Drug Policy, Pregnancy, and Discrimination: Care in Context

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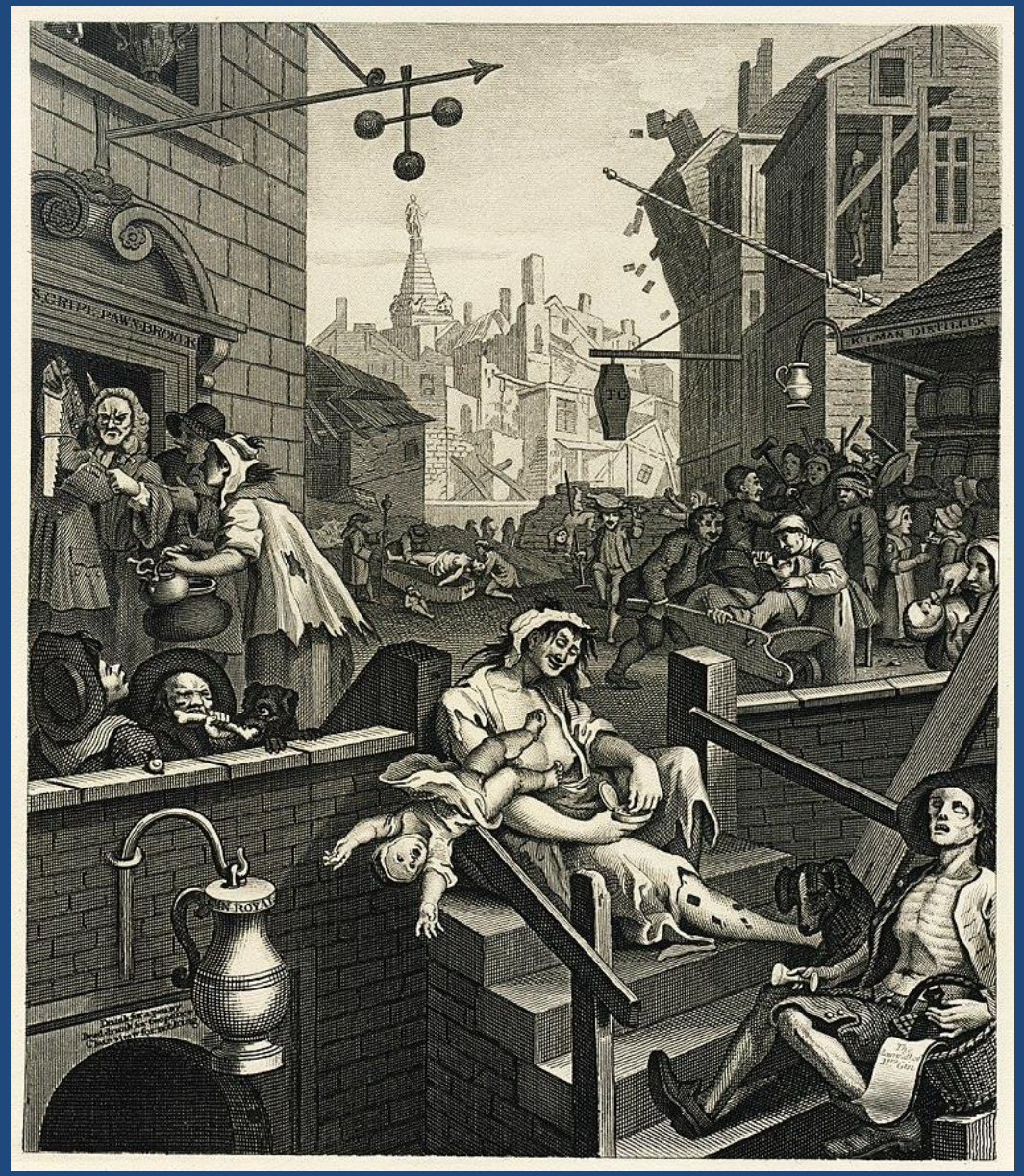
Associate Medical Director, Friends Research Institute
National Clinician Consultation Center, Substance Use Warmline, UCSF
Deputy Chief Clinical Officer, Department Behavioral Health, DC
@DoLessHarm

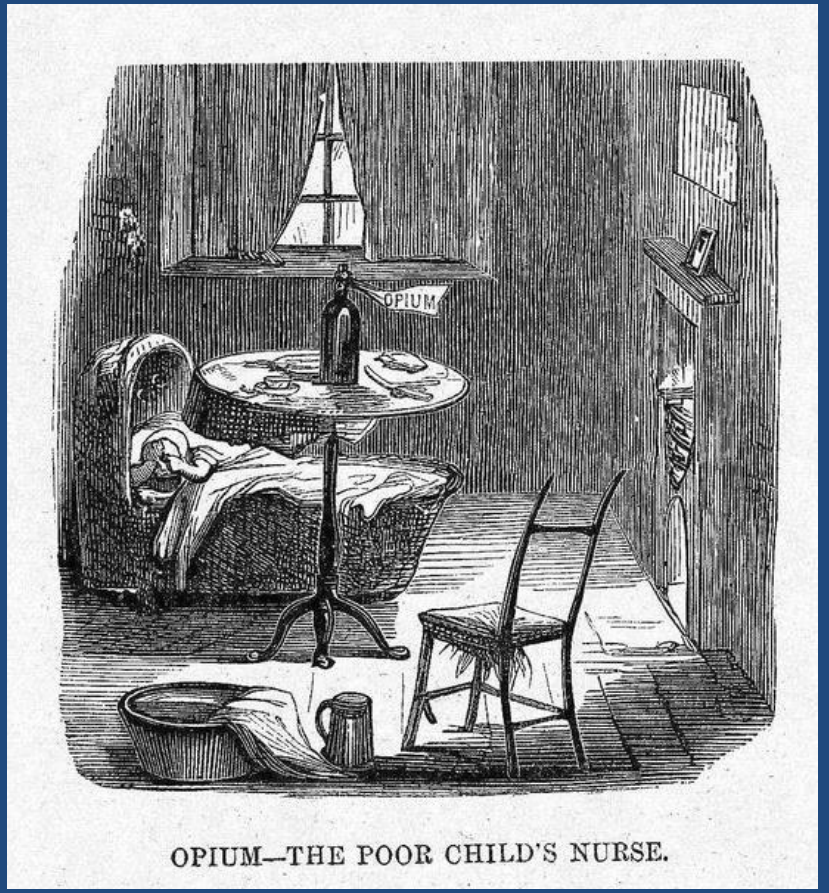
PA PQC March 24, 2021

Psychoactive Substance Use is Ancient

Addiction is Modern Phenomena



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



OPIUM—THE POOR CHILD'S NURSE.

The First Opioid Crisis

MORPHINISM

AND

NARCOMANIAS FROM OTHER DRUGS

THEIR

ETIOLOGY, TREATMENT, AND MEDICOLEGAL RELATIONS

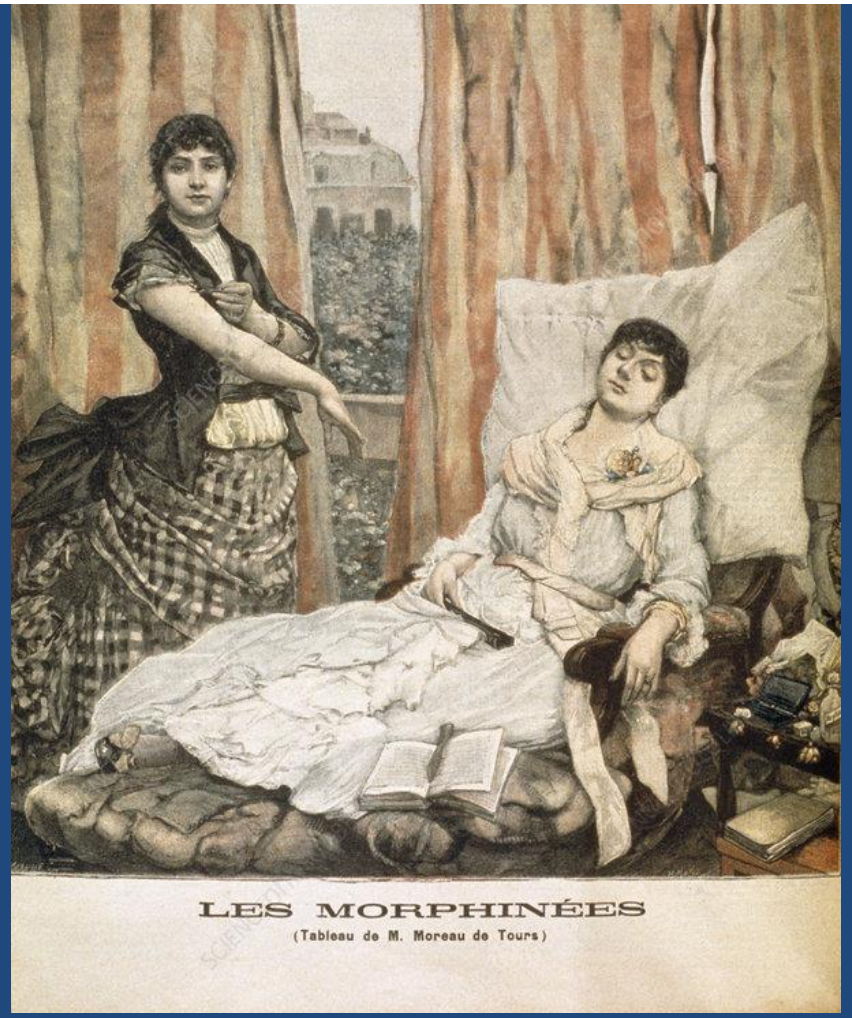
BY

T. D. CROTHERS, M.D.

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

PHILADELPHIA AND LONDON
W. B. SAUNDERS & COMPANY
1902

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

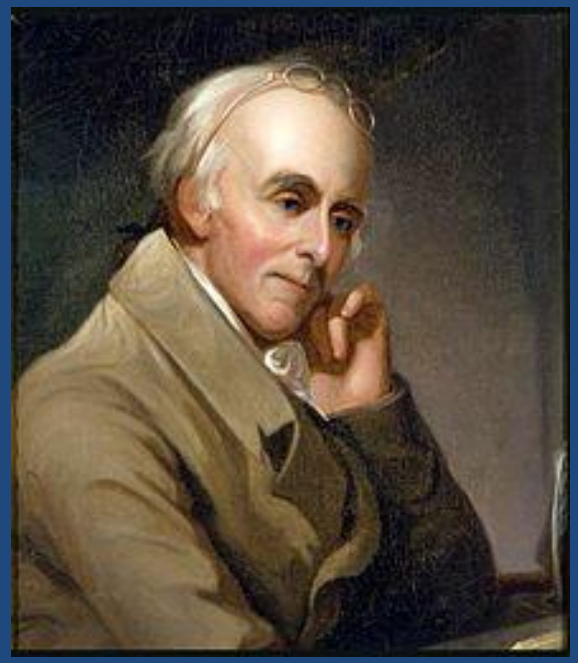


LES MORPHINÉES

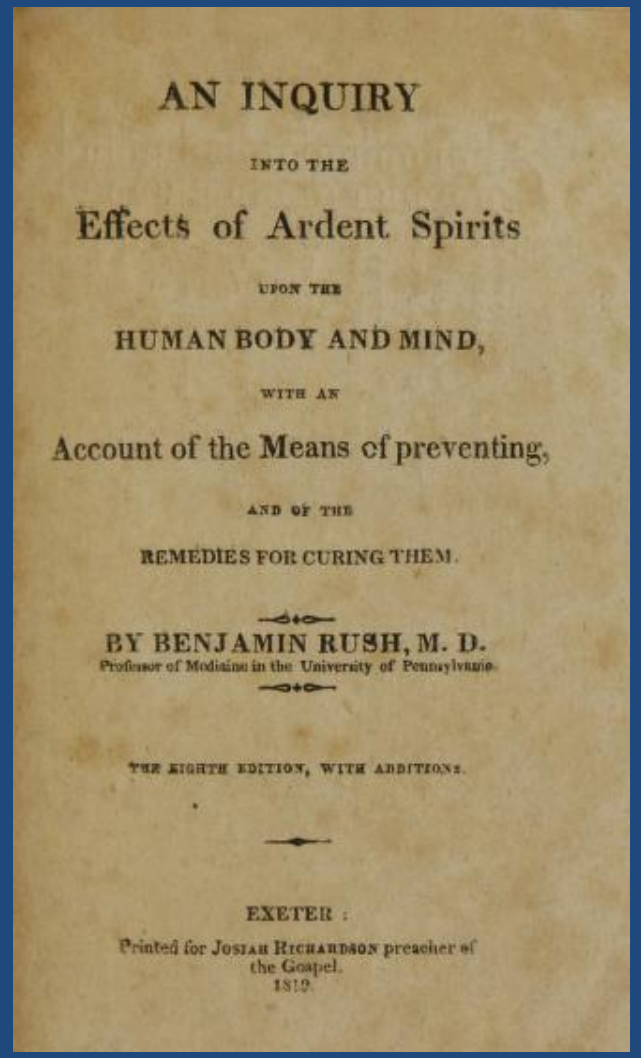
(Tableau de M. Moreau de Tours)

Turn of the Century Treatment: Addiction is a Disease

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



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



AN INQUIRY

INTO THE

Effects of Ardent Spirits

UPON THE

HUMAN BODY AND MIND,

WITH AN

Account of the Means of preventing,

AND OF THE

REMEDIES FOR CURING THEM.

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

THE EIGHTH EDITION, WITH ADDITIONS.

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

Substance Use and Addiction: Early 20th Century

19th Century

Medical
and
Public Health

Women
White
Upper SES

20th Century

Criminal
Justice

Men
Non-White
Lower SES

PUBLIC ACTS OF THE SIXTY-THIRD CONGRESS

OF THE

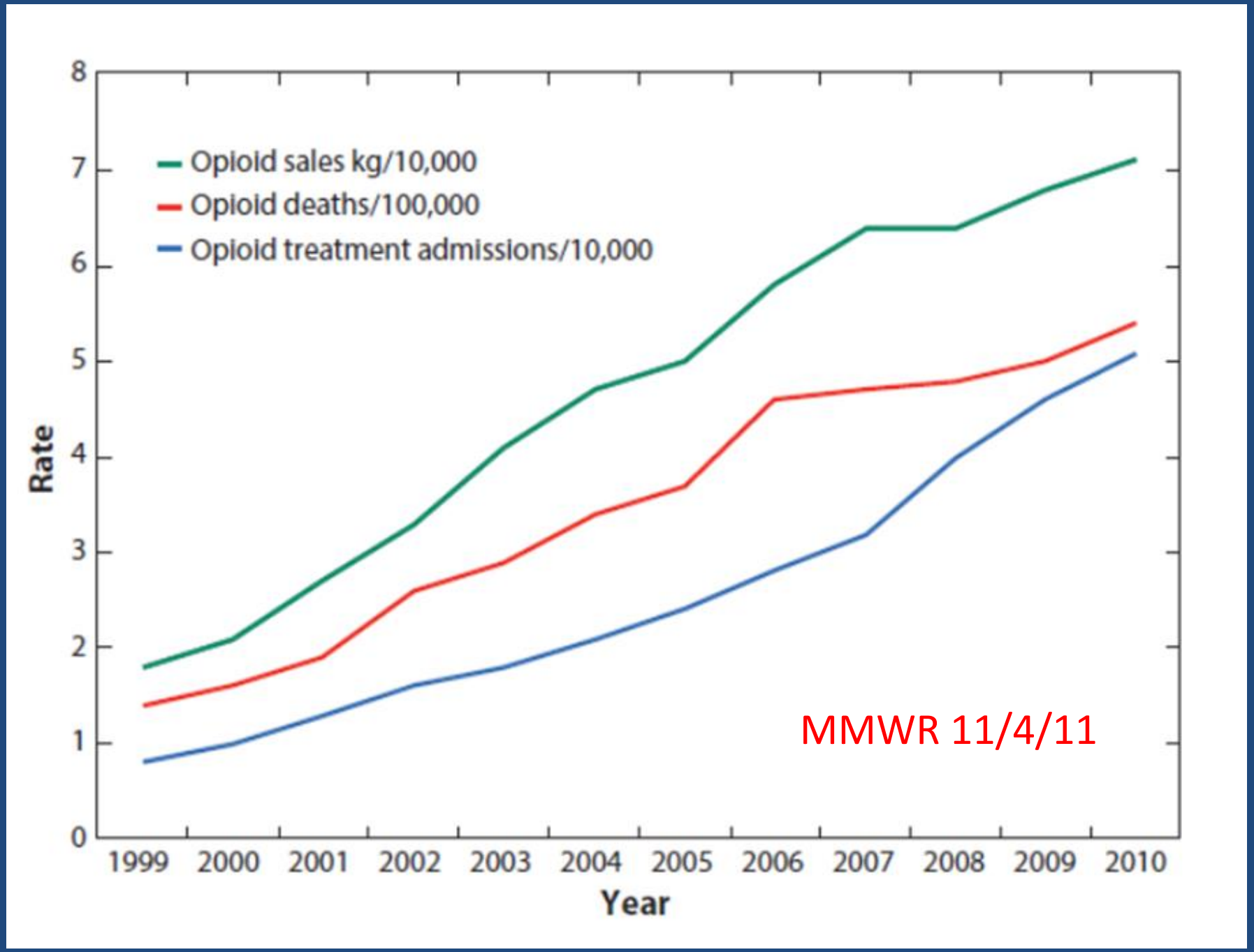
UNITED STATES

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

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

The Current Opioid Crisis:

Iatrogenic



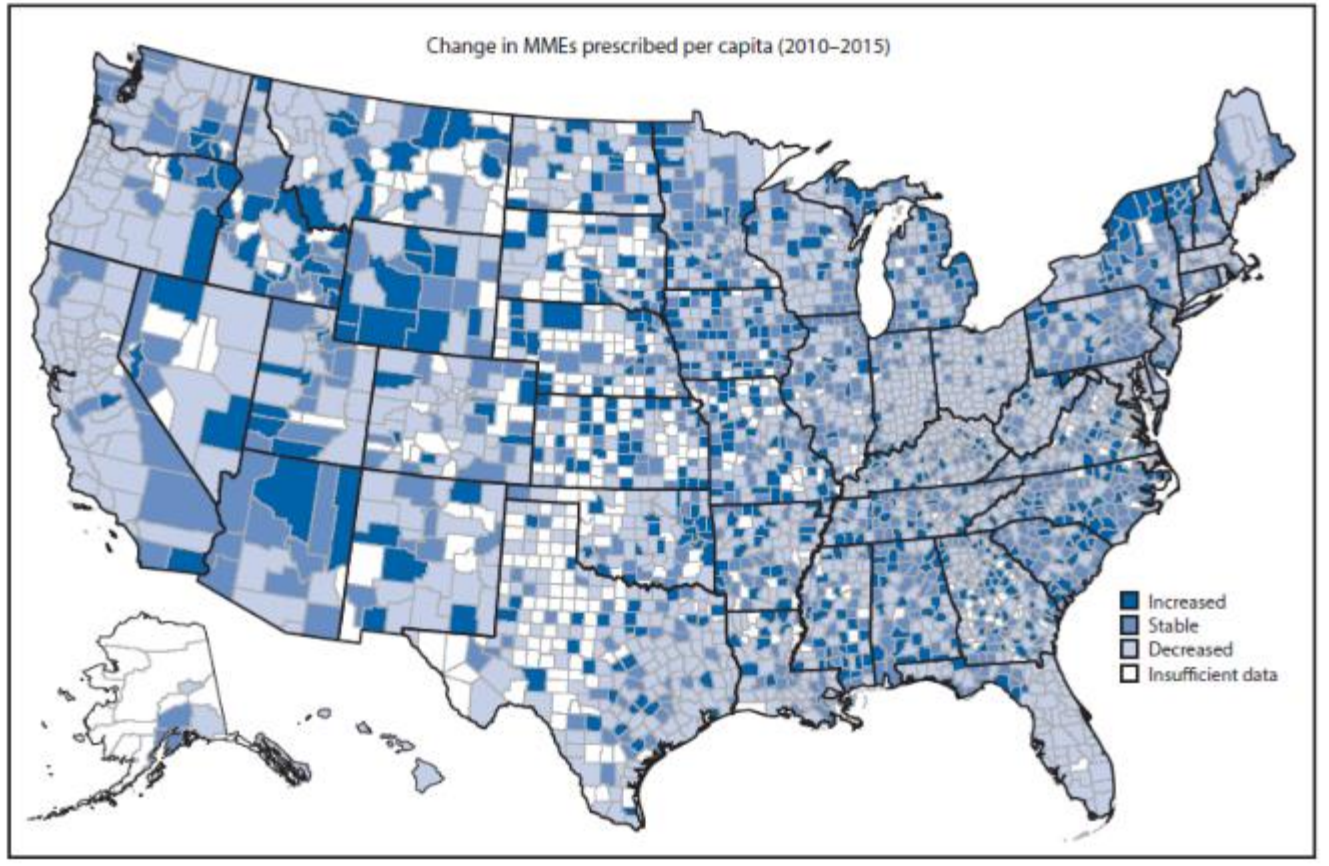
Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015

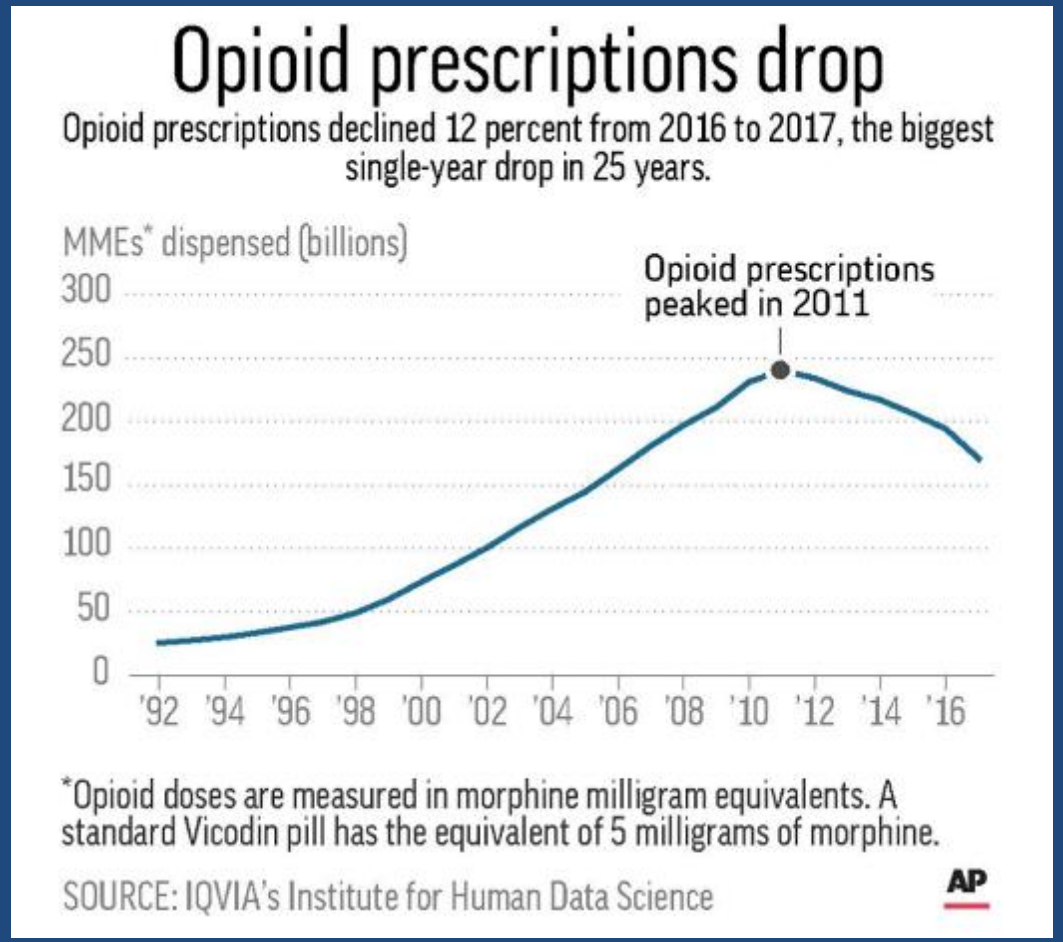
Gery P. Guy Jr., PhD[1]; Kun Zhang, PhD[1]; Michele K. Bohm, MPH[1]; Jan Losby, PhD[1]; Brian Lewis[2]; Randall Young, MA[2]; Louise B. Murphy, PhD[3]; Deborah Dowell, MD[1]

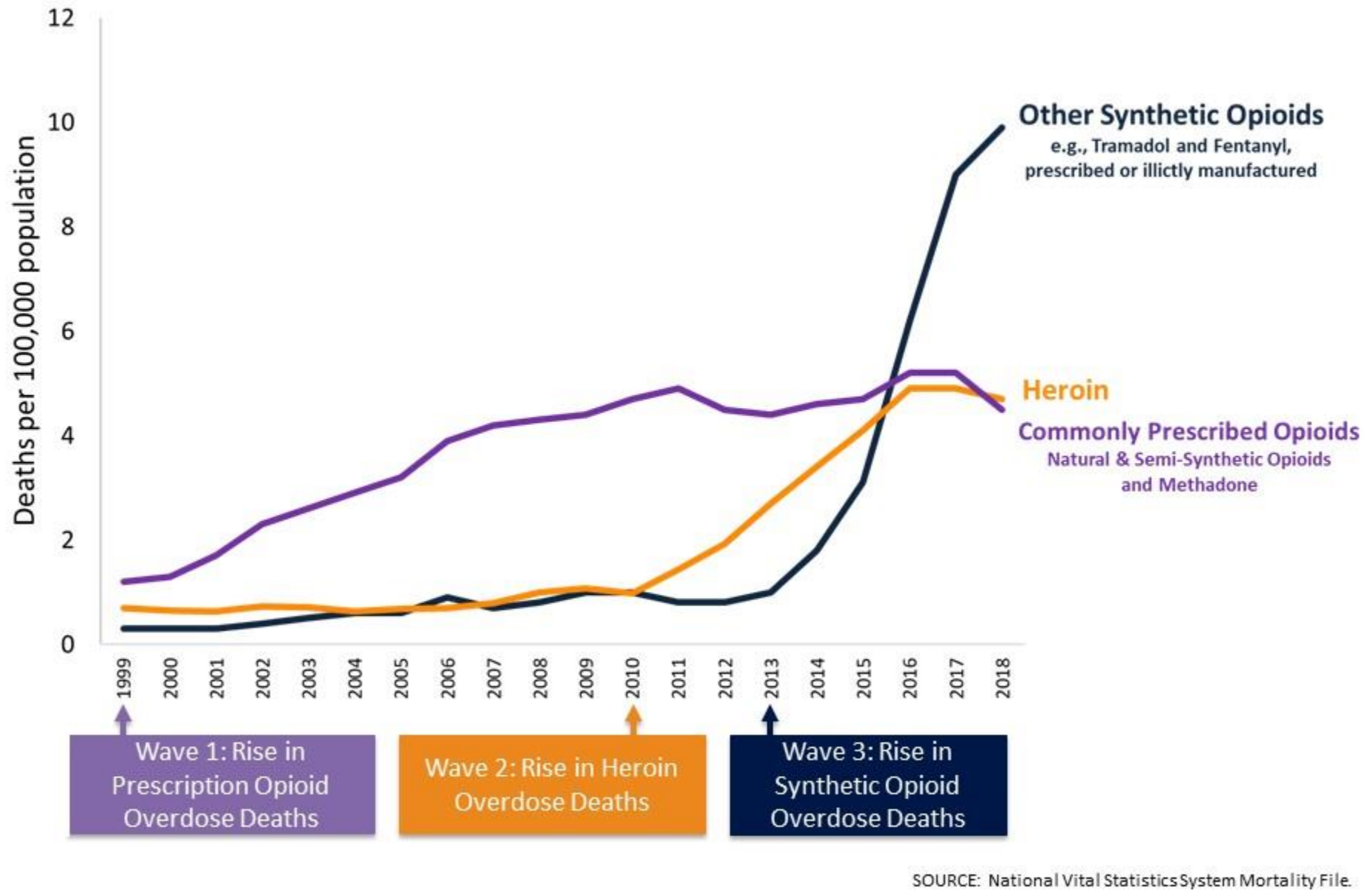
MMWR / July 7, 2017 / Vol. 66 / No. 26

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

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







The Opioid Crisis: A Triple Wave Epidemic

Thanks to Dan Cicarrone

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

Anne Case[1] and Angus Deaton[1]

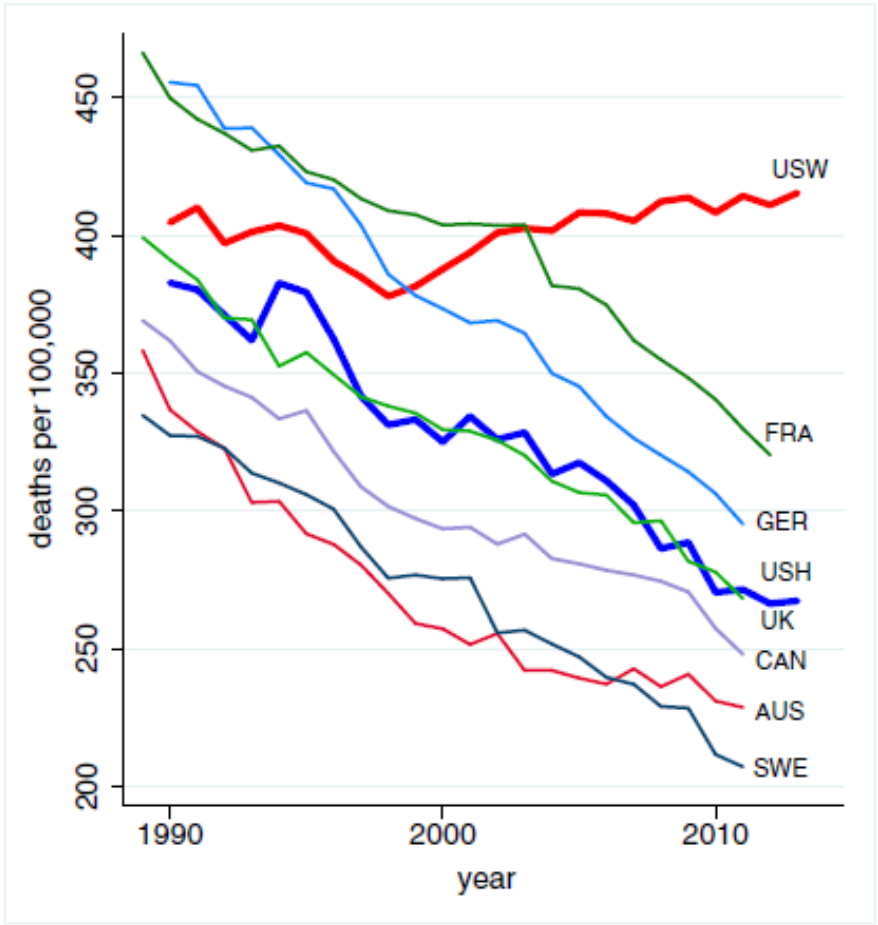


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

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

The New York Times

In Heroin Crisis, White Families Seek Gentler War on Drugs

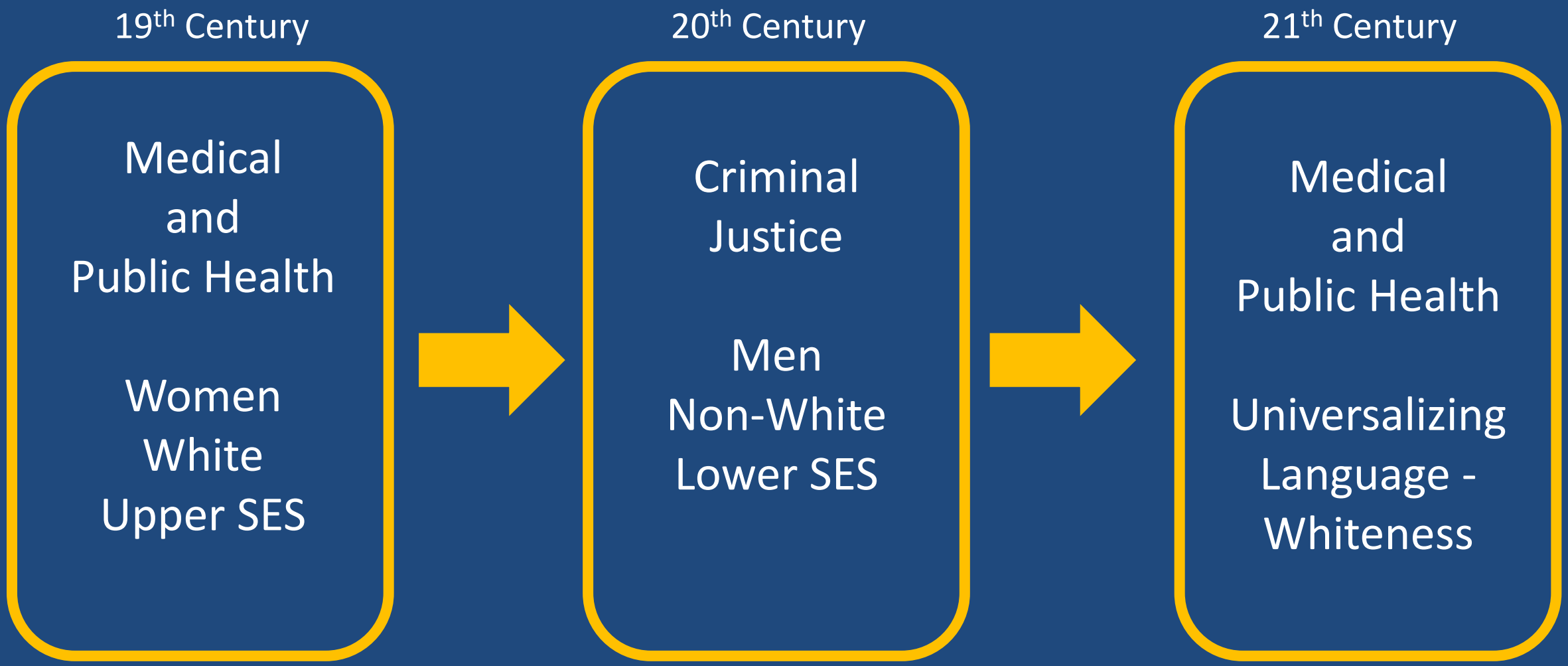
Amanda Jordan with her son Brett Honor outside a meeting for people with addictions and their families in Plaistow, N.H. Her son Christopher died of an overdose. Katherine Taylor for The New York Times

By Katharine Q. Seelye

Oct. 30, 2015

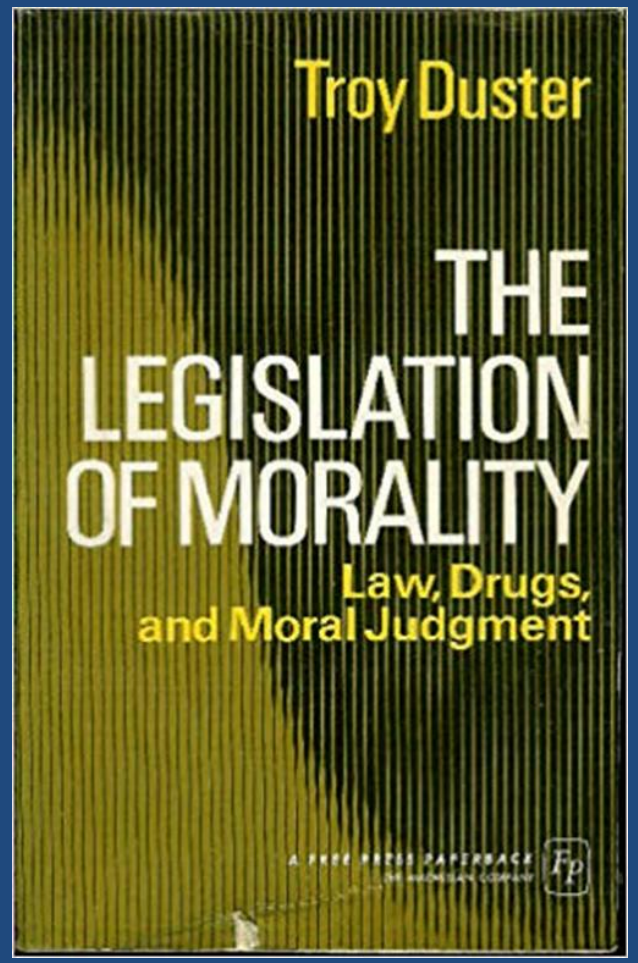
833

Substance Use and Addiction



Race, The War on Drugs and Public Health Response

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



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

Gender and the Opioid Crisis

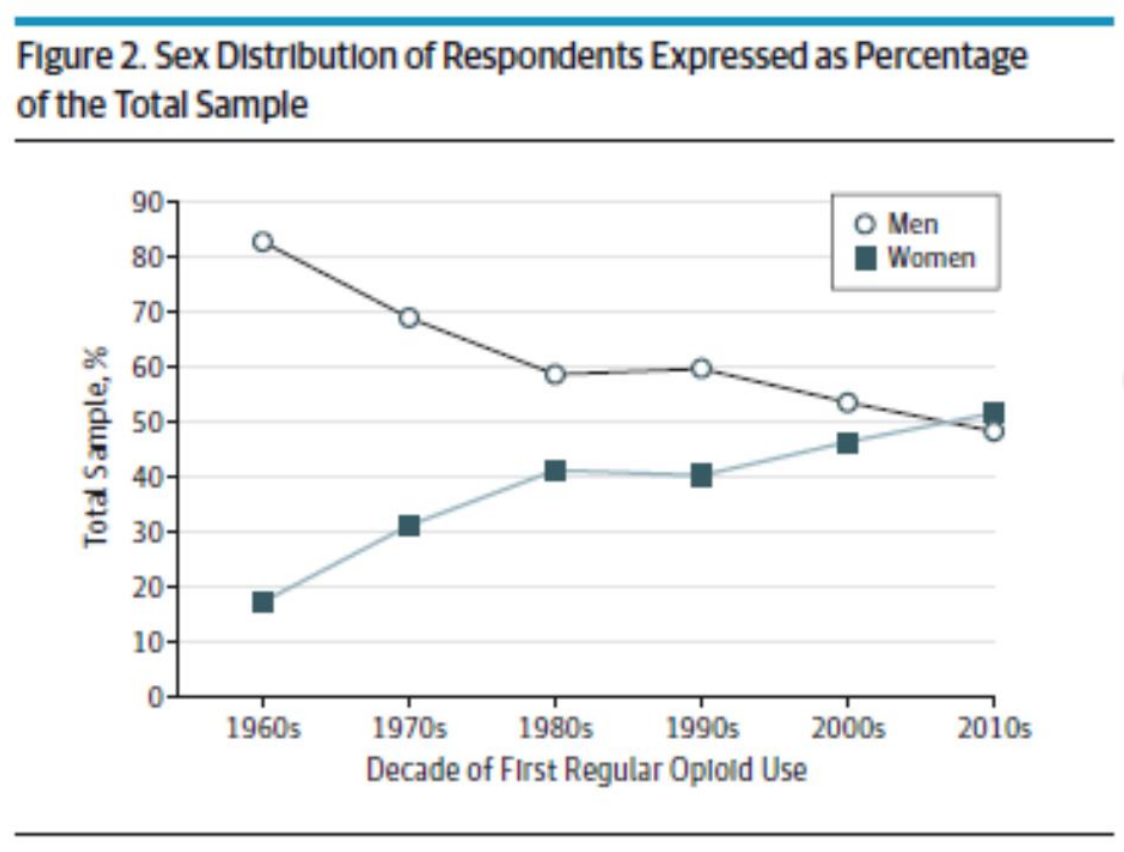


Table 1
Characteristics of heroin vs. prescription opioid initiates, 2005–2015.

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

Ciciero TJ, *JAMA Psychiatry*, 2014, *Addictive Behaviors* 2017

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

ORIGINAL ARTICLE

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

PATRICK W. CORRIGAN & FREDERICK E. MILLER

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

Abstract

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

Keywords: *Stigma, courtesy stigma, famil*

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

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

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

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

Stigma and People Who Use Drugs

We are the Drug Policy Alliance.

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

Stigma and Drugs

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

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

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

What Can Be Done To Fight Stigma?

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

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

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

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

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

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

Gender and Social Norms

Gendered Dimensions of Smoking Among College Students

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

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

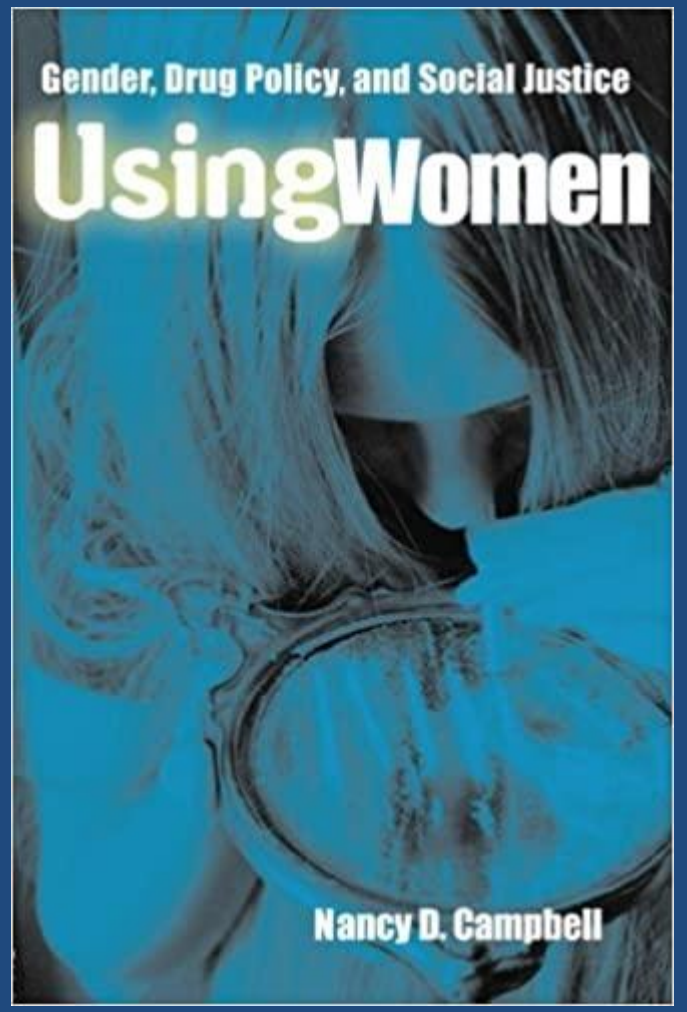
Keywords: *smoking; ethnography; gender; college students; emerging adults*

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

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

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

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



Motherhood, a Social Norm

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

Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness

Libertas Academica
FREEDOM TO RESEARCH

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

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

Supplementary Issue: Harm to Others from Substance Use and Abuse

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

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

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

Opioids and Pregnancy

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

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

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

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

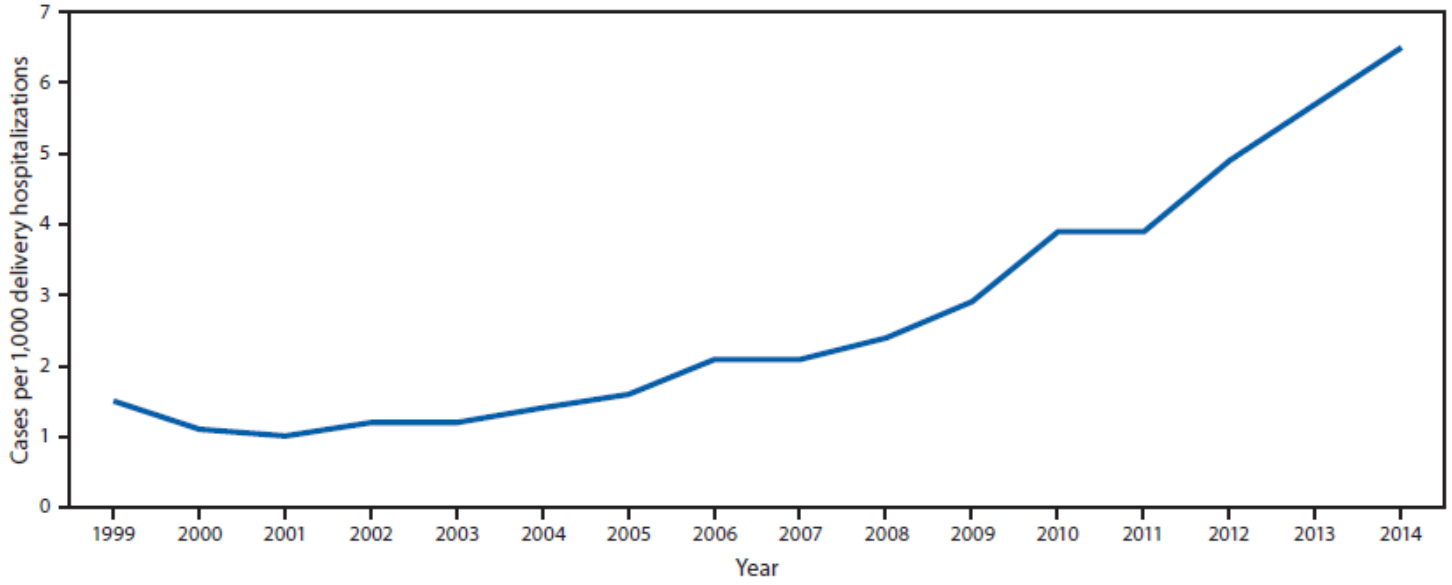
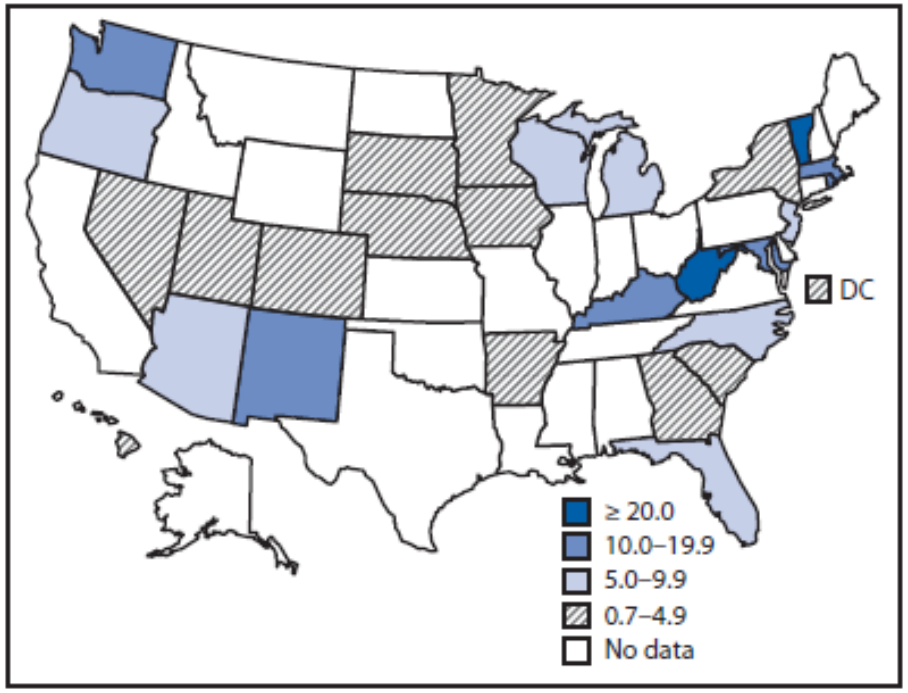


FIGURE 2. Prevalence of opioid use disorder per 1,000 delivery hospitalizations* — State Inpatient Database, Healthcare Cost and Utilization Project, 28 states, 2013–2014†



Opinion

She Was Addicted a
Her Son. She Want

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

Damon Winter/The New York Times

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

Jan. 13, 2019

385

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

Pw
San Francisco | Jan. 14

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

James
DC | Jan. 14

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

Jude Parker Smith
Chicago, IL | Jan. 14

Some people should not be allowed to have children.

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

There
Here | Jan. 14

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

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

Damon Winter/The New York Times

By Jeneen Interlandi

Ms. Interlandi is a member of the editorial board.

Jan. 13, 2019

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Chicago, IL | Jan. 14

Some people should not be allowed to have children.

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 heroin? It comes down to one or the other.

Michael Kramer
Hudson, Fl | Jan. 14

As someone in a similar situation I have no sympathy for her. You use drugs while pregnant you do 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.

Racism and the Legacy of the“Crack Baby”: Where War on Drugs and War on Abortion Collided

Washington Post 1989

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

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

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

Stigma

Stigma

Discrimination and Prejudice

Discrimination and Prejudice: Common among Providers

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

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

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

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

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

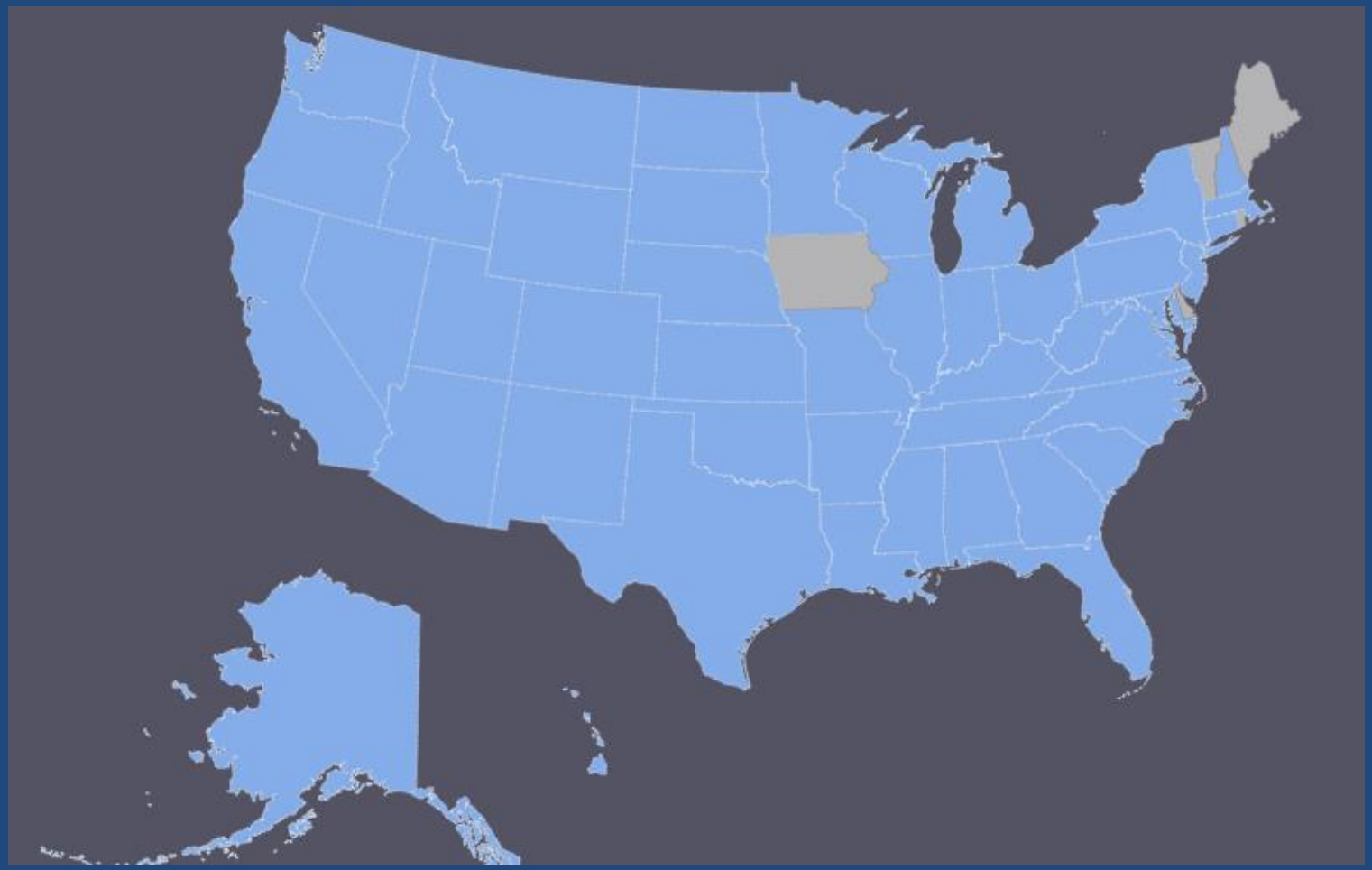
Stigma

Discrimination and Prejudice

Punishment

States where pregnant people have been prosecuted for drug use

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



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

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

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

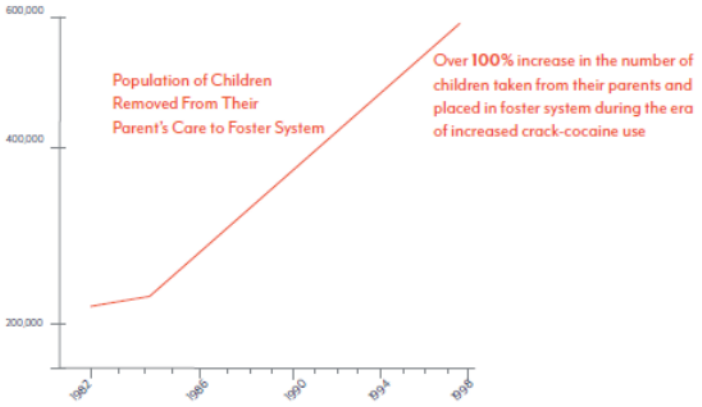
HOW THE FOSTER SYSTEM HAS BECOME GROUND ZERO FOR THE U.S. DRUG WAR

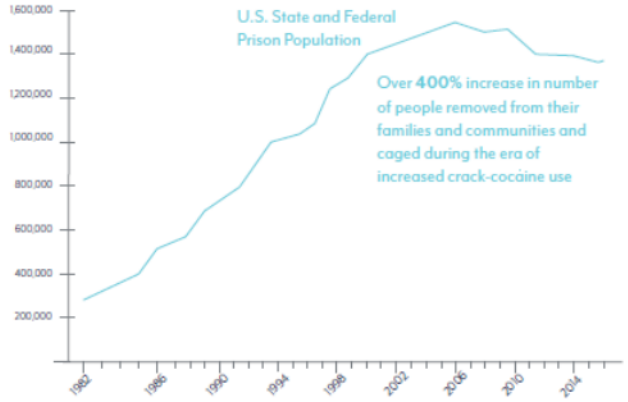
MFP
MOVEMENT FOR FAMILY POWER

NYU FAMILY DEFENSE CLINIC

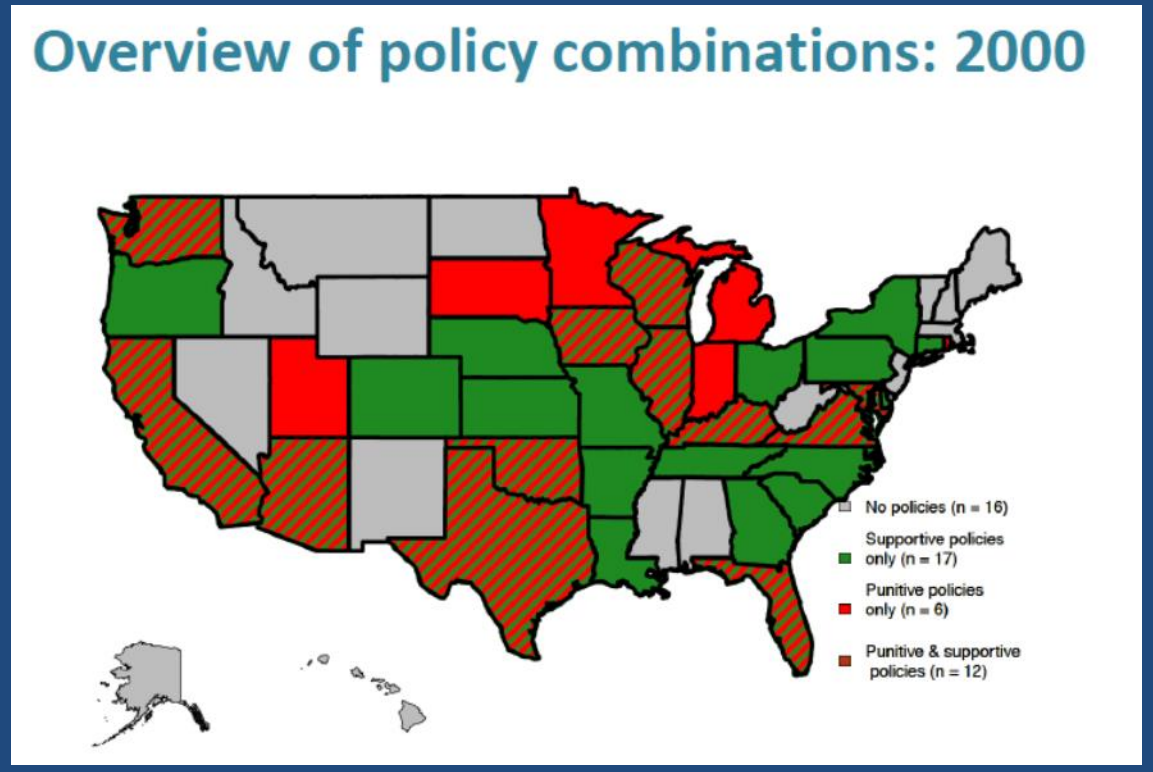
We are the Drug Policy Alliance.

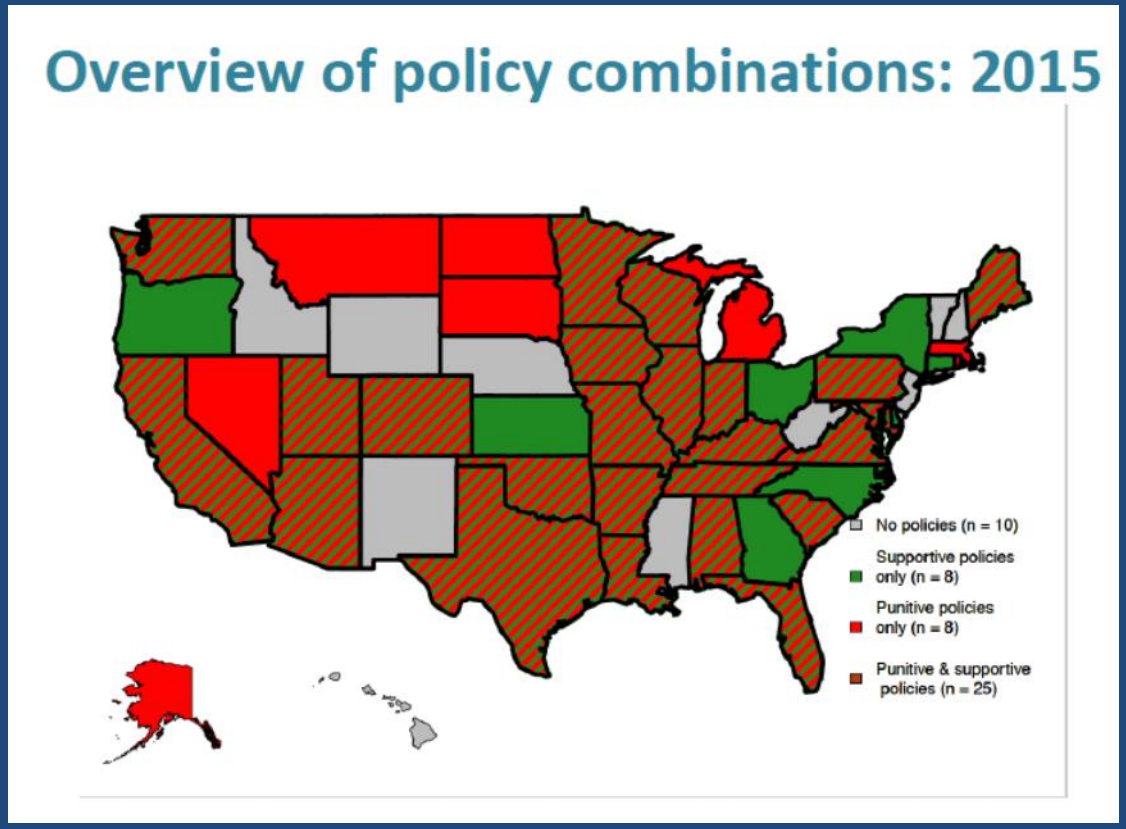
Between 1986 to 1996, **the population of children removed** from their homes to the foster system, like the **prison population**, grew steeply. Between 1996 to 2016, both the **population of children in state custody** and **prison population** have not decreased significantly.





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

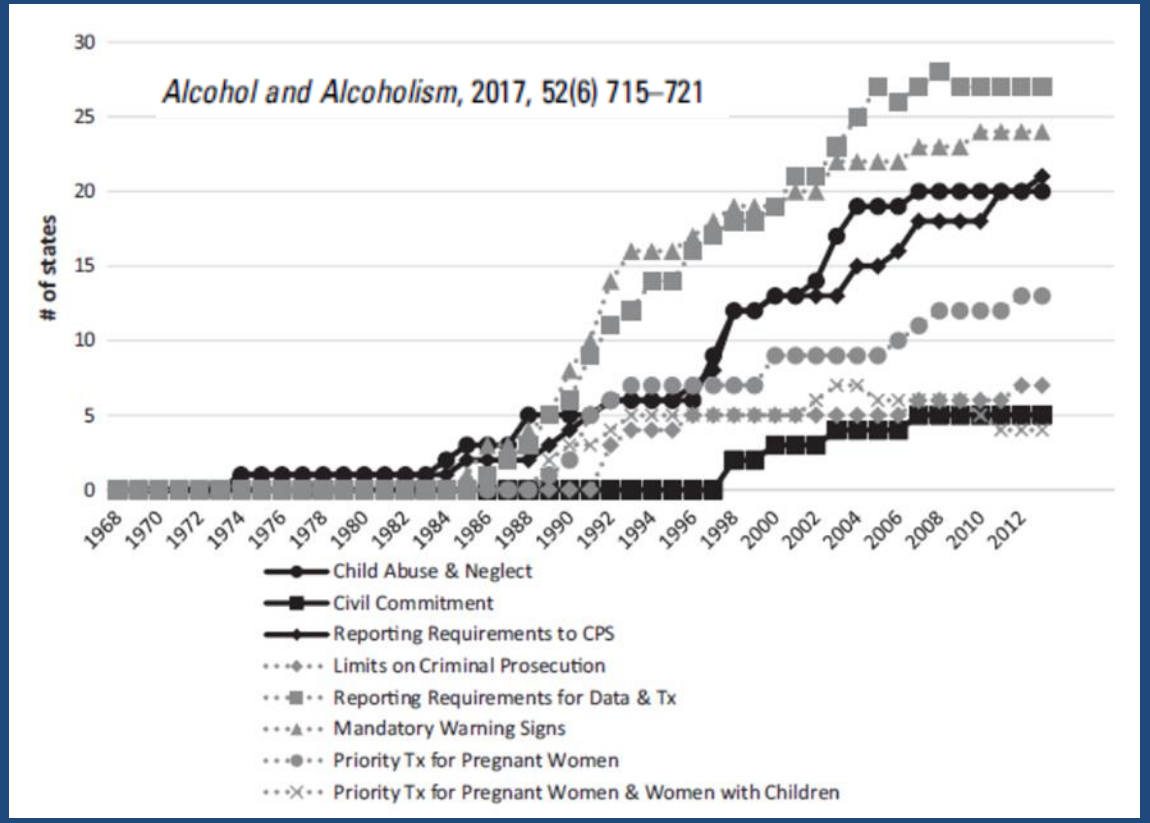




Presentation Dr Faherty, Academy Health Annual Research Conference, June 3 2019

Punitive Policies and Maternal Health

- Punitive Policies Increasing
  - Not Driven by Overall Drug Policy
- Punitive Policies Associated with:
  - Later Entry into PNC
  - Greater PTB and LBW
  - Greater Rates NAS
- Punitive Policies Driven by:
  - Restrictive Reproductive Policies



Subbaraman MS, *Alc Clin Exp Resrch*, 2018
Faherty LJ, *JAMA Open*, 2019

Freedom from Discrimination is a Human Right

Discrimination is Rooted in Ignorance

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

Discrimination is Rooted in Intention

- Intentional Punishment of People Deemed Unworthy

How do we Do Less Harm?

Public Health and Clinical Care that is both

Evidence-Based

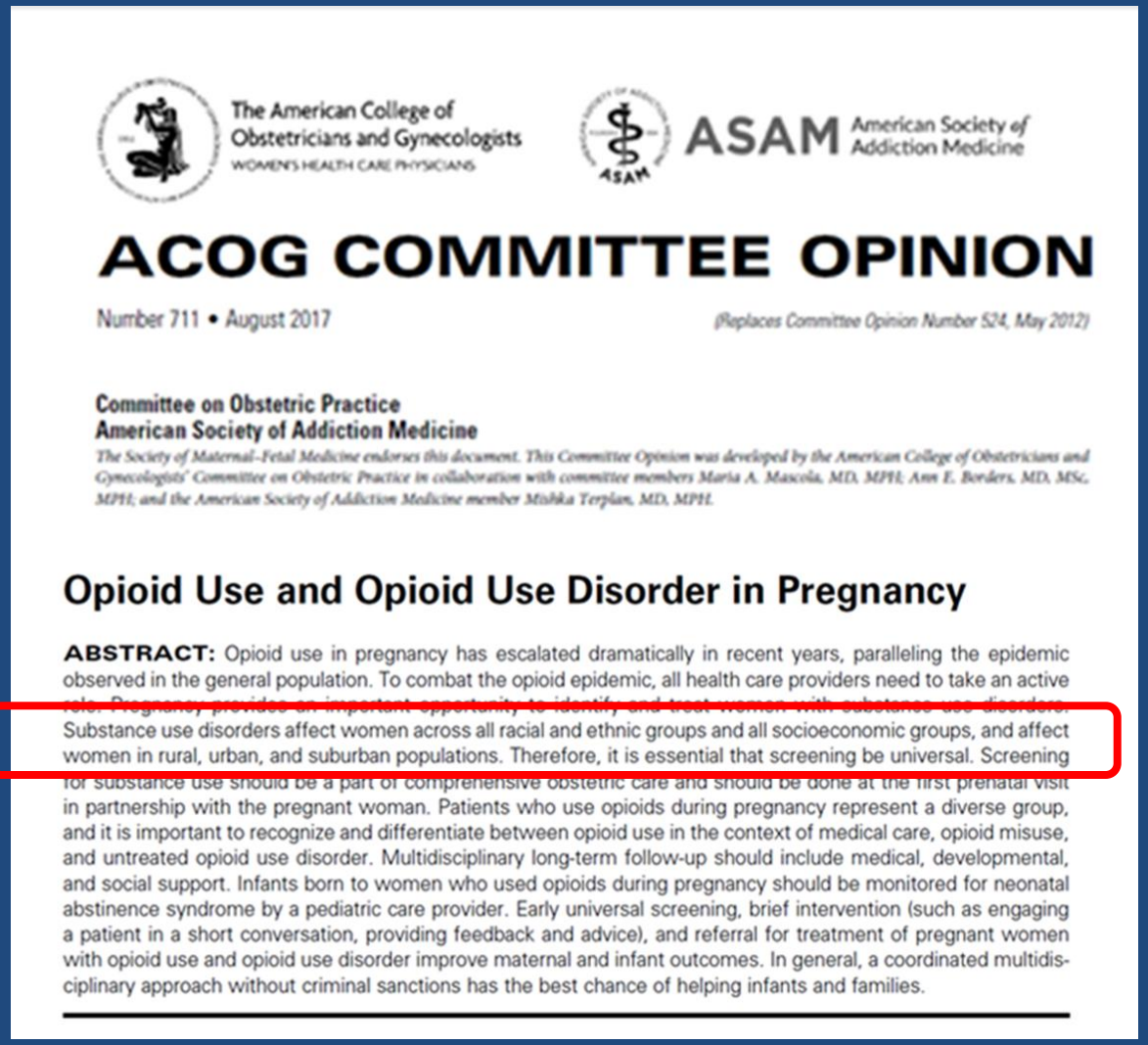
AND

People-Centered

Evidence-Based Care: Screening Vs. Testing

Screening	Testing
Selective	Universal

Universal Screening With Validated Instrument Recommended



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017

(Replaces Committee Opinion Number 524, May 2012)

Committee on Obstetric Practice
American Society of Addiction Medicine

The Society of Maternal–Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

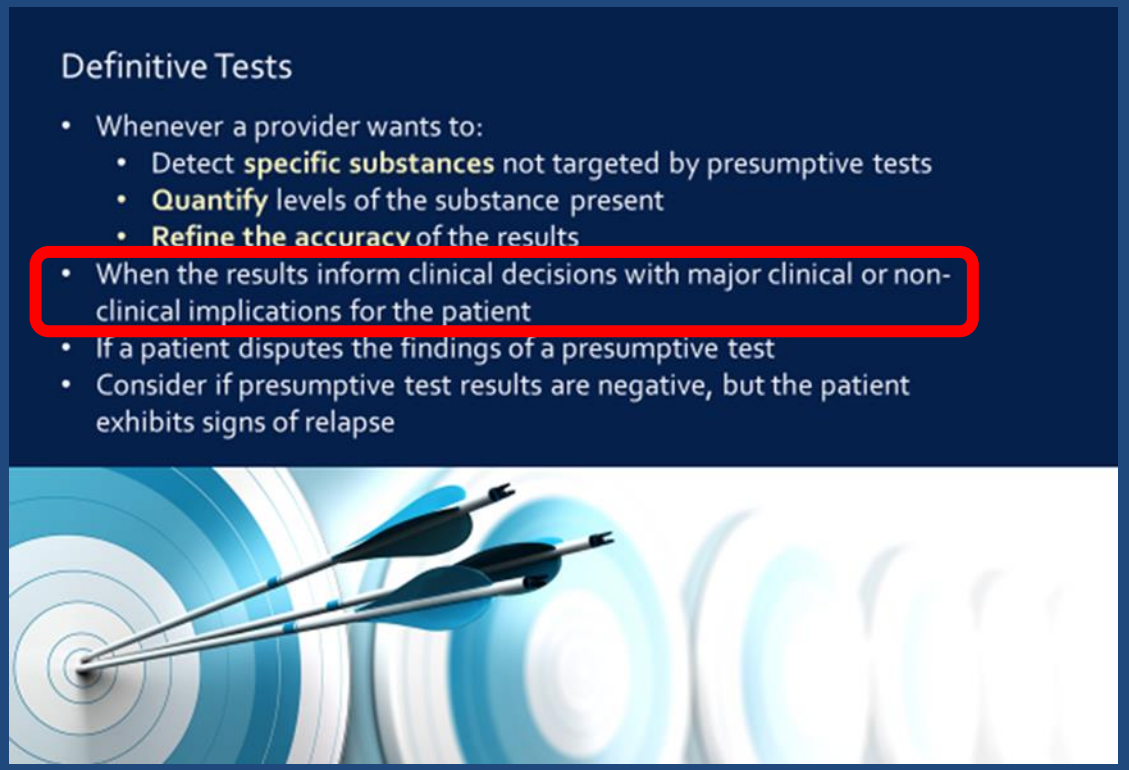
Opioid Use and Opioid Use Disorder in Pregnancy

ABSTRACT: Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. To combat the opioid epidemic, all health care providers need to take an active role. Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Therefore, it is essential that screening be universal. Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Patients who use opioids during pregnancy represent a diverse group, and it is important to recognize and differentiate between opioid use in the context of medical care, opioid misuse, and untreated opioid use disorder. Multidisciplinary long-term follow-up should include medical, developmental, and social support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome by a pediatric care provider. Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

Evidence-Based Care:
Critically Examine Drug Testing

Presumptive Test

Definitive Test



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

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

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

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

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

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

POLICY

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

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

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

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

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

VANDERBILT Center for Child Health Policy

“Test and Report”: Provider Culpability

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

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

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

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

Evidence-Based Care:

- Explicit verbal and written consent prior to urine drug testing of both pregnant person and newborn
- Clear indications for when to do a urine drug test
- Staff training on urine drug test interpretation

ORIGINAL ARTICLE

Urine drug test interpretation: What do physicians know?

Gary M. Reisfield, MD
Roger Bertholf, PhD
Robert L. Barkin, MBA, PharmD
Fern Webb, PhD
George Wilson, MD

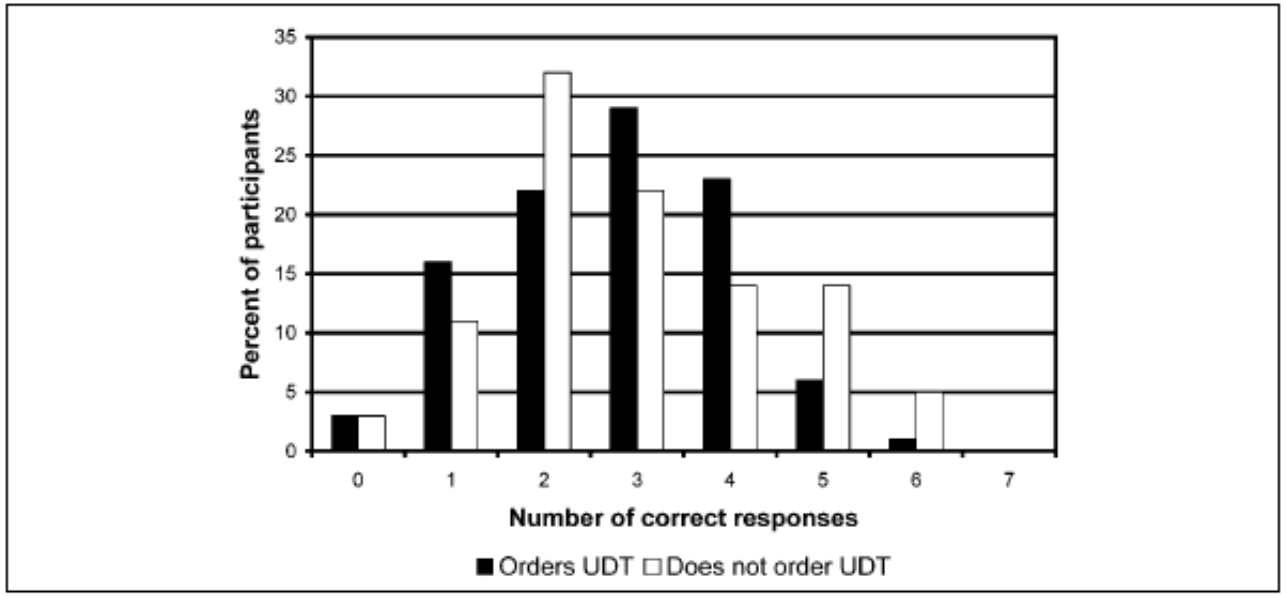


Figure 2.

family medicine physicians attending a University of Kentucky Family Medicine Review Course. We calculated frequencies and performed χ^2 analyses to examine bivariate associations between urine drug test utilization and interpretive knowledge.

***Results**: The instrument was completed by 60/80 (75 percent) of eligible physicians (44 order urine drug testing; 16 do not). None of the physicians who order urine drug testing answered more than five of the seven questions correctly, and only 20 percent answered more than half correctly. Physicians who order urine drug testing performed better than physicians who do not order*

effective pain relievers known, they are also the single most abused class of prescription medications. Physicians are thus faced with the challenge of ensuring the availability of opioids to their patients with legitimate medical need while minimizing the potential for their misuse.

Physicians are generally ambivalent about prescribing opioids for chronic pain. They want to ease their patients' pain, but they are concerned about the possibilities of abuse, addiction, and diversion of prescribed medications. These concerns are justified in view of the prevalence of aberrant prescription and illicit drug use in the general population[2] and the attendant medicolegal

APPENDIX. URINE DRUG TESTING (UDT) QUESTIONNAIRE: KNOWLEDGE QUESTIONS*

1. In a patient prescribed Tylenol #3 (codeine and acetaminophen), one would reasonably expect which of the following to be detected in the urine:
   a. codeine
   b. dihydrocodeine
   c. morphine
   d. all of the above
   e. a and c only

2. In a patient prescribed MS Contin (morphine), one would reasonably expect which of the following to be detected in the urine:
   a. codeine
   b. dihydrocodeine
   c. morphine
   d. all of the above
   e. a and c only

3. In a patient using heroin, one would be likely to detect which of the following in the urine:
   a. heroin
   b. hydromorphone
   c. morphine
   d. all of the above
   e. a and c only

4. A patient on OxyContin (oxycodone) therapy is administered a random urine drug test. He notifies you that he ate a large lemon poppy seed muffin for breakfast. What substances might reasonably be detected in the urine?
   a. oxycodone
   b. codeine
   c. morphine
   d. all of the above
   e. a and c only

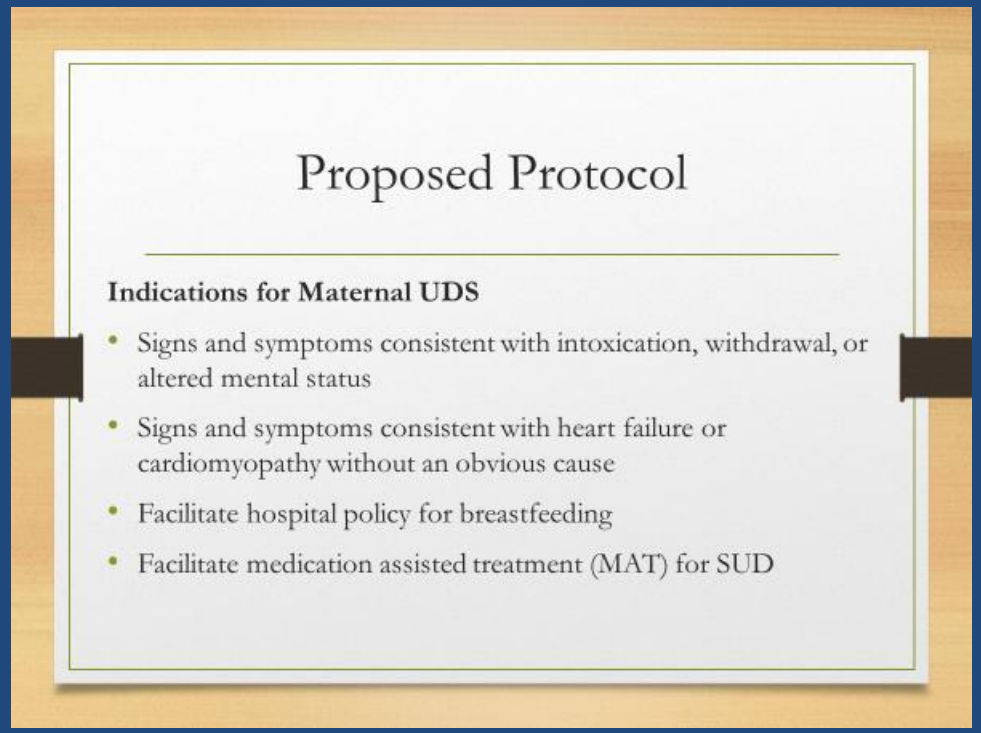
5. A patient on chronic opioid therapy tests positive for cannabis on a random urine drug screen. She explains that her husband sometimes smokes pot in their bedroom. Is this a plausible explanation for the test findings?
   a. yes
   b. no

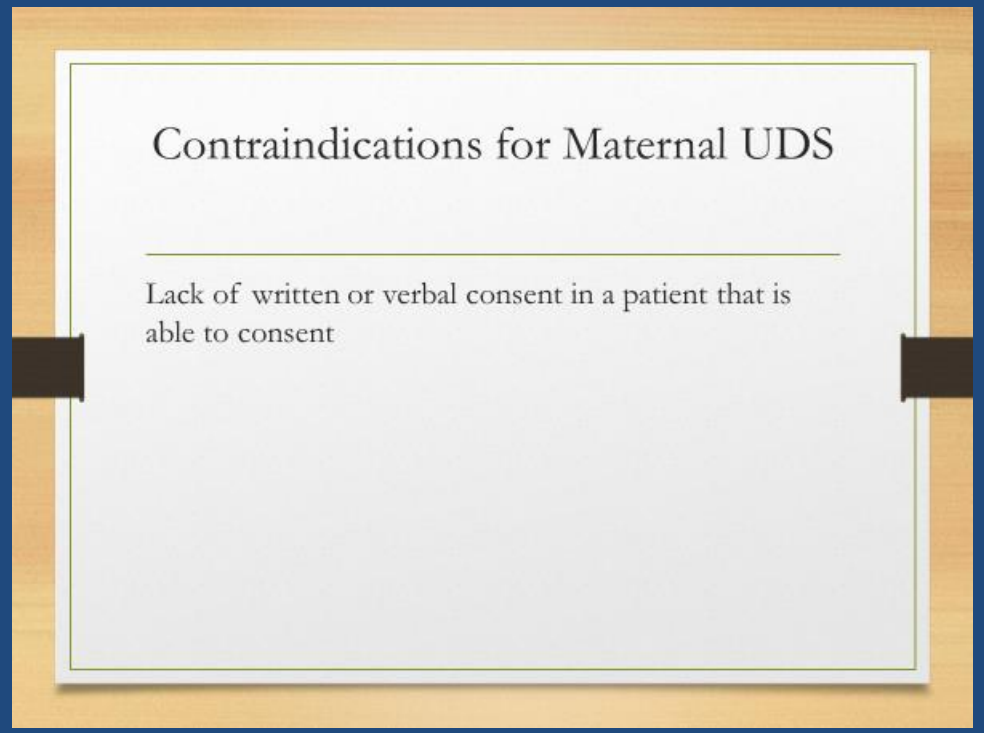
6. Which of the following are plausible explanations for a negative urine opiate drug screen in a patient on chronic opioid therapy:
   a. Patient ran out of opioid early and has not used any in a few days.
   b. Patient is a "fast metabolizer."
   c. Drug screen does not detect that particular opioid.
   d. a, b, and c
   e. a and c only

7. A patient on chronic Dilaudid (hydromorphone) therapy tests negative for opioids on a urine drug screen. The patient claims to be using the medicine as prescribed. The most appropriate next step would be to:
   a. subject this urine to a different type of test
   b. readminister a urine drug screen at the next visit
   c. taper and discontinue opioid therapy
   d. refer the patient to a detoxification/rehabilitation program
   e. notify law enforcement

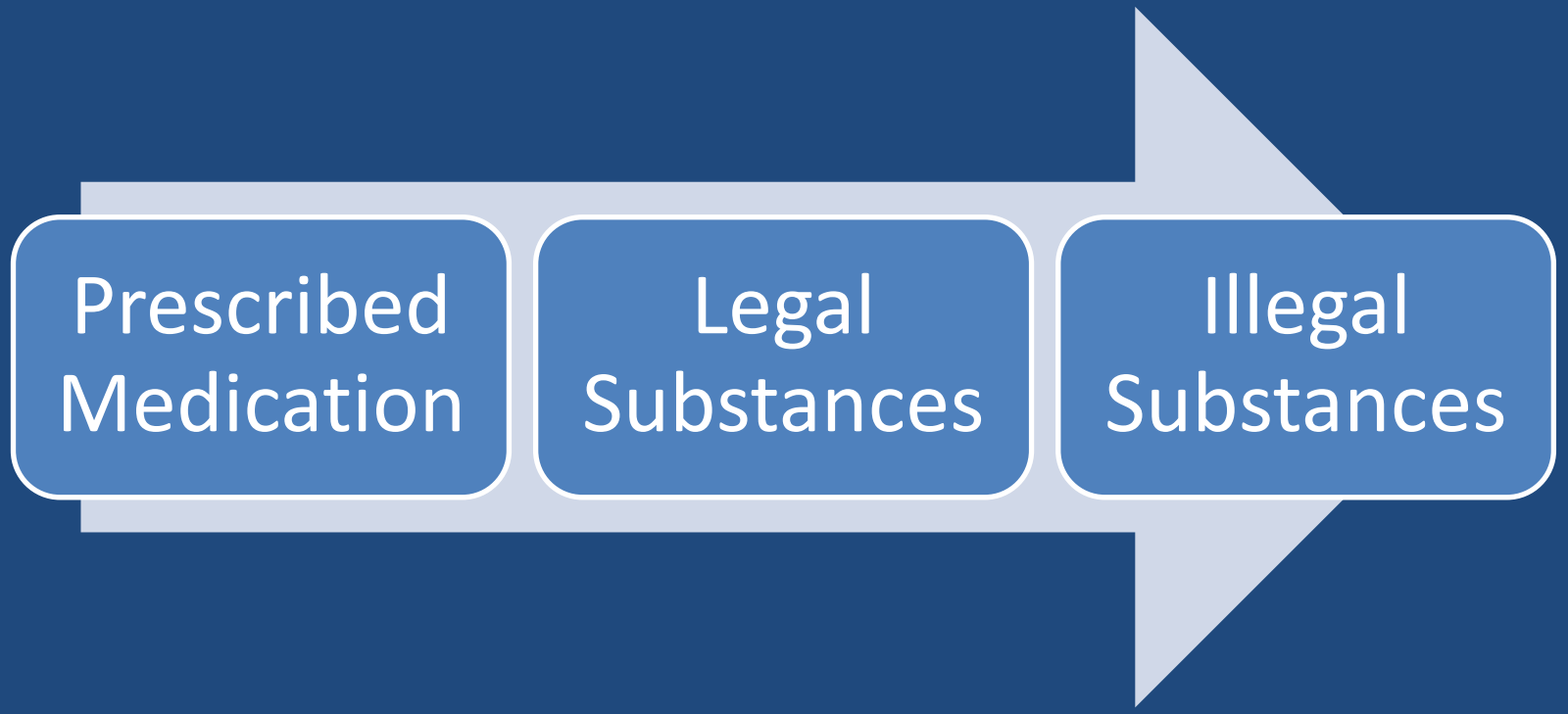
* Correct responses are bolded.

Example: University of Hawaii





Evidence-Based Care:
Data that Reflects Science not Stigma



HARM

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

Substance and Development: Evidence of Nurture

ARTICLE

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

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

ORIGINAL ARTICLE

Inner-city Achievers

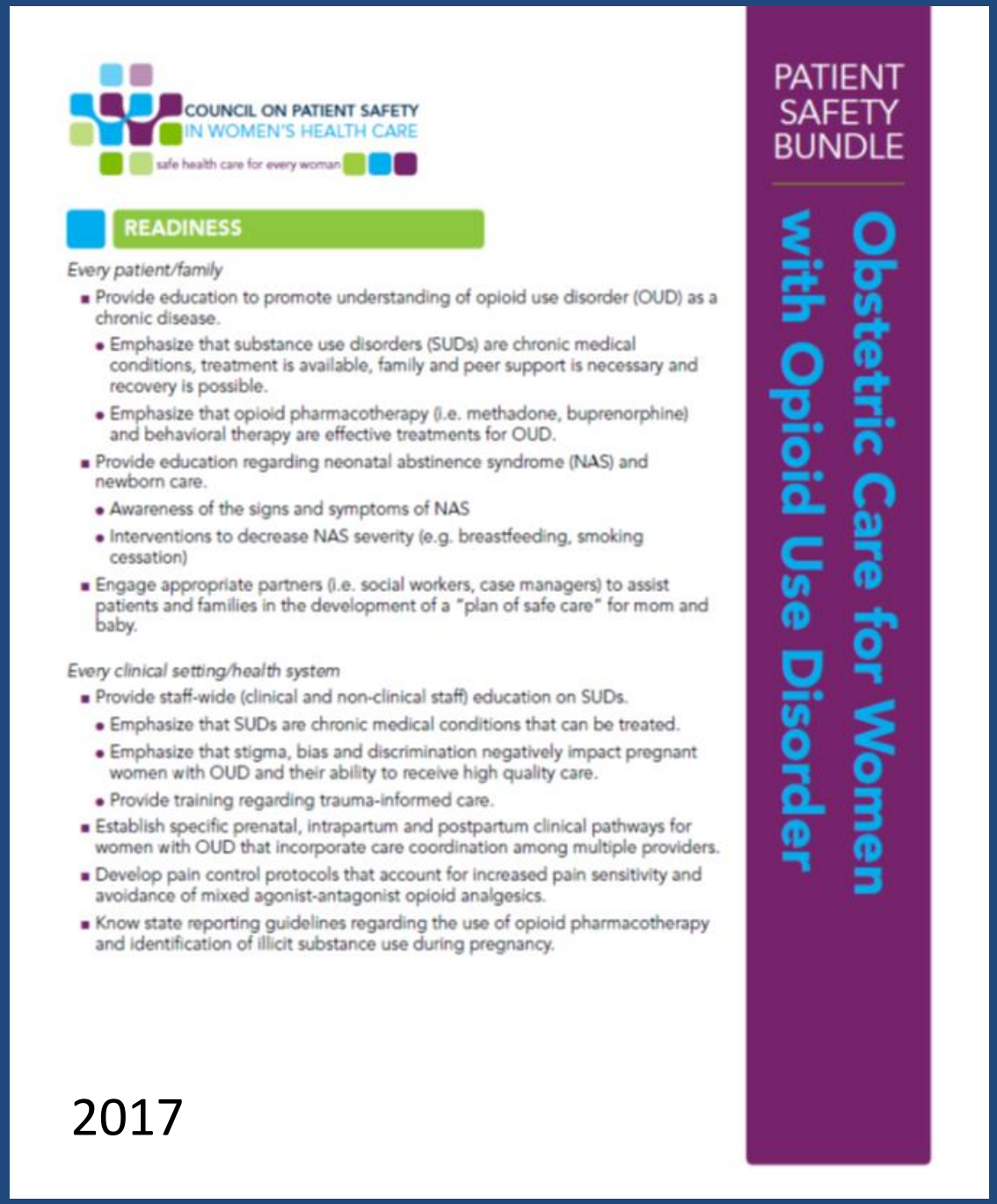
Who Are They?

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

Table 5. Home Observation for Measurement of the Environment*

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

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



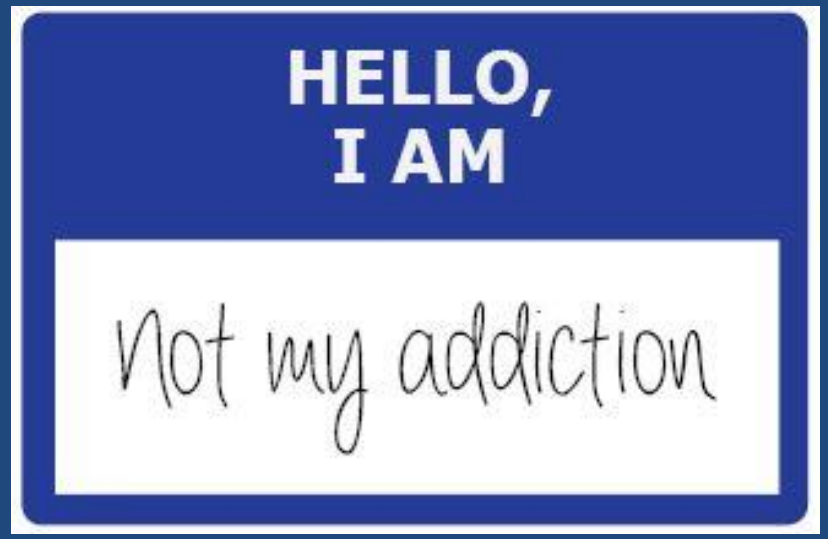
Evidence-Based Care: Aim Bundle Update

From OUD to SUD

Non-gender binary language

More aligned with other bundles

People-Centered Care:
Language to Counter Stigma and Discrimination



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

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

EDITORIAL

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

Richard Saitz, MD, MPH, FACP, DFASAM

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

(*J Addict Med* 2016;10: 1–2)

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

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

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

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

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

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DOI: 10.1080/08897077.2014.930372

Routledge
Taylor & Francis Group

EDITORIAL

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

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

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

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

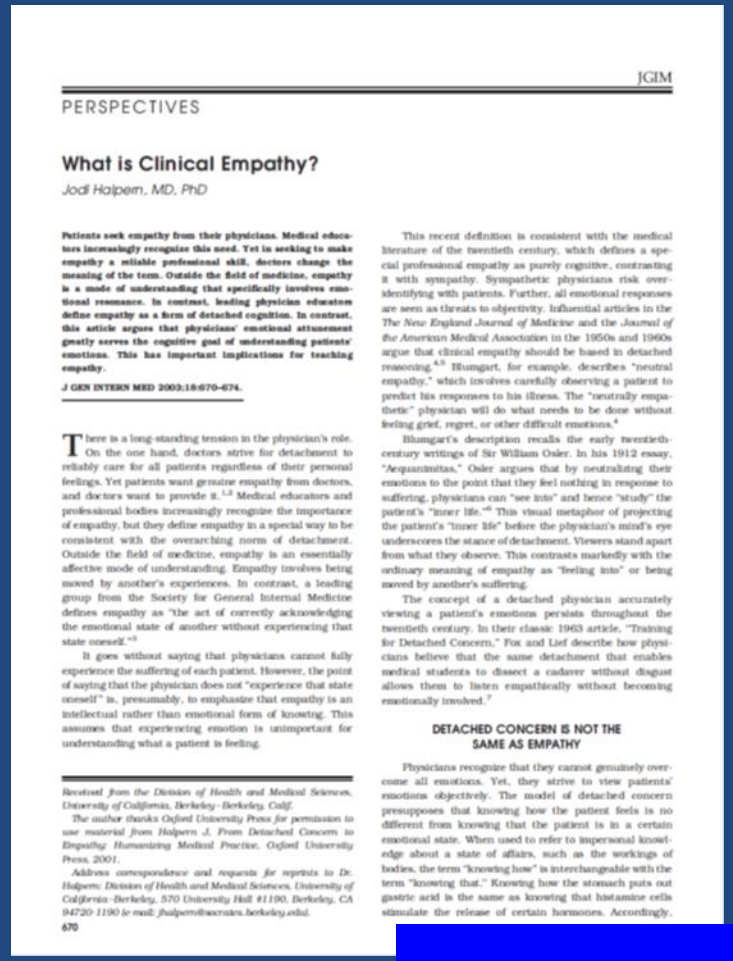
LANGUAGE:

Pay attention to how we speak and write

Language that:

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

People-Centered Care: Empathy



JGIM

PERSPECTIVES

What is Clinical Empathy?

Jodi Halpern, MD, PhD

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

J GEN INTERN MED 2003;18:670–674.

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

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

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

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

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

This recent definition is consistent with the medical literature of the twentieth century, which defines a special professional empathy as purely cognitive, contrasting it with sympathy. Sympathetic physicians risk 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,

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

Language of Empathy vs Shame

People-Centered Care:
Practice Empathy

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

Conclusion 1:
Drug Policy, Pregnancy, and Discrimination

- Drug Policy is Rooted in Racism – punitive policies reinforce discrimination – compound racial inequities

- Drug policies target use – don't capture use disorder – therefore don't identify those that need treatment

- Drug policies target illicit use – don't reflect true substance harms to a population

Conclusion 2:
Drug Policy, Pregnancy, and Discrimination

- Need to resist punitive policies, emphasize treatment and recovery
- Address race, class, and reproduction from a structural perspective: how society produces vulnerabilities
- “Center on the most marginalized”
- Reproductive Justice: Human right to maintain bodily autonomy, have children, not have children, and parent the children in safe and sustainable communities

Loretta Ross & Rickie Solinger, 2017, Reproductive Justice; www.sistersong.net

Thank You

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