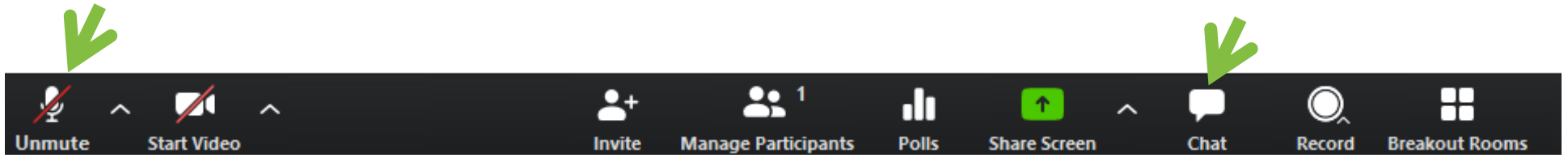
Neonatal Opioid Withdrawal Syndrome Initiative

Action Period Call
September 28, 2022
12:00 – 1:00 PM CT

Welcome

- Please type your name and organization you represent in the chat box and send to “Everyone”
- Please also do for all those in the room with you viewing the webinar.
- Attendees are automatically muted to reduce background noise.
- You may enter questions/comments in the “chat” box during the presentation. We will have Q&A session at the end.
- Slides will be available via email and at https://www.alpqc.org/initiatives/nows/
- We are now recording



Agenda

Welcome & Updates	12:00 – 12:05
Do Less Harm: Stigma & Structure in Pregnancy and Parenting	12:05 – 12:45
Q&A	12:45 – 12:55
Next Steps	12:55 – 1:00

Updates

Welcome new member of the team!
Britta Cedergren, MPH, MPA
Program Director

Do Less Harm: Stigma & Structure in Pregnancy and Parenting

Mishka Terplan,
MD, MPH, FACOG, DFASAM
Medical Director, Friends Research Institute

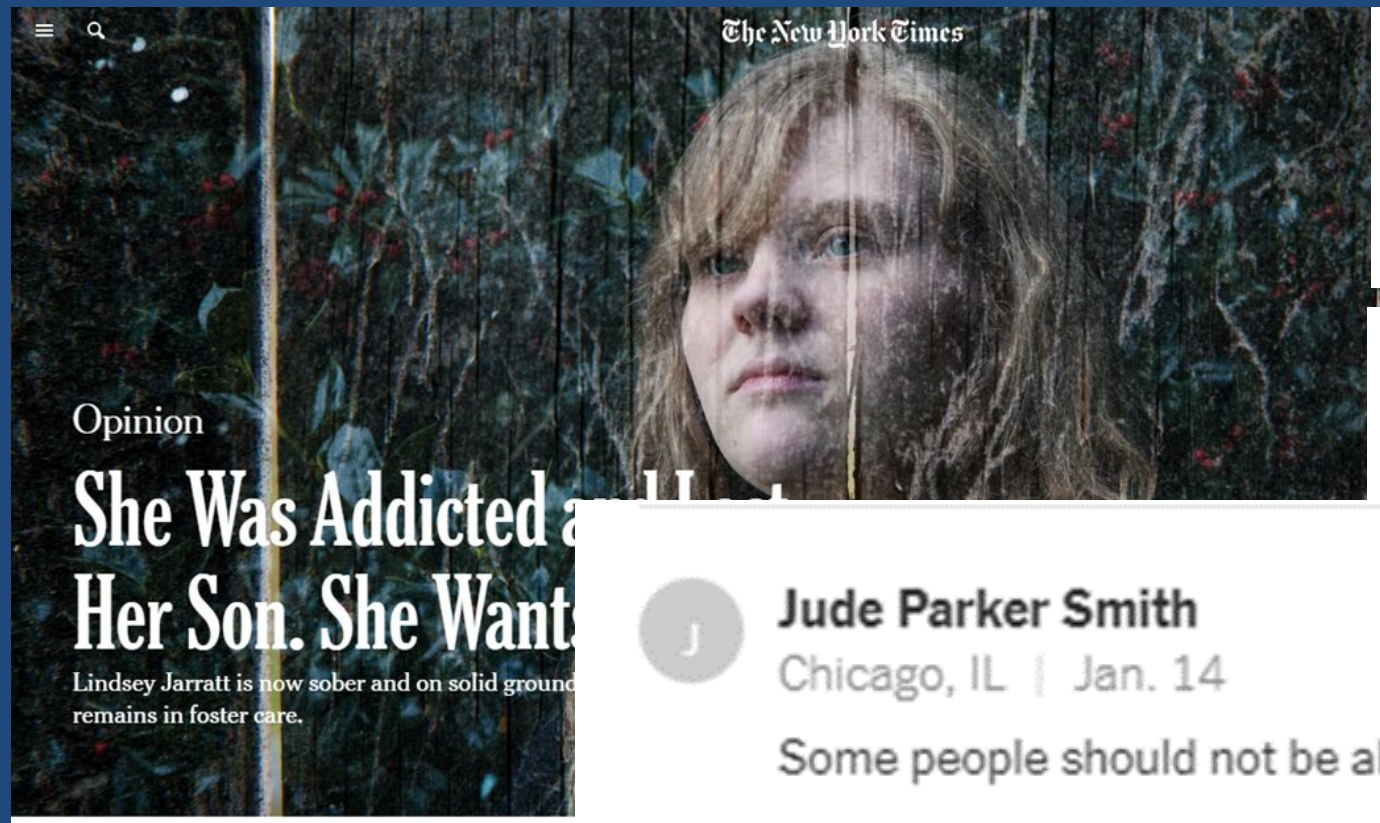
Do Less Harm:
Stigma & Structure in Pregnancy & Parenting

Mishka Terplan MD MPH FACOG DFASAM
Medical Director and Senior Research Scientist
Friends Research Institute
Adjunct Faculty and Substance Use Warmline Clinician
University of California, San Francisco

Shared Values

People who use drugs should be treated with dignity and respect when they seek health care.

Parenting is hard, and we support non-punitive approaches that allows the parent, infant, dyad, and family thrive together.



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 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 social rejection, labeling, stereotyping and discrimination, even in the absence of any negative consequences associated with their drug use. This manifests in a variety of ways, including denial of employment or housing. People with substance misuse issues are less likely to be offered help than are people with a mental illness or physical disability.[3]

According to research, the majority of healthcare professionals hold negative, stereotyped views of people who use illicit drugs.[4] Stigma is a major factor preventing individuals from seeking and completing addiction treatment[5] and from utilizing harm reduction services such as syringe access programs. In a vicious cycle, the social exclusion created by stigma can increase the need for a variety of services.

Even among people who use drugs, stigma toward other people who use drugs can be common. People who use a socially acceptable, legal drug, such as alcohol, may have negative prejudices against people who use illegal drugs, such as marijuana. People who use illegal so-called 'soft drugs' such as marijuana may have negative prejudices against people who use 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 "d
addictive" drugs are often not ba
evidence. You can help end stig
facts about drugs, drug use and
treatment and sharing the inform

Language matters. The way we
the people who use them can cr
Words like 'crackhead,' 'junkie' a
dehumanize a person who may
addiction. Focus on the whole pe
Instead of 'addict', refer to a 'per

1. Corrigan, P. W., Watson, A. C., & Miller, F. E.
contamination: The impact of mental illness and
family members. Journal of Family Psychology,
2. Goffman, E. (1963). Stigma: Notes on the ma
Englewood Cliffs: Prentice-Hall
3. Corrigan, P.W., Kuwabara, S.A., & O' Shaugh
stigma of mental illness and drug addiction:Findi
sample. Journal of Social Work, 9(2), 139-147
4. McLaughlin, D. & Long, A. (1996) An extende
professionals perceptions of illicit drugs and their
Psychiatric and Mental Health Nursing , 3(5), 28
5. Luoma, J.B., Twohig, M.P., et al (2007) An inv
receiving treatment for substance abuse. Addict
6. Comparative epidemiology of dependence on
substances, and inhalants: Basic findings from th
By Anthony, James C.; Warner, Lynn A.; Kessler
Clinical Psychopharmacology, Vol 2(3), Aug 199

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nyc@drugpolicy.org | 212.613.8020 voice | 212.613.8021 fax

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.

Stigma Greater for Drug Addiction than Mental Illness

Published in final edited form as:
Psychiatr Serv. 2014 October ; 65(10): 1269–1272. doi:10.1176/appi.ps.201400140.

Stigma, Discrimination, Treatment Effectiveness and Policy Support: Comparing Public Views about Drug Addiction with Mental Illness

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Johns Hopkins Bloomberg School of Public Health - Health Policy and Management, Baltimore, Maryland

Bernice Pescosolido, and
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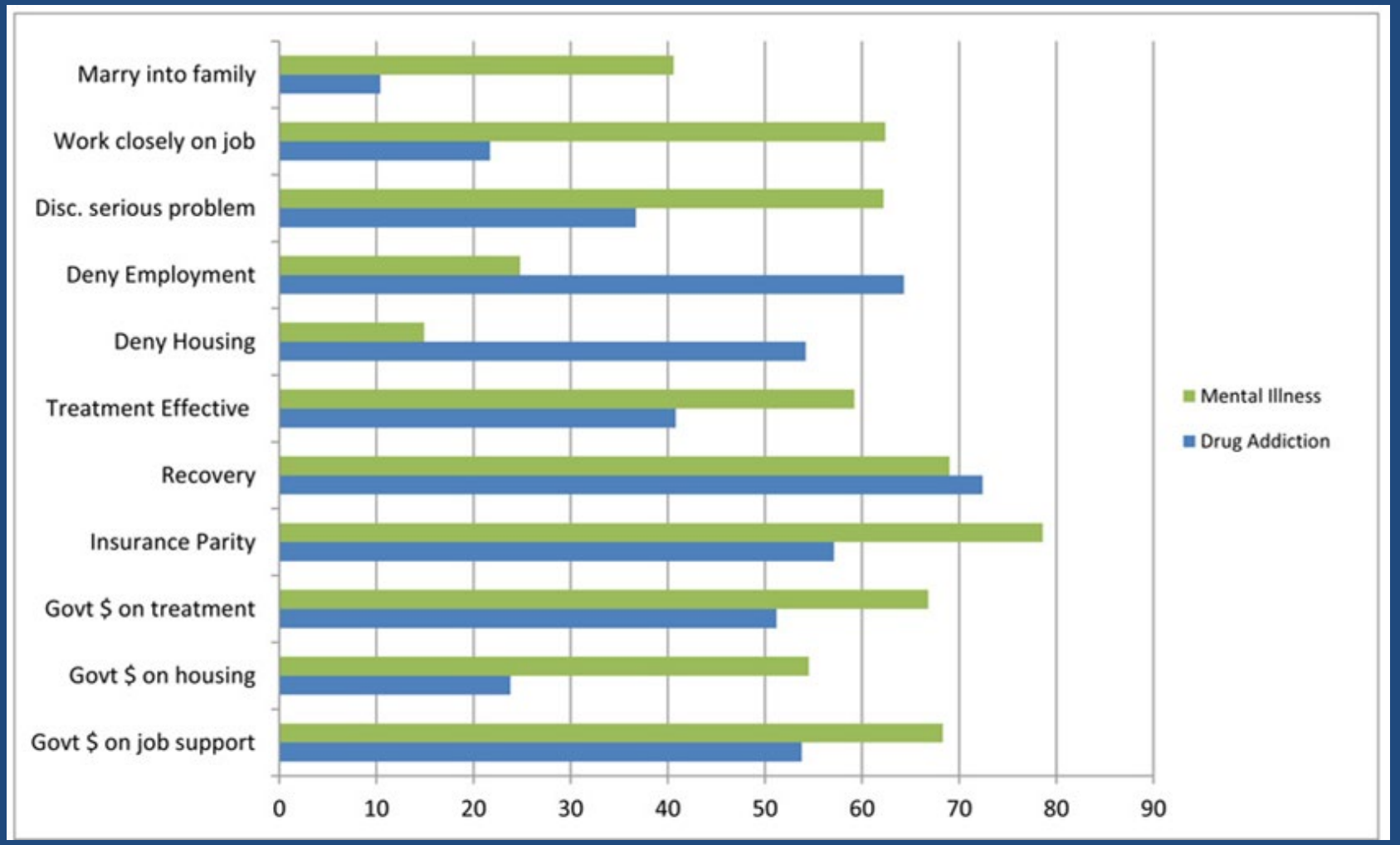
Abstract

Objective—This study compares current public attitudes about drug addiction with attitudes about mental illness.

Methods—A web-based national public opinion survey (N=709) was conducted to compare attitudes about stigma, discrimination, treatment effectiveness, and policy support.

Results—Respondents hold significantly more negative views toward persons with drug addiction compared to those with mental illness. More respondents were unwilling to have a person with drug addiction marry into their family or work closely with them on a job. Respondents were more willing to accept discriminatory practices, more skeptical about the effectiveness of available treatments, and more likely to oppose public policies aimed at helping persons with drug addiction.

Conclusions—Drug addiction is often treated as a sub-category of mental illness, and health insurance benefits group these conditions together under the rubric of behavioral health. Given starkly different public views about drug addiction and mental illness, advocates may need to adopt differing approaches for advancing stigma reduction and public policy.



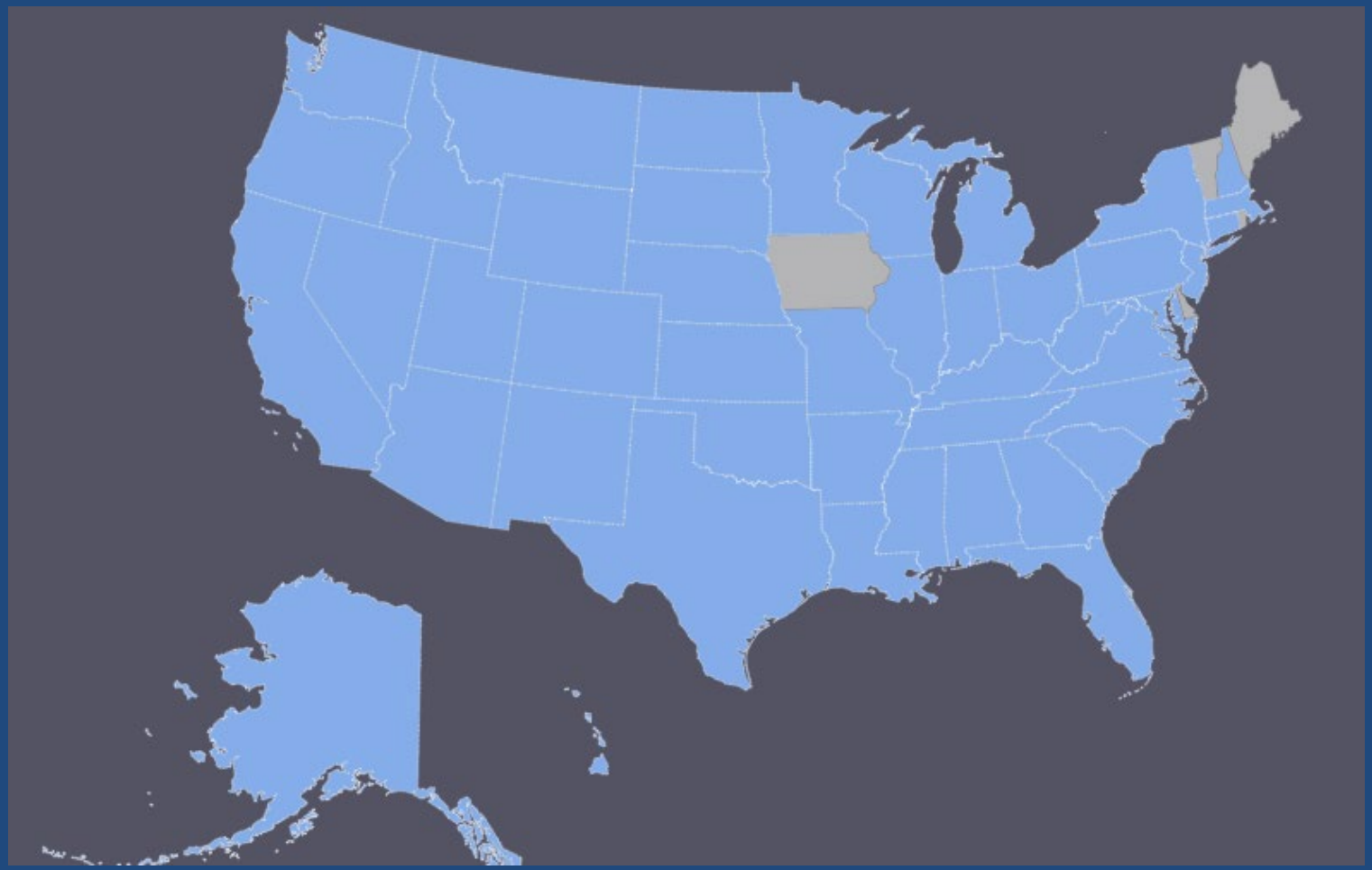
Stigma

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

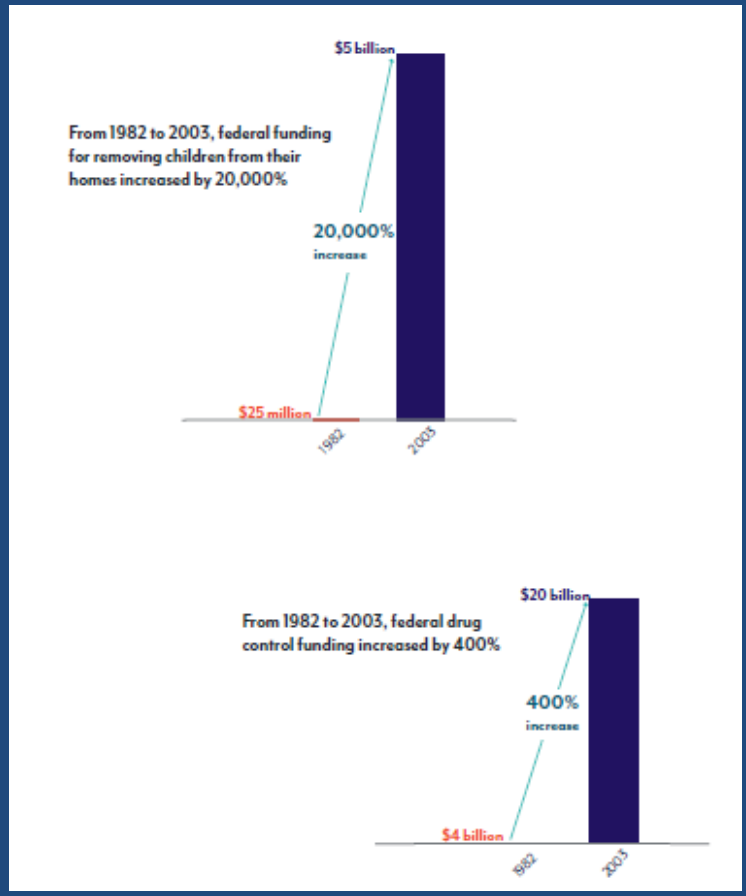


Women prosecuted for drug use during pregnancy in all states but:
DE, IO, ME, RI, VT

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
mama
MFP
MOVEMENT FOR FAMILY POWER
NYU FAMILY DEFENSE CLINIC
We are the Drug Policy Alliance.

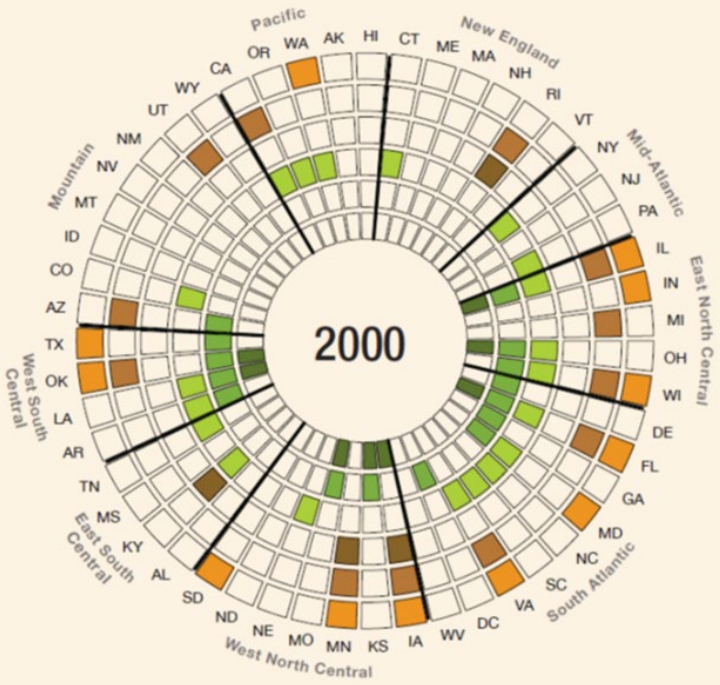

Between 1986 to 1996, the population of children removed from their homes to the foster system, like the prison population, grew steeply. Between 1996 to 2016, both the population of children in state custody and prison population have not decreased significantly.
600,000
400,000
200,000
Population of Children Removed From Their Parent's Care to Foster System
Over 100% increase in the number of children taken from their parents and placed in foster system during the era of increased crack-cocaine use
1982
1986
1990
1994
1998
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
U.S. State and Federal Prison Population
Over 400% increase in number of people removed from their families and communities and caged during the era of increased crack-cocaine use
1982
1986
1990
1994
1998
2002
2006
2010
2014

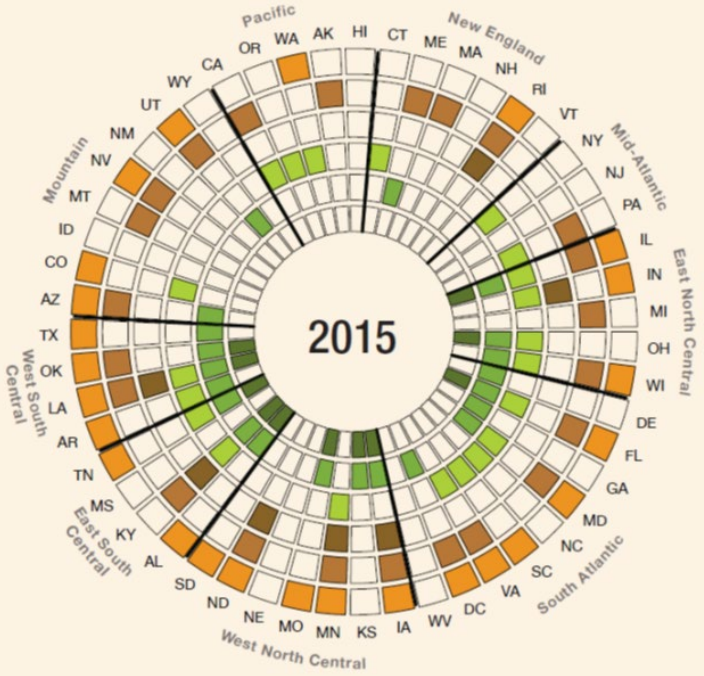

From 1982 to 2003, federal funding for removing children from their homes increased by 20,000%
$5 billion
20,000% increase
$25 million
1982
2003
From 1982 to 2003, federal drug control funding increased by 400%
$20 billion
400% increase
$4 billion
1982
2003

State Policies on Substance Use during Pregnancy

Policy	Number of States
Substance Use Considered Child Abuse	24+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 August 2022

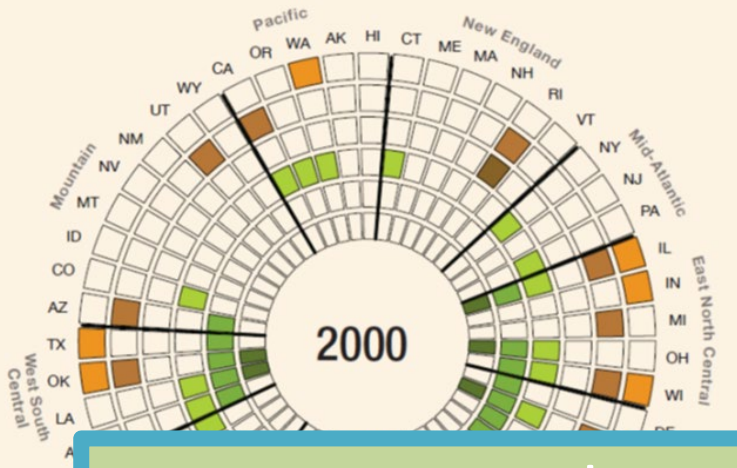




Punitive Policies Related to Substance Use in Pregnancy Proliferated

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

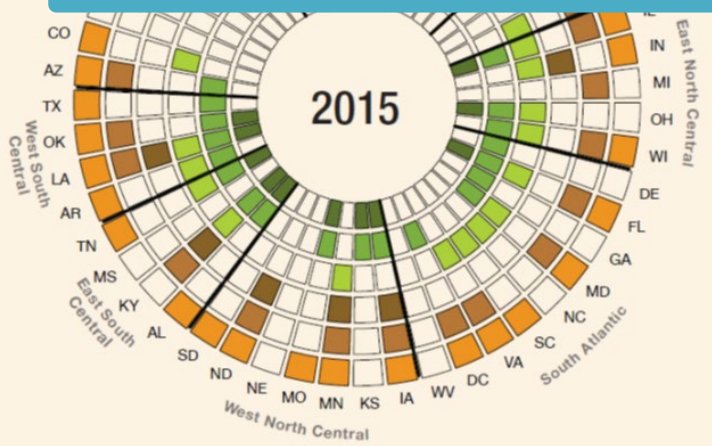


Punitive Policies Related to Substance Use in Pregnancy Proliferated

US Drug Policy: Less Punitive

State Policies Drugs + Pregnancy: More Punitive

Driven by Increasing Restrictive Reproductive Policies



1. Roberts, et al., *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
2. Paltrow, *The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and effects.* Reproductive Health Matters, 2002

“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

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?
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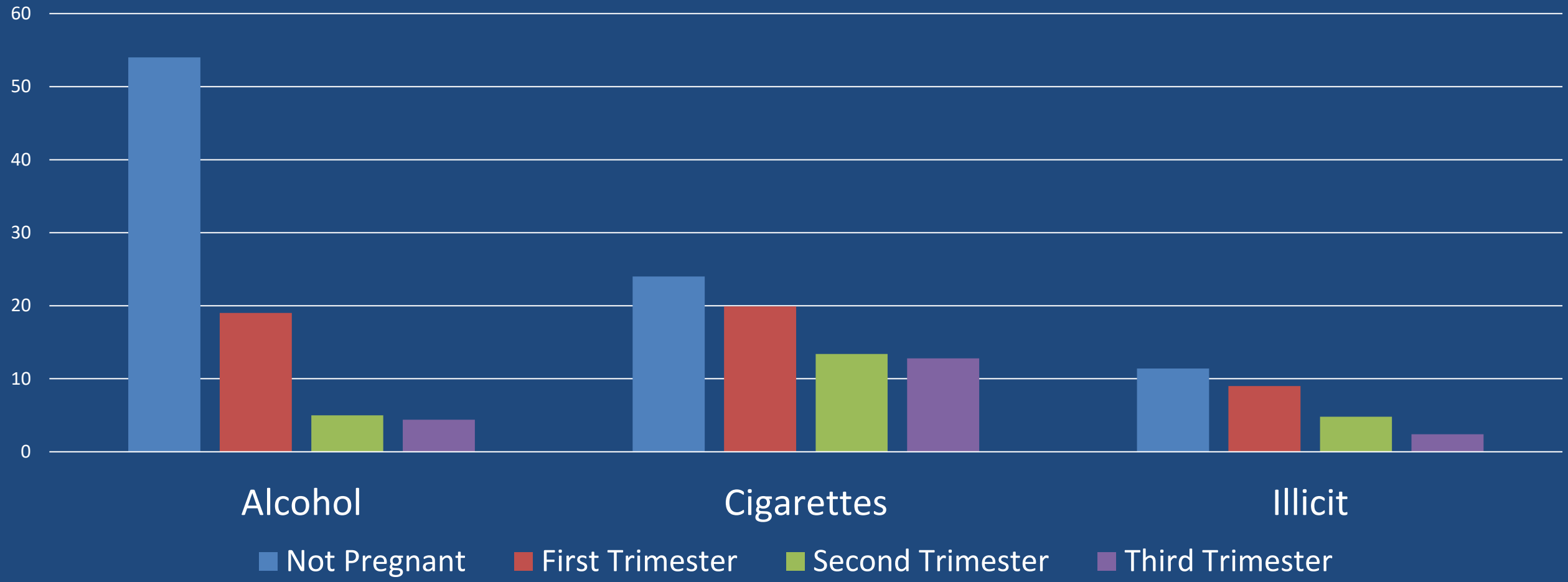
What happens when people who use drugs get pregnant?

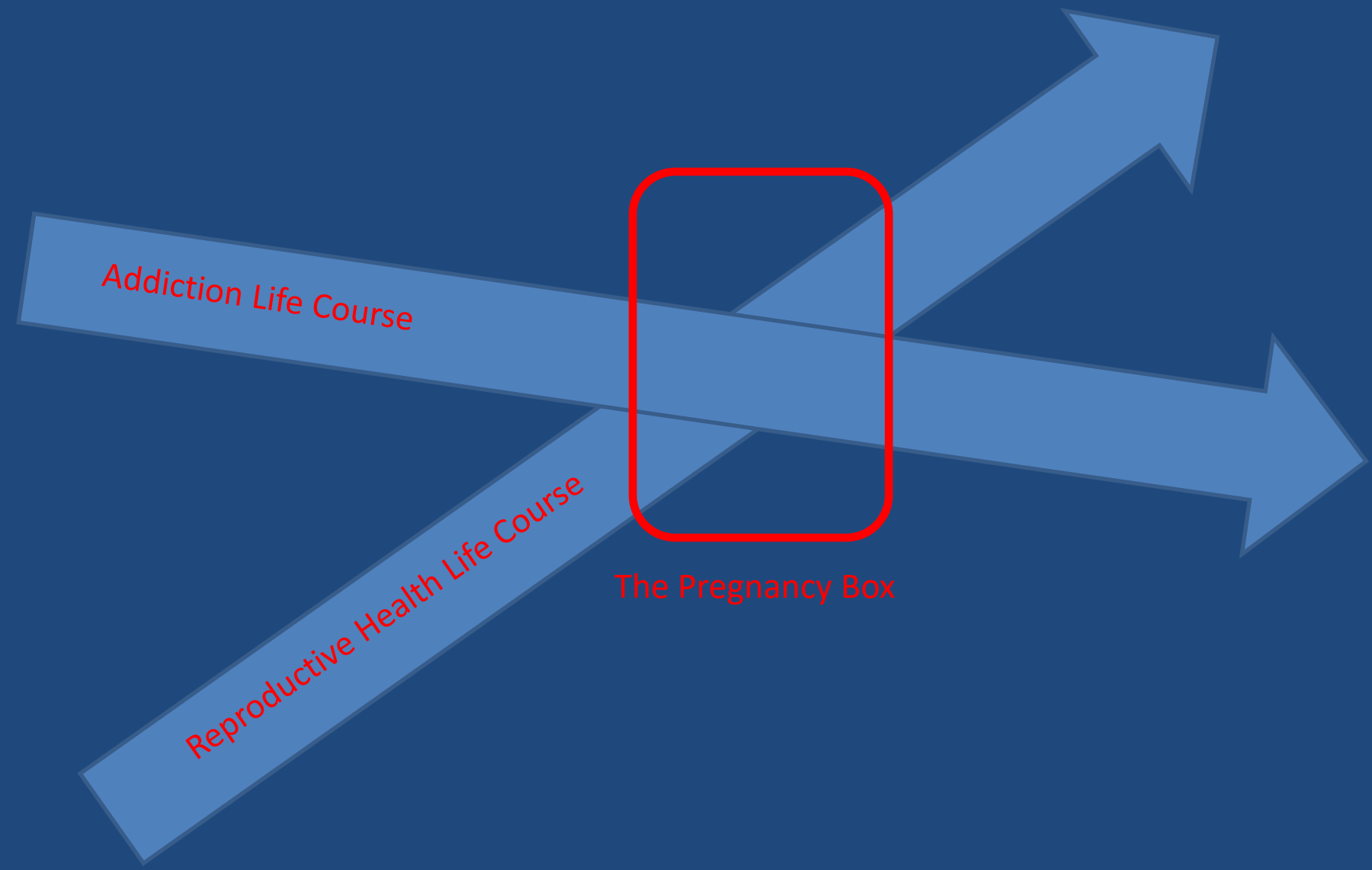


National Survey Drug Use and Health 2015/2016 Past Month Use Data

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 people 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?

Alternative to Punishment: Addiction is a Medical and Public Health not Criminal Legal Issue

- Addiction is a Chronic Medical Condition
- Treatment Works
- Recovery is Possible

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

Barry Stimmel, MD, Karlis Adamsons, MD, PhD

1976

• 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

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%

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

Racial Inequities in MOUD

Table 2. Adjusted and Unadjusted Odds Ratios for Use of Medication and Type of Medication for Pregnant Women With Opioid Use Disorder

Variable	Odds ratio (95% CI)		Pseudo-R^2	
	Unadjusted	Adjusted[a]	Full model	Model without race/ethnicity
Any treatment use			0.09	0.06
Medication vs no medication				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.39 (0.30-0.51)	0.37 (0.28-0.49)		
Hispanic	0.44 (0.36-0.53)	0.42 (0.35-0.52)		
Consistency of treatment use			0.09	0.06
Consistent use vs no medication				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.26 (0.18-0.37)	0.24 (0.17-0.35)		
Hispanic	0.36 (0.28-0.46)	0.34 (0.27-0.44)		
Consistent vs inconsistent treatment use				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.44 (0.30-0.66)	0.44 (0.30-0.65)		
Hispanic	0.65 (0.50-0.85)	0.64 (0.48-0.83)		
Type of medication			0.12	0.09
Buprenorphine (alone) vs methadone (any)				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.53 (0.36-0.79)	0.60 (0.40-0.90)		
Hispanic	0.68 (0.52-0.90)	0.77 (0.58-1.01)		
Buprenorphine vs none				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.27 (0.19-0.39)	0.28 (0.19-0.40)		
Hispanic	0.36 (0.28-0.46)	0.37 (0.29-0.47)		

JAMA Network Open. 2020;3(5):e205734. doi:10.1001/jamanetworkopen.2020.5734

Journal of Substance Abuse Treatment 131 (2021) 108454

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

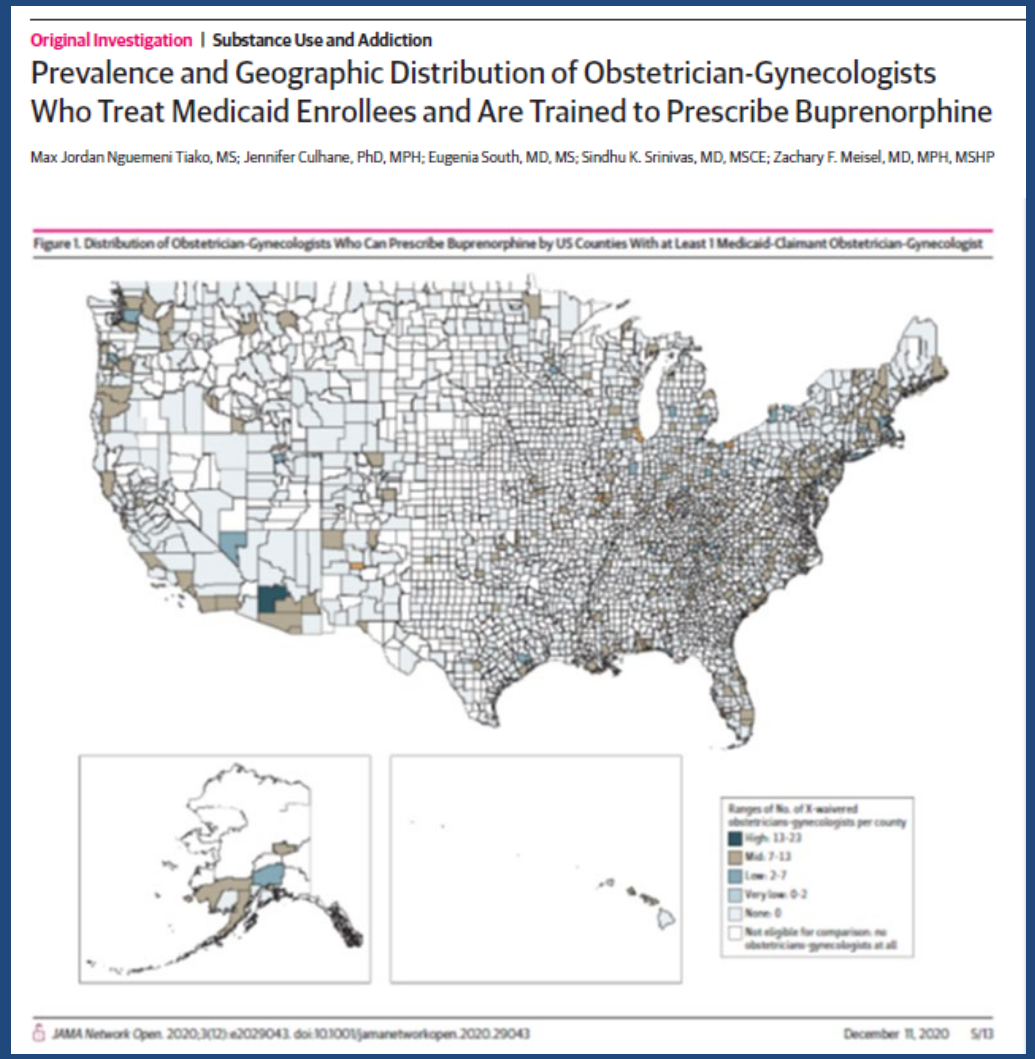
Racial inequity in methadone dose at delivery in pregnant women with opioid use disorder

Emily W. Rosenthal[a,*], Vanessa L. Short[b], Yuri Cruz[c], Cecily Barber[b], Jason K. Baxter[b], Diane J. Abatemarco[b], Amanda R. Roman[b], Dennis J. Hand[b,d]

[a] Department of Obstetrics & Gynecology, Boston Medical Center, 85 E. Concord St., Boston, MA 02118, United States of America
[b] Department of Obstetrics & Gynecology, Thomas Jefferson University, 833 Chestnut St., Philadelphia, PA 19107, United States of America
[c] Department of Obstetrics & Gynecology, St. Luke's Hospital, 801 Ostrum St., Bethlehem, PA 18015, United States of America
[d] Department of Psychiatry & Human Behavior, Thomas Jefferson University, 1233 Locust St. Suite 401, Philadelphia, PA 19107, United States of America

	White NH	Black NH	Hispanic
Methadone Dose	144.9	97.5	129.8

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

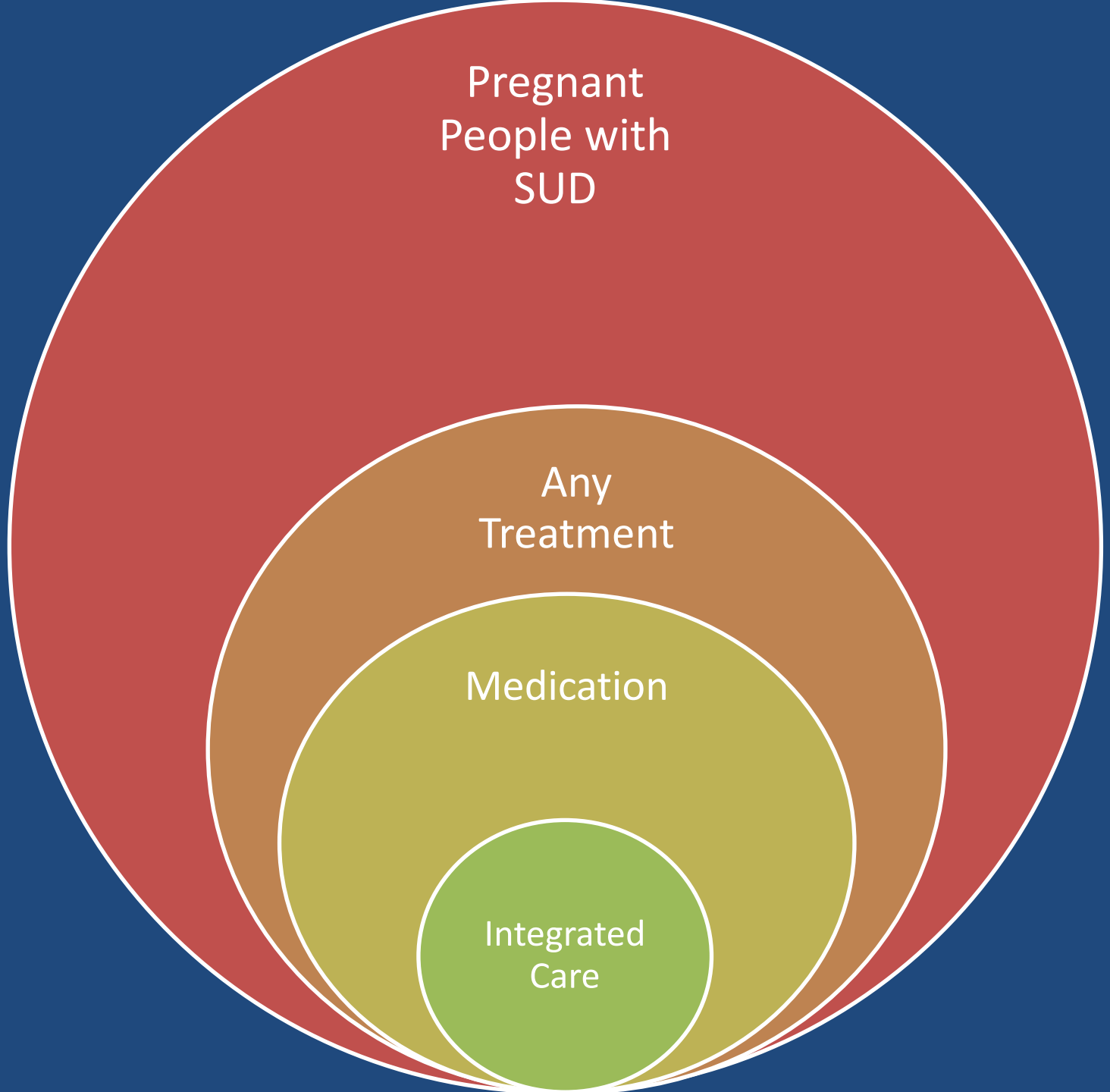
Figure 1. Distribution of Obstetrician-Gynecologists Who Can Prescribe Buprenorphine by US Counties With at Least 1 Medicaid-Claimant Obstetrician-Gynecologist

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 SUD



CONCLUSIONS OF THE NATIONAL ACADEMIES COMMITTEE

1. Opioid use disorder is a treatable chronic brain disease

2. FDA-approved medications to treat opioid use disorder are effective and save lives

3. Long-term retention on medication for opioid use disorder is associated with improved outcomes

4. A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder

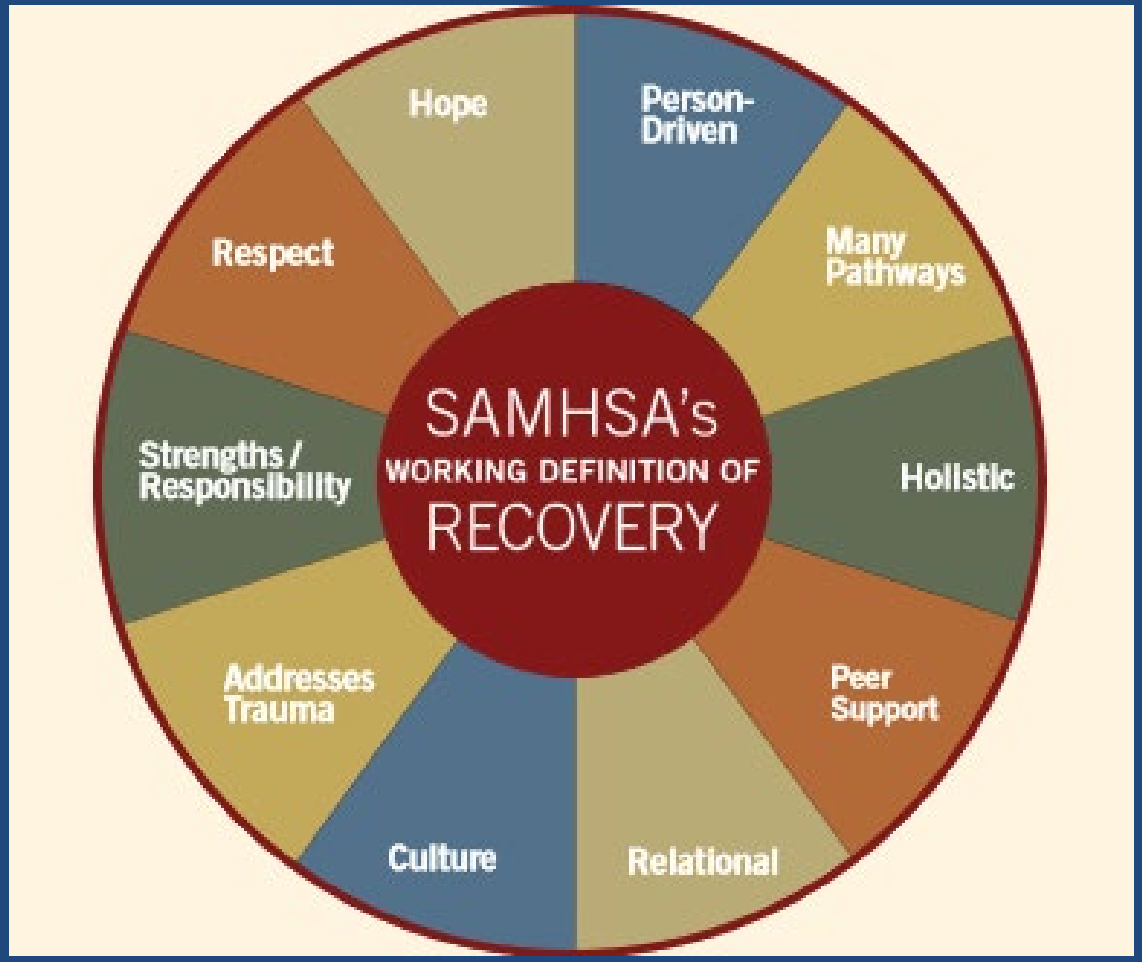
5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population

6. Medication-based treatment is effective across all treatment settings studied to date

7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis

Recovery is the Goal of Treatment

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



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:
Language is Important

Research paper

Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms☆

John F. Kelly*, Cassandra M. Westerhoff

Center for Addiction Medicine, Department of Psychiatry, Massachusetts General Hospital, 60 Staniford Street, Boston, MA 02114, United States

"Substance Abuser"

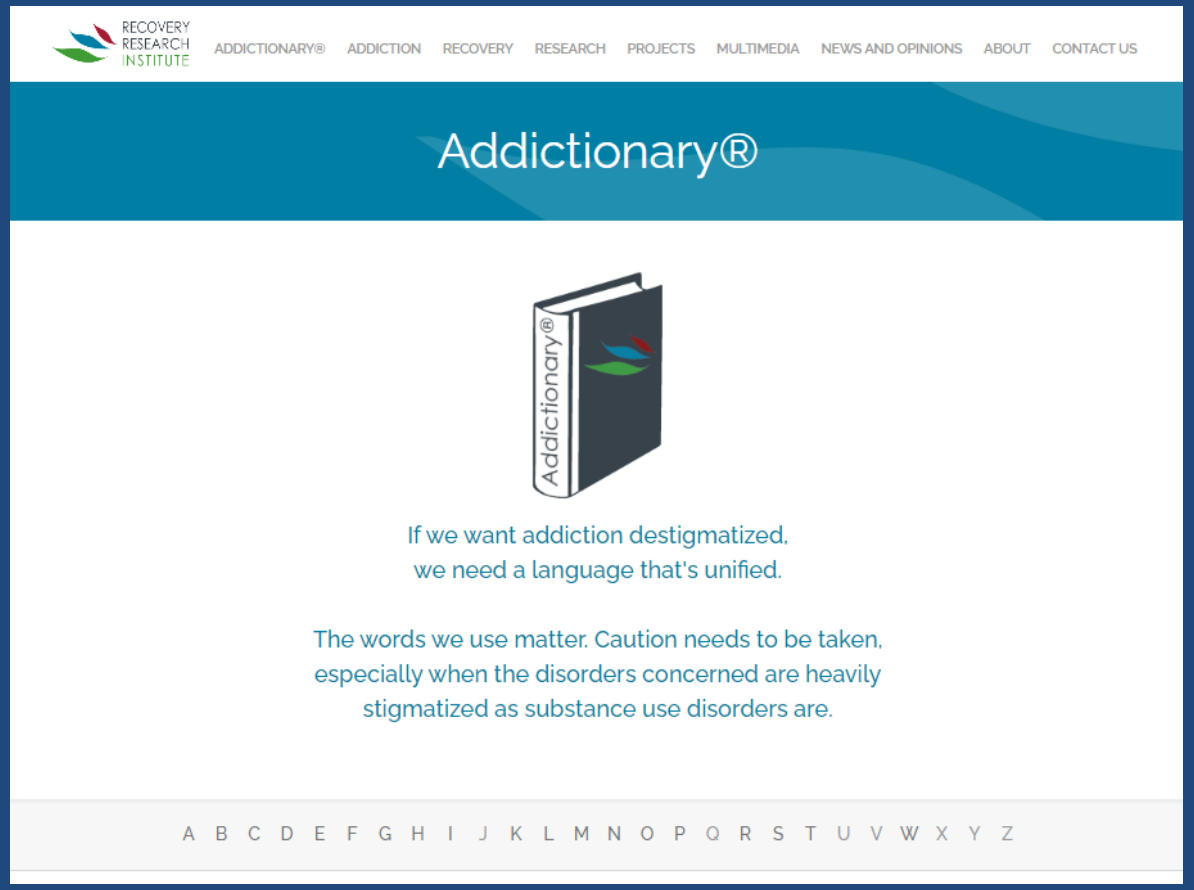
Mr. Williams is a substance abuser and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has been a substance abuser for the past few years. He now awaits his appointment with the judge to determine his status.

"Substance Use Disorder"

Mr. Williams has a substance use disorder and is attending a treatment program through the court. As part of the program Mr. Williams is required to remain abstinent from alcohol and other drugs. He has been compliant with program requirements, until one month ago, when he was found to have two positive urine toxicology screens which revealed drug use and a breathalyzer reading which revealed alcohol consumption. Within the past month there was a further urine toxicology screen revealing drug use. Mr. Williams has had a substance use disorder for the past few years. He now awaits his appointment with the judge to determine his status.

Figure 1 Randomly assigned study vignettes describing the same individual as either a "substance abuser" or as "having a substance use disorder".

Use Language That:



https://www.recoveryanswers.org/addiction-ary/

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

Stigmatizing language	Preferred language
Addict, junkie, abuser	Person in active addiction Person with a substance use disorder Person in recovery
Addicted baby	Neonate with in-utero exposure to [substance] Neonatal abstinence syndrome
Substance abuse	Substance use or misuse Substance use disorder
Clean or sober	Abstinent SUD in remission Testing “negative” for [substance]
Dirty	Using [substance] Testing “positive” for [substance]
Replacement or substitution therapy, medication-assisted treatment	Medication for opioid use disorder (MOUD) Treatment
Getting or being high	Intoxicated Under the influence of [substance]
Shooting up	Intravenous or injection drug use
Relapse	Return to use SUD recurrence

Resisting Stigma and Discrimination By Speaking

Trust-Building through clinical discussion

- What is the most important thing to you about treatment or recovery?
- What do you know about methadone?
- Do you have any fears or concerns from previous treatment experiences?
- What do you need to feel safe?
- What are you looking for in a provider?
- How do you feel your care is going so far?

Build Trust by Practicing Empathy

- 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
Stigma and Discrimination: Patient Safety

Original research

OPEN ACCESS

First do no harm: practitioners' ability to 'diagnose' system weaknesses and improve safety is a critical initial step in improving care quality

Mike English ,[1,2] Muthoni Ogola,[2,3] Jalemba Aluvaala ,[2,3] Edith Gicheha,[2,4] Grace Irimu,[2,3,4] Jacob McKnight,[1] Charles A Vincent[5]

[1]Oxford Centre for Global Health Research, Nuffield Department of Medicine, University of Oxford, Oxford, UK
[2]Health Services Unit, KEMRI-Wellcome Trust Research Programme, Nairobi, Kenya
[3]Department of Paediatrics and Child Health, University of Nairobi, Nairobi, Kenya
[4]Kenya Paediatric Research Consortium, Nairobi, Kenya
[5]Experimental Psychology, University of Oxford, Oxford, UK

Correspondence to

ABSTRACT

Healthcare systems across the world and especially those in low-resource settings (LRS) are under pressure and one of the first priorities must be to prevent any harm done while trying to deliver care. Health care workers, especially department leaders, need the diagnostic abilities to identify local safety concerns and design actions that benefit their patients. We draw on concepts from the safety sciences that are less well-known than mainstream quality improvement techniques in LRS. We use these to illustrate how to analyse the complex interactions between resources and tools, the organisation of tasks and the norms that

What is already known on this topic?

- Harm resulting from unsafe care is common and results in significant adverse health and economic consequences in high-income countries.
- Efforts to prevent or reduce harms often focus on identifying errors so that their specific causes can be addressed.
- More recently, attention has been turned to considering how harms arise as a product of complex interactions in systems.

LOUISIANA DEPARTMENT OF HEALTH

PARTNERS FOR FAMILY HEALTH LOUISIANA

Policy Checklist: Screening For Substance Use Disorder

Drug addiction affects all racial, ethnic, and sociodemographic groups. **Universal screening for substance use disorder (SUD) with a standardized, evidence-based screening tool should be implemented at all locations that provide medical care to pregnant and birthing persons.** Screening *all* birthing persons, regardless of substance use history, minimizes the potential for providers relying on subjective risk factors to determine who should be screened and may also decrease the stigma associated with SUD and screening.

Birthing facilities should include following elements in their SUD/OUD screening-related policies, guidelines and procedures.

addressed in policy?	best practice to include in policy
	screening, assessment and level of care determination
	That all patients, regardless of history of substance use/misuse, will be screened. • Clarify which tool will be used (4Ps, 4Ps Plus, NIDA Quick Screen, CRAFFT (birthing persons 12- 26))
	When and where patients will be **screened.** • For example: Screening is performed privately, at least once a trimester and upon delivery admission
	Process for screening, including: • How it will be administered (print version, computer version, self-administered or administered by staff member) • Who administers (which staff members) • How/when results will be reviewed and documented
	What happens when there is a positive screen relative to: **establishing a diagnosis** • For example: use a validated verbal assessment tool to establish the diagnosis and severity of SUD • Possible tools: AUDIT-C (alcohol specific), ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test), and DAST-10 (drug use)
	What happens when there is a positive screen relative to: **brief intervention and referral to treatment** • Should include who intervenes, how they intervene, where and what level of care the patient will be referred, and who completes the referral • Should include harm reduction strategies • Should include process for warm handoffs, when appropriate
	What happens when there is a positive screen relative to: **polysubstance use** • Patient education and referral to appropriate resources
	What happens when there is a positive screen relative to: **reporting to DCFS** • Who reports and when • How patients are informed of reporting and next steps
	How patient autonomy, confidentiality, and integrity or patient-physician relationship is protected (to the extent allowable by laws regarding disclosure or substance use disorder).

Top 5 Do No Harm Checklist

1) Check your systems in which individuals navigate getting care. Change adversarial systems into supportive spaces
2) Check the entire care team. From the front desk to physicians, everyone who interacts with patients should have an understanding of what harm is, why understanding it is important, and how to prevent it.
3) Check your biases. Understand that everyone is biased, including you. Understanding and addressing your own biases is a life-long journey.
4) Check each other. Sometimes the person causing the harm does not realize s/he is doing it.
5) Check your listening skills. Believe what people are telling you and know that listening is key to understanding and providing respectful care.

Developed through DC Equity Action Lab at DC Primary Care Association. Based on the Top 5 Do No Harm list created by Ebony Marcelle, CNM, MS, FACNM, Director of Midwifery at Community of Hope and Family Health and Birth Center. Contact the DC Primary Care Association for the full Do No Harm Guide.

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

Evidence-Based

AND

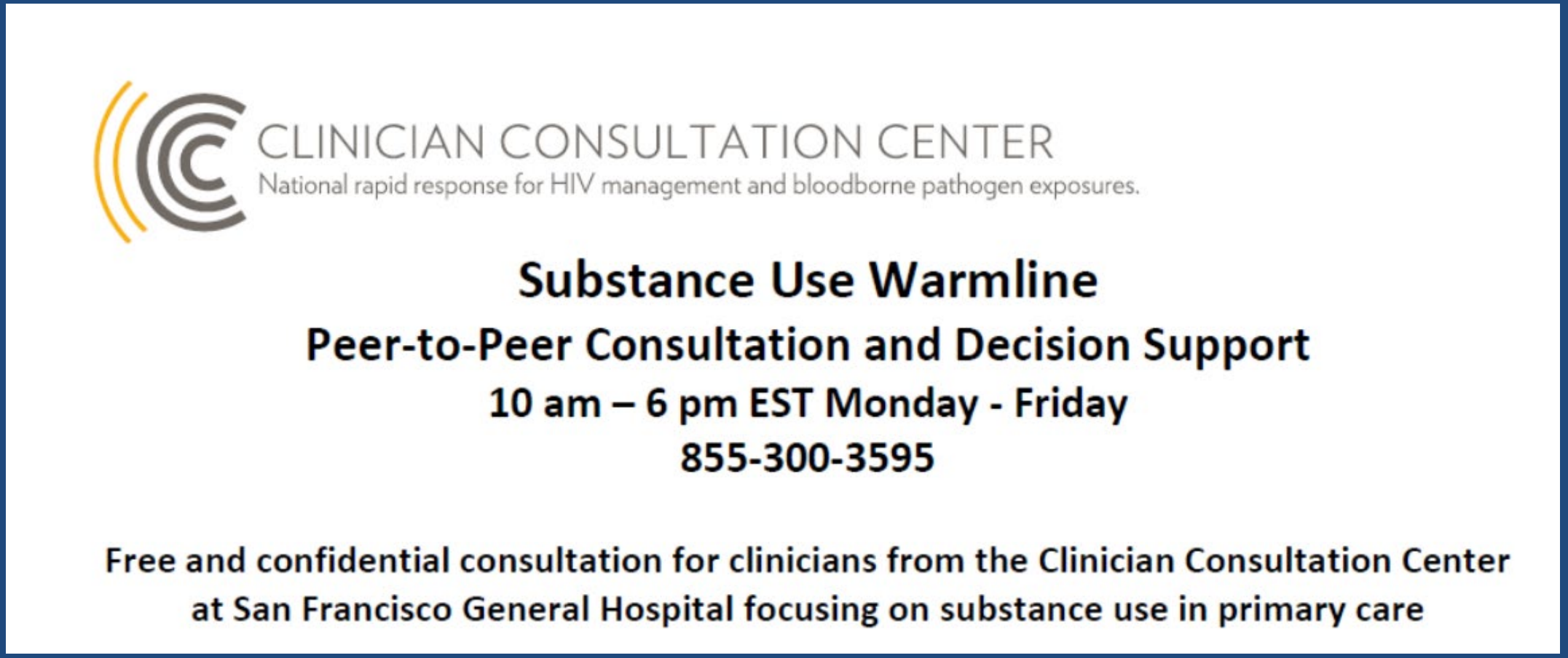
Person-Centered

Do Less Harm

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

Thank You

Mishka Terplan Mterplan@friendsresearch.org



Resources

- Buprenorphine waiver training for OBGYNs ASAM https://elearning.asam.org/products/treatment-of-opioid-use-disorder-course-obgyn-focus#tab-product_tab_overview
- ASAM buprenorphine mini-course https://elearning.asam.org/p/BupMini_2021#tab-product_tab_overview

Q&A

Please feel free to **unmute** and ask questions

You may also enter comments or questions in the ”chat” box

Next Steps

- ✓ Establish team meeting schedule (at least monthly)
  - ✓ Review NOWS toolkit, data collection forms, develop plan for data collection, discuss team roles.
- ✓ Newly enrolled teams:
  - ✓ Submit baseline survey if have not done so already.
- ✓ Update your NOWS Team Roster
  - ✓ alpqc.org/initiatives/nows under “Key Documents” menu.

Important Dates

Data Portal Office Hours:

- September 27: 12:00 – 1:30 PM
- September 29: 8:30 – 10:00 AM

Let us know if you did not receive the zoom link

Reporting Due Dates:

- September 30, 2022
  - Baseline (Current State) data - for April, May, June, July 2022
- October 15, 2022
  - Monthly data - for August 2022; *normally due on last day of month*
  - Quarterly data - for July-September 2022; *normally due on last day of quarter*
- October 31, 2022
  - Monthly data - for September 2022
  - *Resume regular monthly reporting schedule: reporting on last day of the month*

Data Reporting

BASELINE Measures

Process & Outcome Measures		Measurement Period	Reporting Due
Neonatal	A. A: Did the infant have evidence of opioid withdrawal?	April, May, June, July 2022	September 30, 2022
	B. Was a non-pharmacologic guideline used throughout the infant's hospitalization?		
	C. C: Did infant receive pharmacologic treatment?		
	D. D: **If** infant received pharmacologic treatment, for how many days did the infant receive treatment (Birth is day "0")		
	E. How many days old was the infant at discharge (Birth is day "0")		
	F. Was a Collaborative Discharge Plan completed prior to discharge?		
	G. If not born at your facility, how many days old was infant when transfer was received?		
	H. Was the infant readmitted for any cause within 10 days of discharge?		
Obstetrical	A. Was the patient on Medication for Opioid Use Disorder (MOUD)? (e.g. on prescribed methadone/ Subutex/etc.)		
	B. Was the patient referred to addiction services prior to maternal discharge?		
	C. Was Narcan counseling documented in the medical record prior to patient discharge?		

All Measures Reported by Race/ Ethnicity

Find data forms, including ICD-10 codes, on our website at www.alpqc.org/initiatives/nows, under the "Data Resources" menu

Data Reporting

MONTHLY Measures

Process & Outcome Measures		Measurement Period	Reporting Due
Neonatal	A. A: Did the infant have evidence of opioid withdrawal?	Aug 2022	Oct 15 2022*
	B. Was a non-pharmacologic guideline used throughout the infant's hospitalization?		
	C. C: Did infant receive pharmacologic treatment?		
	D. D: **If** infant received pharmacologic treatment, for how many days did the infant receive treatment (Birth is day "0")		
	E. How many days old was the infant at discharge (Birth is day "0")	Sep 2022	Oct 31, 2022
	F. Was a Collaborative Discharge Plan completed prior to discharge?		
	G. If not born at your facility, how many days old was infant when transfer was received?	Oct 2022	**Nov 30, 2022**
	H. Was the infant readmitted for any cause within 10 days of discharge?	Nov 2022	**Dec 31, 2022**
		Dec 2022	**Jan 31, 2023**
		…	…
Obstetrical	A. Was the patient on Medication for Opioid Use Disorder (MOUD)? (e.g. on prescribed methadone/ Subutex/etc.)		
	B. Was the patient referred to addiction services prior to maternal discharge?		
	C. Was Narcan counseling documented in the medical record prior to patient discharge?		

All Measures Reported by Race/ Ethnicity

* Normally data due on last day of the following month.

Find data forms, including ICD-10 codes, on our website at www.alpqc.org/initiatives/nows, under the "Data Resources" menu

Data Reporting

QUARTERLY Measures

Structure Measure	Measurement Period	Reporting Due*
1. Hospital has implemented education practices for hospital staff for reducing stigma in opioid-exposed newborns (OENs)		
2. Hospital has implemented education practices for hospital staff for scoring OENs	July – Sep 2022	Oct 15, 2022*
3. Hospital has implemented standardized non-pharmacologic guidelines for OENs	Oct – Dec 2022	**Dec 31, 2022**
4. Hospital has implemented standardized practices of when to transfer infants with NOWs to a higher level of care	Jan – Mar 2023	**Mar 31, 2023**
5. Hospital has implemented standardized pharmacologic guidelines for infants with NOWS	Apr – Jun 2023	**Jun 30, 2023**
6. Hospital has implemented standardized protocols/guidelines for Collaborative Discharge Plan for mothers and infants	July – Sep 2023	**Sep 30, 2023**
	…	…

* Normally data due on last day of the quarter

Find data forms, including ICD-10 codes, on our website at www.alpqc.org/initiatives/nows, under the “Data Resources” menu

Thank You

Next Meeting:
Wednesday, October 26, 2022
12:00 – 1:00 PM CST

info@alpqc.org