History and epidemiology of drug use in pregnancy
&
Stigma of SUD in pregnancy

Mishka Terplan MD MPH FACOG DFASAM
Associate Medical Director, Friends Research Institute
National Clinician Consultation Center, Substance Use Warmline, UCSF
Deputy Chief Clinical Officer, Department Behavioral Health, DC

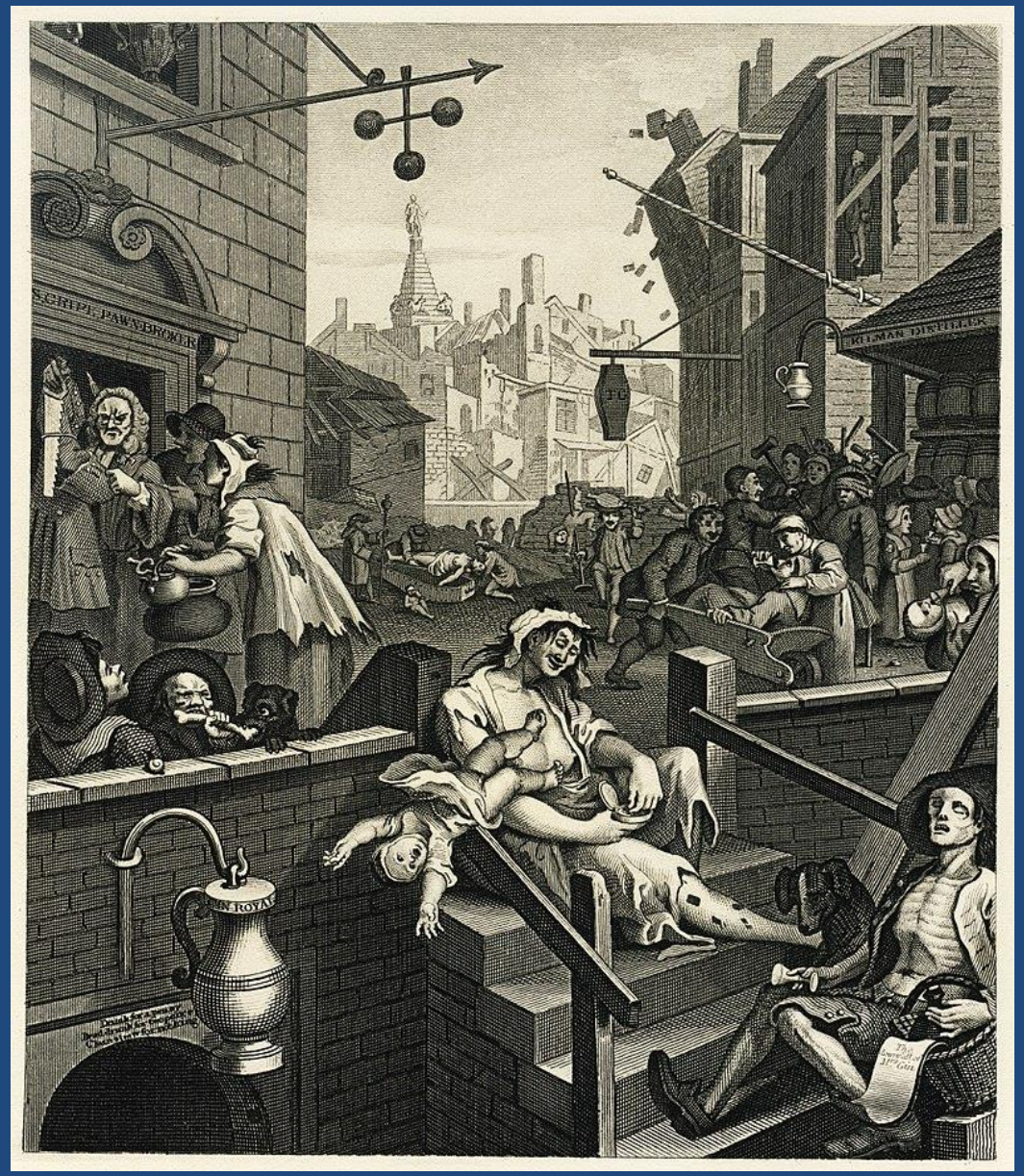
@DoLessHarm

Disclosures

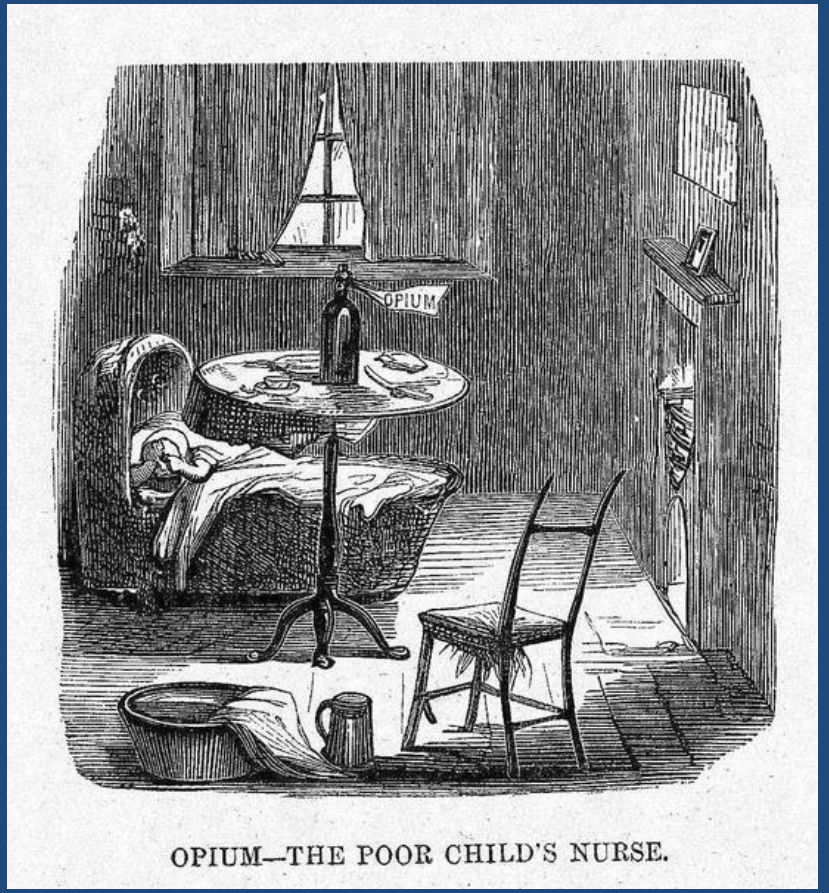
- None

Psychoactive Substance Use is Ancient

Addiction is Modern Phenomena



William Hogarth's ***Gin Lane*** 1751



OPIUM—THE POOR CHILD'S NURSE.

The First Opioid Crisis

MORPHINISM

AND

NARCOMANIAS FROM OTHER DRUGS

THEIR

ETIOLOGY, TREATMENT, AND MEDICOLEGAL RELATIONS

BY

T. D. CROTHERS, M.D.

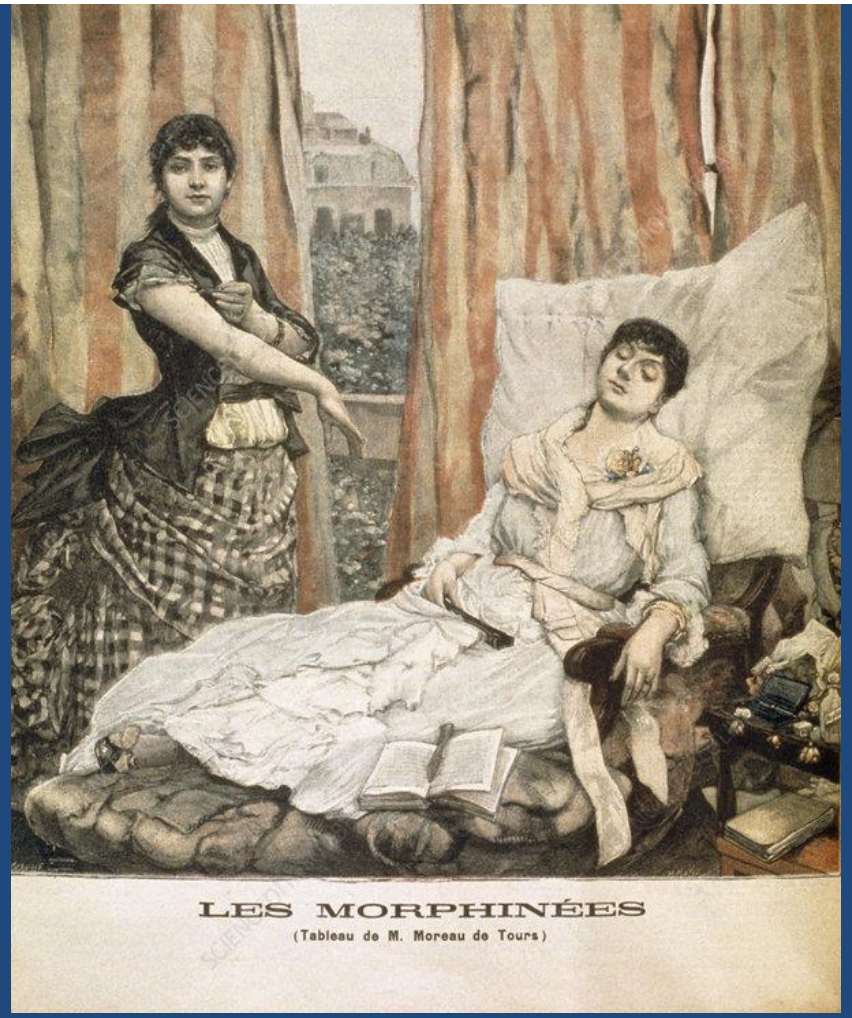
Superintendent of Walnut Lodge Hospital, Hartford, Conn.; Editor of the Journal of Inebriety; Professor of Mental and Nervous Diseases, New York School of Clinical Medicine, etc.

PHILADELPHIA AND LONDON

W. B. SAUNDERS & COMPANY

1902

Capriciousness of mind, irritability, selfishness, restlessness, and excitability are the natural characteristics of many women, who quickly become morphinists, especially if under treatment for disorders of the generative organs. Such persons

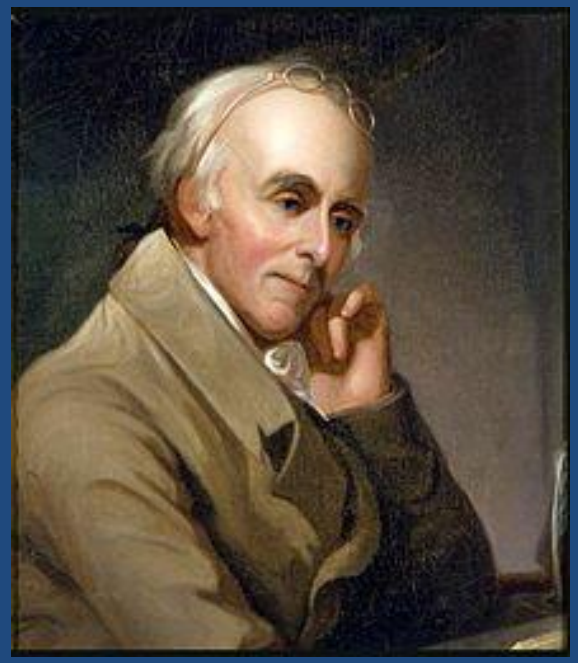


LES MORPHINÉES

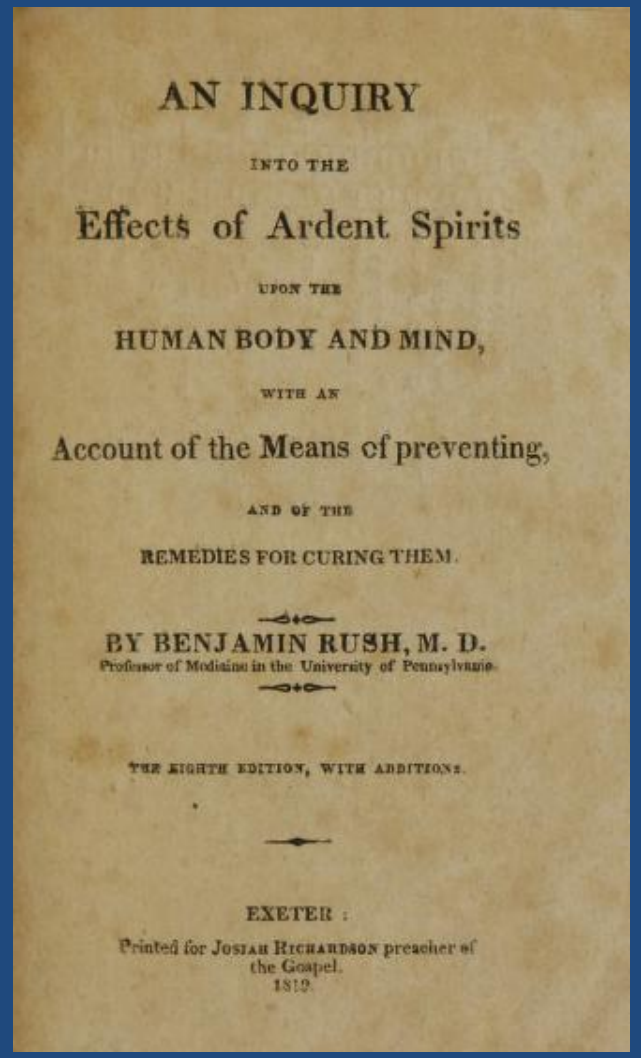
(Tableau de M. Moreau de Tours)

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

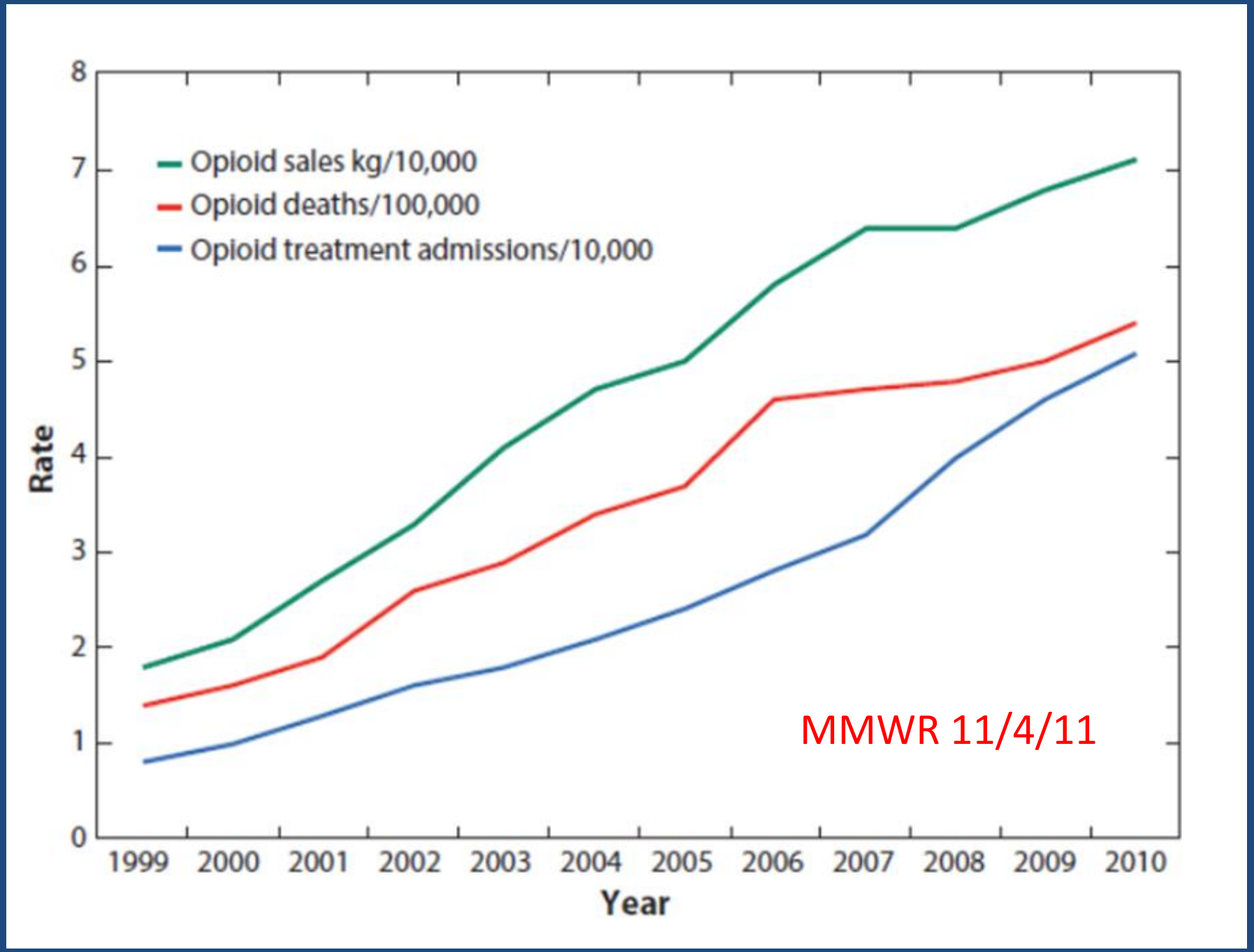
UNITED STATES

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



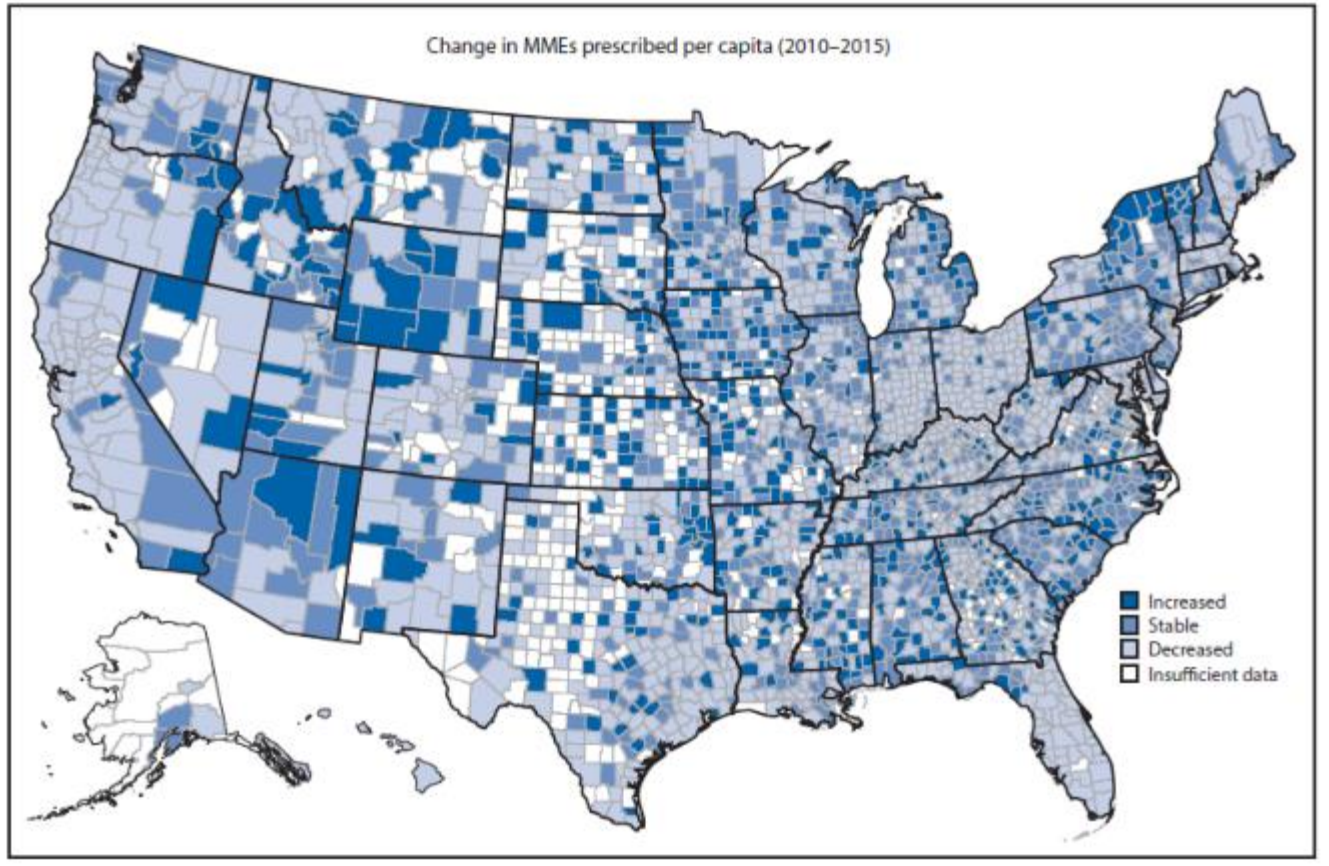
Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015

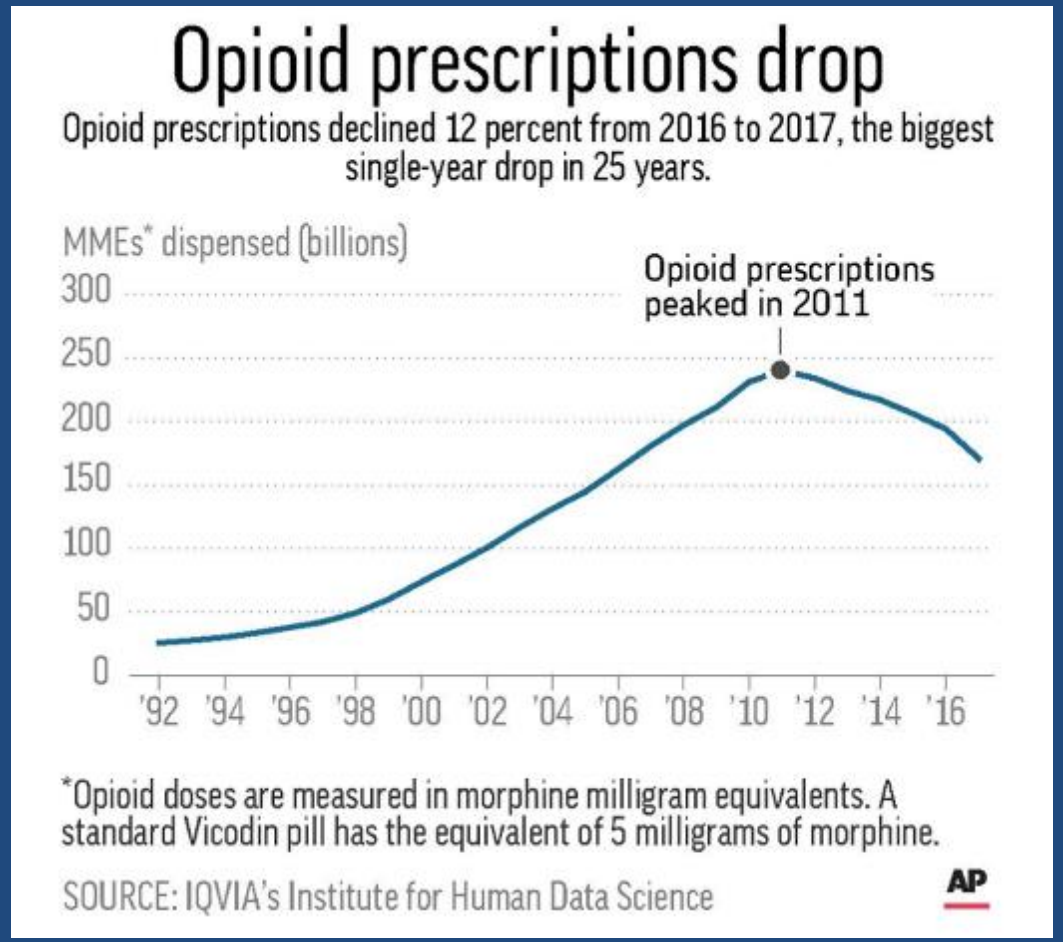
Gery P. Guy Jr., PhD[1]; Kun Zhang, PhD[1]; Michele K. Bohm, MPH[1]; Jan Losby, PhD[1]; Brian Lewis[2]; Randall Young, MA[2]; Louise B. Murphy, PhD[3]; Deborah Dowell, MD[1]

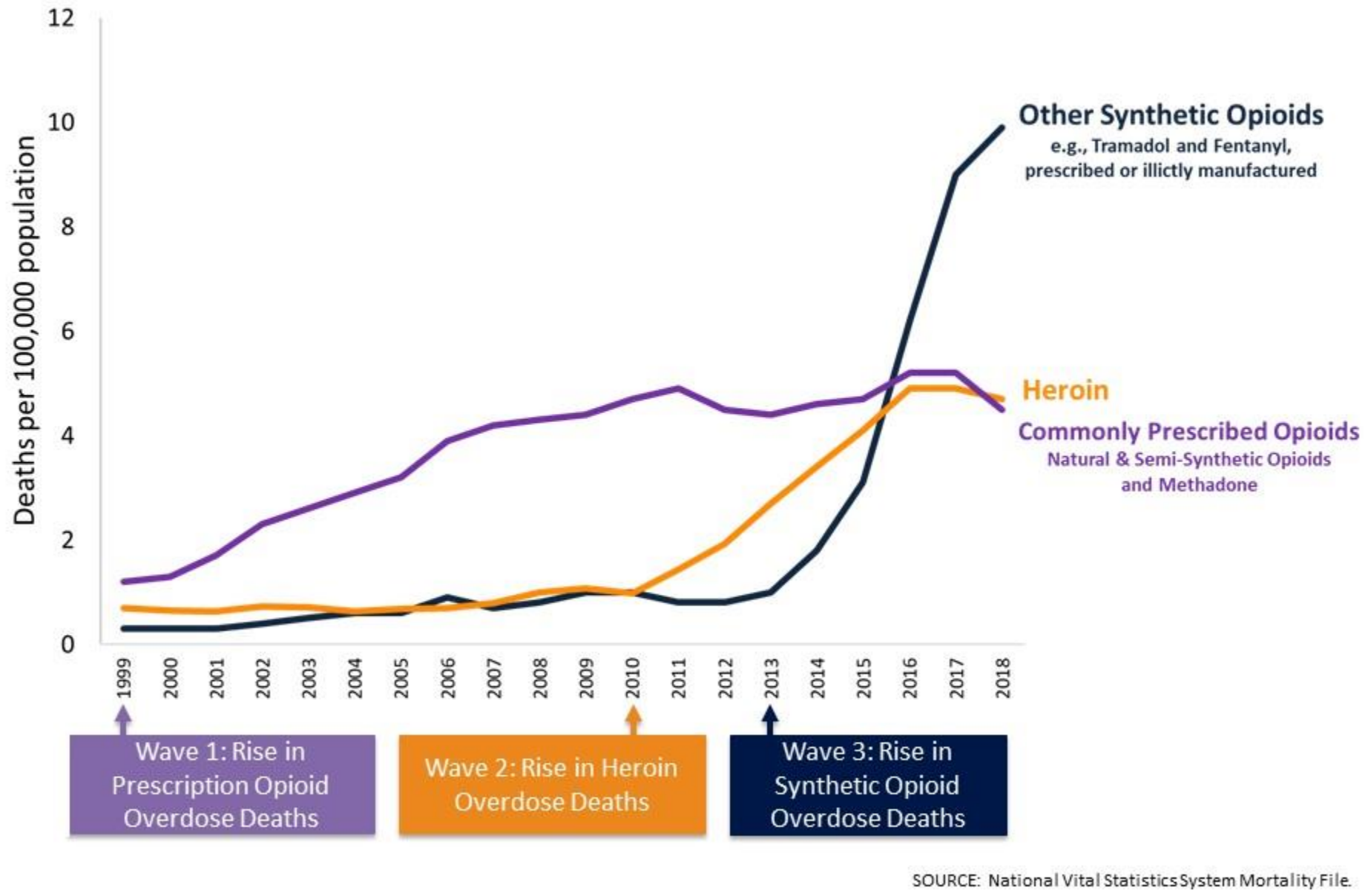
MMWR / July 7, 2017 / Vol. 66 / No. 26

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]

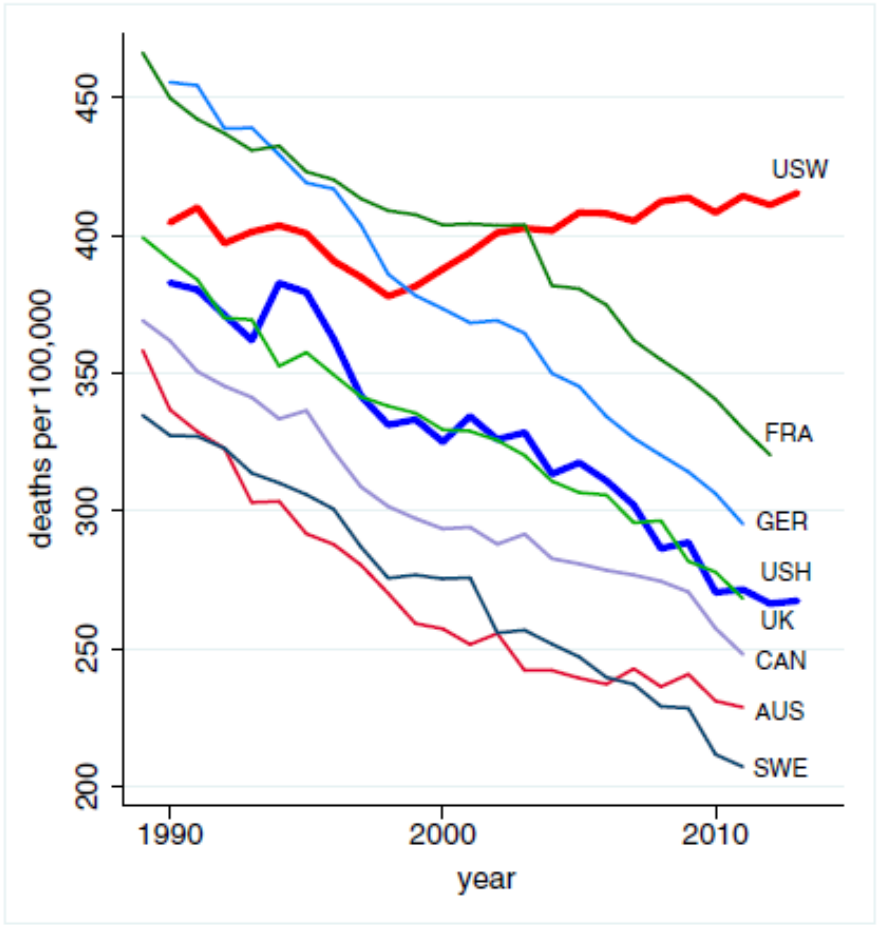


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

The New York Times

In Heroin Crisis, White Families Seek Gentler War on Drugs

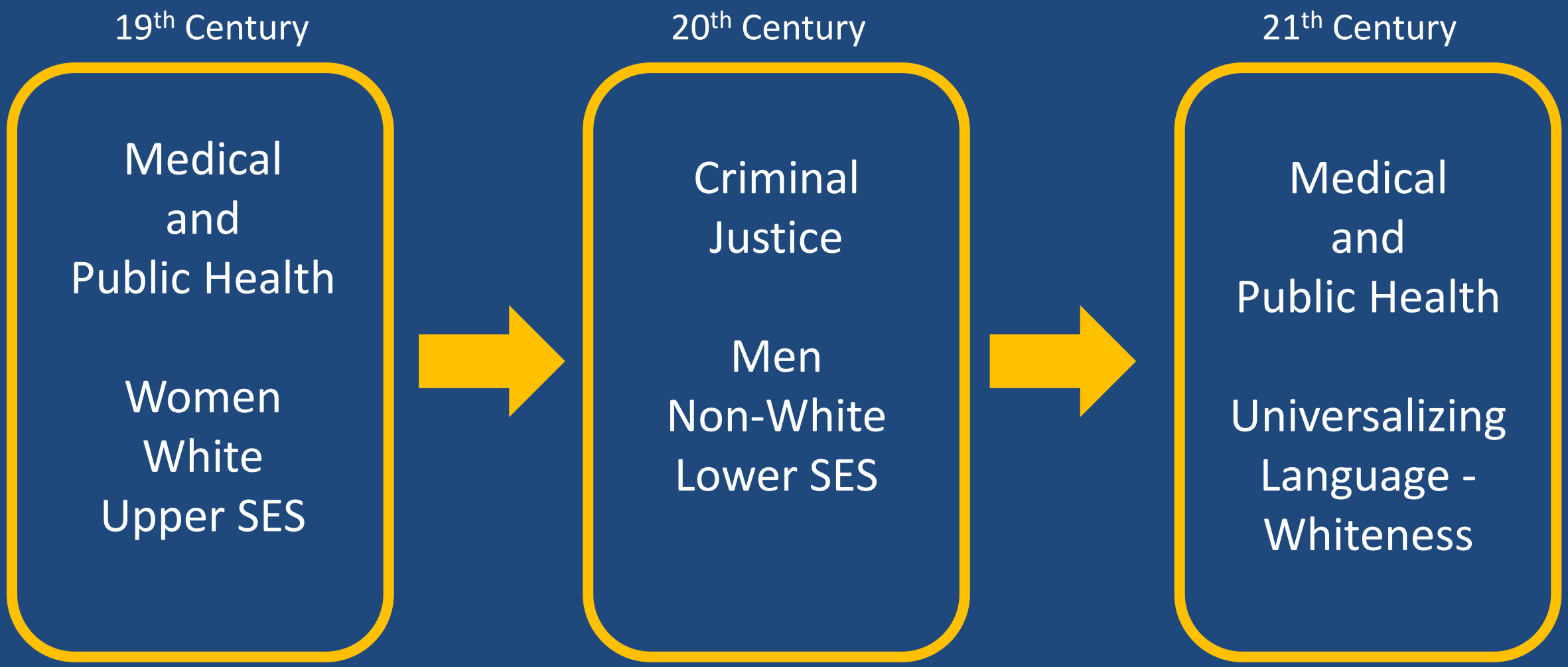
Amanda Jordan with her son Brett Honor outside a meeting for people with addictions and their families in Plaistow, N.H. Her son Christopher died of an overdose. Katherine Taylor for The New York Times

By Katharine Q. Seelye

Oct. 30, 2015

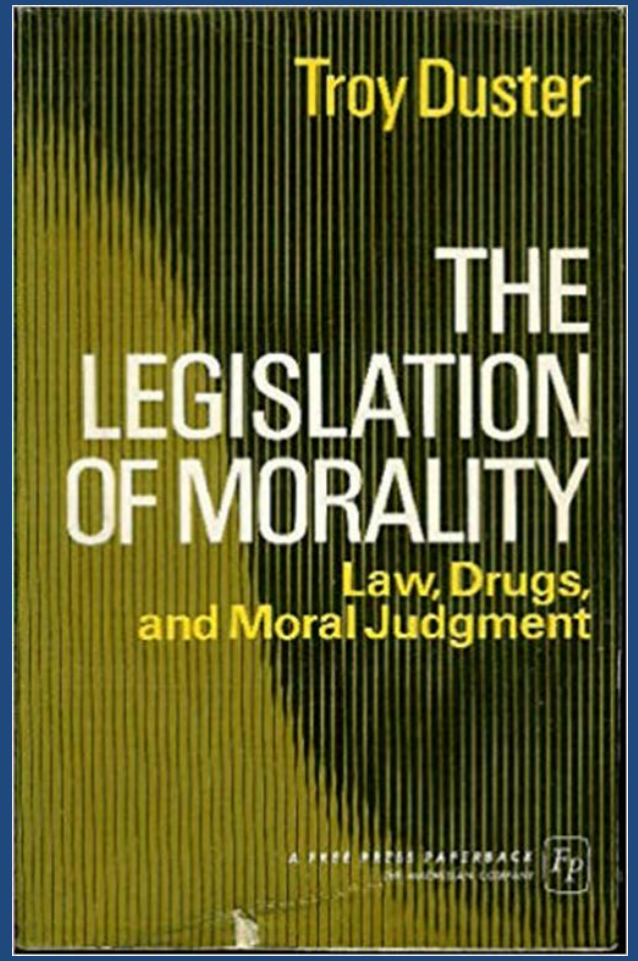
833

Substance Use and Addiction



Race, The War on Drugs and Public Health Response

- There is a relationship between who we associate with drug use and how we view addiction
- Addiction was a medical condition – before it wasn't
  - We are (re)discovering medicine and public health in substance use and addiction
  - Although compassion and empathy predate judgment and discrimination, both are grounded in racism



Forgotten in the Intersections: Gender, Race, Addiction, and Reproduction

Gender, Reproduction, and Addiction in the Context of Racialized Drug Policy

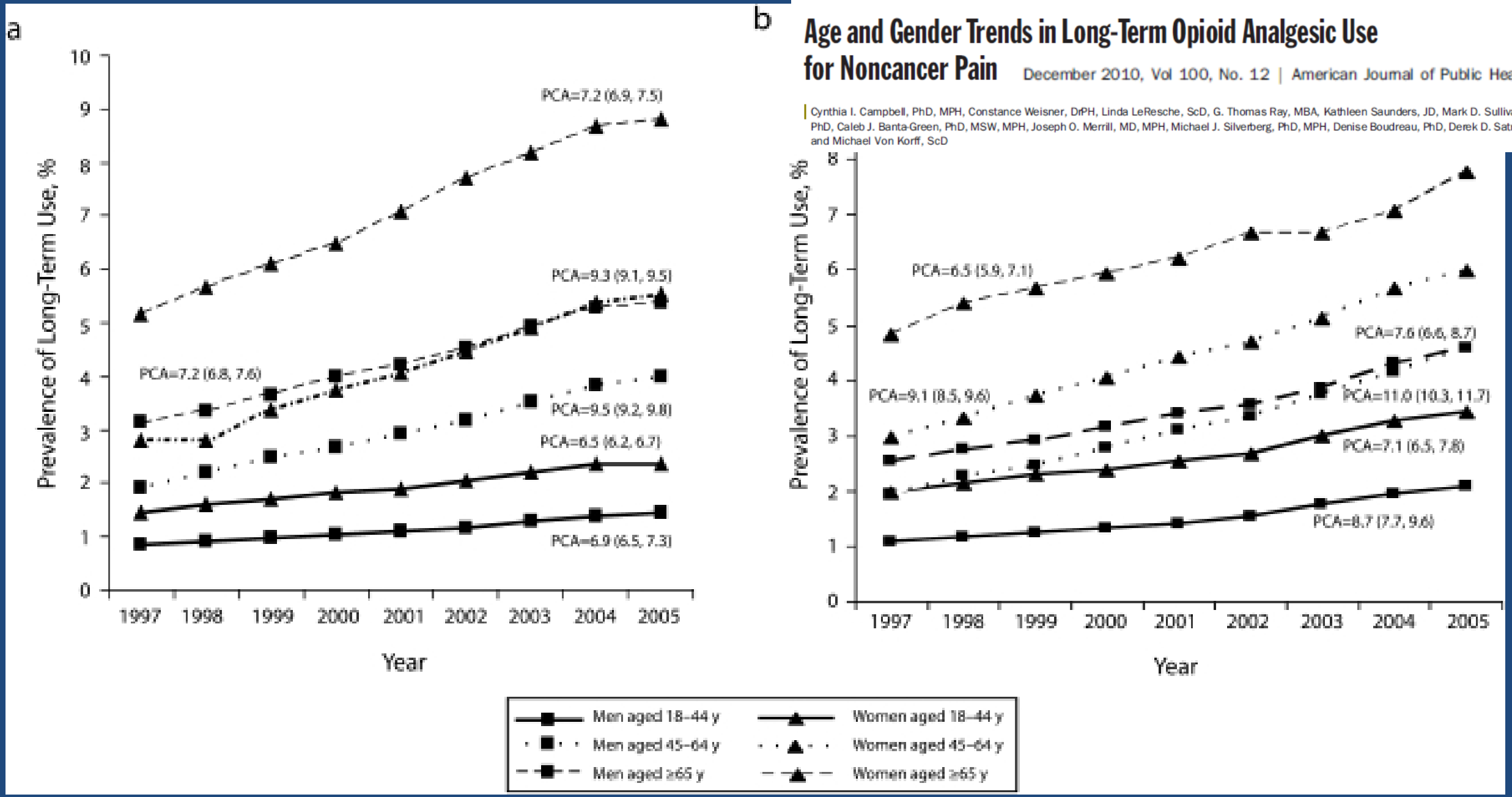
Sex and Gender Differences in Substance Use, Misuse and Addiction

Behavioral Health Burden

Diagnosis	Percent Reporting	
	Female	Male
Serious Psychological Distress (past month)	**6.0%**	**4.1%**
Any Mental Illness (past year)	**26.2%**	**17.3%**
Serious Mental Illness (past year)	**5.0%**	**3.0%**
Major Depressive Episode (past year)	**8.5%**	**4.7%**

Prescription Medication

Past Year	Male	Female
Prescription psychotherapeutic drugs	40.9%	47.8%
Opioid Analgesic	33.9%	38.8%
Tranquilizers	11.3%	17.9%
Sedatives	5.6%	8.2%
Stimulants	6.5%	6.3%



Prevalence of long-term opioid use for noncancer pain among adult members of (a) Kaiser Permanente Northern California and (b) Group Health Cooperative, by gender and year: 1997–2005

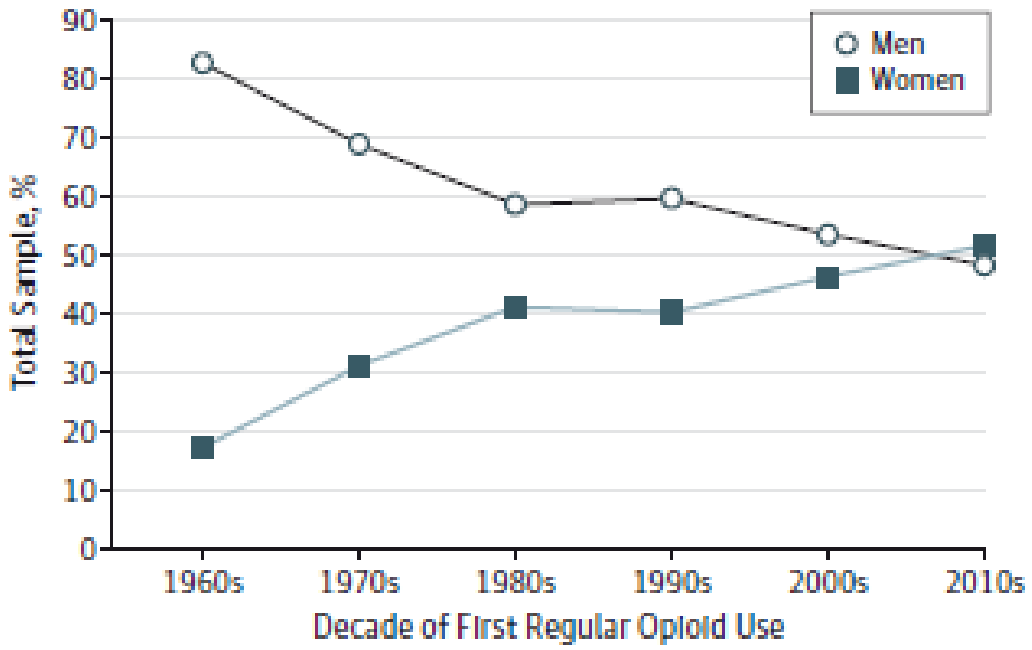
Original Investigation

The Changing Face of Heroin Use in the United States
A Retrospective Analysis of the Past 50 Years

Theodore J. Cicero, PhD; Matthew S. Ellis, MPE; Hilary L. Surratt, PhD; Steven P. Kurtz, PhD

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366
Published online May 28, 2014.

Figure 2. Sex Distribution of Respondents Expressed as Percentage of the Total Sample



Short Communication

Addictive Behaviors 74 (2017) 63–66

Increased use of heroin as an initiating opioid of abuse

Theodore J. Cicero*, Matthew S. Ellis, Zachary A. Kasper

Washington University in St. Louis, Department of Psychiatry, Campus Box 8134, 660 S. Euclid Avenue, St. Louis, MO 63110, United States

Table 1
Characteristics of heroin vs. prescription opioid initiates, 2005–2015.

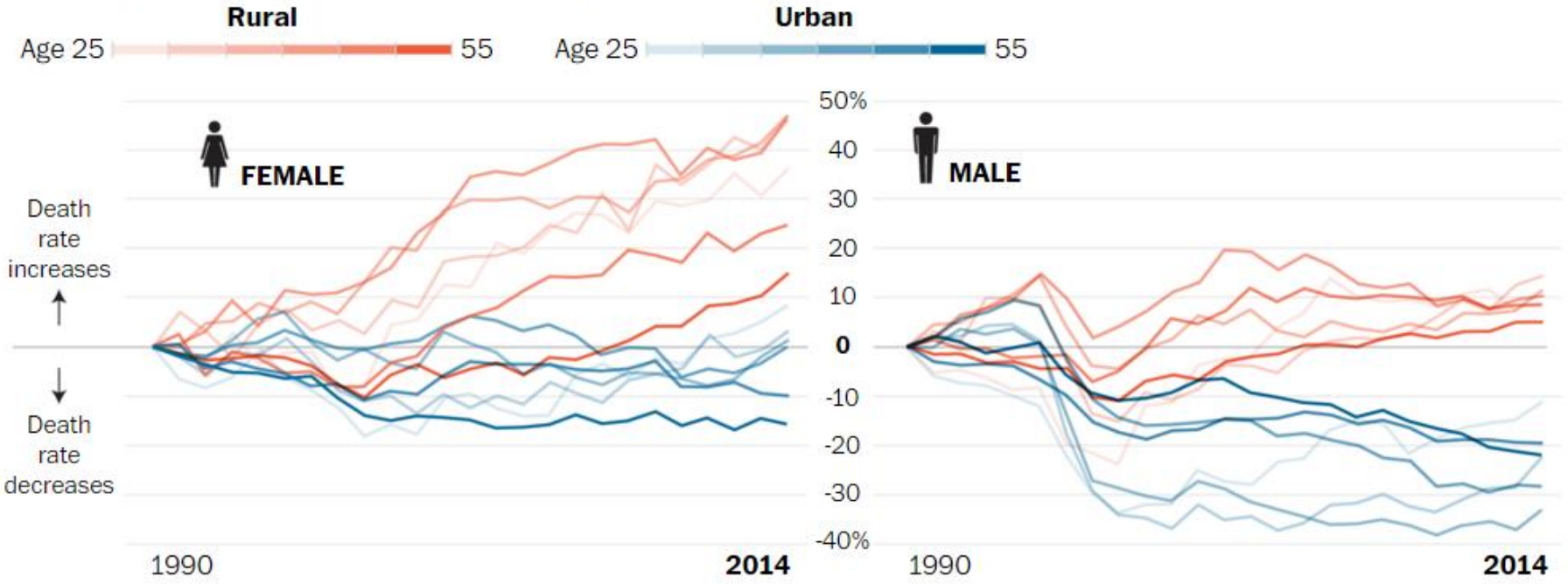
	Initiate Cohort, No. (%)		
	Heroin (n = 631)	Prescription opioid (n = 5254)	Sig.[a]
Age at survey completion (SE)	27.0 (0.28)	28.9 (0.11)	< 0.001[b]
Gender			0.82
Male	299 (47.8%)	2519 (48.3%)	
Female	327 (52.2%)	2701 (51.7%)	
Ethnicity			0.01
White	479 (78.0%)	4262 (82.2%)	
Non-white	135 (22.0%)	922 (17.8%)	
Urbanicity of residence			0.01
Urban	280 (51.6%)	2095 (46.1%)	
Suburban/rural	263 (48.4%)	2454 (53.9%)	
Highest completed education			< 0.001[b]
Some college or more	204 (32.7%)	2141 (41.0%)	
Education lower than college	409 (65.5%)	2994 (57.3%)	
None	11 (1.8%)	90 (1.7%)	

The Washington Post

A new divide in American death

Change in mortality rate, urban vs. rural

White women and men in small cities and rural areas are dying at much higher rates than in 1990, while whites in the largest cities and their suburbs have steady or declining death rates.



Source: Washington Post analysis of Centers for Disease Control and Prevention mortality data

Since 2010

Prescription opioid overdose deaths increased

237% for men

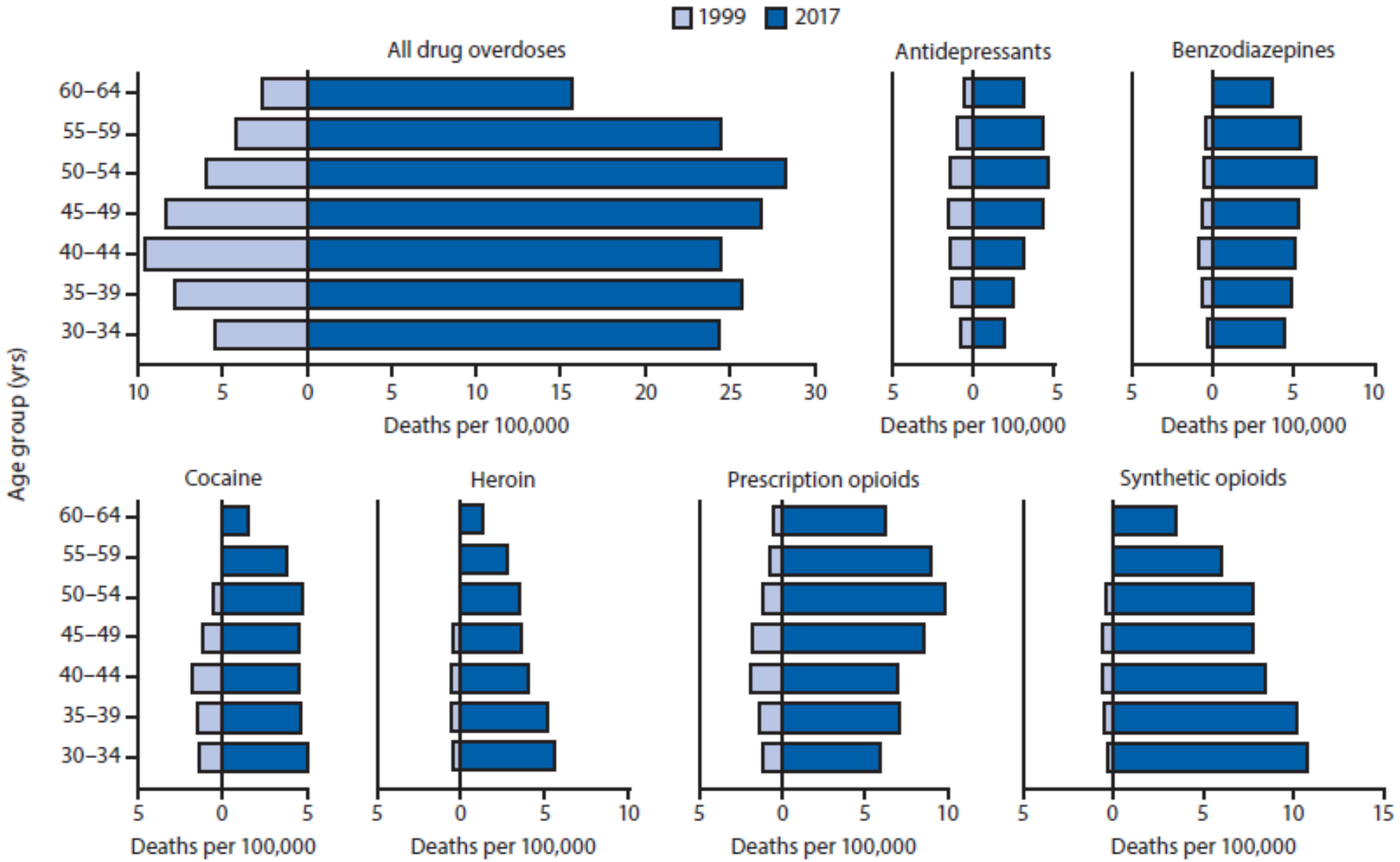
400% for women

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 68 / No. 1
January 11, 2019

Drug Overdose Deaths Among Women Aged 30–64 Years — United States, 1999–2017

Jacob P. VanHouten, MD, PhD[1]; Rose A. Rudd, MSPH[2]; Michael F. Ballesteros, PhD[1]; Karin A. Mack, PhD[1]

FIGURE 2. Drug overdose deaths (unadjusted) per 100,000 women aged 30–64 years, by age group and involved drug or drug class — National Vital Statistics System (NVSS), 1999* and 2017[†,§]



Mertens et al. Addict Sci Clin Pract (2015) 10:26
DOI 10.1186/s13722-015-0047-0

ADDICTION SCIENCE & CLINICAL PRACTICE

RESEARCH Open Access

Physician versus non-physician delivery of alcohol screening, brief intervention and referral to treatment in adult primary care: the ADVISe cluster randomized controlled implementation trial

Jennifer R. Mertens[1*], Felicia W. Chi[2], Constance M. Weisner[2,3], Derek D. Satre[2,3], Thekla B. Ross[2], Steve Allen[2], David Pating[4], Cynthia I. Campbell[2], Yun Wendy Lu[2] and Stacy A. Sterling[2]

Abstract

Background: Unhealthy alcohol use is a major contributor to the global burden of disease and injury. The US Preventive Services Task Force has recommended alcohol screening and intervention in general medical settings since 2004. Yet less than one in six US adults report health care professionals discussing alcohol with them. Little is known about methods for increasing implementation; different staffing models may be related to implementation effectiveness. This implementation trial compared delivery of alcohol screening, brief intervention and referral to specialty treatment (SBIRT) by physicians versus non-physician providers receiving training, technical assistance, and feedback reports.

Methods: The study was a cluster randomized implementation trial (ADVISe [Alcohol Drinking as a Vital Sign]). Within a private, integrated health care system, 54 adult primary care clinics were stratified by medical center and randomly assigned in blocked groups of three to SBIRT by physicians (PCP arm) versus non-physician providers and medical assistants (NPP and MA arm), versus usual care (Control arm). NIH-recommended screening questions were added to the electronic health record (EHR) to facilitate SBIRT. We examined screening and brief intervention and referral rates by arm. We also examined patient-, physician-, and system-level factors affecting screening rates and, among those who screened positive, rates of brief intervention and referral to treatment.

Results: Screening rates were highest in the NPP and MA arm (51 %); followed by the PCP arm (9 %) and the Control arm (3.5 %). Screening increased over the 12 months after training in the NPP and MA arm but remained stable in the PCP arm. The PCP arm had higher brief intervention and referral rates (44 %) among patients screening positive than either the NPP and MA arm (3.4 %) or the Control arm (2.7 %). Higher ratio of MAs to physicians was related to higher screening rates in the NPP and MA arm and longer appointment times to screening and intervention rates in the PCP arm.

Conclusion: Findings suggest that time frames longer than 12 months may be required for full SBIRT implementation. Screening by MAs with intervention and referral by physicians as needed can be a feasible model for increasing the implementation of this critical and under-utilized preventive health service within currently predominant primary care models.

Campbell C, Weisner C, Chi FW, Ross T, Sterling S, Mertens J. Gender differences in alcohol Screening, Brief Intervention, and Referral to Treatment in primary care. J Patient Cent Res Rev. 2016;3:211.

640,000 adult patients

Women less likely to be screened:

- PCP arm OR=0.78 (0.75, 0.82)
- Non MD OR=0.82 (0.77, 0.87)

Among those screened, women less likely to receive BI/RT

- PCP arm OR=0.60 (0.48, 0.76)
- Non MD OR=0.62 (0.51, 0.77)

Manuel and Lee *Substance Abuse Treatment, Prevention, and Policy* (2017) 12:28
DOI 10.1186/s13011-017-0114-5

Substance Abuse Treatment, Prevention, and Policy

RESEARCH Open Access

Gender differences in discharge dispositions of emergency department visits involving drug misuse and abuse—2004-2011

Jennifer I. Manuel[1*] and Jane Lee[2]

Table 1 Characteristics of ED Visits Involving Drug Misuse or Abuse, DAWN 2004–2011

	Total (N = 14,245,776)	Men (n = 8,203,524; 57.6%)	Women (n = 6,042,252; 42.4%)	Men vs. Women[a]		
	Weighted %	Weighted %	Weighted %	Unadjusted OR	95% CI	p
Age (years)						
18–20	12.0	12.3	11.5	1.08	1.01–1.15	0.022
21–34	34.6	35.2	33.8	1.06	1.02–1.10	0.005
35–54	42.1	42.3	41.9	1.02	0.98–1.05	0.318
55 or older	11.4	10.3	12.8	0.78	0.74–0.82	<.001
Race/Ethnicity						
Non-Hispanic White	63.0	59.3	68.2	0.68	0.63–0.73	<.001
Non-Hispanic Black	24.0	25.6	21.7	1.24	1.14–1.35	<.001
Hispanic	11.6	13.8	8.5	1.71	1.59–1.84	<.001
Other	1.4	1.3	1.6	0.87	0.77–0.97	0.016
Drug Misuse or Abuse Category						
Alcohol only	8.7	8.6	8.9	0.97	0.89–1.05	0.433
Prescription Drugs only	30.8	23.8	40.3	0.46	0.44–0.49	<.001
Illicit Drugs only	30.4	34.2	25.2	1.54	1.48–1.61	<.001
Illicit Drugs w/ Alcohol	14.2	17.8	9.4	2.10	1.97–2.24	<.001
Prescription Drugs w/ Alcohol	6.3	5.7	7.1	0.78	0.73–0.84	<.001
Illicit Drugs w/ Prescription Drugs	6.9	6.9	6.9	0.99	0.93–1.06	0.805
Illicit Drugs w/ Prescription Drugs & Alcohol	2.7	3.0	2.2	1.34	1.23–1.47	<.001
Discharge Disposition						
Discharged Home	51.7	50.4	53.4	0.89	0.84–0.93	<.001
Released to Police/Jail	3.3	4.3	2.0	2.25	2.03–2.49	<.001
Referral to Outpatient Detox/Drug Treatment	5.1	5.5	4.4	1.27	1.15–1.42	<.001
Inpatient Detox/Psychiatric Hospital Admission	9.0	9.7	8.2	1.2	1.07–1.35	0.002
General Hospital Admission	20.1	19.1	21.5	0.86	0.81–0.91	<.001
Transferred to Another Facility	8.8	8.8	8.7	1.01	0.92–1.10	0.847
Left Against Medical Advice	2.1	2.3	1.8	1.25	1.12–1.38	<.001

Notes: The table reports weighted frequencies and percentages
[a]Unadjusted logistic regression models of sample characteristics and discharge dispositions as a function of gender. Odds ratio (OR) estimates were tested using design-based t-statistics with 1433 degrees of freedom

Focus on Opioid Overdose

PREHOSPITAL EMERGENCY CARE 2016;20:220–225

Use of Naloxone by Emergency Medical Services during Opioid Drug Overdose Resuscitation Efforts

Steven Allan Sumner, MD, Melissa C. Mercado-Crespo, PhD, M. Bridget Spelke, Leonard Paulozzi, MD, David E. Sugerman, MD, Susan D. Hillis, PhD, Christina Stanley, MD

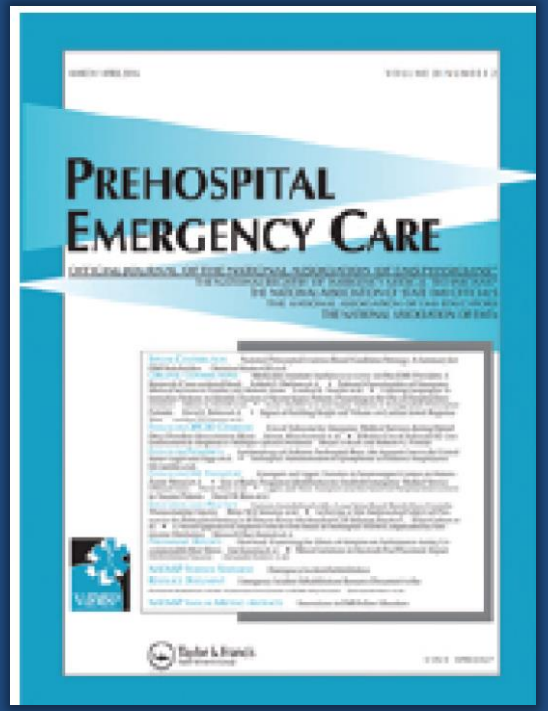


TABLE 1. Administration of naloxone during emergency medical services resuscitation attempts by patient and scene characteristics of individuals deceased due to opioid overdose ($N = 124$)

		Naloxone administered		Naloxone not administered		
		n	%	*n*	%	*p*-value
Heroin present on toxicology at death	Yes ($N = 60$)	45	75.0	15	25.0	0.04
	No ($N = 64$)	37	57.8	27	42.2	
Age (in years)	Younger than 30 ($N = 30$)	26	86.7	4	13.3	< 0.01
	30 to 50 ($N = 52$)	34	65.4	18	34.6	
	Older than 50 ($N = 42$)	22	52.4	20	47.6	
Gender	Male ($N = 89$)	66	74.2	23	25.8	<0.01
	Female ($N = 35$)	16	45.7	19	54.3	

TABLE 2. Association of patient and scene characteristics with no administration of naloxone during emergency medical services resuscitation attempts among individuals deceased due to an opioid overdose ($N = 124$)

		Unadjusted			Adjusted[a]		
		OR	95% CI	*p*-value	OR	95% CI	*p*-value
Age (in years)	Younger than 30 ($N = 30$)	1 (ref)	–	–	1 (ref)	–	–
	30 to 50 ($N = 52$)	3.4	1.0–11.4	0.04	3.2	0.9–11.3	0.07
	Older than 50 ($N = 42$)	5.9	1.8–19.9	<0.01	4.8	1.3–17.4	0.02
Gender	Male ($N = 89$)	1 (ref)	–	–	1 (ref)	–	–
	Female ($N = 35$)	3.4	1.5–7.7	<0.01	2.9	1.2–7.0	0.02

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

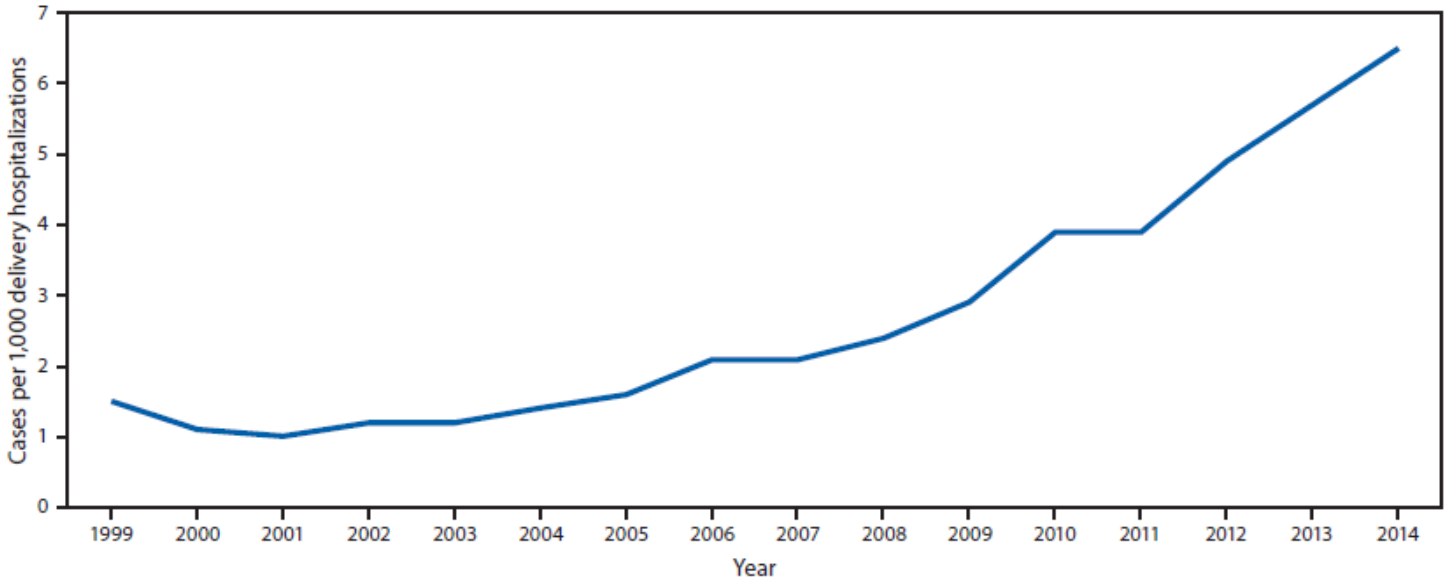
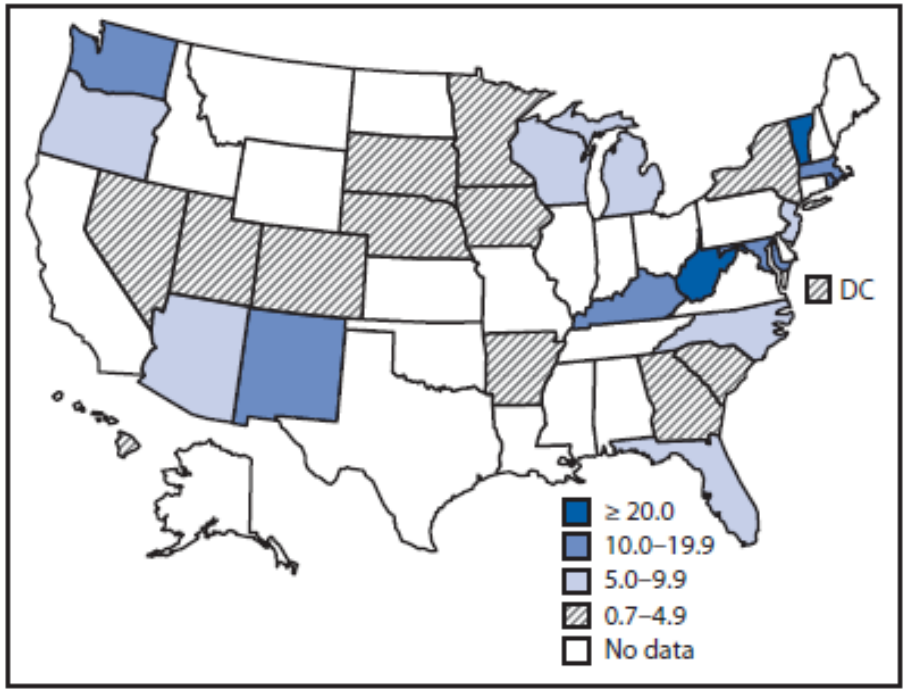


FIGURE 2. Prevalence of opioid use disorder per 1,000 delivery hospitalizations* — State Inpatient Database, Healthcare Cost and Utilization Project, 28 states, 2013–2014†



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.

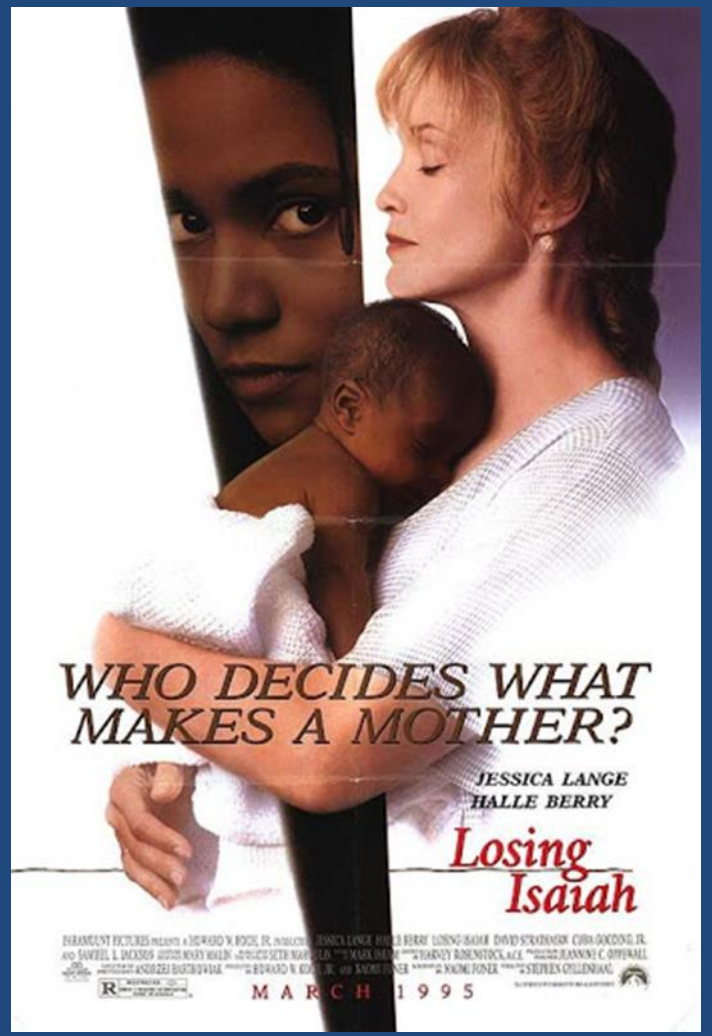
n I have no sympathy for her. You
not care about the child. Period.

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.

The “Crack Baby” Hysteria



“Crack Baby”:
Where War on Drugs and War on Abortion Collided

Washington Post 1989

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

Stigma

Journal of Mental Health, December 2004; 13(6): 537–548 BrunnerRoutledge Taylor & Francis HealthSciences

ORIGINAL ARTICLE

Shame, blame, and contamination: A review of the impact of mental illness stigma on family members

PATRICK W. CORRIGAN & FREDERICK E. MILLER

University of Chicago Center for Psychiatric Rehabilitation, Evanston Northwestern Healthcare, Illinois, USA

Abstract

In his classic text, Goffman (1963) defined courtesy stigma as the negative impact that results from association with a person who is marked by a stigma. Family members of relatives with mental illness are frequently harmed by this kind of stigma. Using a social cognitive model of mental illness stigma, we review ways in which various family roles (e.g., parents, siblings, spouses) are impacted by family stigma. We distinguish between public stigma (the impact wrought by subsets of the general population that prejudge and discriminate against family members) and vicarious stigma (suffering the stigma experienced by relatives with mental illness). Results of our review suggest parents are blamed for causing their child's mental illness, siblings and spouses are blamed for not assuring that relatives with mental illness adhere to treatment plans, an
illness of their father or mother. The current
future research including identification of st
that harm family members; developing ri
stigmatizing attitudes and discriminatory be
manifestations of family stigma.

Keywords: *Stigma, courtesy stigma, famil*

My then 13-year-old daughter summed i
send gifts, but because it is his mind that
the stigma/blame loop. [People would s
because she is?'" (Ben-Dor, 2001, p. 33

"Growing up with a mentally ill mother
development of my sense of self. I wa
something wrong with me. Acutely self-
1988, p. 337).

Correspondence: Patrick Corrigan, Center for Psychia
Place, Suite 450, Evanston, IL 60201 USA. Tel: 708 6

ISSN 0963-8237 print/ISSN 1360-0567 online © Sha
DOI: 10.1080/09638230400017004

Stigma and People Who Use Drugs

We are the Drug Policy Alliance.

Stigma is defined as the experience of being "deeply discredited" or marked due to one's "undesired differentness." To be stigmatized is to be held in contempt, shunned or rendered socially invisible because of a socially disapproved status.[1]

Stigma and Drugs

There is an extensive body of literature documenting the stigma associated with alcohol and other drug problems. No physical or psychiatric condition is more associated with social disapproval and discrimination than substance dependence.[2]

For people who use drugs, or are recovering from problematic drug use, stigma can be a barrier to a wide range of opportunities and rights. People who are stigmatized for their drug involvement can endure

illegal powdered or 'hard' drugs, such as cocaine. And people who inhale or snort their drug of choice may have prejudice against people who inject a drug.

What Can Be Done To Fight Stigma?

Know the facts. The majority of people who ever try *any* drug do not use them problematically and do not develop a physical dependence.[6] People who struggle with drug dependence, however, should be afforded the same dignity, respect and support as a person who struggles with any difficult issue.

The public's perception of the "deadliest" and "most addictive" drugs are often not based on scientific evidence. You can help end stigma by learning the
se and evidence-based drug
e information with others.

way we talk about drugs and
can create or uphold stigma.
junkie' and 'pillhead'
o may be struggling with
whole person, not a behavior.
to a 'person addicted to drugs.'

Miller, F. E. (2006). Blame, shame and
llness and drug dependence stigma on
sychology, 20(2), 239-246.
on the management of a spoiled identity.

O' Shaughnessy, J. (2009) The public
diction:Findings from a stratified random
139-147
An extended literature review of health
gs and their clients who use them. Journal of
g , 3(5), 283-288
2007) An investigation of stigma in individuals
use. Addictive Behaviors, 32(7), 1331-1346.
endence on tobacco, alcohol, controlled
dings from the National Comorbidity Survey
A.; Kessler, Ronald C. , Experimental and
3), Aug 1994, 244-258.

Stigma: the experience of being "deeply discredited" or marked due to one's "undesired differentness". To be stigmatized is to be held in contempt, shunned or rendered socially invisible because of a socially disapproved status.

Gender and Social Norms

Gendered Dimensions of Smoking Among College Students

Mimi Nichter
Mark Nichter
University of Arizona
Elizabeth E. Lloyd-Richardson
Brown University
Brian Flaherty
University of Washington
Asli Carkoglu
Dogus University
Nicole Taylor
University of Arizona
The Tobacco Etiology Research Network

Ethnographic research, including interviews, focus groups, and observations were conducted to explore gendered dimensions of smoking among low level smokers, including the acceptability of smoking in different contexts; reasons for smoking; the monitoring of self and friends' smoking; and shared smoking as a means of communicating concern and empathy. Important gendered dimensions of smoking were documented. Although males who smoked were described as looking manly, relaxed, and in control, among females, smoking was considered a behavior that made one look slutty and out of control. Young women were found to monitor their own and their friends' smoking carefully and tended to smoke in groups to mitigate negative perceptions of smoking. Gender-specific tobacco cessation programs are warranted on college campuses.

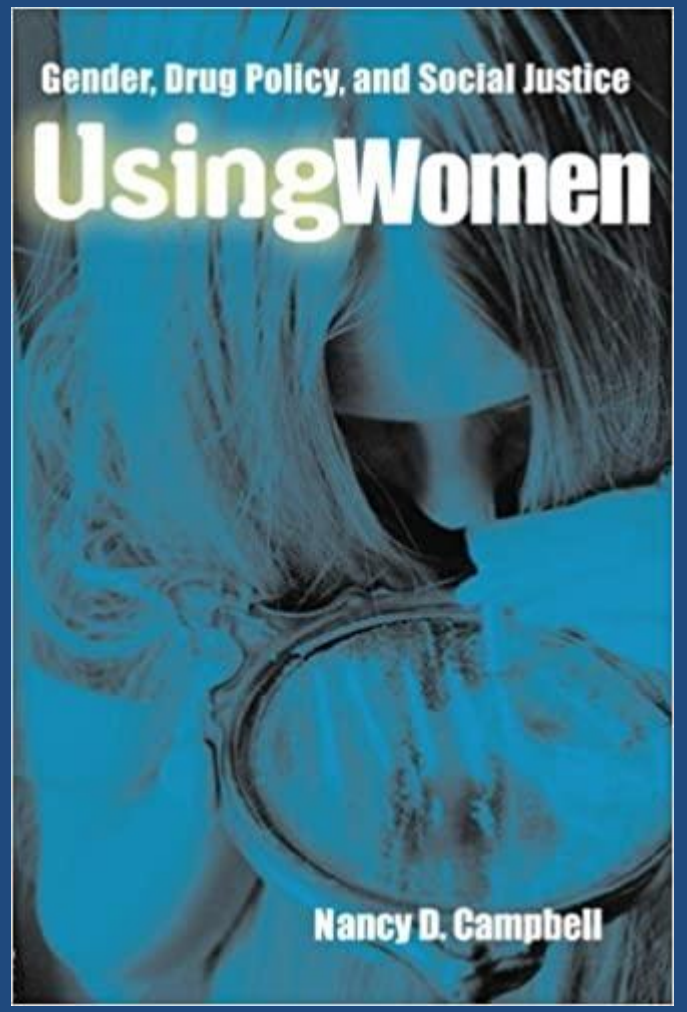
Keywords: *smoking; ethnography; gender; college students; emerging adults*

Social smoking among college students in the United States is a phenomenon that requires careful attention (Moran, Wechsler, & Rigotti, 2004). In contrast to smoking among high school students that peaked in 1996 to 1997 and

Women Smokers: "trash" "sluts"
Men Smokers: "more masculine" "attractive"

Laura Stroud. This study was supported by the Tobacco Etiology Research Network (TERN) of the Robert Wood Johnson Foundation.

Journal of Adolescent Research, Vol. 21 No. 3, May 2006 215-243
DOI: 10.1177/0743558406287400



Motherhood, a Social Norm

Deviations from norms of motherhood: "Deserving" versus "Undeserving" Motherhood Particular and Particularly Harmful Stigma

Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness

Libertas Academica
FREEDOM TO RESEARCH

Mishka Terplan[1,2], Alene Kennedy-Hendricks[3] and Margaret S. Chisolm[4]

[1]Behavioral Health System Baltimore, Baltimore, Maryland, USA. [2]Department of Epidemiology and Public Health, University of Maryland School of Medicine, Baltimore, Maryland, USA. [3]Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA. [4]Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA.

Supplementary Issue: Harm to Others from Substance Use and Abuse

ABSTRACT: In spite of the growing knowledge and understanding of addiction as a chronic relapsing medical condition, individuals with substance use disorders (SUD) continue to experience stigmatization. Pregnant women who use substances suffer additional stigma as their use has the potential to cause fetal harm, calling into question their maternal fitness and often leading to punitive responses. Punishing pregnant women denies the integral interconnectedness of the maternal-fetal dyad. Linking substance use with maternal unfitness is not supported by the balance of the scientific evidence regarding the actual harms associated with substance use during pregnancy. Such linkage adversely impacts maternal, child, and family health by deterring pregnant women from seeking both obstetrical care and SUD treatment. Pregnant women who use substances deserve compassion and care, not pariah-status and punishment.

KEYWORDS: pregnancy, fetal exposure, public attitudes, public policy, pregnant women, opioid use in pregnancy, substance use in pregnancy, neonatal abstinence syndrome

SUBSTANCE ABUSE: RESEARCH AND TREATMENT 2015:9(S2)

Stigma

Discrimination and Prejudice

Discrimination and Prejudice: Common among Providers

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.

Romisher R, *Adv Neonatal Care*; 2018 Apr
Schiff DM, *Subst Abus*; 2017; 38(4)

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%

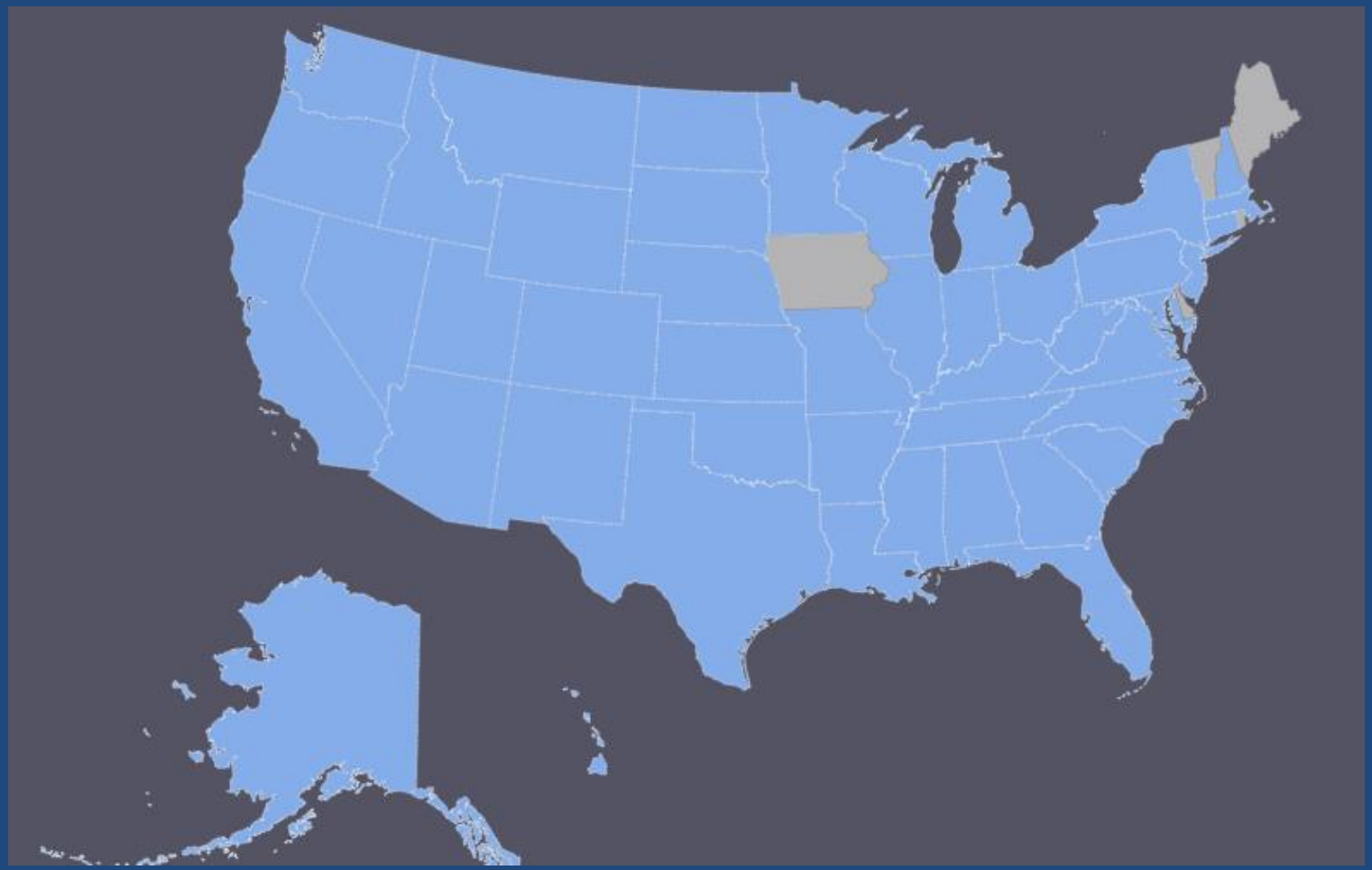
Stigma

Discrimination and Prejudice

Punishment

States where pregnant people have been prosecuted for drug use

The first known indictment of an American woman for drug use in pregnancy was in California in 1977



Women prosecuted for drug use during pregnancy in all states but:
DE, IO, ME, RI, VT

https://projects.propublica.org/graphics/maternity-drug-policies-by-state

"WHATEVER THEY DO, I'M HER COMFORT, I'M HER PROTECTOR."

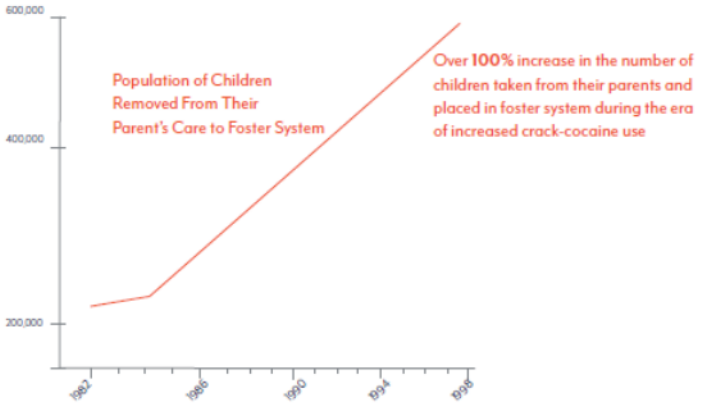
HOW THE FOSTER SYSTEM HAS BECOME GROUND ZERO FOR THE U.S. DRUG WAR

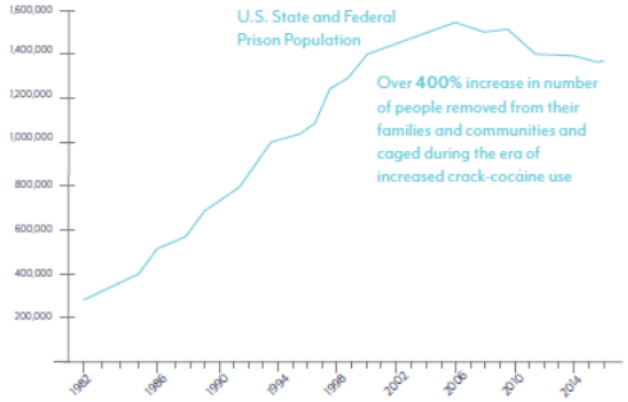
MFP
MOVEMENT FOR FAMILY POWER

NYU FAMILY DEFENSE CLINIC

We are the Drug Policy Alliance.

Between 1986 to 1996, **the population of children removed** from their homes to the foster system, like the **prison population**, grew steeply. Between 1996 to 2016, both the **population of children in state custody** and **prison population** have not decreased significantly.





SUBSTANCE-EXPOSED INFANTS & THE U.S. CHILD WELFARE SYSTEM

The *U.S. CHILD WELFARE SYSTEM* was **not** set up to meet the complex needs of families affected by **substance use disorder.** Recent federal changes have made *IMPROVEMENTS*, but more progress & funding are needed.

FROM 2011 TO 2017:
The number of infants entering the U.S. foster care system grew *BY NEARLY* **10,000**

Overall Foster Care Removals & Parental Substance Use Removals for Infants (<1 year) in the U.S. Foster System Are Growing

At least 1/2 of U.S. foster care placements for infants are associated with ***PARENTAL SUBSTANCE USE***

Rate of Infants (<1 year) in Foster Care per 1000 Live Births

POLICY

In 2016, changes to the Child Abuse Prevention & Treatment Act **(CAPTA)** required "Plans of Safe Care" be *INCLUSIVE OF THE NEEDS OF FAMILY/ CAREGIVERS* of substance-exposed infants.

In 2018, the **SUPPORT Act** amended CAPTA to provide clearer guidance and authorize a new state grant program to *HELP IMPLEMENT "PLANS OF SAFE CARE."*

Clinicians should consider a more ***ACTIVE ROLE*** in shaping how these policies are implemented.

Patrick, SW, Frank, RG, McNeer, E, Stein, BD. Improving the Child Welfare System to Respond to the Needs of Substance-Exposed Infants. Hospital Pediatrics. Supported by NIDA K23DA038720 & R01DA045729

www.childpolicy.org • @VUMCchildpolicy • Play with the data at childpolicy.org/childwelfare

VANDERBILT Center for Child Health Policy

“Test and Report”: Provider Culpability

- Most reports (<1yr) come from hospitals and healthcare providers (HHS 2020)
- Positive test identifies exposure:
  - Not indication of health or ill-health in newborn
  - Not mentioned in AAP discharge criteria
  - Not injury or harm (AAP 2015)
- “Policies that require practitioners to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.” (ACOG 2020)

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/

AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

ACOG 2020 https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period

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 2021

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.

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.

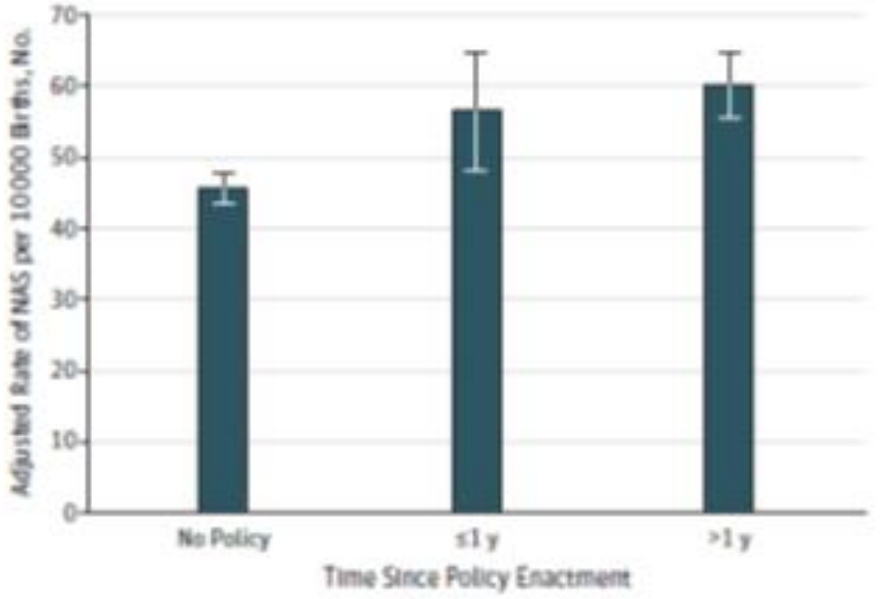
+ Invited Commentary

+ Supplemental content

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

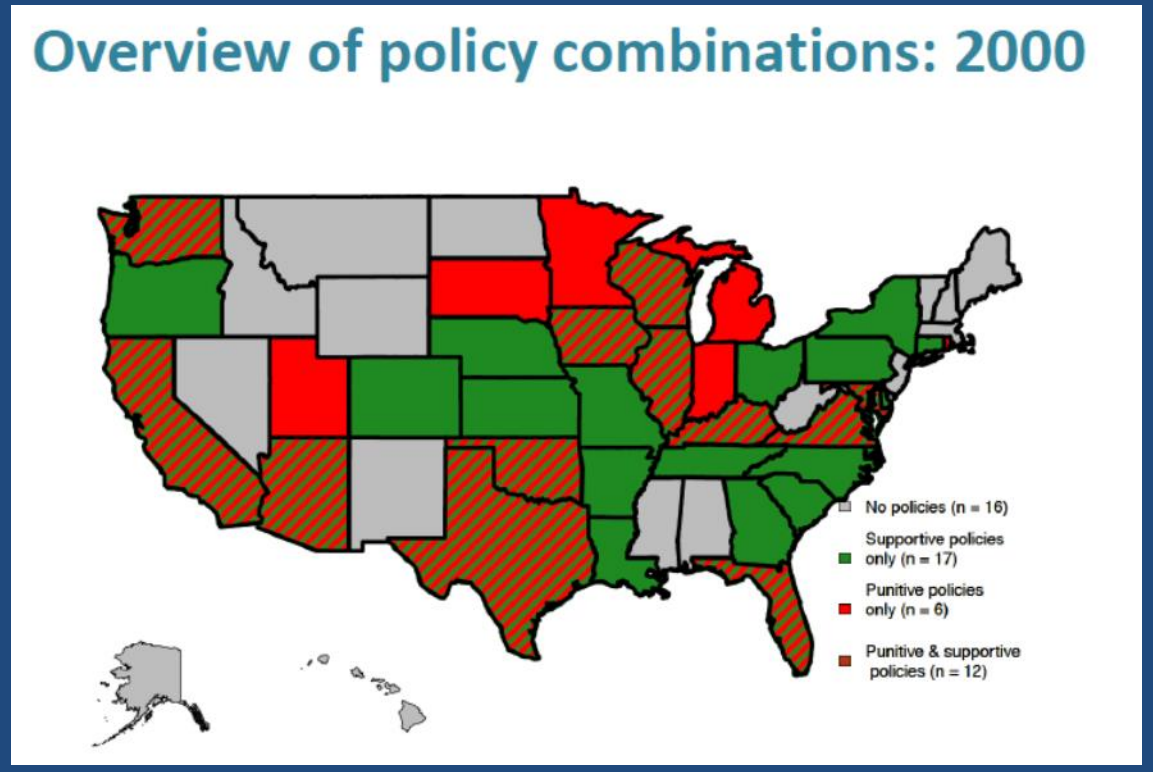
JAMA Network Open. 2019;2(11):e1914078. doi:10.1001/jamanetworkopen.2019.14078

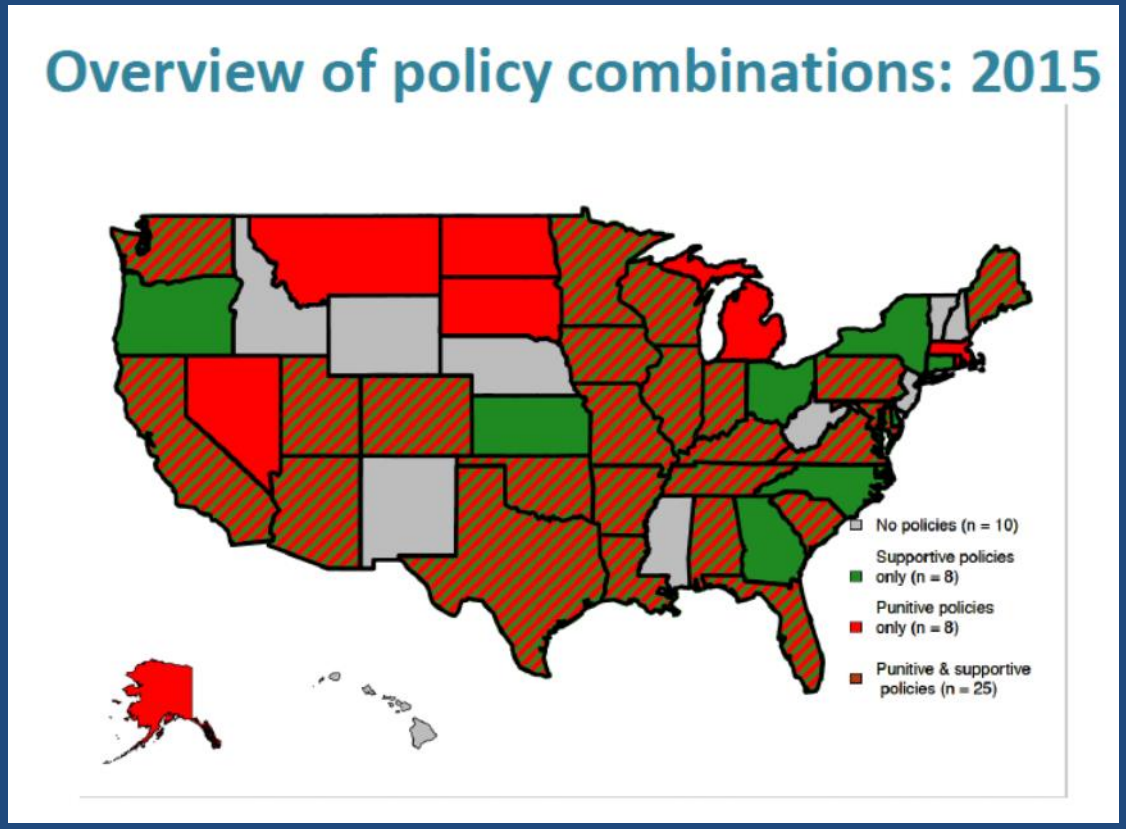
Figure. Annual Rates of Neonatal Abstinence Syndrome (NAS) per 10 000 Live Births Stratified by State Punitive Policies



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.

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





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

Article

Forty Years of State Alcohol and Pregnancy Policies in the USA: Best Practices for Public Health or Efforts to Restrict Women's Reproductive Rights?

Alcohol and Alcoholism, 2017, 52(6) 715–721

Sarah C. M. Roberts[1,*], Sue Thomas[2], Ryan Treffers[2], and Laurie Drabble[3]

[1]Advancing New Standards in Reproductive Health (ANSIRH), Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco, 1330 Broadway, Suite 1100, Oakland, CA 94706, USA, [2]Pacific Institute for Research and Evaluation (PIRE), P.O. Box 7042, Santa Cruz, CA 96061, USA, and [3]San Jose State University School of Social Work, One Washington Square, San Jose, CA 95192-0124, USA

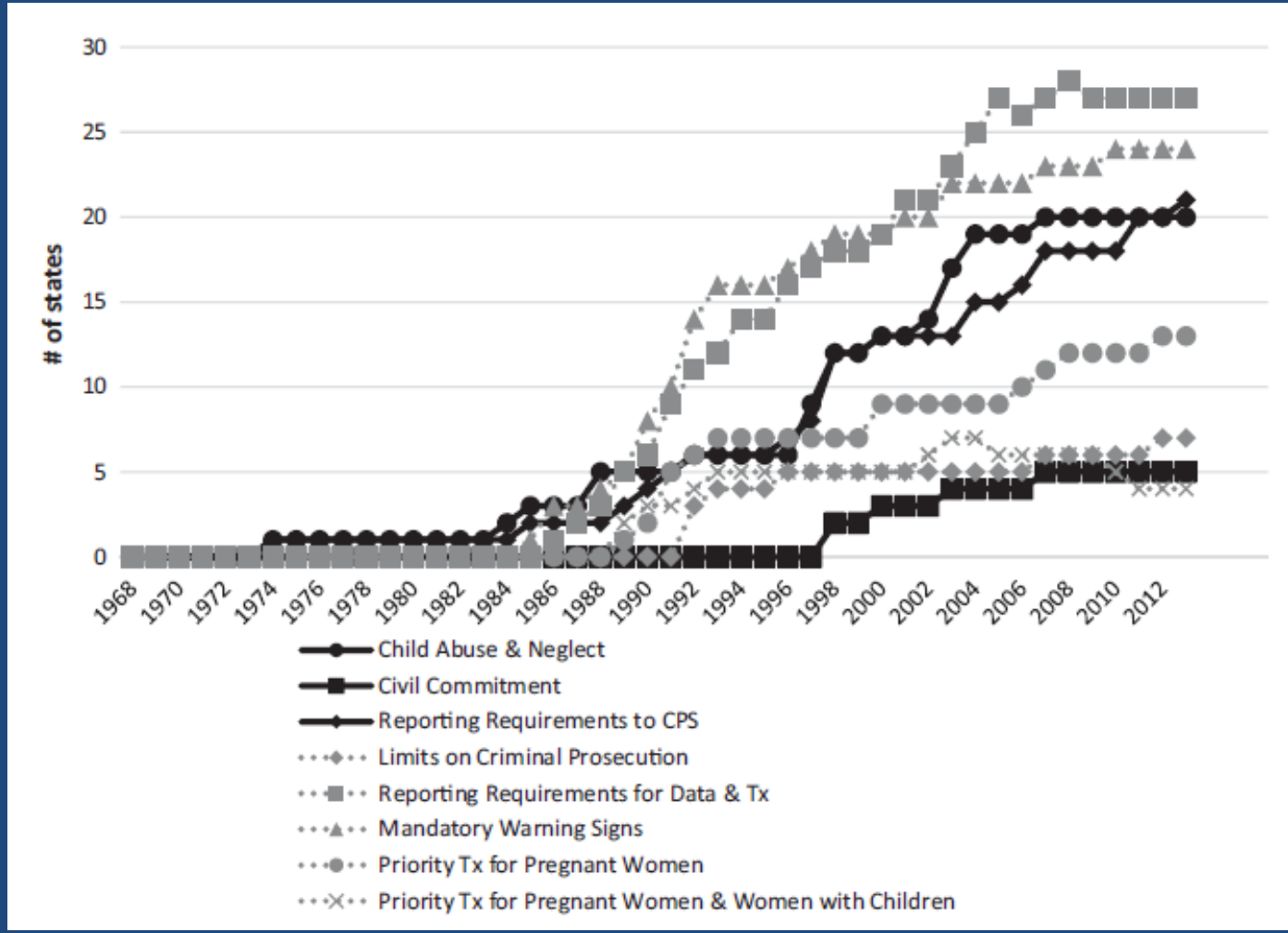
"Punitive policies are associated with efforts to restrict women's reproductive rights rather than policies that effectively curb alcohol-related public health harms."

Number of states with alcohol and pregnancy policies increased from 1 (1974) to 43 (2013)

Punitive policies increasing over time

No association between either supportive or punitive policies and Alcohol Policy Effectiveness Scores

Punitive policies, however, associated with state restrictions on reproductive rights



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

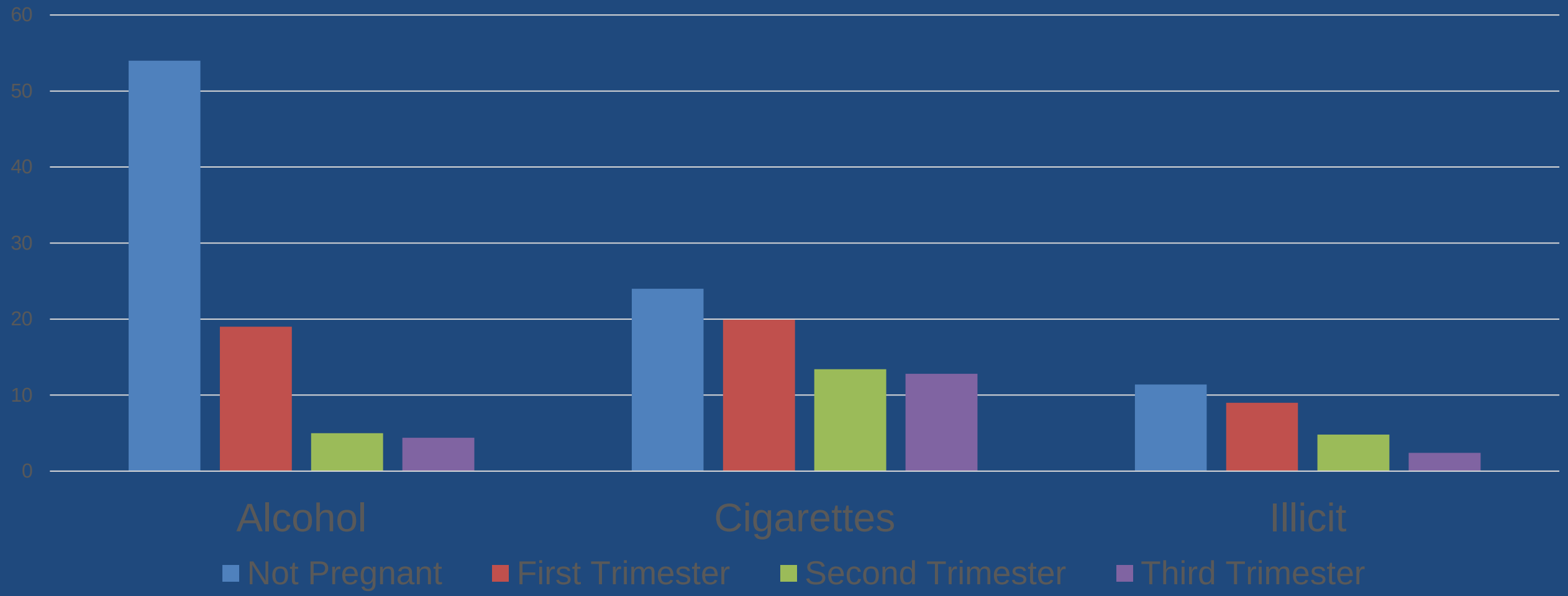
In place of punishment: Questions to ask ourselves

- Why would a pregnant person use drugs?
- Are there alternatives to punishment?
- How can we do less harm?

In place of punishment: Questions to ask ourselves

- Why would a pregnant person use drugs?
- Are there alternatives to punishment?
- How can we do less harm?

What happens when people who use drugs get pregnant?

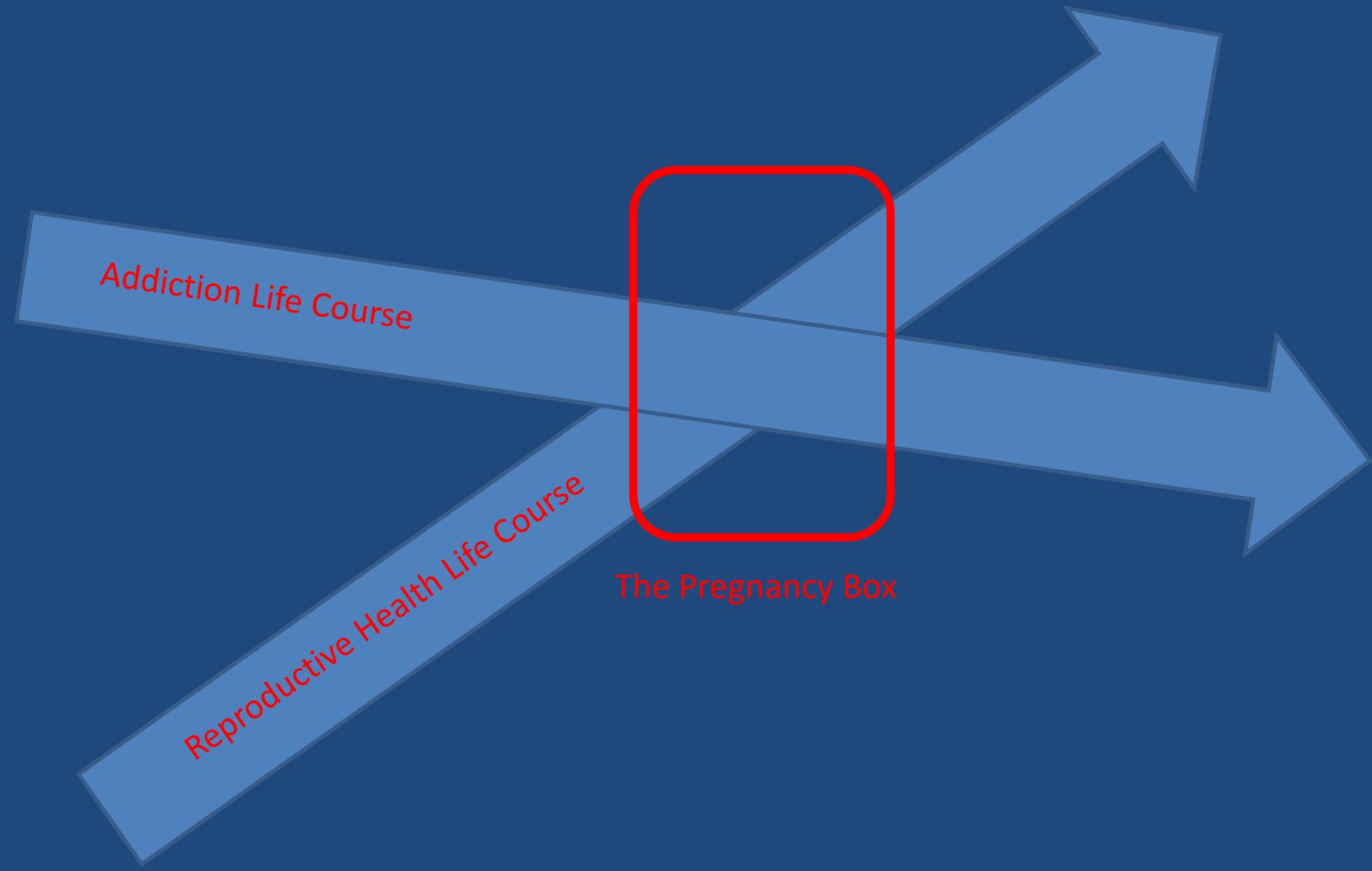


National Survey Drug Use and Health 2015/2016 Past Month Use Data

All pregnant people 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

Punishment of Pregnant People Who Use Drugs

- Punishment for Addiction
  - Unethical, immoral and ineffective to punish people for the illness of addiction
- Punishment for Reproduction
  - Pregnancy increases the likelihood of prosecution, and enhances the penalty upon conviction
  - Drug use is misdemeanor while distribution/child abuse is felony
  - Pregnant women receive harsher sentences men or non-pregnant women for drug-related convictions

Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness

Libertas Academica
FREEDOM TO RESEARCH

Mishka Terplan[1,2], Alene Kennedy-Hendricks[3] and Margaret S. Chisolm[4]

[1]Behavioral Health System Baltimore, Baltimore, Maryland, USA. [2]Department of Epidemiology and Public Health, University of Maryland School of Medicine, Baltimore, Maryland, USA. [3]Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA. [4]Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA.

Supplementary Issue: Harm to Others from Substance Use and Abuse

ABSTRACT: In spite of the growing knowledge and understanding of addiction as a chronic relapsing medical condition, individuals with substance use disorders (SUD) continue to experience stigmatization. Pregnant women who use substances suffer additional stigma as their use has the potential to cause fetal harm, calling into question their maternal fitness and often leading to punitive responses. Punishing pregnant women denies the integral interconnectedness of the maternal-fetal dyad. Linking substance use with maternal unfitness is not supported by the balance of the scientific evidence regarding the actual harms associated with substance use during pregnancy. Such linkage adversely impacts maternal, child, and family health by deterring pregnant women from seeking both obstetrical care and SUD treatment. Pregnant women who use substances deserve compassion and care, not pariah-status and punishment.

Journal of Addictive Diseases, 29:231–244, 2010

ISSN: 1055-0887 print / 1545-0848 online
DOI: 10.1080/10550881003684830

Routledge
Taylor & Francis Group

Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense

Jeanne Flavin, PhD
Lynn M. Paltrow, JD

ABSTRACT. The arrests, detentions, prosecutions, and other legal actions taken against drug-dependent pregnant women distract attention from significant social problems, such as our lack of universal health care, the dearth of policies to support pregnant and parenting women, the absence of social supports for children, and the overall failure of the drug war. The attempts to "protect the fetus" undertaken through the criminal justice system (as well as in family and drug courts) actually undermine maternal and fetal health and discourage efforts to identify and implement effective strategies for addressing the needs of pregnant drug users and their families. In this article, the authors seek to expose some of the flawed premises on which the arrests, detentions, and prosecutions are based. The authors highlight the inherent unfairness of a system that expects low-income and drug-dependent pregnant women to provide their fetuses with the health care and safety that these women themselves are not provided and have not been guaranteed.

In place of punishment: Questions to ask ourselves

- Why would a pregnant people use drugs?
- Are there alternatives to punishment?
- How can we do less harm?

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

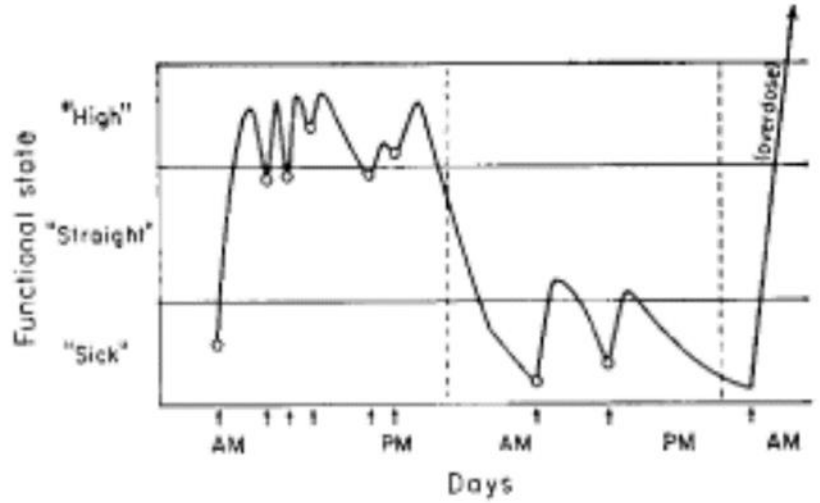


Fig 1.—Diagrammatic summary of functional state of typical "mainline" heroin user. *Arrows* show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

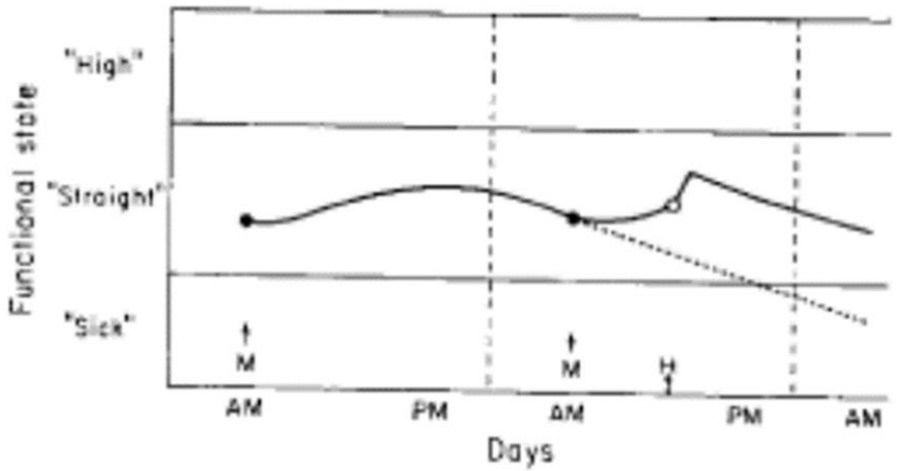
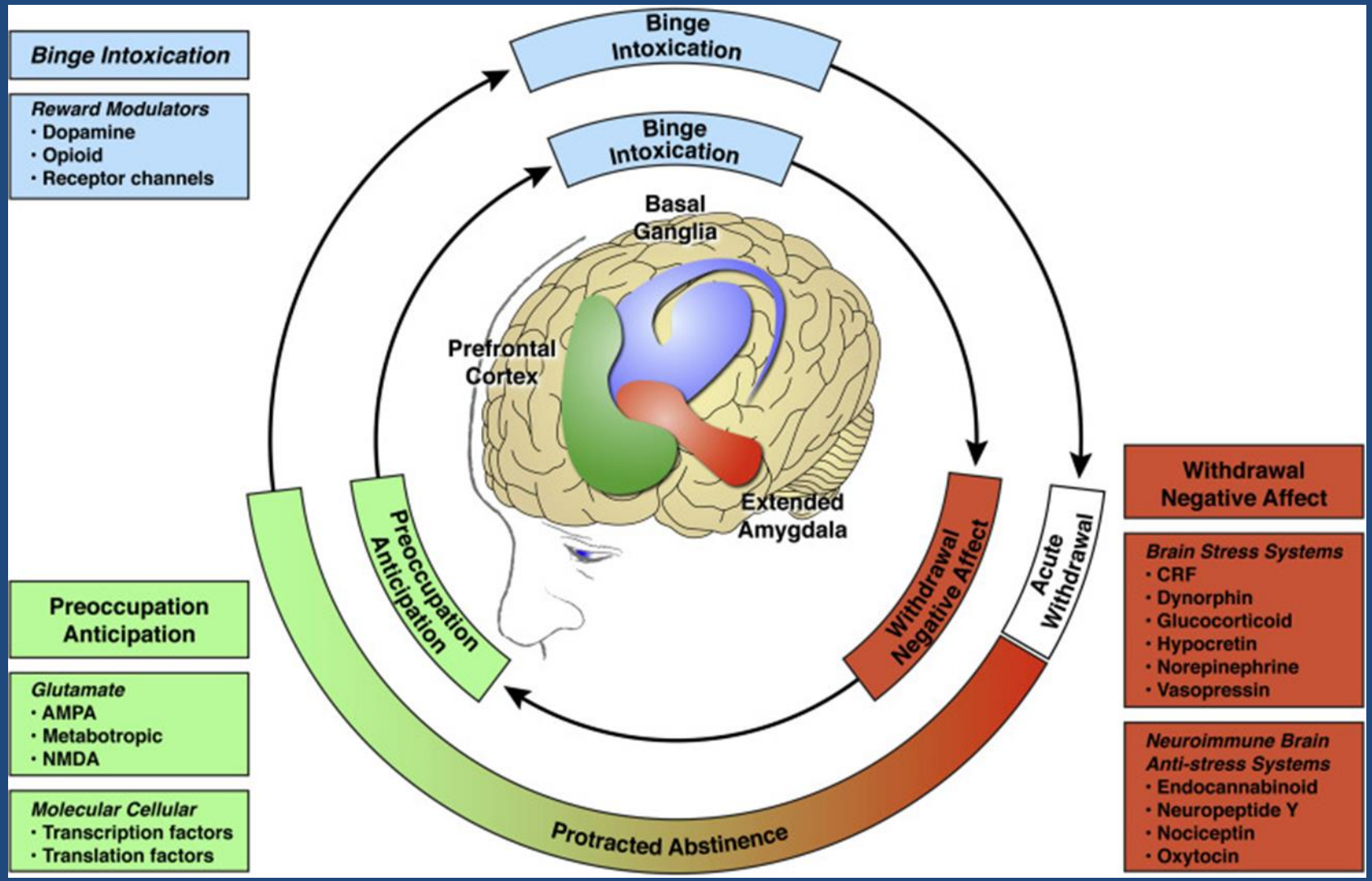


Fig 2.—Stabilization of patient in state of normal function by blockade treatment. A single, daily, oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. *Dotted line* indicates course if methadone is omitted.



Volkow and Koop, Lancet Psychiatry, 2017

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		

There is a positive correlation between medication dose and treatment response

Alternative to Punishment: Treatment

Methadone maintenance during pregnancy: Pregnancy, birth, and neonate characteristics

M. E. STRAUSS, PH.D.
M. ANDRESKO, M.A.
J. C. STRYKER, M.D.
J. N. WARDELL, M.D.
L. D. DUNKEL, B.A.
Detroit, Michigan

1974

The records of 72 pregnant methadone addicts and 72 nonaddicted gravidas, all receiving prenatal care, were examined to determine the degree of obstetric risk associated with low dose methadone maintenance and dimensions of difference between addicted and nonaddicted newborn infants. Rates of pregnancy illness, pregnancy complications, as well as labor and delivery characteristics, did not differ between groups. Low birth weight (≤ 2,500 grams) was not more common among addicted infants, although neonatal weight loss was greater in this group. Most addicted newborns were symptomatic, but pharmacologic treatment was required in only 30 per cent of the cases. Low-dose methadone maintenance in conjunction with comprehensive prenatal care appears to reduce obstetric risk to a level comparable with that of nonaddicted women of similar sociomedical circumstances.

Narcotic Dependency in Pregnancy

Methadone Maintenance Compared to Use of Street Drugs

1976

Barry Stimmel, MD, Karlis Adamsons, MD, PhD

• The course of pregnancy and delivery in 28 women under closely supervised methadone maintenance (group 1) was compared with that of 57 women using heroin or methadone under less controlled circumstances (group 2) and with that of 30 women free of mood-altering medications (group 3). Women in group 1 had the lowest incidence of coexisting medical problems ($P=.025$), with an incidence of fetal distress not statistically different from that of women in group 3. Infants born to women in group 2 had the highest incidence of fetal distress ($P < .05$), with four congenital defects, one stillbirth, and one neonatal death. Symptoms characteristic of narcotic withdrawal occurred with similar frequency in group 1 and 2 infants, appearing earlier in children whose mothers were users of heroin.

These findings indicate that maintenance of the pregnant addict under closely supervised methadone therapy is compatible with an uneventful pregnancy and birth of a healthy infant whose withdrawal symptoms in the neonatal period are readily controllable.

(*JAMA* 235:1121-1124, 1976)

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

	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%

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 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	9.3% (8.4–10.2)	8.8% (7.7–9.8)	12.8% (8.7–16.9)			9.9% (8.5–11.4)	0.063
treatment need[§]			12.5% (7.3–17.7)	9.4% (4.7–14.0)	18.7% (5.5–32.0)		0.246
Alcohol use disorder	7.4% (6.6–8.3)	6.8% (5.9–7.7)	11.8% (7.2–16.5)			8.2% (6.6–9.9)	0.021
			11.7% (5.8–17.6)	9.0% (3.3–14.7)	16.2% (2.6–29.9)		0.505
Illicit drug use disorder[‖]	17.1% (15.5–18.7)	17.0% (14.8–19.2)	21.8% (13.9–29.6)			16.5% (13.7–19.3)	0.439
			26.0% (15.1–36.8)	13.2% (5.1–21.3)	29.2% (8.5–49.9)		0.187
Opioid use disorder[¶]	23.6% (18.9–28.2)	31.1% (27.0–35.1)	34.7% (20.7–48.7)			23.6% (18.9–28.2)	0.033
			54.2% (30.2–78.1)	20.0% (3.5–36.5)	31.1% (0.0–63.7)		0.152

Treatment Gap is Greater for Women

- GAO (2015): “the program gap most frequently cited was the lack of available treatment programs for pregnant women…”
- Overall provision of women-centered services declined 43%-40% (p<0.001)
- Services for pregnant or postpartum women declined 19%-13% (p<0.001)

Women-Centered Drug Treatment Services and Need in the United States, 2002–2009

Mishka Terplan, MD, MPH, Nyaradzo Longinaker, MS, and Lindsay Appel, MD

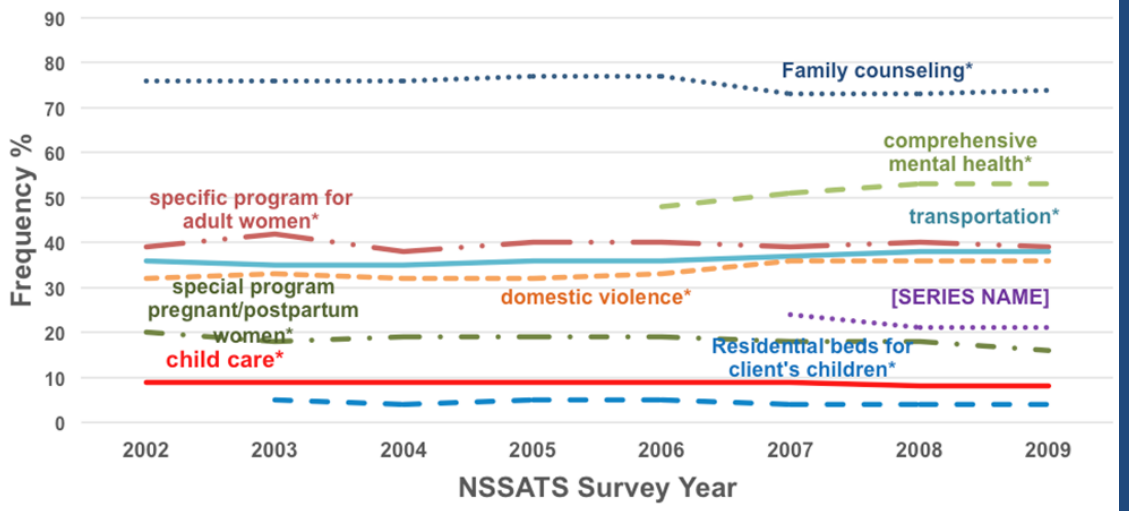
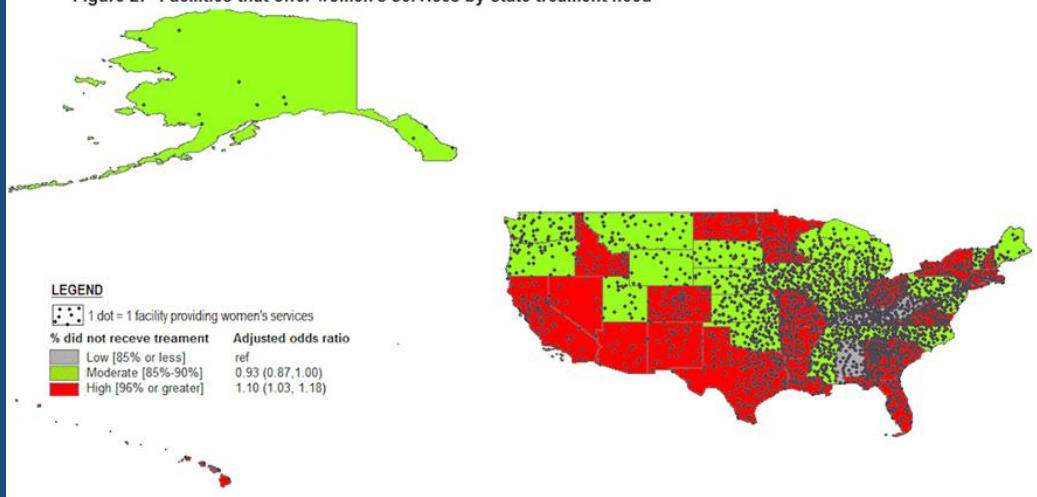


Figure 2. Facilities that offer women's services by State treament need



Journal of Substance Abuse Treatment 89 (2018) 67–74

Contents lists available at ScienceDirect

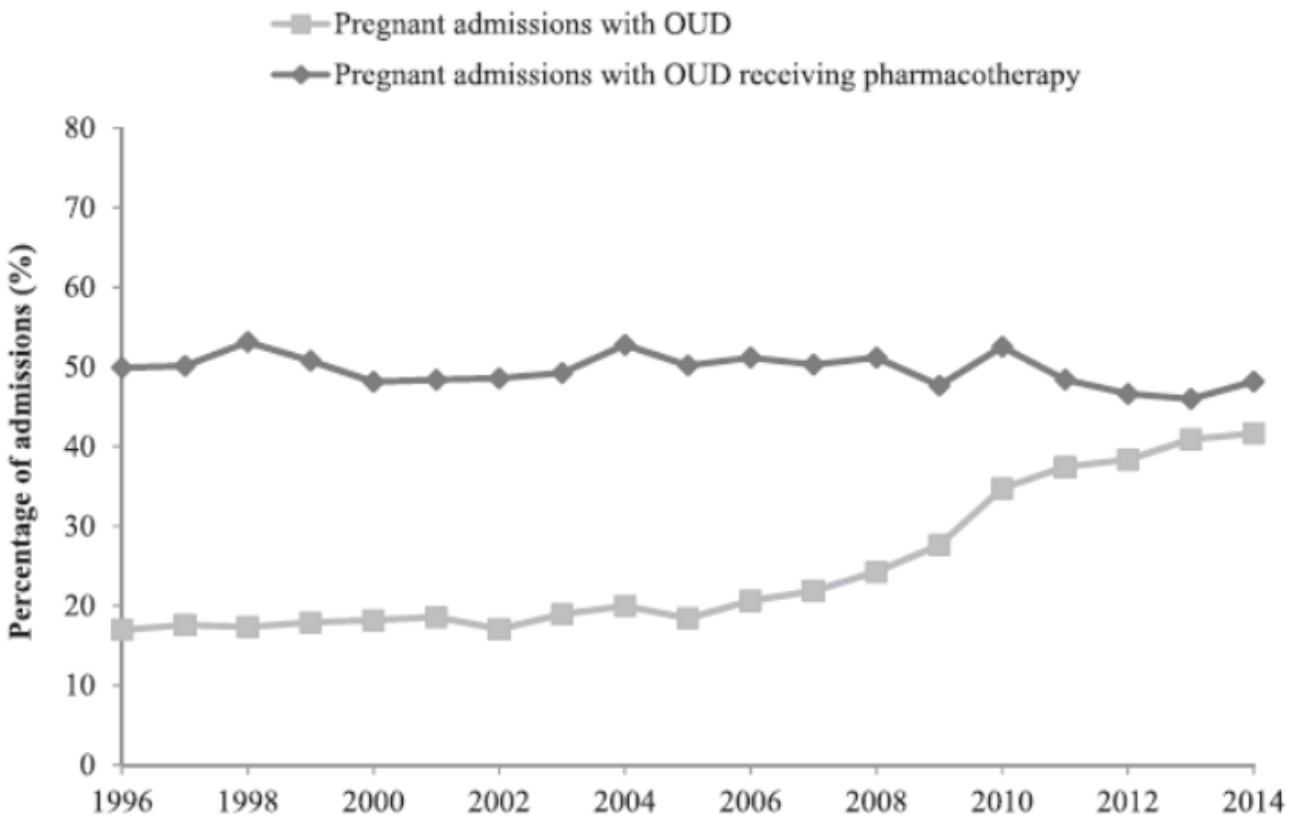
Journal of Substance Abuse Treatment

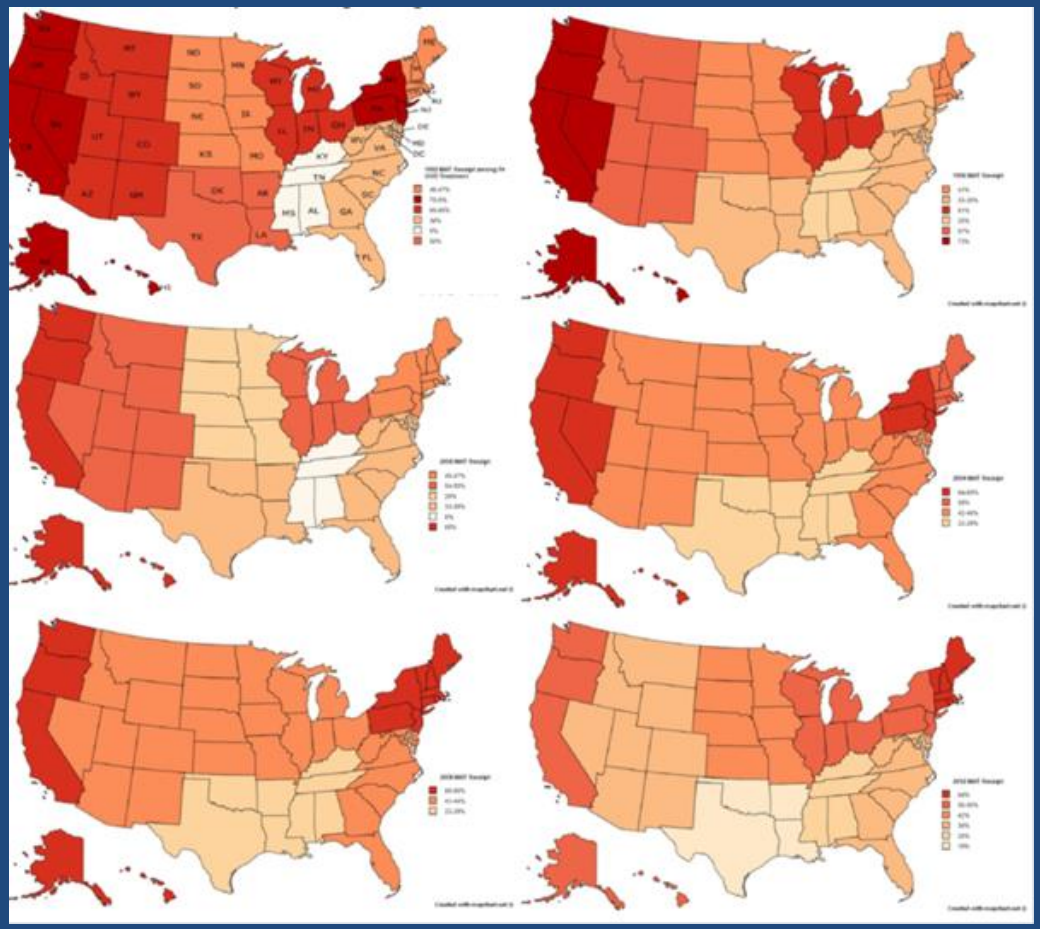
journal homepage: www.elsevier.com/locate/jsat

Trends and disparities in receipt of pharmacotherapy among pregnant women in publically funded treatment programs for opioid use disorder in the United States

Vanessa L. Short[a,*], Dennis J. Hand[a,b], Lauren MacAfee[c], Diane J. Abatemarco[a], Mishka Terplan[d]

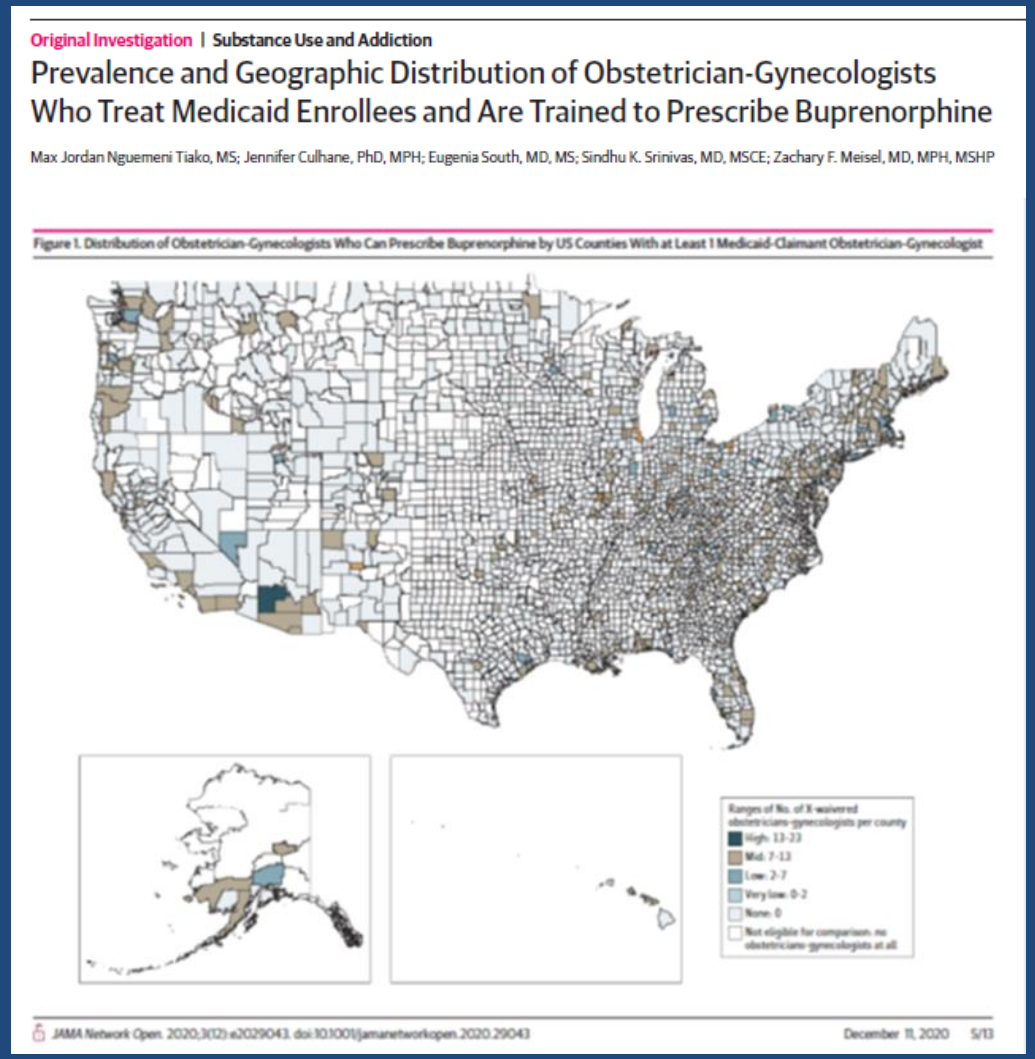
[a] Department of Obstetrics and Gynecology, Thomas Jefferson University, 1233 Locust St. Suite 401, Philadelphia, PA 19107, USA





Only half of pregnant people in treatment for OUD receive medication

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

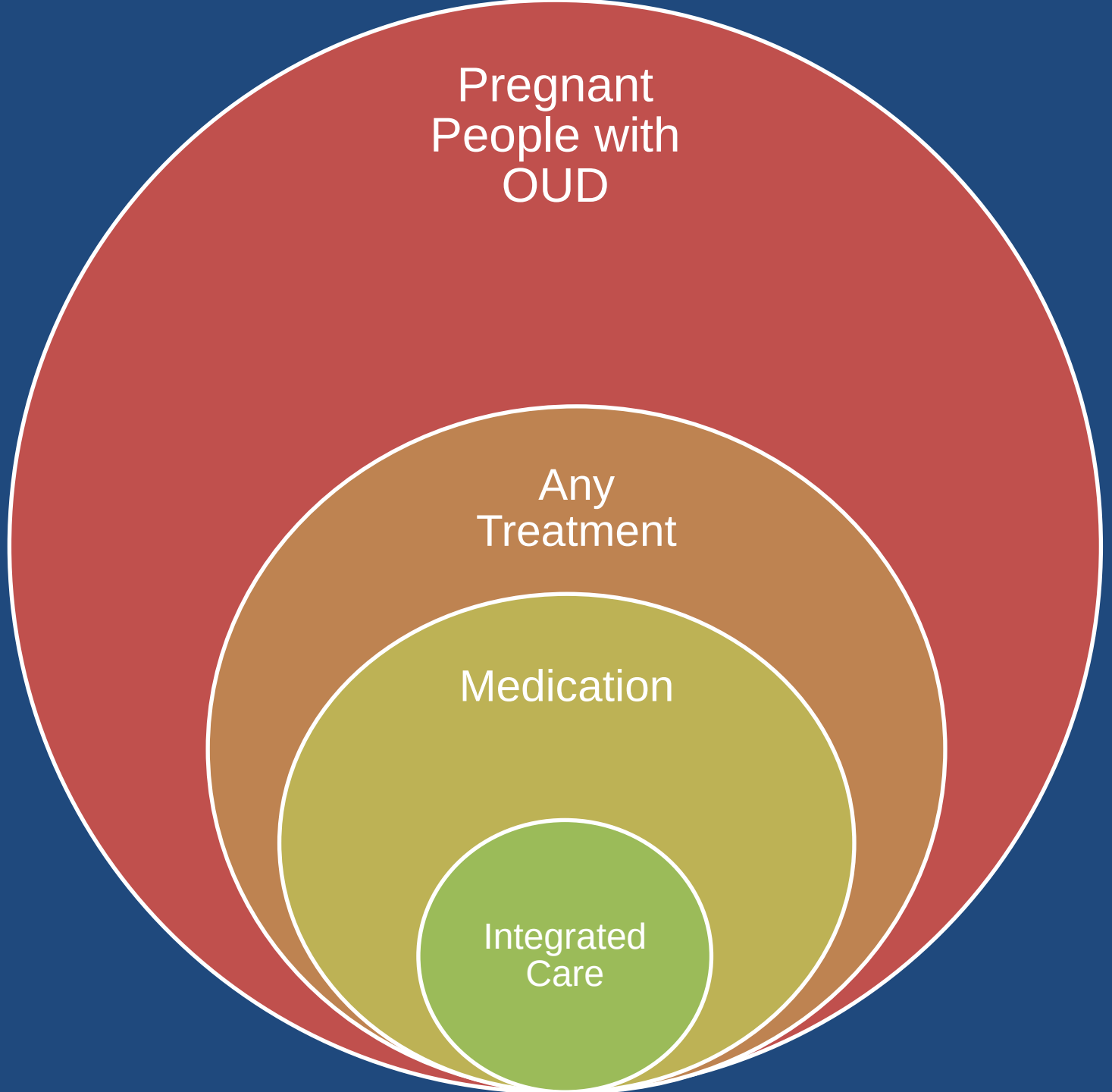
Figure 1. Distribution of Obstetrician-Gynecologists Who Can Prescribe Buprenorphine by US Counties With at Least 1 Medicaid-Claimant Obstetrician-Gynecologist

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

Comprehensive treatment and medication are rare and unavailable for most pregnant people with OUD



Treatment and Punishment

GRANTED

No. 99-936

Supreme Court, U.S.
FILED
AUG 24 2000
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 2000

CRYSTAL M. FERGUSON, *et al.*,

Petitioners,

—v.—

THE CITY OF CHARLESTON, SOUTH CAROLINA, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

REPLY BRIEF FOR PETITIONERS

SUSAN DUNN
171 Church Street, Suite 160
Charleston, South Carolina 29401
(803) 722-6337

DAVID RUDOVSKY
Kairys, Rudovsky, Epstein, Messing & Rau
924 Cherry Street, Suite 500
Philadelphia, Pennsylvania 19107
(215) 925-4400

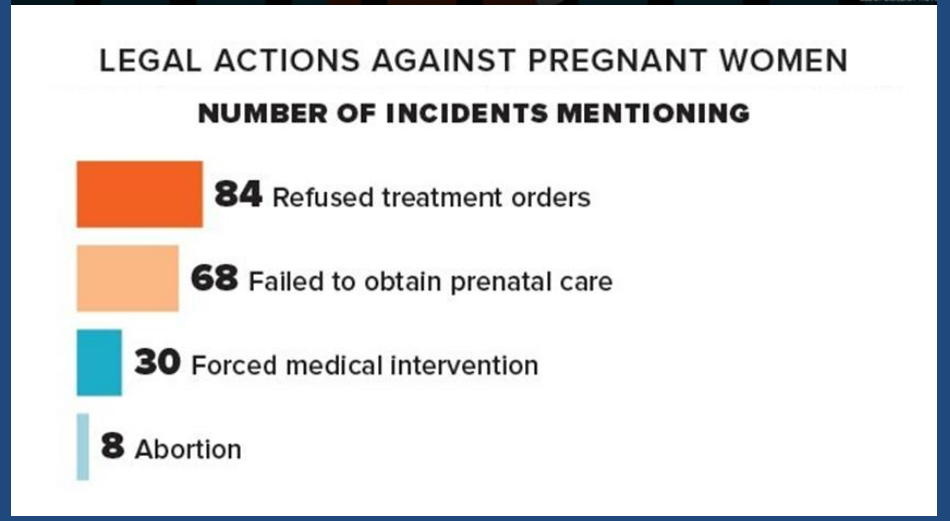
SETH KREIMER
3400 Chestnut Street
Philadelphia, Pennsylvania 19107
(215) 898-7447

PRISCILLA J. SMITH
Counsel of Record
SIMON HELLER
JULIE RIKELMAN
The Center for Reproductive Law & Policy
120 Wall Street, 18th Floor
New York, New York 10005
(212) 514-5534

LYNN PALTROW
SUSAN FRIETSCHE
DAVID S. COHEN
Women's Law Project
125 South Ninth Street, Suite 300
Philadelphia, Pennsylvania 19107
(215) 928-9801

Counsel for Petitioners

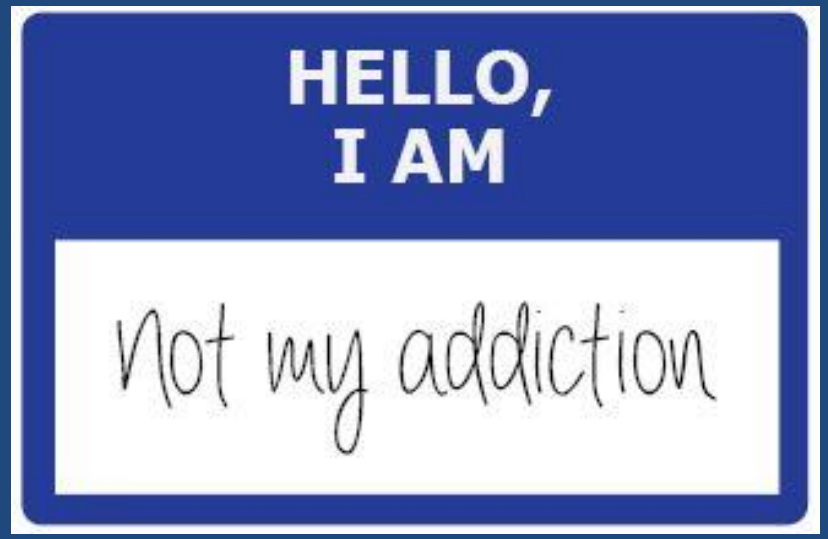
PETITION FOR CERTIORARI FILED DECEMBER 1, 1999
CERTIORARI GRANTED FEBRUARY 28, 2000



In place of punishment: Questions to ask ourselves

- Why would a pregnant woman use drugs?
- Are there alternatives to punishment?
- How can we do less harm?

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

J Addict Med • Volume 10, Number 1, January/February 2016

EDITORIAL

International Statement Recommending Against the Use of Terminology That Can Stigmatize People

Richard Saitz, MD, MPH, FACP, DFASAM

Key Words: addiction, alcohol, author, drugs, editor, language, stigma, terminology

(*J Addict Med* 2016;10: 1–2)

Journal of Addiction Medicine has been encouraging the use of precise and non-stigmatizing terminology (Saitz, 2015 and http://journals.lww.com/journaladdictionmedicine/Pages/informationforauthors.aspx#languageandterminologyguidance). As a member journal of the International Society of Addiction Journal Editors (ISAJE), we endorse the statement made by ISAJE regarding the use of terminology that stigmatizes that appears below, here http://www.parint.org/isajewebsite/ (the ISAJE website), and may be published simultaneously in a number of member journals. The statement, verbatim, is as follows:

"The International Society of Addiction Journal Editors recommends against the use of terminology that can stigmatize people who use alcohol, drugs, other addictive substances or who have addictive behavior.

Rationale: Terms that stigmatize can affect the perception and behavior of patients/clients, their loved ones, the general public, scientists, and clinicians (Kelly et al., 2010; Broyles et al., 2014; Kelly et al., 2015). For example, Kelly and Westerhoff (2010) found that the terms used to refer to individuals with substance-related conditions affected clinician perceptions. Clinicians who read a clinical vignette about "abuse" and an "abuser" agreed more with notions of personal culpability and an approach that involved punishment than did those who read an identical vignette that replaced "abuse" and "abuser" with "substance use disorder" and "person with a substance use disorder."

The International Society of Addiction Journal Editors is aware that terminology in the addiction field varies across cultures and countries and over time. It is thus not possible to give globally relevant recommendations about the use or nonuse of specific terms. "Abuse" and "abuser" or equivalent words in other languages should, however, in general, be avoided, unless there is particular scientific justification (an example of scientific justification of the use of "abuse" is when referring to a person who meets criteria for a *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), alcohol abuse; that person would be said to have "alcohol abuse". Another example of stigmatizing language is describing people as "dirty" (or "clean") because of a urinalysis that finds the presence (or absence) of a drug (Kelly et al., 2015). Instead, the test results and clinical condition should be described."

The above was approved by the International Society of Addiction Journal Editors at its 2015 annual meeting (Budapest, Hungary, August 31–September 2, 2015).

SUBSTANCE ABUSE, 35: 217–221, 2014

ISSN: 0889-7077 print / 1547-0164 online
DOI: 10.1080/08897077.2014.930372

Routledge
Taylor & Francis Group

EDITORIAL

Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response

Lauren M. Broyles, PhD, RN,[1,2,3] Ingrid A. Binswanger, MD, MPH,[4,5] Jennifer A. Jenkins, MPH,[1] Deborah S. Finnell, DNS, PMHNP,[6] Babalola Faseru, MD, MPH,[7,8,9] Alan Cavaiola, PhD,[10] Marianne Pugatch, MSW,[11,12,13,14] and Adam J. Gordon, MD, MPH[1,2,3]

ABSTRACT. Appropriate use of language in the field of addiction is important. Inappropriate use of language can negatively impact the way society perceives substance use and the people who are affected by it. Language frames what the public thinks about substance use and recovery, and it can also affect how individuals think about themselves and their own ability to change. But most importantly, language intentionally and unintentionally propagates stigma: the mark of dishonor, disgrace, and difference that depersonalizes people, depriving them of individual or personal qualities and personal identity. Stigma is harmful, distressing, and marginalizing to the individuals, groups, and populations who bear it. For these reasons, the Editorial Team of *Substance Abuse* seeks to formally operationalize respect for personhood in our mission, our public relations, and our instructions to authors. We ask authors, reviewers, and readers to carefully and intentionally consider the language used to describe alcohol and other drug use and disorders, the individuals affected by these conditions, and their related behaviors, comorbidities, treatment, and recovery in our publication. Specifically, we make an appeal for the use of language that (1) respects the worth and dignity of all persons ("people-first language"); (2) focuses on the medical nature of substance use disorders and treatment; (3) promotes the recovery process; and (4) avoids perpetuating negative stereotypes and biases through the use of slang and idioms. In this paper, we provide a brief overview of each of the above principles, along with examples, as well as some of the nuances and tensions that inherently arise as we give greater attention to the issue of how we talk and write about substance use and addiction.

Keywords: Criminal justice, language, mental disorders, publishing, social stigma, substance-related disorders

Language to Counter Stigma and Discrimination:

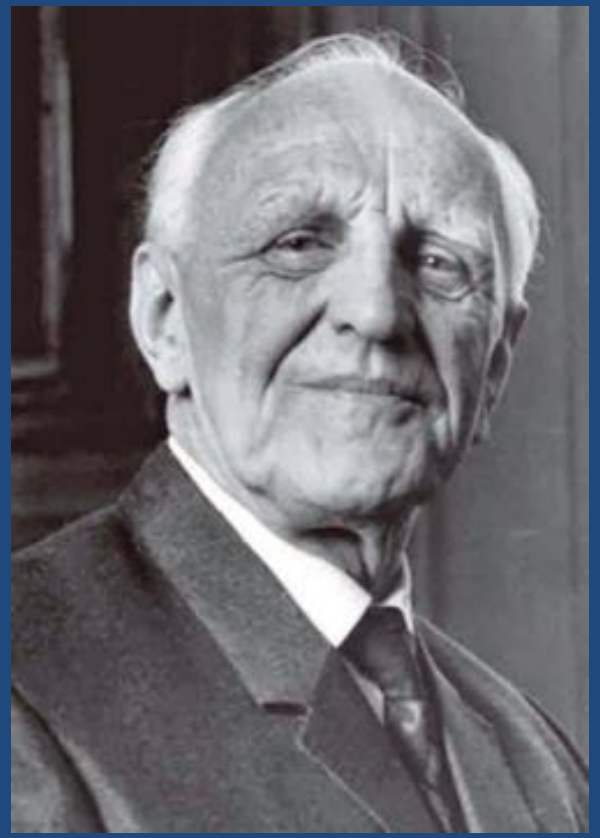
Pay attention to how we speak and write

Language that:

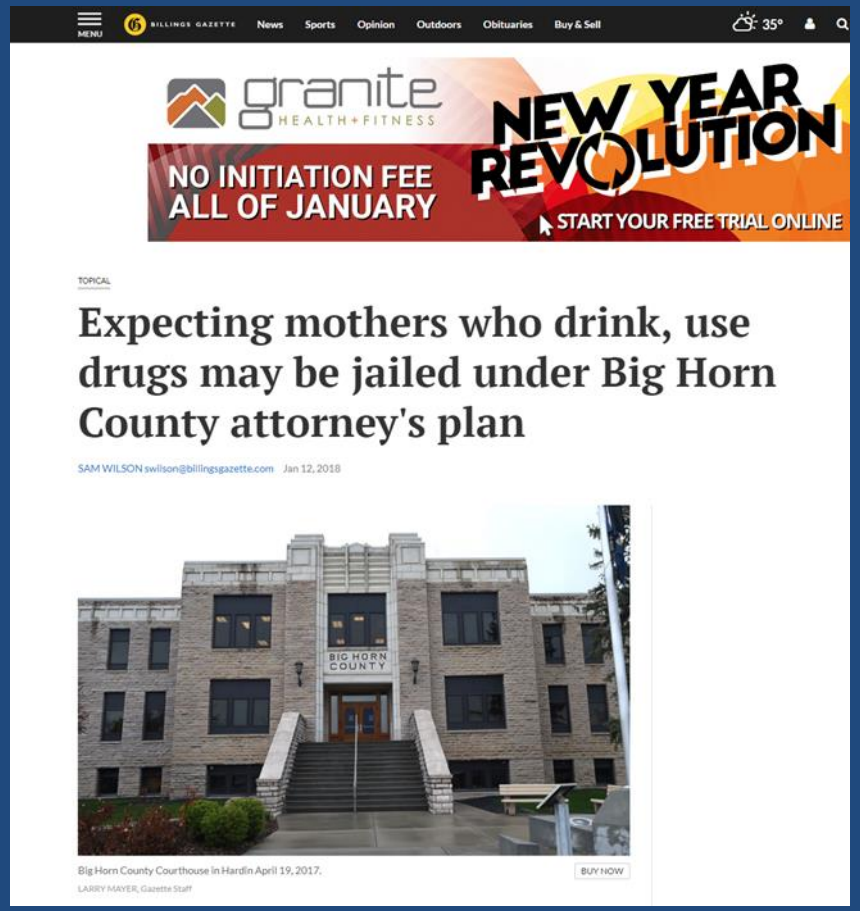
1. Respects the worth and dignity of all persons – "People-first language"
2. Focuses on the medical nature of SUD and treatment
3. Promotes the recovery process
4. Avoids perpetuating negative stereotypes and biases through use of slang and idioms

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 Dyad it is a Disaster



- The Big Horn County Attorney's Office is announcing an immediate crackdown policy of civilly prosecuting any expecting mothers found to be using dangerous drugs or alcohol.
- The state will seek an order of protection restraining a pregnant female from any non-medically prescribed use of drug or alcohol, and the state can seek incarceration to detain her.
- Harris says "It is simply not satisfactory to our community that the protection of innocent, unborn children victimized in this manner and subject to a potential lifetime of disability and hardship relies exclusively on social workers removing the child from the custody of the mother at birth. This approach is not timely and has not proven a sufficient deterrent."

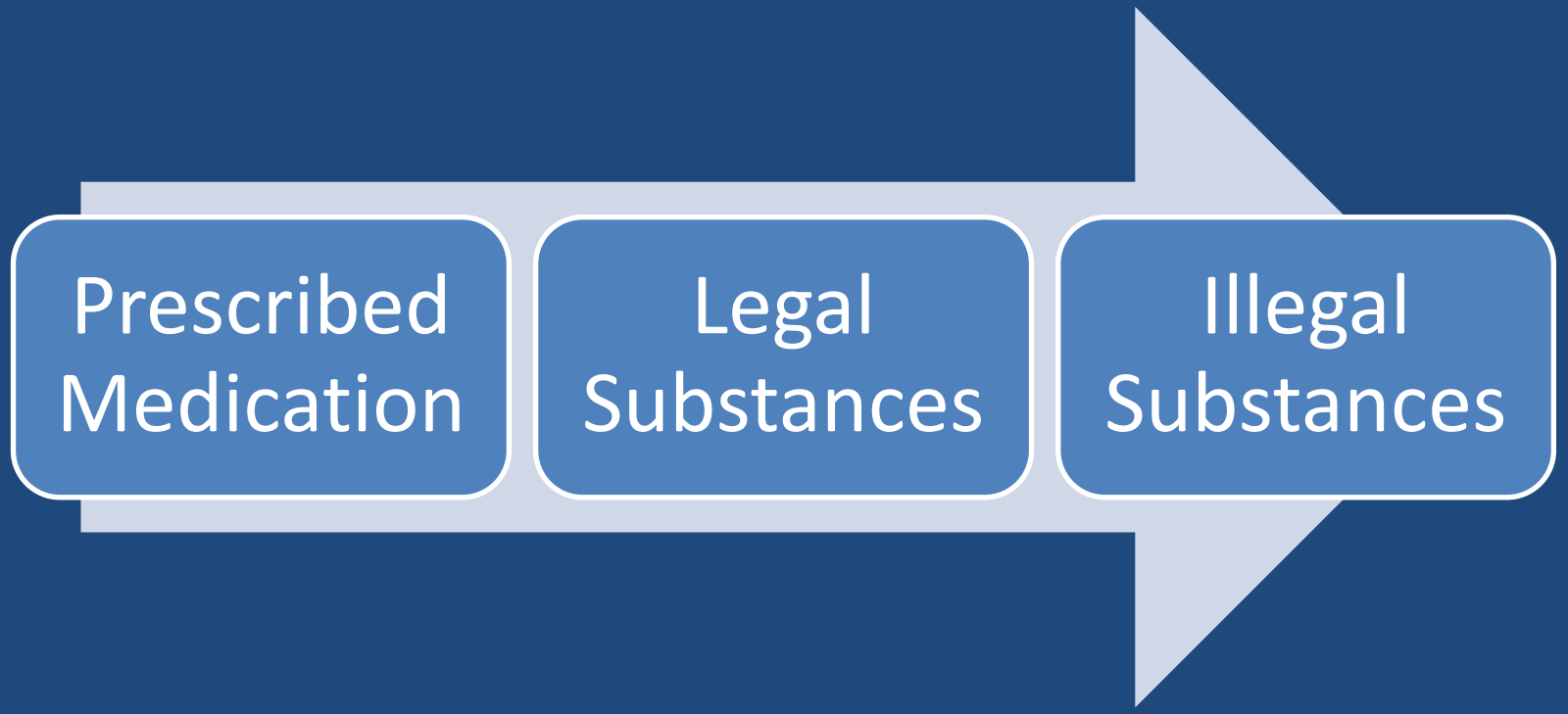
Do Less Harm:
3. Focus on Medicine/Public Health as Practice

Evidence-Based

AND

People-Centered

Evidence-Based Care:
Data that Reflects Science not Stigma



HARM

Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbetrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)

Substance and Development: Evidence of Nurture

ARTICLE

Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing

Hallam Hurt, MD; Elsa Malmud, PhD; Laura Betancourt; Leonard E. Braitman, PhD; Nancy L. Brodsky, PhD; Joan Giannetta

ORIGINAL ARTICLE

Inner-city Achievers

Who Are They?

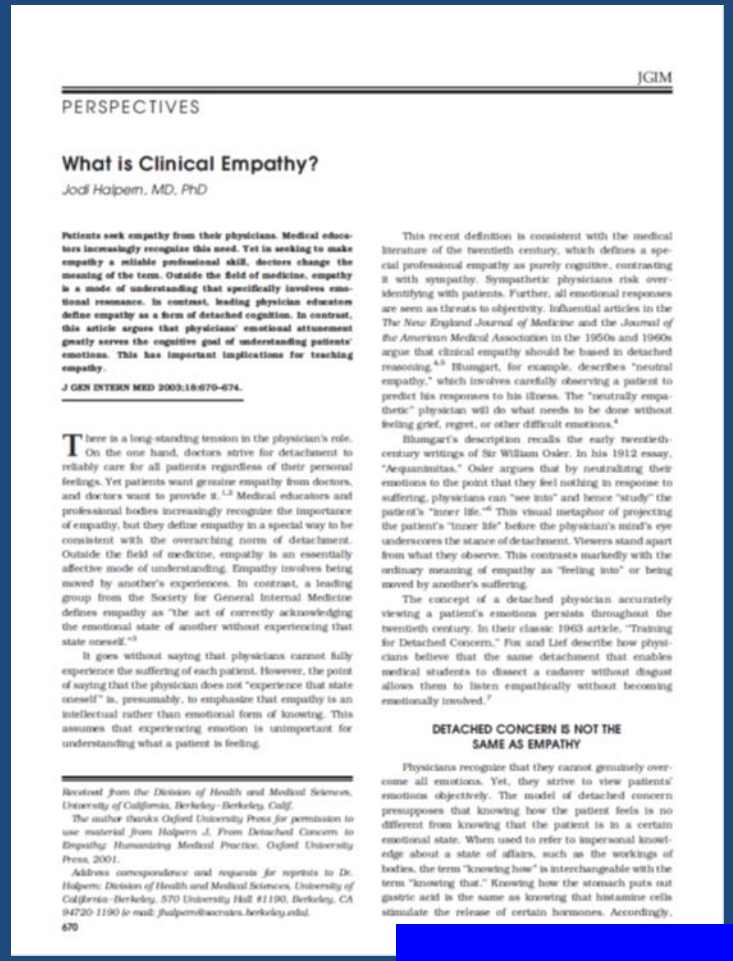
Hallam Hurt, MD; Elsa Malmud, PhD; Leonard E. Braitman, PhD; Laura M. Betancourt, BA; Nancy L. Brodsky, PhD; Joan M. Giannetta, BA

Table 5. Home Observation for Measurement of the Environment*

Measurement	IQ≥90 (n=24)	IQ<90 (n=104)	*P* Value
Learning Stimulation	9 (5-11)	7 (1-11)	<.001
Language Stimulation	7 (6-7)	7 (4-7)	.03
Physical Environment	6 (5-7)	6 (0-7)	.25
Warmth and Affection	6 (2-7)	5 (0-7)	.01
Academic Stimulation	5 (4-5)	5 (1-5)	.006
Modeling	4 (2-5)	4 (0-5)	.05
Variety in Experience	8 (6-9)	7 (4-9)	<.001
Acceptance	4 (3-4)	4 (0-4)	.06
Total	48.5 (40-53)	43 (20-53)	<.001

** Values are expressed as median (range). See Caldwell and Bradley for more information on HOME.*[10]

People-Centered Care: Empathy



JGIM

PERSPECTIVES

What is Clinical Empathy?

Jodi Halpern, MD, PhD

Patients seek empathy from their physicians. Medical educators increasingly recognize this need. Yet in seeking to make empathy a reliable professional skill, doctors change the meaning of the term. Outside the field of medicine, empathy is a mode of understanding that specifically involves emotional resonance. In contrast, leading physician educators define empathy as a form of detached cognition. In contrast, this article argues that physicians' emotional attunement greatly serves the cognitive goal of understanding patients' emotions. This has important implications for teaching empathy.

J GEN INTERN MED 2003;18:670–674.

There is a long-standing tension in the physician's role. On the one hand, doctors strive for detachment to reliably care for all patients regardless of their personal feelings. Yet patients want genuine empathy from doctors, and doctors want to provide it.[1,2] Medical educators and professional bodies increasingly recognize the importance of empathy, but they define empathy in a special way to be consistent with the overarching norm of detachment. Outside the field of medicine, empathy is an essentially affective mode of understanding. Empathy involves being moved by another's experiences. In contrast, a leading group from the Society for General Internal Medicine defines empathy as "the act of correctly acknowledging the emotional state of another without experiencing that state oneself."[3]

It goes without saying that physicians cannot fully experience the suffering of each patient. However, the point of saying that the physician does not "experience that state oneself" is, presumably, to emphasize that empathy is an intellectual rather than emotional form of knowing. This assumes that experiencing emotion is unimportant for understanding what a patient is feeling.

Received from the Division of Health and Medical Sciences, University of California, Berkeley-Berkeley, Calif.

The author thanks Oxford University Press for permission to use material from Halpern J. From Detached Concern to Empathy: Humanizing Medical Practice. Oxford University Press, 2001.

Address correspondence and requests for reprints to Dr. Halpern: Division of Health and Medical Sciences, University of California–Berkeley, 570 University Hall #1190, Berkeley, CA 94720-1190 (e-mail: jhalpern@socrates.berkeley.edu).

This recent definition is consistent with the medical literature of the twentieth century, which defines a special professional empathy as purely cognitive, contrasting it with sympathy. Sympathetic physicians risk over-identifying with patients. Further, all emotional responses are seen as threats to objectivity. Influential articles in the *The New England Journal of Medicine* and the *Journal of the American Medical Association* in the 1950s and 1960s argue that clinical empathy should be based in detached reasoning.[4,5] Blumgart, for example, describes "neutral empathy," which involves carefully observing a patient to predict his responses to his illness. The "neutrally empathetic" physician will do what needs to be done without feeling grief, regret, or other difficult emotions.[4]

Blumgart's description recalls the early twentieth-century writings of Sir William Osler. In his 1912 essay, "Aequanimitas," Osler argues that by neutralizing their emotions to the point that they feel nothing in response to suffering, physicians can "see into" and hence "study" the patient's "inner life."[6] This visual metaphor of projecting the patient's "inner life" before the physician's mind's eye underscores the stance of detachment. Viewers stand apart from what they observe. This contrasts markedly with the ordinary meaning of empathy as "feeling into" or being moved by another's suffering.

The concept of a detached physician accurately viewing a patient's emotions persists throughout the twentieth century. In their classic 1963 article, "Training for Detached Concern," Fox and Lief describe how physicians believe that the same detachment that enables medical students to dissect a cadaver without disgust allows them to listen empathically without becoming emotionally involved.[7]

DETACHED CONCERN IS NOT THE SAME AS EMPATHY

Physicians recognize that they cannot genuinely overcome all emotions. Yet, they strive to view patients' emotions objectively. The model of detached concern presupposes that knowing how the patient feels is no different from knowing that the patient is in a certain emotional state. When used to refer to impersonal knowledge about a state of affairs, such as the workings of bodies, the term "knowing how" is interchangeable with the term "knowing that." Knowing how the stomach puts out gastric acid is the same as knowing that histamine cells stimulate the release of certain hormones. Accordingly,

- Empathy involves associative reasoning: appreciate the personal meanings of patients' words
- Emotions help guide and hold attention on what is humanly significant: nonverbal attunement
- Empathy facilitates trust and disclosure and can be directly therapeutic: empathy directly enhances therapeutic efficacy
- Empathy makes being a physician more meaningful and satisfying

Language of Empathy vs Shame

People-Centered Care:
Practice Empathy

- Use people’s names
- Smile
- Listen
- Don't interrupt people
- Tune in to non-verbal communication (the "93% rule“)
- Be fully present when you are with people
- Take a personal interest in people

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 raise children in safe environments
  - 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

CLINICIAN CONSULTATION CENTER
National rapid response for HIV management and bloodborne pathogen exposures.

Substance Use Warmline
Peer-to-Peer Consultation and Decision Support
10 am – 6 pm EST Monday - Friday
855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

mterplan@friendsresearch.org