JOIN US WEDNESDAY FEBRUARY 5TH
AT 12:00 EST FOR A FREE WEBINAR

EQUITY, AUTONOMY AND SUBSTANCE USE DISORDER:

LIFECOURSE CONSIDERATIONS FOR PREGNANT AND PARENTING PEOPLE

Featuring
Mishka Terplan MD, MPH
and Dr. Kimá Joy Taylor MD, MPH
Moderated by Lois McCloskey MPH, DrPH

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH
BU Boston University School of Public Health
HRSA Maternal & Child Health

You have now entered the webinar.

Please hold and we will begin the presentation momentarily.

Thank you!

Centers of Excellence in Maternal and Child Health

BU Boston University School of Public Health

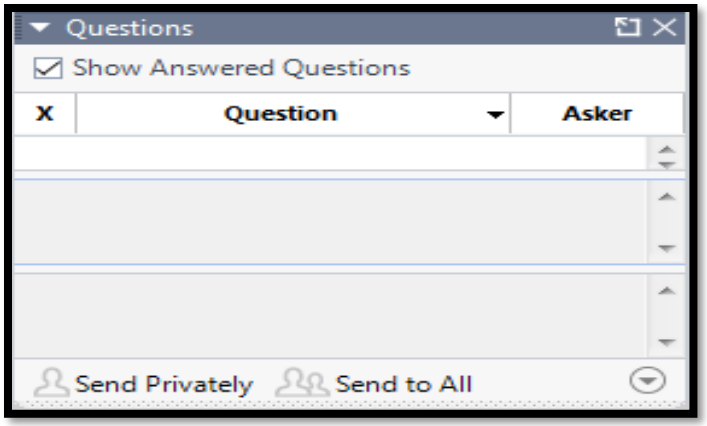
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

Funding provided by:

HRSA Maternal & Child Health

Welcome: webinar housekeeping

- Use computer or dial-in information for your audio
- Please submit all questions in “questions” webinar tool tray



Questions option

Agenda

1. Welcome
2. Introductions
3. Presentations
4. Q & A

Lois McCloskey, DrPH

Today's presenters

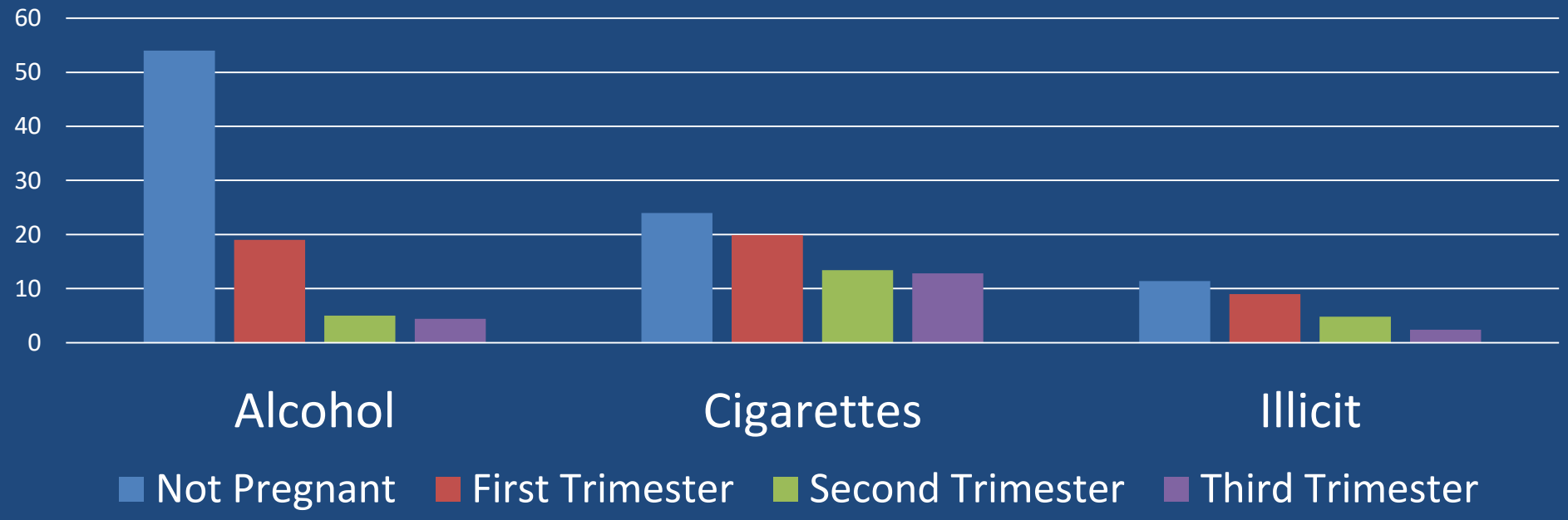
Mishka Terplan, MD MPH

Kimá Joy Taylor, MD MPH

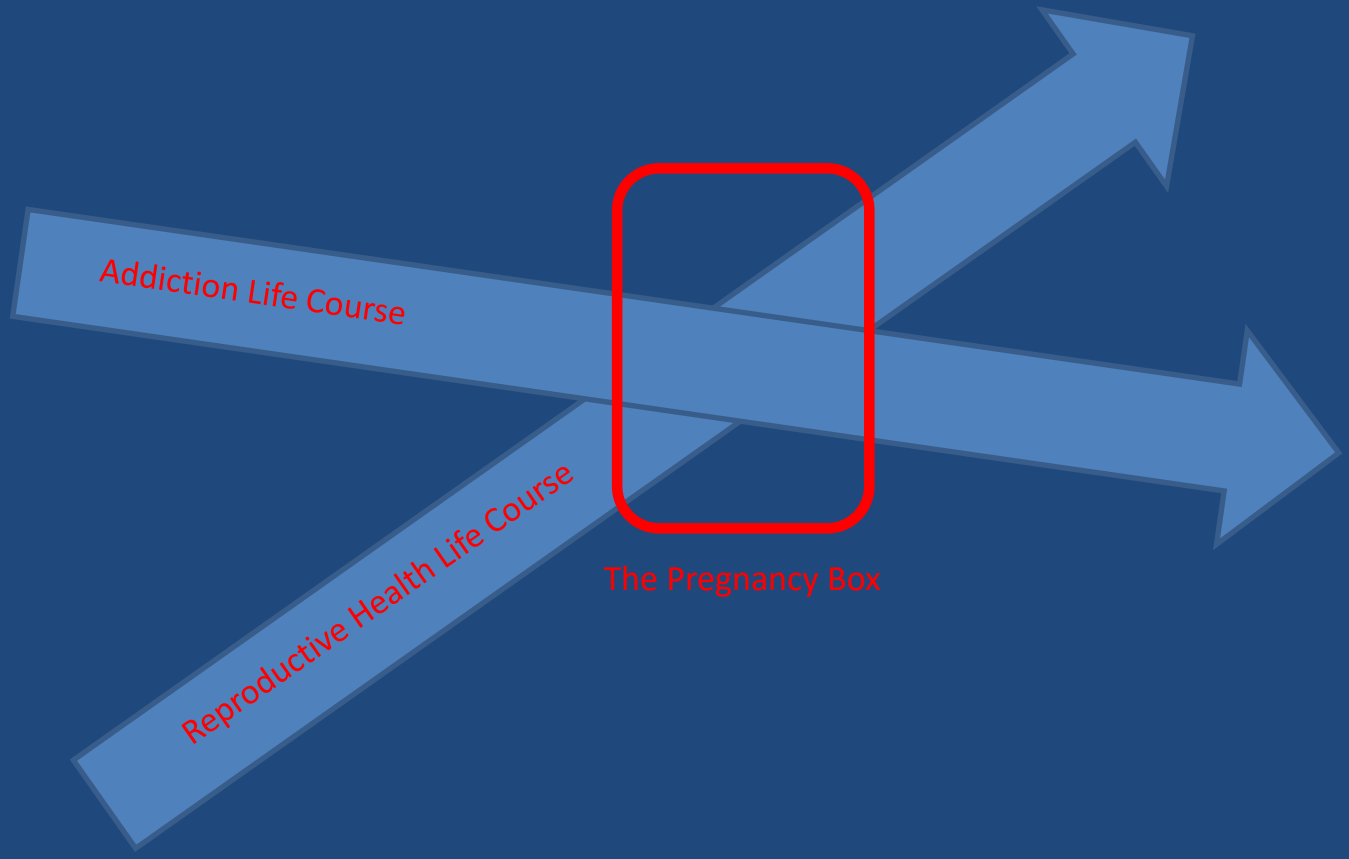
Equity, Autonomy and Substance Use Disorder: Lifecourse Considerations for Pregnant and Parenting People

Mishka Terplan MD MPH FACOG DFASAM
Senior Physician Research Scientist, Friends Research Institute
Adjunct Faculty, UCSF, Clinical Consultation Center
Addiction Medicine Consultant, Virginia Medicaid

What happens when people who use drugs get pregnant?



National Survey Drug Use and Health 2013/2014 Past Month Use Data


Addiction Life Course
Reproductive Health Life Course
The Pregnancy Box

ASAM American Society *of* Addiction Medicine

Definition of Addiction

Definition:

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.

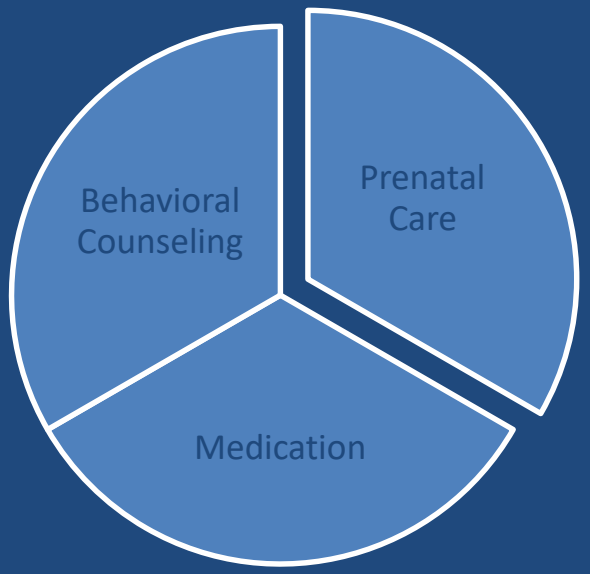
Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

DSM5 OUD criteria

Opioids are often taken in larger amounts or over a longer period of time than intended.
There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
Craving, or a strong desire to use opioids.
Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
Important social, occupational or recreational activities are given up or reduced because of opioid use.
Recurrent opioid use in situations in which it is physically hazardous
Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

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%**

Treated vs Un-Treated Addiction

Optimizing Maternal Health = Core Principle of Prenatal Care

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

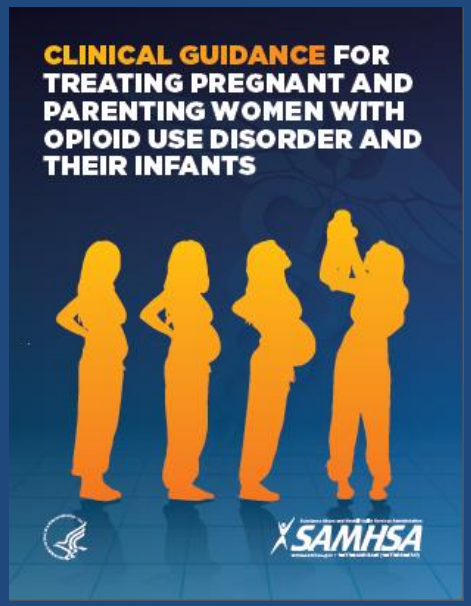
The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

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]

	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 Guidance

- 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



https://store.samhsa.gov/system/files/sma18-5054.pdf

Medications for opioid use disorder in pregnancy

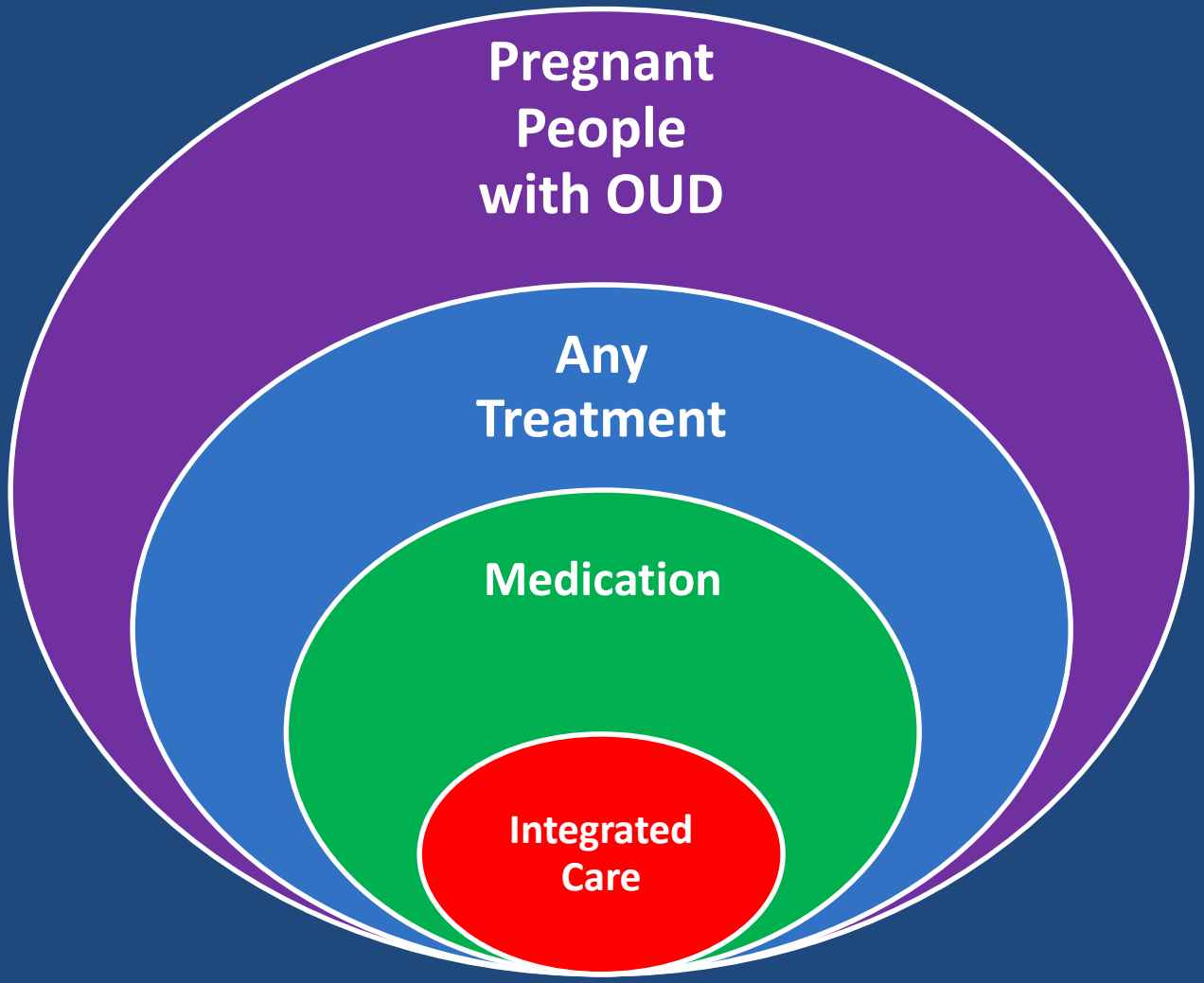
Maternal

- Reduction in overdose and overdose death
- 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

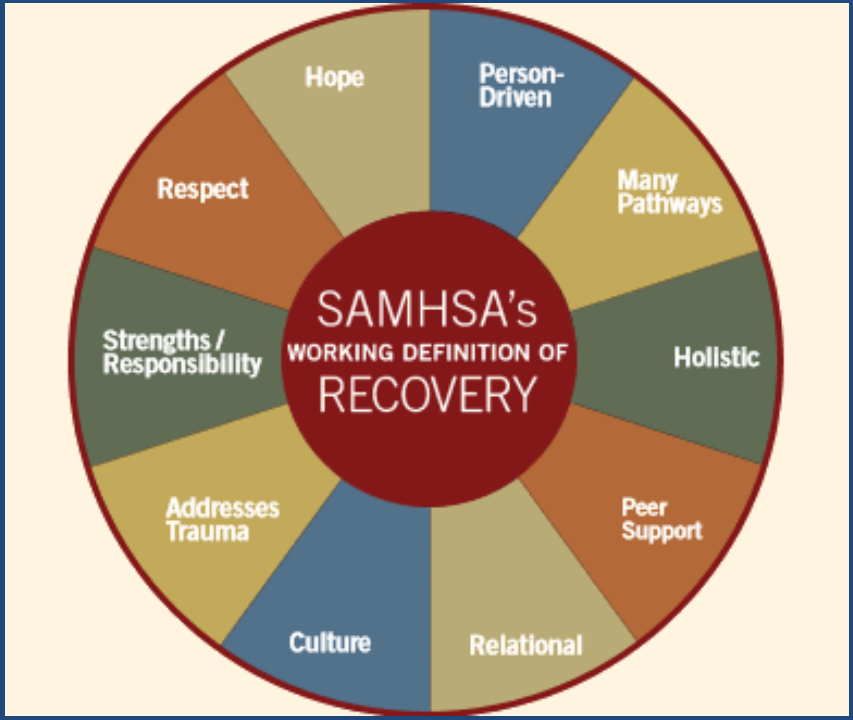
- Reduces fluctuations in maternal opioid levels; reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

Medications, much less comprehensive care, much less culturally appropriate care are rare and unavailable for most pregnant people with OUD

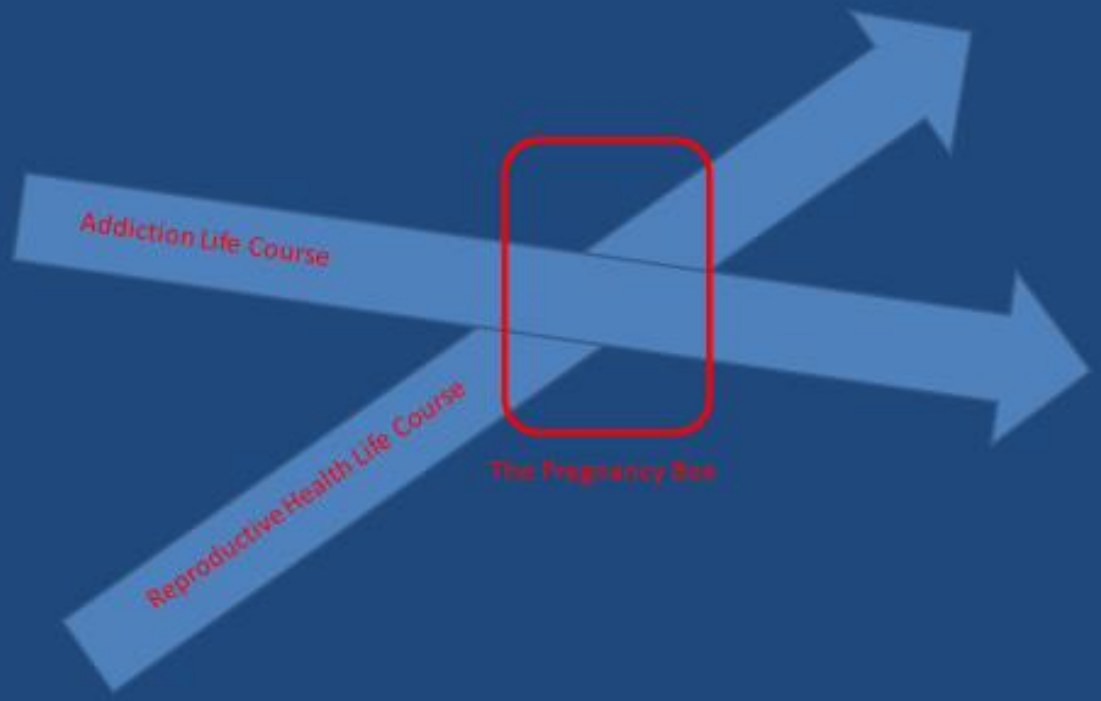


Recovery is the Goal of Treatment

- 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



Pregnancy, Treatment and Recovery: Part of the Life Course



Drug and Alcohol Dependence 149 (2015) 225–231

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

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

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

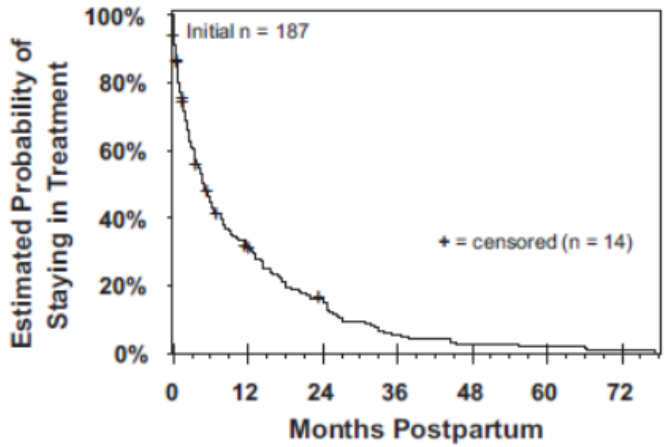


Fig. 1. Kaplan–Meier estimates for remaining in methadone treatment after pregnancy.

Table 1
Studies reporting treatment retention results for MAT in pregnant women.

	Location	Sample size	Mean age	Racial composition	Mean EGA (wks) at study entry[a]	MAT medication and dosage information	Discontinuation rates and other treatment attendance results
Randomized controlled trials							
Tuten et al. (2012)	Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD	n = 133	30.0	71.4% African American, 26.3% Caucasian, 2.3% Biracial	16.1	Methadone, mean dose at delivery = 81.3 mg	Overall: 23% (discontinuation prior to delivery)
Jones et al. (2010)	4 US cities, 2 US rural sites, and Vienna, Austria	n = 175 (methadone = 89, buprenorphine = 86)	28.9	83% Caucasian, 14% African American, 3% Other	18.7	Methadone (51%), mean dose at delivery = 82.9 mg Buprenorphine (49%), mean dose at delivery = 17.2 mg	Overall: 25% (discontinuation prior to delivery) Methadone group: 18% (n = 16) Buprenorphine group: 33% (n = 28)
Jones et al. (2005)	Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD	n = 30 (methadone = 15, buprenorphine = 15)	30	75% African American, 20% Caucasian, 5% Other	23.2	Methadone (50%), mean dose at delivery = 79.1 mg Buprenorphine (50%), mean dose at delivery = 18.7 mg	Overall: 33% (discontinuation prior to delivery) Methadone group: 27% (n = 4) Buprenorphine group 40% (n = 6)
Jones et al. (2001)		n = 85 (intervention = 47 : control = 38)	28	76% African American	23.4	Methadone, mean dose = 42 mg	Overall: 6% (discontinuation within 14 days) Intervention group: 6.4% (n = 3) Control group: 5.3% (n = 2) Among individuals who did not drop out, the intervention group attended a mean of 12.1 days versus the control group which attended a mean of 10.6 days ($p < 0.05$)
Silverman et al. (2001)		n = 40 (intervention = 20, control = 20)	31.8	83% African American, 17% Caucasian	NR	Methadone, mean dose = 55.5 mg	Overall: 53% (discontinuation within 6 months) Intervention group: 45% Control group: 60% Mean treatment duration was 18.6 wks for intervention group and 15.1 wks for control group ($p = 0.17$)
Svikis et al. (1997)[b]		n = 66 randomized among 4 treatment groups[c]	28.3	80.3% African American	22.5	Methadone, dosing NR	MAT participants: 13.6% (discontinuation within 30 days)
Cohort studies							
Peles and Adelson (2006)	Tel Aviv, Israel	n = 45 pregnant women (out of total n = 470 for entire cohort)	31.5	78.3% Israeli, 21.7% Immigrant	NR	Methadone, mean dose at end of study period = 141.1	Pregnant women: 22.2% (discontinuation within 1 year; this was not significantly different from the dropout rate of non-pregnant women or of men)
McCarthy et al. (2005)	Sacramento, CA	n = 94	32	64% Caucasian, 25% Hispanic, 6% African American, 4% Asian, 1% Other	NR	Methadone, mean dose at delivery = 101 mg	Overall 4% (discontinuation prior to delivery) 2% had unavailable outcome information
Laken et al. (1997)[b]	Eleonore Hutzel Recovery Program, Detroit, MI	n = 40	29.7	88% African American	26.2	Methadone, dosing NR	24.4% attended 4–7 treatment visits; 23.2% attended 8–14, 25.6% attended 15–26, and 26.8% attended 27–96.
Laken and Ager (1996)[b]		n = 55	29.6	88% African American	26.1	Methadone, dosing NR	44.0% of participants attended no treatment visits; 18.8% attended 1–5 treatment visits; 17.8% attended 6–12 visits, and 20.4% attended 13–62 visits
DePetrillo and Rice (1995)	Location not identified	n = 45	29.3	78% Caucasian, 22% Latin or African American	10.6	Methadone, mean dose at delivery = 52 mg	Overall 0% (discontinuation prior to delivery)
Chappel and Senay (1973)	Special Treatment Unit, Illinois Drug Abuse Program, Chicago, IL	n = 11	NR	NR	NR	Methadone, dosing NR	Overall: 63.6% (discontinuation within 2 years)
Case control studies							
Crandall et al. (2004)	Hennepin Faculty Associates Addiction Medicine Program, Minneapolis, MN	n = 102 (pregnant cases = 51, non-pregnant controls = 51)	29.9	51% Caucasian, 45% African American, 4% Other	NR	Methadone, dosing NR	Pregnant women: 25.5% (discontinuation within 9 months) Average length of participation was 7.7 months out of a maximum of 9 months which was not significantly different from the control group of non-pregnant women
Observational studies							
Fitzsimons et al. (2007)	Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD	n = 106	30.6	78% African American, 22% Caucasian	14.7	Methadone, mean dose at treatment day 30 = 64 mg	Average number of days that counseling sessions were attended was 57 for individuals with co-occurring anxiety disorder versus 45 for individuals with either a co-occurring mood disorder or no co-occurring disorder, out of a maximum of 84 days ($p < 0.01$)
Fischer et al. (1998)	University of Vienna Drug Addiction Outpatient Clinic, Vienna, Austria	n = 98	NR	NR	20.1	Methadone (52%), mean dose at delivery = 45 mg Slow release methadone (35%), mean dose at delivery = 250.4 mg Buprenorphine (12%), mean dose at delivery = 6.6 mg	Overall: 0% (discontinuation prior to termination of pregnancy or delivery)

Is Addiction a Recurring / Remitting Illness?

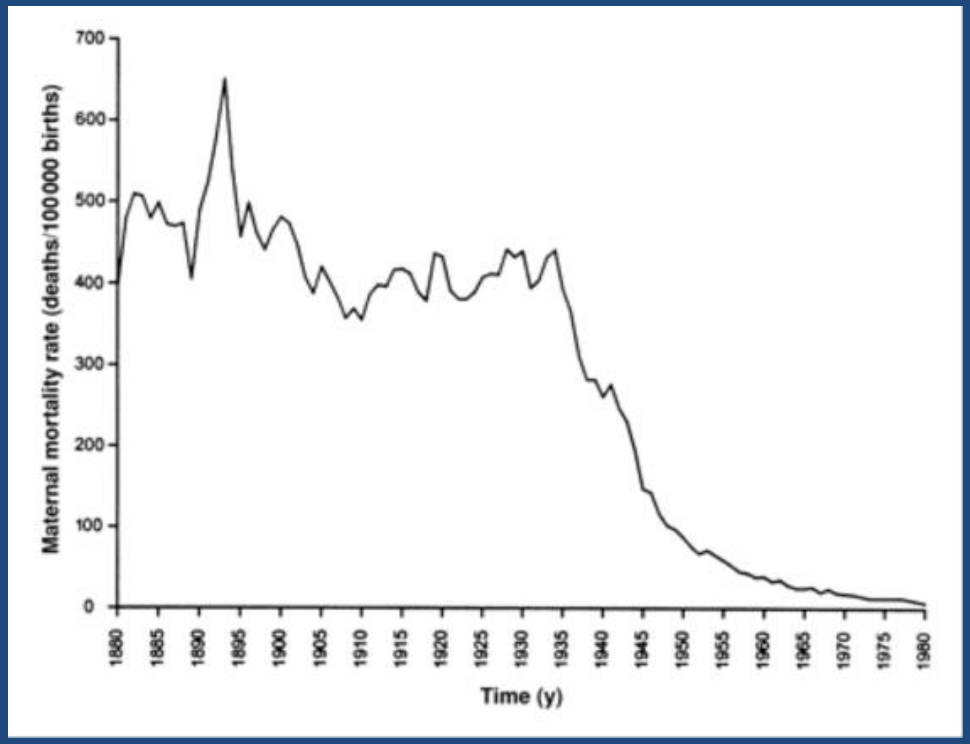
Or

Is Addiction Recurring / Remitting because we only provide Episodic Care for a Chronic Condition?

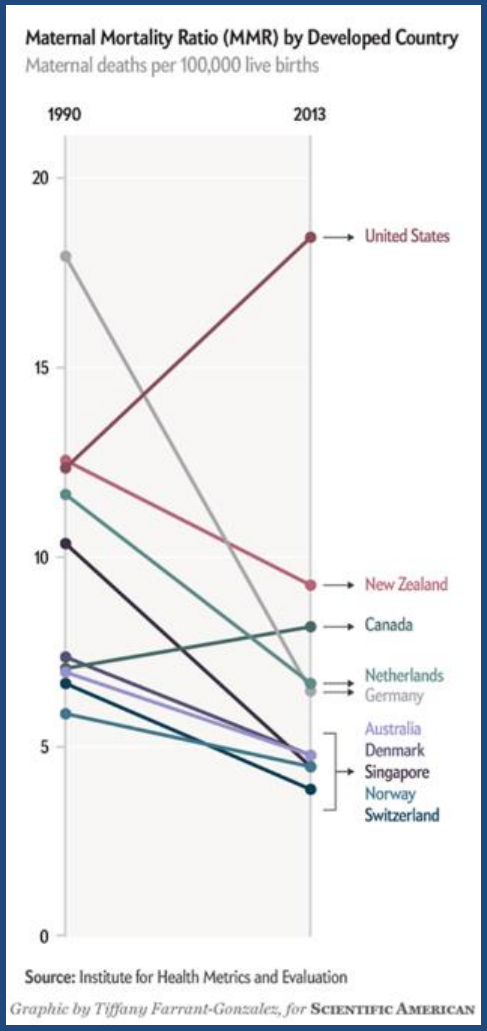
The 4th Trimester - Postpartum

- Critical Period
  - Newborn care, breastfeeding, maternal/infant bonding
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn
  - 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, if any

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	Delivery Hospitalizations without Opioid Abuse or Dependence	Multivariable Odds Ratio* (95% CI)
	n (%)	n (%)	
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

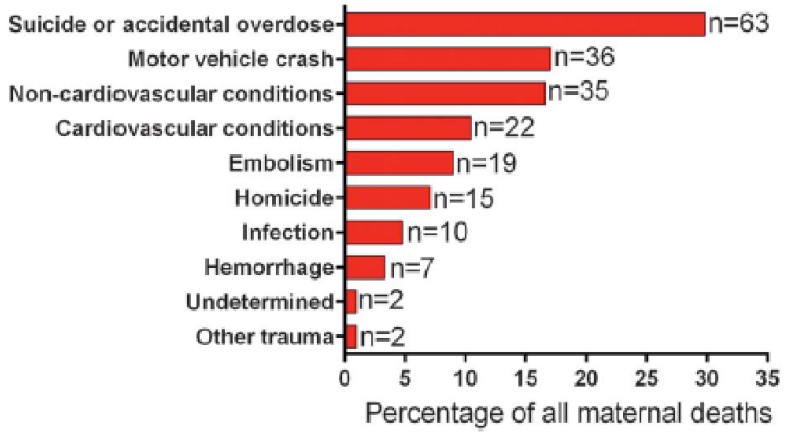


Fig. 1. Maternal deaths in Colorado from 2004 to 2012 (N=211) classified by cause. The x-axis delineates the percentage of maternal deaths in each category stated on the y-axis with the frequency in each category provided at the end of each bar. Classifications are mutually exclusive.

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

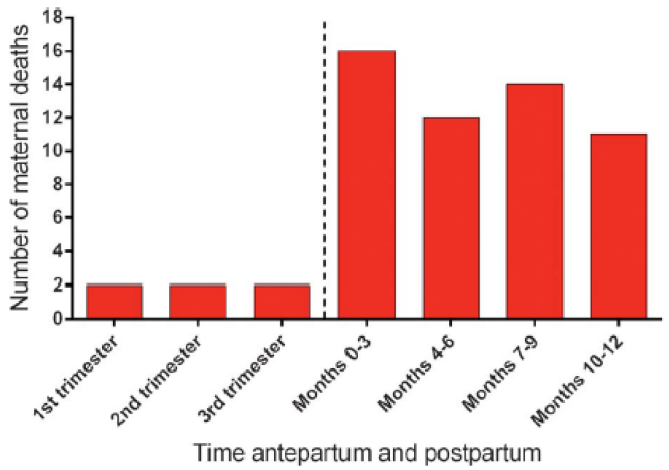


Fig. 3. Temporal distribution of maternal deaths from self-harm by trimester of pregnancy and number of months postpartum. Relatively few cases occurred during the pregnancy.

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

Original Research

OBSTETRICS & GYNECOLOGY

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

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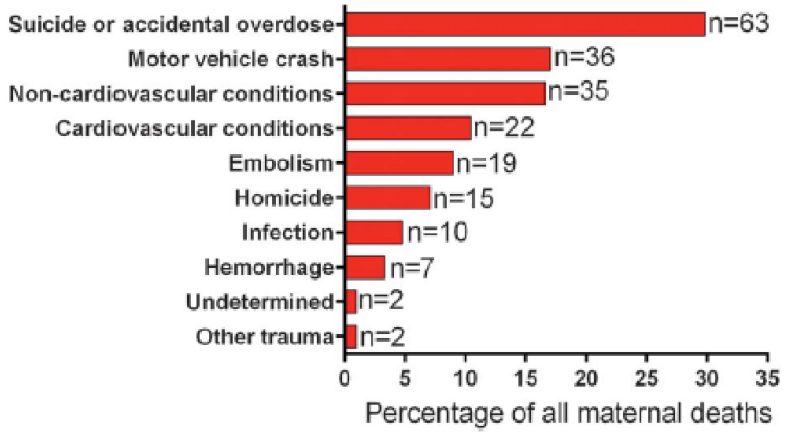

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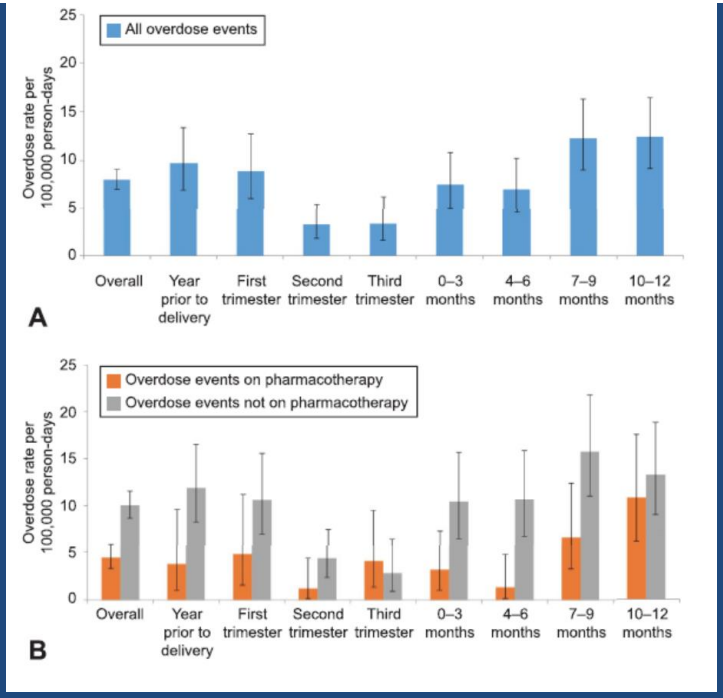
Metz. Maternal Deaths From Self-Harm in Colorado. Obstet Gynecol 2016.

Opioids: *Original Research*

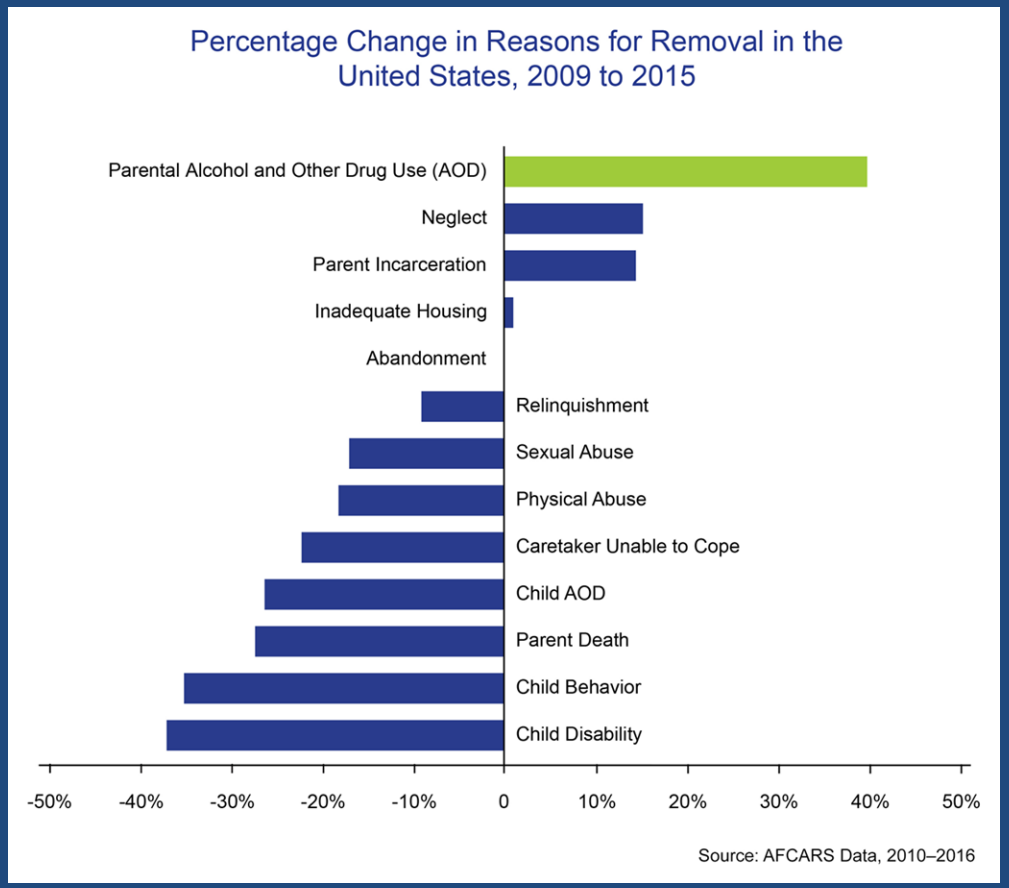
OBSTETRICS & GYNECOLOGY

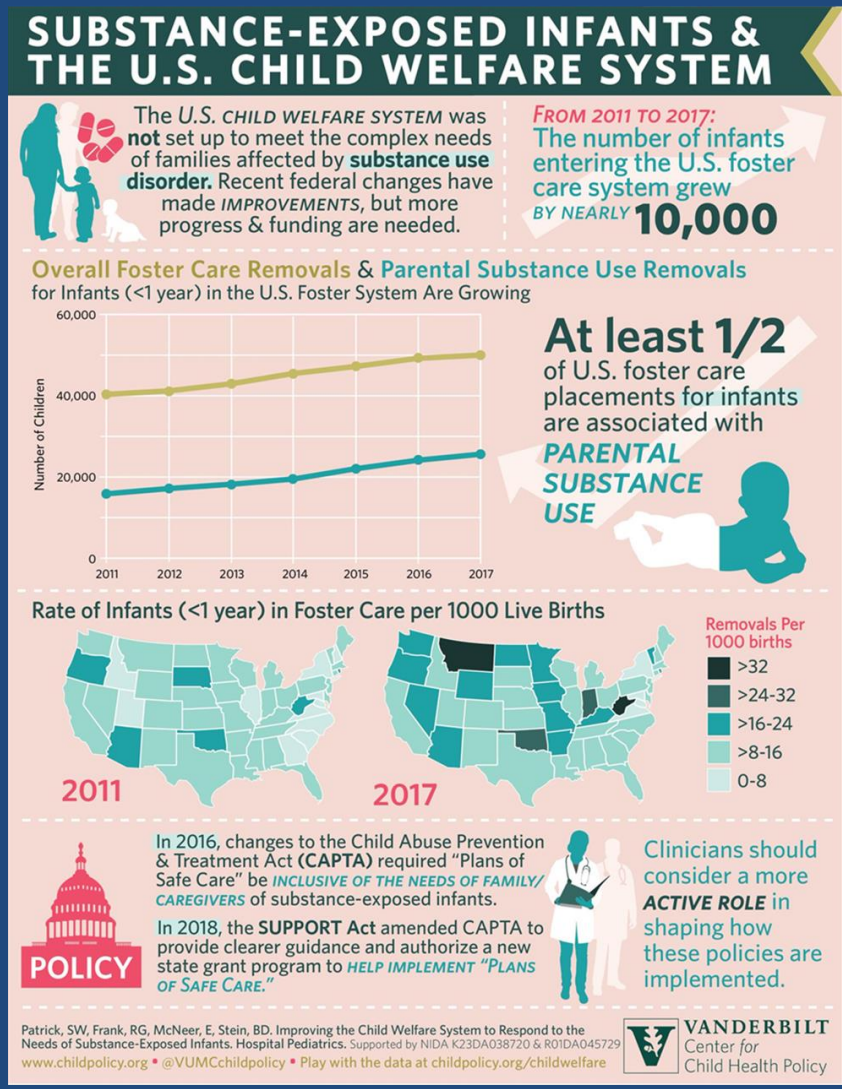
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

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



The Opioid Crisis and Child Welfare





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

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ALCOHOLISM: CLINICAL AND EXPERIMENTAL RESEARCH

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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

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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 wh
were in effect during gestation: Mandatory Warning Signs (MWS), Pric
Women, Priority Treatment for Pregnant Women/Women with Children,
Data and Treatment Purposes, Prohibitions Against Criminal Prosecution
ing Requirements for Child Protective Services Purposes, and Child Ab
were low birthweight (<2,500 g), premature birth (<37 weeks), any prenat
PCU, inadequate PCU, and normal (≥7) APGAR score. Multivariable fi
controlling for both maternal- and state-level covariates were used for stat

Results: Of the 8 policies, 6 were significantly related to worse outcom
related to any outcomes. The policy requiring MWS was related to the m
ing in a state with MWS was related to 7% higher odds of low birthweigh
of premature birth ($p < 0.004$); 18% lower odds of any PCU ($p < 0.001$);
($p < 0.002$); and 10% lower odds of a normal APGAR score ($p < 0.001$)
without MWS.

Conclusions: Most policies targeting alcohol use during pregnancy do
and are related to worse birth outcomes and less PCU.

Key Words: Alcohol, Pregnancy, Policy, Birth Outcomes, Vital Statist

Punitive State Policies:

Evidence-Base = Worse Public Health Outcomes

Table 2. State-Level Policies Regressed on Birth Outcomes from 1972 to 2013 Vital Statistics Birth Certificate Data (N = 148,048,208 Singleton Births)

	Odds of LBW		Odds of premature		Odds of any PCU		Odds of late PCU		Odds of inadequate PCU		Odds of 7+ APGAR	
State-level covariates	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Mandatory Warning Signs (MWS)	**1.07**	**1.03, 1.10**	**1.05**	**1.01, 1.08**	**0.82**	**0.74, 0.91**	**1.12**	**1.04, 1.19**	1.00	0.81, 1.23	**0.90**	**0.86, 0.94**
Child Abuse/Child Neglect (CACN)	**1.06**	**1.02, 1.10**	**1.09**	**1.04, 1.14**	**0.87**	**0.76, 1.00**	0.96	0.91, 1.02	0.85	0.64, 1.14	**0.90**	**0.83, 0.97**
Civil Commitment (CC)	1.02	0.91, 1.15	1.00	0.88, 1.13	0.90	0.56, 1.45	**1.12**	**1.00, 1.25**	1.04	0.65, 1.67	1.09	0.90, 1.33
Prohibitions Against Criminal Prosecution (PCP)	**1.08**	**1.01, 1.15**	**1.11**	**1.04, 1.17**	0.91	0.77, 1.09	0.96	0.88, 1.06	0.89	0.75, 1.06	0.95	0.85, 1.07
Reporting requirements for CPS (RRCPS)	1.00	0.95, 1.04	0.96	0.91, 1.02	0.95	0.69, 1.32	1.04	0.94, 1.15	1.24	0.91, 1.69	1.05	0.94, 1.17
Reporting Requirements for Data and Treatment Purposes (RRDATA)	1.04	1.00, 1.08	**1.06**	**1.01, 1.10**	0.97	0.74, 1.27	1.00	0.91, 1.10	0.86	0.68, 1.09	0.94	0.87, 1.01
Priority Treatment for Pregnant Women (PTPREG)	**1.09**	**1.05, 1.13**	**1.07**	**1.02, 1.11**	0.91	0.75, 1.09	1.13	1.00, 1.27	**0.66**	**0.48, 0.91**	0.92	0.79, 1.07
Priority Treatment for Pregnant Women/Women with Children (PTPREGWC)	1.03	0.98, 1.08	1.05	1.00, 1.10	1.02	0.83, 1.24	0.93	0.84, 1.04	1.01	0.91, 1.12	0.94	0.84, 1.05
Wine retail control	**0.87**	**0.83, 0.91**	**0.87**	**0.80, 0.99**	**1.66**	**1.22, 2.26**	0.98	0.91, 1.08	0.90	0.71, 1.14	1.06	0.98, 1.14
Spirits retail control	0.91	0.82, 1.01	0.94	0.84, 1.01	0.90	0.75, 1.08	1.02	0.93, 1.12	0.95	0.74, 1.22	1.10	0.96, 1.25
Per capita alcohol consumption[a]	**1.02**	**1.00, 1.05**	**1.03**	**1.01, 1.06**	1.04	0.97, 1.13	0.98	0.94, 1.01	0.96	0.83, 1.10	0.97	0.93, 1.00
% Poverty	1.01	1.00, 1.02	1.01	1.00, 1.02	1.03	1.00, 1.05	1.00	0.98, 1.02	0.97	0.91, 1.03	0.97	0.96, 0.99
% Unemployment	1.00	1.00, 1.00	1.00	1.00, 1.01	1.00	1.00, 1.00	1.00	1.00, 1.00	1.00	1.00, 1.00	1.00	0.99, 1.01
Per capita cigarette consumption[b]	0.99	0.99, 0.99	0.99	0.99, 0.99	1.01	1.00, 1.02	1.00	1.00, 1.00	1.00	0.99, 1.00	1.01	1.01, 1.02

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THE WAR ON DRUGS AND THE WAR ON ABORTION: SOME INITIAL THOUGHTS ON THE CONNECTIONS, INTERSECTIONS AND THE EFFECTS

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While many people view the war on abortion and the war on drugs as distinct, there are in fact many connections and overlaps between the two. Their history, the strategies used to control and punish some reproductive choices and those to control the use of certain drugs, the limitations that exist to access to reproductive health care and drug treatment, and the populations most harmed by those limitations are remarkably similar. These similarities are particularly apparent where the issues coalesce in the regulation and punishment of pregnant, drug-using women.[1]

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

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

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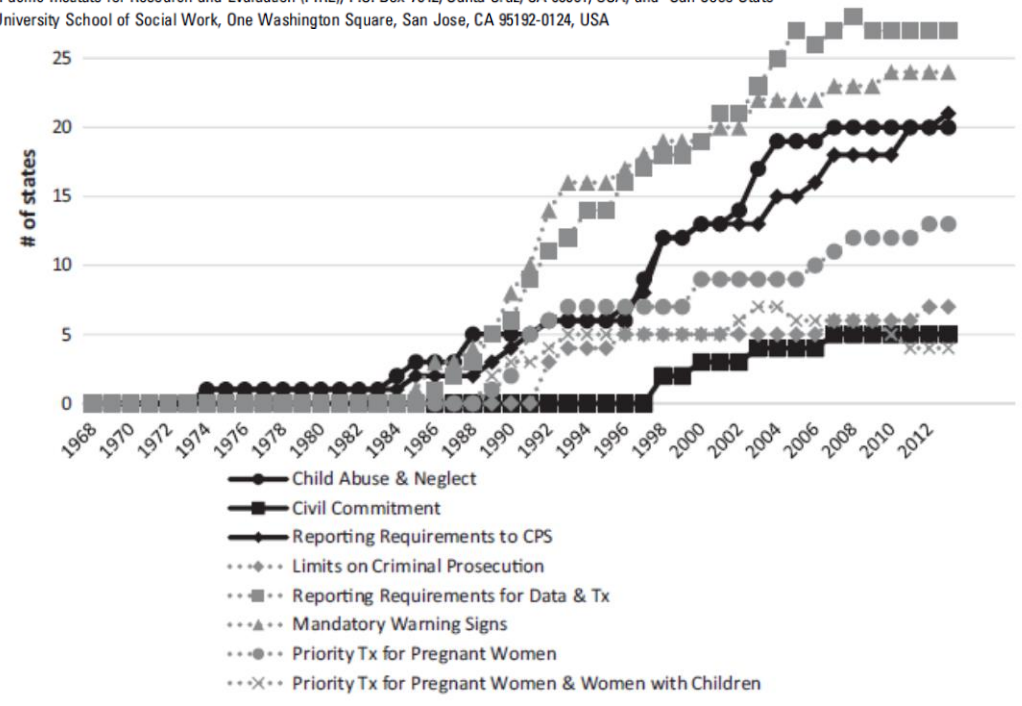

Do Less Harm

Evidence-Based

AND

Person-Centered

Do Less Harm

- Evidence-Based: Grounded in Science
  - Focus on the Life Course
  - 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
  - Support autonomy and maternal subjectivity in decision making surrounding pregnancy
  - Remain attuned to the unique demands we place on pregnant and parenting people and their bodies

Thank You

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Equity, Autonomy and Substance Use Disorder: Lifecourse Considerations for Pregnant and Parenting People

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Urban Institute, Non-Resident Fellow
Mom, Pediatrician

Autonomy

- **Women Who Report Having No Personal Doctor/Health Care Provider by Race/Ethnicity | The Henry J. Kaiser Family Foundation; 2016-2018** https://www.kff.org/disparities-policy/state-indicator/no-personal-doctor/
- **All women-18%**
  - **Non-Hispanic White-14%**
  - **Non-Hispanic Black-18%**
  - **Hispanic-33%**
  - **Asian and Native Hawaiian and Pacific Islander-21%**
  - **American Indian and Alaska Native-26%**
  - **Other -20%**

Equity

https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Racial-and-Ethnic-Disparities-in-Obstetrics-and-Gynecology?IsMobileSet=false

Table 1. Select Examples of Disparities in Obstetric and Gynecologic Health and Health Care

Disparities in Health Outcomes	AI/AN	Asian	Black	Hispanic	White
Infertility in last 12 months (% of women)[a]	N/A	10	12	9	7
Unintended pregnancy (% of pregnancies)[b]	N/A	N/A	69	56	42
Preterm birth (% of live births)[c]	13	10	17	12	10
Fetal death (/1,000 live births + fetal deaths)[d]	N/A	N/A	11	5	5
Maternal death (/100,000 live births)[e,f]	N/A	8	26	5	7
Gonorrhea (/100,000 population)[g]	96	18	570	N/A	24
Cervical cancer (/100,000 population)[h]	7	7	10	11	7
Breast cancer deaths (/100,000 population)[i]	15	11	31	15	22
Diabetes-related deaths (/100,000 population)[j]	22	11	33	13	24
Disparities in Health Care Access and Services					
Birth control provided in past year (% of women aged 15–44 years)[k]	N/A	N/A	29	29	37
Pap testing within 3 years (% of women aged 21–65 years)[l]	79	75	85	79	83
Mammography within 2 years (% of women aged 50–74 years)[l]	69	64	73	70	73
Ever received infertility treatment (% of women)[a]	N/A	N/A	11	12	16
Prenatal care in first trimester (% of births)[c]	69	84	75	76	89
Cesarean delivery (% of births)[c]	29	34	36	32	32

Baseline

- We are on shaky grounds in terms of autonomy and equity for women without substance use
- If you add care for pregnant and parenting women with substance use you must also address underlying systemic flaws

Nation and Health System's Relationship to Caring for People Who Use Drugs

- Justice and other Punitive Responses
- War on Drugs
- Ehrlichman was quoted as saying: "We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did.""

  » https://www.history.com/topics/the-war-on-drugs

What should happen when a pregnant woman uses drugs?

- Easy access to high quality, culturally effective, evidence informed substance use services including harm reduction, treatment including medications if available, recovery and other social services and supports as needed and use the results as a means to improve mothers/families outcomes
- Easy access to high quality, culturally effective evidence informed OB and other physical and mental health services as needed
- Screening for and referral to social services and supports as needed
- Case management to help navigate the needlessly complicated health and social systems and continued outreach even if she does not make it to every appointment
- Assess whether care, services, and outcomes are consistent across different populations or do you need to work with patients to make practice more effective? Or do you need to refer?
- Listen!

What happens when women use drugs?

- Difficulty accessing trauma informed, culturally effective patient centered care
  - https://pubs.niaaa.nih.gov/publications/arh291/55-62.htm

- Study of Pregnant women with OUD and Commercial Insurance
- "Pregnant women with [opioid use disorders] face not only medical consequences, such as an increased risk [for] obstetric morbidity and mortality, but also a predisposition to the potential loss of child custody and even criminalization in some states," they wrote. "Overall, 18 states since 2012 have required health professionals to report substance use disorder in pregnant women and have established civil or criminal laws that consider substance use to be child abuse."
  https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2727267

Why aren't we there yet in pregnancy

- Opioid focus as opposed to other drugs licit and illicit more broadly
- Fear of Child Removal and inability to achieve the hurdles to reunification
  - The complexity of non-consent based universal screening
- Patients know the racial/ethnic and other disparities; they know they are treated differently even if the system pretends this is not so
- Health System rarely thinks about what is best for each individually and the dyad.

Ok, you have had the baby; now what happens?

- Who knows?
- Who cares?
- Who is supposed to care?
- Who has incentive to care?
- How can we get them to care?

History Can be Altered for the Better

- What could the new world look like? One size never fits all
  - Linked Care (OB, SU, MH, other physical health, social services)
    - Care manager across pregnancy, post-partum (though ideally even before pregnancy)
  - Culturally and linguistically appropriate/effective care in all realms
    - Humility, Time and ability to listen, Flexibility to change to fit patient needs-payment that allows this
  - Supportive SUD services for ALL types of substances
    - Non-punitive, community-based prevention, harm reduction, treatment (including medications as clinically appropriate), recovery services that are evidence informed
  - Physical and mental health services that are accessible, affordable and effective
  - Social supports and connections; rethinking what is available and changing to what should be available to improve health and social outcomes which benefit the individual, families and communities.

Is there Hope? Promising Principles

- Take Ideas from other areas
  - Maternal depression, early social and emotional learning work
- Embrace culturally effective, patient centered high quality, evidence informed policies, programming and practices
  - Humility
  - Implicit Bias work
- Seek to increase access to services AND to eliminate disparities at the same time
  - Requires Data and subgroup data
  - Know your service area
  - Ask the people who come to and use your clinic services

Is there Hope? Promising Principles

- Training
  - What is SU; what does care look like? What DOES happen after pregnancy?
  - What are the referral sources available in your community etc.
- Diversify and expand the care team; including but not limited to case management
  - Include people with lived experience, experience of the neighborhood, from different cultures at ALL levels of the team
- Reject the punitive frame at all turns
  - When looking at new policies; think how you can support the family
- There are no perfect parents or parenting situations, we are all winging it

Promising Ideas/Policies/Programs

- Insurance coverage over the entire span; Medicaid included
  - Medicaid for a year post partum with easy access to care
- Payment Reform
  - Payors should Incentivize high quality, equitable outcomes and care that addresses social needs;
  - Providers should be given the time, funding and research partners to innovate
- Two Generation Family Policies

Challenges to new vision

- Focus on opioids on and only certain populations that use opioids
- Law enforcement/justice approach still embedded in all arenas
  - Collateral consequences
- Funding-not just reimbursement, but up front funding needed to change infrastructure and ”business as usual”
- Research-the punitive frame slowed much needed research into honest effects of licit/illicit drugs and slowed research on new treatments, harm reduction and recovery measures

Challenges to new vision

- Data-Random data sharing not the answer
  - Privacy
- Stigma –Society's response to people who use drugs
- Racism-policies, systems, practices and people still embrace past racist infrastructure and beliefs and at times do not seem to realize this
- Politics-US likes to punish; punishment wins more votes than compassion

Audience questions and answers

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