OPIOID USE DISORDER AND PREGNANCY SEMINAR

- Describe the **issue** of maternal **opioid** use in **pregnancy**
- Discuss **gender-specific considerations** in the **assessment** and **treatment** of **opioid** use among **pregnant** women
- Discuss **treatment options** for **opioid** use among **pregnant** women

PRESENTERS

- Angela Bonaguidi, LCSW, LAC, MAC
- Kaylin Klie, MD
- Daniele Wolff, MS, CACIII

MEDICATION ASSISTED TREATMENT

Angela Bonaguidi, LCSW, LAC, MSW, MAC
Director Adult Outpatient Program
Angela.Bonaguidi@ucdenver.edu

MAT IS NOT DETOX

OTP

- •Gender Responsive Care
- •EBP Substance Abuse and Cognitive Therapy Groups
- •Individual Sessions
- •Medication Assisted Treatment
- •Primary Care with Nurse Practitioner
- •Medical Case Management with RN
- •Transportation Assistance
- •Psychiatric Care
- •Trauma-Informed Care

- •Seeking Safety
- •Helping Women Recover
- •EMDR
- •Auricular Acupuncture
- •CFT- Knitting
- •Abstinence Monitoring
- •Cont' Management
- •Infectious Disease Testing
- •Hepatitis A & B Vaccination
- •Tobacco Cessation

MEDICATION ASSISTED TREATMENT

Opioid Use Disorder

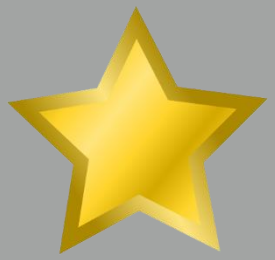
- Methadone
- Buprenorphine Products
- Naltrexone
- Extended Release Injectable Naltrexone
- Naloxone

Alcohol Use Disorder

- Antabuse
- Naltrexone
- Extended Release Injectable Naltrexone
- Campral

PROGRAM CERTIFICATIONS

- SAMHSA (OTP)
- State Treatment License
- Controlled Substances License
- DEA
- CARF



MEDICAL OFFICE-BASED VS. SPECIALTY CLINIC TREATMENT

- Licensed as opioid treatment programs and are approved by OBH and DEA to use schedule II and III substances in the treatment of addiction
- No cap

TAKE-HOME MEDICATION

- ✓ Most recent toxicology screen is negative
- ✓ Clinical assessments completed
- ✓ Minimum of one (1) hour of counseling per month
- ✓ No unexcused dosing absences
- ✓ No unexcused counseling absences
- ✓ Compliance with OMAT policies and procedures
- ✓ No known recent criminal activity
- ✓ No alcohol abuse
- ✓ Competent to safely handle take-home doses
- ✓ Responsible behavior
- ✓ Stable living environments
- ✓ Stable social relationships
- ✓ Adherence to service plans
- ✓ Compliance with on-site dosing schedules

FEDERAL REGULATIONS **WHO** CAN DISPENSE?

- Medical staff in OTP only
- Physicians cannot maintain unless
  - Licensed by DEA and state authority
- Use in hospital settings
  - Only for detoxification treatment
  - Temporary OMAT during hospitalization

Regulation 21 CFR 291.505

"You've got to want to connect the dots, Mr. Michaelson."

WHY MAT FOR PREGNANT WOMEN?

- **Methadone** and **buprenorphine** **prevent** withdrawal.
- **Withdrawal** for **pregnant** women is **dangerous** because it causes the uterus to **contract** and **may** bring on **miscarriage** or **premature** birth.
- IVDU is **associated** with **infections.**

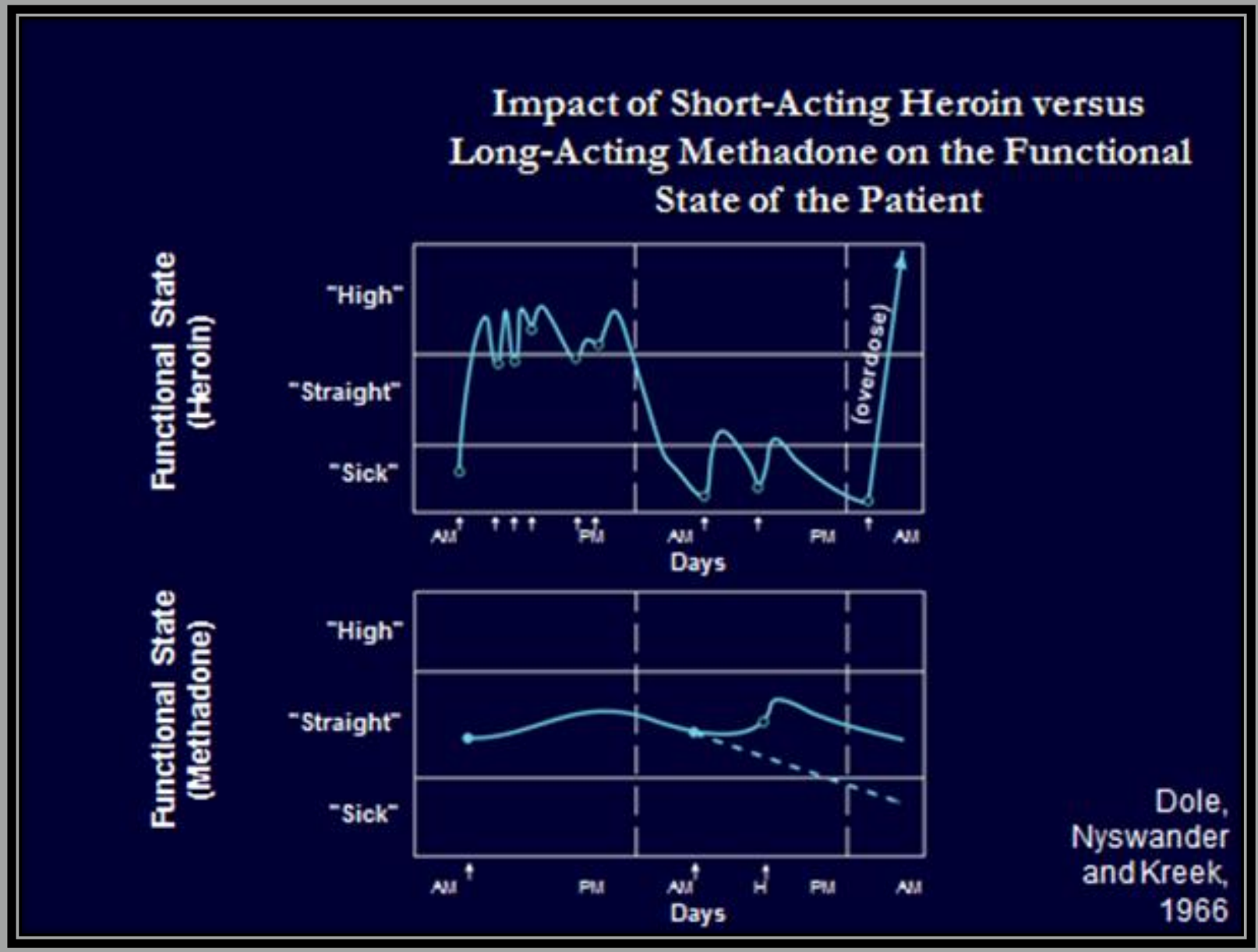
BIRTH CONTROL

- Opioid use may interrupt menstrual cycle
- As Opioid use decreases, reproductive system "wakes up"
- Increased change of pregnancy
- Review birth control options

Addiction/Chronic Illness

	Compliance Rate	Relapse Rate
Addiction		
Alcohol	30-50%	50%
Opioid	30-50%	40%
Cocaine	30-50%	45%
Nicotine	30-50%	70%
Insulin Dependent Diabetes		
Medication	<50%	30-50%
Diet and Foot Care	<50%	30-50%
Hypertension		
Medication	<30%	50-60%
Diet	<30%	50-60%
Asthma		
Medication	<30%	60-80%

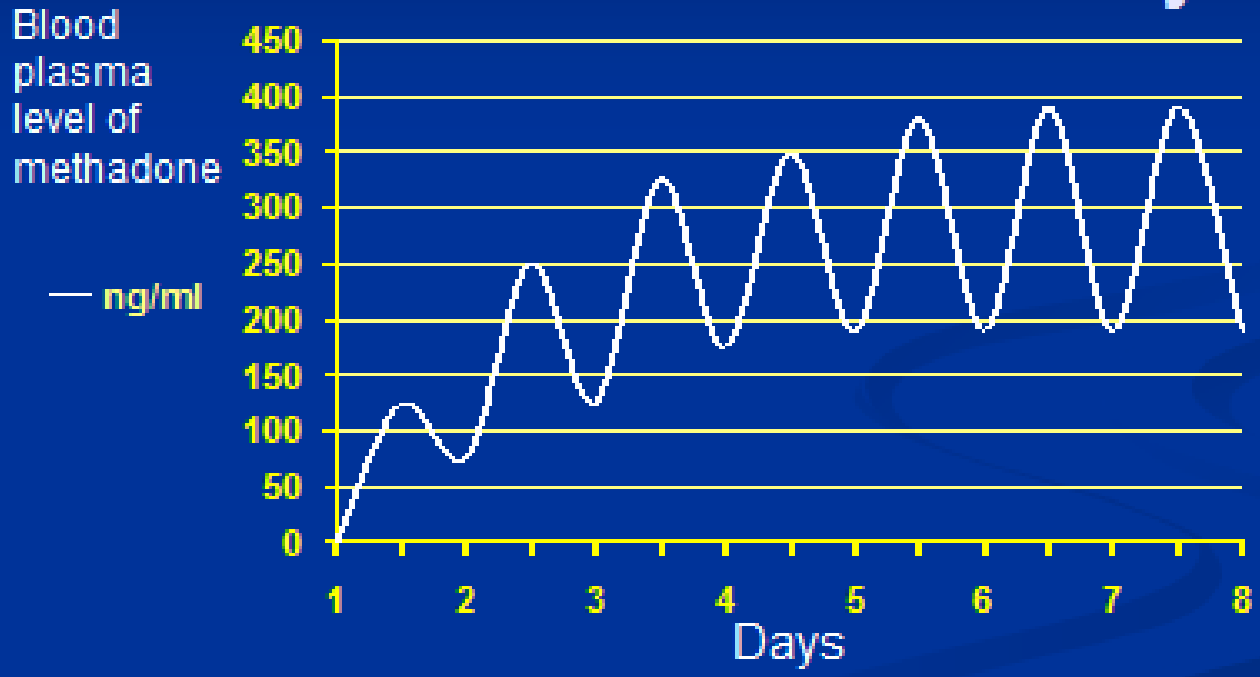
(O'Brien & McLellan, 1996)


Impact of Short-Acting Heroin versus Long-Acting Methadone on the Functional State of the Patient
Functional State (Heroin)
"High"
"Straight"
"Sick"
(overdose)
AM
PM
AM
PM
AM
Days
Functional State (Methadone)
"High"
"Straight"
"Sick"
AM
PM
AM
H
PM
AM
Days
Dole, Nyswander and Kreek, 1966

Induction & Initial Dosing

- Administered under supervision
- No signs of sedation or intoxication
- Manifestation of withdrawal symptoms
- Single dose of 20-30 mg Methadone, not to exceed 40 mg
- Same day adjustment, wait 2-4hrs after initial dose (peak effect), 5-10 mg increase
- Maximum dose first day 40 mg

Slow "Build-up" of Constant Dose of Methadone to Steady-State



Dose constant at 30 mg to steady-state

Opioid Maintenance Pharmacotherapy - A Course for Clinicians

MYTHS: METHADONE

- Myth #1: Methadone isn't effective
  - Success rates 60%-90%, improves with longer treatment stays.
- Myth #2: Methadone is just another addictive substance
  - Physically dependent, but not necessarily addicted. Lack cravings and tolerance.
- Myth #3: Methadone rots your teeth and gets in your bones
  - No issues with good dental hygiene and does not cause harm to skeletal system.
- Myth #4 Methadone leads to increase overdoses
  - As an opioid, it acts a protective barrier, reducing risks.
- Myth #5 Methadone produces abnormalities in fetuses
  - Women can conceive, and have normal pregnancies and deliveries while on methadone.
- Myth #6: The lower the dose of methadone, the better
  - Dose is individualized to manage withdrawal symptoms.
- Myth #7: Methadone is harder to kick than dope
  - Different- withdrawal takes longer.

GUIDELINES

- ✓ Methadone dose is carefully monitored
  - -Third trimester
- ✓ Patients are maintained at their pre-pregnancy dosage, if effective.
- ✓ Pregnant women are encouraged to consider ongoing maintenance treatment after delivery.
- ✓ Medically supervised tapering after if clinically indicated or requested.
- ✓ Babies born to mothers on methadone do as well as other babies.
- ✓ Pregnant women with concurrent HIV infection
  - -Same policies/procedures as HIV-infected patients in medication-assisted treatment.
  - -HIV medication treatment is recommended to reduce perinatal transmission.
  - -Referrals and case management.

CPS AND SPECIAL FUNDING

- Supportive programs to assist pregnant women
- Caseworkers want to see healthy, loving and secure homes
- Misuse of drugs leads to questioning of ability to care for baby
- Disclose MAT and ROIs
- Special Connections
- Enrollment during pregnancy
- Inpatient/residential treatment SUD treatment

IMPORTANT RESOURCES

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

SAMHSA's National Helpline
1-800-662-HELP (4357)

SAMHSA Store
www.store.samhsa.gov

SAMHSA's Behavioral Health Treatment Services Locator
www.findtreatment.samhsa.gov

SAMHSA's Division of Pharmacologic Therapies
www.dpt.samhsa.gov

SAMHSA's Fetal Alcohol Spectrum Disorders Center for Excellence
www.fascenter.samhsa.gov

SAMHSA's National Center on Substance Abuse and Child Welfare
www.ncsacw.samhsa.gov

This brochure was prepared under contract number HHSS283201200073I/HHSS28342001T by A-G Associates for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, opinions, and policies of this publication are those of the author and do not necessarily reflect the views, opinions, and policies of SAMHSA or HHS. The information presented should not be considered a substitute for individualized client care and treatment decisions.

SAMHSA

HHS Publication No. (SMA) 14-4124
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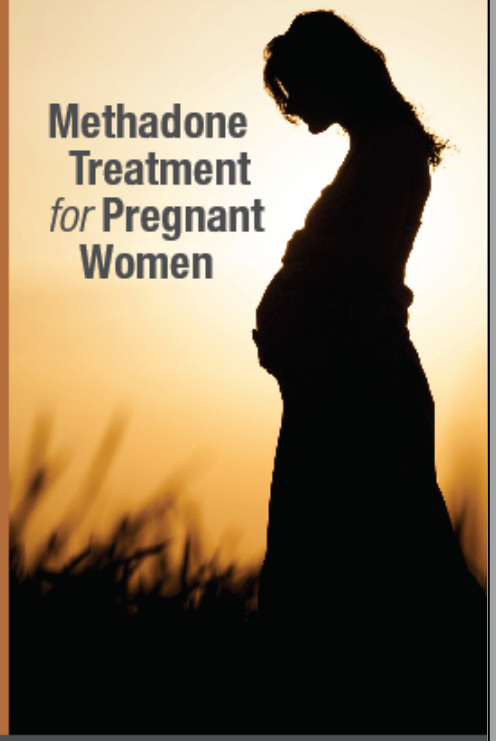
Revised 2014

Methadone Treatment *for* Pregnant Women



If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself.

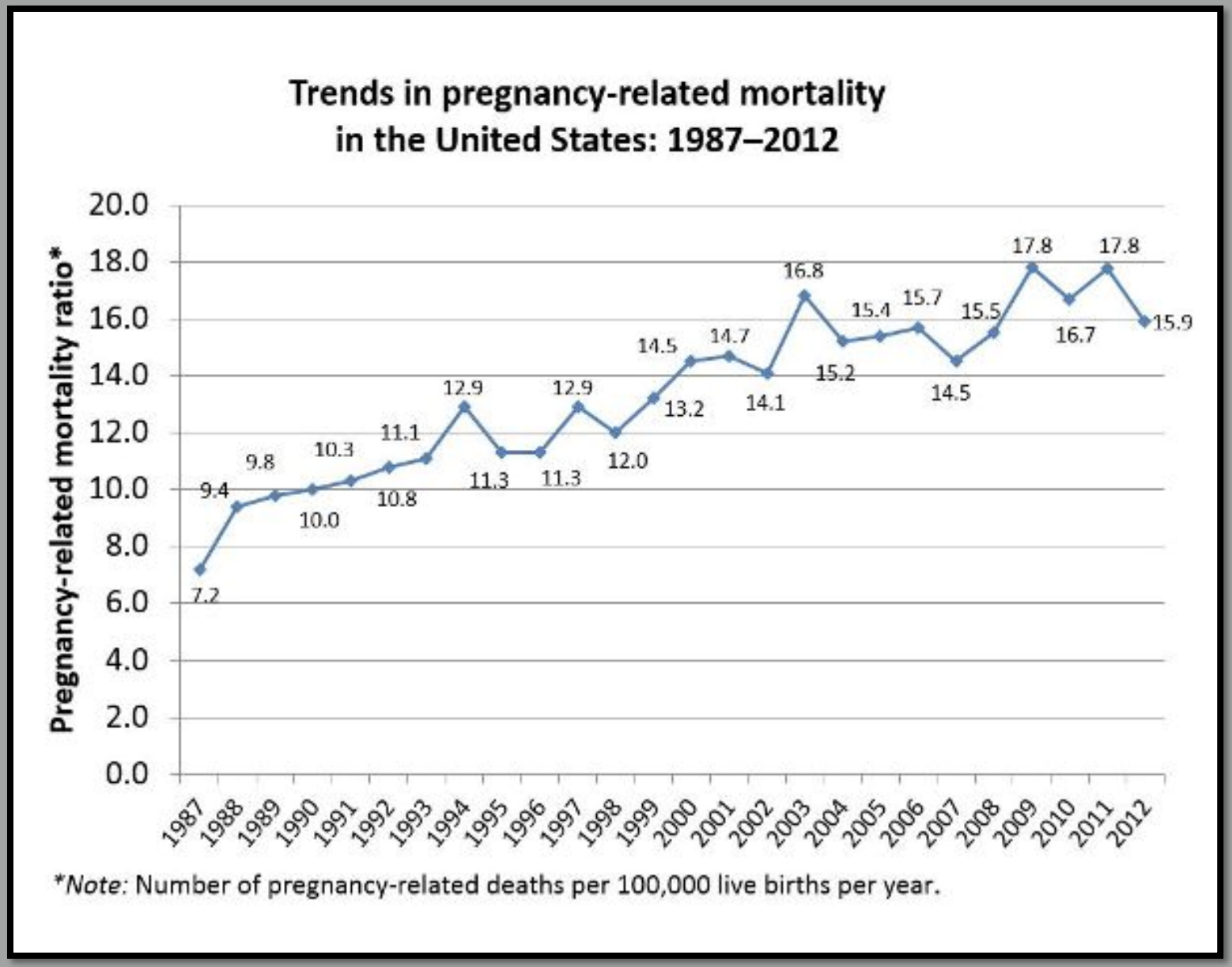
SAMHSA


If You Don't Talk To your Cat
About Catnip
Who Will?

Angela Bonaguidi, LCSW, LAC, MSW, MAC
Director, Adult Outpatient Program
Angela.Bonaguidi@ucdenver.edu

SPECIAL POPULATIONS: PREGNANT WOMEN

Kaylin Klie, MD, MA
Assistant Professor
Department of Family Medicine
Kaylin.Klie@ucdenver.edu


Trends in pregnancy-related mortality in the United States: 1987–2012
Pregnancy-related mortality ratio*
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
7.2
9.4
9.8
10.0
10.3
10.8
11.1
11.3
12.9
11.3
12.9
12.0
13.2
14.5
14.1
14.7
15.2
16.8
15.4
15.7
14.5
15.5
16.7
17.8
17.8
15.9
1987
1988
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1994
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1998
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2003
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2007
2008
2009
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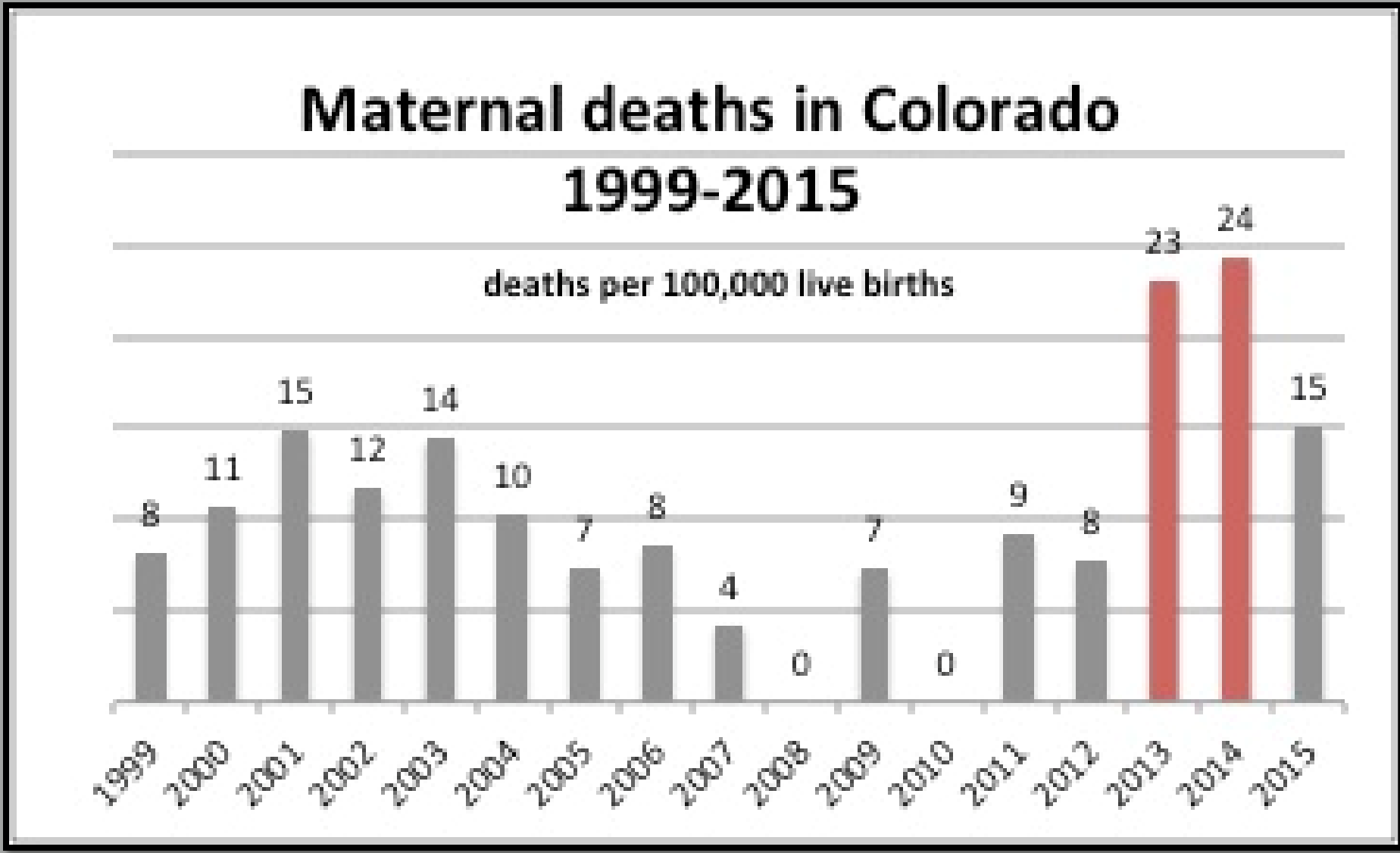
2011
2012
*Note: Number of pregnancy-related deaths per 100,000 live births per year.

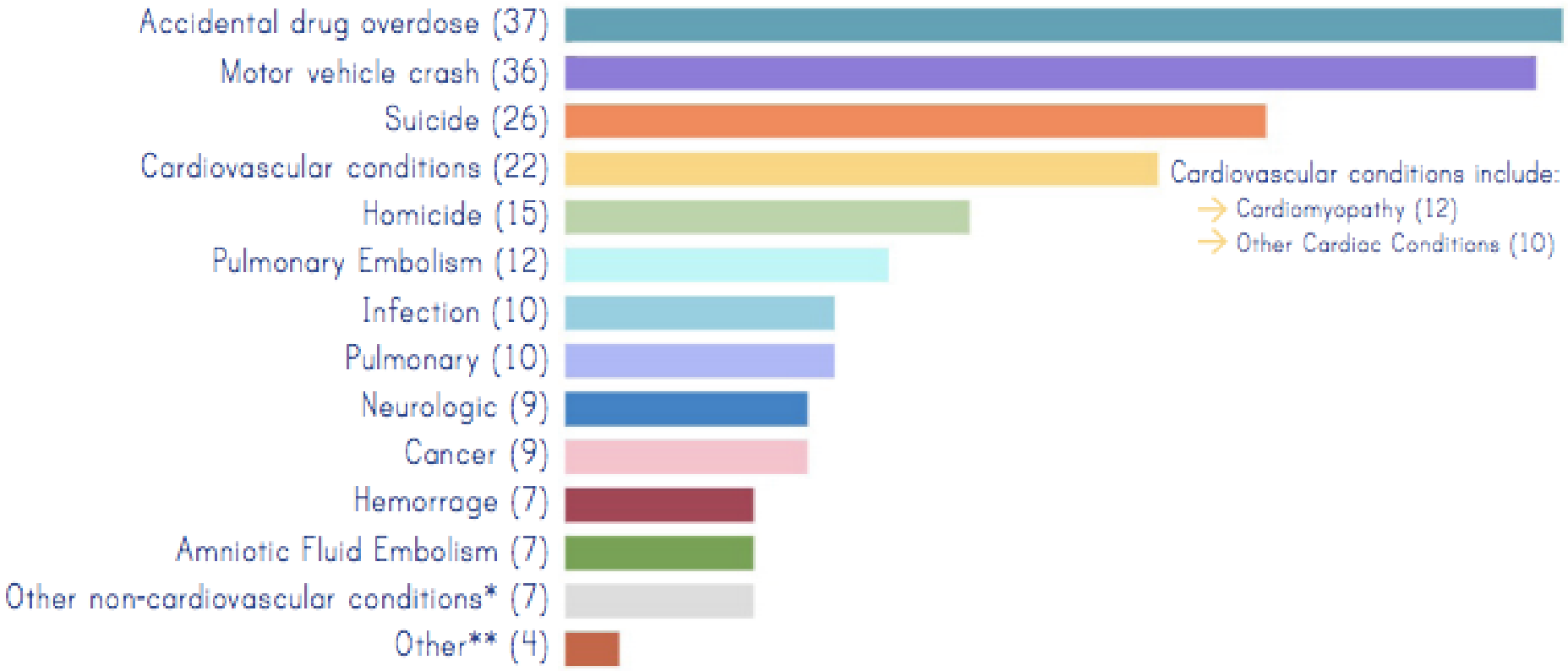

Maternal deaths in Colorado
1999-2015
deaths per 100,000 live births
8
11
15
12
14
10
7
8
4
0
7
0
9
8
23
24
15
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015

WHY?

Even as medical care improves at preventing death from traditional obstetric complications (hemorrhage, embolism, infection, etc.), deaths related to substance use and mental health conditions continue to rise.

MATERNAL DEATHS IN CO

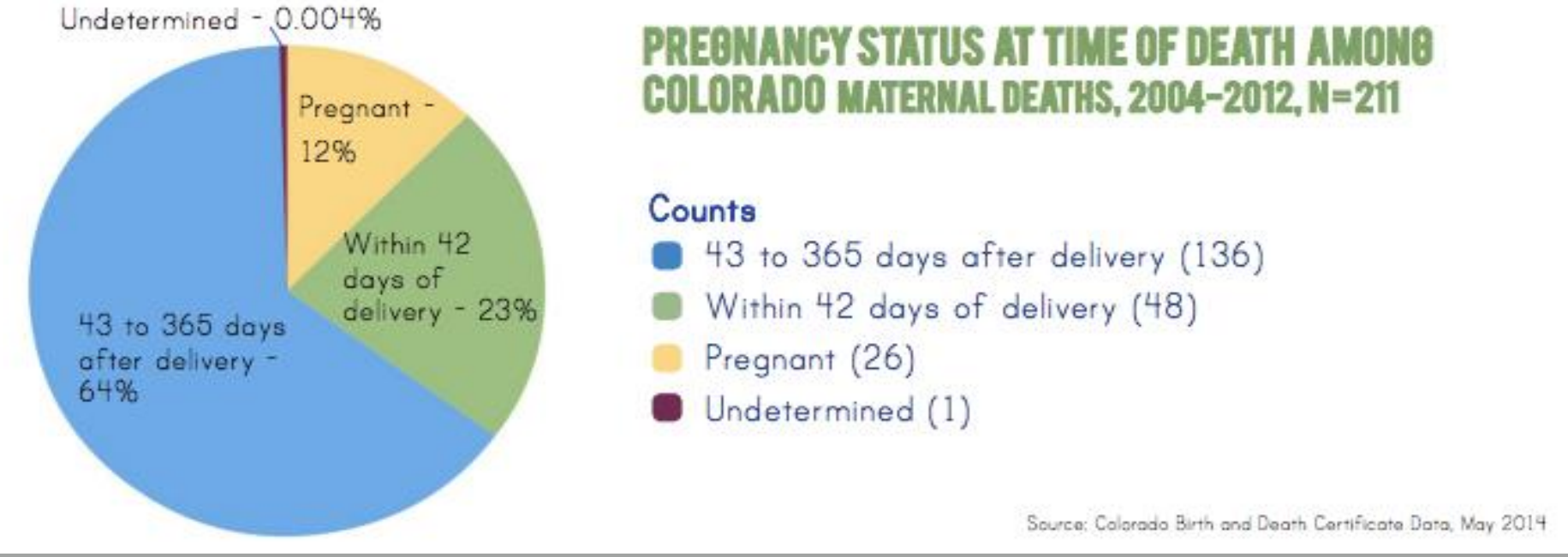
CAUSE OF DEATH AMONG COLORADO MATERNAL DEATHS, PREGNANT UP TO ONE YEAR POST DELIVERY, 2004-2012, N=211



*Other non-cardiovascular conditions include renal, hematologic and gastrointestinal conditions.
**Data suppressed due to low numbers.

Source: Colorado Death Certificate Data, May 2014

MOST DEATHS, AND THEREFORE OVERDOSES, OCCUR POST-PARTUM



OPTIONS FOR OPIOID DEPENDENCE DURING PREGNANCY

- **Detoxification**
- **Methadone**
- **Buprenorphine**

INITIAL EVALUATION

- Know about specialized treatment services available in the community for pregnant, opioid-dependent patients
  - Referral should be made regardless of the patient's decision to continue the pregnancy
- Obtain consent to talk to her obstetric provider (or consent to talk to substance use treatment provider, parole officer, etc)

WHY HAS DETOXIFICATION FROM OPIOIDS DURING PREGNANCY BEEN LONG AVOIDED?

Narcotic withdrawal in pregnancy: Stillbirth incidence with a case report

JOSÉ LUIS REMENTERÍA, M.D.
NEMESIO N. NUNAG, M.D.
Bronx, New York

A stillborn infant was born to a drug-addicted mother who had withdrawal symptoms shortly before delivery. Mechanisms are presented to help explain the possible relationship between the maternal withdrawal and the fetal death. Statistics are also presented to show an increased stillborn and neonatal mortality rate in the over-all pregnant drug-addicted population.

DETOXIFICATION: NOT BEST APPROACH FOR MATERNAL CARE

- 93 patients
- All offered detoxification
- Gestational age about 20 weeks at entry
- Duration of detoxification: 25 days
- 3 women with fetal demise not counted in statistics: 2 of them failed detox, had no treatment, continued illicit drug use, and presented with IUFD.

42/95 (44%) women were not engaged in treatment, 2 had IUFD

There was no f/u of how the women fared after delivery

Detox can be done: are we treating women only for the benefit of the fetus?

TABLE 3
Infant outcomes of women electing inpatient opioid detoxification compared by illicit maternal drug use at delivery

Variable	No illicit drug use at delivery, n = 53	Illicit drug use at delivery, n = 40	*P* value
Max NAS score	0 [0, 0]	8.3 [6.5, 10]	< .001
Infant treated for withdrawal	5 (10)	33 (80)	< .001
Infant hospital duration, d	3 [2, 6]	22 [15, 26]	< .001
Gestational age at delivery	39 ± 1.9	37.8 ± 2.4	.008
≤34 wk	4 (8)	4 (10)	.69
≤36 wk	5 (10)	7 (18)	.27
Birthweight percentile	3065 ± 487	2788 ± 516	.01
<10th	7 (13)	12 (30)	.05
<3rd	1 (2)	2 (5)	.40
5-min Apgar <4	0	1 (3)	.26
pH <7	0	0	NA
Neonatal death	0	0	NA

Data reported as n (%), mean ± SD, median [First Quartile, Third Quartile].

NA, not applicable; *NAS*, neonatal abstinence syndrome.

Stewart. Opioid detoxification in pregnancy. Am J Obstet Gynecol 2013.

Stewart, AJOG, 2013

DETOX SAFE. IS IT EFFECTIVE?

- Bell et al (2016) reported on 301 patients who underwent detoxification during pregnancy
- No adverse fetal outcomes, but NAS rates…
  - Incarcerated: 18.5%
  - Intensive outpatient: 17.4%
  - Buprenorphine taper: 17.2%
  - No follow up (70.1%)
- Relapse rates 36% (17-74)
- Treating a chronic condition with an acute treatment without clear fetal benefit

BENEFITS OF OPIOID AGONIST THERAPY (METHADONE)

Maternal Benefits

- **70% reduction in overdose related deaths**
- Decrease in risk of HIV, HBV, HCV
- Increased engagement in prenatal care and recovery treatment

Fetal Benefits

- Reduces fluctuations in maternal opioid levels; reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

OPIOID MAINTENANCE THERAPY

- Methadone:

- Buprenorphine:

MAINTENANCE THERAPY REMAINS THE STANDARD OF CARE

- Methadone and buprenorphine are safe and effective treatment options in pregnancy
- The decision of which therapy to start is complex and should be individualized for each woman
  - Based on available options, patient preference, patients' previous treatment experiences, disease severity, social supports, and intensity of treatment needed

Fischer et al. 1998, 1999.
Jones et al. 2010.

MOTHER STUDY

Randomized trial of methadone versus buprenorphine

Primary outcome: NAS

- Similar prevalence of treatment for NAS
- Less neonatal abstinence severity and treatment (bup)
- Shorter neonatal LOS (bup)
- Bigger HC

Table 2. Primary and Secondary Outcomes in the Methadone and Buprenorphine Groups.*

Outcome	Methadone (N=73)	Buprenorphine (N=58)	Odds Ratio (95% CI)	P Value
Primary outcomes				
Treated for NAS — no. (%)	41 (57)	27 (47)	0.7 (0.2–1.8)	0.26
NAS peak score	12.8±0.6	11.0±0.6		0.04
Total amount of morphine for NAS — mg	10.4±2.6	1.1±0.7		<0.0091†
Duration of infant's hospital stay — days	17.5±1.5	10.0±1.2		<0.0091†
Infant's head circumference — cm	33.0±0.3	33.8±0.3		0.03
Secondary neonatal outcomes				
Duration of treatment for NAS — days	9.9±1.6	4.1±1.0		<0.003125†
Weight at birth — g	2878.5±66.3	3093.7±72.6		0.03
Length at birth — cm	47.8±0.5	49.8±0.5		0.005
Preterm, <37 wk — no. (%)	14 (19)	4 (7)	0.3 (0.1–2.0)	0.07
Gestational age at delivery — wk	37.9±0.3	39.1±0.3		0.007
Apgar score				
1 min	8.0±0.2	8.1±0.2		0.87
5 min	9.0±0.1	9.0±0.1		0.69

Jones, NEJM, 2010

Summary of outcomes:	FAVORS Methadone	EQUIVALENT	FAVORS Buprenorphine
Maternal			
Treatment efficacy	*better for women that failed treatment in past	X*	*can be considered reasonable first line treatment
Access to treatment			X
Requires withdrawal for initiation	X		
Treatment automatically coordinated	X		
Maternal medical complications			X
Neonatal			
Long-term outcome: data	X		
Birthweight			X
Gestational age			X
% requiring NAS treatment		X	
Severity of NAS symptoms			X
Duration of NAS treatment			X

GUIDELINES

- ✓ Methadone/buprenorphine dose is carefully monitored (third trimester).
- ✓ Patients are maintained at their pre-pregnancy dosage, if effective.
- ✓ Pregnant women are encouraged to consider ongoing maintenance treatment after delivery.
- ✓ Medically supervised tapering after if clinically indicated or requested.
- ✓ Babies born to mothers on methadone do as well as other babies.
- ✓ Pregnant women with concurrent HIV infection
  - -Same policies/procedures as HIV-infected patients in medication-assisted treatment.
  - -HIV medication treatment is recommended to reduce perinatal transmission.
  - -Referrals and case management.

NEONATAL ABSTINENCE SYNDROME (NAS)

- **Some** infants **may** go through **withdrawal** after birth.
- Withdrawal does **not** mean the baby is **addicted**.
- Dose of medication has **no** bearing on **withdrawal**.
- **Signs** of withdrawal may begin at any time, from minutes to hours to
- 2 weeks after birth.
  - **Most appear** within **72 hours**.
- Withdrawal **symptoms may** last several **weeks**.
  - Fussiness/restlessness
  - Trembling
  - Vomiting not eating or sleeping well
- Mothers should **NEVER** give methadone or **any** other **medication** to
- baby **without** doctor's **approval**.
- **If** the **symptoms** are **severe**, prescribed medicine **may help**.
- **Rooming in, skin-to-skin and breastfeeding.**

BREASTFEEDING

- **Breast** is **BEST**
- **Not** recommended for women **HIV-positive**
- Hepatitis C-positive- breastfeed but check with a **doctor first**
- **Benefits** of breastfeeding often **outweigh** the **effect** of the **tiny** amount of **methadone** that enters the **breast milk**

TAKE HOME MESSAGE:

- Methadone or buprenorphine may be used during pregnancy

- It is acceptable care to initiate or maintain women on buprenorphine that meet the criteria and in whom it is the best therapeutic option/methadone is not available

HOW DO WE KNOW?

We have to ask!

- ACOG Committee Opinion 422:
  - At first prenatal visit -and-
  - At least once per trimester (alcohol in 3rd tri)
- WHO Guidelines: every visit

WHO DO WE ASK?

- Every pregnant woman….period.
  - Selective “screening” based on subjective risk factors does two things:
    - Perpetuates bias and stigma
    - Misses most women who need help!

TOX TESTS?

- What about urine?
  - Urine toxicology is not a screen, it's a test
  - More important to start with a conversation than an "accusation"
  - ACOG (2012) "Not to be used as sole assessment of substance problems"

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
1951
WOMEN'S HEALTH CARE PHYSICIANS

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

ARTS Addiction Research & Treatment Services

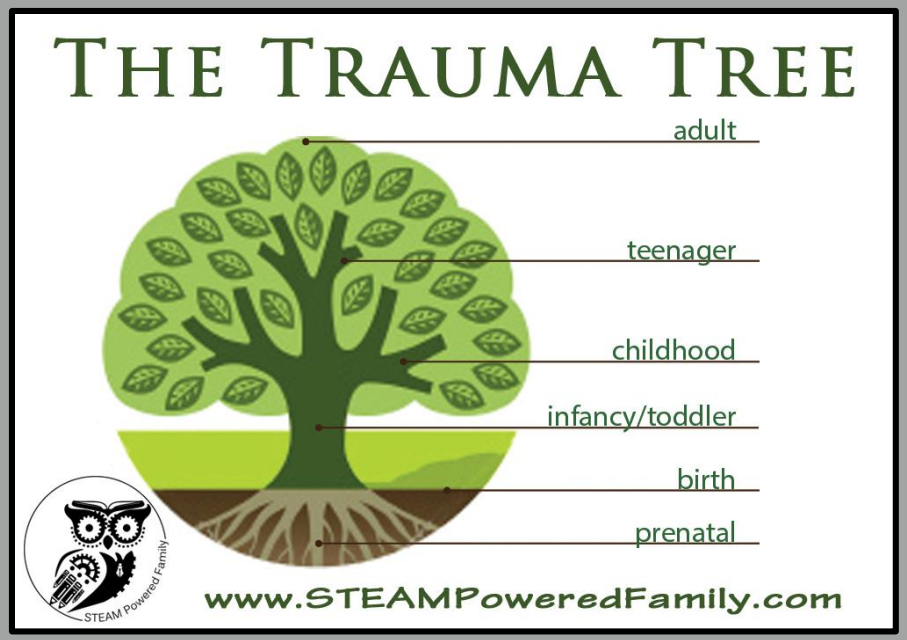
University of Colorado Anschutz Medical Campus

HOW DO WE ASK?

- Women are not offended by questions asked in an open, caring, and nonjudgmental manner
- Normalize
- Ask permission

STARTING THE CONVERSATION

- 4 “P”s
  - Parents?
  - Partner/Peers?
  - Past?
  - Present?



- Asking about peer/partner substance use is more highly associated with individual’s risk of use the younger the individual is

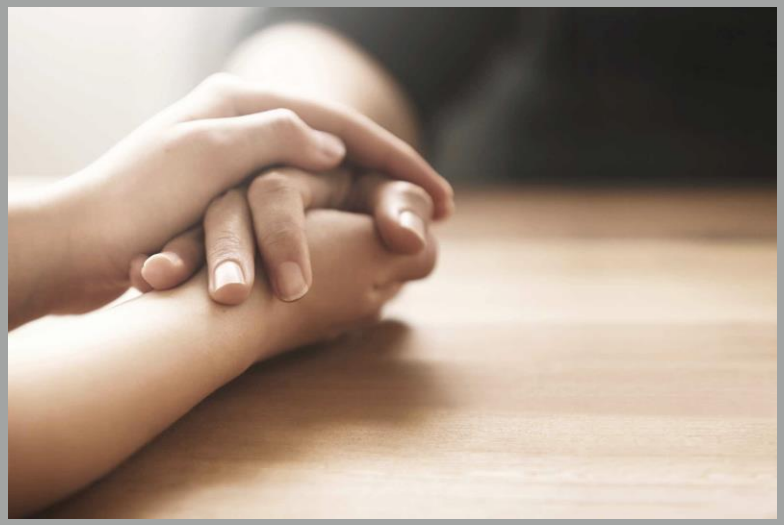
SCREENING TOOLS

- SBIRT
- AUDIT-C/AUDIT
- T-ACE
- DAST
- Adolescents:
  - Ages 12-17: S2BI
  - Ages 14-21: CRAFFT

IF ALL ELSE FAILS…

"I will still take care of you"

"You are not alone"



OK, NOW WHAT?

- If you have the experience of a woman disclosing substance use in pregnancy:
  1) Thank her for coming in to care
  2) Commend her honesty and bravery
  3) Refer for further assessment and treatment, regardless of intention to continue pregnancy
- Document discussion with pt and referral
- Addiction specialists can do further assessment and make treatment recommendations

KAYLIN KLIE, MD, MA
Assistant Professor
Department Of Family Medicine
KAYLIN.KLIE@UCDENVER.EDU

TREATMENT OPTIONS
THE HAVEN

Daniele Wolff, MS, CAC III
Director of The Haven
Daniele.Wolff@ucdenver.edu

SUBSTANCE USE DISORDER TREATMENT FOR PREGNANT AND PARENTING WOMEN

- Factors that encourage a woman to stay in treatment include:
  - Supportive therapy that reduces barriers
  - A collaborative therapeutic alliance. Safe, supportive, and confidential
  - Onsite child care and children services
  - Other integrated and compressive treatment services
    - Services tailored to effectively address pregnancy, child care, children services, and parenting skills.
    - Integrated care for co-occurring disorders including PTSD, anxiety, postpartum depression, and other mood disorders, and eating disorders.

Criminal justices system or child protective service involvement is associated with longer retention in treatment (*SAMHSA 2014*)

THE HAVEN PROGRAMS MODIFIED THERAPEUTIC COMMUNITIES FOR WOMEN

- 20 beds for Women at the Haven
- 16 beds for Pregnant Women or Women of Infant Children
  - Special Connections Program where women who are eligible for Medicaid may qualify to have their treatment paid for up to one year post partum
  - Long term residential care designed to treat severe substance use disorders and co-occurring mental health

THE HAVEN…PUTTING LIVES BACK ON TRACK AND KEEPING FAMILIES TOGETHER

The Haven and Haven Mother's House Missions are to provide a safe and empowering environment where women, pregnant women, and women with infant children can recover from addictions and co-occurring illnesses; deliver healthy, drug-free infants; improve parenting skills; and become self-sufficient, confident, and productive members of the community.

WHEN DO CLIENTS NEED RESIDENTIAL TREATMENT?

ASAM CRITERIA FOR PLACMENT

- Severity of Use
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness for Change
- Relapse, Continued Use or Continued Problem Potential
- Recovery Environment
- Other factors that would affect placement

Our Intake Specialists will complete an assessment and make additional referrals for other levels of care as needed.

SERVICES FOR MOTHERS, INFANTS AND FAMILIES

- Pregnancy and Post Partum Counseling Services
- Focus on bonding, attachment, and social emotional health
- Prenatal care and vitamins
- Postnatal care and coordinated pediatric care
- Case management related to benefits, CCAP, WIC, etc.
- Incredible Years Parenting Groups

COMPREHENSIVE, INDIVIDUALIZED SERVICES

- Evidenced based curriculums
- Gender responsive, trauma informed, culturally sensitive treatment
- Cognitive Behavioral Therapy
- Individual and Group Therapy
- Family Group
- Case Management
- Medical Evaluation
- Dental Care
- GED Classes
- Vocational Assessment and Classes
- Exercise Classes
- Random Drug and Alcohol Screening
- Extensive assessment and treatment Planning
- Integrated treatment for co-occurring mental health disorders including DBT and EMDR
- Opioid Replacement Therapy and Mediation Assisted Treatments
- Infectious disease screening and counseling
- Transition to Outpatient Therapeutic Community and supportive transitional living

BABY HAVEN
LICENSED AND QUALITY RATED CHILDCARE

- 2 Generational Model
- Developmental Assessments
- Consultation in Social and Emotional Development with MHCD
- Evidenced Based Child Curriculums
- Family Partnerships and Integrated Care with the Community.

ARTS Addiction Research & Treatment Services

University of Colorado Anschutz Medical Campus

COMMUNITY AS METHOD

TCs differ profoundly from other communities in their rationale and purpose. Their specific objective is to treat the individual disorder, but their larger purpose is to transform lifestyles and personal identities. TCs use active participation in group living and activities to drive individual change and attainment of therapeutic goals. With an emphasis on social learning and mutual self-help, individual participants take on some of the responsibility for their peers' recovery. This aid to others is seen as an important part of changing oneself.---George DeLeon.

"What we can't do alone, we can do together."

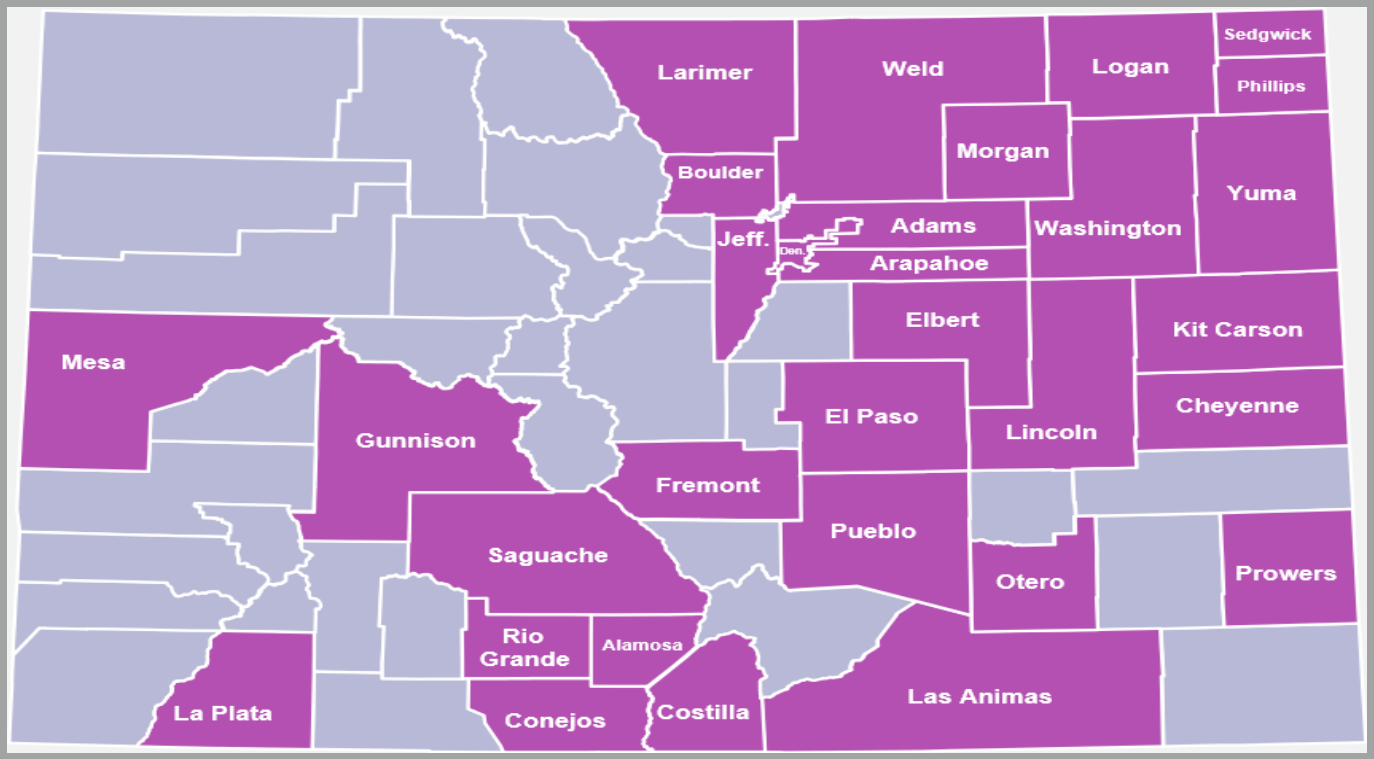
SUPPORT IS THE FOUNDATION OF THE PROGRAM

“I don’t know what I would have done without the support of the Haven women. I think if I had to do this on my own, I would have lost myself and most definitely would have lost my child to social services. The other ladies were there when I delivered and to help me through it. I had a lot of guilt for using while pregnant and seeing my child in the hospital. The ladies were with me at the hospital and when I came home, helping me every step of the way. I am the most grateful for the support I received through the Haven Mother’s House.”

ADDITIONAL TREATMENT RESOURCES

Mother's Connection

COMPASSIONATE CARE FOR MOTHERS STRUGGLING WITH ADDICTION



ARTS Addiction Research & Treatment Services

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THANK YOU

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INTAKE INFORMATION

303-336-1600

Daniele Wolff, MS, CAC III
Director of The Haven
Daniele.Wolff@ucdenver.edu