

The Association Between Environmental Exposure to Illicit Drugs and Child Abuse

By Joseph Jones, MS, NRCC-TC Vice President Laboratory Operations

Children in an environment where illicit drugs are allowed, used, or manufactured are at high risk for a number of negative health outcomes including physical abuse, sexual abuse, psychological abuse, and neglect. The ill-effects of substance abuse extend beyond the obvious self-inflicted damage caused by the use of the drug itself. The responsibility of caring for a child is very demanding and substance abuse by an adult charged with a child's well-being is counter-productive to this task (Wells, 2009). Intoxicated caregivers will not respond appropriately and will have impaired judgment. Withdrawing caregivers are likely to be inattentive, violent, and paranoid.

The association between drug abuse and child abuse has been well documented. Several studies have demonstrated that children living in an environment of substance abuse were approximately 2.7 and 4.2 times more likely to experience abuse and neglect, respectively (White, 1995; Kelleher et al, 1994; SAMHSA, 1996). A national survey conducted by Prevent Child Abuse America reported that substance abuse in the home was one of the leading contributing factors for families reported for child abuse (Wang and Harding, 1999). A study conducted of cases before a metropolitan juvenile court reported that 43% of child abuse cases before that court involved parents engaged in substance abuse (Murphy et al, 1991). Lastly, Reid, Macchetto, and Foster (1999) reported that up to two-thirds of child abuse related fatalities also involved caregiver substance abuse.

A child who has been identified as drug exposed is also identified to be at high risk for a

number of negative consequences. The primary objective for testing is to assist authorities in identifying those in need of substance abuse treatment and connect them to the appropriate resources. However, in the absence of compliance with substance abuse treatment, Wells (2009) points out that court-ordered termination of parental rights must be considered to ensure a safe and stable environment for the child.

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Prescription Painkiller Overdoses: Methadone

CDC Vital Signs Report July 2012

Almost one-third of prescription painkiller overdose deaths involve methadone. Six times as many people died of methadone overdoses in 2009 than a decade before.

More than 15,500 people die every year of prescription drug overdoses, and nearly one-third of those overdoses involve the drug methadone. Researchers found that while methadone accounts for only 2 percent of painkiller prescriptions in the United States, it is involved in more than 30 percent of prescription painkiller overdose deaths.

Methadone has been used for decades to treat drug addiction, but in recent years it has been increasingly prescribed to relieve pain. As methadone prescriptions for pain have increased so have methadone-related fatal overdoses. CDC results showed that six times as many people died of methadone overdoses in 2009 as died in 1999.

The *CDC Vital Signs Report* discusses this problem, shares data on methadone overdose death rates, and suggests prevention measures that can help.

The Problem

- Methadone is frequently prescribed for pain.
- Methadone, like other painkillers, is commonly prescribed for chronic problems like back pain even though it might not help these problems in the long run.

- More than 4 million methadone prescriptions were written for pain in 2009, despite US Food and Drug Administration (FDA) warnings about the risks associated with methadone.
- Methadone is available as a low-cost generic drug. It is often listed as a preferred drug by insurance companies.

Methadone's Risks Include:

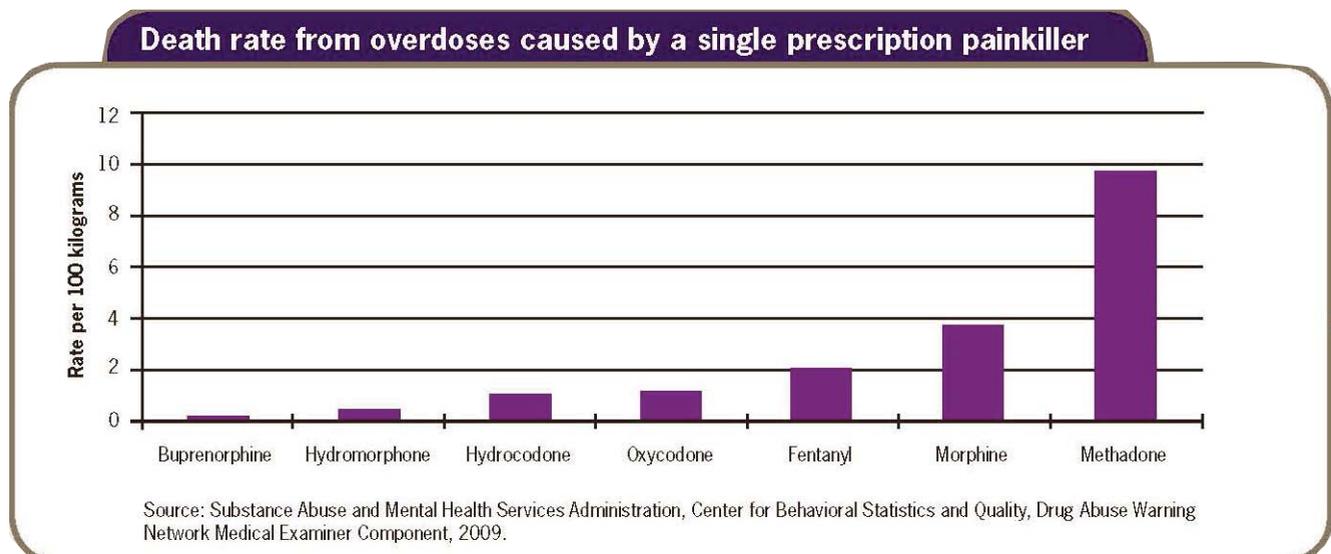
- The difference between prescribed doses and dangerous doses of methadone is small.
- Methadone has special risks as a painkiller. For example, taking it more than 3 times a day can cause the drug to build up in a person's body, leading to dangerously slowed breathing.
- Methadone can seriously disrupt the heart's rhythm.
- Methadone can be particularly risky when used with tranquilizers or other prescription painkillers.
- In one study, four in ten overdose deaths involving single prescription painkillers involved methadone, twice as many as any other prescription painkiller.

Steps for Safety

Individuals can:

- Use methadone only as directed by a healthcare provider.
- Make sure they are the only ones to use their methadone and never sell or share it with others.
- Store methadone in a secure place and dispose of it properly.
- Get help for substance abuse problems, if needed.

<http://www.cdc.gov/Vitalsigns/MethadoneOverdoses/index.html>



Initial Studies Show Substituted Cathinones Informally Known as “Bath Salts” may be as Addictive as Meth or Cocaine

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At this year’s 74th Annual College on Problems of Drug Dependence Meeting (CPDD) in LaQuinta, California the pharmacology of “Bath Salts” was addressed in several scientific presentations. “Bath Salts” are a series of substituted cathinone compounds that have been marketed primarily as “Not for Human Consumption” products to avoid legal constraints.

These studies of the basic pharmacological properties of these arrays of compounds suggest that as a group, the substituted cathinones from mephedrone to MDPV to 4-FMC, etc. all produced significant increases in locomotor activities in rats and mice, were all potent reinforcers of behaviors and appeared to produce their own individual forms of behavioral toxicity on a scale not less damaging than cocaine or methamphetamine.

While the data sets are still quite thin, this early data along with the empirical data from “the street” in the form of ER admissions and Poison Control Center calls indicates that the substituted cathinones are anything but safe, legal highs as some internet sites suggest.

Study Describes Illicit Use of Buprenorphine Among Nonmedical Users of Opioids in Ohio

While buprenorphine misuse has been reported in many states, most studies have focused on opioid-dependent individuals, heroin users, and/or those in treatment. For example, an Ohio study of treatment providers, law enforcement officials, and drug users recruited through treatment programs found evidence of increasing buprenorphine misuse (see *CESAR FAX*, Volume 21, Issue 2). New research in Ohio now provides evidence of illicit use of buprenorphine among a population not previously studied—young adults not involved with heroin or injection drug use nor dependent on pharmaceutical opioids.

Following are findings from this community-recruited sample of young adults from the Columbus, Ohio area:

Knowledge About Buprenorphine:

The majority of users reported that when they were first introduced to buprenorphine they had limited knowledge about the drug. Some had no idea it was used to treat opioid dependence and were told that it would work like any other pain pill.

Street Availability:

While the majority of respondents reported that buprenorphine was more difficult to obtain than more commonly used prescription opioids (such as oxycodone or hydrocodone), several respondents reported that they felt the popularity of and demand for buprenorphine has been rising. Friends or acquaintances who were addicted to prescription opioids or heroin and networks of users with legitimate prescriptions were the most common sources of illicitly used buprenorphine. In fact, some users “expressed a belief that buprenorphine doses prescribed by physicians were too high for most patients who needed much lower amounts to control their withdrawal symptoms” (p. 205).



Use to Get High:

While approximately one-half said that they took buprenorphine to get high, the reported effects ranged from no effect to too intense. Those who used buprenorphine to get high typically used it on very few occasions, either because the street availability was limited or they did not get the euphoric effects they expected or wanted. Some believed that you need to inhale buprenorphine and/or have a low tolerance to opiates to get high.

Use to Self-Medicate:

About one-half reported using buprenorphine to self-medicate withdrawal symptoms, using the drug regularly to replace their preferred opiates, to reduce their illicit pain pill use, or to quit altogether. Self-medication was preferred to going to a substance abuse treatment program because of the high cost of buprenorphine-based treatment at primary care, waiting lists at publicly-funded facilities, and the stigma related to seeking drug treatment.

SOURCE: Adapted by CESAR from Daniulaityte, R., Falck, R., and Carlson, R.G., “Illicit Use of Buprenorphine in a Community Sample of Young Adult Non-Medical Users of Pharmaceutical Opioids,” *Drug and Alcohol Dependence* 122(3):201-207, 2012.



United States Drug Testing Laboratories, Inc.

Up Coming Events:

- July 26-28 – Texas Association of Addiction Professionals – San Antonio, TX
- August 5-7 – American Association of Nurse Anaesthetists – San Francisco, CA
- August 18-22 – National Association for Addiction Professionals (NAADAC) – Indianapolis, ID
- Sept 5-8 – CSAM – Long Beach, CA
- Sept 13-15 – Behavioral Health and Addictive Disorders – New Brunswick, NJ
- Sept 28-Oct 2 – National Conference on Addiction Disorders (NCAD) – Gaylord Palms, Orlando FL

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