Welcome!

Thank you for joining us today.

The **Weaving Wellness Webinar Series (Part I)**
Learning with the Expert: A Dialogue with Dr. Mishka Terplan will begin shortly.

- You can join either through computer audio *or* phone audio. If you can't/do not want to use computer audio, please dial in by phone:
  - **888 475 4499** or **877 853 5257** (both US Toll-free).
  - When prompted, enter Meeting ID: **992 4521 7313**, followed by #.
- Please note that all participants will have video and speaker phone automatically turned off upon entering the Zoom meeting.
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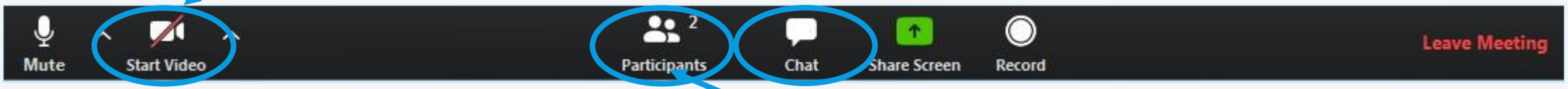
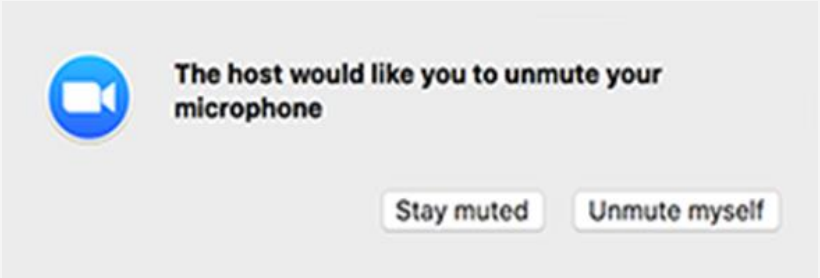


If you'd like to speak, send us a chat or raise your hand! You will receive the notification once we've enabled you to speak *(see screenshot below).*



Click here to raise your hand if you'd like to speak. You can also click the other icons to submit non-verbal feedback.

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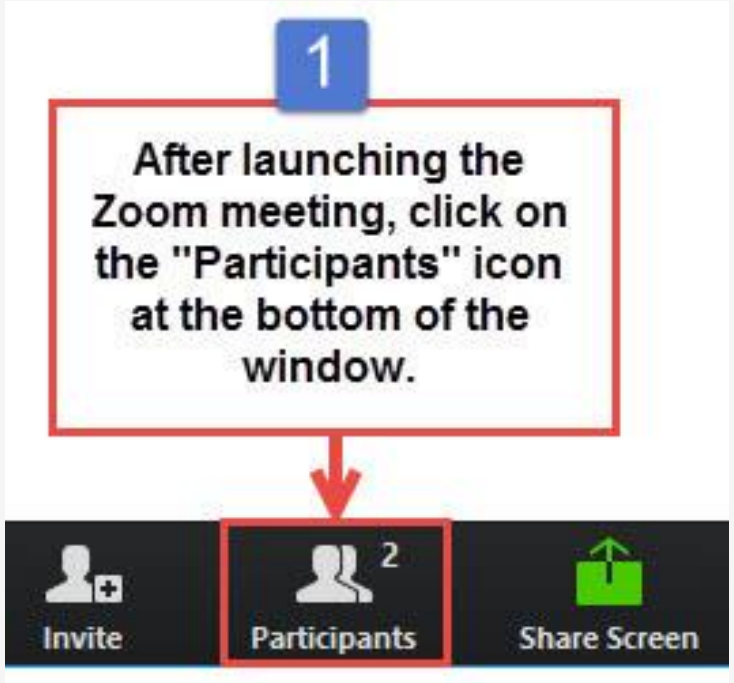

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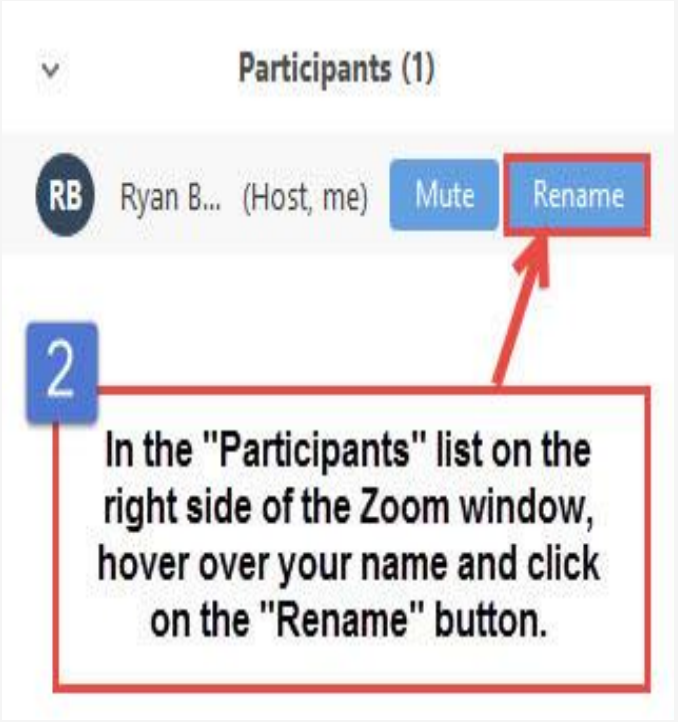

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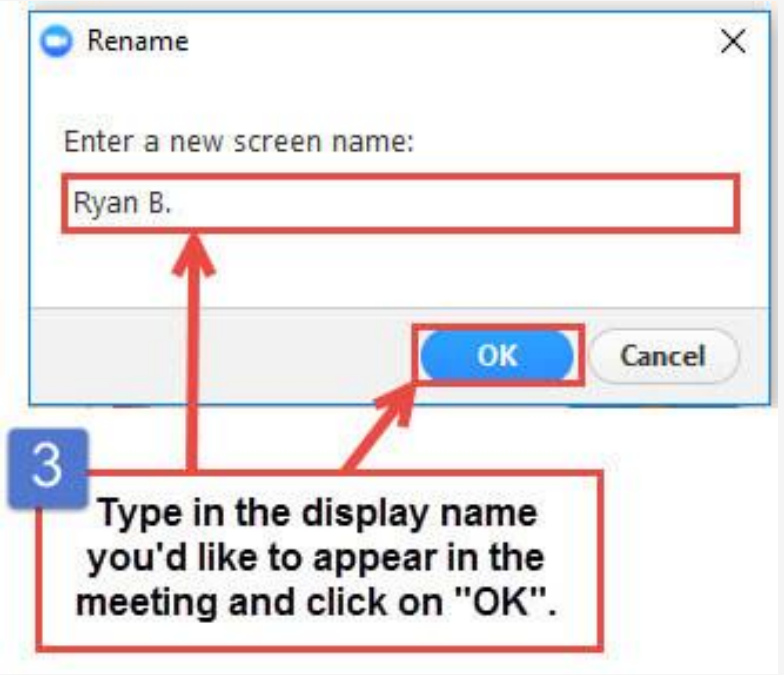

Weaving Wellness: A Webinar Series

Webinar 1:
Supporting pregnant women with substance use disorder

February 11, 2021

- Dr. Mishka Terplan: National perspective
- Dr. Carrie Griffin: Local champion
- Alita Redner, MSW: Yurok leader

Webinar 2:
Effective supports for moms and newborns with prenatal substance exposure

February 25, 2021

- Dr. Matthew Grossman: National perspective (Eat, Sleep, Console)
- Susan Johnson, RN: Local champion
- Sandra Lowry: Local champion (cultural practices)

Webinar 3:
Weaving together wellness supports for families with substance use disorder

March 15, 2021

- Dr. Ira Chasnoff: National perspective
- Heidi O'Hanen: Local champion (Road to Resilience)
- Lori Nesbitt: Local champion (Healing to Wellness Court)
- Jessica Osborne-Stafsnes: Local champion (resource mapping)

Welcoming

Laura White Woods

Yurok Elder and Community Outreach Specialist

Yurok Tribal Court

Weaving Wellness Webinar Series (Part I)
Learning with the Expert: A Dialogue with Dr. Mishka Terplan

Heidi O'Hanen, First 5 Humboldt

Dr. Mishka Terplan, Friends Research Institute; Clinical Consultation Center; Department of Behavioral Health DC

Dr. Carrie Griffin, United Indian Health Services/K'imaw/Open Door Community Health Centers

Alita Redner, Yurok Health and Human Services

Thursday, February 11th, 2021

Children's Bureau
An Office of the Administration for Children & Families

Quality Improvement Center
Collaborative Community Court Teams

Center for Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

Tribal Law & Policy Institute
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National Quality Improvement Center for Collaborative Community Court Teams

A Program of

Administration on Children, Youth and Families

Children's Bureau

This webinar was prepared by the National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) through cooperative agreement #90CA1854 with the Administration on Children, Youth and Families (ACYF), Children's Bureau. The QIC-CCCT is operated by the Center for Children and Family Futures and its partners. Points of view or opinions expressed in this webinar are those of the presenters and do not necessarily represent the position, opinions, or policies of ACYF or the Children's Bureau.

QIC-CCCT Goals

IMPLEMENTATION

Enhance the capacity of CCCTs to appropriately implement the provisions of the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse and Prevention Treatment Act (CAPTA)

CAPACITY

Enhance and expand CCCTs' capacity to effectively collaborate to address the needs of infants, young children, and their families/caregivers affected by substance use disorders (SUDs) and prenatal substance exposure

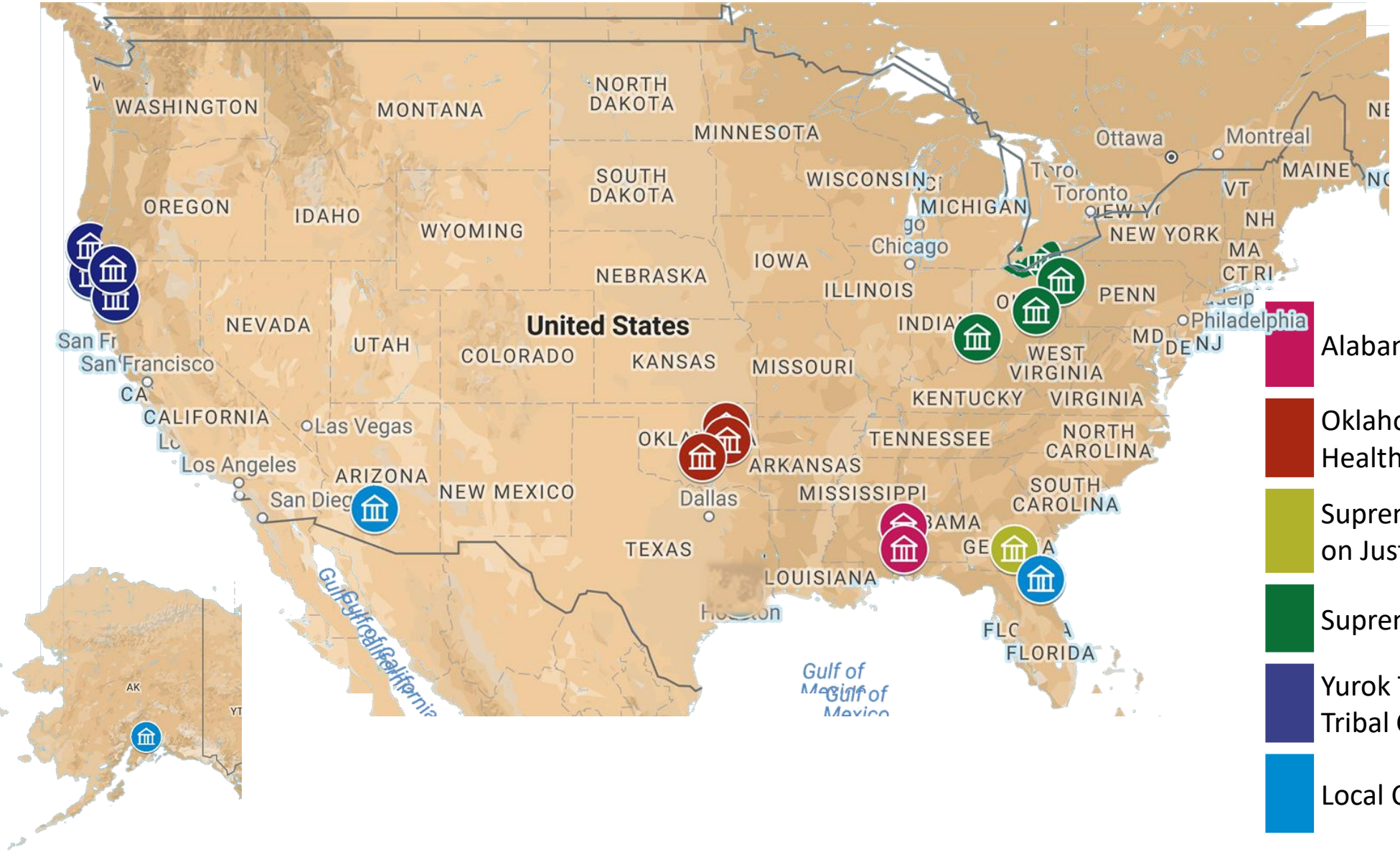
SUSTAINABILITY

Sustain the effective collaborative partnerships, processes, programs, and procedures implemented to achieve the goals of each demonstration site

DISSEMINATION

Provide the field with lessons they can apply about effective practices for implementing the requirements of CARA and meeting the needs of children and families affected by substance use disorders

QIC-CCCT Demonstration Sites



- Alabama Administrative Office of Courts
- Oklahoma Department of Mental Health and Substance Abuse Services
- Supreme Court of Georgia, Committee on Justice for Children
- Supreme Court of Ohio
- Yurok Tribe for Northern California Tribal Court Coalition
- Local Court

Today's Presenters

Heidi O'Hanen, *Road to Resilience Project Coordinator,* First 5 Humboldt

Dr. Mishka Terplan, MD MPH FACOG DFASAM
Associate Medical Director, Friends Research Institute
Adjunct Faculty, UCSF, Clinical Consultation Center
Deputy Chief Clinical Officer, Department of Behavioral Health DC

Dr. Carrie Griffin, DO, *Doctor of Osteopathic Medicine,* United Indian Health Services/K'imaw/Open Door Community Health Centers

Alita Redner, MSW, *Clinical Coordinator,* Yurok Health and Human Services

Improving Care Improves Outcomes for Pregnant and Postpartum Women with Opioid Use Disorder

Mishka Terplan MD MPH FACOG DFASAM
Associate Medical Director, Friends Research Institute
Adjunct Faculty, UCSF, Clinical Consultation Center
Deputy Chief Clinical Officer, Department of Behavioral Health DC
@ Do_Less_Harm

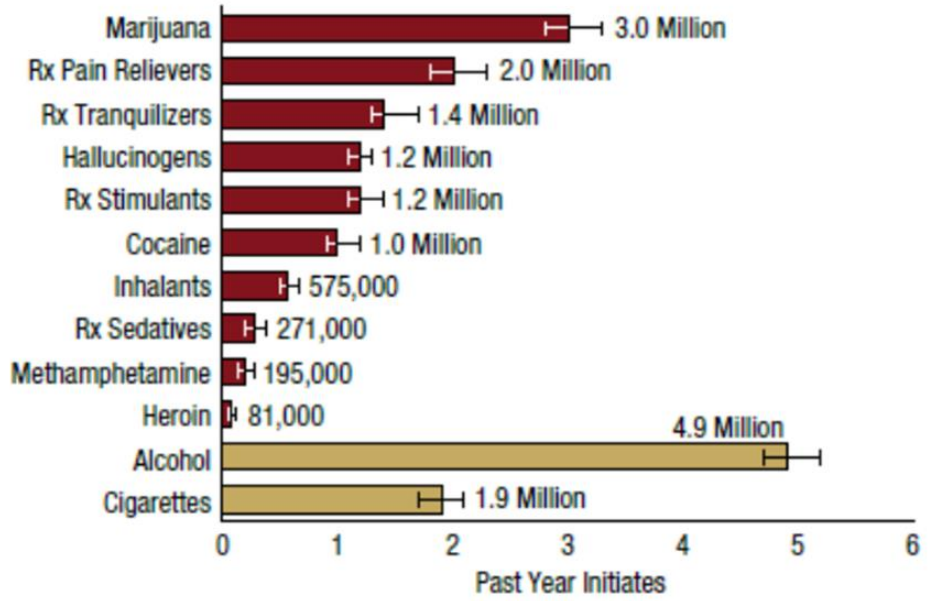
Outline

- 1) Introduction to Addiction as a Chronic Condition
- 2) Addiction in Pregnancy and Postpartum
- 3) Stigma and Discrimination

United States Today
Most people have used drugs

Substance	Lifetime Use	Lifetime Use
Illicit	131 mil	49%
Cannabis	119 mil	44%
Tobacco	169 mil	63%
Alcohol	216 mil	80%

Figure 27. Numbers of Past Year Initiates of Substances among People Aged 12 or Older: 2017



Rx = prescription.

Note: Estimates for prescription pain relievers, prescription tranquilizers, prescription stimulants, and prescription sedatives are for the initiation of misuse.

Experimental and Clinical Psychopharmacology
1994, Vol. 2, No. 3, 244–268

Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings From the National Comorbidity Survey

James C. Anthony, Lynn A. Warner, and Ronald C. Kessler

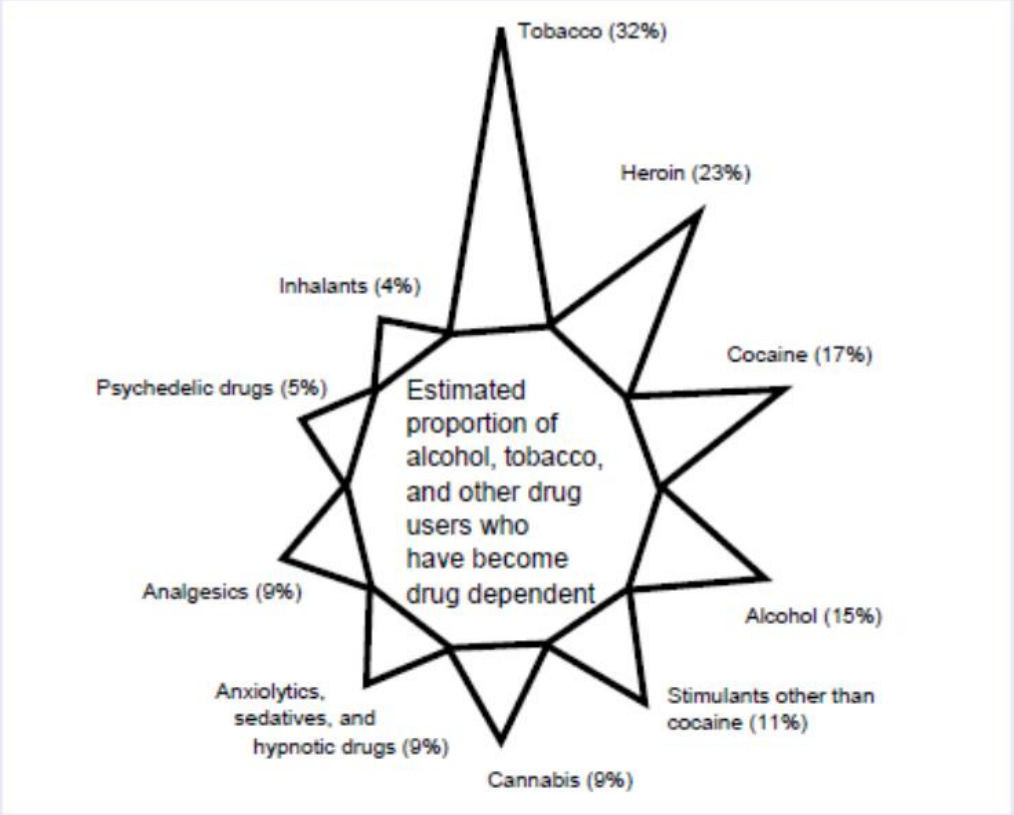
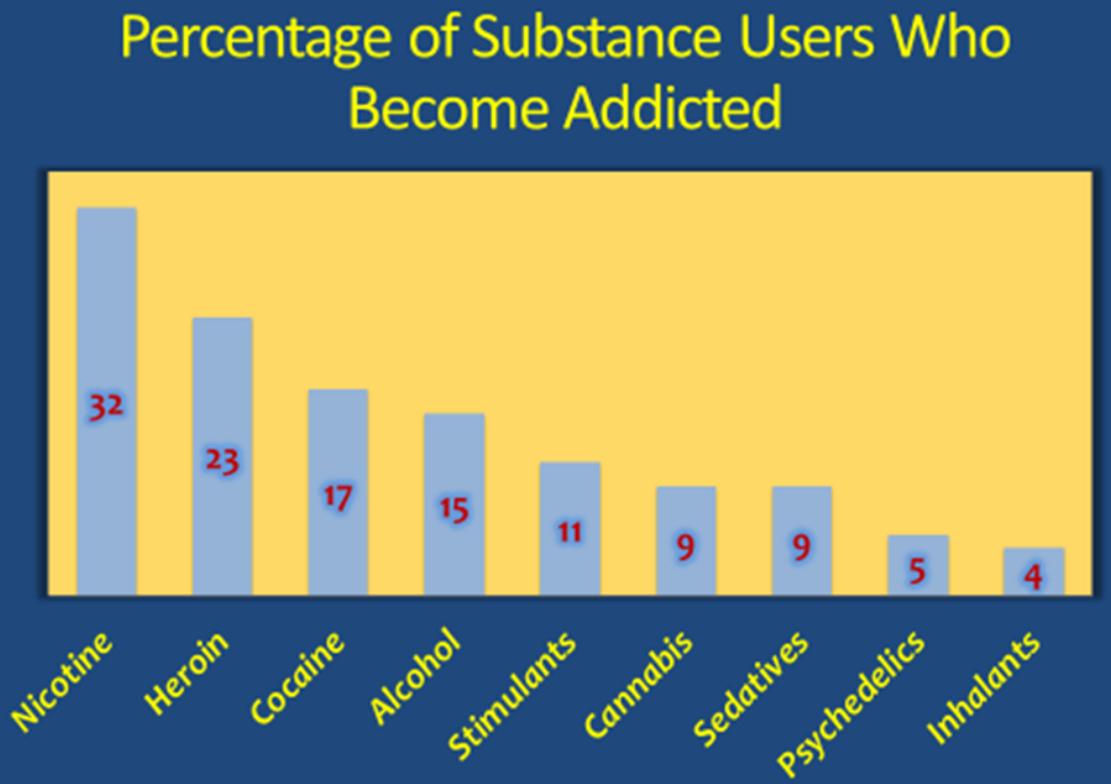


Figure 2 Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. The data were obtained from the National Comorbidity Survey, 1990–1992.

SOURCE: Adapted from Anthony et al. 1994.

Not everyone who uses drugs becomes addicted



What is the risk of opioid addiction among individuals prescribed opioids for pain?

Rates of misuse 12-29% (95%CI:13-38%)

Rates of addiction 8-12% (95% CI: 3-17%)

PAIN

Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis

Kevin E. Vowles[a,*], Mindy L. McEntee[a], Peter Siyahhan Julnes[a], Tessa Frohe[a], John P. Ney[b], David N. van der Goes[c]

April 2015 • Volume 156 • Number 4

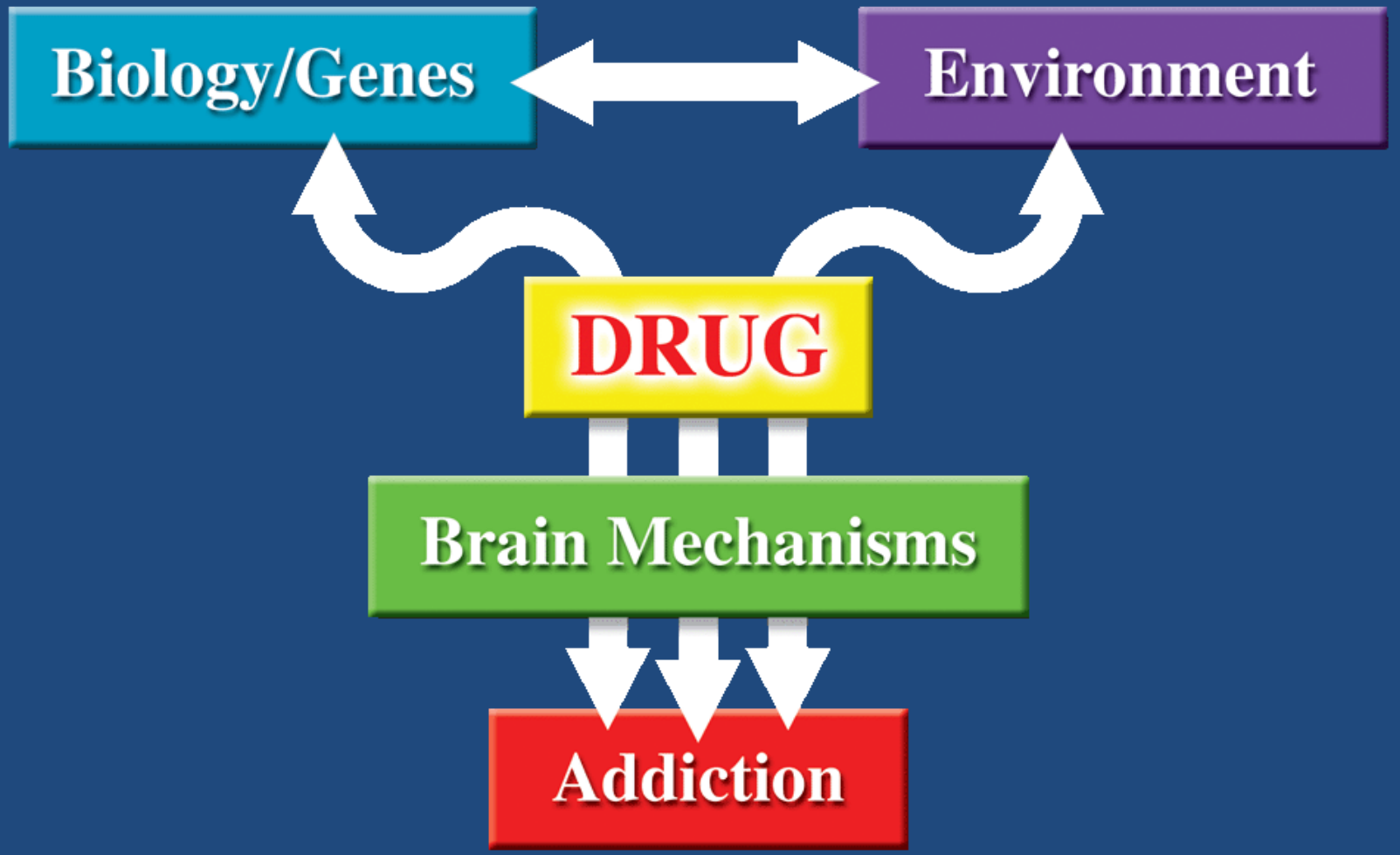
Table 4

Opioid addiction—unweighted and weighted means, SD, and 95% confidence interval (CI).

	Minimum, %		Maximum, %	
	Mean (SD)	95% CI	Mean (SD)	95% CI
Unweighted	10.9 (9.8)	5.3-16.5	11.7 (9.9)	6.1-17.3
Weighted means				
Sample size	4.3 (6.2)	0.8-7.8	4.7 (6.5)	1.0-8.4
Log sample size	10.1 (9.5)	4.7-15.5	10.8 (9.6)	5.4-16.2
Winsorized	7.8 (8.2)	3.2-12.4	8.6 (8.3)	3.9-13.3
Quality rating	10.5 (8.8)	5.5-15.5	10.4 (8.9)	5.4-15.4
Sample size × quality*	9.9 (8.7)	5.0-14.8	10.7 (8.9)	5.7-15.7
Quality				
High-quality studies	8.8 (7.3)	4.3-13.3	9.8 (7.8)	5.0-14.6
Low-quality studies	23.1 (12.9)	3.4-39.2	23.1 (12.9)	3.4-39.2

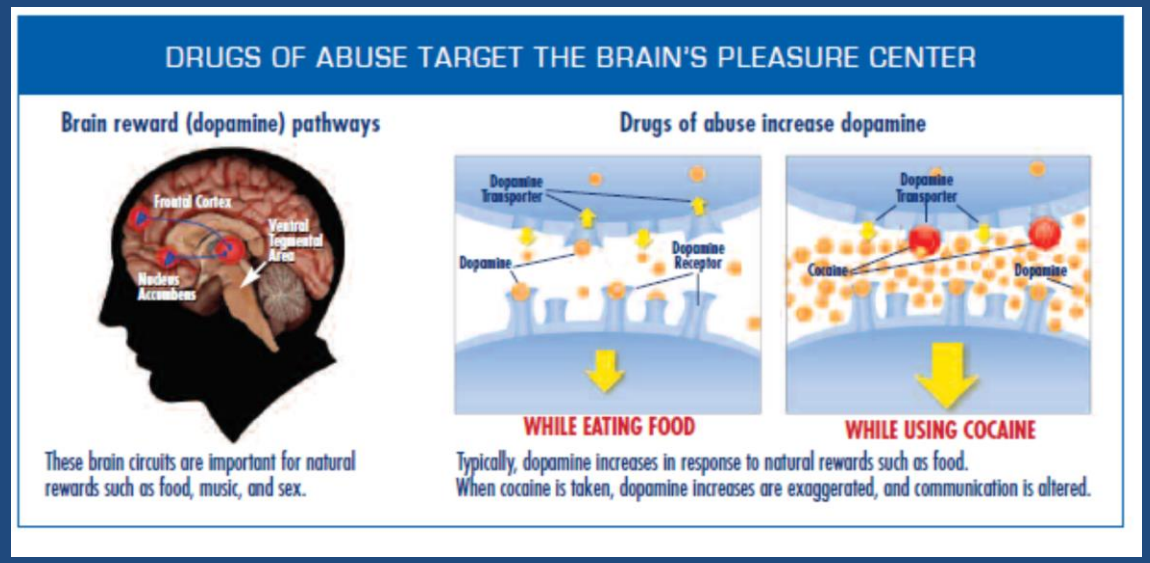
*Interaction term the product of standardized scores for the log transformed sample size and quality rating.

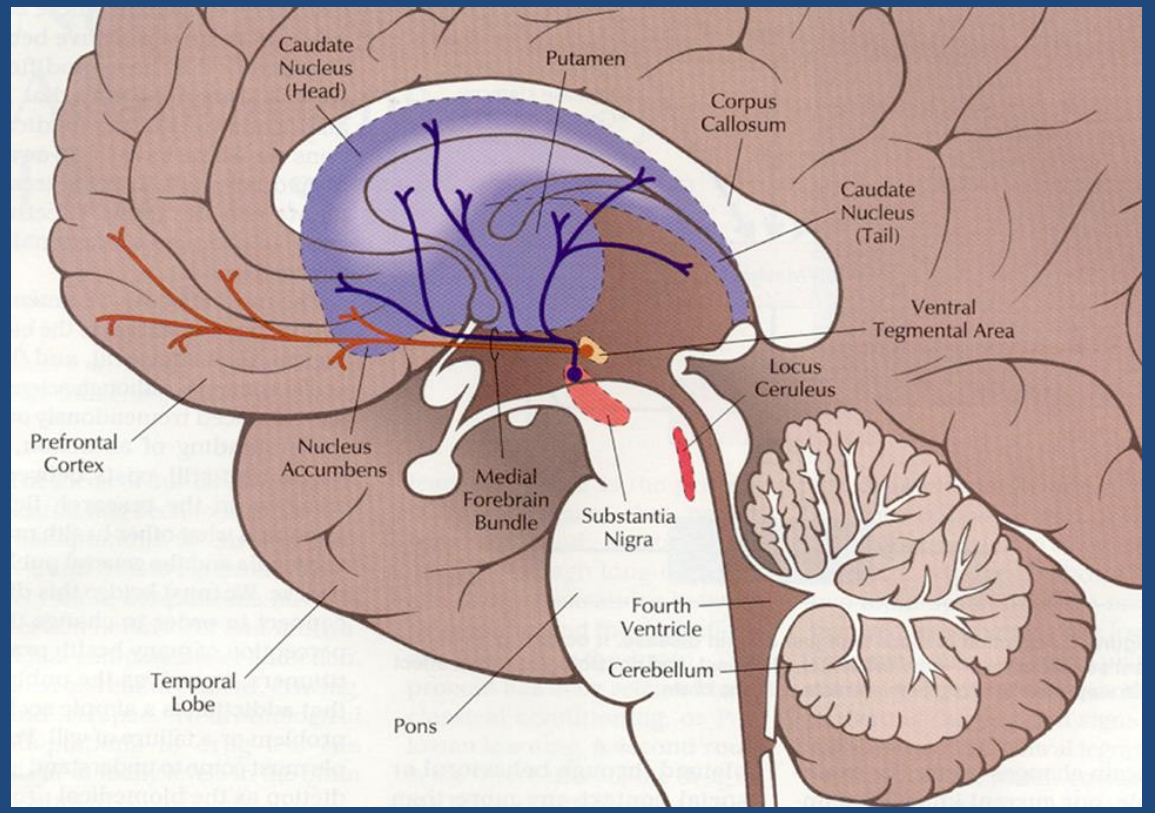
Development of Addiction Involves Multiple Factors



NIDA

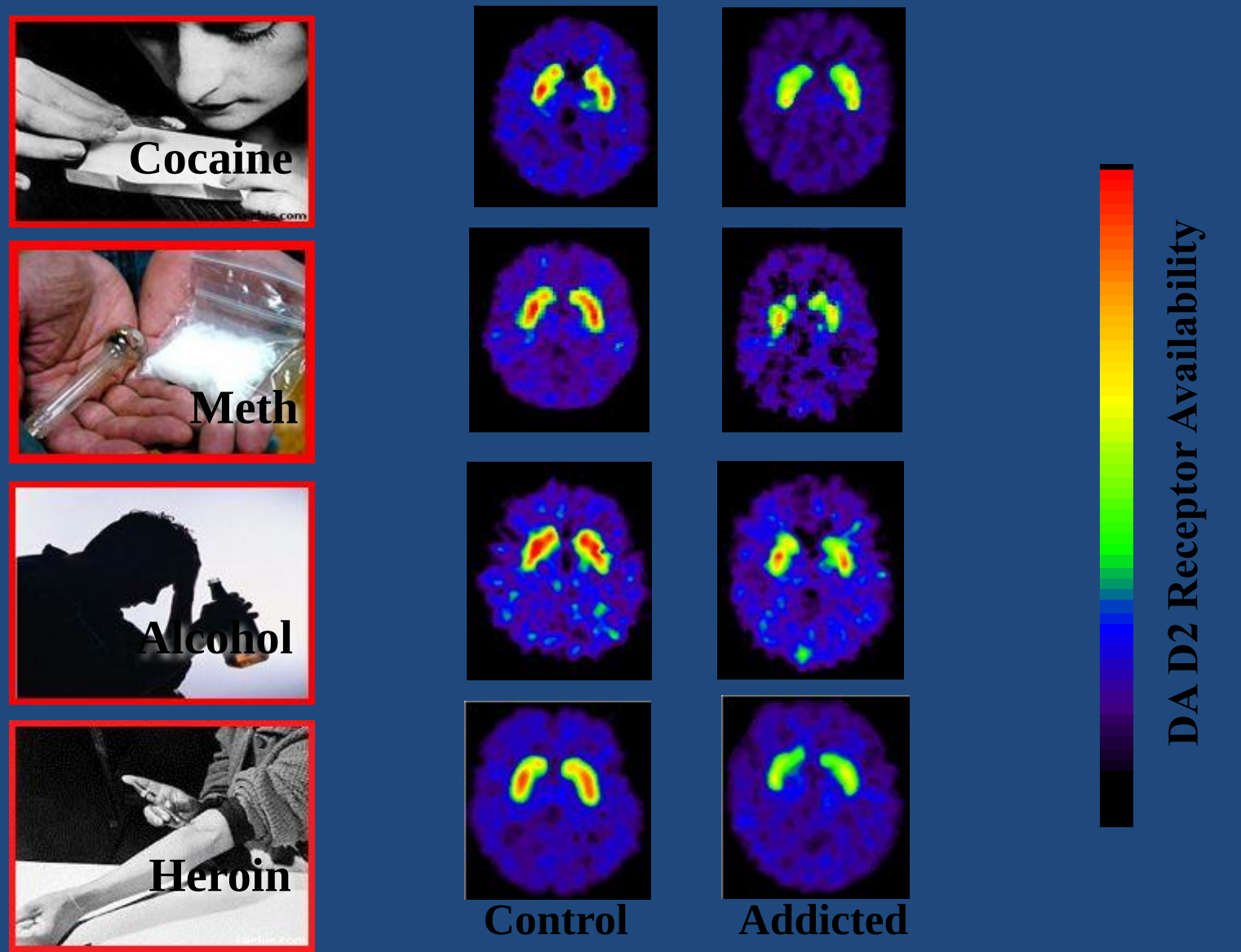
Addiction: Reward/Reinforcement Disturbance

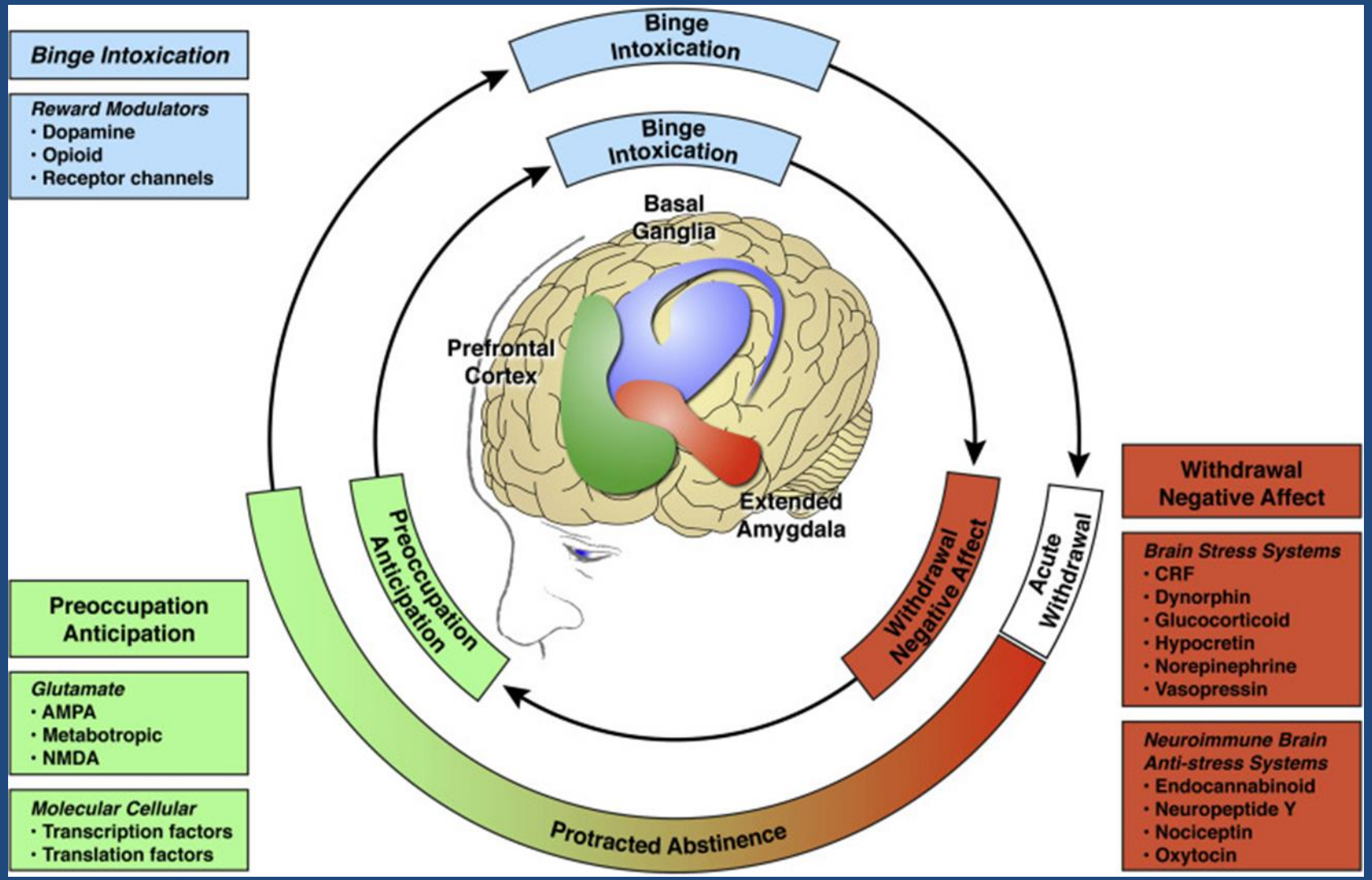




Prolonged drug use changes the brain: Functionally…

Dopamine D2 Receptors are Decreased by Addiction





Volkow and Koop, Lancet Psychiatry, 2017

Addiction: From Reward Seeking to Relief Seeking

Heroin Addiction—A Metabolic Disease

Vincent P. Dole, MD, and Marie E. Nyswander, MD, New York

THE METHADONE Maintenance Research Program[1-3] began three years ago with pharmacological studies conducted on the metabolic ward of the Rockefeller University Hospital. Only six addict patients were treated during the first year, but the results of this work were sufficiently impressive to justify a trial of maintenance treatment of heroin addicts admitted to open medical wards of general hospitals in the city.

Methadone therapy was started in low dosage (10 to 20 mg/day in divided portions) and increased slowly over a period of four to six weeks to avoid narcotic effects. After the patients had reached the stabilization level (80 to 120 mg/day) it was possible to maintain them with a single, daily, oral ration, without further increase in dose. At the end of the six weeks of hospitalization the patients were discharged to outpatient clinics where they received their daily

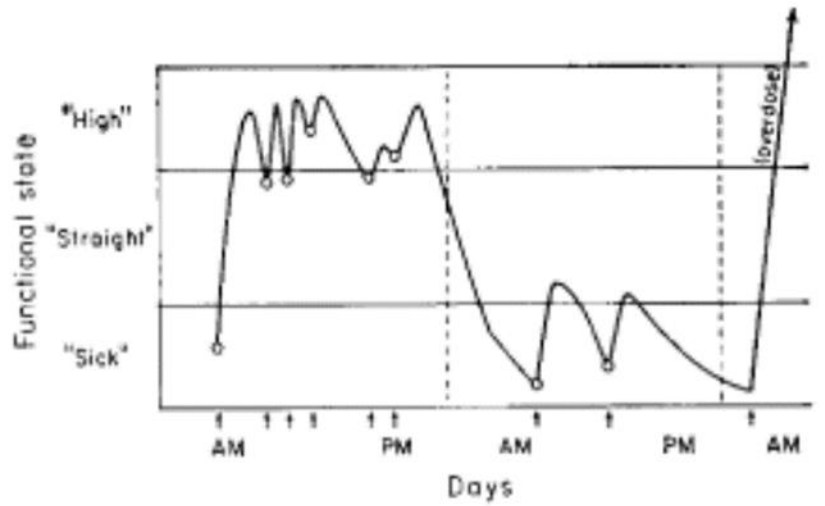


Fig 1.—Diagrammatic summary of functional state of typical "mainline" heroin user. *Arrows* show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

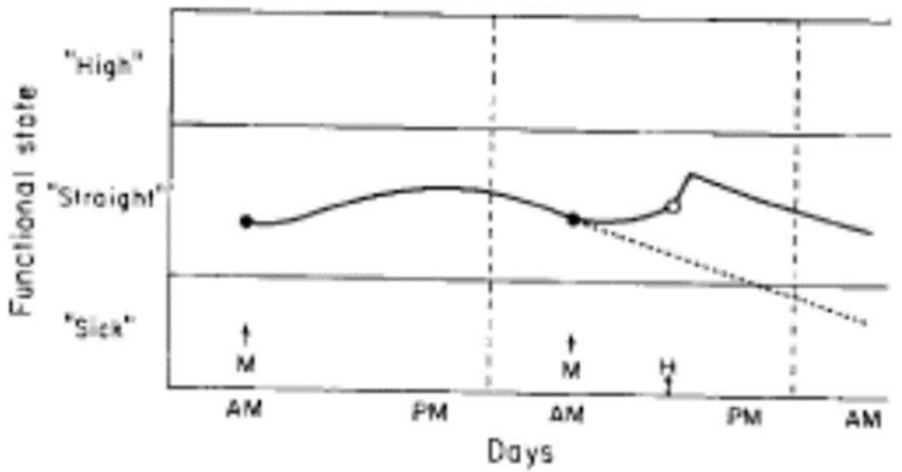
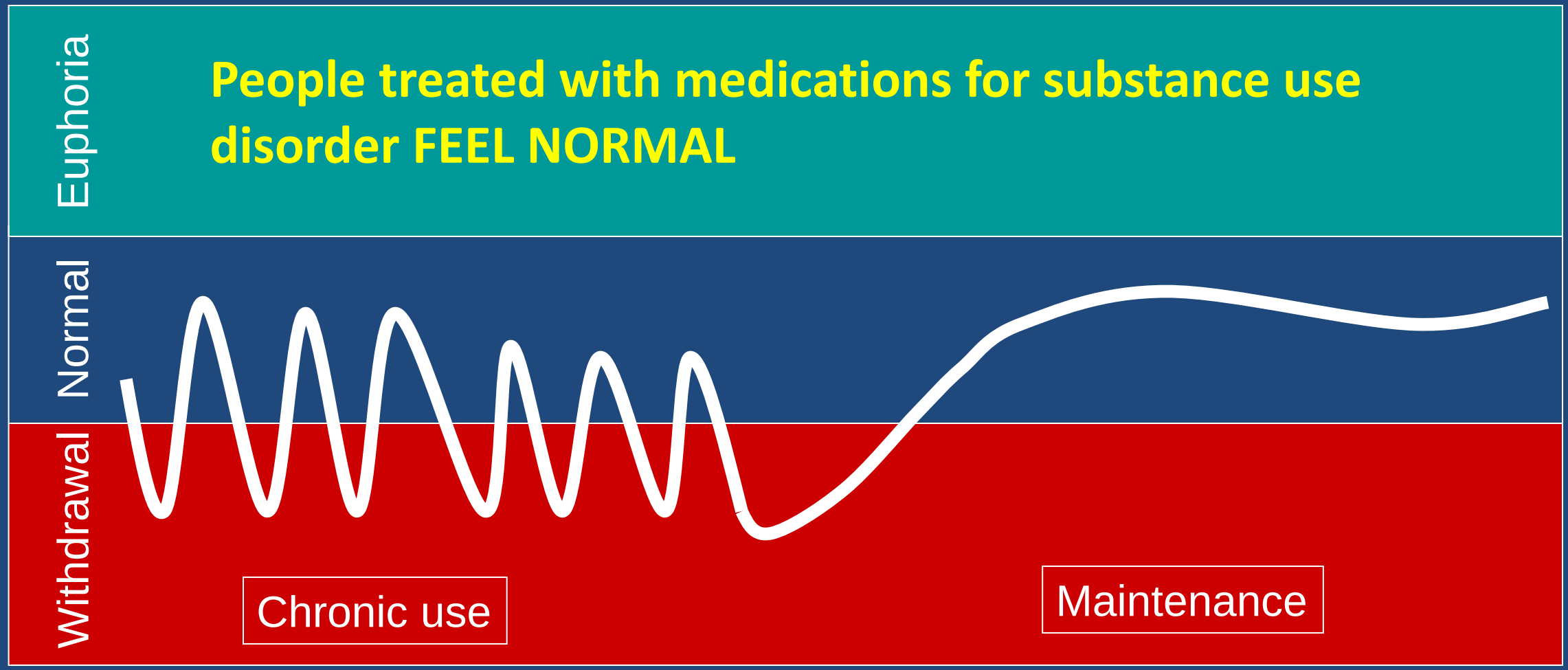


Fig 2.—Stabilization of patient in state of normal function by blockade treatment. A single, daily, oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. *Dotted line* indicates course if methadone is omitted.

Treatment for Substance Use Disorder



DSM-5 Opioid Use Disorders[1]

1. Tolerance[2]

2. Withdrawal[2]

Loss of Control

3. Larger amounts and/or longer periods

4. Inability to cut down on or control use

5. Increased time spent obtaining, using or recovering

6. Craving/Compulsion

Use Despite Negative Consequences

7. Role failure, work, home, school

8. Social, interpersonal problems

9. Reducing social, work, recreational activity

10. Physical hazards

11. Physical or psychological harm

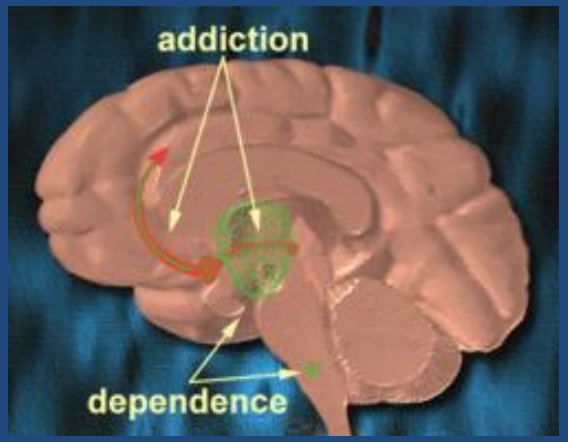
[1] Mild (2-3), moderate (4-5), severe (≥6)

[2] Not valid if opioid taken as prescribed

APA. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)

Addiction vs Dependence/Tolerance

- Physical dependence/tolerance is not addiction
  - Addiction is a brain disease that affects behaviour
  - Dependence is an expected adaptation of the body to a specific substrate so that in the absence of that substrate a withdrawal syndrome develops
  - Tolerance is pharmacologic principle where reaction to specific concentration of drug is reduced with repeated use
  - Affect different parts of the brain
- Many medications cause either tolerance or dependence or both (SSRIs, HTN medication)
  - Everyone taking enough opioid continuously for longer than a week



ASAM American Society *of* Addiction Medicine

Definition of Addiction

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

Addiction as Chronic Disease

Drug Dependence, a Chronic Medical Illness

Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O'Brien, MD, PhD
Herbert D. Kleber, MD

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

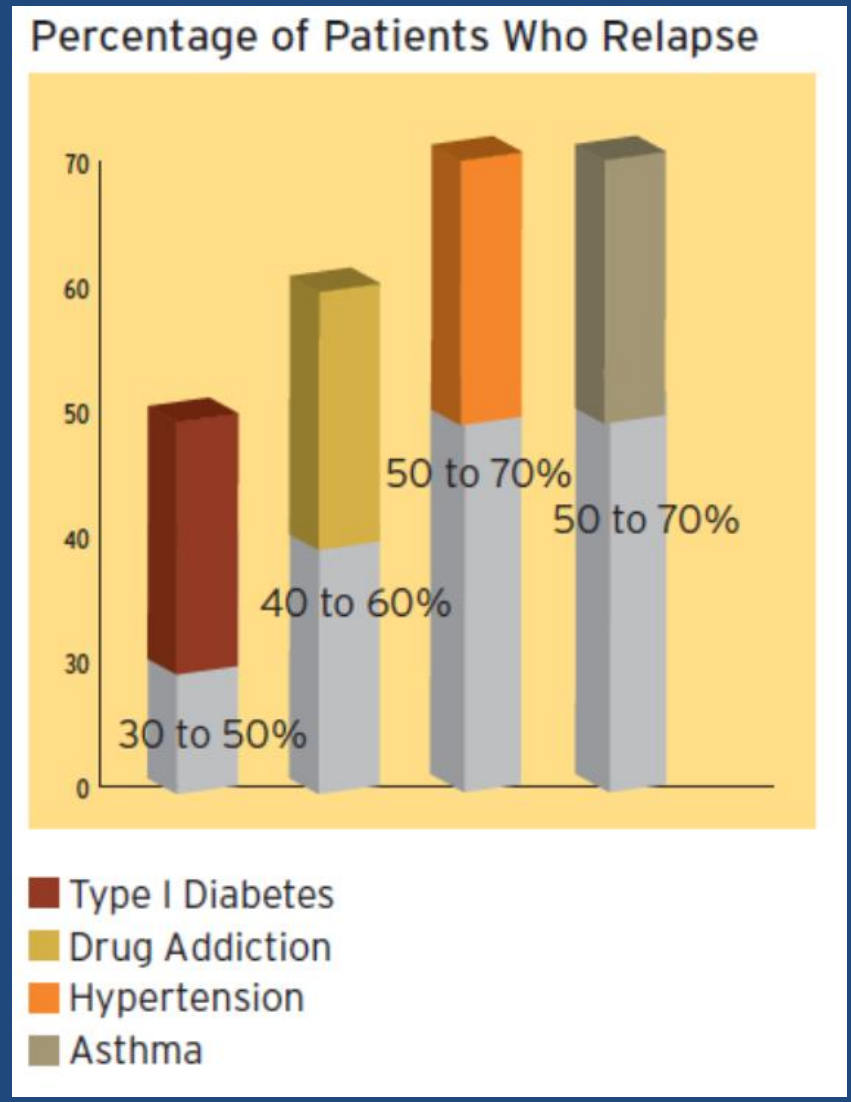
JAMA. 2000;284:1689-1695 www.jama.com

MANY EXPENSIVE AND DISturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that requires interdiction and law enforcement rather than a health problem that requires prevention and treatment.

This view is apparently shared by many physicians. Few medical schools or residency programs have an adequate required course in addiction. Most physicians fail to screen for alcohol or drug dependence during routine examinations.[5] Many health professionals view such screening efforts as a waste of time. A survey[6] of general practice physicians and nurses indicated that most believed no available medical or health care interventions would be "appropriate or effective in treating addiction." In fact, 40% to 60% of patients treated for alcohol or other drug dependence return to active substance use within a year following treatment discharge.[7-9] One implication is that these disappointing results confirm the suspicion that drug dependence is not a medical illness and thus is not significantly affected by health care interventions. Another possibility is that current treatment strategies and outcome expectations view drug dependence as a curable, acute condition. If drug dependence is more like a chronic illness, the appropriate standards for treatment and outcome expectations would be found among other chronic illnesses.

To explore this possibility, we undertook a literature review comparing drug dependence with 3 chronic illnesses: type 2 diabetes mellitus, hypertension, and asthma. These examples were selected because they have been well studied and are widely believed to have effective treatments, although they are not yet curable. Our review searched all English-language medical and health journals in MEDLINE from 1980 to the present using the following key words: *heritability*, *pathophysiology*, *diagnosis*, *course*, *treatment*, *compliance*, *ad-*

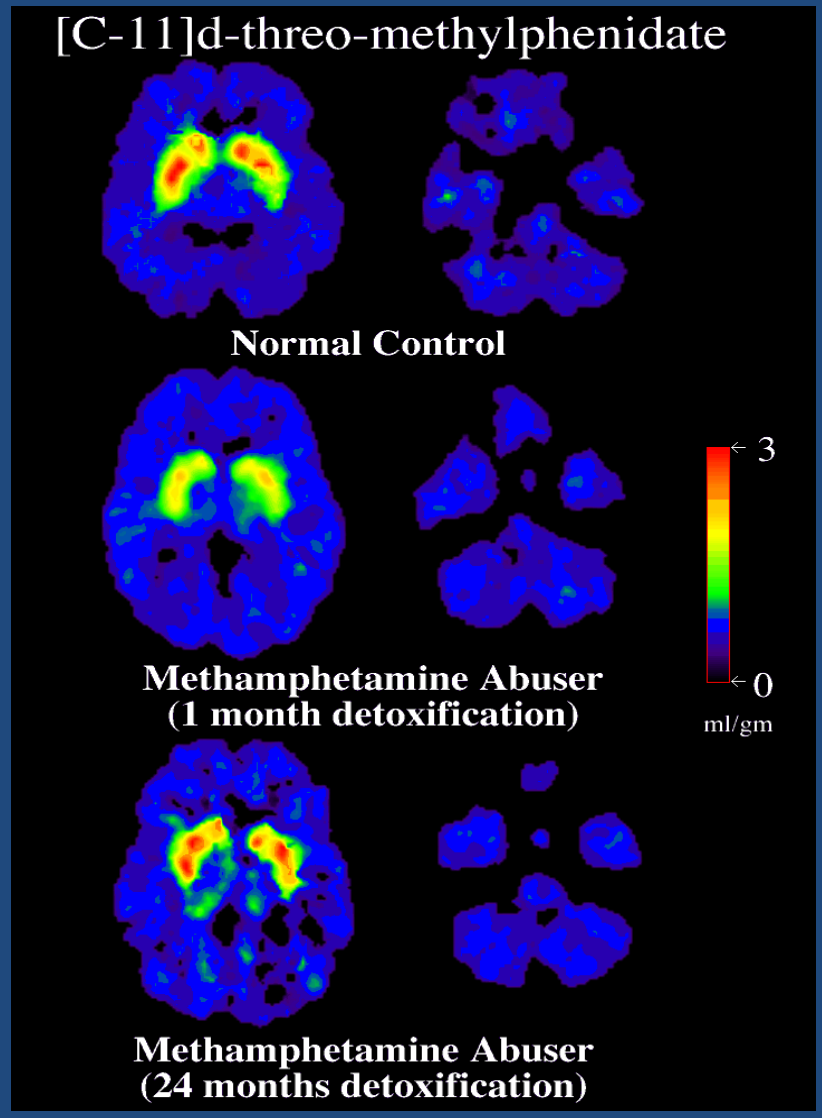
Author Affiliations: The Treatment Research Institute, Philadelphia, Pa (Dr McLellan); The Penn/VA Center for Studies of Addiction at the Veterans Affairs Medical Center and the University of Pennsylvania, Philadelphia (Drs McLellan and O'Brien); The Brown University Center for Alcohol and Addiction Studies, Providence, RI (Dr Lewis); and The National Center on Addiction and Substance Abuse at Columbia University, New York, NY (Dr Kleber).
Corresponding Author and Reprints: A. Thomas McLellan, PhD, The Treatment Research Institute, 150 S Independence Mall W, Suite 600, Philadelphia, PA 19106-3475 (e-mail: tmclellan@treasearch.org).



Recovery Leads to Return of Normal Brain Structure and Function

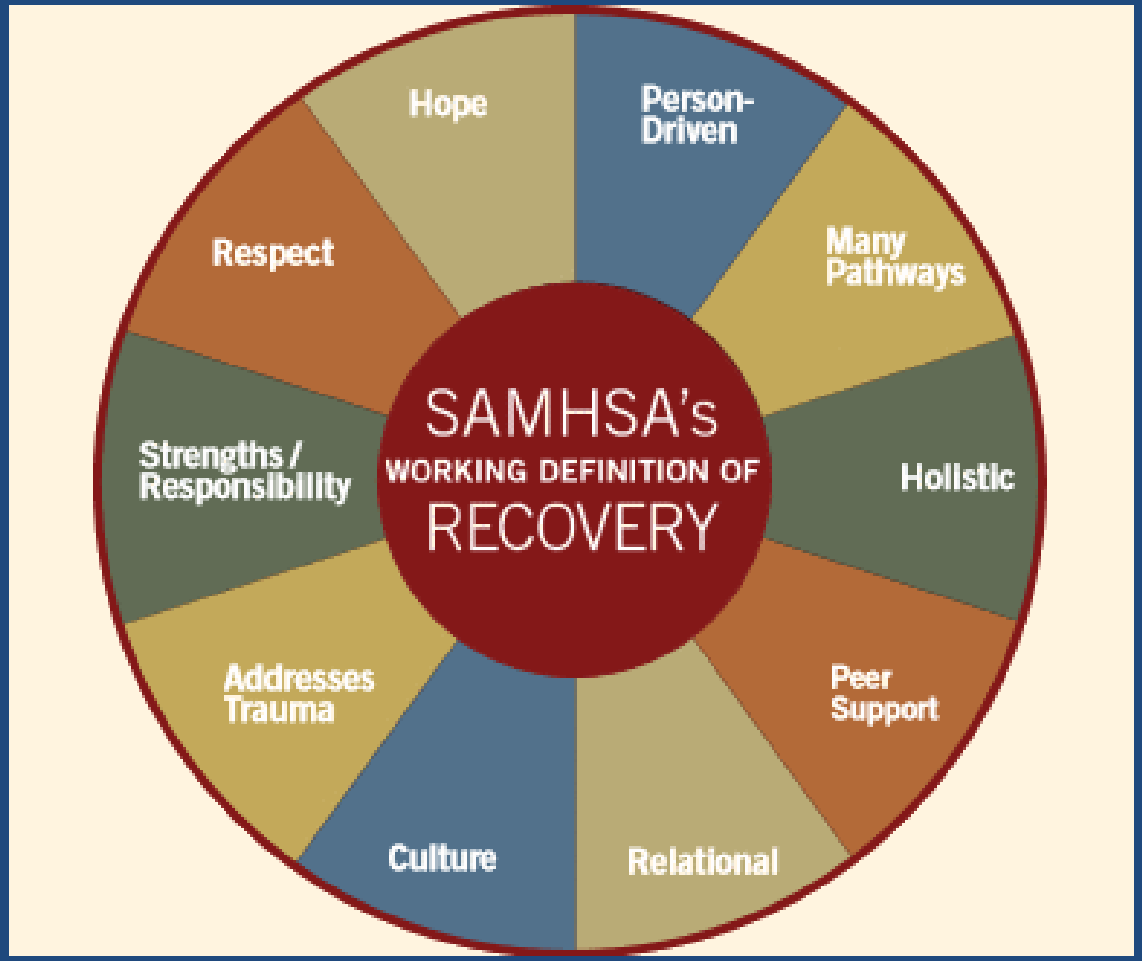
DAT Recovery with prolonged abstinence from methamphetamine

Volkow et al., J. Neuroscience, 2001.



Recovery is the Goal of Treatment

- Recovery is more than abstinence
- Building a life of integrity,
- Connection to others,
- Purpose and
- Serenity
- Recovery is fully compatible with the use of medications



Point 1

- Most people who use drugs don’t become addicted to them
- Addiction is a behavioral condition
- The goal of treatment is recovery – there are as many paths to recovery as there are people in recovery

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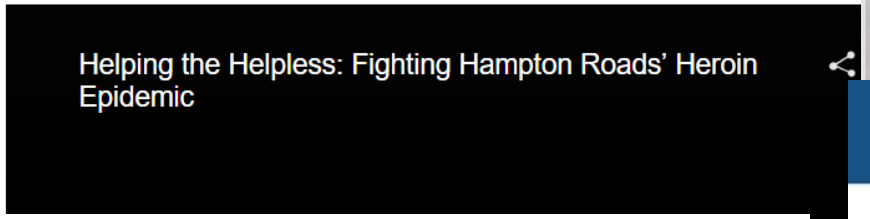
Helping the Helpless: Fighting Hampton Roads' Heroin Epidemic



Number of children born addicted to drugs skyrockets in the Tampa Bay area

BY: Michael Paluska
POSTED: 11:24 PM, Jan 26, 2017

NBC NEWS HOME TOP VIDEOS ONGOING: ROBERT DURST EBOLA VIRUS OUTBREAK

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Pill-Popping Mommas: 'Many' Pregnant Women Take Opioids, CDC Finds

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A bill sponsored by state Rep. Jered Taylor, a Nixa Republican, would make it a felony if a pregnant woman drugs or controlled substances without a prescription. Bigstock

GOVERNMENT & POLITICS

Missouri bill would criminalize pregnant women who do drugs. Would that help or hurt?

NEWS ▾ VIDEO ▾ WEATHER ▾ SPORTS ▾ PERFECT HEALTH PERFECT HOME COMMUNITY

Number of mothers using opioids while pregnant is rising in Tennessee

By Jessica Jaglois
Published: February 2, 2017, 4:45 pm | Updated: February 3, 2017, 3:38 pm

The Washington Post
Democracy Dies in Darkness

National

Pregnant women addicted to opioids face tough choices, fear treatment can lead to separation and harm

MORPHINISM

AND

NARCOMANIAS FROM OTHER DRUGS

THEIR

ETIOLOGY, TREATMENT, AND MEDICOLEGAL RELATIONS

BY

T. D. CROTHERS, M.D.

Superintendent of Walnut Lodge Hospital, Hartford, Conn.; Editor of the Journal of Inebriety; Professor of Mental and Nervous Diseases, New York School of Clinical Medicine, etc.

PHILADELPHIA AND LONDON

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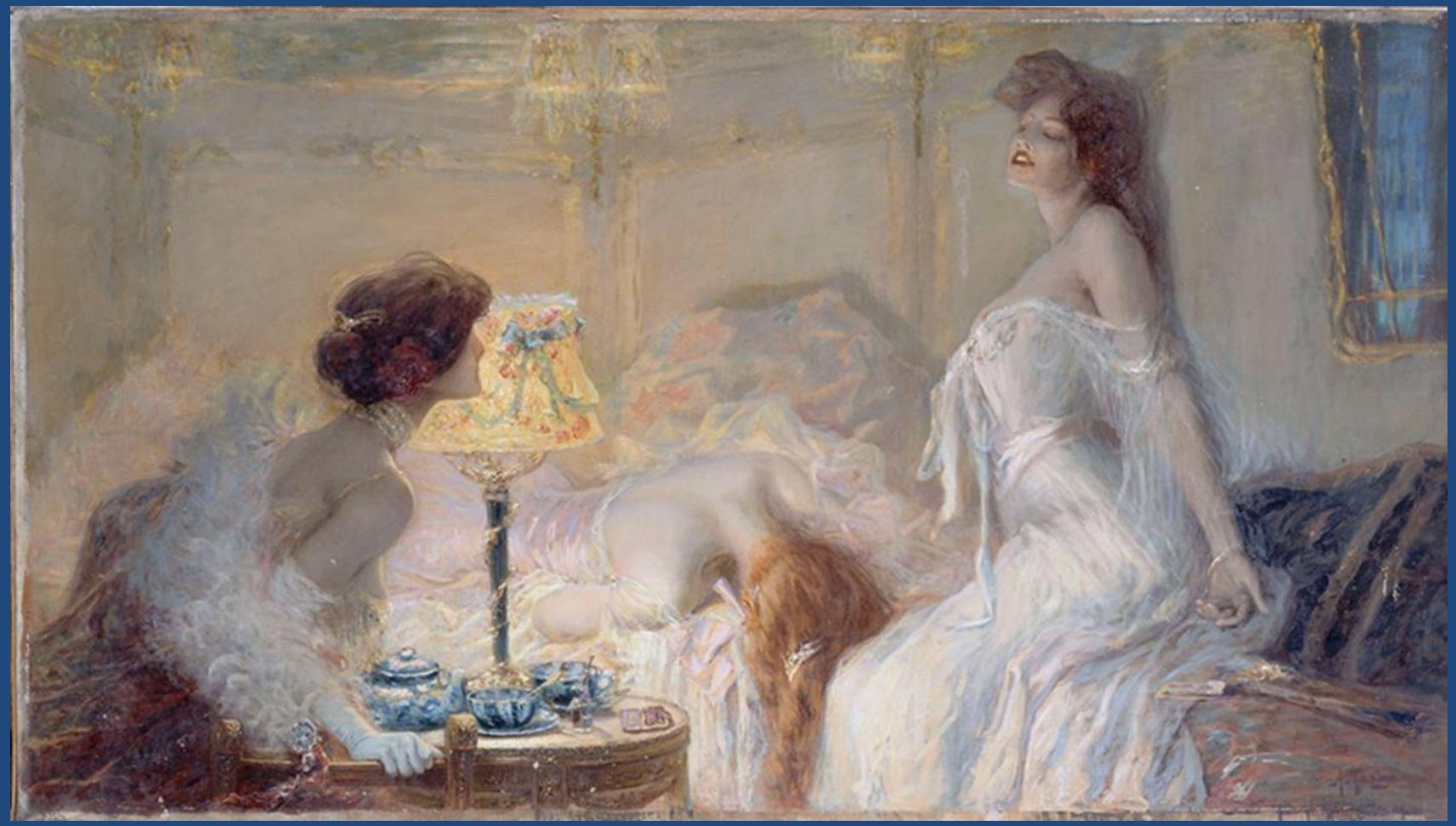
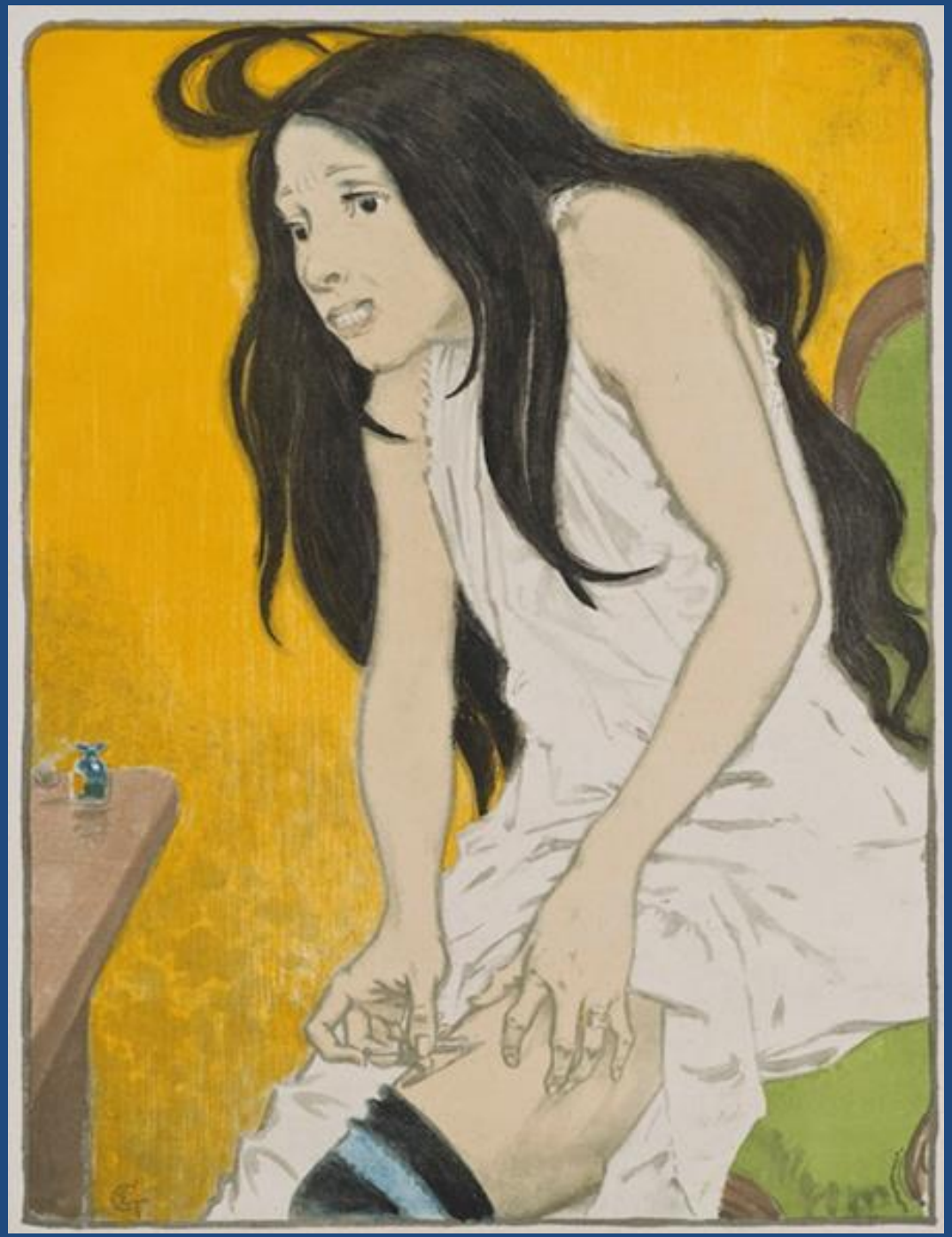
1902

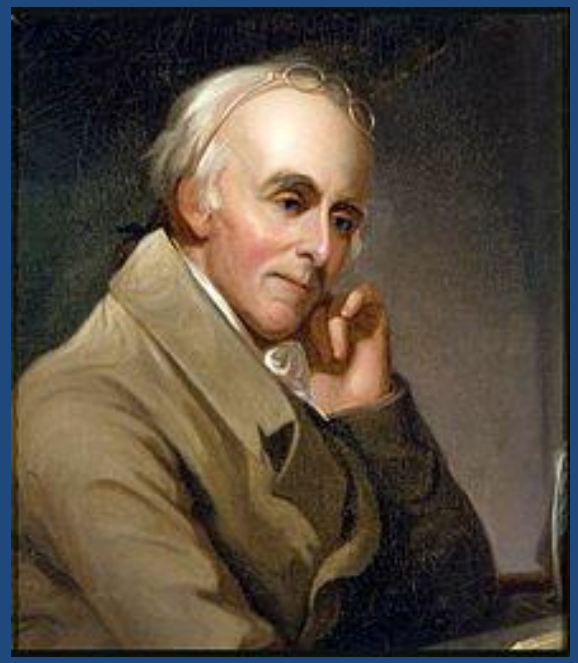
Within a few years many authorities have pointed out the danger of morphinism in women who come under treatment for gynecologic disorders. The



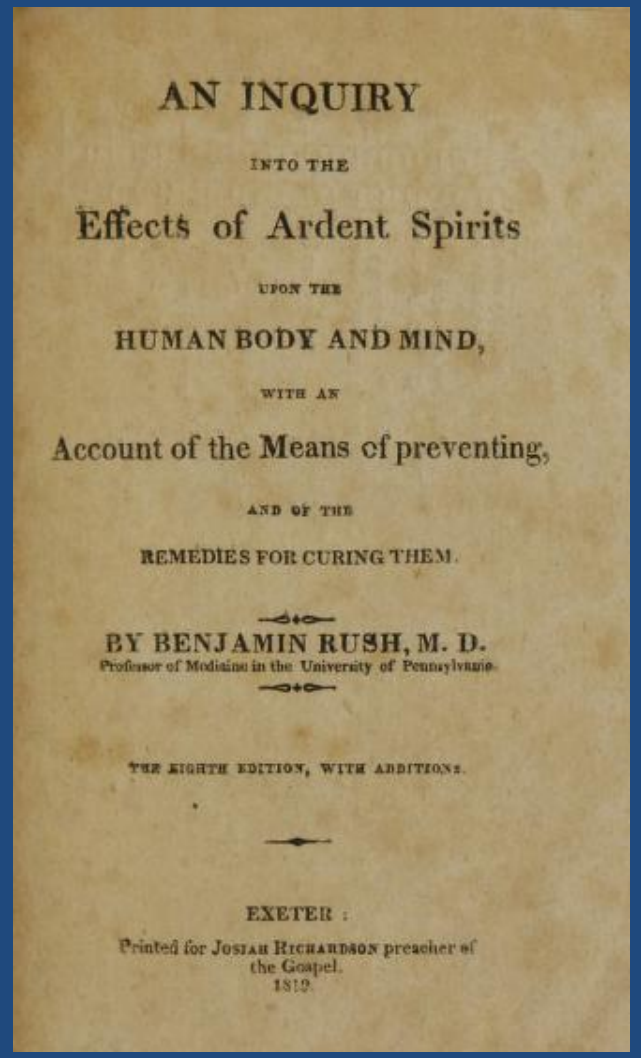


Turn of the Century Treatment: Addiction is a Disease

- Morphinism: seen as medical condition and treated like one
  - Short acting opioids used for detox and “maintenance”
  - Specialty (morphine) clinics – run by both public health and police departments
  - Neonatal Abstinence Syndrome first described (and treated)



Dr Benjamin Rush:
Father of Addiction Medicine
Signatory of Declaration of Independence
Owner of Enslaved Peoples



AN INQUIRY

INTO THE

Effects of Ardent Spirits

UPON THE

HUMAN BODY AND MIND,

WITH AN

Account of the Means of preventing,

AND OF THE

REMEDIES FOR CURING THEM.

BY BENJAMIN RUSH, M. D.
Professor of Medicine in the University of Pennsylvania.

THE EIGHTH EDITION, WITH ADDITIONS.

EXETER:
Printed for JOSIAH RICHARDSON preacher of the Gospel.
1812.

Substance Use and Addiction: Early 20th Century

19th Century

Medical
and
Public Health

Women
White
Upper SES

20th Century

Criminal
Justice

Men
Non-White
Lower SES

PUBLIC ACTS OF THE SIXTY-THIRD CONGRESS

OF THE

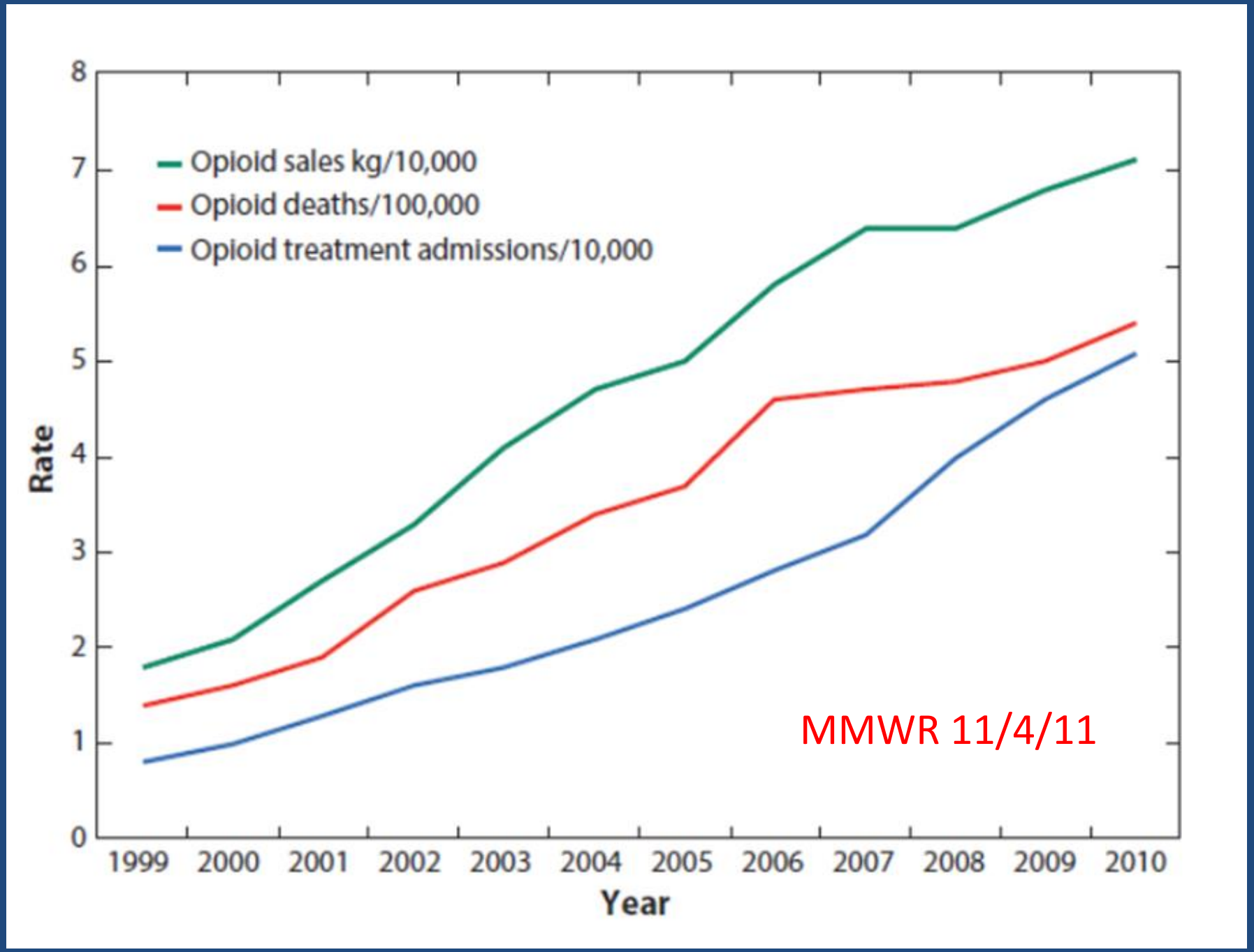
UNITED STATES

Passed at the third session, which was begun and held at the city of Washington, in the District of Columbia, on Monday, the seventh day of December, 1914, and was adjourned without day on Thursday, the fourth day of March, 1915.

WOODROW WILSON, President; THOMAS R. MARSHALL, Vice President; JAMES P. CLARKE, President of the Senate *pro tempore*; CLAUDE A. SWANSON, Acting President of the Senate *pro tempore*, December 21 to 23, 29 to 31, 1914, and January 2, 1915; NATHAN P. BRYAN, Acting President of the Senate *pro tempore*, January 22, 1915; CHAMP CLARK, Speaker of the House of Representatives.

The Current Opioid Crisis:

Iatrogenic



Opioids and Pregnancy

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 31
August 10, 2018

Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014

Sarah C. Haight, MPH[1,2]; Jean Y. Ko, PhD[1,3]; Van T. Tong, MPH[1]; Michele K. Bohm, MPH[4]; William M. Callaghan, MD[1]

FIGURE 1. National prevalence of opioid use disorder per 1,000 delivery hospitalizations* — National Inpatient Sample (NIS),† Healthcare Cost and Utilization Project (HCUP), United States, 1999–2014

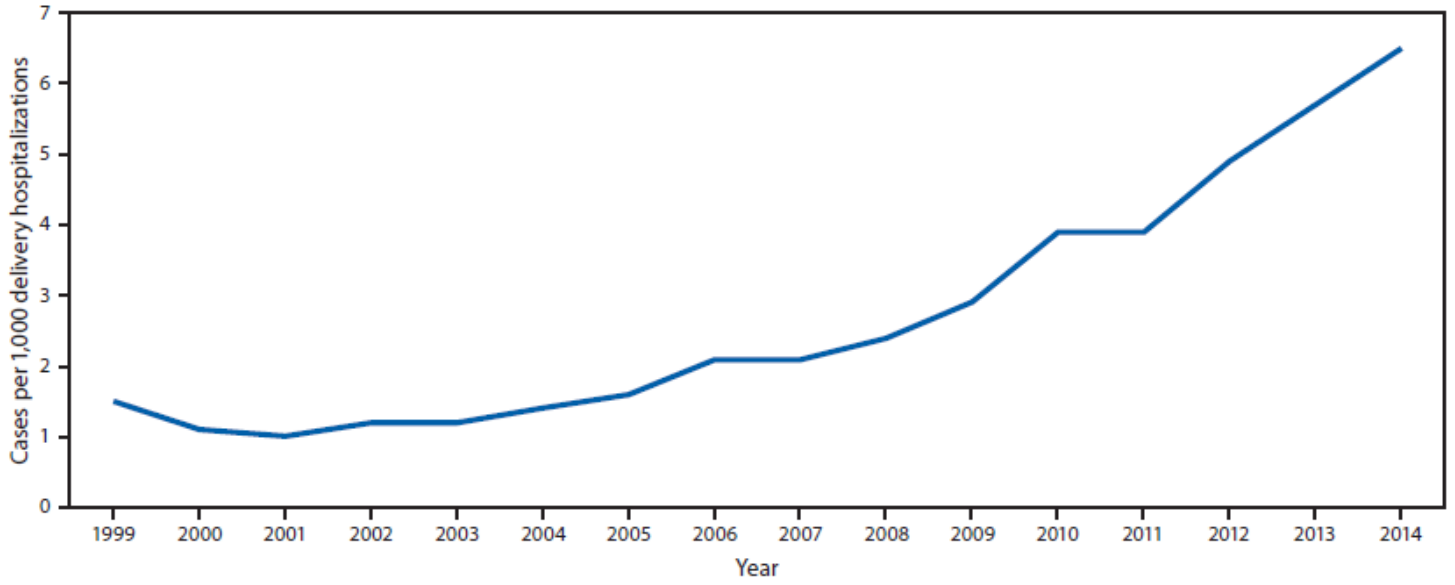
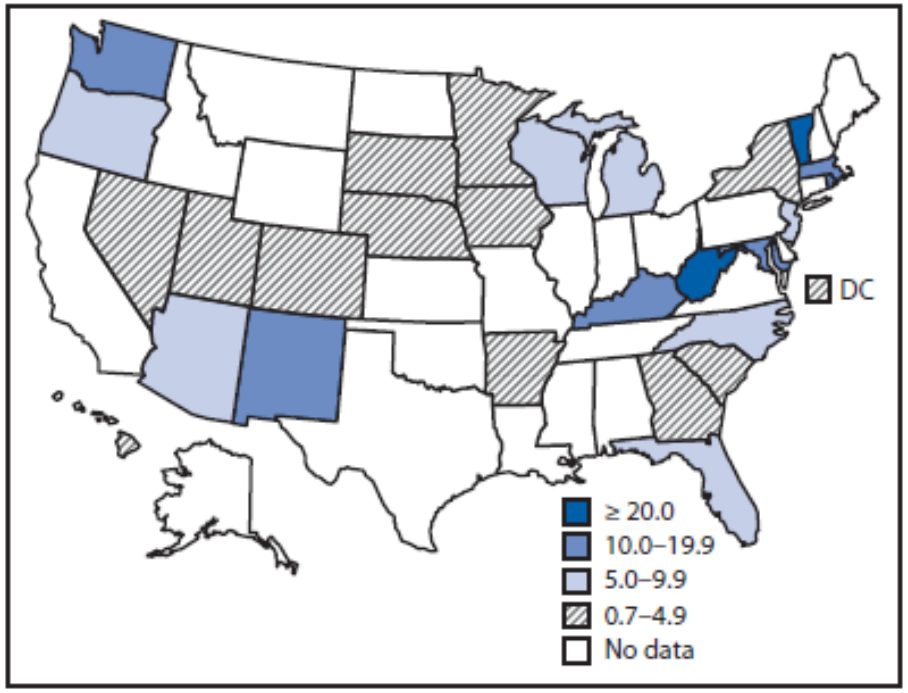


FIGURE 2. Prevalence of opioid use disorder per 1,000 delivery hospitalizations* — State Inpatient Database, Healthcare Cost and Utilization Project, 28 states, 2013–2014†



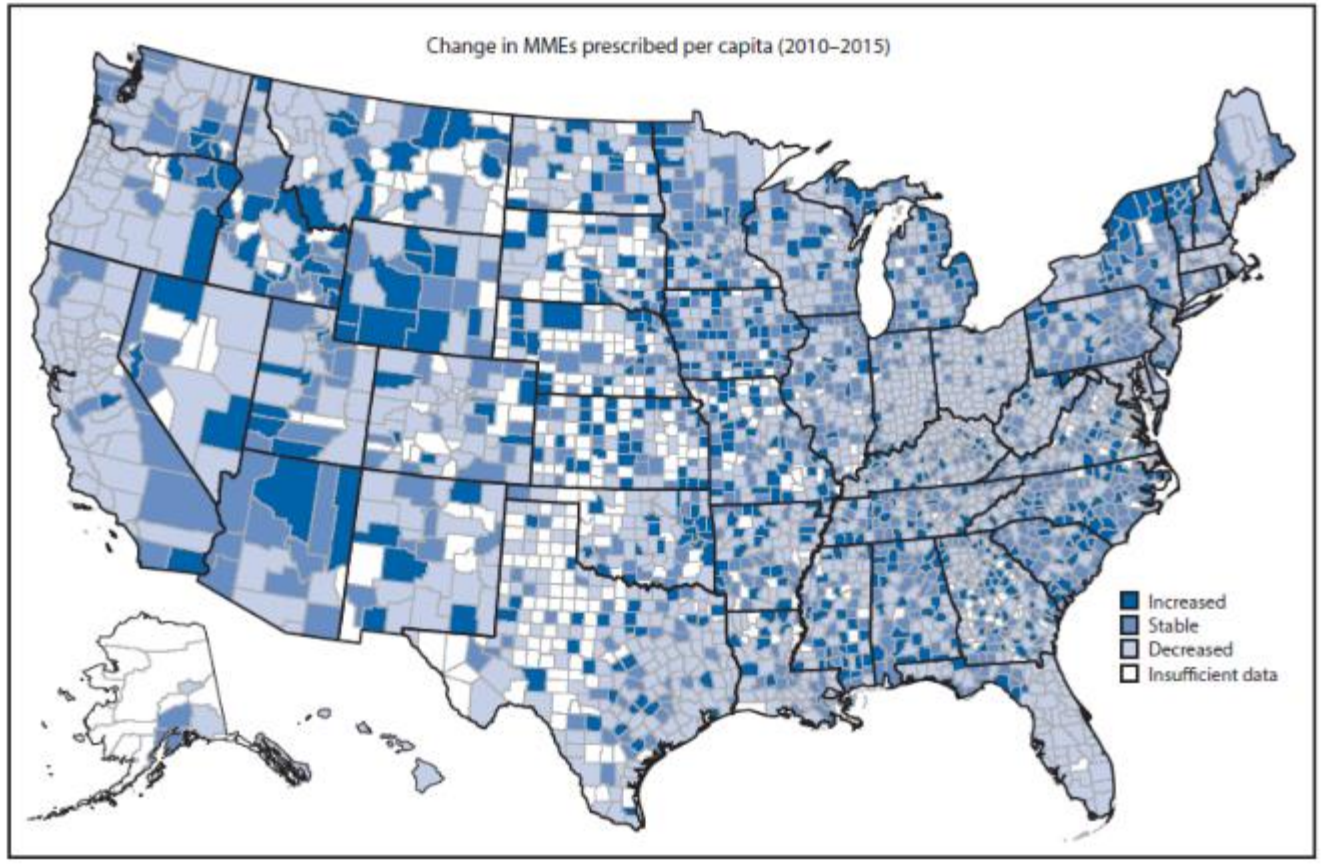
Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015

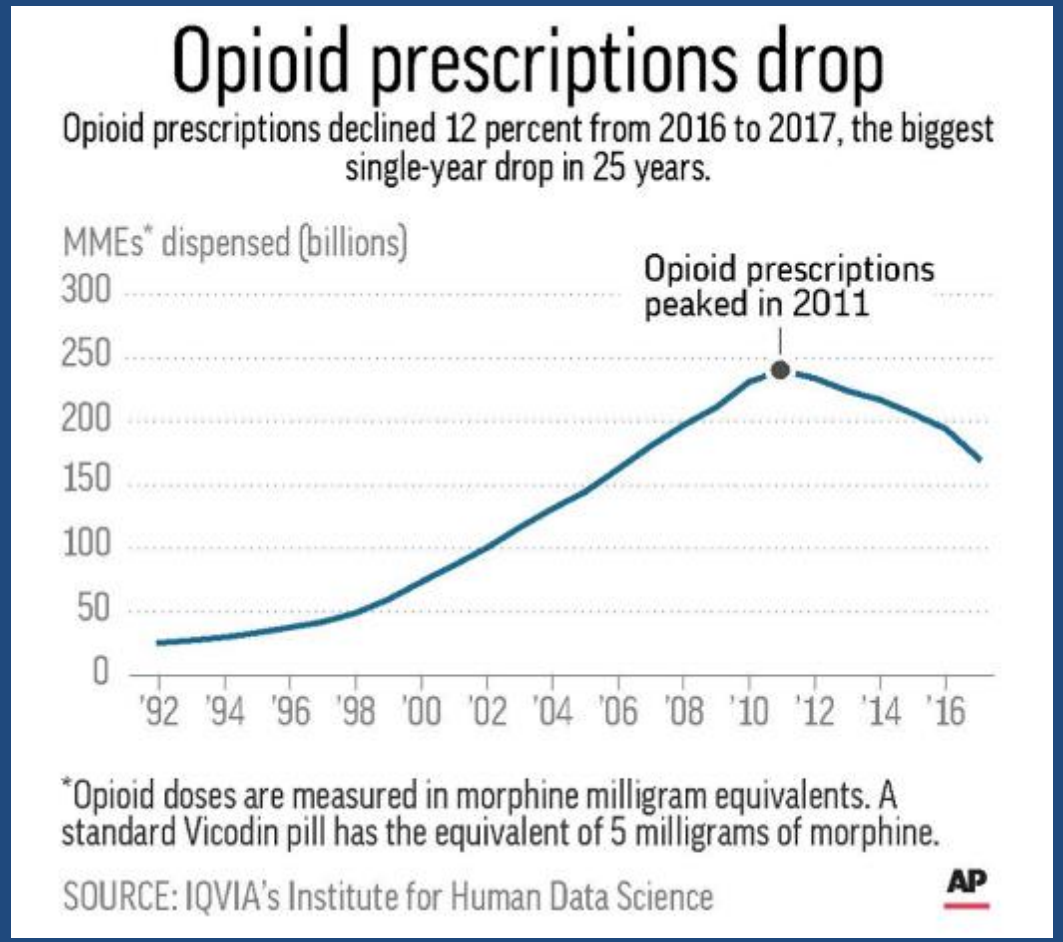
Gery P. Guy Jr., PhD[1]; Kun Zhang, PhD[1]; Michele K. Bohm, MPH[1]; Jan Losby, PhD[1]; Brian Lewis[2]; Randall Young, MA[2]; Louise B. Murphy, PhD[3]; Deborah Dowell, MD[1]

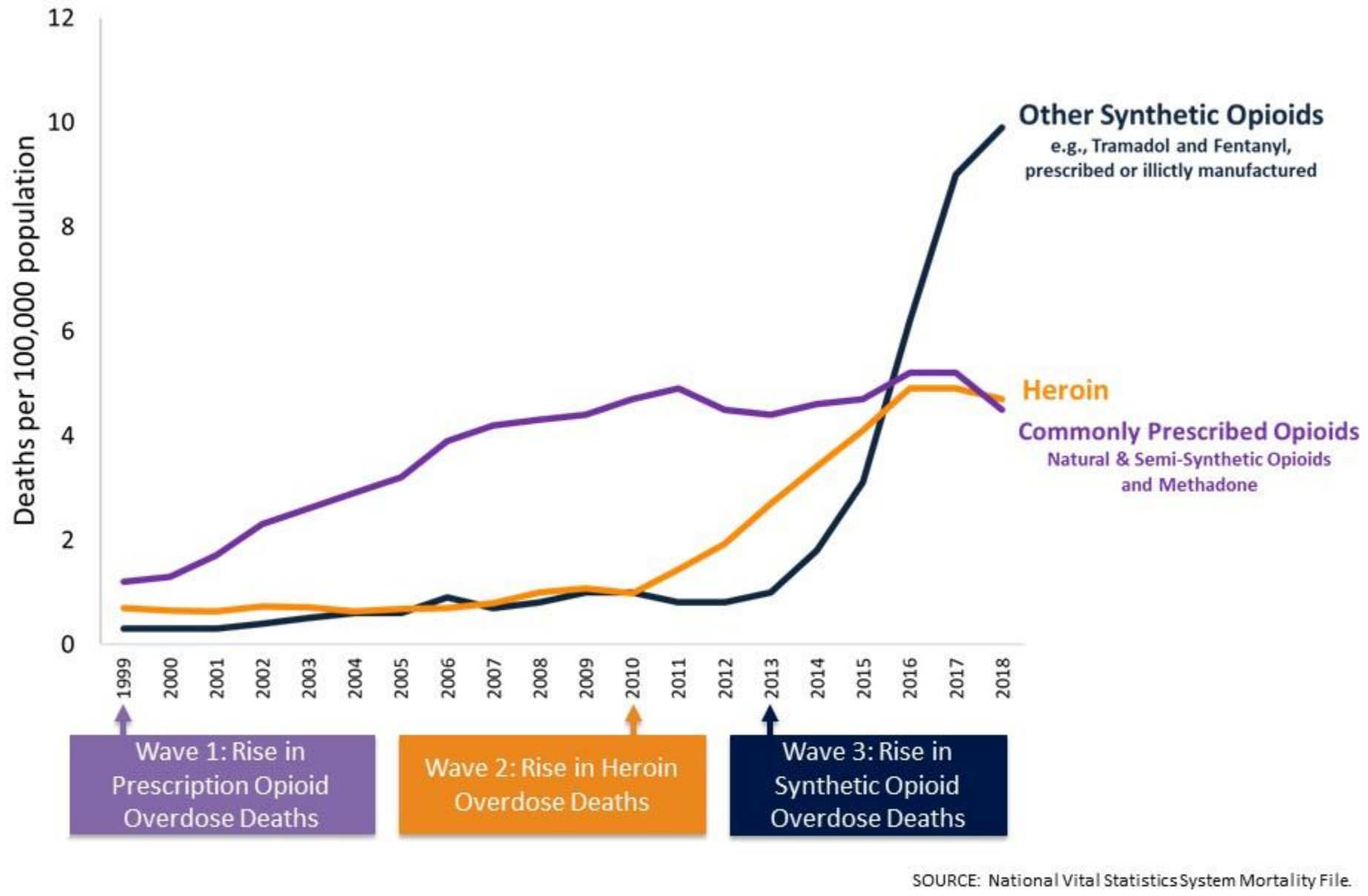
MMWR / July 7, 2017 / Vol. 66 / No. 26

Peak Opioid MME in US 782 (2010); 2015 = 640

FIGURE 2. (*Continued*) Morphine milligram equivalents (MMEs) of opioids prescribed per capita in 2015 and change in MMEs per capita during 2010–2015, by county — United States, 2010–2015







The Opioid Crisis: A Triple Wave Epidemic

Thanks to Dan Cicarrone

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case[1] and Angus Deaton[1]

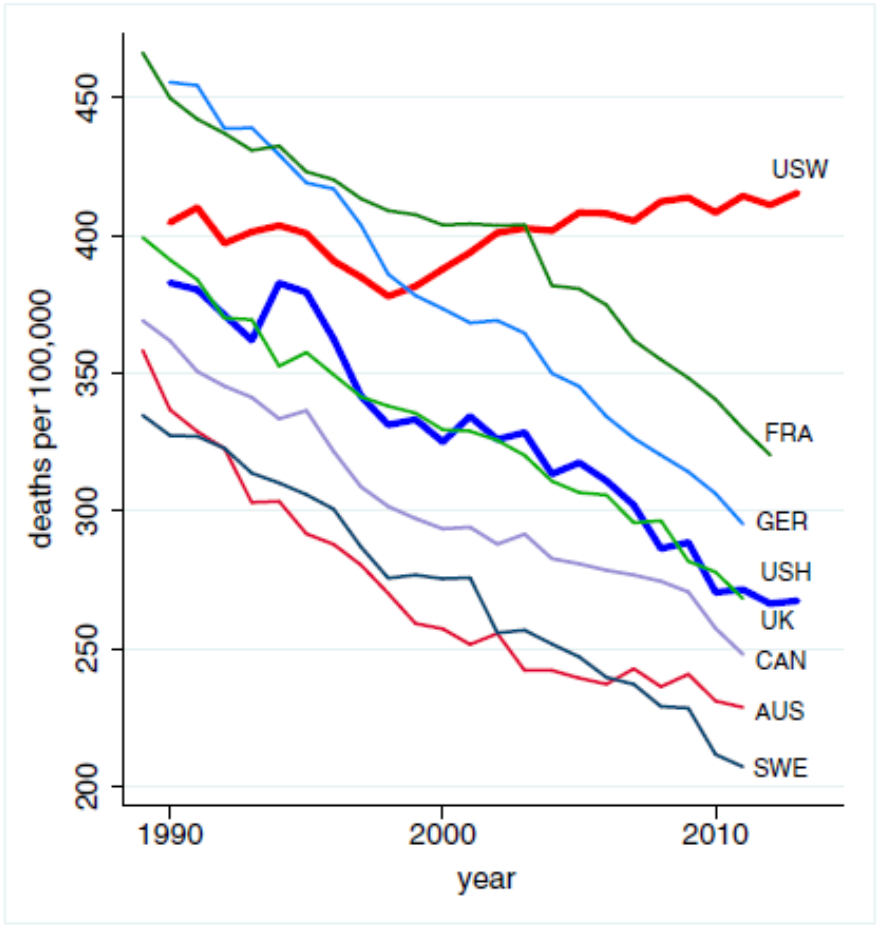


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

15078–15083 | PNAS | December 8, 2015 | vol. 112 | no. 49

The New York Times

In Heroin Crisis, White Families Seek Gentler War on Drugs

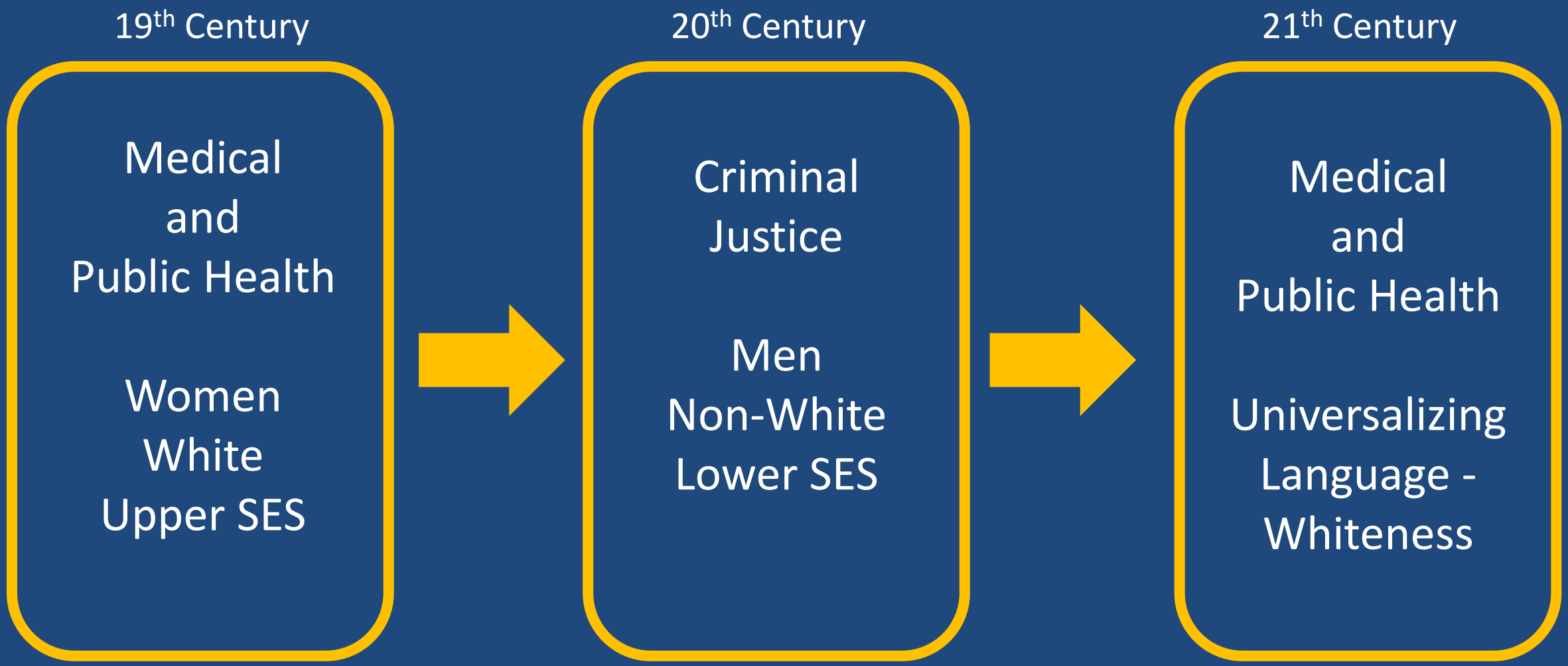
Amanda Jordan with her son Brett Honor outside a meeting for people with addictions and their families in Plaistow, N.H. Her son Christopher died of an overdose. Katherine Taylor for The New York Times

By Katharine Q. Seelye

Oct. 30, 2015

833

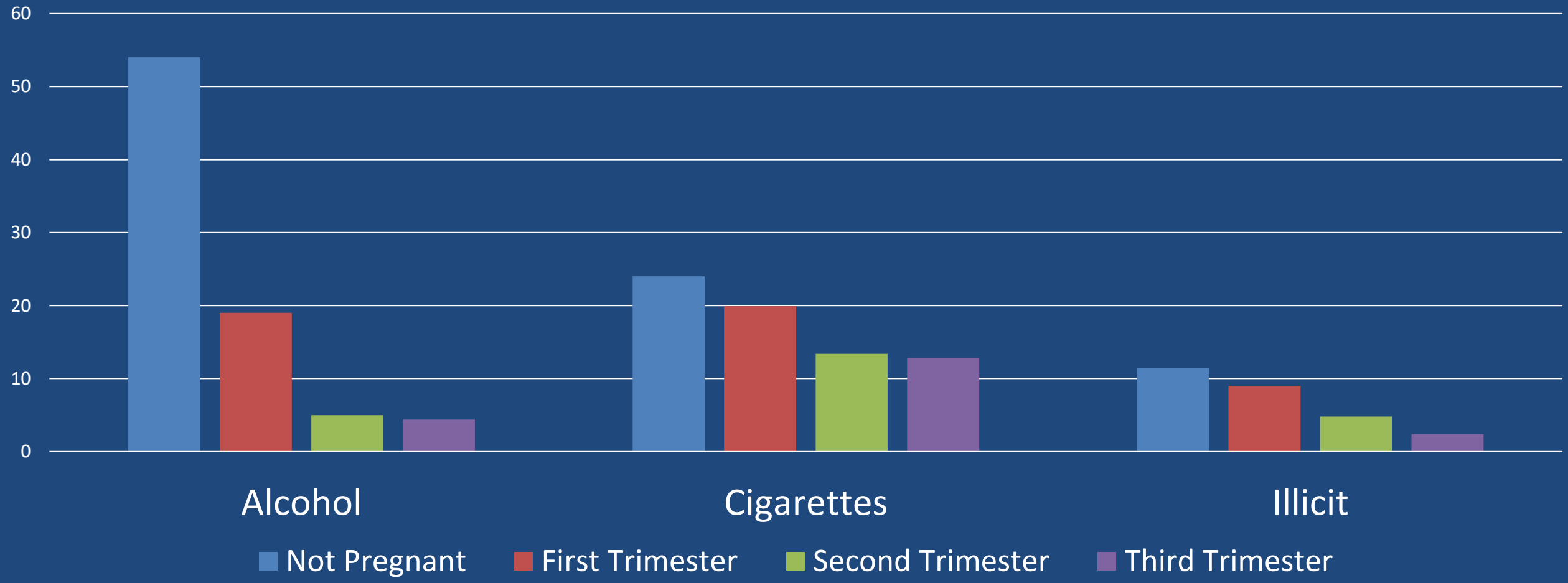
Substance Use and Addiction



Point 2

- Addiction was a medical condition – before it wasn't
  - We are (re)discovering medicine and public health in substance use and addiction
- There is a relationship between what we consider addiction to be, and how we treat people with the disorder
  - Compassion and empathy predate judgment and discrimination

What happens when people who use drugs get pregnant?

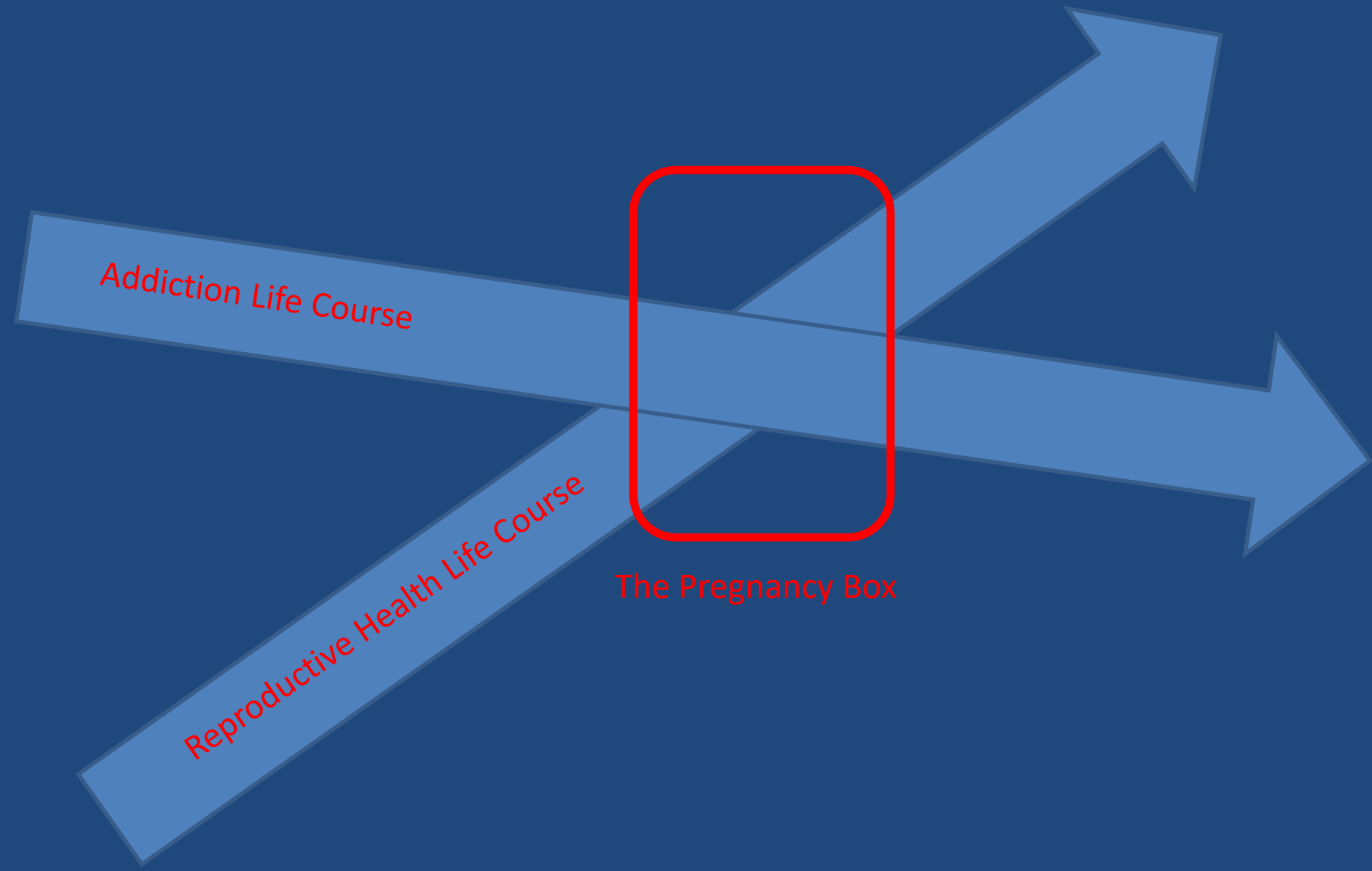


National Survey Drug Use and Health 2015/2016 Past Month Use Data

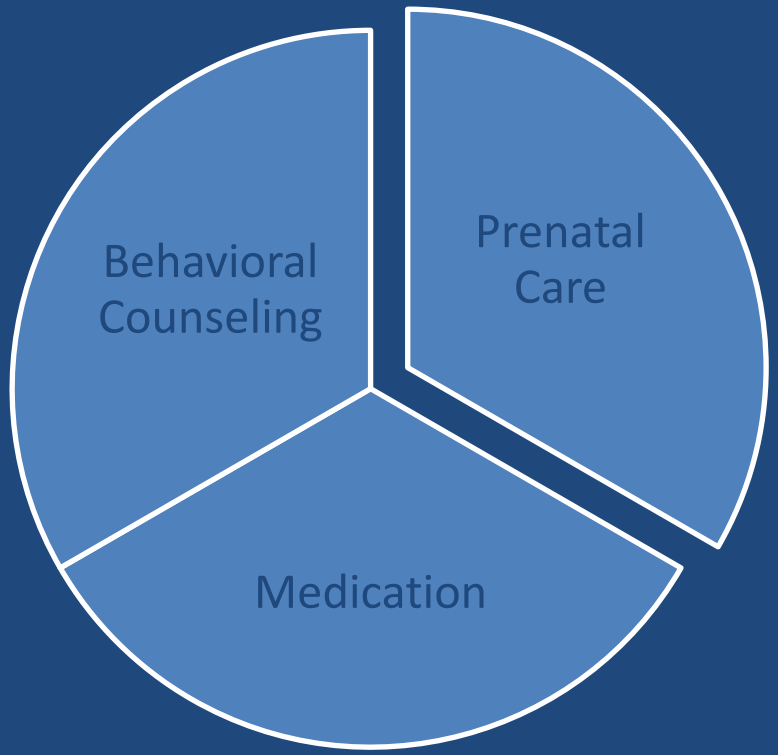
All pregnant women are motivated to maximize their health and that of their baby-to-be

Those who can’t quit or cut back – likely have a substance use disorder

Continued use in pregnancy is pathognomonic for addiction


Addiction Life Course
Reproductive Health Life Course
The Pregnancy Box

Individuals with the Disease of Addiction Need Treatment



“Gold Standard” is Integration: Comprehensive co-located service delivery

MANAGEMENT OF PREGNANT DRUG-DEPENDENT WOMEN

Loretta P. Finnegan

Department of Pediatrics
Thomas Jefferson University
Philadelphia, Pennsylvania 19107

1978

TABLE 2

OBSTETRICAL COMPLICATIONS IN 367 DRUG-DEPENDENT WOMEN AND 215 CONTROLS; FAMILY CENTER PROGRAM, 1969–1976

Groups	No. of Patients	Average no. of Prenatal Visits	Obstetrical Complications %	LBW Incidence %	Pre-eclampsia %
A	65	0	36.9	47.7	9.2
B	109	1.9	32.1	35.5	2.8
C	193	8.2	33.7	19.7	4.7
D	93	0	32.3	19.4	8.6
E	122	9.2	32.0	13.9	8.2

LOW BIRTH WEIGHT	PNC	No PNC
No drug use	14%	19%
Drug Use	19%	**48%**

Matern Child Health J (2017) 21:893–902
DOI 10.1007/s10995-016-2190-y

The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck[1] · Erika R. Cheng[2] · Candice Belanoff[3] · Howard J. Cabral[3] · Hermik Babakhanlou-Chase[4] · Taletha M. Derrington[5] · Hafsatou Diop[6] · Stephen R. Evans[3] · Judith Bernstein[3]

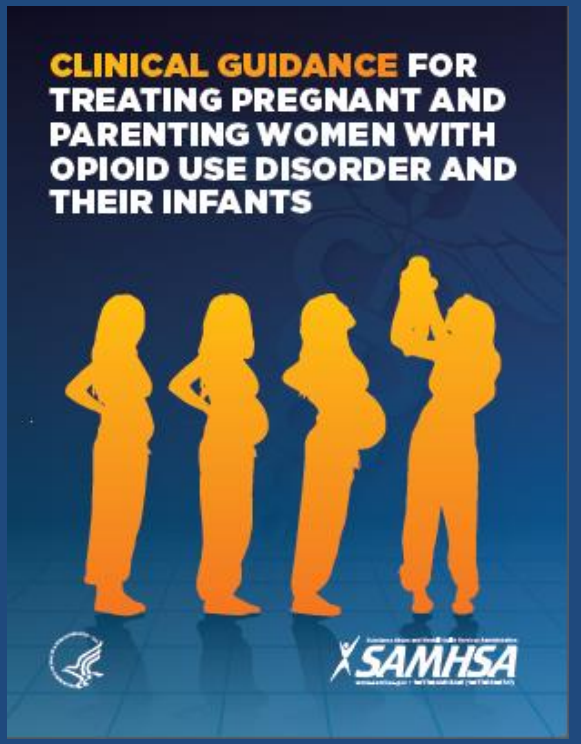
Core Principle of PNC: Optimize maternal health via chronic disease management

Treated vs. Untreated Addiction

	No Addiction	Treated Addiction	Untreated Addiction
Preterm Birth	8.7%	10.1%	19.0%
Low Birthweight	5.5%	7.8%	18.0
Fetal Death	0.4%	0.5%	0.8%
Neonatal Mortality	0.4%	0.4%	1.2%
Post Neonatal Mortality	0.05%	0.03%	0.1%

SAMHSA Clinical Guide Recommendations

- Buprenorphine and methadone are the safest medications for managing OUD during pregnancy
- Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended
- Medically supervised withdrawal is not recommended during pregnancy



Medications for opioid use disorder in pregnancy

Maternal

- 70% reduction in overdose related deaths
- Decrease in risk of HIV, HBV, HCV acquisition/transmission
- Increased engagement in prenatal care and recovery treatment
- Treatment is platform for delivery of other services

Fetal

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

Pharmacokinetic Goals of MOUD

Target	Methadone Dose	Buprenorphine Plasma Conc	MOR Binding
Withdrawal	30-40mg	>1ng/ml	>50%
Craving	>60mg	>2ng/ml	>70%
Opioid Blockade	>85 mg	>3ng/dl	>80%
Restoration of Reward Pathway	Time = 18+ months		

Pregnant People: A Priority Population

- “Because it is crucial that pregnant women engage in treatment for their addictions, OTPs should give priority to admitting pregnant patients at any point during pregnancy and providing them with all necessary care, including adequate dosing strategies as well as referrals for prenatal and follow-up postpartum services.” (Federal Guidelines for Opioid Treatment Programs, 2015)

- Pregnant people – don’t need to meet DSM criteria for use disorder to receive medication for OUD (TIP 43)

Most People with Addiction Receive no Treatment in Pregnancy

Drug and Alcohol Dependence 206 (2020) 107679

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Full length article

Unmet substance use disorder treatment need among reproductive age women

Caitlin E. Martin[a,*], Anna Scialli[b], Mishka Terplan[b,c]

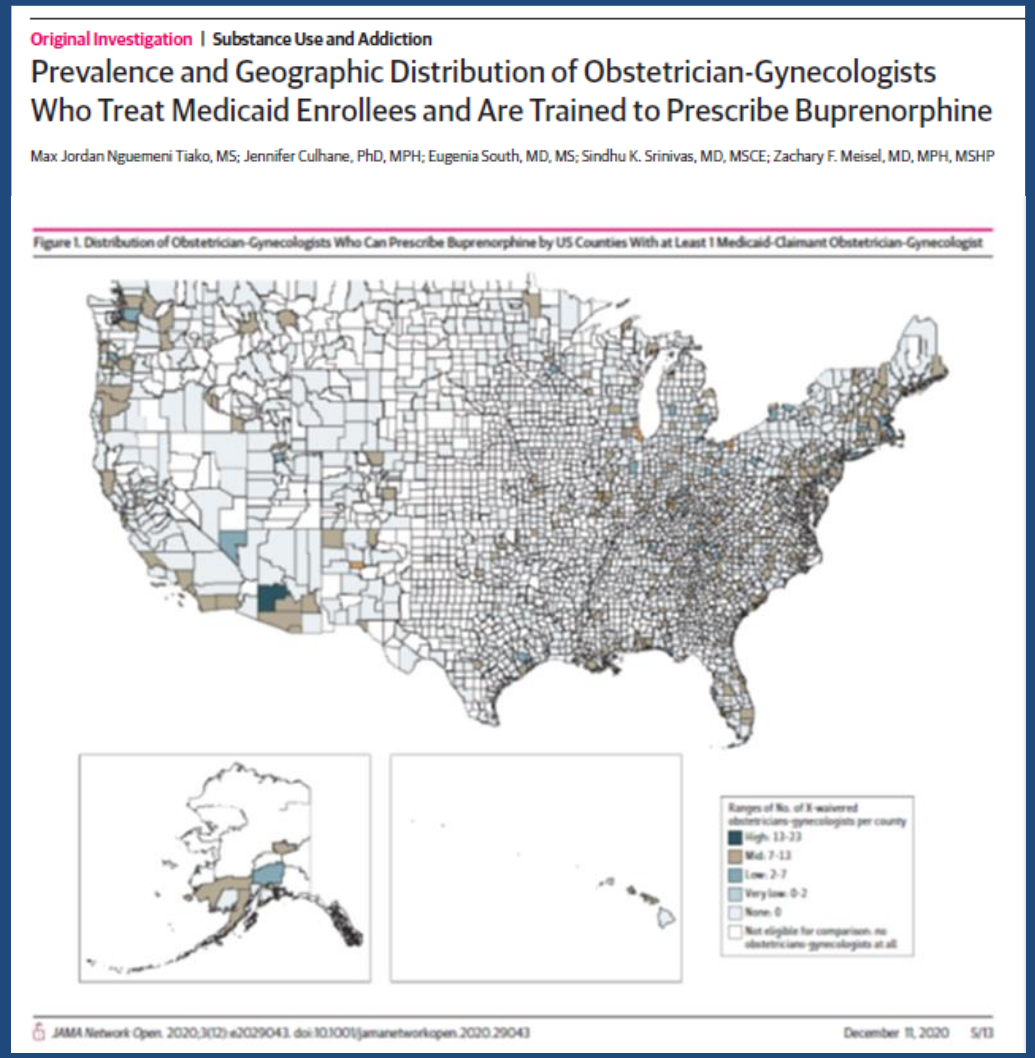
[a] Department of Obstetrics and Gynecology & Institute for Drug and Alcohol Studies, Virginia Commonwealth University School of Medicine, 1250 E. Marshall St, Richmond, VA, 23298, USA
[b] Department of Obstetrics and Gynecology, Virginia Commonwealth University School of Medicine, 1250 E. Marshall St, Richmond, VA, 23298, USA
[c] Friends Research Institute, 1040 Park Ave Suite 103, Baltimore, MD, 21202, USA

Table 3

Past year substance use disorder treatment receipt among reproductive age women in need of treatment.

Substance use disorder diagnosis	Total[a]	Not pregnant nor parenting	Pregnant[†]			Parenting	P values[‡]
			1st trimester	2nd trimester	3rd trimester		
Any past year substance use disorder treatment need[§]	9.3% (8.4–10.2)	8.8% (7.7–9.8)	12.8% (8.7–16.9) 12.5% (7.3–17.7)	9.4% (4.7–14.0)	18.7% (5.5–32.0)	9.9% (8.5–11.4)	0.063 0.246
Alcohol use disorder	7.4% (6.6–8.3)	6.8% (5.9–7.7)	11.8% (7.2–16.5) 11.7% (5.8–17.6)	9.0% (3.3–14.7)	16.2% (2.6–29.9)	8.2% (6.6–9.9)	0.021 0.505
Illicit drug use disorder[‖]	17.1% (15.5–18.7)	17.0% (14.8–19.2)	21.8% (13.9–29.6) 26.0% (15.1–36.8)	13.2% (5.1–21.3)	29.2% (8.5–49.9)	16.5% (13.7–19.3)	0.439 0.187
Opioid use disorder[¶]	23.6% (18.9–28.2)	31.1% (27.0–35.1)	34.7% (20.7–48.7) 54.2% (30.2–78.1)	20.0% (3.5–36.5)	31.1% (0.0–63.7)	23.6% (18.9–28.2)	0.033 0.152

OBGYN Lacks Capacity to Treat OUD



Original Investigation | Substance Use and Addiction

Prevalence and Geographic Distribution of Obstetrician-Gynecologists Who Treat Medicaid Enrollees and Are Trained to Prescribe Buprenorphine

Max Jordan Nguemeni Tiako, MS; Jennifer Culhane, PhD, MPH; Eugenia South, MD, MS; Sindhu K. Srinivas, MD, MSCE; Zachary F. Meisel, MD, MPH, MSHP

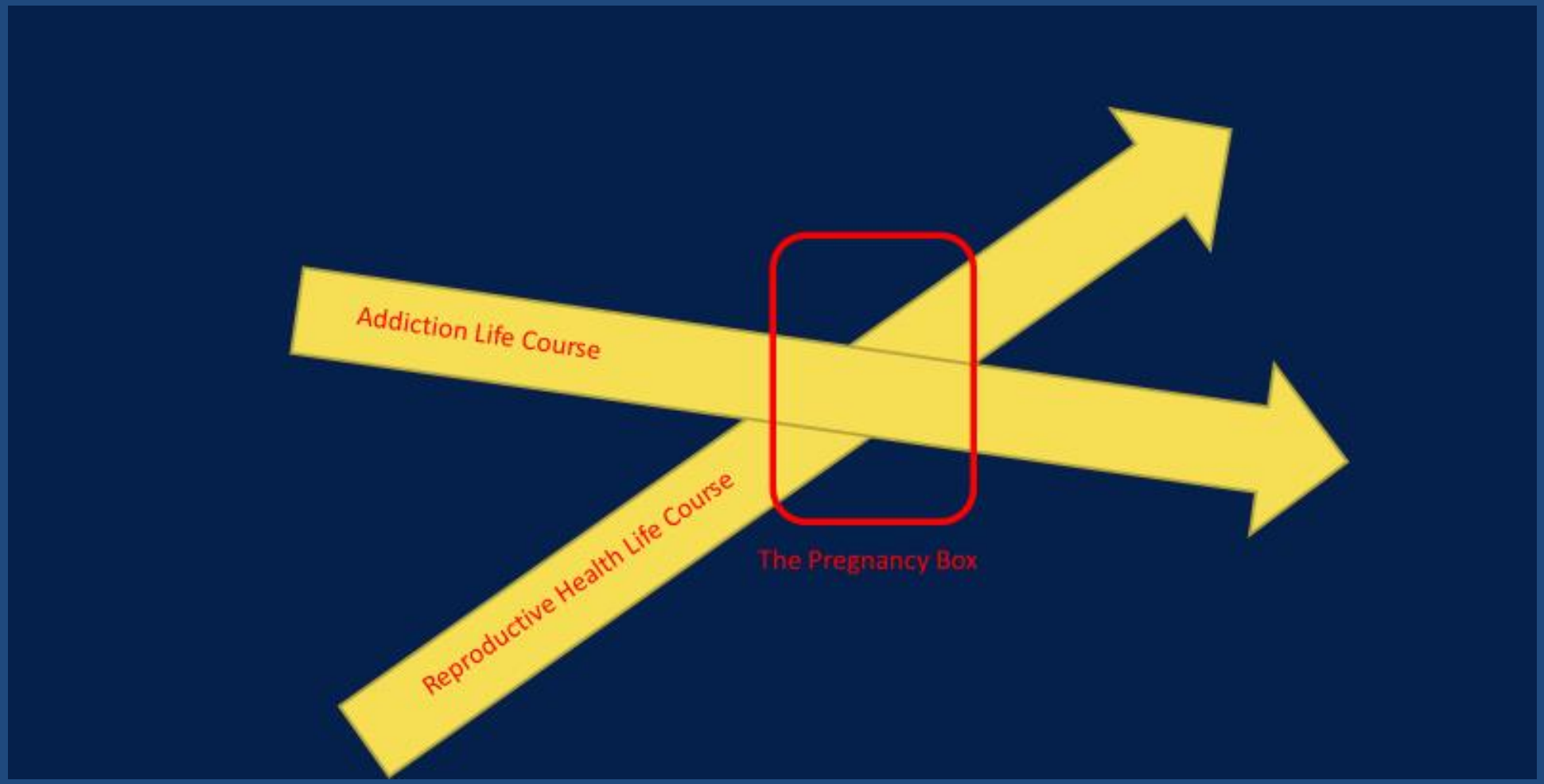
Figure 1. Distribution of Obstetrician-Gynecologists Who Can Prescribe Buprenorphine by US Counties With at Least 1 Medicaid-Claimant Obstetrician-Gynecologist

JAMA Network Open. 2020;3(12):e2029043. doi:10.1001/jamanetworkopen.2020.29043 December 11, 2020 5/13

	N (%) X Waivered OBGYNs in US
2012	181 (0.4%)
2020	560 (1.8%)

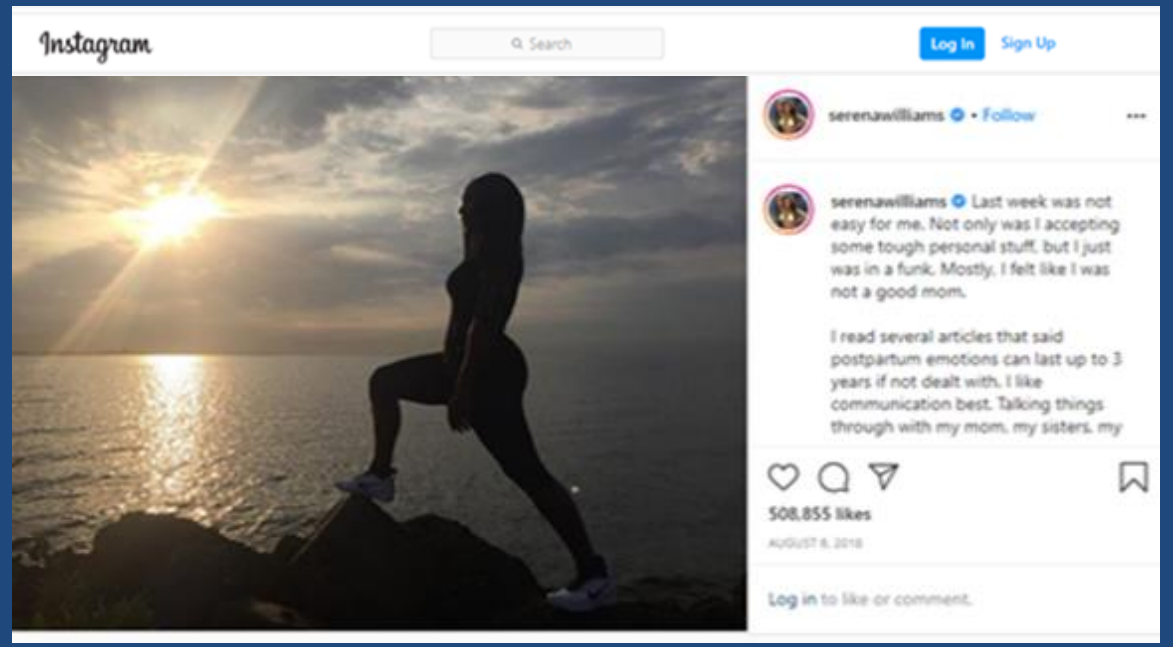
Nguemeni_Tiako MJ et al, *JAMA Network Open*, 2020
Rosenblatt RA et al, *AFM*, 2015

Pregnancy is Part of a Life Course

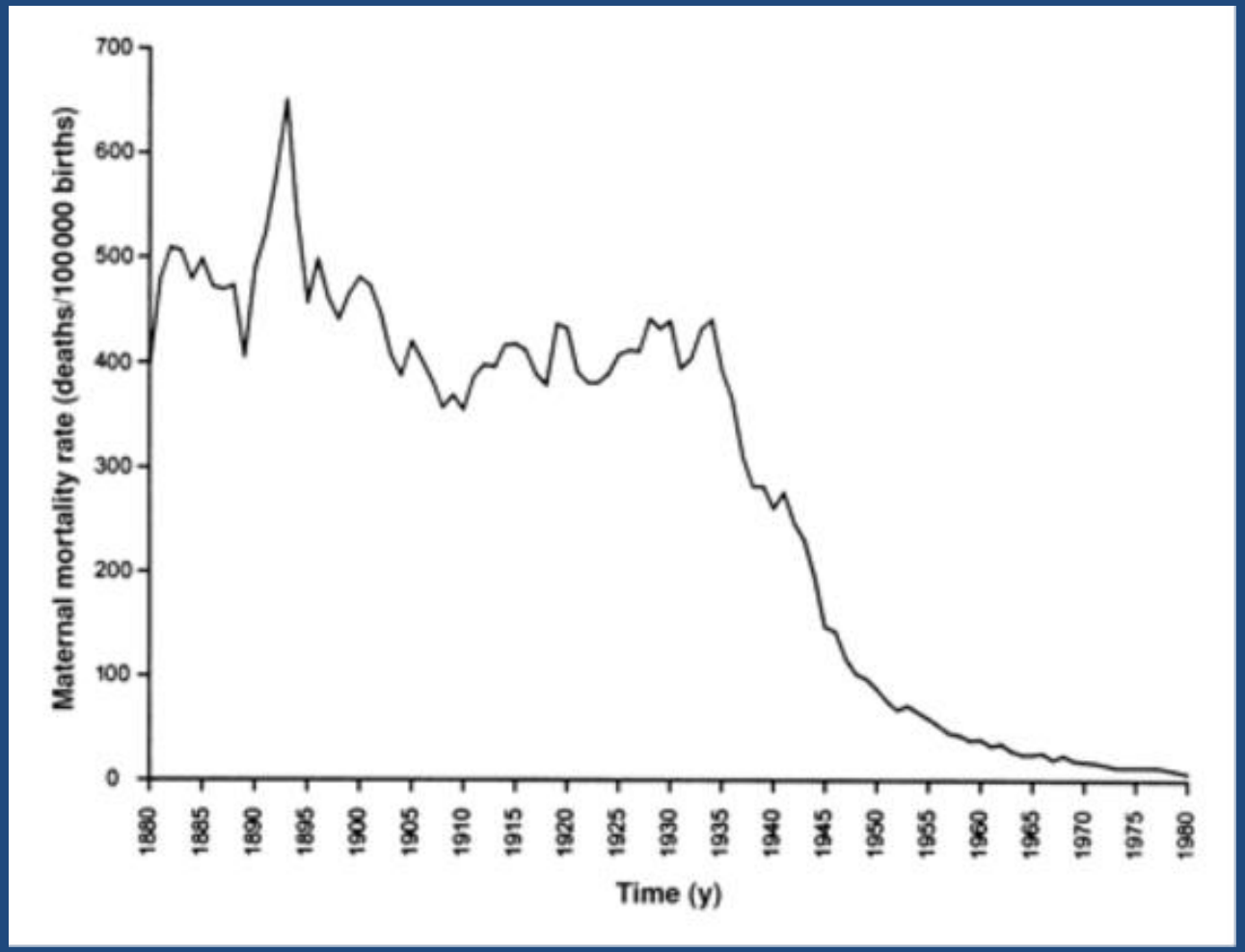


The 4th Trimester - Postpartum

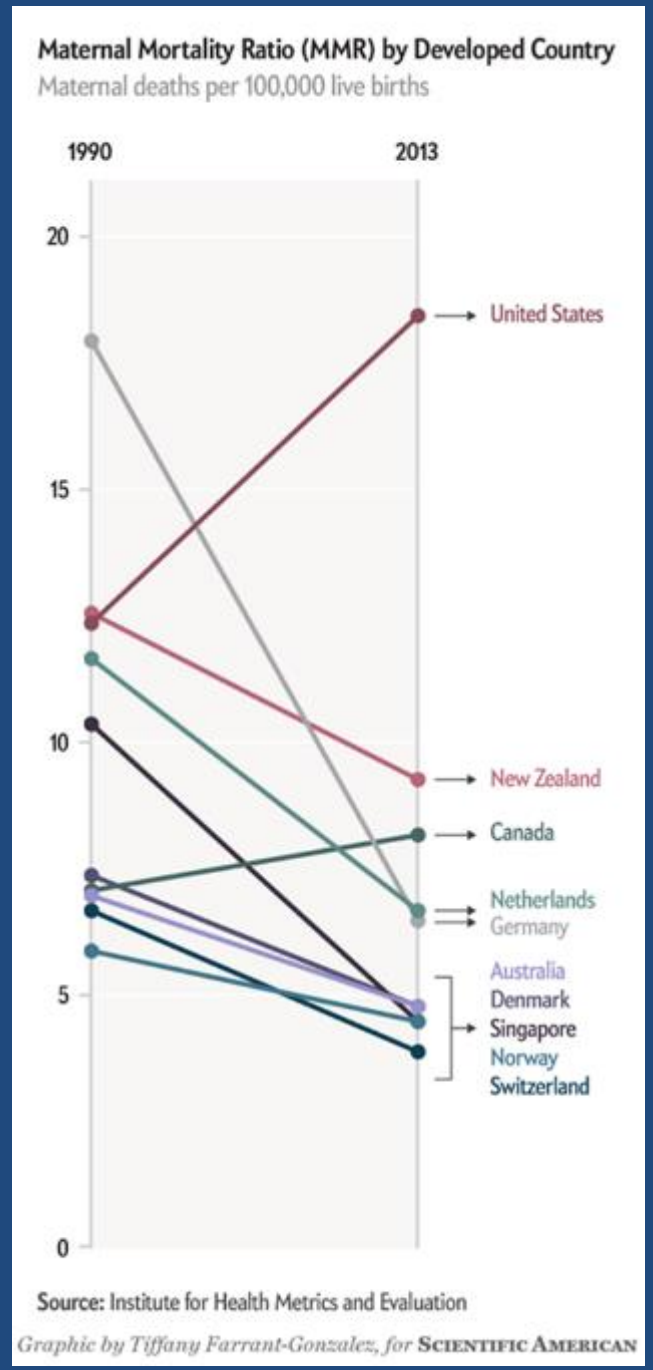
- Critical Period
  - Newborn care, breastfeeding, maternal/infant attachment
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, “the ideal mother” in conflict with actuality of newborn care
  - Insurance and welfare realignment
- Neglected Period
  - Care shifts from frequent to infrequent
  - From Mom-focused (PNC provider) to Baby-focused (Pediatrician)
  - From “medical” to “social” (WIC)
  - Continuity of Care: Addiction Provider



The 4th Trimester: Maternal Mortality



Maternal mortality in the past and its relevance to developing countries today
Am J Clin Nutr. 2000;72(1):241S-246S. doi:10.1093/ajcn/72.1.241S



PERIOPERATIVE MEDICINE

Opioid Abuse and Dependence during Pregnancy

Temporal Trends and Obstetrical Outcomes

Ayumi Maeda, M.D., Brian T. Bateman, M.D., M.Sc., Caitlin R. Clancy, B.A., Andreea A. Creanga, M.D., Ph.D., Lisa R. Leffert, M.D.

Table 2. Associations between Opioid Abuse or Dependence during Pregnancy and Obstetrical Outcomes: United States, 2007–2011

	Delivery Hospitalizations with Opioid Abuse or Dependence n (%)	Delivery Hospitalizations without Opioid Abuse or Dependence n (%)	Multivariable Odds Ratio* (95% CI)
Total	60,994	20,456,485	
Died during hospitalization	20 (0.03)	1,311 (0.006)	**4.6 (1.8–12.1)**
Cardiac arrest	24 (0.04)	1,873 (0.01)	**3.6 (1.4–9.1)**
Intrauterine growth restriction	4,157 (6.8)	431,032 (2.1)	**2.7 (2.4–2.9)**
Placental abruption	2,315 (3.8)	215,057 (1.1)	**2.4 (2.1–2.6)**
Length of stay >7 days	1,837 (3.0)	235,738 (1.2)	**2.2 (2.0–2.5)**
Preterm	10,538 (17.3)	1,506,941 (7.4)	**2.1 (2.0–2.3)**
Oligohydramnios	2,736 (4.5)	564,410 (2.8)	**1.7 (1.6–1.9)**
Transfusion	1,205 (2.0)	208,073 (1.0)	**1.7 (1.5–1.9)**
Stillbirth	727 (1.2)	124,607 (0.6)	**1.5 (1.3–1.8)**
Premature rupture of membranes	3,499 (5.7)	778,157 (3.8)	**1.4 (1.3–1.6)**
Cesarean delivery	22,130 (36.3)	6,768,679 (33.1)	**1.2 (1.1–1.3)**
Severe preeclampsia or eclampsia	722 (1.2)	289,668 (1.4)	**0.8 (0.7–0.9)**
Anesthesia complications	20 (0.03)	3,123 (0.02)	2.1 (0.8–5.3)
Cerebrovascular complications	37 (0.06)	5,079 (0.02)	2.0 (0.9–4.4)
Sepsis	273 (0.4)	79,169 (0.4)	1.3 (1.0–1.7)
Postpartum hemorrhage	1,866 (3.1)	589,811 (2.9)	1.1 (0.9–1.2)

Research Article

Maternal Opioid Drug Use during Pregnancy and Its Impact on Perinatal Morbidity, Mortality, and the Costs of Medical Care in the United States

Valerie E. Whiteman,[1] Jason L. Salemi,[2] Mulubrhan F. Mogos,[3] Mary Ashley Cain,[1] Muktar H. Aliyu,[4] and Hamisu M. Salihu[1,2]

TABLE 2: Rates[a] of selected clinical outcomes by opioid use status and odds ratios and 95% confidence intervals for the association between opioid use and each outcome among pregnancy-related discharges, NIS, 1998–2009.

Outcomes	Rate[a] of outcome		OR (95% CI)		
	Opioid users	Nonopioid users	Model 1[b]	Model 2[c]	Model 3[d]
Maternal					
Threatened preterm labor	30.1	22.3	1.36 (1.24–1.49)	1.34 (1.22–1.47)	1.32 (1.19–1.45)
Early onset delivery	124.0	65.2	2.03 (1.88–2.20)	1.92 (1.77–2.07)	1.72 (1.59–1.85)
PROM	38.5	35.4	1.10 (1.00–1.20)	1.12 (1.03–1.23)	1.06 (0.98–1.16)
Wound infection	7.0	5.0	1.41 (1.18–1.68)	1.19 (1.00–1.42)	1.17 (0.98–1.40)
Acute renal failure	2.1	0.5	4.10 (3.11–5.41)	2.78 (2.09–3.72)	2.84 (2.11–3.84)
Postpartum depression[f]	24.7	2.1	12.04 (10.83–13.40)	2.09 (1.79–2.44)	1.75 (1.49–2.05)
Hospital stay >5 days[e]	133.4	29.9	5.00 (4.16–6.02)	4.83 (4.10–5.69)	4.02 (3.41–4.74)
In-hospital maternal mortality	0.8	0.1	5.89 (3.74–9.28)	3.63 (2.32–5.68)	3.69 (2.32–5.87)
Fetal					
Poor fetal growth	35.9	15.9	2.31 (2.10–2.55)	2.21 (2.00–2.44)	1.61 (1.46–1.77)
Stillbirth	10.0	6.3	1.60 (1.39–1.83)	1.41 (1.23–1.62)	1.32 (1.15–1.51)

Original Research

OBSTETRICS & GYNECOLOGY

Maternal Deaths From Suicide and Overdose in Colorado, 2004–2012

VOL. 128, NO. 6, DECEMBER 2016

Torri D. Metz, MD, MS, Polina Rovner, MD, M. Camille Hoffman, MD, MSc, Amanda A. Allshouse, MS, Krista M. Beckwith, MSPH, and Ingrid A. Binswanger, MD, MPH, MS

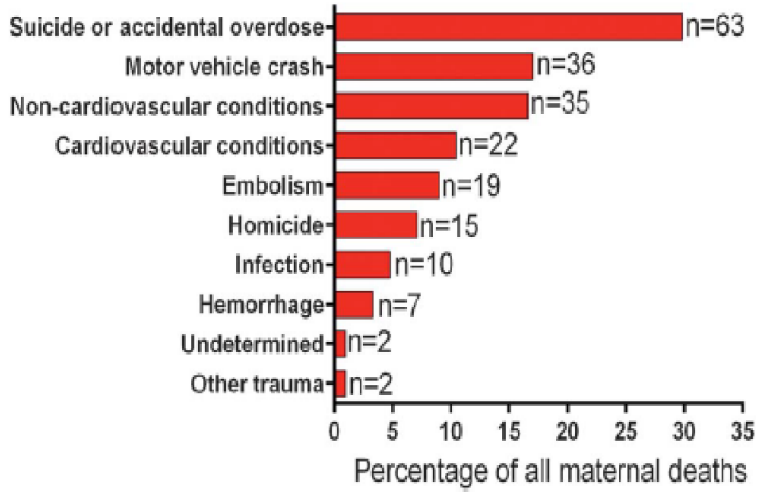


Fig. 1. Maternal deaths in Colorado from 2004 to 2012 (N=211) classified by cause. The x-axis delineates the percentage of maternal deaths in each category stated on the y-axis with the frequency in each category provided at the end of each bar. Classifications are mutually exclusive.

Metz. Maternal Deaths From Self-Harm in Colorado. Obstet Gynecol 2016.

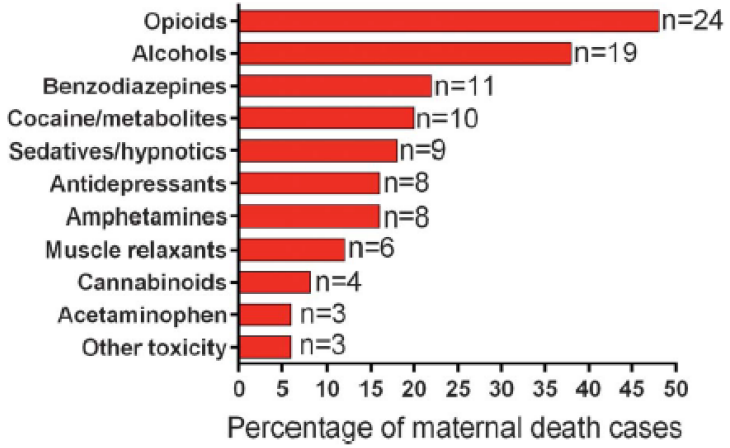


Fig. 2. Frequency of drugs and pharmaceuticals detected on toxicology testing during autopsy (n=50, toxicology testing not performed in n=9). Toxicology testing did not find any positive results for anesthetics, antipsychotics, barbiturates, or phencyclidine. Opioids include heroin and pharmaceutical opioids (including methadone). Frequencies in figure are not mutually exclusive.

Metz. Maternal Deaths From Self-Harm in Colorado. Obstet Gynecol 2016.

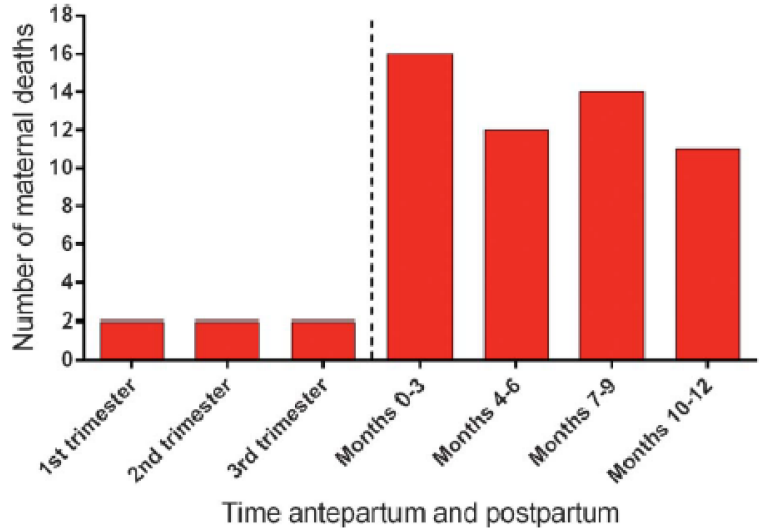


Fig. 3. Temporal distribution of maternal deaths from self-harm by trimester of pregnancy and number of months postpartum. Relatively few cases occurred during the pregnancy.

Metz. Maternal Deaths From Self-Harm in Colorado. Obstet Gynecol 2016.

Drug and Alcohol Dependence 149 (2015) 225–231

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder

Christine Wilder[a,b,*], Daniel Lewis[a], Theresa Winhusen[a]

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[b] Department of Veterans Affairs Medical Center, 3200 Vine Street, Cincinnati, OH 45220, USA

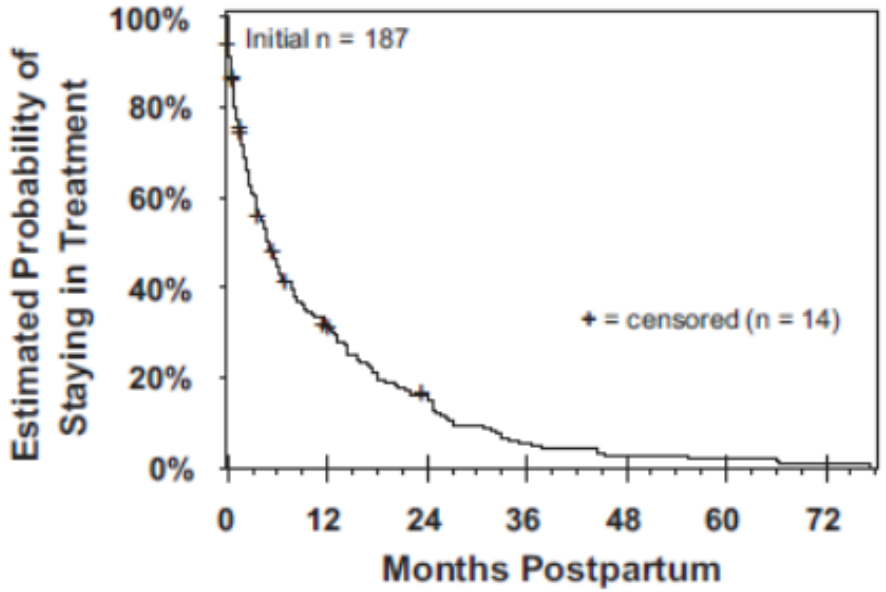


Fig. 1. Kaplan–Meier estimates for remaining in methadone treatment after pregnancy.

Medication discontinuation is common postpartum due, in part, to changes in insurance status

Opioids: *Original Research*

Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

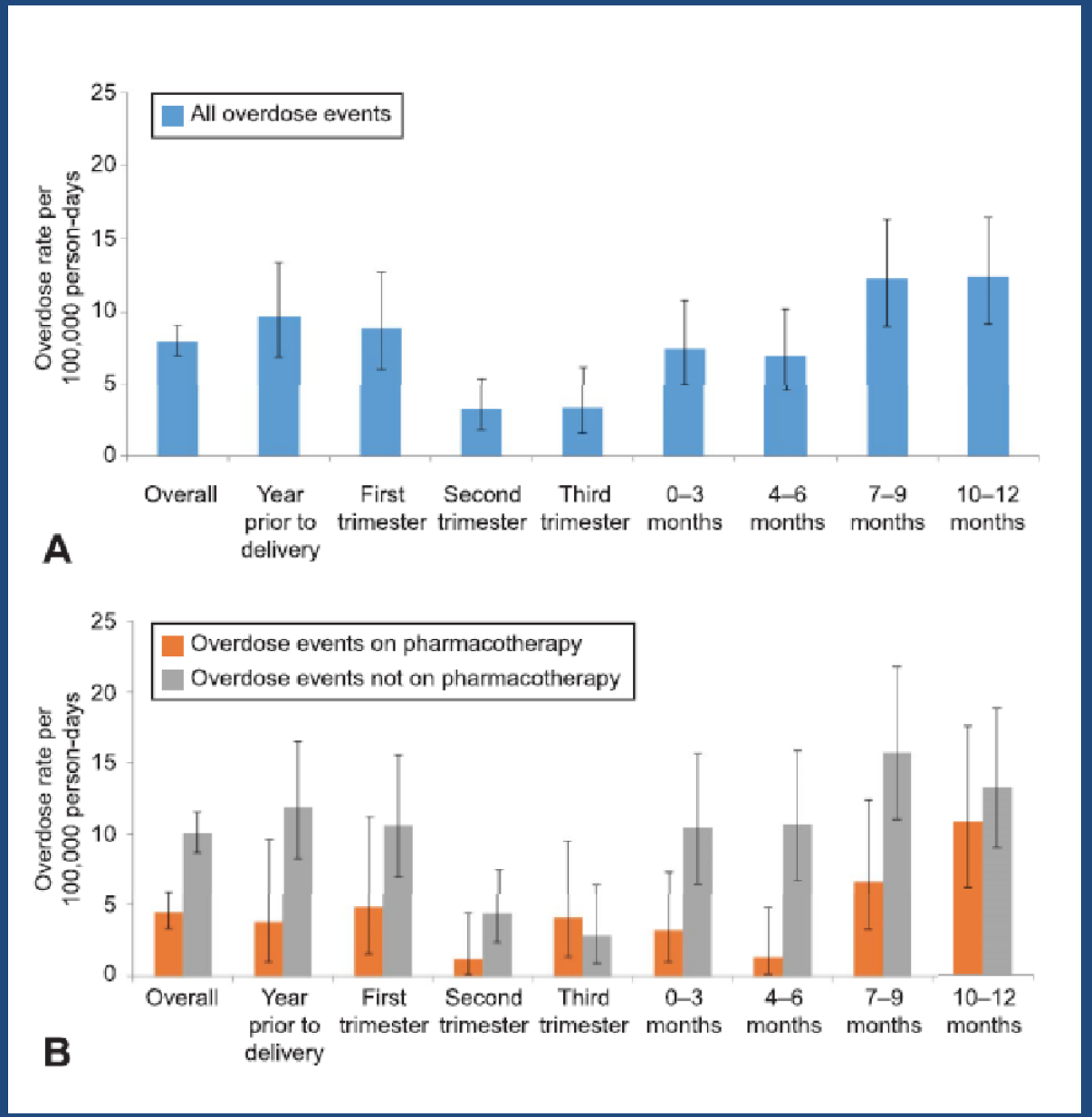
OBSTETRICS & GYNECOLOGY

Davida M. Schiff, MD, MSc, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Bernson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MSc, and Thomas Land, PhD

Table 2. Opioid Overdose Rates Among Pregnant and Parenting Women With Evidence of Opioid Use Disorder in the Year Before Delivery (n=4,154)

Period Relative to Delivery	All OD Events	OD Events While Receiving Pharmacotherapy	OD Events Not Receiving Pharmacotherapy
Overall	7.99 (7.01–9.06)	4.43 (3.28–5.86)*	10.04 (8.67–11.56)*
Year before delivery–conception	9.72 (6.91–13.29)	3.74 (1.02–9.57)	11.89 (8.28–16.54)
Trimester (weeks of gestation)			
1st (0–12)	8.88 (6.04–12.61)	4.79 (1.56–11.18)	10.63 (6.94–15.58)
2nd (13–28)	3.23 (1.81–5.32)	1.20 (0.15–4.35)	4.35 (2.32–7.44)
3rd (29 or greater)	3.32 (1.59–6.10)†	4.08 (1.32–9.51)	2.80 (0.91–6.53)
Postpartum (mo)			
0–3	7.41 (4.92–10.71)	3.17 (1.03–7.41)	10.44 (6.62–15.67)
4–6	6.89 (4.50–10.10)	1.31 (0.16–4.74)*	10.67 (6.84–15.88)*
7–9	12.2 (8.93–16.28)†	6.74 (3.23–12.40)	15.75 (11.03–21.80)
10–12	12.35 (9.07–16.42)†	10.84 (6.20–17.60)	13.3 (9.04–18.88)

OD, opioid overdose.
Data are rate/100,000 person-days (95% CI).
* Denotes statistically significant difference between overdose rates among women receiving pharmacotherapy vs women not receiving pharmacotherapy.
† Denotes statistically significant difference between overall overdose rates during third trimester and 7–12 months postpartum.



Point 3

- Addiction is a chronic condition
- Birth outcomes of people with treated addiction are similar to those of a general population
- Care drops off postpartum

Opinion

She Was Addicted a
Her Son. She Want

Lindsey Jarratt is now sober and on solid ground
remains in foster care.

Damon Winter/The New York Times

By Jeneen Interlandi
Ms. Interlandi is a member of the editorial board.

Jan. 13, 2019

385

Lindsey Jarratt's son, Brayden, was a year old when the Child Protective Services of Dinwiddie, Va., took him to live with strangers. There are things about the months surrounding that moment that Ms. Jarratt can't remember — heroin has a way of erasing time. But this much is still etched in her mind: how he screamed and sobbed, the way his baby fists clutched at the nape of her shirt, the feel of his tiny body pressed so desperately against hers that the two had to be pried apart.

Pw
San Francisco | Jan. 14

Using H while pregnant is the deal breaker..
Sorry lady..

James
DC | Jan. 14

Sure, the parents love the child but do they love him more than
r the other.

Jude Parker Smith
Chicago, IL | Jan. 14

Some people should not be allowed to have children.

n I have no sympathy for her. You
not care about the child. Period.

There
Here | Jan. 14

There are consequences of being a junkie. You just don't return to life expecting all you had before.

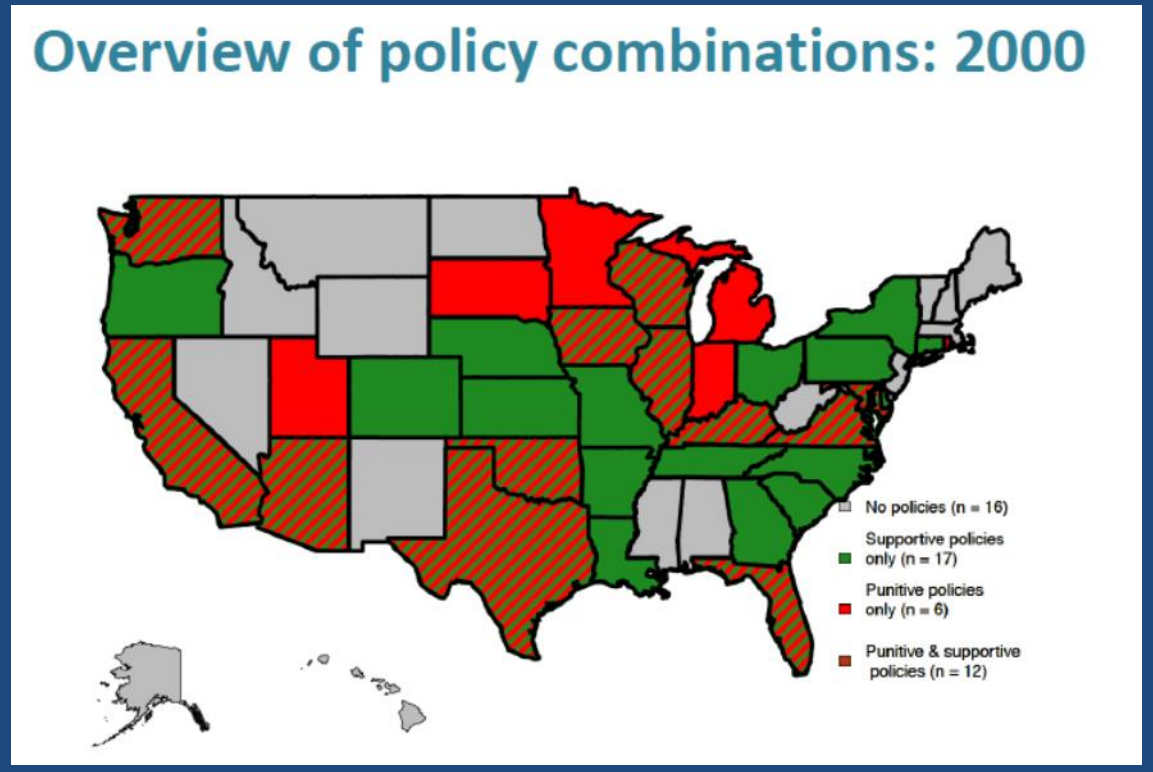
The state needs to let the children from junkie parents as heroin is a tough addiction and one that she'll probably fail to beat based on statistics.

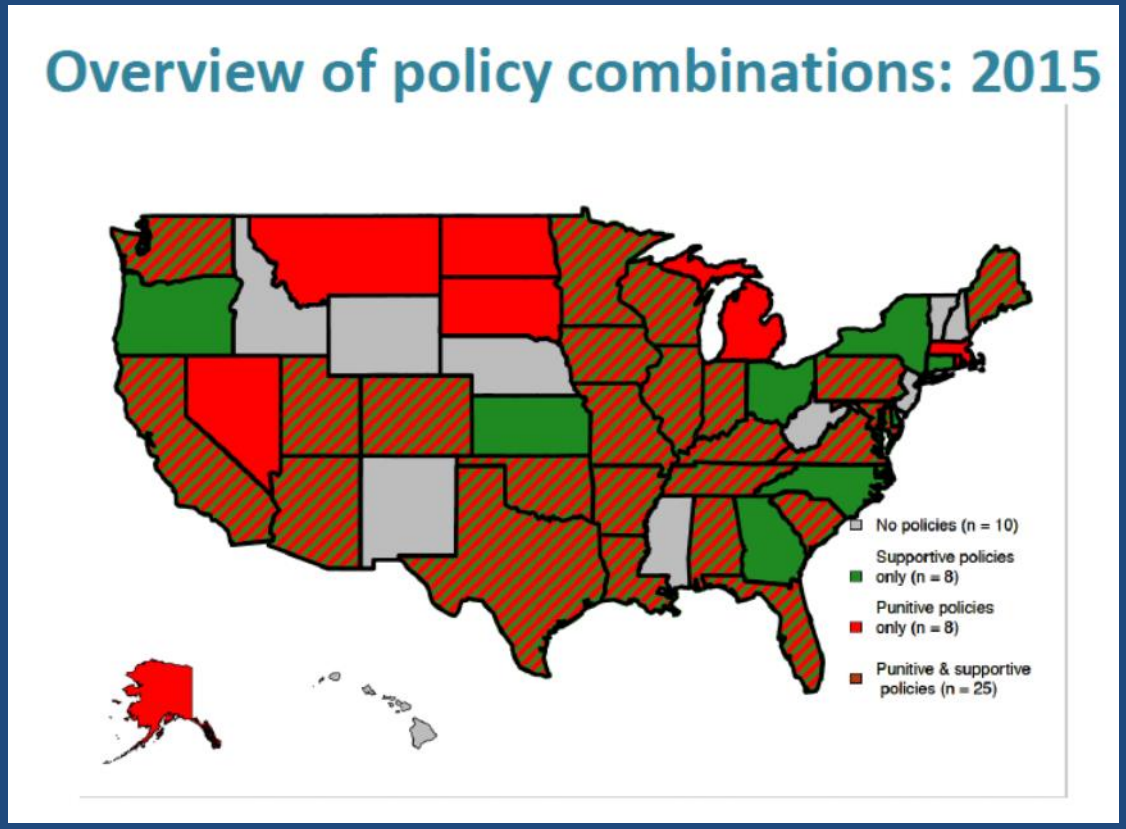
Stigma

Discrimination and Prejudice

Punishment

State Policies related to drug use during pregnancy have become increasingly punitive





Presentation Dr Faherty, Academy Health Annual Research Conference, June 3 2019

State Policies on Substance Use during Pregnancy

Policy	Number of States
Substance Use Considered Child Abuse	23+DC
Substance Use Grounds for Civil Commitment	3
Mandatory Reporting	25+DC
Targeted Programs for Pregnant Women	19
Pregnant Women Given Priority Access	17+DC
Pregnant Women Protected from Discrimination	10

Guttmacher Institute January 1, 2020

Punitive State Policies: Worse Public Health Outcomes

Alcoholism: Clinical and Experimental Research
Vol. 42, No. 8
August 2018

Associations Between State-Level Policies Regarding Alcohol Use Among Pregnant Women, Adverse Birth Outcomes, and Prenatal Care Utilization: Results from 1972 to 2013 Vital Statistics

Meenakshi S. Subbaraman, Sue Thomas, Ryan Treffers, Kevin Delucchi, William C. Kerr, Priscilla Martinez, and Sarah C.M. Roberts

Background: Policies regarding alcohol use during pregnancy continue to be enacted and debated in the United States. However, no study to date has examined whether these policies are related to birth outcomes—the outcomes they ultimately aim to improve. Here, we assessed whether state-level policies targeting alcohol use during pregnancy are related to birth outcomes, which has not been done comprehensively before.

Methods: The study involved secondary analyses of birth certificate data from 148,048,208 U.S. singleton births between 1972 and 2013. Exposures were indicators of whether the following 8 policies were in effect during gestation: Mandatory Warning Signs (MWS), Priority Treatment for Pregnant Women, Priority Treatment for Pregnant Women/Women with Children, Reporting Requirements for Data and Treatment Purposes, Prohibitions Against Criminal Prosecution, Civil Commitment, Reporting Requirements for Child Protective Services Purposes, and Child Abuse/Child Neglect. Outcomes were low birthweight (<2,500 g), premature birth (<37 weeks), any prenatal care utilization (PCU), late PCU, inadequate PCU, and normal (≥7) APGAR score. Multivariable fixed-effect logistic regressions controlling for both maternal- and state-level covariates were used for statistical analyses.

Results: Of the 8 policies, 6 were significantly related to worse outcomes and 2 were not significantly related to any outcomes. The policy requiring MWS was related to the most outcomes: specifically, living in a state with MWS was related to 7% higher odds of low birthweight ($p < 0.001$); 4% higher odds of premature birth ($p < 0.004$); 18% lower odds of any PCU ($p < 0.001$); 12% higher odds of late PCU ($p < 0.002$); and 10% lower odds of a normal APGAR score ($p < 0.001$) compared to living in a state without MWS.

Conclusions: Most policies targeting alcohol use during pregnancy do not have their intended effects and are related to worse birth outcomes and less PCU.

Key Words: Alcohol, Pregnancy, Policy, Birth Outcomes, Vital Statistics.

- Mandatory Warning Signs and Child Abuse/Neglect designation:
  - Increase odds of low birth weight and premature delivery
  - Decrease odds of any prenatal care and APGAR 7+
- CPS Reporting Requirement:
  - No effect of low birth weight, premature delivery, prenatal care or APGAR score

Punitive Policies and Increased NAS

JAMA Network Open

Original Investigation | Pediatrics

Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome

Laura J. Faherty, MD, MPH, MS; Ashley M. Kranz, PhD; Joshua Russell-Fritch, MS; Stephen W. Patrick, MD, MPH, MS; Jonathan Cantor, PhD; Bradley D. Stein, MD, PhD

Abstract

IMPORTANCE Despite the rapidly changing policy environment regarding substance use during pregnancy, information is lacking on the association of state policies with neonatal abstinence syndrome (NAS).

OBJECTIVE To determine if punitive or reporting state policies related to substance use during pregnancy are associated with NAS rates.

DESIGN, SETTING, AND PARTICIPANTS This repeated cross-sectional study used retrospective, difference-in-difference analysis of live births in the State Inpatient Databases from 8 US states in varying years between January 1, 2003, and December 31, 2014. States without punitive or reporting policies were compared with states with policies before and after policy enactment using logistic regression models adjusted for individual and county-level factors and state and year fixed effects. Analyses were conducted from April 10, 2019, to July 30, 2019.

EXPOSURES Time since enactment of state policies related to substance use in pregnancy, county-level rurality and unemployment, and presence of specialized treatment programs for pregnant and postpartum women in a county.

MAIN OUTCOME AND MEASURES Rates of NAS.

RESULTS Among 4 567 963 live births, 23 377 neonates (0.5%) received a diagnosis of NAS. Among neonates with NAS, 3394 (14.5%) lived in counties without any treatment programs specifically for pregnant and postpartum women, 20 323 (86.9%) lived in metropolitan counties, and 8135 (34.8%) lived in counties in the highest unemployment quartile. In adjusted analyses among neonates in states with punitive policies, odds of NAS were significantly greater during the first full calendar year after enactment (adjusted odds ratio, 1.25; 95% CI, 1.06-1.46; $P = .007$) and more than 1 full year after enactment (adjusted odds ratio, 1.33; 95% CI, 1.17-1.51; $P < .001$). After regression adjustment, the annual NAS rate was 46 (95% CI, 43-48) neonates with NAS per 10 000 live births in states without punitive policies; 57 (95% CI, 48-65) neonates with NAS per 10 000 live births in states with punitive policies during the first full year after enactment; and 60 (95% CI, 56-65) neonates with NAS per 10 000 live births in states with punitive policies in effect for more than 1 full year. There was no association between reporting policies and odds of NAS.

CONCLUSIONS AND RELEVANCE In this repeated cross-sectional analysis of 8 states, states with punitive policies were associated with greater odds of NAS immediately and in the longer term, but there was no association between NAS and states with reporting policies.

JAMA Network Open. 2019;2(11):e1914078. doi:10.1001/jamanetworkopen.2019.14078

Key Points

Question Are state punitive or reporting policies related to substance use during pregnancy associated with rates of neonatal abstinence syndrome (NAS)?

Finding In this repeated cross-sectional study of nearly 4.6 million births in 8 states, policies that criminalized substance use during pregnancy, considered it grounds for civil commitment, or considered it child abuse or neglect were associated with significantly greater rates of NAS in the first full year after enactment and more than 1 full year after enactment. Policies requiring reporting of suspected prenatal substance use were not associated with rates of NAS.

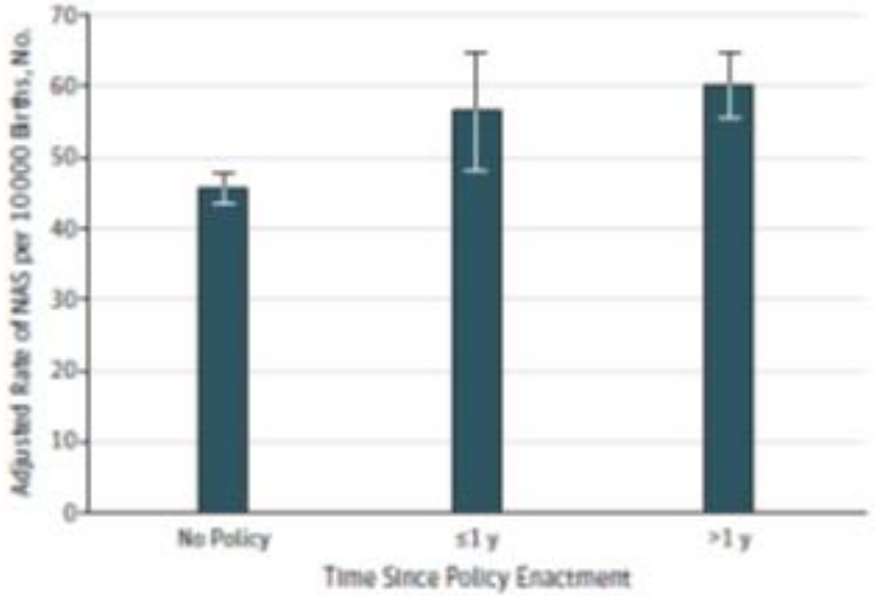
Meaning Policy makers seeking to reduce NAS rates may wish to consider approaches favored by public health experts that focus on primary prevention.

+ Invited Commentary

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Figure. Annual Rates of Neonatal Abstinence Syndrome (NAS) per 10 000 Live Births Stratified by State Punitive Policies



The adjusted rate of NAS per 10 000 live births for neonates was estimated from the regression model conditional on residing in states without punitive policies, during the first full calendar year after punitive policies went into effect, and with punitive policies in effect for more than 1 full calendar year, while keeping all other covariates at their original values. Error bars indicate 95% CI.

Stigma Decreases Treatment Receipt

American Journal of Epidemiology
Vol. 172, No. 12
DOI: 10.1093/aje/kwq304
Advance Access publication: November 2, 2010

Original Contribution

Stigma and Treatment for Alcohol Disorders in the United States

K. M. Keyes*, M. L. Hatzenbuehler, K. A. McLaughlin, B. Link, M. Olfson, B. F. Grant, and D. Hasin

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Initially submitted June 3, 2010; accepted for publication August 12, 2010.

Among a nationally representative sample of adults with an alcohol use disorder, the authors tested whether perceived stigmatization of alcoholism was associated with a lower likelihood of receiving alcohol-related services. Data were drawn from a face-to-face epidemiologic survey of 34,653 adults interviewed in 2004–2005 who were aged 20 years or older and residing in households and group quarters in the United States. Alcohol abuse/dependence was diagnosed by using the Alcohol Use Disorder and Associated Disabilities Interview Schedule–*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, version (AUDADIS-IV). The stigma measure used was the Perceived Devaluation-Discrimination Scale. The main outcome was lifetime intervention including professional services and 12-step groups for alcohol disorders. Individuals with a lifetime diagnosis of an alcohol use disorder were less likely to utilize alcohol services if they perceived higher stigma toward individuals with alcohol disorders (odds ratio = 0.37, 95% confidence interval: 0.18, 0.76). Higher perceived stigma was associated with male gender ($\beta = -0.75$; $P < 0.01$), nonwhite compared with non-Hispanic white race/ethnicity, lower income ($\beta = 1.0$; $P < 0.01$), education ($\beta = 1.48$; $P < 0.01$), and being previously married ($\beta = 0.47$; $P = 0.02$). Individuals reporting close contact with an alcohol-disordered individual (e.g., relative with an alcohol problem) reported lower perceived stigma ($\beta = -1.70$; $P < 0.01$). A link between highly stigmatized views of alcoholism and lack of services suggests that stigma reduction should be integrated into public health efforts to promote alcohol treatment.

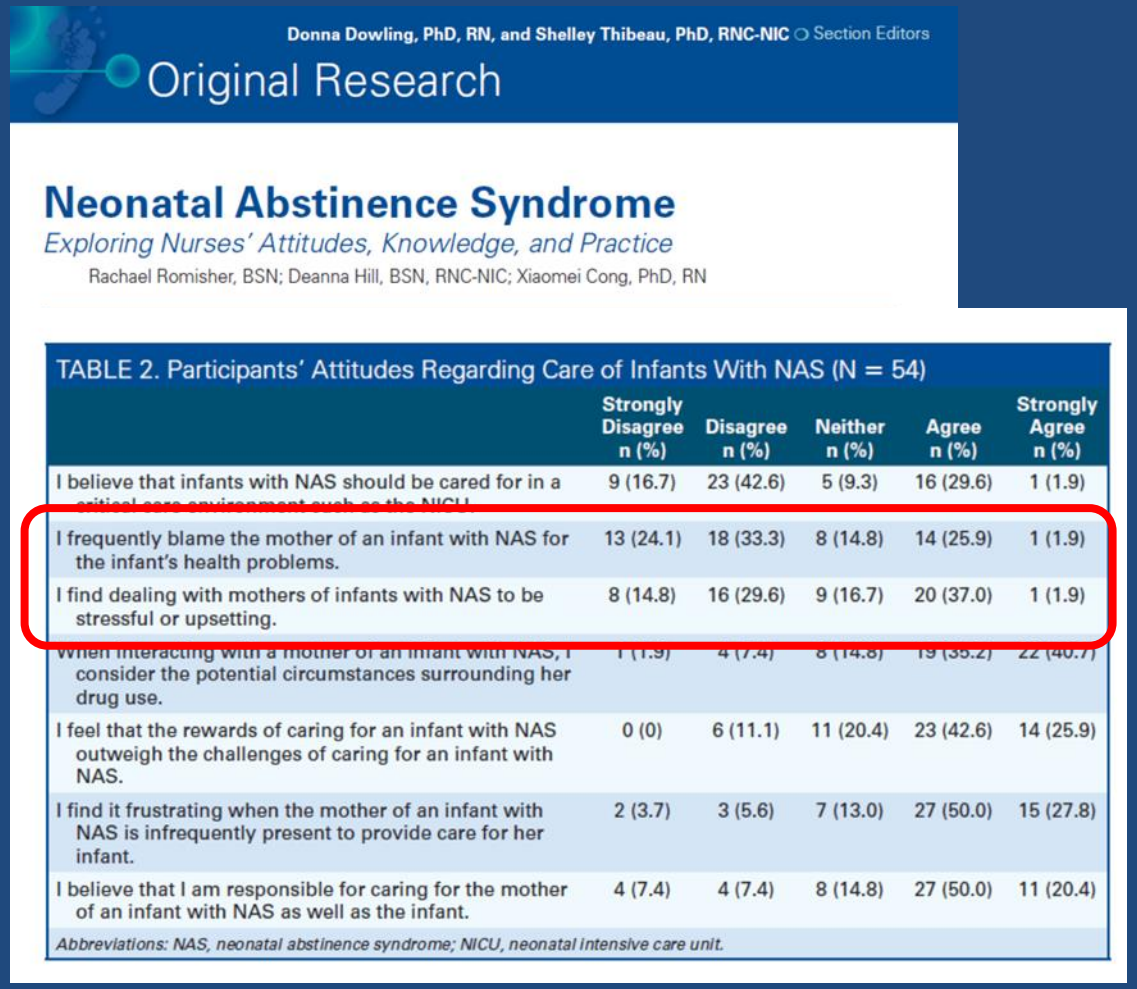
"Dose-dependent" relationship between Stigma and Odds of lifetime AUD services

Table 3. Association Between Alcohol Stigma and Any Lifetime Treatment Utilization Among Individuals With a Lifetime Alcohol Disorder, United States, 2004–2005 ($n = 6,309$)

	Utilized Alcohol Services, Lifetime ($n = 1,401$)				
	% (SE)	Unadjusted OR	95% CI	Adjusted OR[a]	95% CI
High stigma ($n = 1,911$)	21.25 (1.32)	0.88	0.71, 1.08	0.37	0.18, 0.76
Middle high ($n = 1,692$)	17.69 (1.06)	0.70	0.58, 0.84	0.47	0.23, 0.95
Middle low ($n = 1,533$)	17.17 (1.05)	0.67	0.57, 0.81	0.61	0.32, 1.16
Low stigma ($n = 1,173$)	23.51 (1.06)	1.00		1.00	

Abbreviations: CI, confidence interval; OR, odds ratio; SE, standard error.
[a] Adjusted for sex, age, race/ethnicity, income, education, marital status, and number of lifetime alcohol dependence criteria met.

Addiction Stigma Common among Providers



Donna Dowling, PhD, RN, and Shelley Thibeau, PhD, RNC-NIC ○ Section Editors

Original Research

Neonatal Abstinence Syndrome

Exploring Nurses' Attitudes, Knowledge, and Practice

Rachael Romisher, BSN; Deanna Hill, BSN, RNC-NIC; Xiaomei Cong, PhD, RN

TABLE 2. Participants' Attitudes Regarding Care of Infants With NAS (N = 54)

	Strongly Disagree n (%)	Disagree n (%)	Neither n (%)	Agree n (%)	Strongly Agree n (%)
I believe that infants with NAS should be cared for in a critical care environment such as the NICU.	9 (16.7)	23 (42.6)	5 (9.3)	16 (29.6)	1 (1.9)
I frequently blame the mother of an infant with NAS for the infant's health problems.	13 (24.1)	18 (33.3)	8 (14.8)	14 (25.9)	1 (1.9)
I find dealing with mothers of infants with NAS to be stressful or upsetting.	8 (14.8)	16 (29.6)	9 (16.7)	20 (37.0)	1 (1.9)
When interacting with a mother of an infant with NAS, I consider the potential circumstances surrounding her drug use.	1 (1.9)	4 (7.4)	8 (14.8)	19 (35.2)	22 (40.7)
I feel that the rewards of caring for an infant with NAS outweigh the challenges of caring for an infant with NAS.	0 (0)	6 (11.1)	11 (20.4)	23 (42.6)	14 (25.9)
I find it frustrating when the mother of an infant with NAS is infrequently present to provide care for her infant.	2 (3.7)	3 (5.6)	7 (13.0)	27 (50.0)	15 (27.8)
I believe that I am responsible for caring for the mother of an infant with NAS as well as the infant.	4 (7.4)	4 (7.4)	8 (14.8)	27 (50.0)	11 (20.4)

Abbreviations: NAS, neonatal abstinence syndrome; NICU, neonatal intensive care unit.

SUBSTANCE ABUSE
2017, VOL. 38, NO. 4, 414–421
https://doi.org/10.1080/08897077.2017.1356423

Taylor & Francis
Taylor & Francis Group

ORIGINAL RESEARCH

Trainees' knowledge, attitudes, and practices towards caring for the substance-exposed mother-infant dyad

Davida M. Schiff, MD[a,b], Barry Zuckerman, MD[a,b], Elisha M. Wachman, MD[a,b,c], and Megan Bair-Merritt, MD, MSCE[a,b]

[a]Department of Pediatrics, Boston Medical Center, Boston, Massachusetts, USA; [b]Boston University School of Medicine, Boston, Massachusetts, USA; [c]Division of Neonatology, Boston Medical Center, Boston, Massachusetts, USA

Question	Overall	Medical Students	Interns	Residents
I feel angry towards women who use drugs while they are pregnant	48%	55%	54%	37%
Mothers who use drugs during pregnancy should not be allowed to retain custody of their kids	38%	44%	34%	34%
Mothers who use drugs over utilize health care resources	46%	57%	49%	33%

Freedom from Discrimination is a Human Right

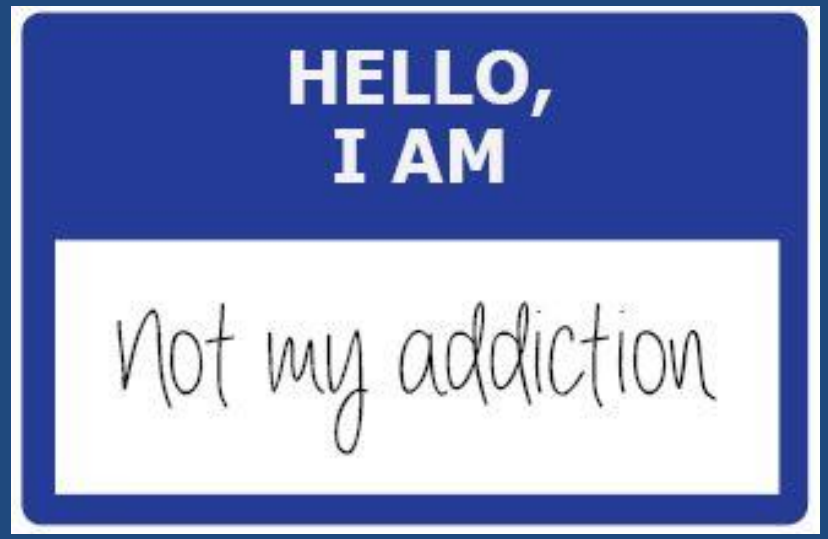
Discrimination is Rooted in Ignorance

- Ignorance of Addiction as a Disease
- Ignorance of Addiction Treatment
- Ignorance of Recovery
- Ignorance regarding Risks to Newborn of Substance Exposure

Discrimination is Rooted in Intention

- Intentional Punishment of People Deemed Unworthy

Do Less Harm:
1. Language is Important



- Counter de-humanizing discourse with humanizing language
- Language: Evidence-based and Person-centered
- The words we use influence how others conceptualize addiction and public health

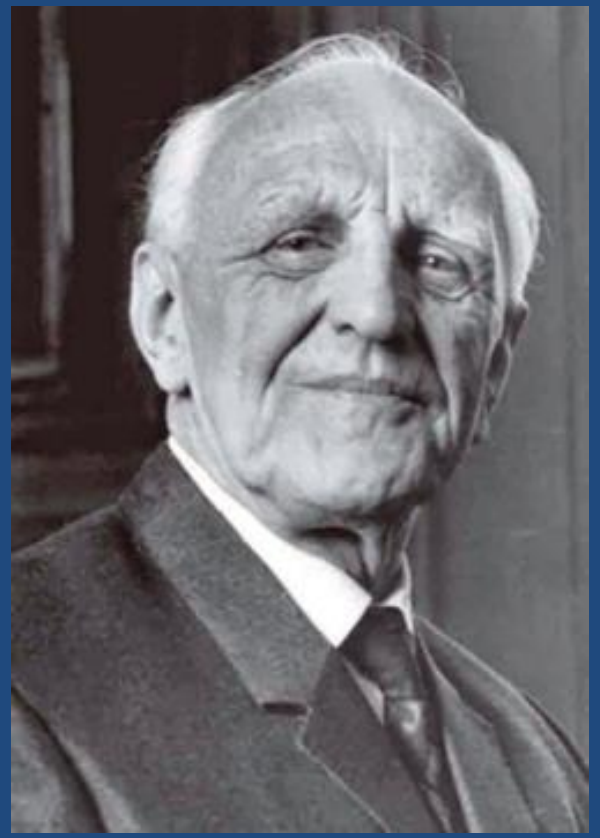
The Power of Words to Hurt or Heal

Stigmatizing Words	Preferred Words
Addict, Abuser, Junkie	Person in active addiction, Person with a substance use disorder, Person experiencing an alcohol/drug problem, Patient
User	Person who misuses alcohol/drugs Person engaged in risky use of substances
Abuse	Misuse, Harmful use, Inappropriate use, Hazardous use, Problem use, Risky use
Clean, Dirty	Negative, positive, Substance-free
Habit or Drug Habit	Substance misuse, Substance use disorder, Alcohol and drug disease, Active addiction, Untreated addiction
Replacement or Substitution Therapy	Treatment, Medication for Opioid Use Disorder, Medication

The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L. White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04

Do Less Harm:
2. Center on the Dyad

"There is no such thing as a baby … If you set out to describe a baby, you will find you are describing a baby and someone. A baby can not exist alone, but is essentially part of a relationship"
(D.W. Winnicott 1966)



If it is not a Dyad, It is a Disaster

TOPICAL

Expecting mothers who drink, use drugs may be jailed under Big Horn County attorney's plan

Judge Orders Drug-Addicted Mother of 4 to Not Get Pregnant Again

by The Associated Press | 6:02 pm, February 14th, 2017

True Crime

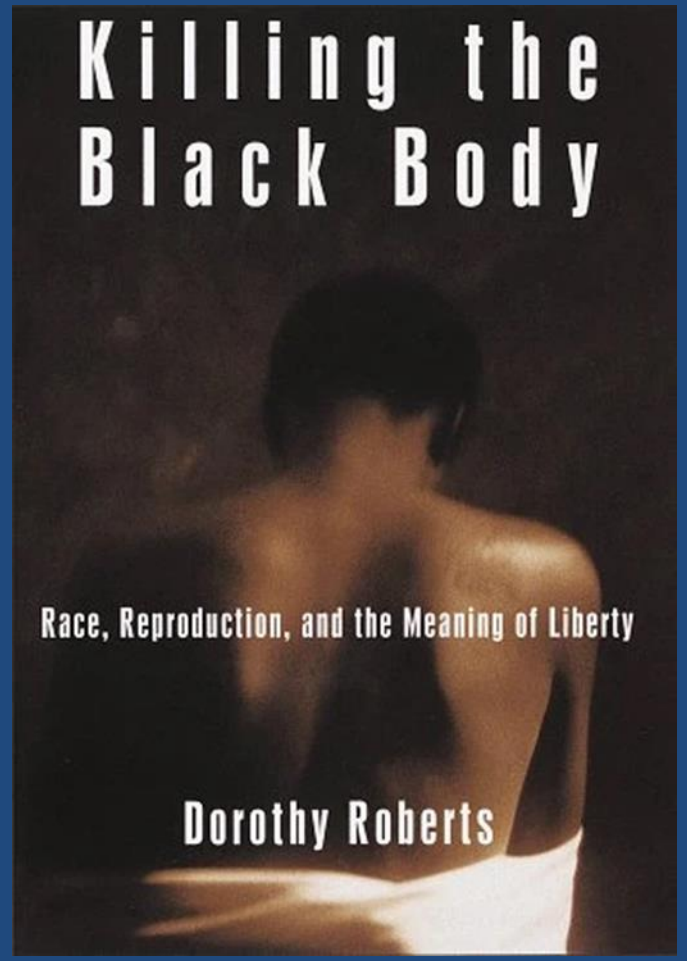
Judge suggests drug-addicted woman get sterilized before sentencing, and she does

By Tom Jackman February 8 Email the author

UPDATE, 6:05 p.m. Thursday: The judge issued findings at the sentencing hearing, noted below, and sentenced Creel to 12 months in prison.

Summer Creel, captured

In her 34 years, Summer Thyme Creel has passed a lot of bad checks, taken a lot of drugs and borne a lot of children (seven). After her sentencing today in federal court in Oklahoma, her involvement with checks and drugs will stop at least temporarily, but she will never have another baby. That's because the judge in her case suggested, in writing, that Creel consider getting herself sterilized before the sentencing, and Creel proceeded to do just that.



Do Less Harm:
3. Focus on Medicine/Public Health as Practice

Evidence-Based

AND

Person-Centered

Do Less Harm

- Evidence-Based: Grounded in Science
  - Harms of illicit substances exaggerated; Effects of licit substances minimized
  - Overstate the importance of intrauterine exposure; Neglect the role of the care-giving environment
- Person-Centered: Ethical and Grounded in Human Rights
  - Reproductive Health as a Human Right - Right to determine whether and when to become pregnant, and
  - Support autonomy and maternal subjectivity in decision making surrounding pregnancy
  - Remain attuned to the unique demands we place on pregnant and parenting people, their bodies and their minds

Thank You

- Mishka Terplan
- @do_less_harm
- Mishka.Terplan@ucsf.edu

Carrie Griffin DO

United Indian Health Services/K'imaw/Open Door Community Health Centers

February 11, 2021

Humboldt County Perinatal SUD Treatment

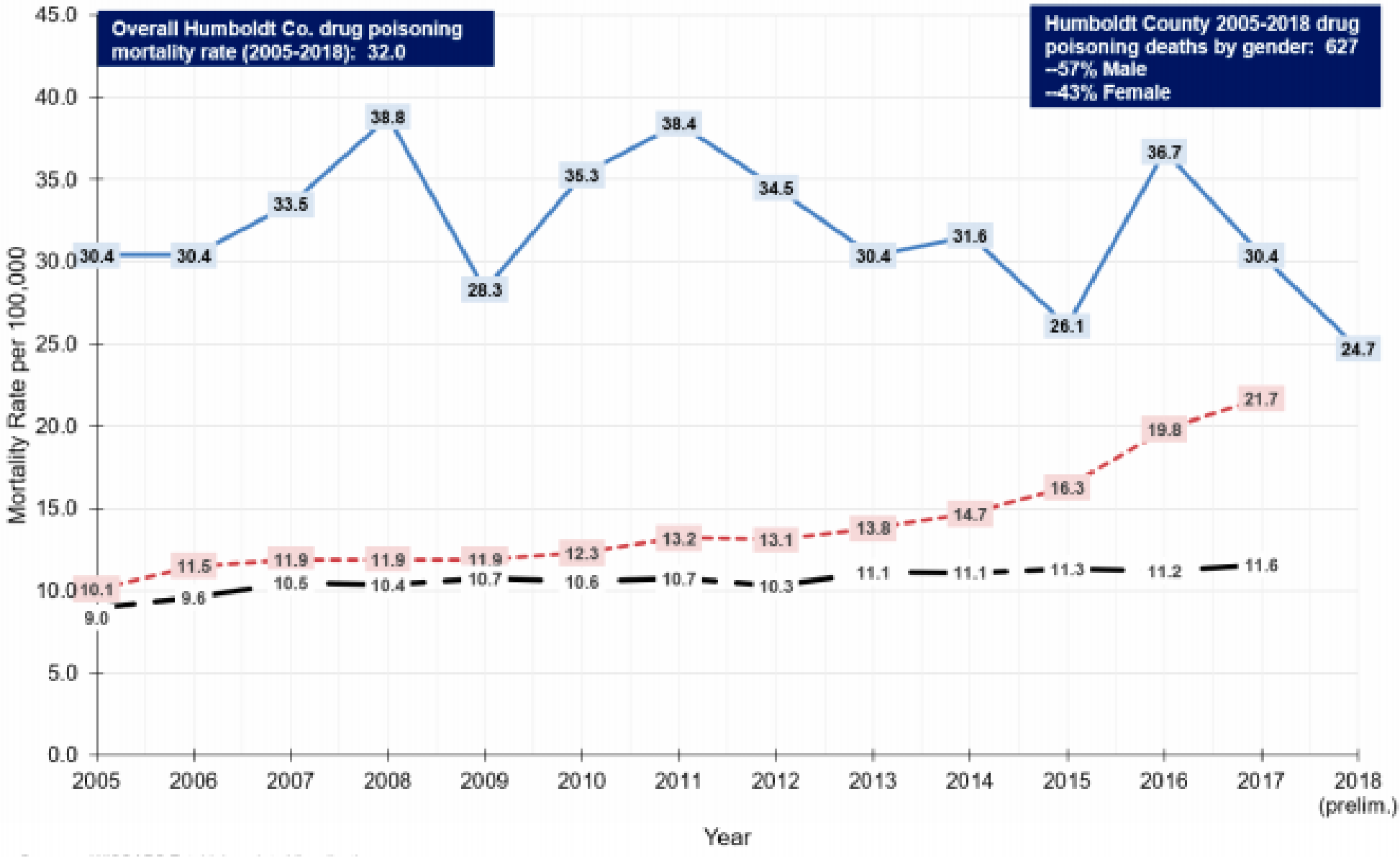
objectives

- Local epidemiology of native populations & SUD
- ASAM Continuum screening & levels of care
- Humboldt's perinatal substance use disorder services
- Combating stigma as a barrier to care

“Addiction is pretty simple.

It’s what happens when people don’t get what they need and end up soothing themselves.”

Gabor Mate MD


Overall Humboldt Co. drug poisoning mortality rate (2005-2018): 32.0
Humboldt County 2005-2018 drug poisoning deaths by gender: 627
–57% Male
–43% Female
Mortality Rate per 100,000
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
30.4
30.4
33.5
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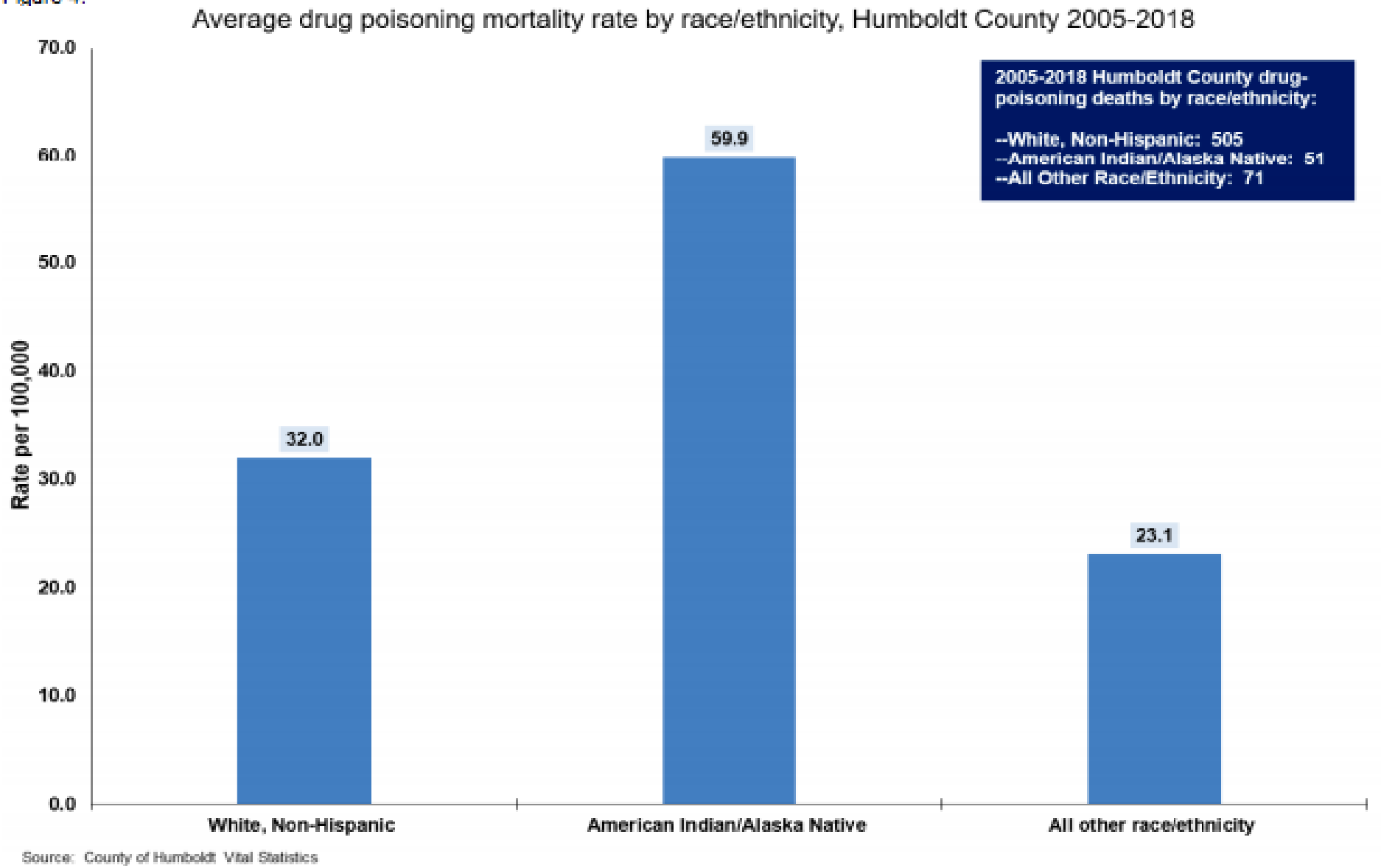
2018 (prelim.)
Year

Figure 4:



Source: County of Humboldt Vital Statistics

epidemiology

- Pregnant persons in Humboldt are 3.7 times more like to be diagnosed with a SUD than the rest of CA (CA Child Welfare Project 2018)
- Children in Humboldt are 2 times more likely to be placed in foster care

epidemiology

- In 2015, 35.7 % of all children placed in foster care were Native American despite comprising only 7% of the county population

- 30.5 % of all child abuse & neglect cases in 2015 were Native children

California Child Welfare Project 2015

Indian Child Welfare Act

“ to protect the best interest of Indian Children & to promote the stability & security of Indian tribes & families by the establishment of minimum Federal standards for the removal of Indian children & placement of such children in homes which will reflect the unique values of Indian culture”

California a Public Law 280 state – state has concurrent jurisdiction for native children both on/off reservations – framework for how Family Wellness Court came to be

From the 2017 California County Health Profiles	Humboldt County	Significant Difference from CA? (Y/N)	California	Healthy People 2020 Objective
Infant Mortality (2012-14) (per 1,000)	6.6*	N	4.6	6
% Low Birth Weight Births (2013-15)	5.60%	N	6.80%	7.80%
% pregnancies beginning prenatal care during first trimester (2013-15)	76.50%	Y	83.30%	77.90%
Births to Mothers age 15-19 (per 1,000) (2013-15)	20.2	N	21	42.5
Births to Repeat Teen Mothers (2012-15)	10% (2015)		17% (2013)	
Initiation of Breastfeeding (2013-15)	93.00%	N	93.50%	81.90%
Mood disorder hospitalizations per 100,000 female population age 15-44 (2011-2013)	1413.9	Y	1074.8	N/A
Substance use diagnosis per 1,000 hospitalizations of pregnant females age 15-44 (2011-2013)	63.7	Y	17.3	N/A

Screening tool that looks at six dimensions to offer a holistic assessment of a patient's biopsychosocial circumstances

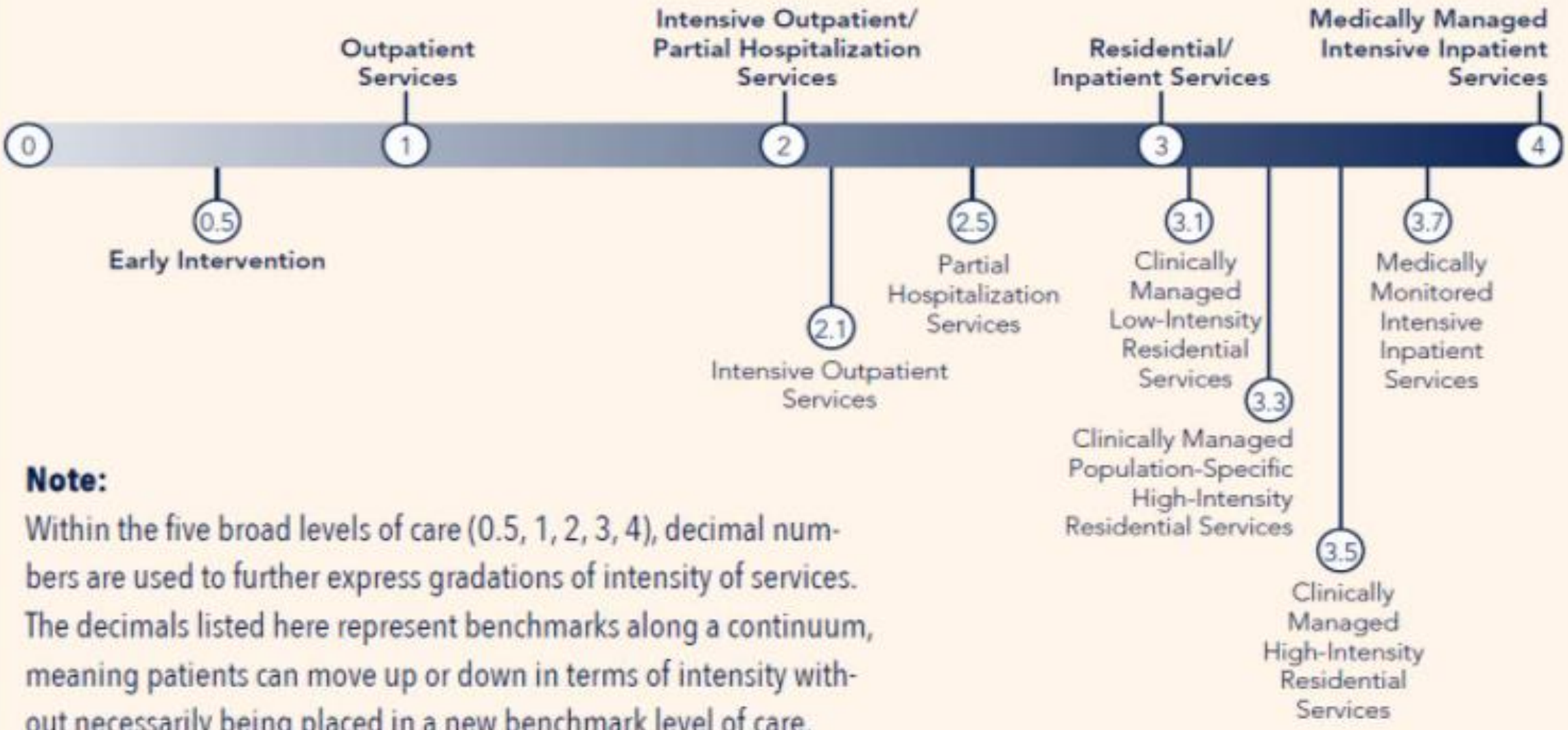
Determines well matched placement options for an individual with a substance use disorder

ASAM Continuum & Levels of Care

ASAM SIX DIMENSIONS

1. Acute Intoxication & Withdrawal
2. Biomedical Conditions & Complications
3. Emotional, Behavioral or Cognitive Complications
4. Readiness to Change
5. Relapse, Continued Use or Continued Problem Potential
6. Recovery/Living Environment

REFLECTING A CONTINUUM OF CARE



Note:

Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

Humboldt County Level 1: Outpatient Services

Prenatal care with MAT/Buprenorphine Providers

- United Indian Health Services
- K'imaw
- Open Door Pregnancy Services

MAT (Medication Assisted Treatment)

- Aegis Treatment Center (methadone)
- All clinics listed above + Humboldt IPA Priority Care Center

Humboldt County: 2.1 Intensive Outpatient Programs (IOP)

- DHHS Healthy Moms & Dads' Programs
- UIHS Substance Use IOP
- County Mental Health IOP

Humboldt County Level 3: Residential Treatment Centers

Level 3.1

- Humboldt Recovery Center
- Crossroads

Level 3.7

- Waterfront Recovery Services (medical detox)

Humboldt County Level 4: Inpatient Services

ST JOSEPH'S HOSPITAL

MAD RIVER COMMUNITY HOSPITAL

REDWOOD MEMORIAL HOSPITAL

Care Coordination Services

- UIHS CHW (Road to Resilience)
- K'imaw CHW
- NFP & PHN
- SJH Care Navigation
- Humboldt RISE online directory of SUD services

Why not seek out care?

For pre-contemplative patients harm reduction services available

HACHR

County SEP

in her own words

"My prenatal care was great. I didn't know I was pregnant until later on in pregnancy but the clinic was nice and didn't judge me. When I got to the hospital it was really bad. The nurses, everybody, the only person that was nice was the anesthesiologist.

I went into the bathroom because I had been constipated for a week. Before they even knew that I used drugs, my mom could hear them outside the door talking about how I was using drugs in the bathroom. All of it was depressing.

I try not to think about it too much because it's too much to think about and it makes me depressed."

Embodied Ways to Combat Stigma

Self Inquiry: What beliefs, feelings, judgements do you hold about substance use in general? About substance use in pregnancy?

- Journaling
- Spiritual Practice (prayer, tonglen, mindfulness, metta)
- Community of Support (compassion fatigue support groups)
- Counseling (consider trauma therapy for secondary trauma)

Embodied Ways to Combat Stigma

Word Choice: What language & vocabulary do you use to describe people with substance use disorders?

• Clean	In Recovery
• Addict, Junkie	Patient with a SUD
• Drug Baby	Substance Exposed NB

Embodied Ways to Combat Stigma

Education: what do you know about the science of substance use, of trauma? What about how substance use affects native communities?

How can you share what you learn with others

Embodied Ways to Combat Stigma

Resiliency: how can you focus on the positive, stabilizing, health-affirming choices a person makes?

- Learn about protective factors
- Identify what is working well for a person both present & past
- Slow down and celebrate small successes

Embodied Practices for Cultural, Historical & Intergenerational Trauma

Acknowledge	Encourage	Use
Acknowledge the history & complexity of trauma & practice curiosity about how this affects an individual's life	Encourage reconnection with culture & community	Use cultural practices as primary treatments

in her own words – take two

" We had talked about it [NAS] early in my prenatal care and were reassured that babies were adaptable. I wasn't nervous going to the hospital.

The nurses were helpful, they checked on us. They also seemed to have experience from past people being more dramatic and things.

My experience was great. I got all the information I needed, all my questions answered."

Yurok Health and Human Services

Alita Redner, MSW

Indian Child Welfare Manager

Yurok Health and Human Services

February 11, 2021

‘E ko nor (Keep Safe)

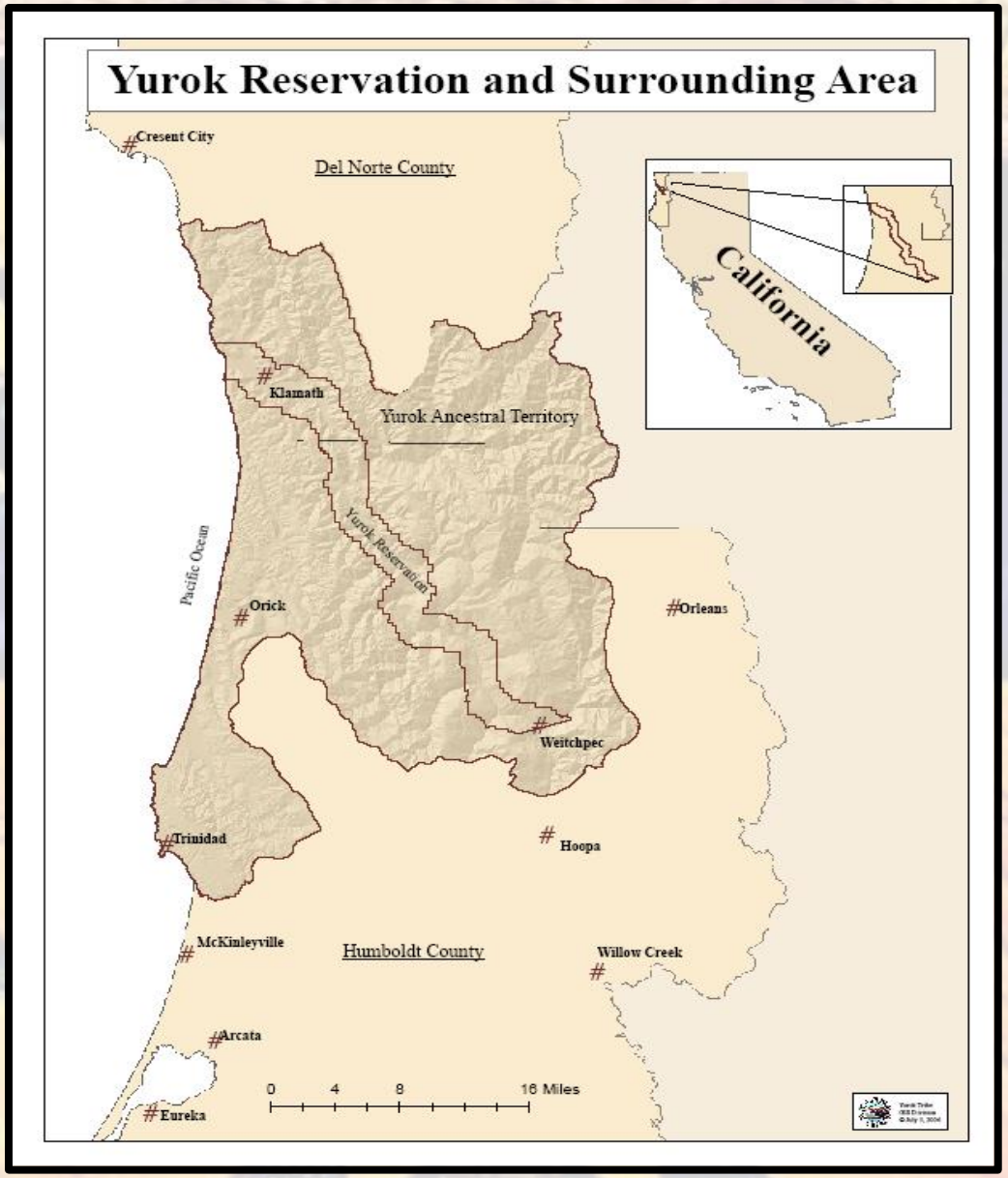
- **Address substance use disorders among pregnant women**
- **Understand the number of infants born with prenatal substance exposure continues to rise.**
- **Education on the Child Abuse Prevention and Treatment Act (CAPTA) requires that states develop Plans of Safe Care**
- **Implementation of policies and procedures to address the needs of this population.**
- **Review best practices and evidence based practices**

Capturing the experience of engaging across jurisdictions in a multi-disciplinary process to implement Empowerment Plans (Plans of Safe Care) and the role of their Joint Jurisdiction Family Wellness Courts.

Yurok Tribe

Largest Tribe in California & 95% grant funded

- Federally recognized in 1993- fairly young as a government, well developed Tribal court
- Signed State Title IV-E Agreement in 2010
- Title IV-B
- 32%-35% in state system



Historical Context

- **Assimilation**
- **Slavery**
- **Boarding School**
- **Relocation Act**

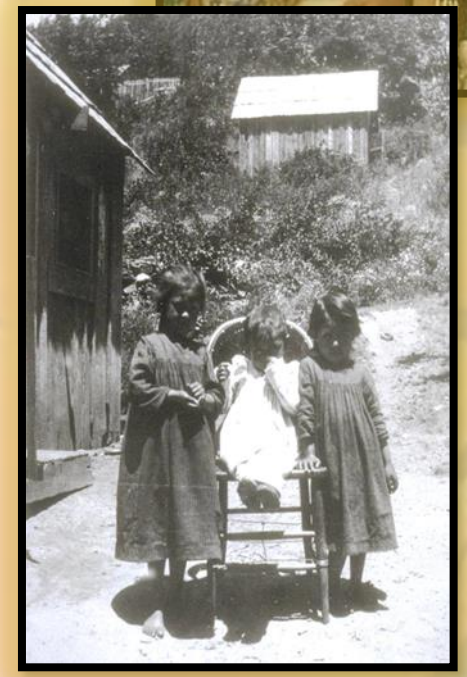
Indian Adoption Project

Social workers assessed the Native American family without cultural knowledge and imposed their own cultural values and system values and behavioral standards.

This practice and values behind it are contrastingly different of Tribes.

How is this practice different today?

Opportunities to rethink our interventions and supports through looking at our outcomes



Stigma Reduction

At ‘E ko nor (Keep Safe) , awareness that families heal within communities. What we believe is that everyone has the power to do what is right – for yourself, your baby, your family, and your community.

Assessment:

Immediate Needs

Health Care

Medical Assisted Treatment (MAT)

Recovery

Public Health

Financial Stability

TANF/Tribal TANF

Employment

General Assistance

Assessments:

To access service tailored to your needs and that of your family's, we ask your permission to conduct applicable assessments with you

ACES
ASAM level for client (.5 – 4)
Ask Revise Refer
Cultural Connections
Four 4 Ps Plus
Mental Health: Edinburgh PHQ9
NCFAS
SDOH
TANF (At-Risk)
Eat, Sleep, Console

‘E ko nor (Keep Safe)

- **Empowerment Plan**

My Family, Friends, Tribe, and Community Resources are here to support me attain Pyuech we-son-o-wok (a state of being when everything is just as it should be—balanced/wellness)

Prenatal Period

Prenatal Plan

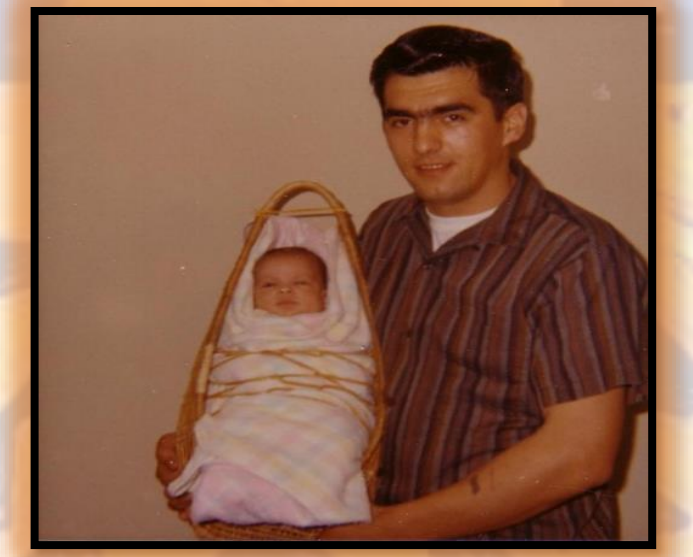
Assessing Engagement

Access to Education/Resources

Mandated Reporting/Role of Child Welfare

‘E ko nor (Keep Safe)

- Importance of Connection rather than bonding
- First 10 days
- Ceremony
- Accountability, responsibility, balance and shame
- Children are not owned by parents
- Children are everyone’s responsibility
- Help and roles
- Ceremony to heal and out of balance
- Payment and true justice system
- Asking for support and help is ok
- Based on village and Yurok values
- Harm reduction and engagement
- Minimizing harm to fetus, infant, and child
- Utilize EBP along with cultural assessment



Yurok Program Design

- Use of braided funding- TANF, BIA self governance, grants
- TANF staff
- Benefits
- Services and supports tailored to the needs of your children
- Healing mind, body, and spirit through culturally sensitive approaches and activities
- Family advocate who will be a member of your Tribe (”auntie/ uncle”) who will help advocate for you and access services
- Family wellness team who will walk with you through your recovery
- Help navigating all the care providers working with your family

- *You are a valued person!*
- *Your children need you!*
- *Your family needs you!*
- *Your community needs you!*
- *You can feel better!*

- Partners, families, and community building trust and engaging mothers- connection in community, validate journey and experience, power to history, etc.
- Role of elders, peer support, and cultural mentors
- Partnership with road of resiliency – First 5 and other partners
- Next steps- accessing data, phase II, cultural assessment and planning for program services.
- Utilizing format for all ages of youth universal screening.

‘E ko nor (Keep Safe) Program Flow Chart

Identification sources

tribal

EARLY IDENTIFICATION OF PARTICIPANT

- Pregnant parent with SUD
- Pregnant parent with Substantial risk of SUD during pregnancy
- Parent with SUD and child under the age of 5

‘E ko nor OFFERED TO PARTICIPANT

- Tribal clinic, social services, TANF, or other Tribal provider (Tribe) describes ‘E ko nor and provides brochure
- Tribe offers ‘E ko nor
- Tribe completes Intake Form with participant (as much as possible)
- Tribe completes its own assessments
- Tribe obtains signed Release of Information

REFERRAL TO TRIBAL SOCIAL WORKER OR ADVOCATE

- Tribe makes warm hand-off to Yurok or Hupa Family Advocate/Navigator and provides any assessments to them (TANF or court)
- Family Advocate completes *Intake Form* with participant

PLAN OF SAFE CARE INITIATED

- Family Advocate with participant
- Develops plan of safe care
- Explains Release of Information
- Obtains releases so that the family wellness team members can share information to support the participant and family
- Family Advocate meets with participant at least weekly (and is available 24/7 on-call)

BUILDING *SAFETY

- Family Advocate with participant
  - Identifies family, friends, and community service providers
  - Convenes healthy circle bi-monthly meetings
  - Updates *Plan of Safe Care* at family wellness team and bi-monthly team meetings
  - Advises expecting mother to share her *Plan of Safe Care* with hospital

Prenatal Period

Questions for our panelists?

Contact Information

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