Pregnancy and Substance Use DIsorders

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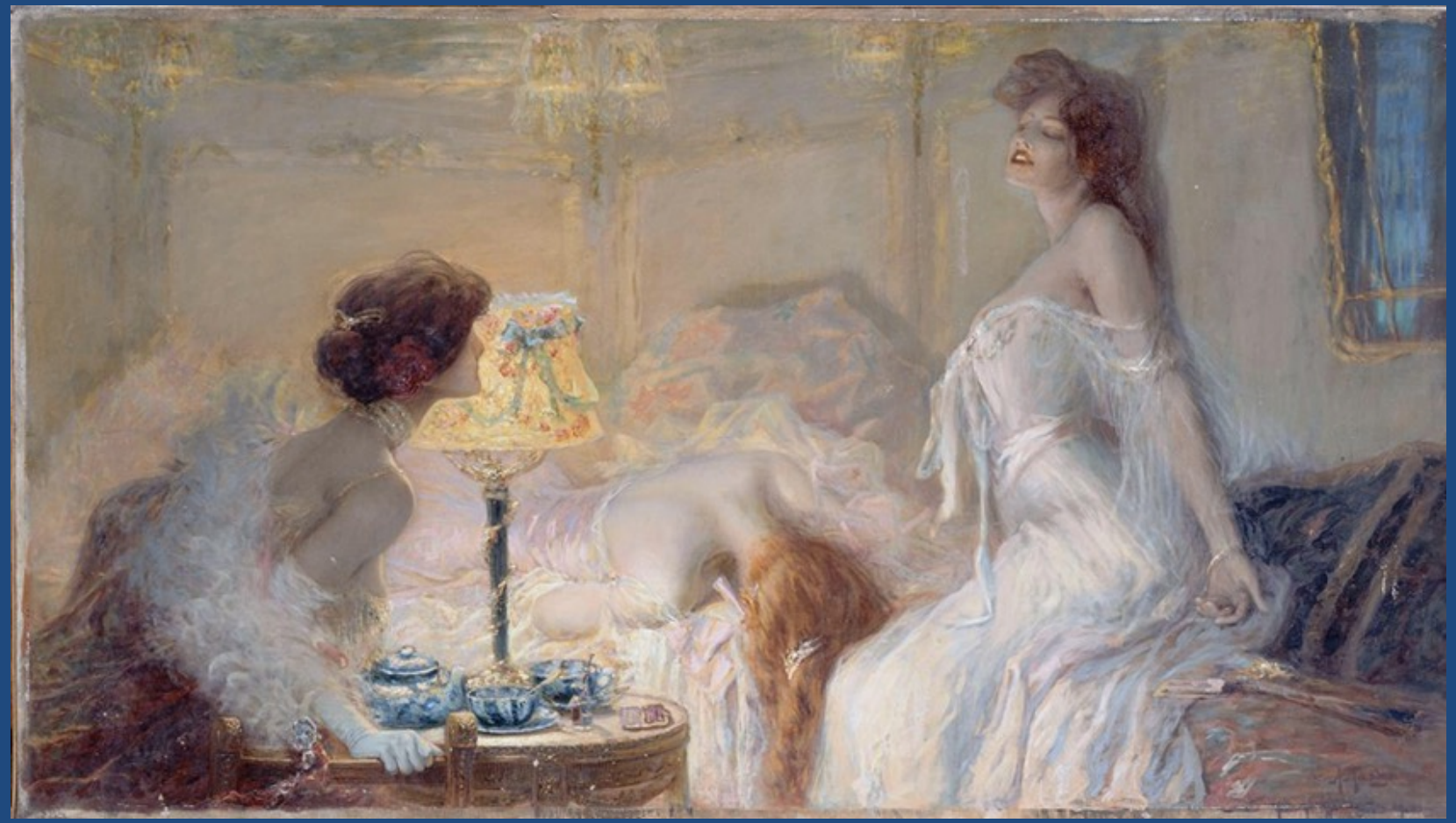
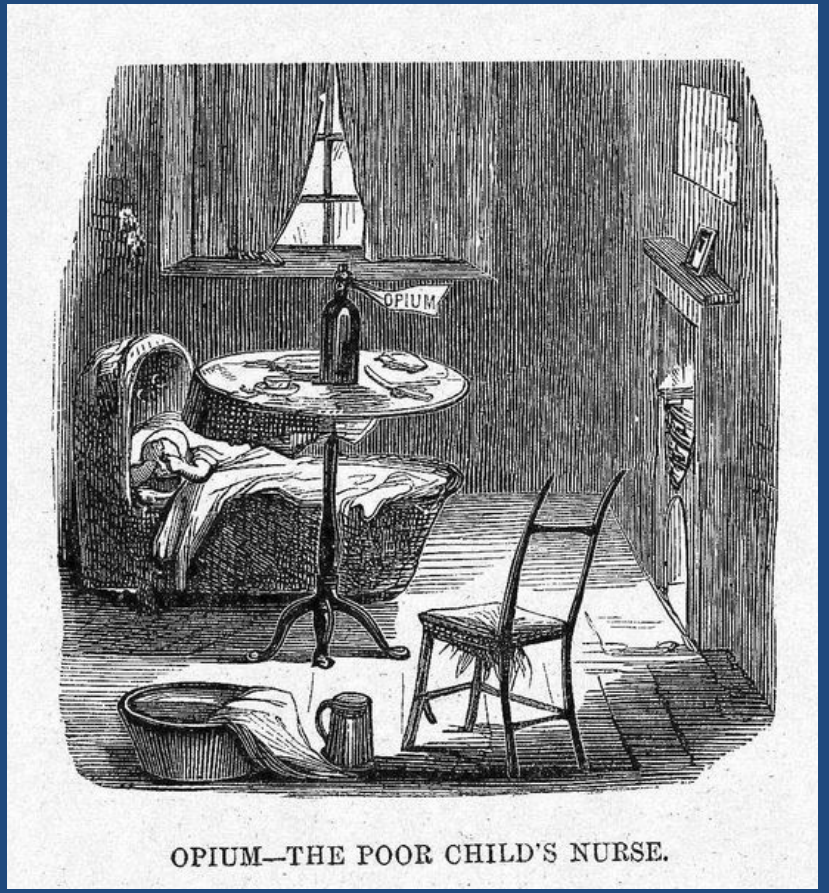
@DoLessHarm

Indian Country ECHO Grand Rounds, June 28 2022

Psychoactive Substance Use is Ancient

Addiction is Modern Phenomena





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.

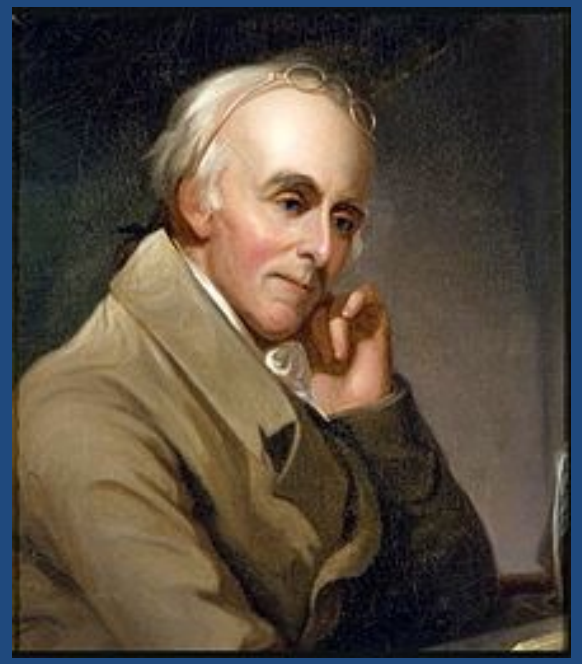
PHILADELPHIA AND LONDON
W. B. SAUNDERS & COMPANY
1902

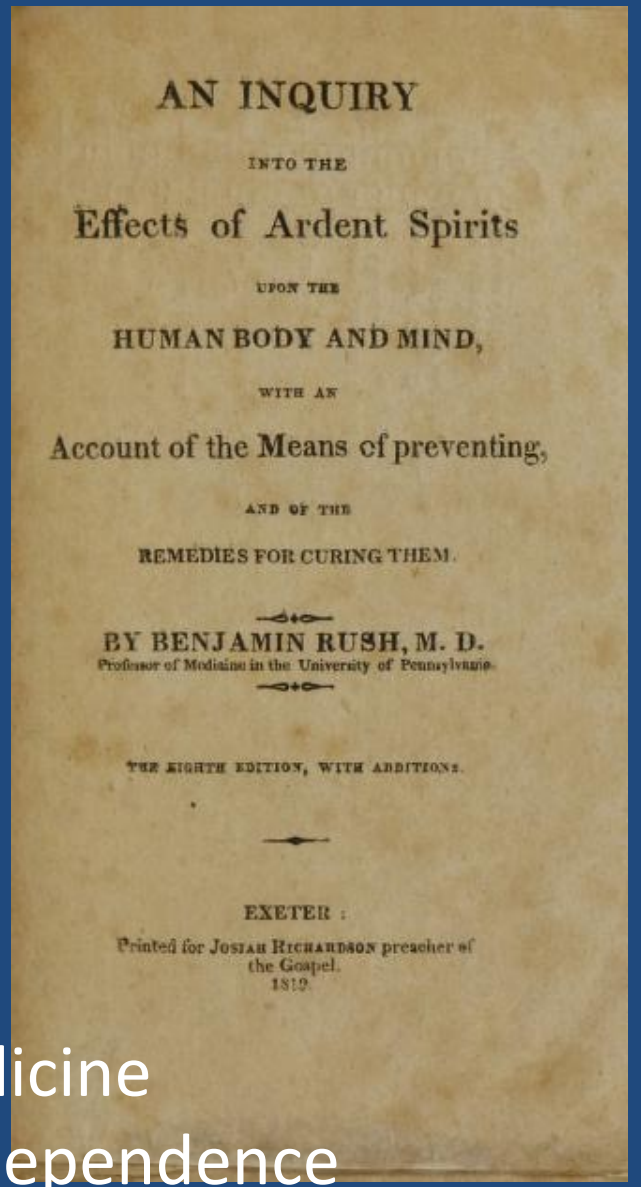
Within a few years many authorities have pointed out the danger of morphinism in women who come under treatment for gynecologic disorders. The impulse to secure relief from pain and to induce sleep is so imperative that morphin is taken without regard to its perils. The patient is both physiologically and psychologically impressed with the intense satisfaction of rapid relief, and ever after this impression becomes dominant in pain and suffering. All control of the will, feelings, and emotions is overcome by it. The desire to escape pain and suffering becomes in many cases a mania.

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

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)




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.

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

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

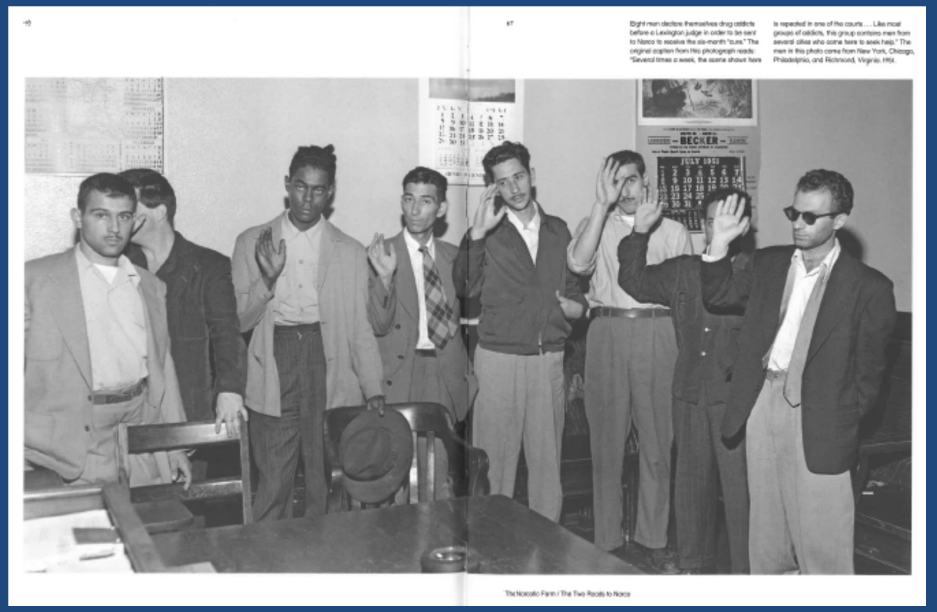
PUBLIC ACTS OF THE SIXTY-THIRD CONGRESS

OF THE

UNITED STATES

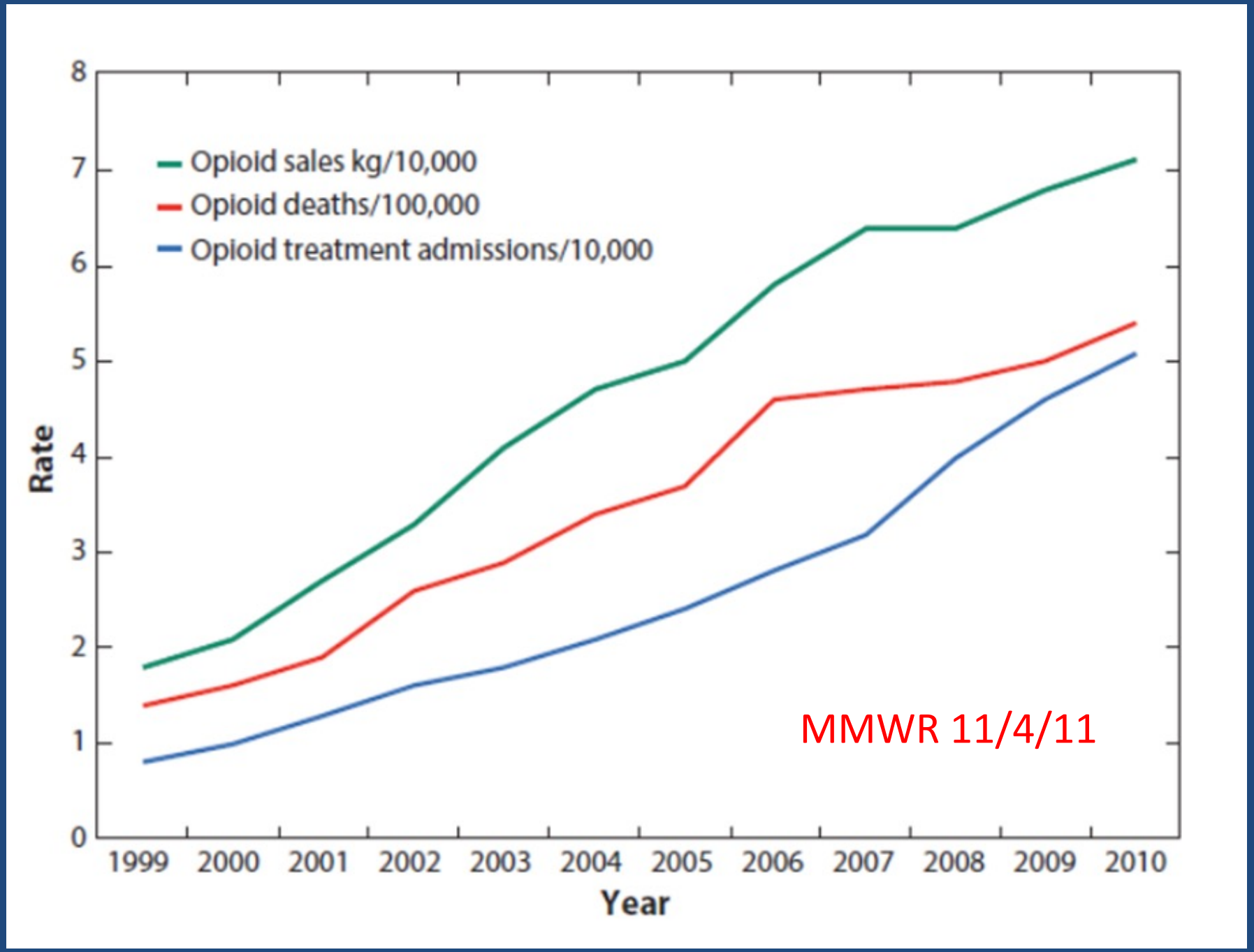
Passed at the third session, which was begun and held at the city of Washington, in the District of Columbia, on Monday, the seventh day of December, 1914, and was adjourned without day on Thursday, the fourth day of March, 1915.

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



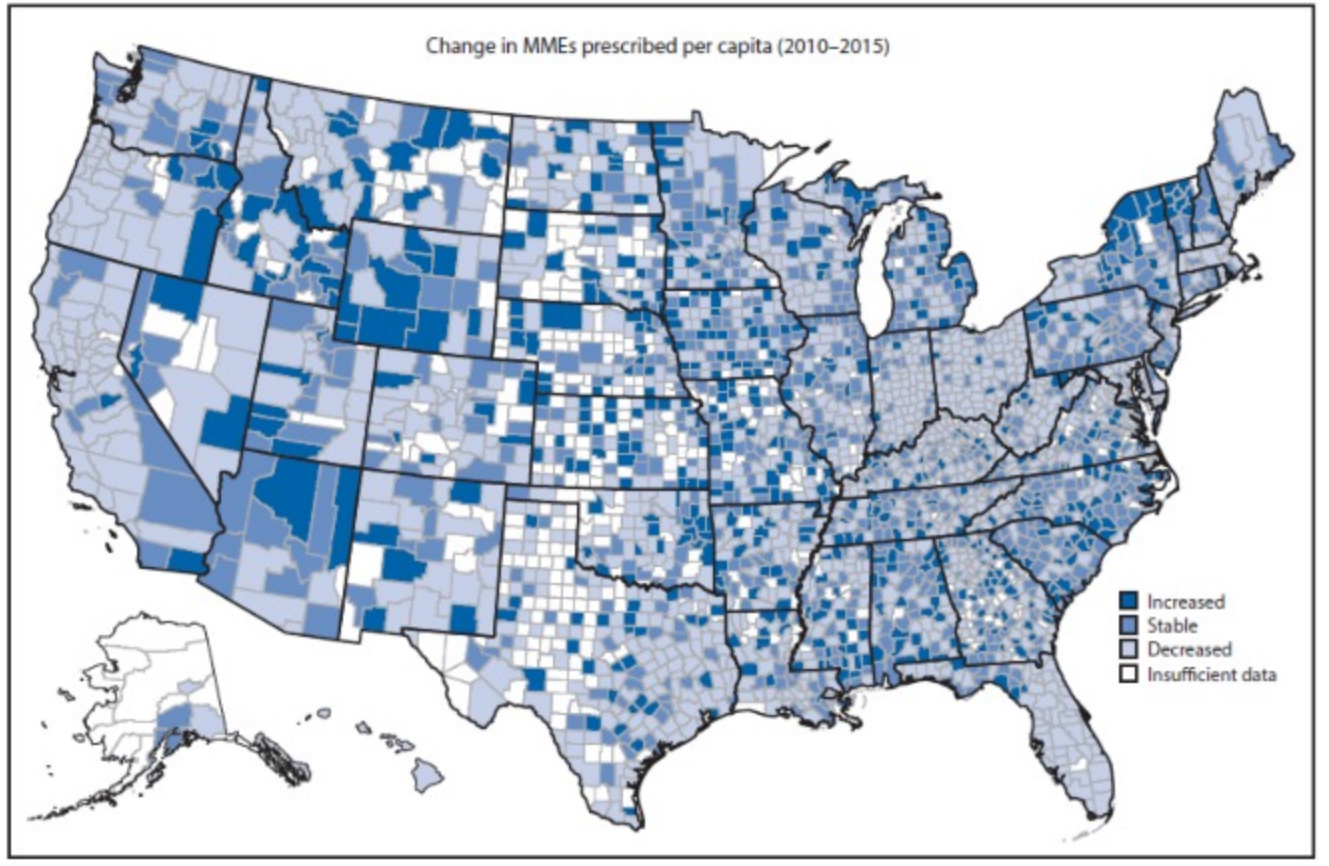
Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015

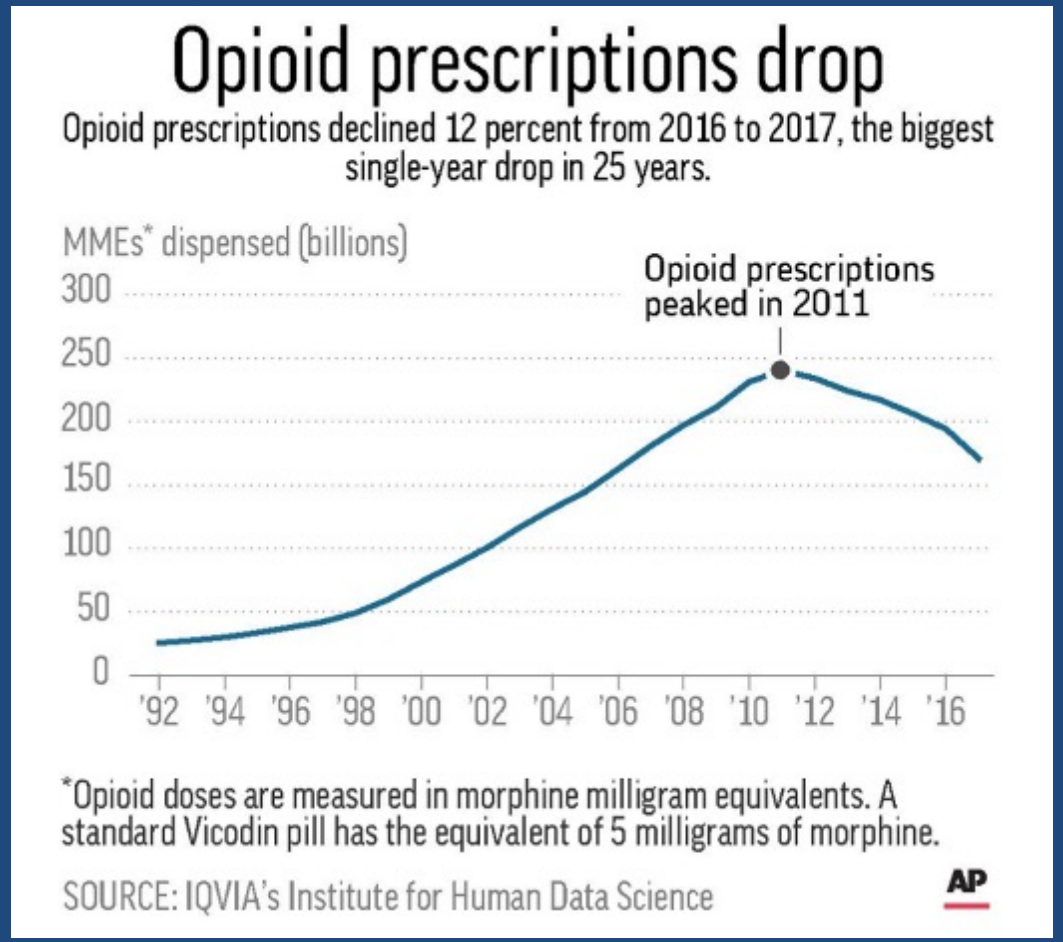
Gery P. Guy Jr., PhD[1]; Kun Zhang, PhD[1]; Michele K. Bohm, MPH[1]; Jan Losby, PhD[1]; Brian Lewis[2]; Randall Young, MA[2]; Louise B. Murphy, PhD[3]; Deborah Dowell, MD[1]

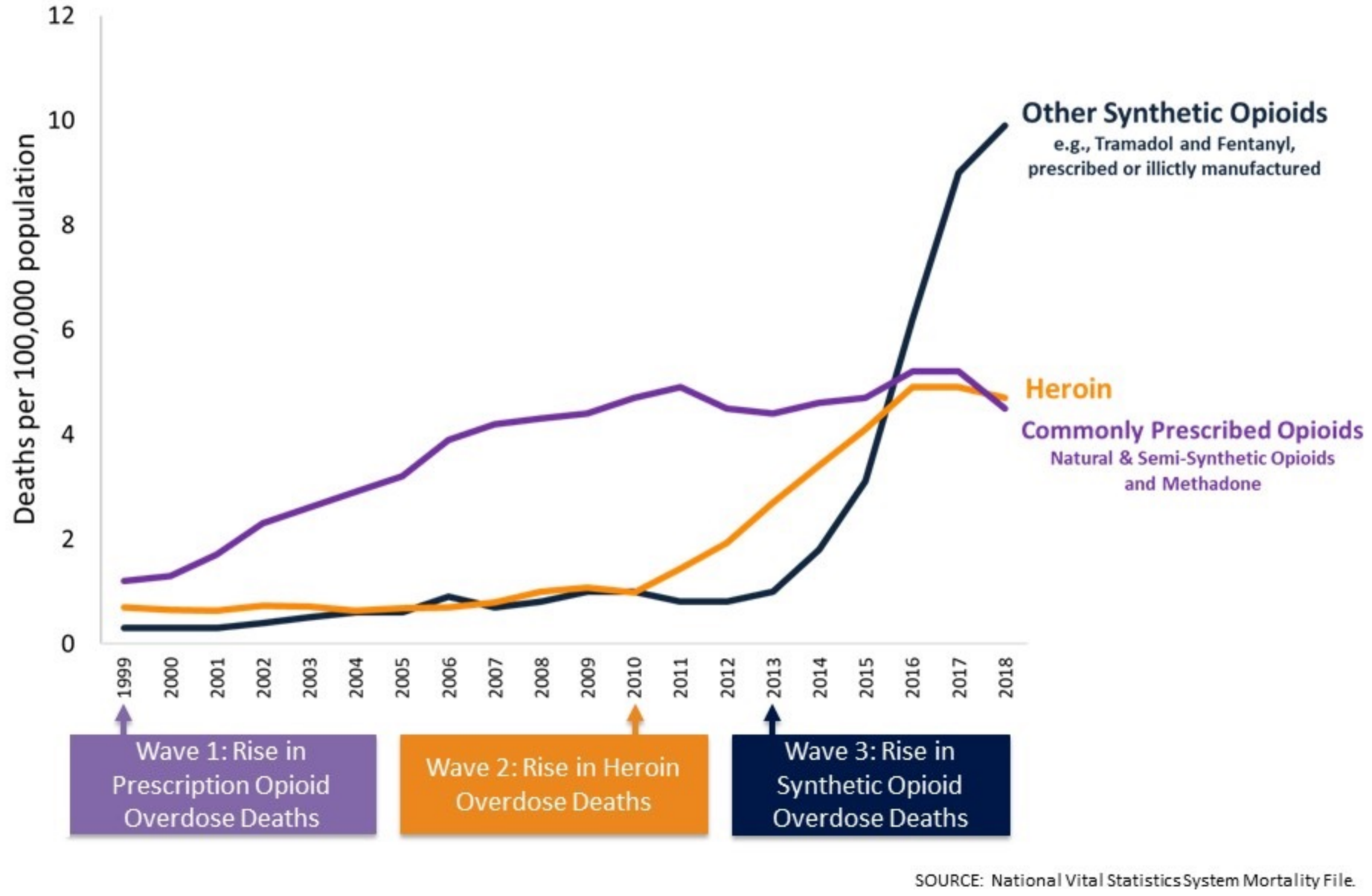
MMWR / July 7, 2017 / Vol. 66 / No. 26

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]

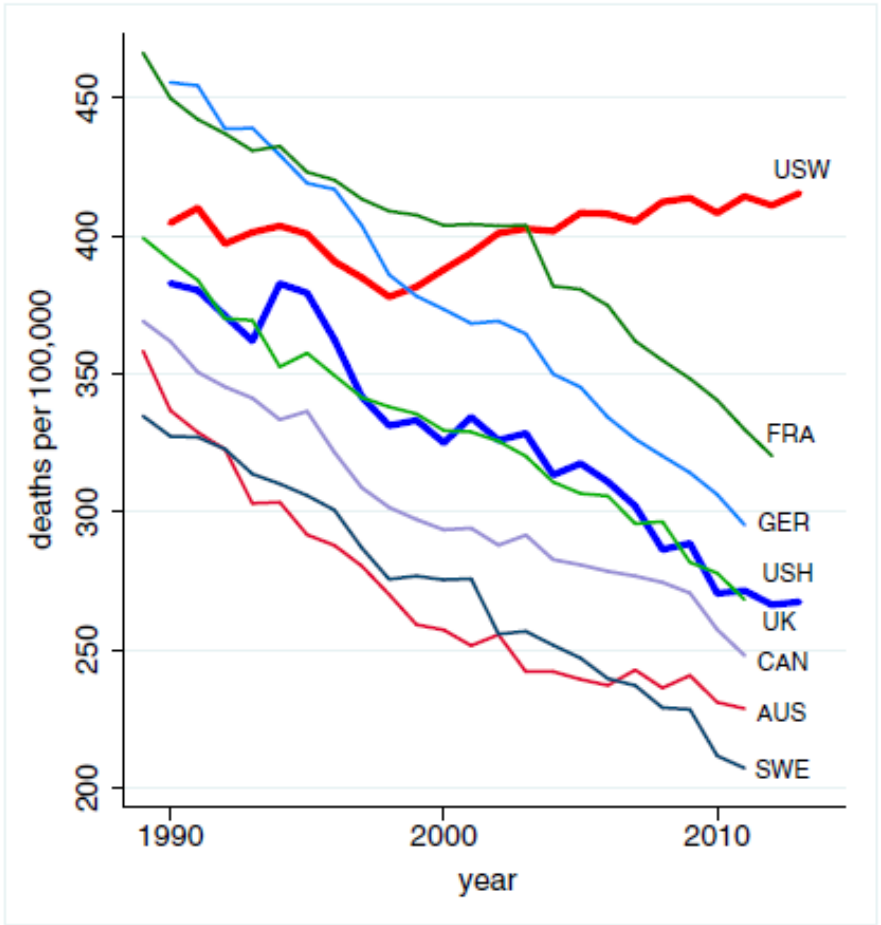


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

The New York Times

In Heroin Crisis, White Families Seek Gentler War on Drugs

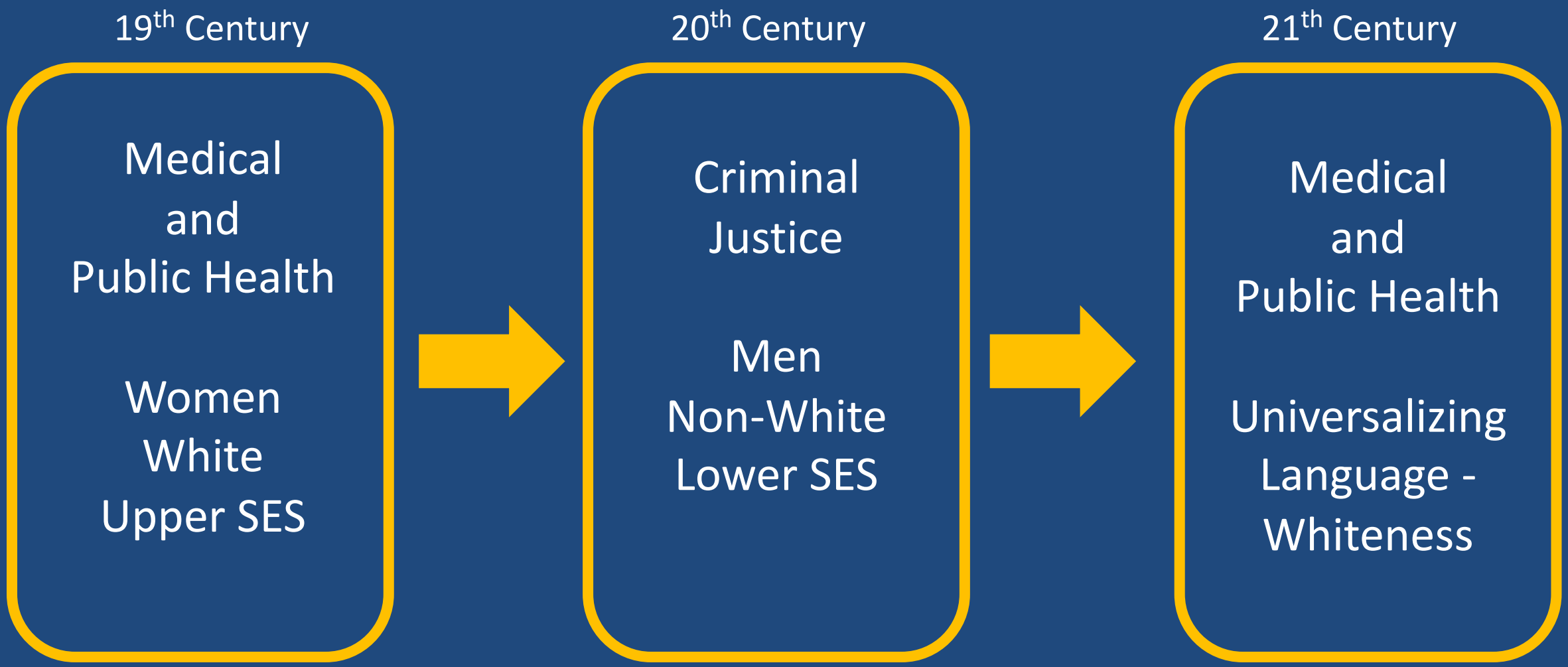
Amanda Jordan with her son Brett Honor outside a meeting for people with addictions and their families in Plaistow, N.H. Her son Christopher died of an overdose. Katherine Taylor for The New York Times

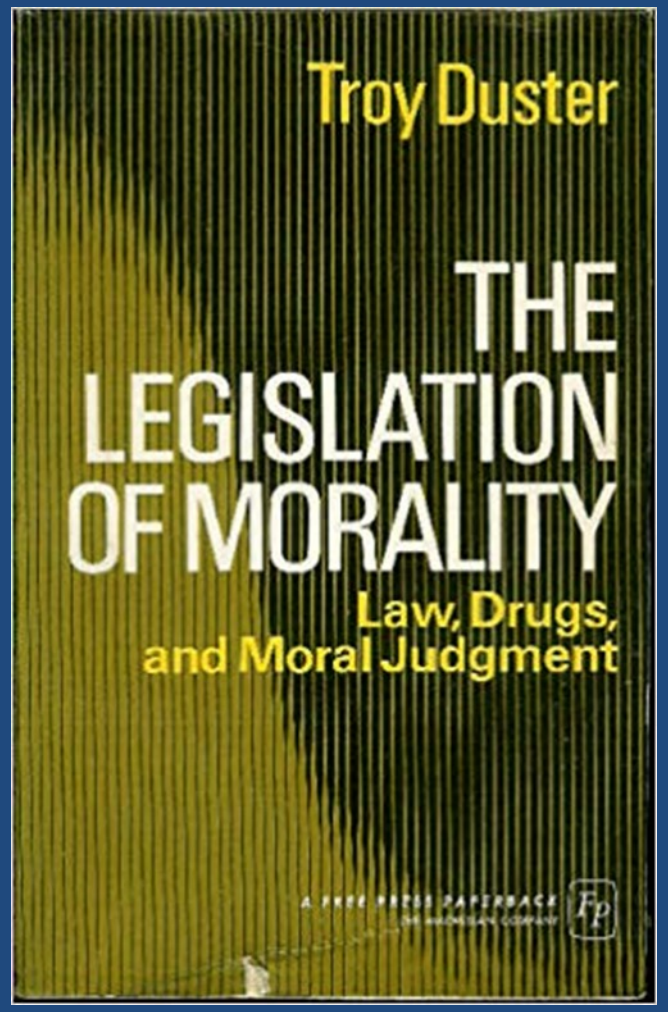
By Katharine Q. Seelye

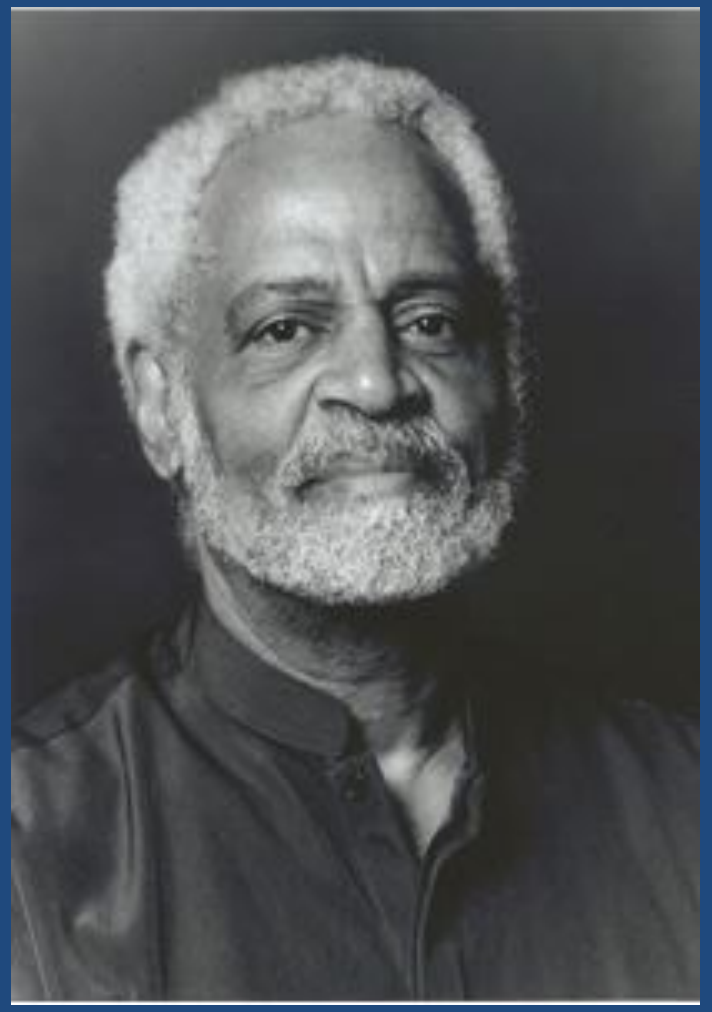
Oct. 30, 2015

833

Substance Use and Addiction







Race, The War on Drugs and Public Health Response

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

Sex and Gender Differences in Substance Use, Misuse and Addiction

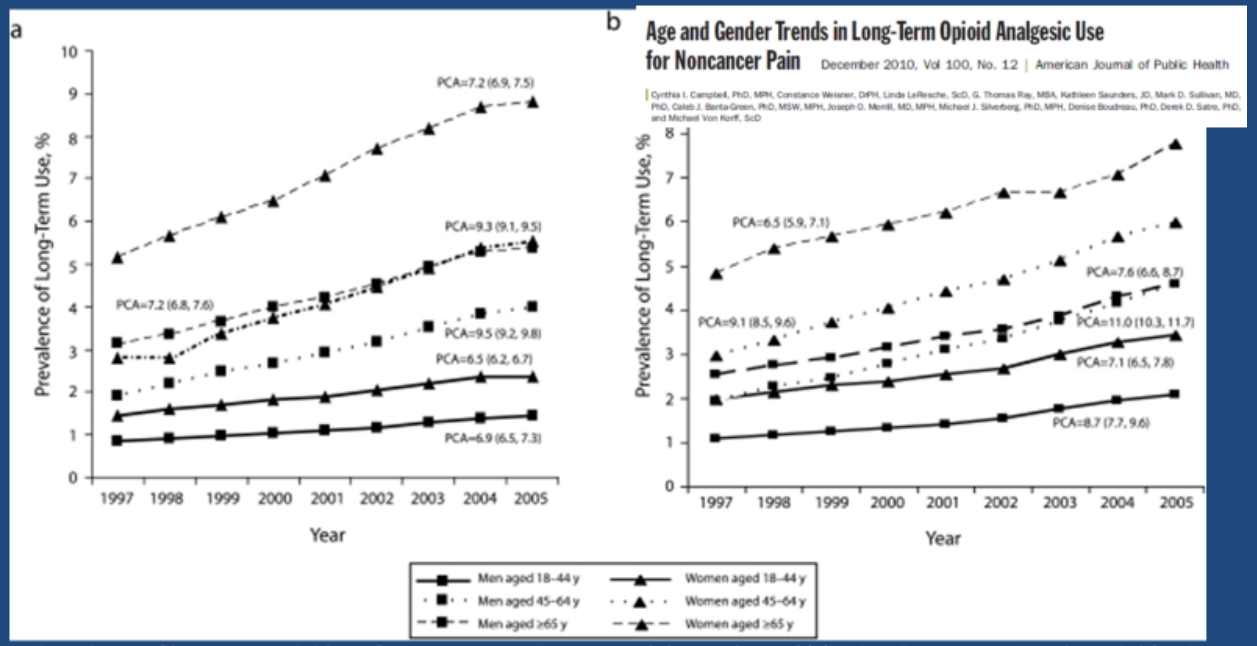
Behavioral Health Burden

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%**

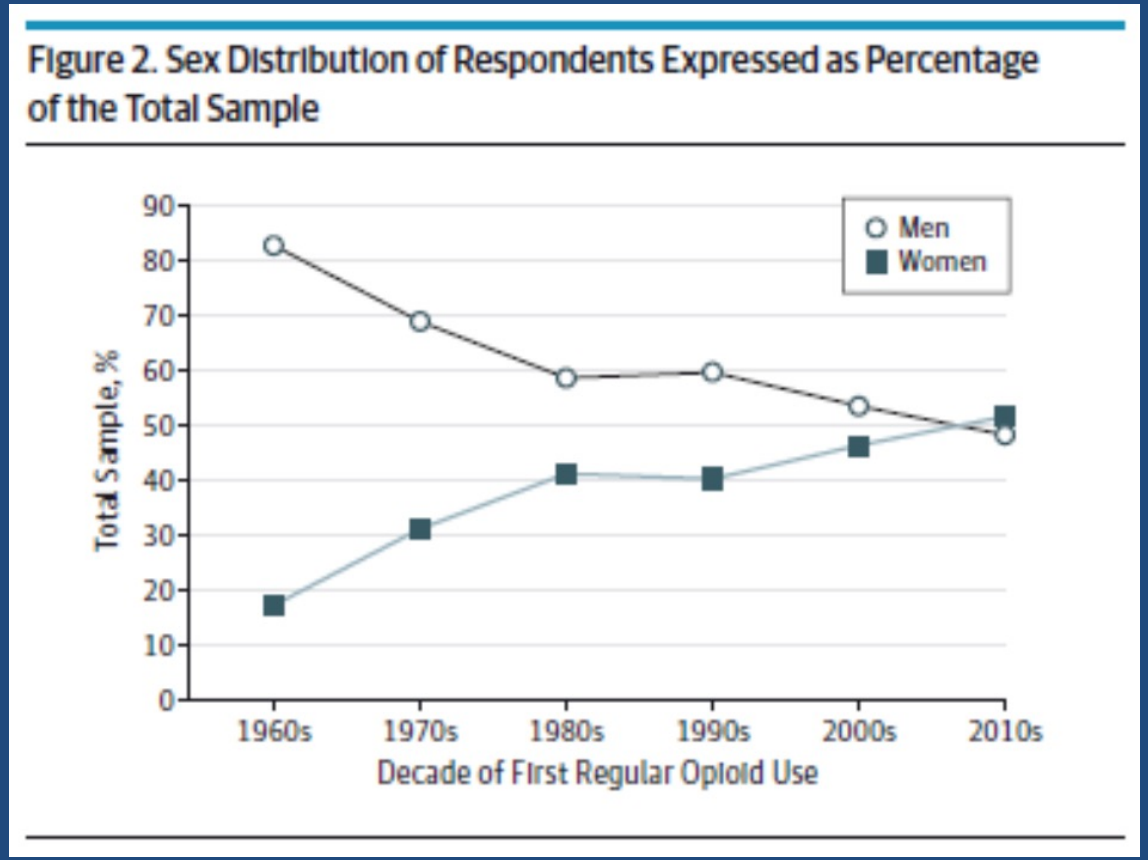
Prescription Medication

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%

Gender, Opioids, and Who Uses Heroin



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



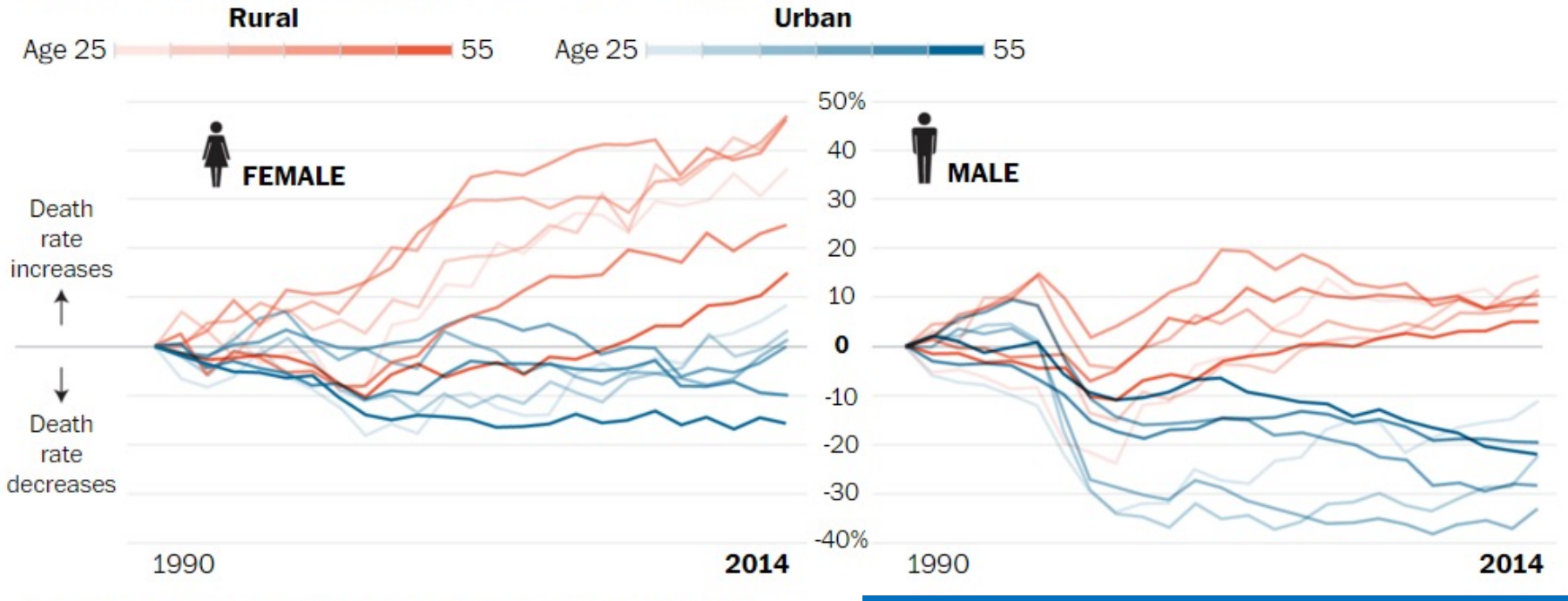
JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366
Published online May 28, 2014.

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

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

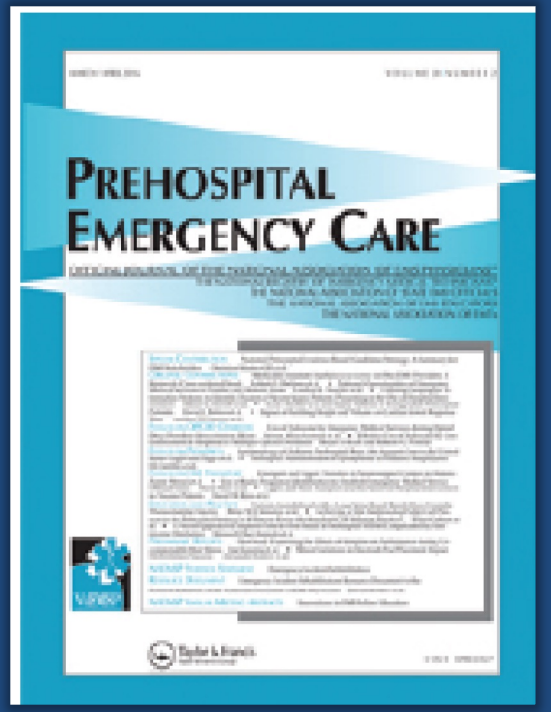


TABLE 1. Administration of naloxone during emergency medical services resuscitation attempts by patient and scene characteristics of individuals deceased due to opioid overdose ($N = 124$)

		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

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]

Opioids and Pregnancy

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

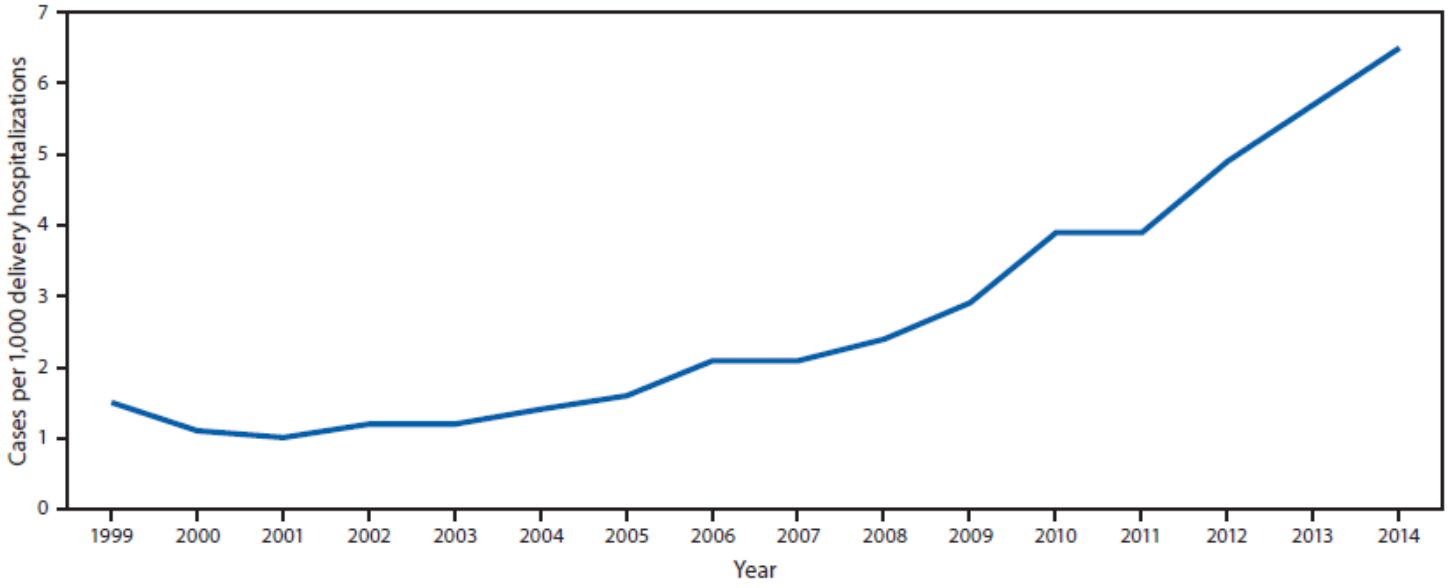
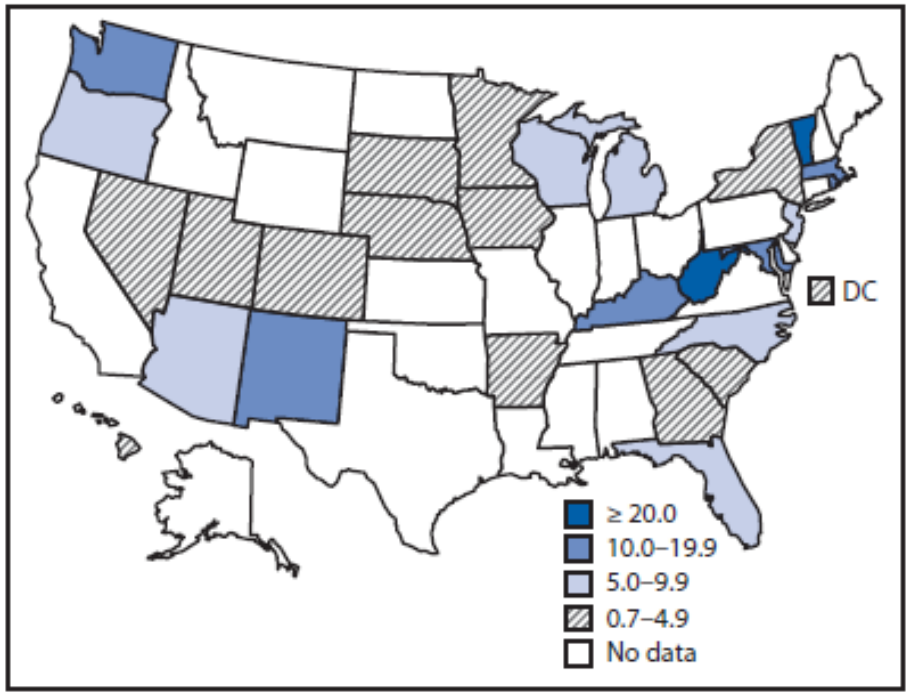


FIGURE 2. Prevalence of opioid use disorder per 1,000 delivery hospitalizations* — State Inpatient Database, Healthcare Cost and Utilization Project, 28 states, 2013–2014†



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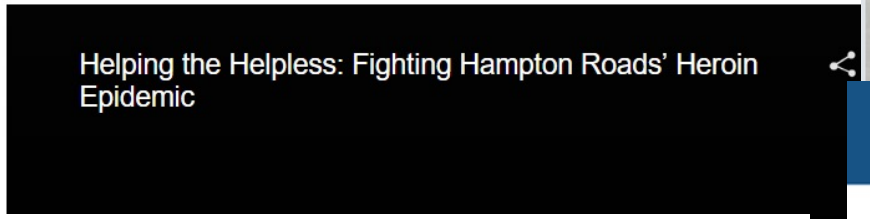
Helping the Helpless: Fighting Hampton Roads' Heroin Epidemic



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

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

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

U.S. WORLD LOCAL POLITICS HEALTH TECH SCIENCE POP CULTURE BUSINESS INVESTIGATIONS SPORTS MORE

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

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THE KANSAS CITY STAR.

FULL MENU NEWS SPORTS BUSINESS FOOD

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

GOVERNMENT & POLITICS

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

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

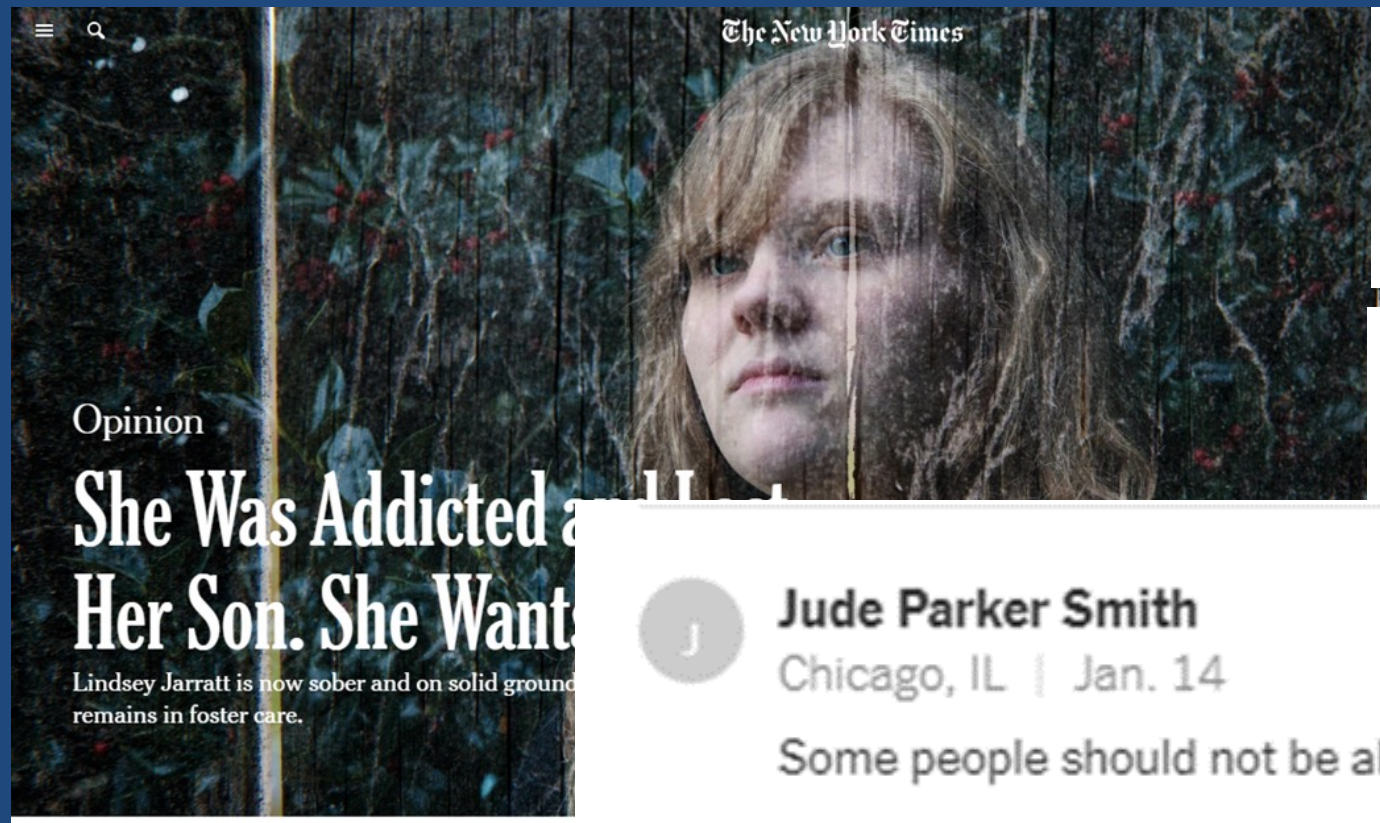
Number of mothers using opioids while pregnant is rising in Tennessee

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

The Washington Post
Democracy Dies in Darkness

National

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



Opinion

She Was Addicted a
Her Son. She Want

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

Damon Winter/The New York Times

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

Jan. 13, 2019

385

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

Pw
San Francisco | Jan. 14

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

James
DC | Jan. 14

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

Jude Parker Smith
Chicago, IL | Jan. 14

Some people should not be allowed to have children.

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

There
Here | Jan. 14

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

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

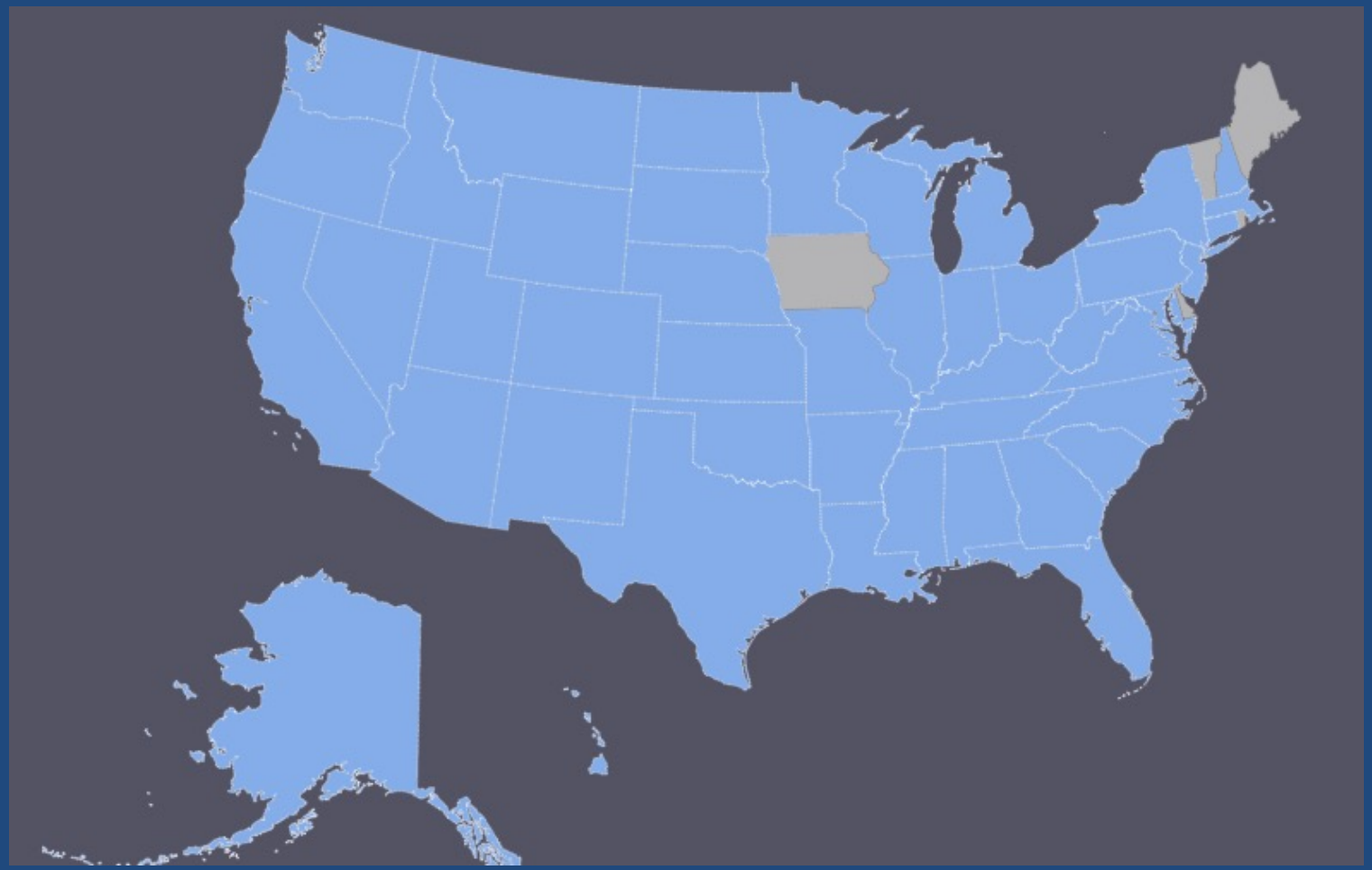
Stigma

Discrimination and Prejudice

Punishment

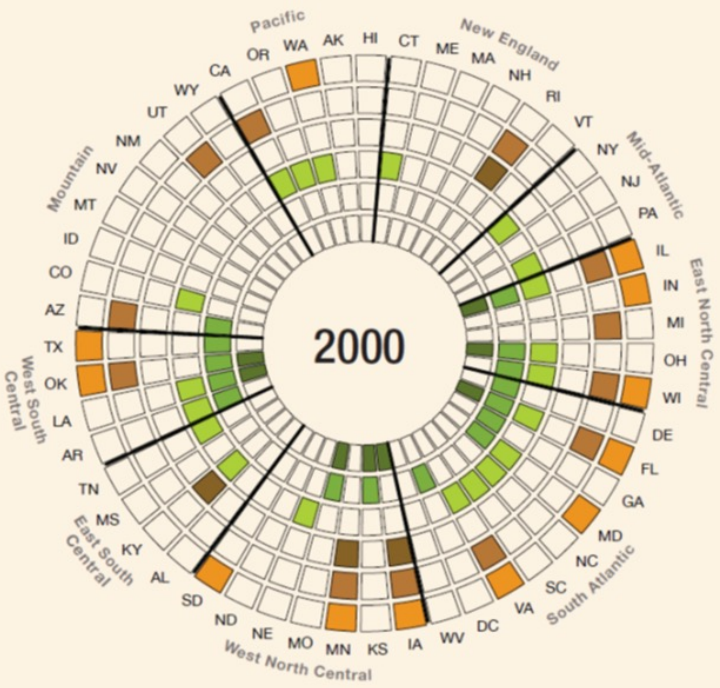
States where pregnant people have been prosecuted for drug use

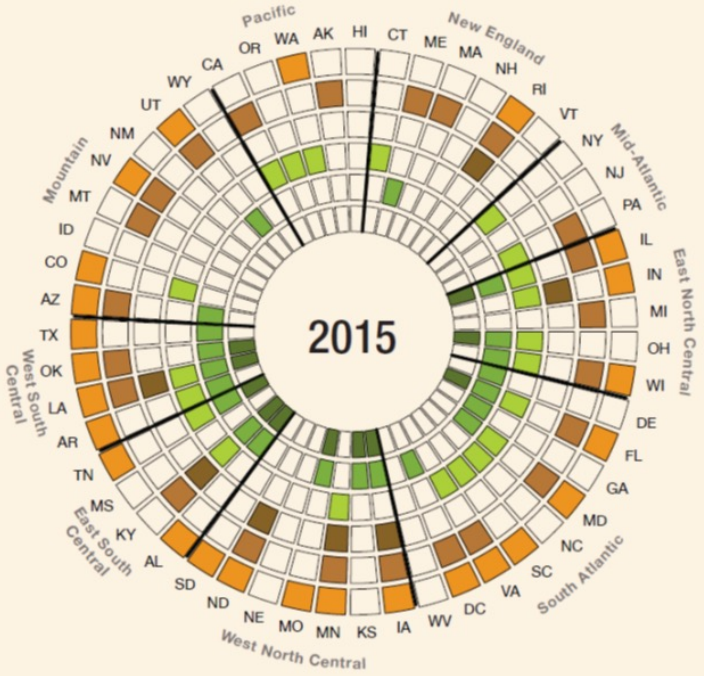
The first known indictment of an American woman for drug use in pregnancy was in California in 1977



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

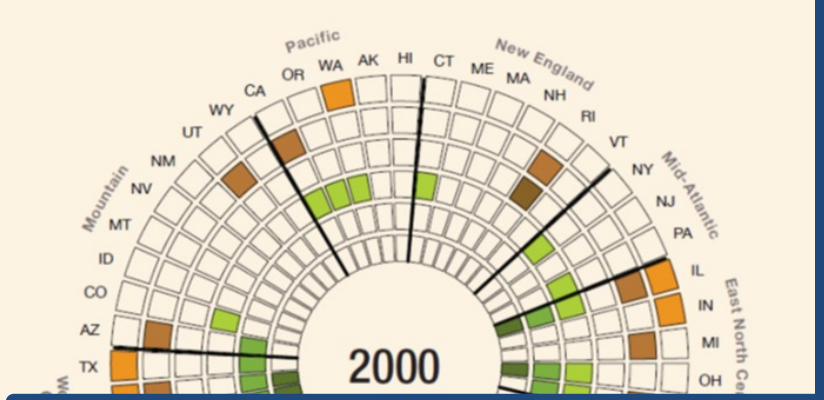




Punitive Policies Related to Substance Use in Pregnancy Proliferated

Punitive Policies Associated with:
Increased Odds of Neonatal Abstinence Syndrome
Increased Odds of Low Birth Weight
Increased Odds of Preterm Delivery
Decreased Odds of any Prenatal Care and APGAR 7+

1. Faherty, et al., *Association between punitive policies and neonatal abstinence syndrome among Medicaid-insured infants in complex policy environments.* Addiction, 2022
2. Thomas, et al., *Drug use during pregnancy policies in the United States from 1970 to 2016.* Contemporary Drug Problems, 2018
3. Carroll, *The harms of punishing substance use during pregnancy.* IJDP, 2021
4. https://www.rand.org/pubs/infographics/IG148.html



Punitive Policies Related to Substance Use in Pregnancy Proliferated

US Drug Policy: Less Punitive

State Policies Drugs + Pregnancy: More Punitive

Driven by Increasing Restrictive Reproductive Policies

1. Faherty, et al., *Association between punitive policies and neonatal abstinence syndrome among Medicaid-insured infants in complex policy environments.* Addiction, 2022
2. Thomas, et al., *Drug use during pregnancy policies in the United States from 1970 to 2016.* Contemporary Drug Problems, 2018
3. Carroll, *The harms of punishing substance use during pregnancy.* IJDP, 2021
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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?

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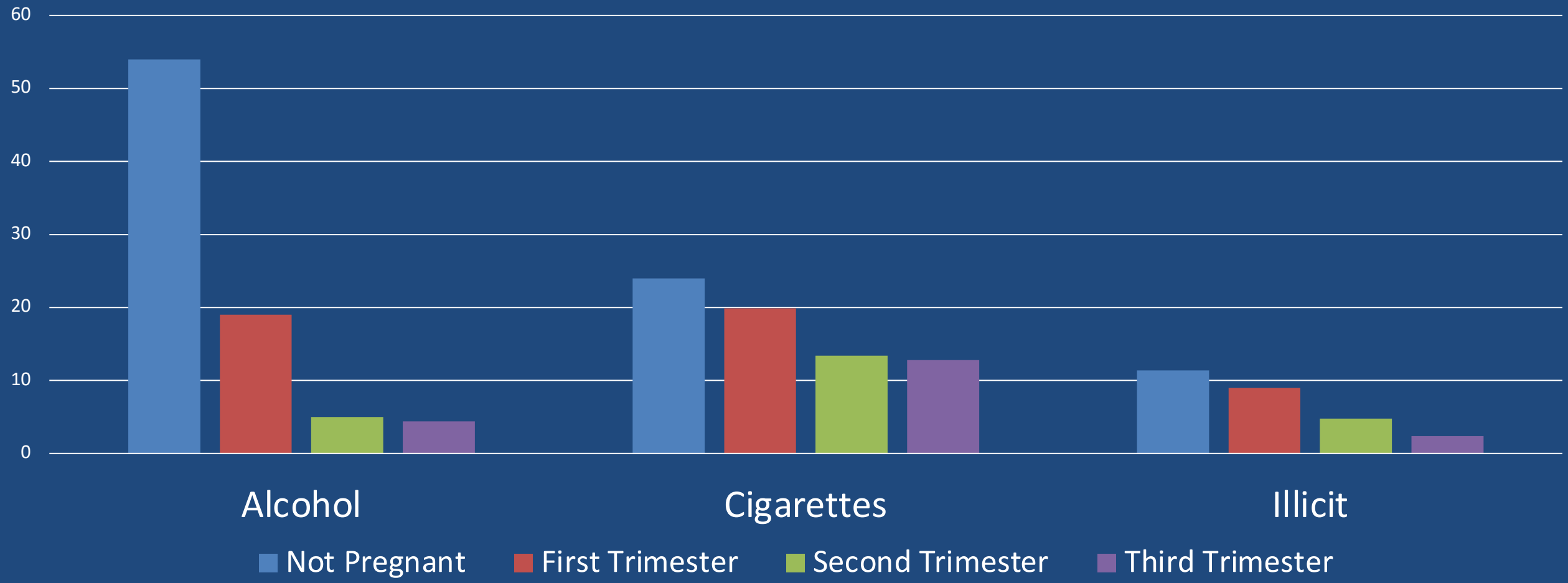
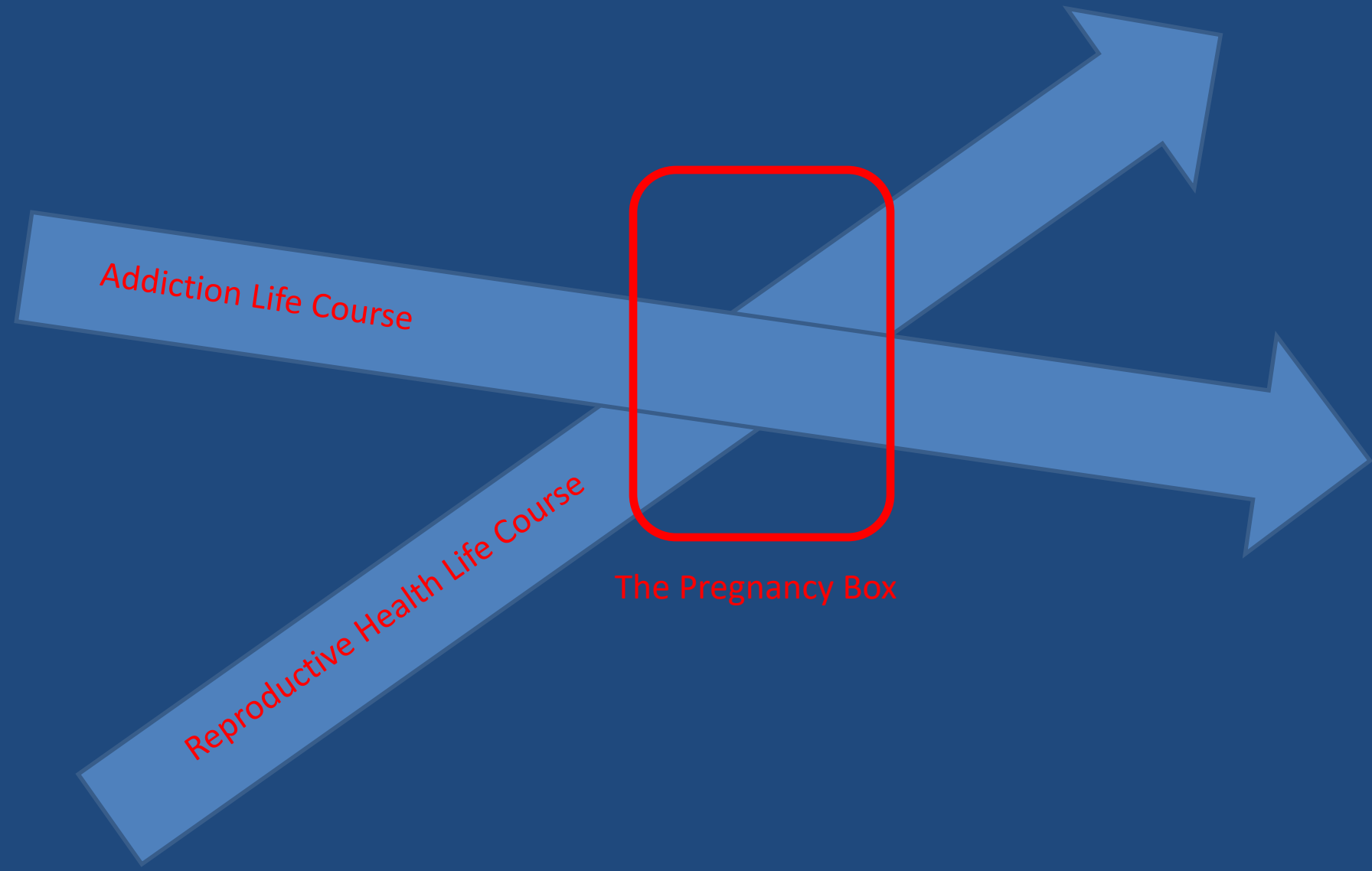
What happens when people who use drugs get pregnant?



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


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]

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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

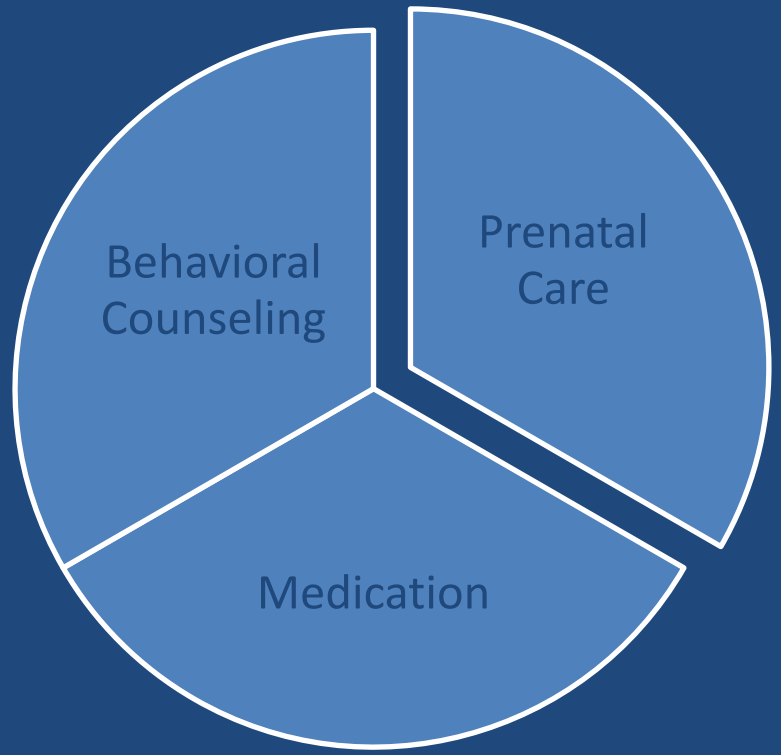
ABSTRACT. The arrests, detentions, prosecutions, and other legal actions taken against drug-dependent pregnant women distract attention from significant social problems, such as our lack of universal health care, the dearth of policies to support pregnant and parenting women, the absence of social supports 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?

Alternative to Punishment: Treatment

Individuals with the Disease of Addiction Need Treatment



"Gold Standard" is Integration: Comprehensive co-located service delivery

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

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

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

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

Treated vs. Untreated Addiction

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

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

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

Martin, 2020, DAD

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

Contents lists available at ScienceDirect

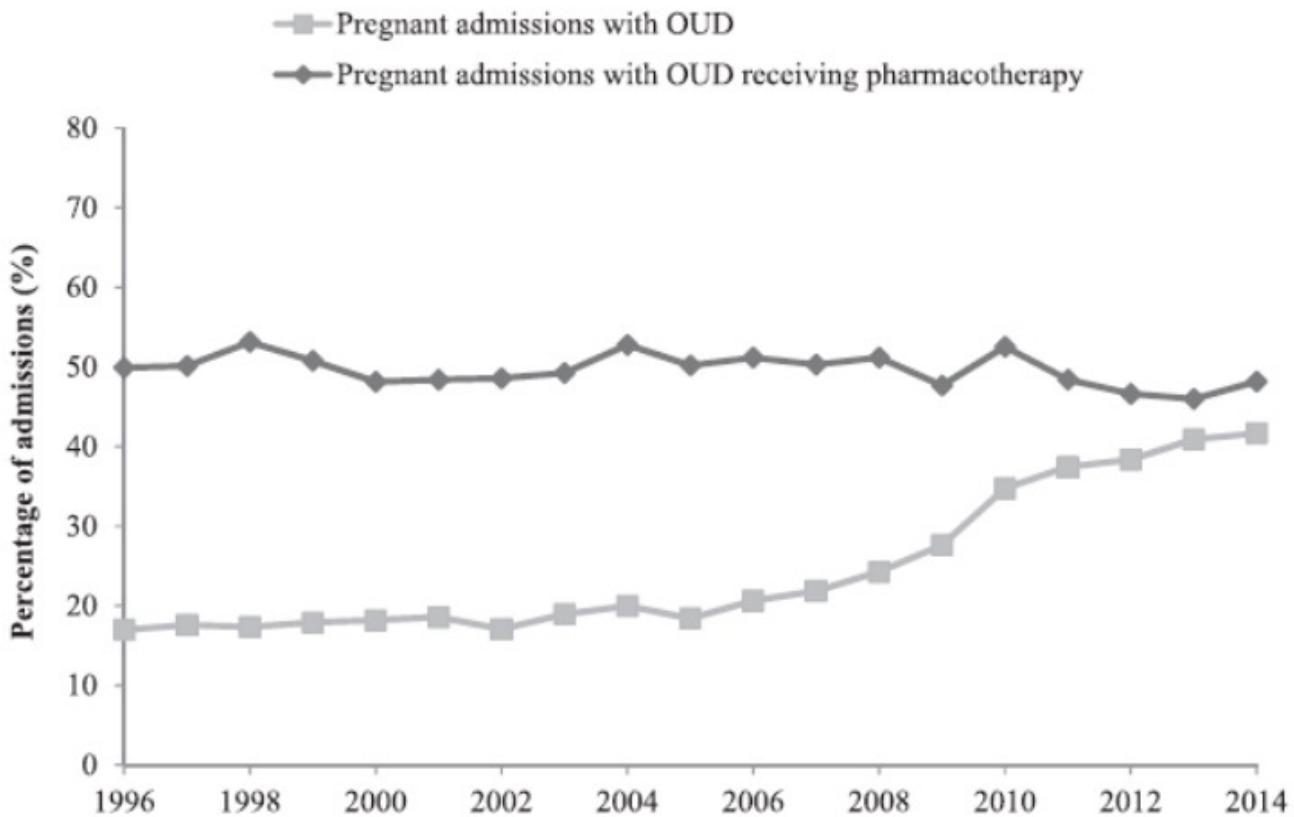
Journal of Substance Abuse Treatment

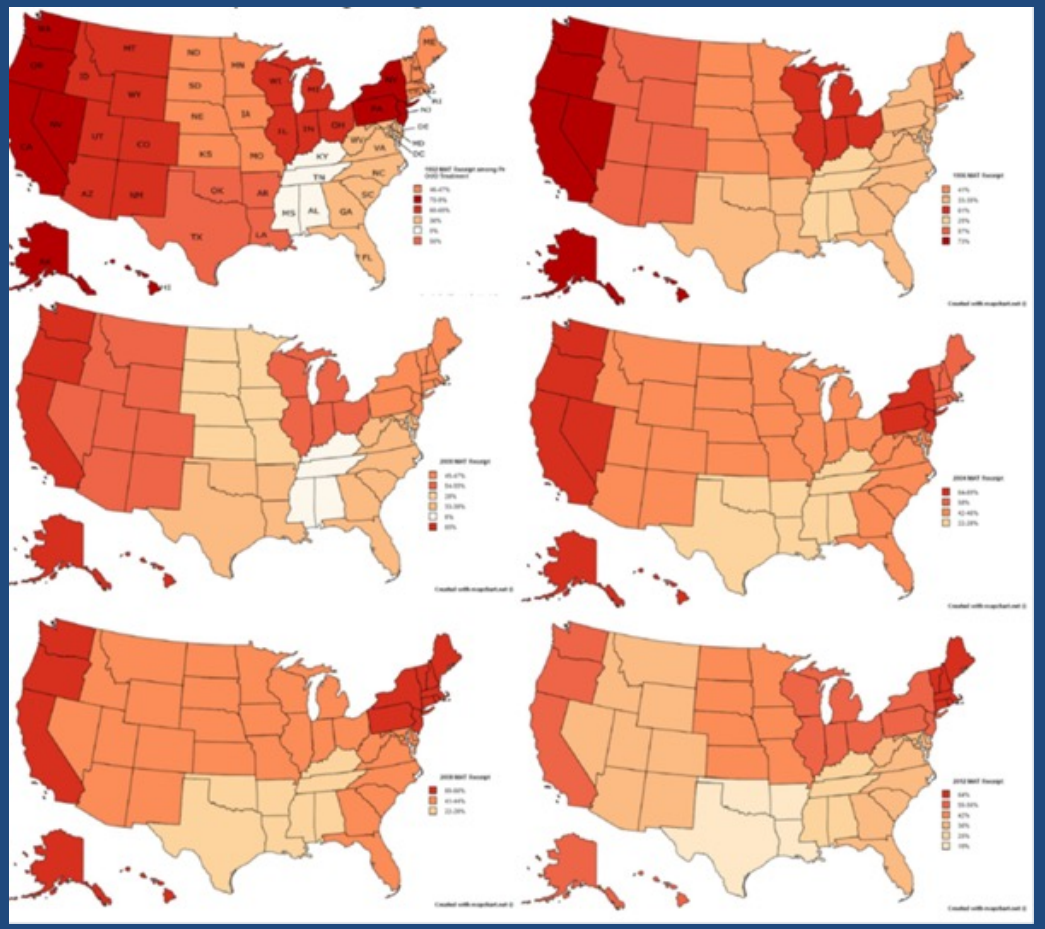
journal homepage: www.elsevier.com/locate/jsat

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]

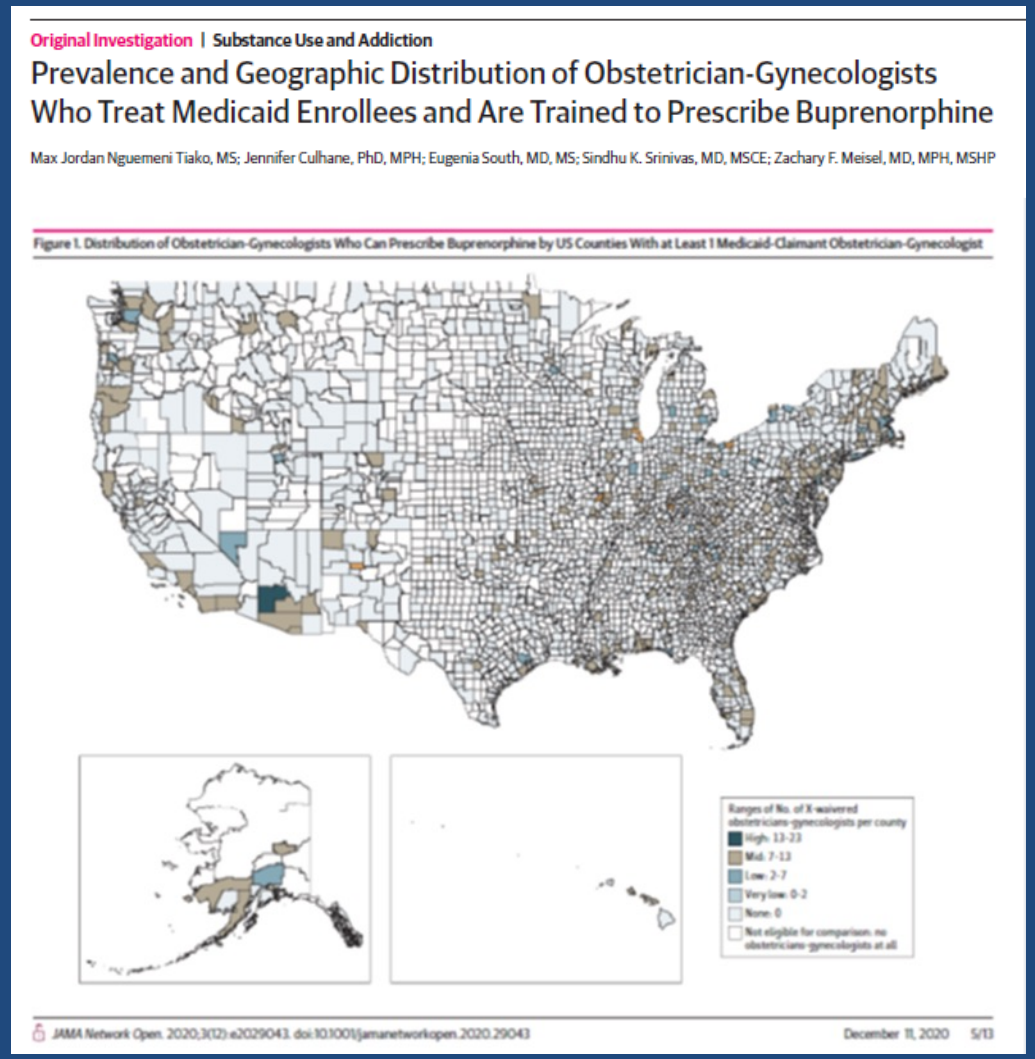
[a] Department of Obstetrics and Gynecology, Thomas Jefferson University, 1233 Locust St. Suite 401, Philadelphia, PA 19107, USA





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

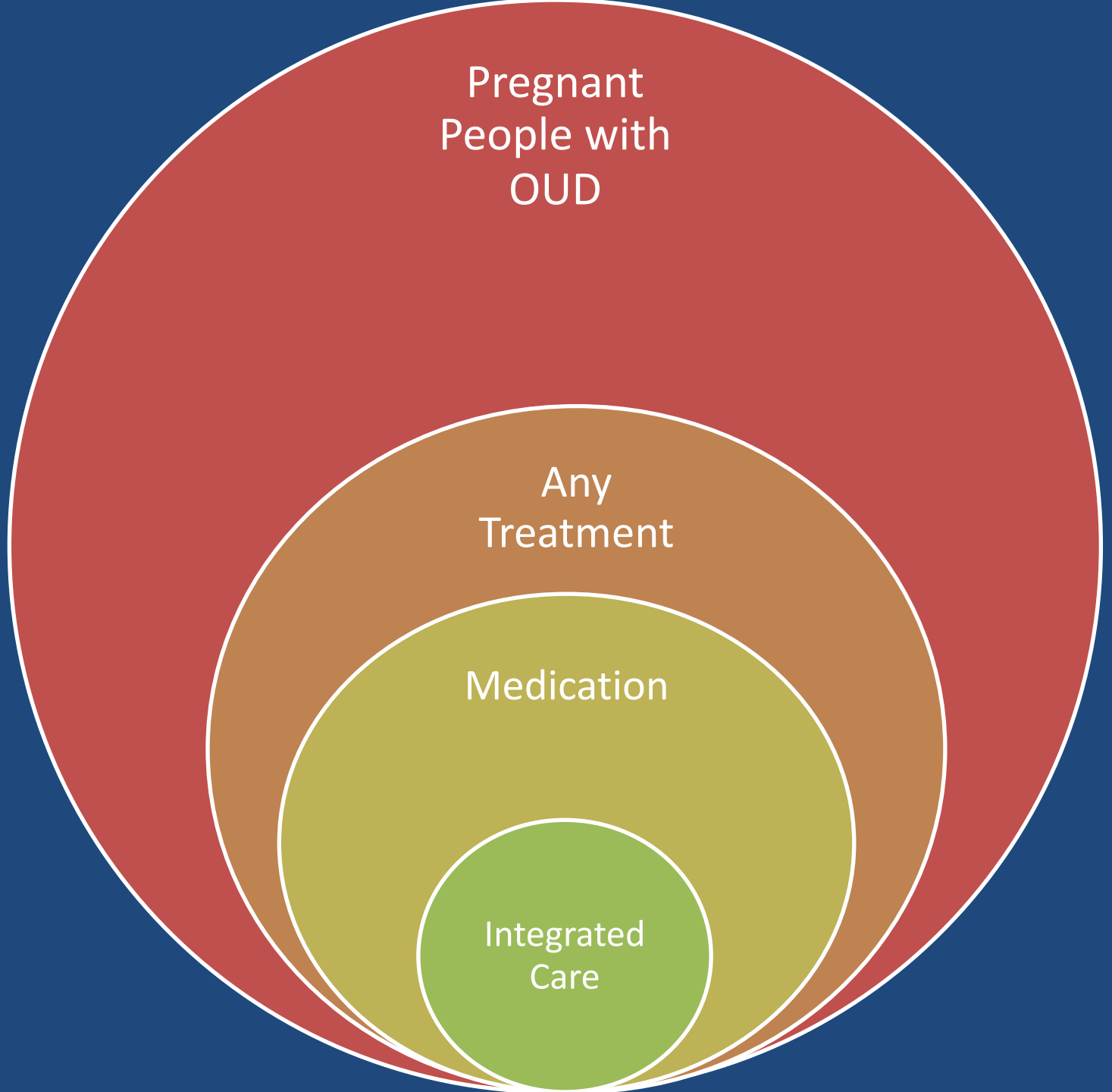
Figure 1. Distribution of Obstetrician-Gynecologists Who Can Prescribe Buprenorphine by US Counties With at Least 1 Medicaid-Claimant Obstetrician-Gynecologist

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

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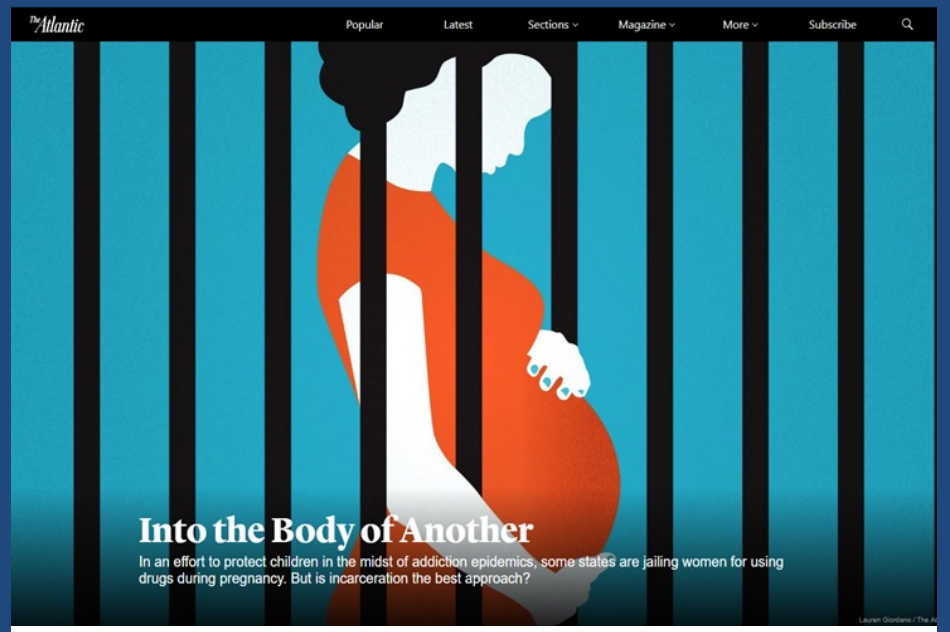
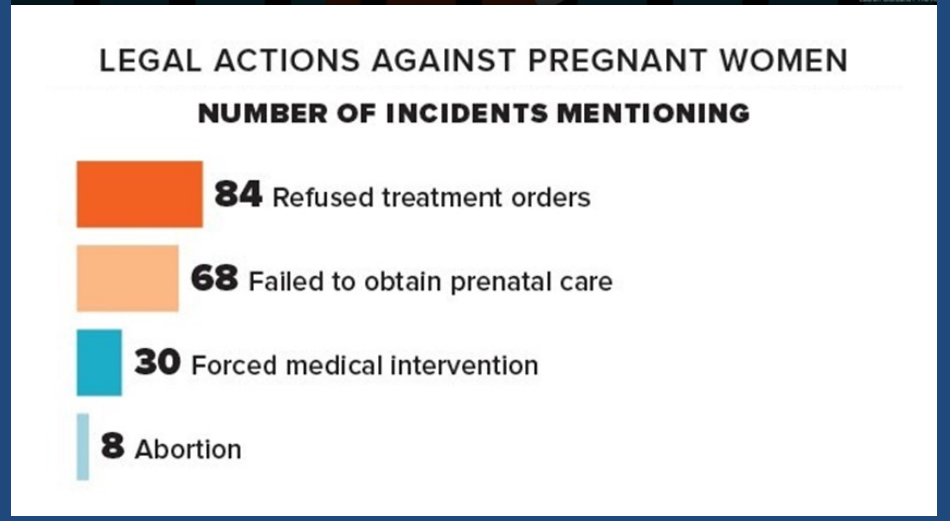
PETITION FOR CERTIORARI FILED DECEMBER 1, 1999
CERTIORARI GRANTED FEBRUARY 28, 2000





In place of punishment: Questions to ask ourselves

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- How can we do less harm?

How do we Do Less Harm?

Public Health and Clinical Care that is both

Evidence-Based

AND

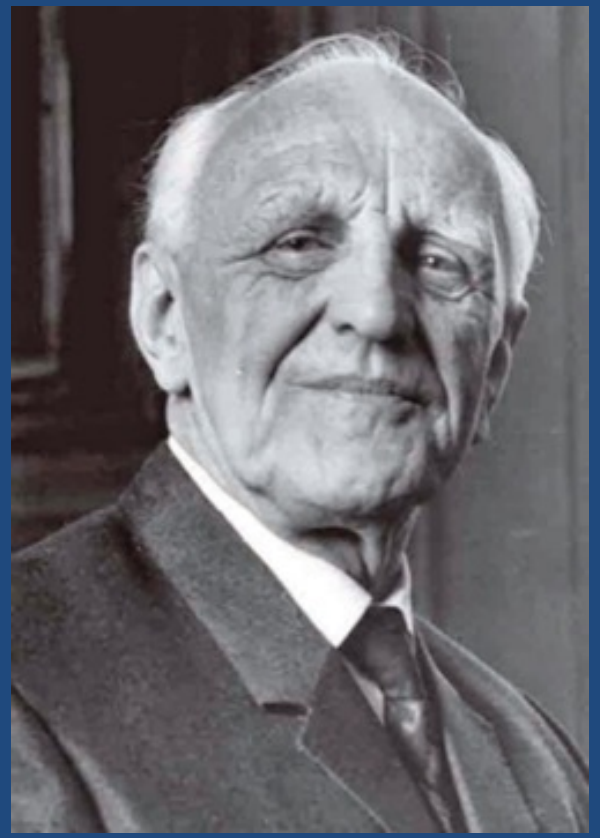
People-Centered

Do Less Harm:
1. Language is Important

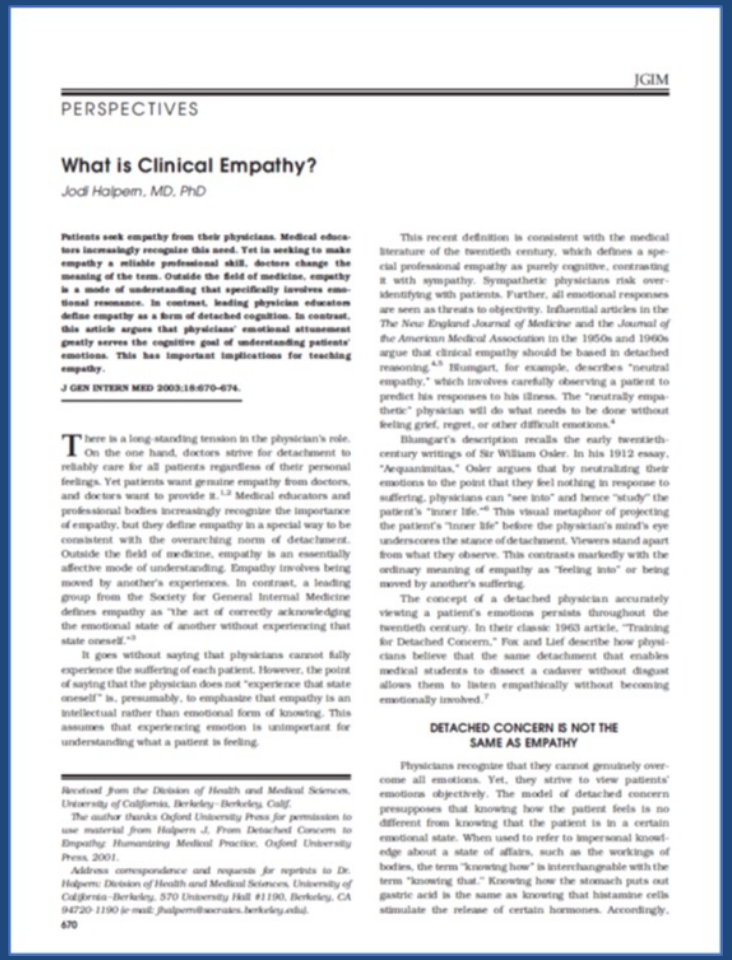
- Counter de-humanizing discourse with humanizing language
- Language: Evidence-based and Person-centered
- The words we use influence how others conceptualize addiction and public health

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)



3. Practice 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 overidentifying 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,

- Use people's names
- Smile
- Listen
- Don't interrupt people
- Tune in to non-verbal communication
- 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
  - 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

mterplan@friendsresearch.org
@Do_Less_Harm

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