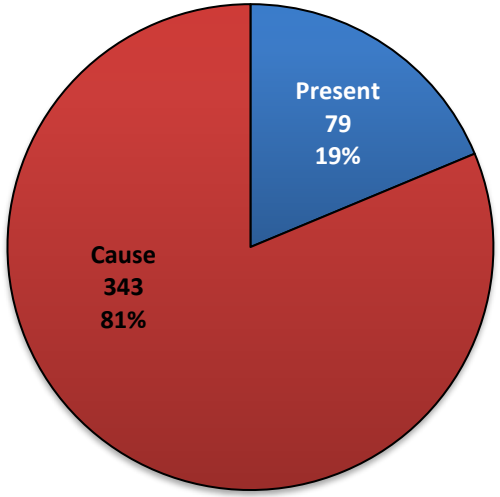
Occurrences
Per 100,000 Population

- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

Fentanyl Analog Deaths*

Occurrences of fentanyl analogs decreased by **12%** and deaths caused by fentanyl analogs decreased by **14%.**

Fentanyl Analog* Deaths
Total Occurrences = 422

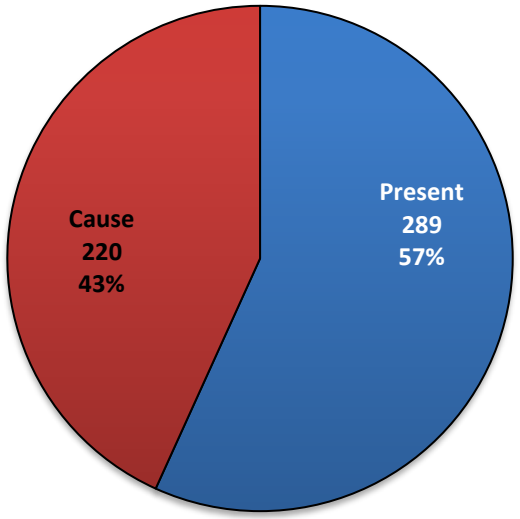


*These comparisons remove 4-ANPP from occurrences of fentanyl analogs

Oxycodone Deaths

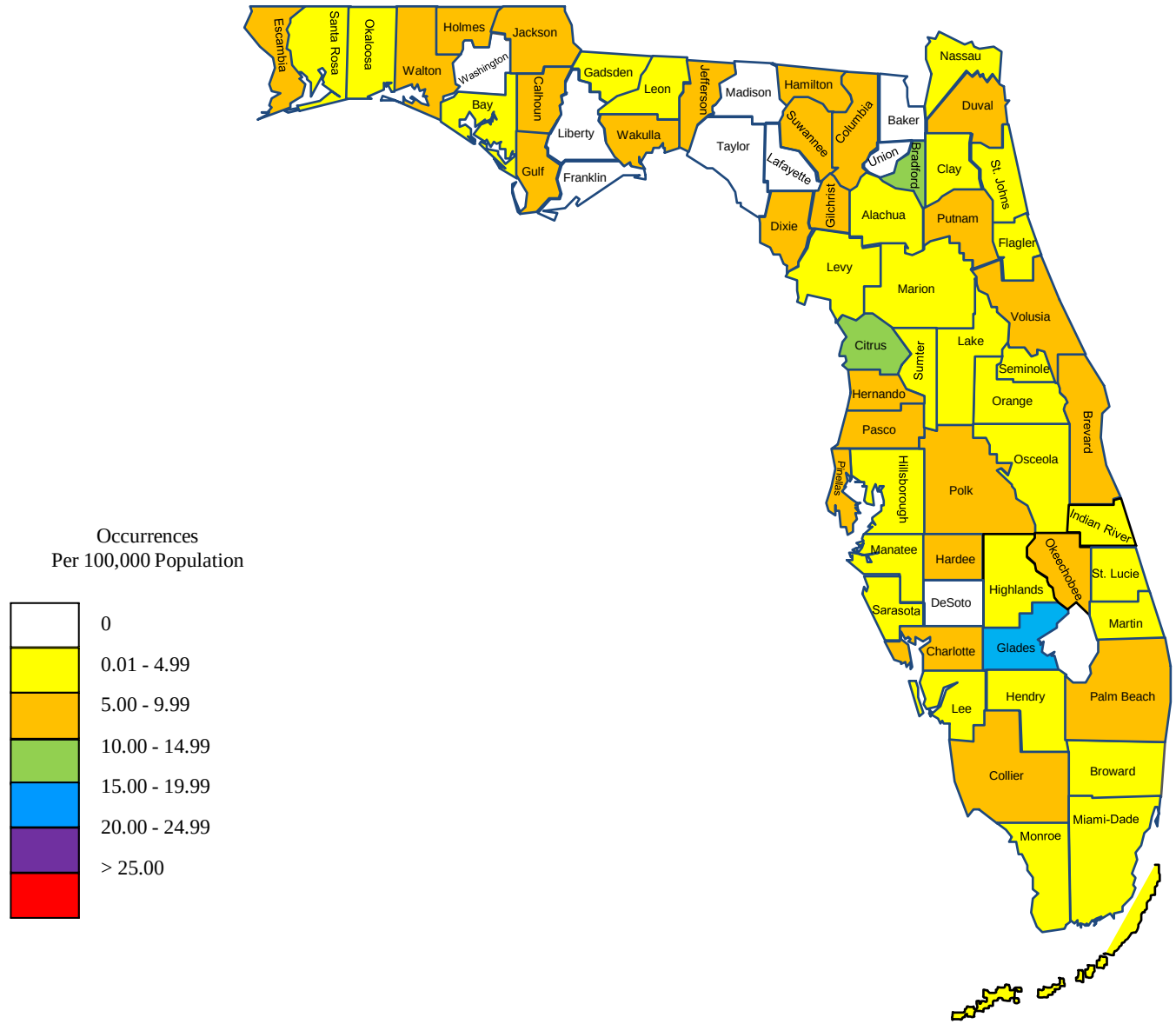
Occurrences of oxycodone decreased by **8%** and deaths caused by oxycodone decreased by **6%**.

Oxycodone Deaths
Total Occurrences = 509



Oxycodone Deaths by County

2022



Additional Highlights

- ✓Occurrences of cathinones increased by **105%** (221 more) and deaths caused by cathinones increased by **101%** (148 more). The majority of cathinones reported were **N,N-Dimethylpentylone and its metabolite, pentylone.**

- ✓Occurrences of **gabapentin** decreased by **10%** and **mitragynine** decreased by **8%**

- ✓There were a total of **10** occurrences of **difluoroethane** reported for January – June 2023.

- ✓There were a total of **278** occurrences of **xylazine.**

Questions?

Full 2023 Interim Report available at:

2023-Interim-Drug-Report-FINAL.aspx (state.fl.us)

Summary of Drug Occurrences in Decedents

January – June 2023

	Drug Present in Body	Cause	Present	Total Occurrences
Amphetamines	Amphetamine	472	778	1,250
	Methamphetamine	995	354	1,349
Benzodiazepines	Alprazolam	263	302	565
	Chlordiazepoxide	9	39	48
	Clonazepam	56	192	248
	Diazepam	66	125	191
	Lorazepam	11	136	147
	Midazolam	3	129	132
	Nordiazepam	15	173	188
	Oxazepam	3	104	107
	Temazepam	11	124	135
Ethanol		641	2,316	2,957
Hallucinogenics	Phencyclidine (PCP)/PCP Analogs	0	0	0
	Phenethylamines/Piperazines	33	26	59
	Tryptamines	1	5	6
Inhalants	Halogenated	10	1	11
	Hydrocarbon	1	0	1

Summary of Drug Occurrences in Decedents (continued)

	Drug Present in Body	Cause	Present	Total Occurrences
Opioids	Buprenorphine	28	73	101
	Codeine	11	42	53
	Fentanyl	2,541	281	2,822
	Fentanyl Analogs*	343	79	422
	Heroin	44	13	57
	Hydrocodone	61	129	190
	Hydromorphone	35	112	147
	Methadone	65	57	122
	Morphine	110	218	328
	Oxycodone	220	289	509
	Oxymorphone	27	214	241
	Tramadol	44	124	168
	U-47700	0	0	0
Other	Cannabinoids	18	1,652	1,670
	Carisoprodol/Meprobamate	6	15	21
	Cathinones	294	138	432
	Cocaine	1,149	584	1,733
	GHB	0	1	1
	Gabapentin	75	373	448
	Ketamine	17	132	149
	Mitragynine	96	50	146
	Sympathomimetic Amines	2	16	18
	Synthetic Cannabinoids	7	1	8
	Xylazine	155	123	278
	Zolpidem	28	46	74

Note: The total occurrences for buprenorphine and cannabinoids are under reported. The rate will vary from district-to-district based on the scope of drug analysis utilized by the medical examiner office. Since heroin is rapidly metabolized to morphine, this may lead to a substantial over-reporting of morphine-related deaths as well as significant under-reporting of heroin-related deaths. Many deaths were found to have several drugs contributing to the death; therefore, the count of specific drugs listed is greater than the number of deaths.

**Does not include 4-ANPP.*

Comparison of Drug Occurrences in Decedents

Drug Present in Body		January – June 2022	January – June 2023	Percentage Change
Amphetamines	Amphetamine	1,429	1,250	-12.5%
	Methamphetamine	1,525	1,349	-11.5%
Benzodiazepines	Alprazolam	670	565	-15.7%
	Chlordiazepoxide	26	48	84.6%
	Clonazepam	285	248	-13.0%
	Diazepam	213	191	-10.3%
	Lorazepam	138	147	6.5%
	Midazolam[1]	135	132	-2.2%
	Nordiazepam	201	188	-6.5%
	Oxazepam	120	107	-10.8%
	Temazepam	152	135	-11.2%
Ethanol		3,123	2,957	-5.3%
Hallucinogenics	Phencyclidine (PCP)/PCP Analogs	0	0	0.0%
	Phenethylamines/Piperazines	53	59	11.3%
	Tryptamines	2	6	**
Inhalants	Halogenated	15	11	-26.7%
	Hydrocarbon	**0**	**1**	**

***Due to the small number of occurrences, percent changes were not calculated.*
[1]Midazolam is used clinically as a sedative and anesthetic. It is not currently a known drug of abuse.
Note: Many deaths were found to have several drugs contributing to the death; therefore, the count of specific drugs listed is greater than the number of deaths.

Comparison of Drug Occurrences in Decedents (Continued)

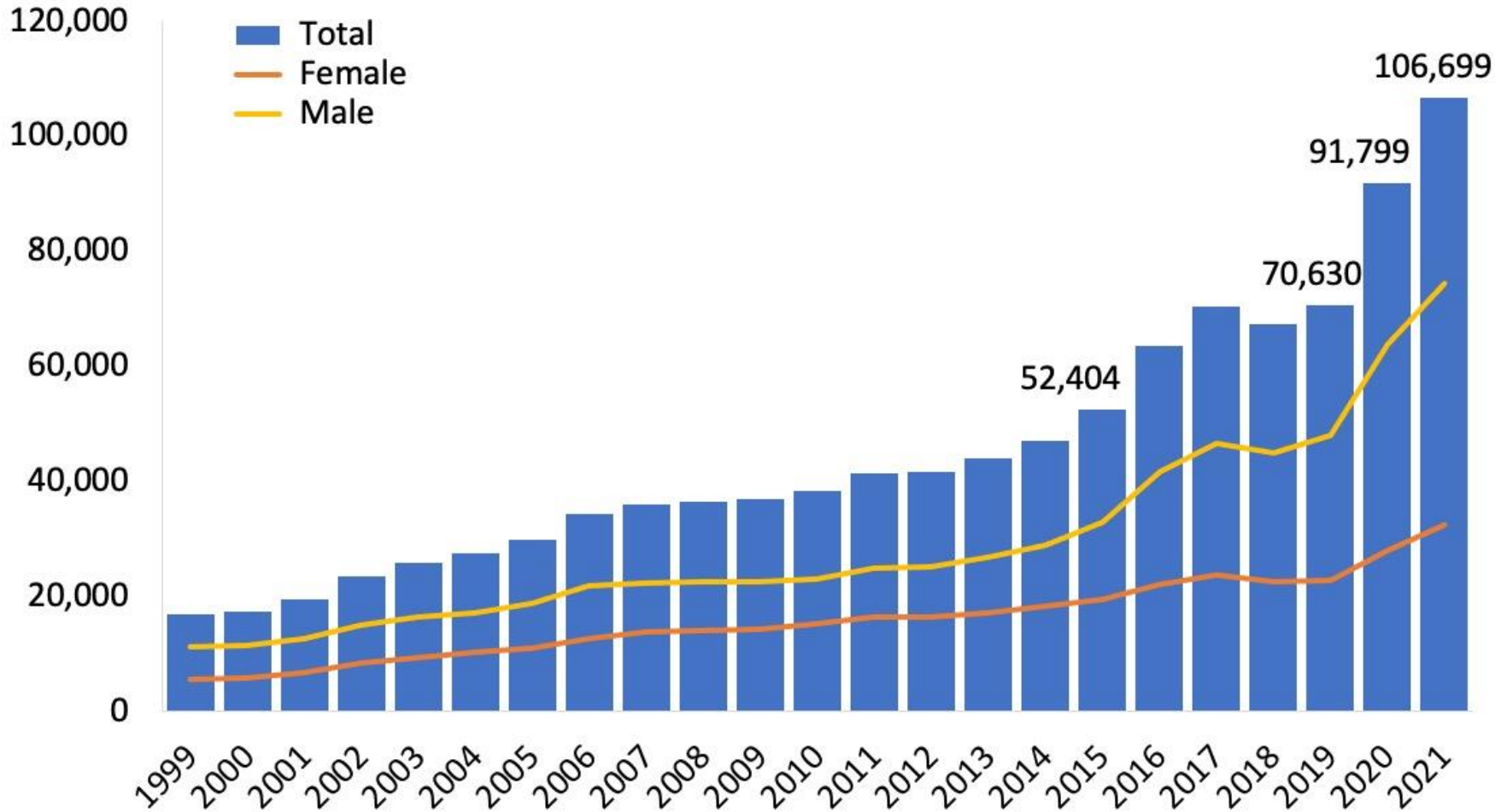
	Drug Present In Body	January – June 2022	January – June 2023	Percentage Change
Opioids	Buprenorphine	114	101	-11.4%
	Codeine	102	53	-48.0%
	Fentanyl	3,150	2,822	-10.4%
	Fentanyl Analogs*	478	422	-11.7%
	Heroin	124	57	-54.0%
	Hydrocodone	239	190	-20.5%
	Hydromorphone	228	147	-35.5%
	Methadone	155	122	-21.3%
	Morphine	474	328	-30.8%
	Oxycodone	551	509	-7.6%
	Oxymorphone	253	241	-4.7%
	Tramadol	181	168	-7.2%
	U-47700	0	0	0.0%
Other	Cannabinoids	1,894	1,670	-11.8%
	Carisoprodol/Meprobamate	14	21	50.0%
	Cathinones	211	432	104.7%
	Cocaine	1,960	1,733	-11.6%
	GHB	4	1	**
	Gabapentin	499	448	-10.2%
	Ketamine	107	149	39.3%
	Mitragynine	158	146	-7.6%
	Sympathomimetic Amines	13	18	38.5%
	Synthetic Cannabinoids	5	8	**
	Xylazine	233	278	19.3%
	Zolpidem	**57**	**74**	**29.8%**

**Does not include 4-ANPP.*
***Due to the small number of occurrences, percent changes were not calculated.*

Why Is It Important to Treat Opioid Use Disorder In Pregnancy?

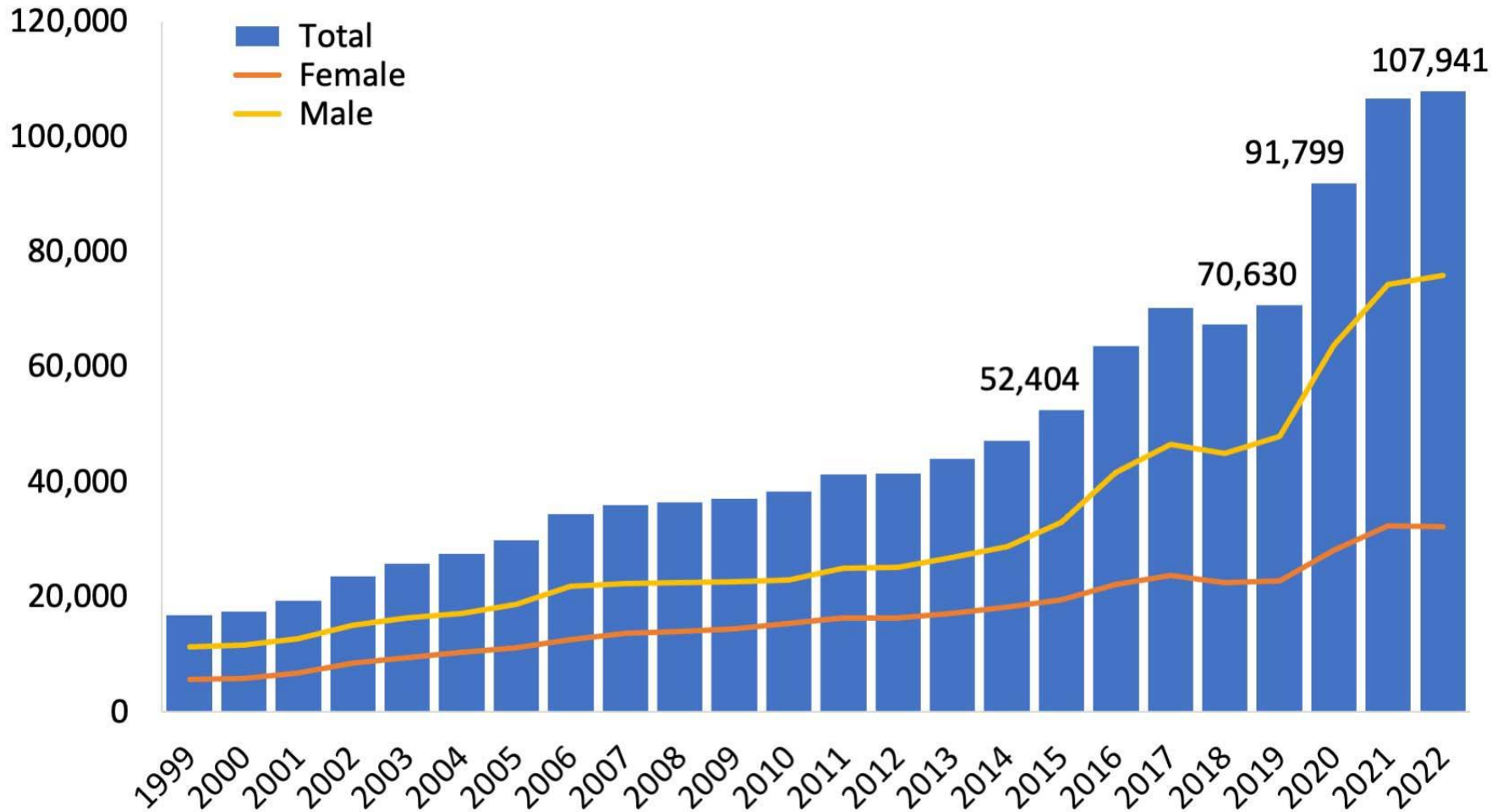
Kay Roussos-Ross, MD
Professor and Chief
Departments of OBGYN and Psychiatry
University of Florida

Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021



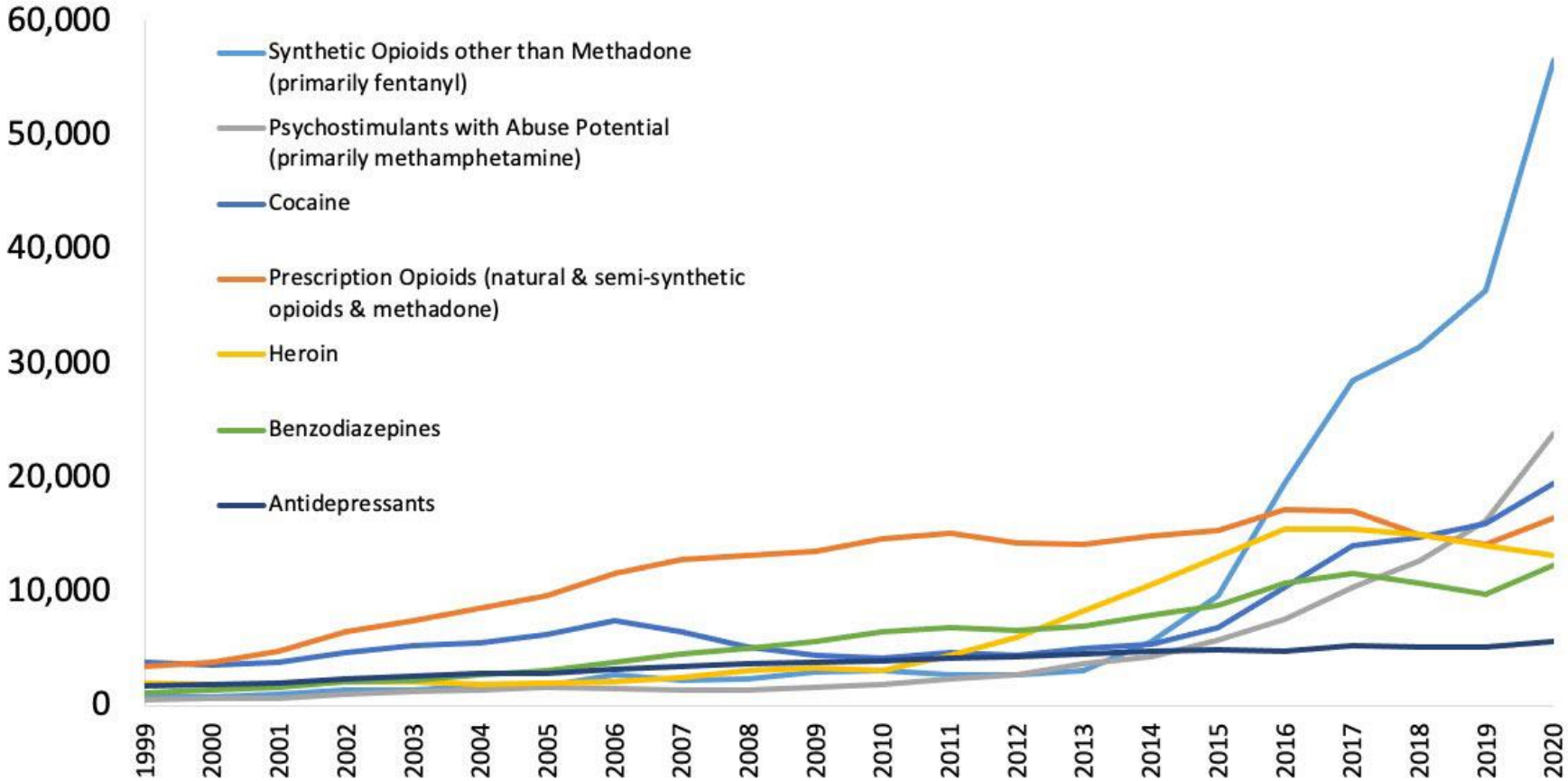
*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Figure 1. U.S. Overdose Deaths* by Sex, 1999-2022



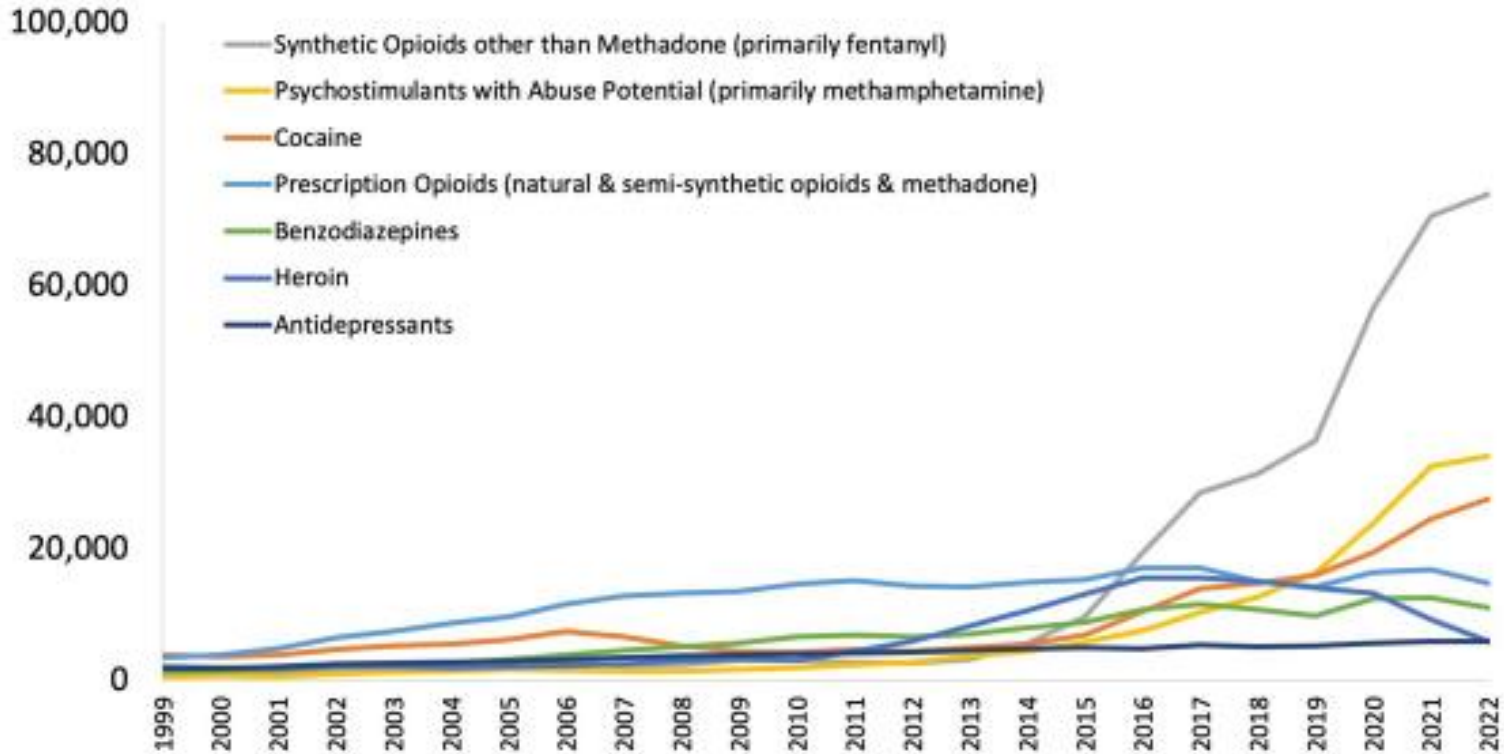
*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2020



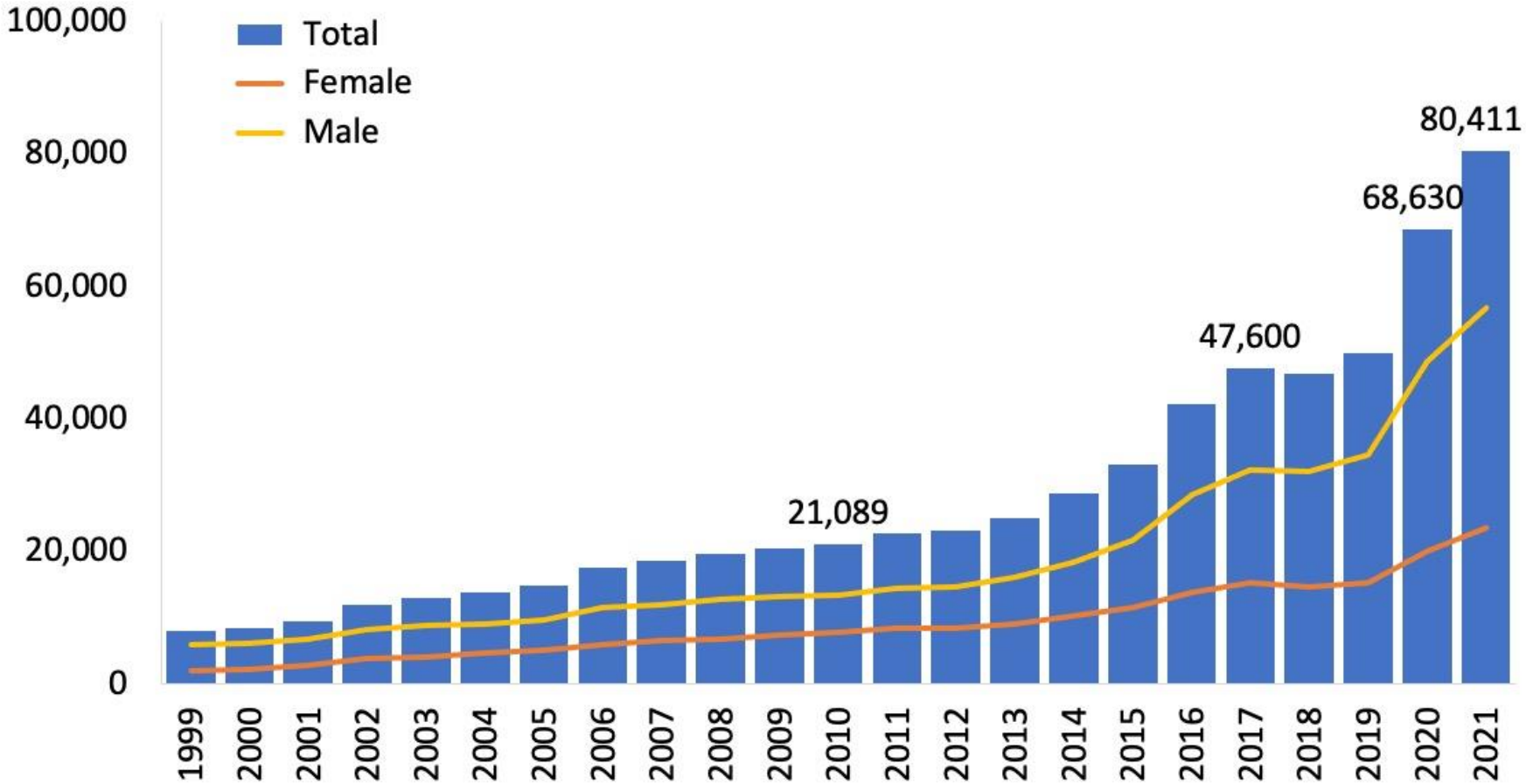
*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

Figure 2. U.S. Overdose Deaths*, Select Drugs or Drug Categories, 1999-2022



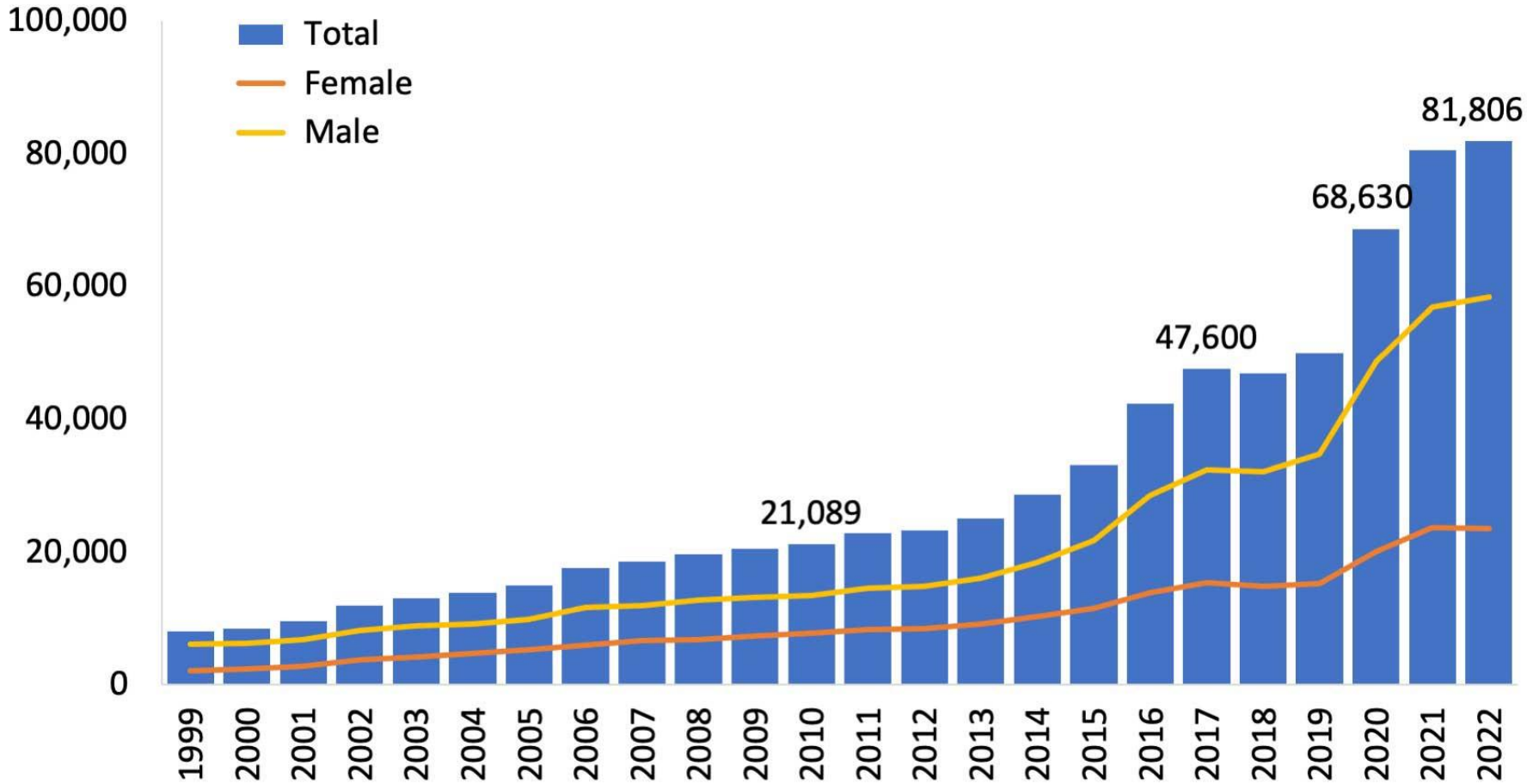
*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

Figure 3. National Overdose Deaths Involving Any Opioid*, Number Among All Ages, by Gender, 1999-2021



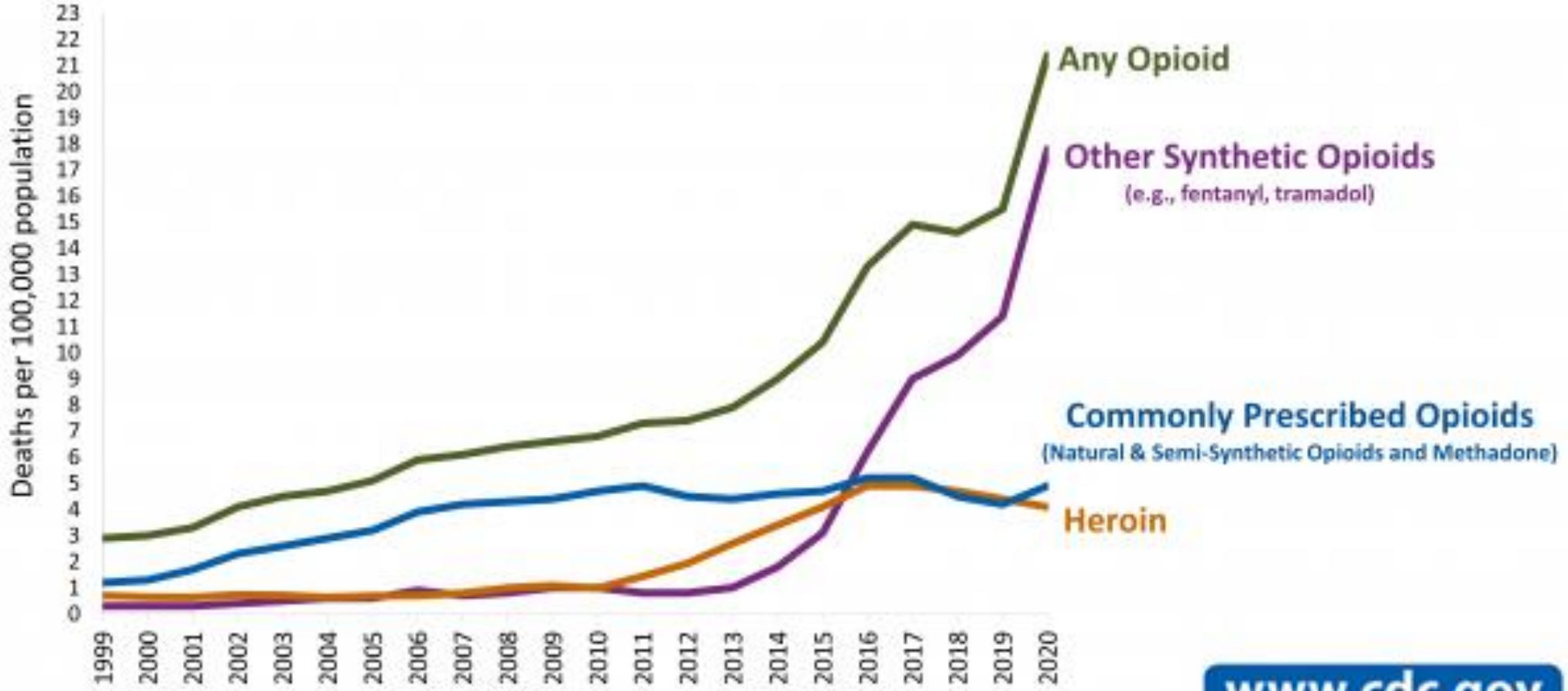
*Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Figure 3. U.S. Overdose Deaths Involving Any Opioid* by Sex, 1999-2022



*Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

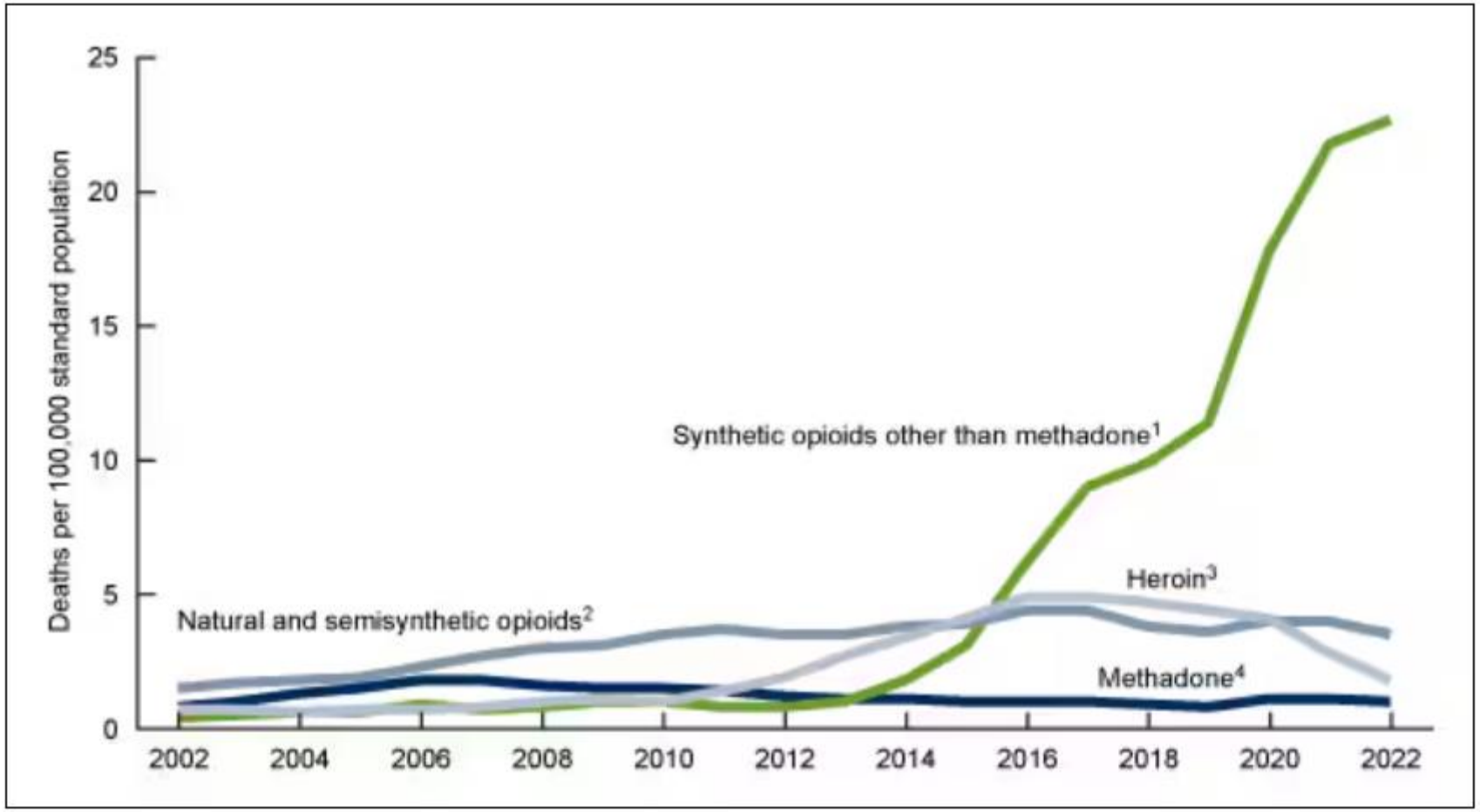
Overdose Death Rates Involving Opioids, by Type, United States, 1999-2020



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/.

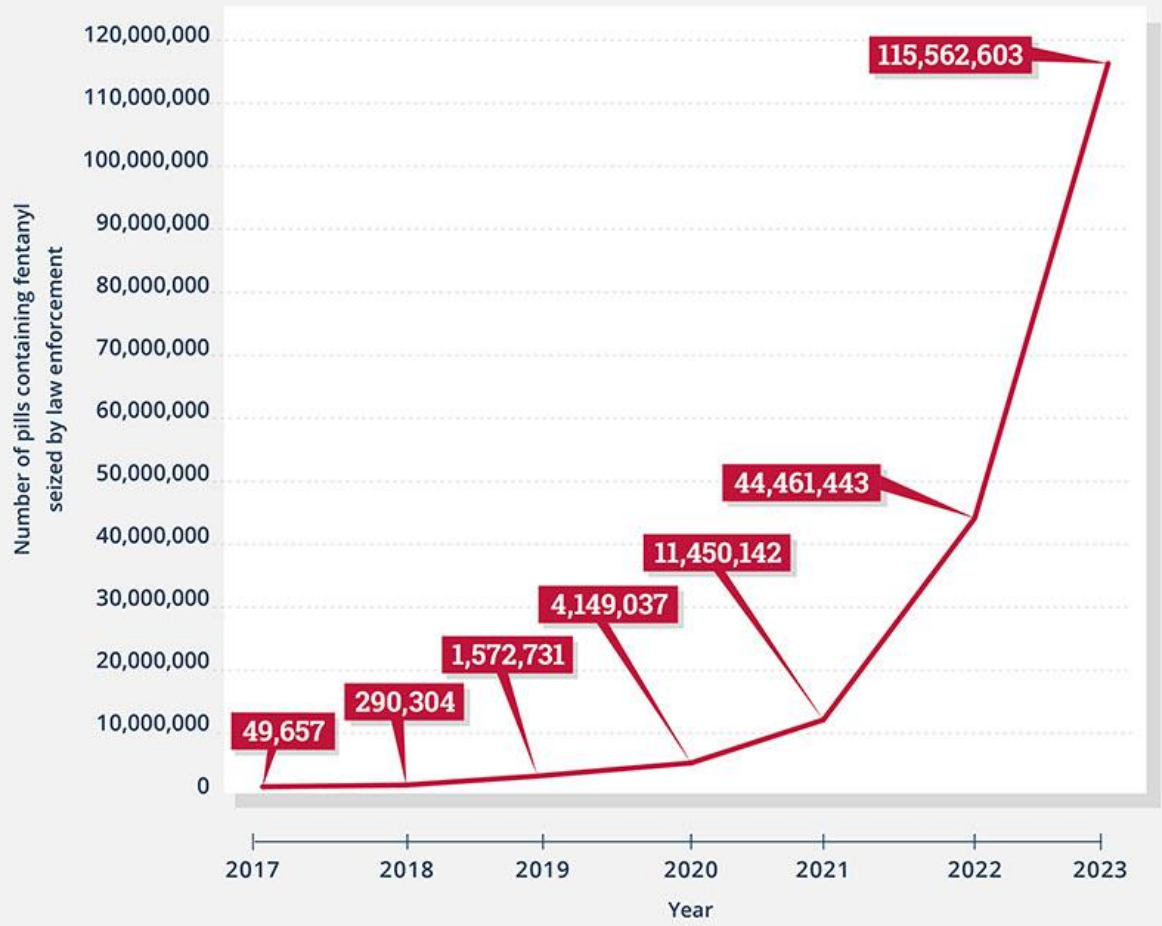
www.cdc.gov
Your Source for Credible Health Information

Figure 4. Age-adjusted rate of drug overdose deaths involving opioids, by type of opioid: United States, 2002–2022



SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file
CDC

Number of Pills Containing Fentanyl Seized by Law Enforcement in the United States, 2017 – 2023

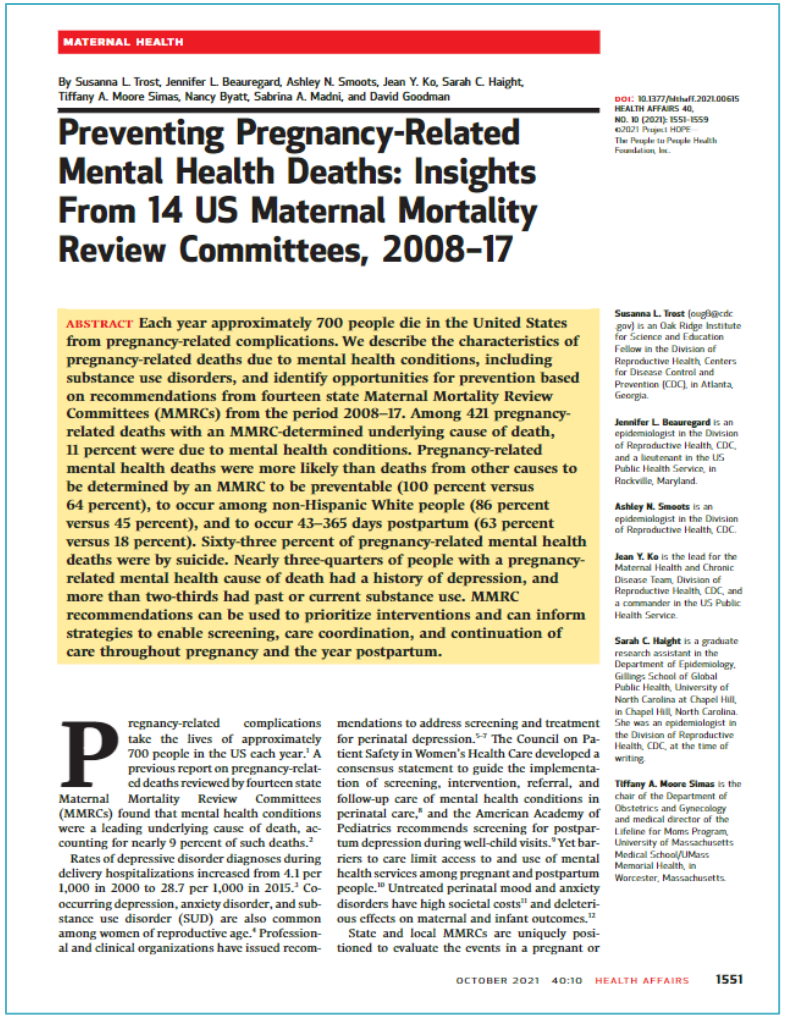


Estimates based on data reported by the Office of National Drug Control Policy's High Intensity Drug Trafficking Areas program

Reference: JJ Palamar, et al. *International Journal of Drug Policy.* DOI: 10.1016/j.drugpo.2024.104417 (2024)

NIH National Institute on Drug Abuse

nida.nih.gov



MATERNAL HEALTH

By Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman

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HEALTH AFFAIRS 40,
NO. 10 (2021): 1551–1559

Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008–17

ABSTRACT **Each year approximately 700 people die in the United States from pregnancy-related complications. We describe the characteristics of pregnancy-related deaths due to mental health conditions, including substance use disorders, and identify opportunities for prevention based on recommendations from fourteen state Maternal Mortality Review Committees (MMRCs) from the period 2008–17. Among 421 pregnancy-related deaths with an MMRC-determined underlying cause of death, 11 percent were due to mental health conditions. Pregnancy-related mental health deaths were more likely than deaths from other causes to be determined by an MMRC to be preventable (100 percent versus 64 percent), to occur among non-Hispanic White people (86 percent versus 45 percent), and to occur 43–365 days postpartum (63 percent versus 18 percent). Sixty-three percent of pregnancy-related mental health deaths were by suicide. Nearly three-quarters of people with a pregnancy-related mental health cause of death had a history of depression, and more than two-thirds had past or current substance use. MMRC recommendations can be used to prioritize interventions and can inform strategies to enable screening, care coordination, and continuation of care throughout pregnancy and the year postpartum.**

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Tiffany A. Moore Simas is the chair of the Department of Obstetrics and Gynecology and medical director of the Lifeline for Moms Program, University of Massachusetts Medical School/UMass Memorial Health, in Worcester, Massachusetts.

Pregnancy-related complications take the lives of approximately 700 people in the US each year.[1] A previous report on pregnancy-related deaths reviewed by fourteen state Maternal Mortality Review Committees (MMRCs) found that mental health conditions were a leading underlying cause of death, accounting for nearly 9 percent of such deaths.[2]

Rates of depressive disorder diagnoses during delivery hospitalizations increased from 4.1 per 1,000 in 2000 to 28.7 per 1,000 in 2015.[3] Co-occurring depression, anxiety disorder, and substance use disorder (SUD) are also common among women of reproductive age.[4] Professional and clinical organizations have issued recommendations to address screening and treatment for perinatal depression.[5–7] The Council on Patient Safety in Women's Health Care developed a consensus statement to guide the implementation of screening, intervention, referral, and follow-up care of mental health conditions in perinatal care,[8] and the American Academy of Pediatrics recommends screening for postpartum depression during well-child visits.[9] Yet barriers to care limit access to and use of mental health services among pregnant and postpartum people.[10] Untreated perinatal mood and anxiety disorders have high societal costs[11] and deleterious effects on maternal and infant outcomes.[12]

State and local MMRCs are uniquely positioned to evaluate the events in a pregnant or

100%

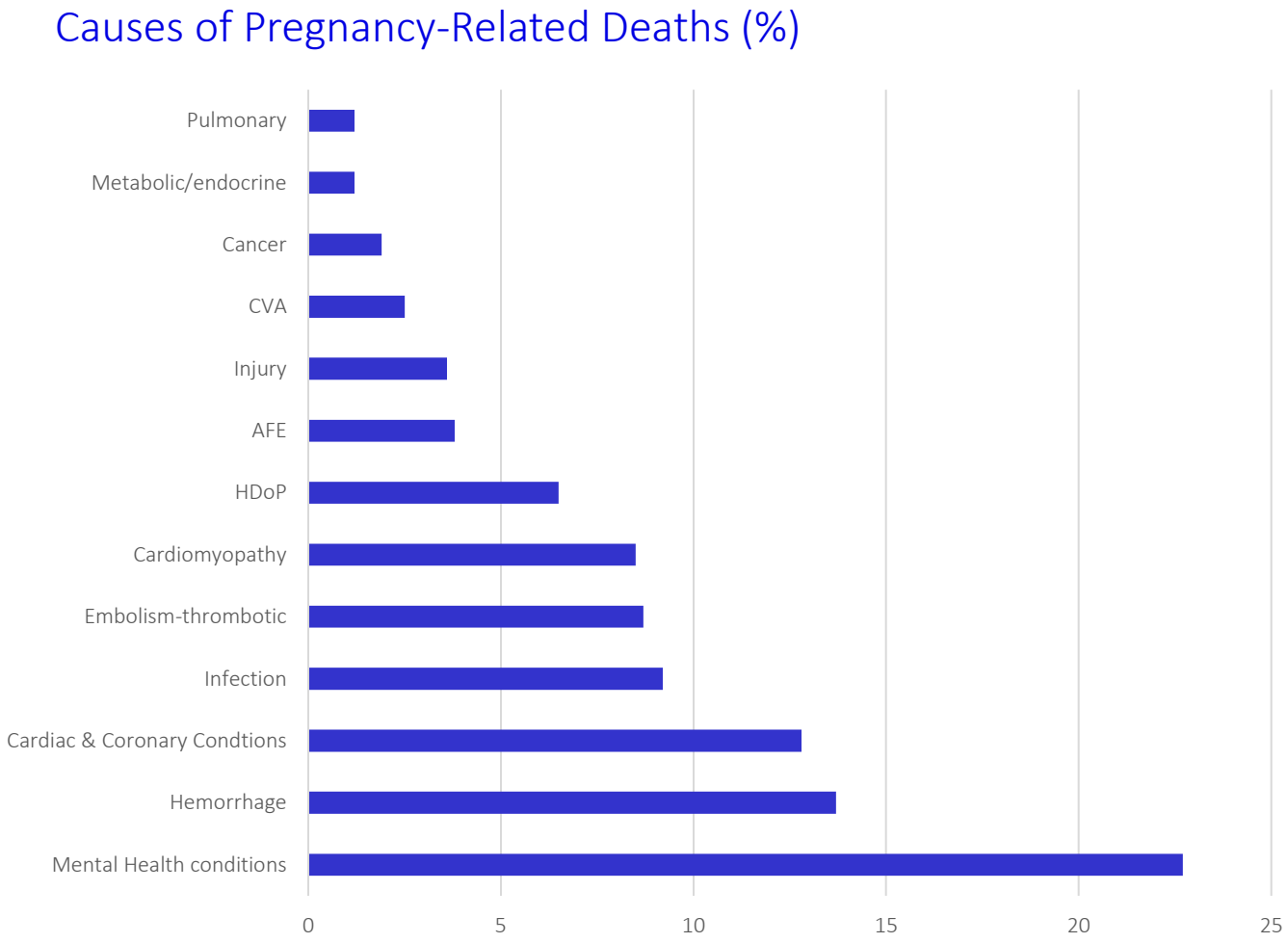
of pregnancy-related mental health deaths were determined to be preventable

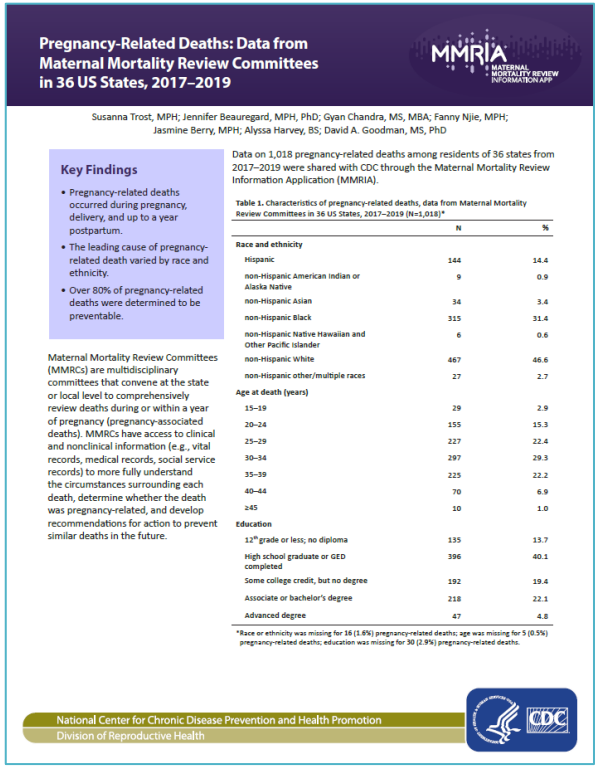
MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

ERASE MM

REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

Mental Health Conditions are the Leading Cause of Pregnancy Related Deaths (22.7%)





Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019

MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

Susanna Trost, MPH; Jennifer Beauregard, MPH, PhD; Gyan Chandra, MS, MBA; Fanny Njie, MPH; Jasmine Berry, MPH; Alyssa Harvey, BS; David A. Goodman, MS, PhD

Key Findings

- Pregnancy-related deaths occurred during pregnancy, delivery, and up to a year postpartum.
- The leading cause of pregnancy-related death varied by race and ethnicity.
- Over 80% of pregnancy-related deaths were determined to be preventable.

Maternal Mortality Review Committees (MMRCs) are multidisciplinary committees that convene at the state or local level to comprehensively review deaths during or within a year of pregnancy (pregnancy-associated deaths). MMRCs have access to clinical and nonclinical information (e.g., vital records, medical records, social service records) to more fully understand the circumstances surrounding each death, determine whether the death was pregnancy-related, and develop recommendations for action to prevent similar deaths in the future.

Data on 1,018 pregnancy-related deaths among residents of 36 states from 2017–2019 were shared with CDC through the Maternal Mortality Review Information Application (MMRIA).

Table 1. Characteristics of pregnancy-related deaths, data from Maternal Mortality Review Committees in 36 US States, 2017–2019 (N=1,018)*

	N	%
Race and ethnicity		
Hispanic	144	14.4
non-Hispanic American Indian or Alaska Native	9	0.9
non-Hispanic Asian	34	3.4
non-Hispanic Black	315	31.4
non-Hispanic Native Hawaiian and Other Pacific Islander	6	0.6
non-Hispanic White	467	46.6
non-Hispanic other/multiple races	27	2.7
Age at death (years)		
15–19	29	2.9
20–24	155	15.3
25–29	227	22.4
30–34	297	29.3
35–39	225	22.2
40–44	70	6.9
≥45	10	1.0
Education		
12th grade or less; no diploma	135	13.7
High school graduate or GED completed	396	40.1
Some college credit, but no degree	192	19.4
Associate or bachelor's degree	218	22.1
Advanced degree	47	4.8

*Race or ethnicity was missing for 16 (1.6%) pregnancy-related deaths; age was missing for 5 (0.5%) pregnancy-related deaths; education was missing for 30 (2.9%) pregnancy-related deaths.

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

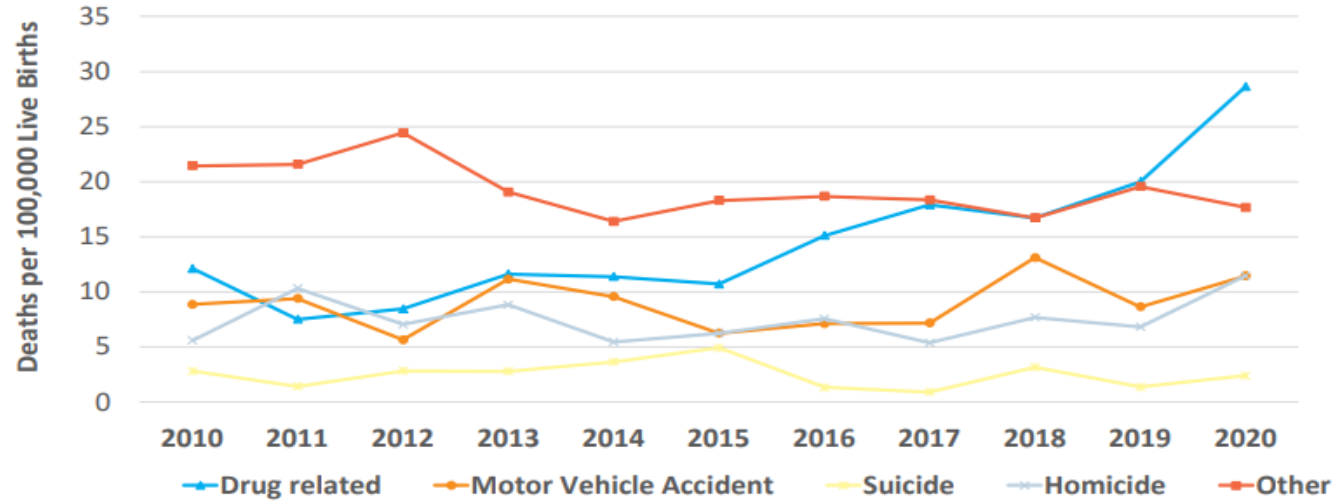
Key Findings:
Among pregnancy-related deaths with information on timing, 22% of deaths occurred during pregnancy, 25% occurred on the day of delivery or within 7 days after, and 53% occurred between 7 days to 1 year after pregnancy.

The leading underlying causes of pregnancy-related death include:

- Mental health conditions (including deaths to suicide and overdose/poisoning related to substance use disorder) (23%)
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (relating to the heart) (13%)
- Infection (9%)
- Thrombotic embolism (a type of blood clot) (9%)
- Cardiomyopathy (a disease of the heart muscle) (9%)
- Hypertensive disorders of pregnancy (relating to high blood pressure) (7%)

https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

PREGNANCY-ASSOCIATED DEATH RATIOS BASED ON THE FORM OF NON-SELECTED CASES PRESENTED EVERY QUARTER, BY CAUSE OF DEATH, FLORIDA, 2010–2020



Florida HEALTH

This slide presents the not-pregnancy-related death ratios based on the form "Florida MMRC Quarterly Demographic Data on Non-Selected Cases" presented every quarter, by cause of death for the period 2010–2020.

- Not-Pregnancy-Related Deaths (NPRD) are a subset of PAD.
- The causes of maternal death in the NPRD ratios for 2010–2020 are based on the "Florida MMRC Quarterly Demographic Data on Non-Selected Cases" form.
- These maternal deaths were identified through the case identification process.
- In 2020, the NPRD ratio due to drug related causes was 28.6 per 100,000 live births, followed by other causes with a ratio of 17.6, motor vehicle accidents (MVA) with a ratio of 11.4, homicides with a ratio of 11.4, and suicides 2.4 per 100,000 live births, respectively.

Year of Death	Count of Mental Health Cases Reviewed	Pregnancy-Relatedness for MH Cases	Count of Drug Overdose MH Deaths	Count Opioid-Drug Overdose Deaths
2021	65	PR= 15 NR=33; UDR= 17	56	36

Note: Opioid Deaths include ICD 10 Codes: T40.0 -T40.4 for contributing with underlying cause of death with codes X40-X44

PR=Pregnancy-Related; NR= Pregnancy-Associated but not Related; UDR= Pregnancy-Associated but not Related; Not PAD= False Positive but reviewed or Out of Scope

Count of Mental Health Cases Reviewed does not include cases sent to full committee or out of scope/false positive cases.

* There was a total of 65 of pregnancy-associated Mental Health maternal deaths in 2021 reviewed by the Mental Health Subcommittee.
* Out of the 65 MH maternal deaths in 2021, 15 of these deaths were pregnancy related (23.1%).
* In addition, the majority of the mental health cases reviewed by the subcomittee were due to drug overdose, 56 out of 65 cases (86.2%).
* Also, 64.3% of the Drug Overdose Mental Health Deaths also had a contributing factor including Opioid drug use.

Obstetric providers and hospitals are the first health care contact for most mothers with Opioid Use Disorder (OUD) and need to lead the effort to screen, assess, and refer these mothers as well as providing for their obstetrical needs.

Florida PAMR Findings:

- Opioid Use Disorder (OUD) is a life-threatening chronic condition and is dangerous to pregnant and postpartum women.
- The rate of Florida women with OUD identified at delivery admission quadrupled from 0.5 per 1,000 deliveries in 1999, to 6.6 in 2014.[1] Use of illicit opioid and related drugs is now increasing as prescription opioids are becoming more restricted.[2]
- Drug-related deaths are the leading cause of death to mothers during pregnancy or within one year afterwards in 2017, accounting for 1 in 4 of these deaths in Florida. There are now as many maternal drug-related deaths as deaths due to traditional causes of maternal mortality. 75% of maternal drug-related deaths occur after the baby is born and the mother has been discharged.[3]

Risk Factors:

- Stigma and bias by the public and by health professionals make it very difficult for patients to discuss their condition and get help. Getting treatment during pregnancy and continuing afterwards are key to maternal survival and healthy families.[4]
- More than 30% of women with OUD have underlying depressive disorders that complicate patient care during pregnancy and postpartum.[5]
- Women with OUD who decide to stop medication-assisted treatment are at high-risk of relapse and potentially fatal consequences.[5]
- Loss of Medicaid or other health care benefits after delivery (such as, through loss of infant custody) may result in reduced access to the needed medication-assisted treatment.

PAMR Recommendations:

Prenatal Care and Screening

- Screen all pregnant women for OUD during prenatal care and at the time of delivery using a validated verbal or written screening tool: NIDA Quick Screen, 5P's, or CRAFFT. Using only biological testing for opioids and other drugs is not recommended.[6]
- Assess patients' prescription history though the Prescription Drug Monitoring Program (PDMP), preferably during the first prenatal visit.
- Be prepared to counsel women regarding opioid use during pregnancy and postpartum in a non-judgmental way. Tools such as SBIRT (Screening, Brief Intervention, Referral to Treatment) have been developed to help.[6]
- If a provider is unable to provide care for women with OUD, direct referral to another prenatal care provider or clinic to assure complete and compassionate care of the mother is essential.[6]
- A plan of safe care should be developed during prenatal care with input from all involved including prenatal care providers, community support services, and medication-assisted treatment providers.[6]

Referral and Treatment

- Provide direct referrals for medication-assisted treatment and/or other community support services. Connecting and supporting treatment with rehabilitation specialists is essential to maintaining these patients in obstetrical care.[7]

continued

Florida HEALTH

More information on a maternal opioid care bundle is available on the FPQC website:

Screening

Screening Pregnant Women for Substance Use

Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, **universal screening** (for licit and illicit substance use) is recommended.

Selective screening based on “risk factors” perpetuates discrimination and misses most women with problematic use.

ACOG Screening Guidelines

Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma.

Early **universal screening, brief intervention** (such as engaging the patient in a short conversation, providing feedback and advice), and **referral for treatment (SBIRT)** of pregnant women with opioid use disorder improve maternal and infant outcomes.

Who can perform SBIRT? Physicians, nurse practitioners, physician assistants, nurses, health or substance use counselors, prevention specialists, and other health or behavioral health staff.

Source: ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711. ACOG Committee Opinion on Obstetric Practice & the American Society of Addiction Medicine. Replace Opinion No. 524, May 2012. Published August 2017.

SBIRT

Screening, **B**rief **I**ntervention, and **R**eferral to **T**reatment

Screening - a health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.

Brief Intervention - a health care professional engages a patient showing risky substance use behaviors in short conversation, providing feedback and advice.

Referral to Treatment - a health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

This approach improves maternal and infant outcomes.

http://www.integration.samhsa.gov/clinical-practice/SBIRT

Screening Instruments

No single best screening instrument to identify pregnant women with substance use disorders.

Self-administered or part of the patient interview.

Developed for or validated in pregnant women

- 4P’s Plus (Chasnoff, 1999)
- NIDA Quick Screen
- CRAFFT (Chang, 2011) (women 26 years or younger)

The 4 P’s

1. Have you ever used drugs or alcohol during pregnancy?
2. Have you had a problem with drugs or alcohol in the past?
3. Does your partner have a problem with drugs or alcohol?
4. Do you consider one of your parents to be an addict or alcoholic?

***5 P’s

5. Do any of your peers have problems with drugs or alcohol?

NIDA Quick Screen

Screen Your Patients

- Step 1. Ask patient about past year drug use—the NIDA Quick Screen
- Step 2. Begin the NIDA- Modified ASSIST
- Step 3. Determine risk level

Conduct a Brief Intervention

- Step 4. Advise, Assess, Assist and Arrange

NIDA Drug Screening Tool

NIDA-Modified ASSIST (NM ASSIST)

Clinician's Screening Tool for Drug Use in General Medical Settings*

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Tobacco Products

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

Illegal Drugs

Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily

PREVIOUS NEXT

*Note: This website collects no personally identifiable information and does not store your responses to any of the following questions.

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should <u>not</u> indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

CRAFFT

Substance Abuse Screen for Adolescents and Young Adults

C	Have you ever ridden in a *car* driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, *alone*?
F	Do you ever *forget* things you did while using alcohol or drugs?
F	Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into *trouble* while you were using alcohol or drugs?

Screening: Urine Drug Screen?

Do not use as sole assessment of substance use/use disorder (ACOG, 2012).

- Short detection window (substance dependent)
- Might not capture binge or intermittent use
- Rarely detects alcohol
- Doesn’t capture prescription opioids (without confirmation testing)

Useful adjunct primarily for individuals in treatment.

Ethical issues –patient needs to give consent prior to specimen collection.

Why Screen?

Early Identification is Key:

Allows for early intervention and treatment that minimizes potential harms to the mother and her pregnancy

Maximizes motivation for change during pregnancy

American Society of Addiction Medicine(ASAM) National Practice Guideline (May 2015)

Pregnant women who are physically dependent on opioids should receive treatment using **agonist medications rather than withdrawal management or abstinence** as these approaches may pose a risk to the fetus.

Furthermore, **withdrawal** management has **been found to be inferior in effectiveness over pharmacotherapy with opioid agonists and increases the risk of relapse without fetal or maternal benefit**.

ACOG Committee Opinion #711

Universal screening should occur at the 1st prenatal visit

Validated screening tools should be used

Patients with chronic pain should be offered alternatives such as PT, exercise, behavioral approaches, and non-opioid pharmacotherapy

For women with opioid use disorders, opioid maintenance treatment is preferred to medically supervised withdrawal due to concerns about relapse and safety

ACOG Committee Opinion #711

Opioid exposed infants should be monitored for NAS by pediatric providers

Before prescribing opioids for pregnant women, providers should utilize PDMP to determine whether other prescriptions are being obtained

Breastfeeding should be encouraged unless there are other illicit drugs being used by the mother or if there are contraindications to breastfeeding such as HIV

ACOG Committee Opinion #711

Access to substance treatment facilities should be made available to pregnant women

Pregnant women should be referred for postpartum psychosocial support services if available

Contraceptive counselling and access to contraception should be part of substance use disorder treatment to minimize risk of unplanned pregnancy

Treatment

Opioid Assisted Treatment (OAT)

Goal

Administer methadone/buprenorphine in doses sufficient to prevent withdrawal and reduce/ eliminate cravings.

Opioid Assisted Treatment (OAT)

Methadone/Buprenorphine maintenance dramatically reduces illicit opioid use, criminal behavior, risky sexual practices, and the transmission of HIV.

People in methadone/buprenorphine programs have 30 percent the mortality rate of opioid users who are not in treatment programs.

Opioid Assisted Treatment (OAT)

Treatment of choice for opiate-dependent pregnant women.

Reduces fluctuations in maternal opioid levels, which reduces stress on the fetus.

Reduces drug-seeking behaviors.

Illicitly purchased heroin is adulterated with other compounds that may be harmful to the fetus.

Enhances the ability of the woman to participate in prenatal care and addiction treatment.

Treatment

What about Medically Supervised Withdrawal?

- Done slowly due to concerns related to withdrawal symptoms and concerns related to cravings.
- Consider doing this on an inpatient basis.
- Abrupt discontinuation of opioids in pregnancy not recommended.
  - Preterm labor
  - Fetal distress
  - Fetal demise
  - Withdrawal
  - High relapse rates

Methadone

Long half-life (>24 hrs)

Peak dose 2-4 hrs

Pure mu agonist

80-90% bioavailability; highly lipophilic

Accumulation with repeated dosing for pain may result in sedation and respiratory depression in the non-tolerant patient

Buprenorphine

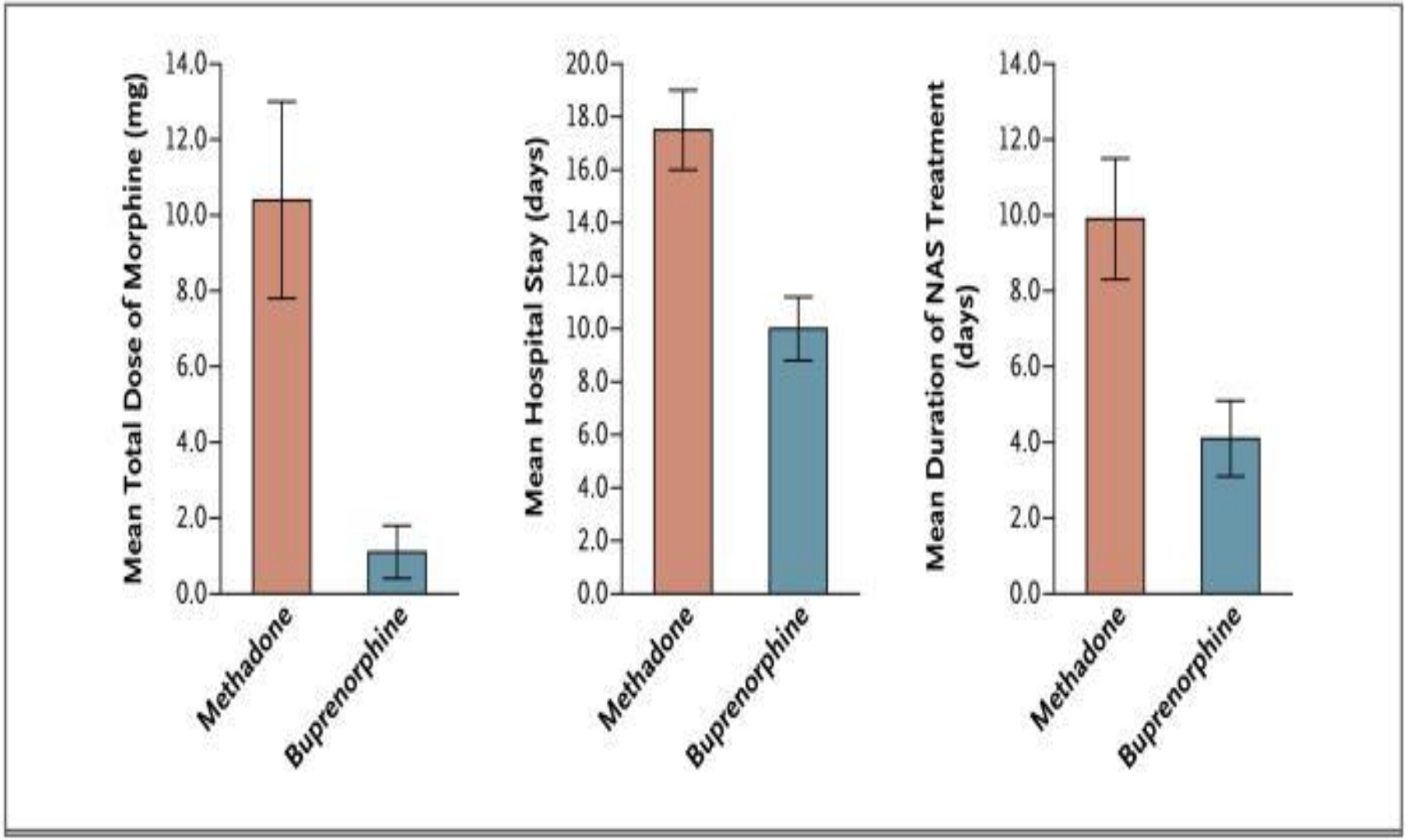
Long half life (>24hrs)

Peak dose 90 min

Partial mu receptor agonist (but has high affinity for receptor and displaces other full opioid agonists)

Kappa receptor antagonist

Less risk of respiratory depression in overdose



New England Journal of Medicine 2010; 363:2320-31

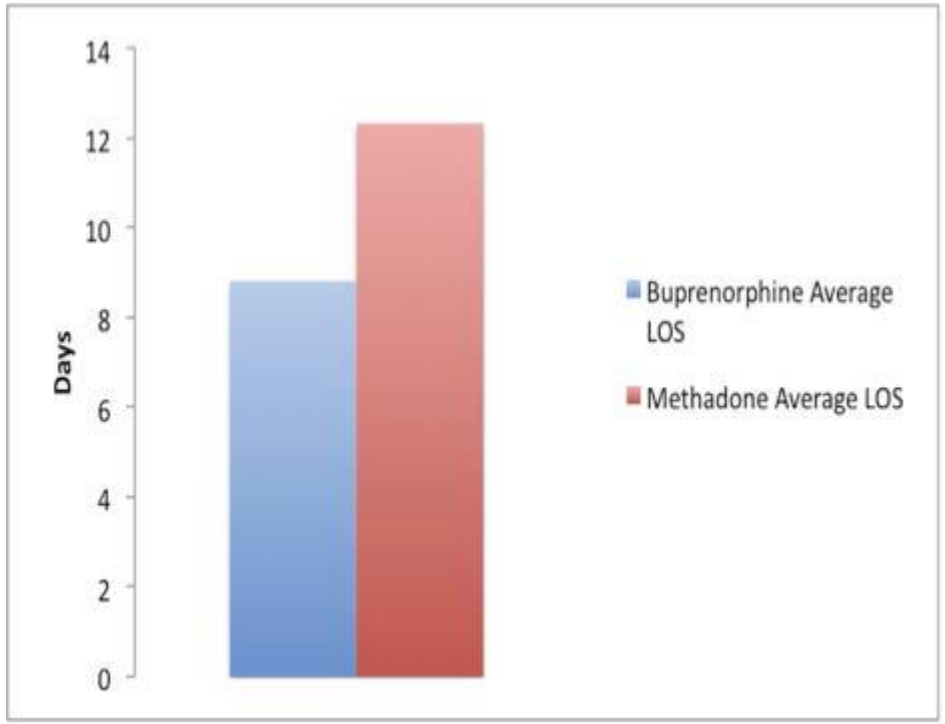


Figure 2: Average length of stay for buprenorphine-exposed and methadone-exposed infants diagnosed with NAS.

Triplett K, Goodin A, Delcher C, Brown J, and Roussos-Ross K. 2017. Opioid drug exposures and healthcare utilization measures associated with neonatal abstinence syndrome in Florida, 2011-2015. *Journal of Obstetrics and Gynecology.* 1(4): 018

For Addicted Women, the Year After Childbirth Is the Deadliest

Sleep deprivation, dramatic hormonal shifts and the day-to-day realities of caring for an infant create enormous stress for all women, but especially for those who are struggling to stay in recovery from drug use.

Most medical protocols and social safety net programs are set up to shift attention away from the mother after delivery and focus exclusively on the new baby.

For many women, access to medical care and social supports evaporates after a baby is born.

Growing evidence suggests that women should receive continuous medical attention during what is now called the “fourth trimester” — a period lasting at least a year after childbirth. Even for women without an opioid addiction, the likelihood of severe depression soars. Research indicates that nearly 15 percent of all mothers suffer postpartum depression. For minority women and those living in poverty, the rate can more than double.

In 2018, the American College of Obstetricians and Gynecologists issued new medical guidelines for postpartum care, saying that ongoing attention rather than a single encounter with a medical professional is urgently needed to “reduce severe maternal morbidity and mortality.”

Stateline Article August 14, 2018 By: Christine Vestal Pew Charitable Trusts

Caring for Moms Improves Neonatal Outcomes

Family Planning support

- Over 80% of pregnancies are unintended.
- Fewer than 10% of women use highly-effective contraception (i.e. LARC).

Support for co-occurring psychiatric disorders

- 65-73% of women suffer from anxiety and depression.
- 45% of women screen positive for postpartum depression.

Support for parenting

- Many women lack knowledge about basic infant care.
- 64% believed they would spoil their newborn by holding them when they cried.

Holbrook A, 2012; Chapman SL, 2013; Benningfield MM, 2012; Velez ML, 2004; Terplan, 2015; Heil, 2011

Recommendation 7

To increase physicians with an addiction medicine specialty, ensure graduate medical education positions are allocated to fellowship and residency programs for addiction medicine.

Recommendation 8

Promote legislation that adds the Secretary of the Agency for Health Care Administration and the Commissioner of the Office of Insurance Regulation as members of the Statewide Drug Policy Advisory Council.

Recommendation 9

Continue the statewide Recovery Oriented System of Care (ROSC) initiative designed to promote and enhance recovery efforts in Florida and support the continued development of the Recovery Community Organization (RCO) and a statewide RCO that helps link community initiatives.

Recommendation 10

The Council recommends that efforts and initiatives to modify Baker and Marchman Act laws, regulation, and funding ensure that Floridians have access to emergency crisis services and maintain the safety of individuals, families, and communities.

Agency and Member Updates

Statewide Drug Policy Advisory Council members or designees will be recognized to provide updates.

Public Comment

Members of the public will have time to speak to the council. Those wishing to address the group are asked to raise their hands (in-person or virtually) to be recognized.

Next Steps/Adjournment

Future meeting dates will be posted on the Statewide Drug Policy Advisory Council's webpage: https://www.floridahealth.gov/provider-and-partner-resources/dpac/dpac-meetings.html

Thank you to council members, designees, and members of the public for joining today's meeting.