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Megan: Hello, everyone. Welcome to this "Ask the Expert" webinar, "Substances and Pregnancy. What do we know and what do we do?" I'm Megan Hiltner with the Healthy Start EPIC Center. And we have approximately 60 minutes set aside for the webinar. It is being recorded. And the recording, along with the transcript and slides, will be posted at the EPIC Center website following the webinar. We are lucky enough to have a nationally well-known expert speaker here with us today to share his knowledge with us, but before we get to Dr. Brown's introduction and his presentation, I have a couple more housekeeping announcements. We want your participation today. So at any point, if you have questions or comments, please chat them into the chat box at the lower left corner of your screen. We'll only be taking questions through the chat box. And we will be taking those questions following Dr. Brown's presentation. We also want your feedback on this event, so please take a moment following the webinar to complete the survey that will pop up on your screen right after.

And before we do move onto Dr. Brown's presentation, we do want to do a quick pre-test with you all to check your knowledge. So if you will take a moment and respond to this question we've put up on the screen here, of the following substances listed here, which do you think has the lowest percent of women who abstain during pregnancy among women who report "risky use" before pregnancy? Do you think it's alcohol, cannabis, cocaine, or tobacco? So if you'll take a moment and click on those radio buttons, which one do you think? And I see the results coming in here. And I'll show you all the results here in a second, but I'm going to give folks a couple more minutes as you're logging in to click in. And here we are with the results. All right. So it looks like we've kind of divided here with a lot of folks, 32% of folks saying it's alcohol, both 16% of folks are thinking maybe cannabis or cocaine, and 36% of folks thinking it's tobacco. Dr. Brown's going to get to the answer within his presentation. So hold that in your brains as we move along with the presentation.

All right. Here one more question for you to get your brain juices flowing. So reporting of substance use is not mandatory. Is that a true or false statement? The answers are coming in here. I see them coming in. And we will show you the results here in a second more. Okay. Let's see what folks are thinking. It looks like almost 63% of folks think it's true. And about 37%, almost 38% of folks think it's false. Well, thanks folks for taking some time to respond to that. As I said, Dr. Brown is going to get to that in his presentation. And so now I'm going to turn it over to Ms. Dawn Levinson with the Division of Healthy Start and Perinatal Services.

She's the Behavioral Health Advisor to the Division for a brief welcome and introduction. Dawn?

Dawn: Thanks, Megan. Good afternoon, everyone. This is Dawn Levinson, the Behavioral Health Lead in the Division of Healthy Start and Perinatal Services and a coordinator of all things behavioral health. And here it says in Maternal and Child Health Bureau. And I am very pleased to be the division representative on today's webinar. I want to say welcome to our speaker, whom I'll introduce in a moment and welcome to all of our Healthy Start grantees across the country. As it relates to behavioral health, Healthy Start's role is to prevent mental health and/or substance use disorders through health education and use screen, intervene, refer, and support women and their families who may have a behavioral health problem. You address toxic stress in the family and support trauma informed care. We hope today's presentation will add some knowledge and tools to your tool box as you support women and their families who may have a substance use or misuse disorder. And to mention in discussion groups we had earlier this year with the grantees, this particular topic was something that you all requested. So here it is. And without further ado, I will introduce Dr. Randy Brown.

Dr. Brown's primary interests revolve around the treatment and prevention of substance use disorders and their complications in setting outside of the specialist's treatment environment such as primary care, hospitals, pharmacies, and criminal justice settings. Dr. Brown enjoys patient care, teaching, and conducting research in these areas. He's board certified in family medicine and in addiction medicine. He serves as a consulting physician in addiction medicine in several settings at the University of Wisconsin Hospital where he's the Director of the Center for Addictive Disorders, at the William S. Middleton Memorial Veterans Hospital, at the University of Wisconsin's HIV and AIDS Clinic, and at Access Community Health Centers. He is a certified prescriber of buprenorphine as adjunctive treatment for opioid dependence. And Dr. Brown is a director of the American Board of Addiction Medicine and the Addiction Medicine Foundation and the president-elect of the Addiction Medicine Fellowship Director's Association. Dr. Brown, we are so thrilled to have you with us today. Thank you so much. And I will pass it onto you.

Dr. Brown: Great. Thank you very much. It is a pleasure to be here to engage in the discussion around this topic, which is really important for those of us making contact with this population since clearly what we do has the potential to impact the health of an expectant mother, her

developing infant, as well as the home environment in which that infant might be raised, so really a potentially high impact area for us. And as women get to the childbearing years, those are really the years where risky or problem substance use tend to peak for both men and women, that being adolescents and young adulthood. And so certainly something that care providers should have on their radar and engage in evidence-based practices around addressing those issues. And certainly, that substance use we know can have adverse effects associated with it for both the mother, as well as for the baby, but I think some aspects of this may not be completely intuitive. And that's another reason I think this is an important set of topics to review in terms of the impact it may have on the developing infant. Another issue that I'll get to a little bit that may present opportunity for interesting discussion is how we address substance use disorders in pregnancy has some tensions inherent in it so far as when we think about potentially reporting and the extent to which that might have negative impact on ongoing care during the pregnancy. And I think that's an interesting issue to explore and that I'll be talking a little bit about.

So the material that I plan to get to over the course of our time together is talk a little bit about what we know about the interaction between substance use and environmental effects on developing fetus and child. And that's an important consideration because sometimes it's difficult to tease apart the impact that substance exposure has from the impact of the environment in which the substance use is occurring. That's sometimes not a straightforward set of considerations and makes the data we have available sometimes somewhat confusing, but there are some things that we do know about particular substances. And I'll be going through the most common ones so far as use in pregnancy and the ones that we know something about so we know how to advise and assist in the care and coordination for our patients in terms of screening, assessment and treatment and then discuss some of those EPIC one policy issues around when we consider reporting.

Just to be sure folks have some understanding of this issue that comes from epidemiology, this issue is called confounding in that field. And this is represented diagrammatically here. And what confounding means is if I'm doing an observational study and I expect that some exposure bears a relationship or causes some sort of outcome, I need to be careful in considering other associated things that might actually be responsible for that outcome. An example that was actually published in "The New England Journal of Medicine" entailed there was interest in exploring the association between heavy coffee consumption and pancreatic cancer.

And initial findings seem to indicate that that relationship was particularly strong. However, what these early studies failed to take into account is that that exposure to heavy coffee drinking, X, was associate with heavy tobacco use, as well, Z. And so what was really driving increased pancreatic cancer risk in that population wasn't the coffee. It was the cigarette smoking.

So in the case of substance exposure during pregnancy, there's a similar set of considerations or things that we need to think about that might be associated with or run along with maternal substance use that might bear greater causative impact on adverse outcomes for babies than the substance use itself and can be pretty tricky to tease apart sometimes. So for mothers using tobacco, alcohol, or other drugs heavily during pregnancy that, for example, might be associated with maternal factors that could adversely affect development during childhood such as other mental health issues, social struggles, or environmental struggles for them such as domestic violence or other stressors. And these are all things that can adversely affect the way a child develops in terms of their behavior, their attentional capacity, their cognitive and motor development, and downstream maybe things instead of or in addition to the substance exposure that creates challenges even further downstream as they develop into adults. So given all that and the difficulties in differentiating substance exposure from other environmental exposures during child raising, what are some things we do know? And I'll be talking a little bit about some particular substances and what that state of the science looks like.

So historically, tobacco use has, you know, cut across a lot of those sort of confounding factors by way of the presence of, say, domestic violence or mental illness or socioeconomic status. And confounding has become to be thought of somewhat less of an issue and the findings a bit more firm in terms of the impact that we can attribute to tobacco. And that includes things like what's called placental abruption. For those not familiar, that's when the placenta providing blood, oxygen, and nutrients to the infant starts pulling away from the uterine wall. And that can result in the death in the uterus of the baby. It can cause growth restriction or decreased birth weight. It can cause pre-term labor and delivery, which is a significant consideration. The earlier prior to term an infant develops, the greater the risk for potentially catastrophic health issues, as well as difficulties with development later in life. We know a lot about the benefits of breastfeeding for babies, as well as for mothers and their attachment to infants and women engaging in regular tobacco use are what's less likely to continue to have that. I'm sure you also

know of associations between tobacco use during pregnancy, as well as after, and sudden infant death syndrome. As children exposed to tobacco develop, there also appears to be an association between tobacco exposure and attentional issues, even conduct disorder or lack of respect for authority as they're going through their schooling. And it's even been associated with frank learning disabilities and even reduction in potential IQ.

Alcohol is also something about which I'm sure most of you know a good deal in terms of fetal alcohol effects and the spectrum of potentially quite serious developmental issues that it can create that includes, but isn't limited to, also preterm labor and preterm delivery and all the complications with which that can be associated, deficiencies in growth, frank fetal alcohol syndrome develops and can be associated with more severe actual deformities or malformations like craniofacial. And alcohol is actually fairly unique in the fact that it is actually what we term as teratogenic or causes actual deformities in infants. It has a potentially significant impact on intellectual disability, as well as attention, motor development, as well as the development of speech and language. We don't have data telling us that any level of alcohol use during pregnancy is safe. And so most professional guidelines in the United States recommend that we counsel our pregnant patients to abstain completely during pregnancy lacking that information. Internationally, that guideline varies to some degree, however.

So far as illicit substances or, well, illicit in most places still, but not all, cannabis is a substance where use during pregnancy, effects are somewhat unclear. And findings have conflicted quite a bit. Where adverse effects have been found, it tends to be difficult to tease apart with other substance use going along with the cannabis. It's also more likely to be associated with heavy use. And when use is heavy and daily, there have been findings around more limited fetal growth, as well, and preterm labor. Cannabis has not been found to be, again, what we call teratogenic or something that causes frank malformations. It doesn't look like there may be a subtle withdrawal syndrome in newborn babies with cannabis. It looks in some ways similar, but much more mild than what I'll be describing around opioid withdrawal issues and is primarily characterized by irritability or sort of deficiencies in an infant's ability to self-regulate and self-comfort. There have been some subtle academic deficits associated, again, with heavy daily use, but frank impact on IQ hasn't been found. There have also been some questions about whether infants exposed to cannabis while developing in the uterus might have a greater risk for depression during adolescence, but, again, this is

another area where teasing apart use from the environment in which the child rearing is occurring has been somewhat difficult.

Next in the category is substances known as stimulants in so far as the illicit substances that young women might use that would be a consideration, cocaine and methamphetamine would be the primary concerns. And part of what stimulants do that has an impact on the developing fetus is it causes constriction of blood vessels. And so the blood supply through placenta to baby may be limited. This also can cause restrictions in fetal growth, as well as what I described earlier, that placental abruption where the placenta begins tearing away from the side of the uterus, which can be catastrophic. The stimulants are also substances that don't appear to be associated with physical malformations or deformities. Evidence also conflict with it around early childhood development and cognitive issues, behavioral issues moving into school. Where they're found, it looks like they're fairly mild in that post-delivery, the environment is nurturing and high functioning, that a lot of those potential issues may wash out. Methamphetamine, we don't have nearly as many data to tell us about impacts as opposed to cocaine, but the potential effects look to be fairly similar to those for cocaine, which makes them intuitive in the sense in that it's also being a stimulant, it's something that constricts blood vessels and may interfere with blood supply and the normal growth of a developing fetus. Interestingly, if stimulants are prescribed to a woman who has an attention deficit disorder, there doesn't appear to be any effect by way of growth restriction or academic issues later in life.

Of course, the hot button set for the substances these days in the midst of the crisis are the opioids. And so as many of you might have questions about this set of substances. So when we say opioids, that can refer to substances sometimes prescribed for pain, be it acute or chronic, with common examples being morphine, oxycodone, hydrocodone preparations, and things along those lines. There are also categories of…or types of opioids that are used to assist in recovery from an opioid addiction with those examples being methadone and buprenorphine. So the primary consideration in the setting of regular opioid use during pregnancy is actually avoidance of the withdrawal syndrome. Opioids don't appear to be associated with frank physical deformities or anything beyond subtle behavioral issues in later childhood, but if a woman tries to dramatically reduce or abstain from opioid use after developing a physical dependence on them, that opioid withdrawal syndrome the mother experiences puts the pregnancy at risk for miscarriage or preterm labor and preterm delivery and, again, the

potentially catastrophic issues that can be associated with that.

I'm sure you've also heard a bit about the withdrawal syndrome that a newborn baby might experience after delivery. I also refer to it as neonatal opioid withdrawal syndrome. Interestingly, the likelihood of a baby experiencing this syndrome and how severe it is doesn't seem to be particularly closely related to the dose or the amount of that use. Really, the primary risk factor, if it's present, would be if a currently pregnant woman has had a previous pregnancy in which she delivered an infant that suffered neonatal opioid withdrawal syndrome, that's really the strongest risk factor for the baby resulting from the currency pregnancy to experience it. For this reason, infants post-delivery tend to be kept in the hospital for two or three days at least because the manifestations of this syndrome may take that long to manifest themselves. And in the case of buprenorphine, which is most often used to assist in recovery from an opioid use disorder, plus other indications, that onset may be even later, say five days. And so in your communities, you may see infants born to mothers on buprenorphine preparations kept in the hospital for that long or even slightly longer to make sure that they don't develop this set of difficulties. Many aspects of it look similar to what I was mentioning about cannabis withdrawal, primarily centered around irritability and difficulty with regulation of their own discomfort and self-comforting, excessive crying and irritability. Their sleep patterns may be even more erratic than a typical newborn. They may startle quite easy and be tremulous. Their tone may be increased. They may appear quite tense, yawn frequently, have difficulty with feeding and vomiting. Sneezing is another manifestation. And unlike in adults where we never see seizures as a result of opioid withdrawal, that is something that has been documented in infants going through this syndrome.

So those being some of the common substances and considerations around potential impacts, with that, I'd like to transition into some ideas, some evidence, around what evidence-based practices might be to prevent these issues or get women to the treatment that they need. So clearly it's a set of questions that we should be asking women of childbearing age about their typical use of tobacco, alcohol, or other drugs. And nearly all professional guidelines recommend screening for risky alcohol use. A number of them also recommend screening for illegal drug use, though the U.S. Preventive Services Task Force doesn't specifically make that recommendation, with their position being that we don't have all the evidence we need to tell us that screening for illegal drug use improves outcomes downstream from the screening, but again, there are a number of other professional agencies that do make that

recommendation.

A continued challenge in general medical settings, however, is how those screenings get addressed. While screening for alcohol problem and risky alcohol use is fairly common and illicit drug use less so, we do an even worse job of getting positive screens addressed. And so, it's certainly something bearing some improvement and thought. Why in part might that be the case? Well, a lot of providers really don't receive much education around these issues and aren't given the opportunity to develop those competencies and that confidence. And so there may be some trepidation around opening that can of worms, if they feel uncertain about what to do with the information. Patients may also be reluctant to share that information, perhaps particularly during pregnancy where the stigma attached to that use may be even more intense. Additionally, getting patients to the care that they need may be complicated by a lack of access to resources, either geographically or due to their pair status or ability to get to them on a day-to-day basis logistically.

When we're thinking about screening for substance use in pregnancies, it's important to think about what we're screening for because, in general, in adult populations, most often we want to make sure that the patient is in the low-risk category or abstinent category that you see on this slide. We want to make sure that folks engaging in risky use or that have a use disorder are getting to the prevention or treatment resources that they need. However, during pregnancy, our threshold is lower for most of these things because, for example, in the case of alcohol, we don't know what a safe level of use is. So we want to encourage recommendations that we encourage abstinence in that setting. And similarly, we'd be wanting to make recommendations along those lines for other substances, as well. How do we screen? Many of you likely know that there are instruments out there that increase the efficiency with which we can do this. The majority of them have been best studied in men. However, there are a few instruments targeting women of childbearing age, again, with the interest being in detecting this lower-risk use. And I'm going to show you just a couple of examples of those so you know a little bit about what we might be looking for. T-ACE is one example. And this is a modification of another widely-used instrument that was best studied in men called the Cage Questionnaire. C, have you felt like you needed to cut down on your alcohol use? A, have you been annoyed when people talk to you about it? G, do you feel guilty around your current level of alcohol use? And E, do you sometimes feel like you need a drink or to use upon waking in order to calm your nerves

or to get going?

The trajectory so far as problem alcohol use, what that looks like, it tends to be a little bit different for women. And so that's led to some exploration of modifying these questionnaires so they might be better able to detect that. And one of the primary issues that those investigators discovered with fairly high yield was asking women about their tolerance for alcoholic beverages, how many drinks? Being careful to define what you mean by a drink, right, this refers to standard drinks. And a standard drink means, of course, a 12-ounce standard beer around 3%, a 5-ounce glass of wine or one and a half ounces of 80-proof spirits. And if it takes three or more beverages along those lines for a woman to experience the effects, then that's a positive answer there. Now on this screen, two or more is positive and requires further evaluation because with all screens, none of these are diagnostic. They simply indicate that more exploration is needed, as opposed to a negative screen, which we can view as reassuring, assuming we have confidence in accurate reporting. The TWEAK is another example that actually performs superiorally to the T-ACE. So this is one to potentially keep in mind. It also has that same tolerance question around when, at what drink do you begin experiencing the subjective effects of alcohol? Have others confronted you or are worried about your drinking? The eye-opener question is there. Have you blacked out when drinking over the last year? And have you made attempts to cut down? On this instrument piece, the first two questions, the tolerance one and the question regarding worry that others have about their drinking, those two items, if positive, score two points each. So answering affirmatively to either one of those is a positive screen, where the other three items score one point.

Screening for other substance use can be a fairly tricky matter. Again, this is where the U.S. Preventive Services Task Force has expressed that they feel like the evidence needs to be improved before we can recommend this universally, but certainly I think intuitively, you know, we might agree that that sort of screening is reasonable in this population, given the potential impact on a developing infant. And there are a few instruments that can be delivered quite efficiently where if they're negative, again, assuming you're confident that the reporting is accurate, the screening can be sort of the complete assessment, but if it's positive, further evaluation is required. And that CAGE Questionnaire that I mentioned and with which many providers are familiar can be reframed to include other drug use, as well. They screen for both simultaneously. So if you felt the need to cut down on your alcohol or

drug use or you've been annoyed when confronted about your alcohol or drug use, etc., with two or more positive items requiring further evaluation.

The DAST-10 is a 10-item questionnaire around substances, frequencies, as well as some items addressing consequences of that substance use. The patients can self-administer. They can then be scored and followed up on as appropriate. An instrument developed somewhat more recently that seems to perform particularly well during pregnancy as opposed to just during the childbearing years is what's called the 4P's Plus where you ask a pregnant woman about substance use pattern in her parents, in her partner, in her own past prior to the pregnancy, ask a particular question about smoking, since smoking regularly can have higher rates of other substance use. And again, if it's negative and you have confidence in that reporting, it's very reassuring, but if any item is positive, it requires further evaluation.

And this, I just put up to illustrate some very broad strokes as to how that evaluation then tends to move forward in treatment agencies to gain a sense of the sort of environment that might be needed to foster recovery or medications that might be helpful. You certainly want to get a detailed sense of the substance use history in terms of when it began, amount and frequency of use, the route of use, be it oral, nasal, or injected so we know about other health conditions that might be an issue for the women in order to arrive at a diagnosis of a use disorder. We also need to know about the consequences with which that use is associated. And that gives us a sense of severity, that use is continuing despite those consequences. Co-morbidity, we also need to know about other mental health issues, for example, or physical health issues that need to be addressed during the course of their recovery planning. Particularly certain mental health issues may make it really challenging for an addicted patient to avoid substances in an effort to treat those symptoms. And an issue to which I draw particular attention for this population is the history of trauma, pre-adolescent sexual abuse, or child abuse, which is really common, particularly among women struggling with opioid use disorders. So I'd encourage you to keep that consideration on your radar.

We also want to engage in a discussion about what their goals are, get a sense of their readiness to make positive change, and what that looks like. And it's also really important to get a sense of what their recovery environment or their household environment and social network look like. And do we have the sense that that's an environment that can

appropriately foster recovery? If a woman is in an abusive relationship and lives with that partner or lives with someone who's actively using, for example, we might move to thoughts about a residential treatment environment as opposed to sending them to outpatient programming when every day they're returning to an environment that makes that recovery a big challenge.

These are the most commonly used diagnostic criteria for a substance use disorder or addiction in the United States. For those not familiar, the Diagnostic and Statistical Manual of Mental Disorders, the DSM, currently in its fifth edition, is really what's looked to most. And this condition is defined as maladaptive use that's resulting in three or more…in consequences in three or more of these areas over the course of the last year. These first two criteria, tolerance and withdrawal, are the indicators that someone is physically dependent on a substance. So tolerance, I need to use more of the substance to get my customary effects or I get less effect with my customary use withdrawal. When I try to reduce use or abstain, I experience an illness that's classic for the withdrawal from that substance. An important consideration here is, again, just to call attention to that stem for this definition, a substance use disorder by definition is characterized by maladaptive use, by maladaptive use. And so if a woman is receiving an opioid prescription for pain, for example, is adherent to the directions for taking that medication, it's improving pain and improving function, the tolerance and withdrawal criteria don't really apply. And we need to be digging a little deeper into history around some of these other indicators that tell us they're engaging in compulsive use, they're losing control over their use, and it's having negative impact in multiple aspects of their life otherwise. And you see the severity modifier there down at the bottom of the slide. If they're experiencing repetitive consequences in two or three of these areas that's characterized as a mild use disorder, four or five, moderate, and six or more, severe.

So we've gone through the screening and the assessment. And if we have suspicion that the patient has a substance use problem, where do we go? Well, I would lead off with the good news. Actually, the majority of women who prior to pregnancy who are engaging in substance use that could be characterized as risky are able to abstain. And 96% have abstained from alcohol, 78% cannabis, 73% cocaine, and tobacco can be the real struggle for a lot of women with actually a minority able to abstain completely during pregnancy. And given that we have more evidence and are more confident and potentially more serious harm is attributable to tobacco than perhaps other substances is a really

important issue also to have on our radar and get women the assistance that they need to abstain from tobacco. The other thing is care providers following up after a pregnancy. What's important to realize is even though women are quite able in a lot of these cases to abstain, the rates for relapse are quite high after delivery, since that motivation to abstain isn't present any longer. And we need to keep our eye out for that.

And now I'm going to get to some particulars about how we think about addressing some of these issues. And I expect a lot of you, if not most or all, are familiar with some of the interventions around tobacco cessation. There are quit lines available that can provide patients some advice around formulating their quit plan, can get them some workbooks to go through to help provide some structure of that plan. There are medications that can be helpful. An important set of thoughts when we're thinking about a prescription medication during pregnancy is how safe is it, and balancing the risk of the substance use with the potential risk of the medication. And the categories of substances or prescription medications during pregnancy, the primary ones are A, B, C, and D. Category A means we have great data from large randomized studies that tells us it's completely safe. B, we don't have completely optimal data, but we have a fair volume of good data telling us that it's safe. C means we don't know. And that can be sort of a tricky category by way of engaging in appropriate counseling with patients and being sure they have the information that they need. Honestly, there are quite a number of Category C prescription medications that are used fairly routinely during pregnancy. So it's a complicated matter, but a matter of engaging the patient in a conversation around potential risks. We don't know a lot about them, but we do know about the risks of tobacco, for example. And so that risk-benefit balance might favor, say, a prescription, if it can be successful in moving a woman toward abstaining from tobacco during pregnancy. And this is a conversation to have repeatedly over the course of pregnancy because quitting at any time throughout the course of pregnancy reduces the risk of complications for the infant after delivery.

Another framework in general medical and other settings where the practices are busy and we may not have time for details, psychotherapy is known as brief interventions. And brief interventions is simply, you know, to put it fairly broadly, and perhaps over-simplified to some degree, it involves 5 to 15 minutes assessment intervention, interviewing the patient, gaining some sense of the perceived benefit from continued use as opposed to the risks or the negative impacts that have been associated with that use and getting them to do their own considering

about the advisability of modifying that current behavior pattern and making positive steps toward change. As we're engaging in that set of conversations, it's really important that we're engaging in conversations in a way to maintain engagement and prenatal care because honestly, that's about the strongest predictor of positive fetal outcomes after delivery is that continued engagement in prenatal care, so I'll just emphasize that.

When we think about treating use disorders other than tobacco, we think about two major components, behavioral therapy, which can take a variety of forms, including but not limited to, group self-help, one-to-one counseling, outpatient group therapeutic modalities, as well as residential treatment environments. And there could be a variety of frameworks guiding that psycho-therapeutic intervention that some of you may have heard of, cognitive behavioral, dialectical behavioral, and things like that. Is one psychotherapeutic philosophy superior to another? Probably not. The data don't seem to indicate that there's one philosophy that fits all. And that really is something that needs to be tailored to the individual in the context of a treatment program. There are also, in addition to behavioral treatments, medications or pharmacotherapy that may assist in reducing use and achieving abstinence eventually. In the setting of heavy alcohol use, it's important to consider at the front end how likely it is that the woman might experience alcohol withdrawal symptoms. Sometimes that can progress from the mild withdrawal syndrome of just anxiety and tremulousness and maybe an increased heart rate to something more severe and potentially life-threating for mother and baby. It can involve seizures or a state of delirium and combativeness that has a fairly high mortality rate associated with it. So that's an initial consideration. Before advising complete abstinence out of the gate, this needs to be unpacked a bit so that one can give appropriate advice around the care that they need to address that withdrawal potential.

There are a number of medications available that can calm craving for alcohol and may encourage cessation. These for the most part are in that category C where we don't have data to tell us with certainty about the fetal effects of these medications. For the most part, they do not look like any of these three FDA-approved medications that are associated with actual fetal malformations. And again, we do know a lot about the potential harms attributable to alcohol. So considering medication to assist in this area involves, again, that conversation with the patient around the risk versus the potential benefit and thinking carefully about that. In the setting of opioid addiction, medication-assisted treatment is

pretty clearly first-line, in addition to behavioral treatment. And the medications that we know the most about that we know save lives and that we know improves pregnancy outcomes are methadone and buprenorphine. As many of you likely know, methadone for the addiction or use disorder indication, it needs to be administered under the supervision of a federally and state-licensed treatment facility. So a woman can't simply go to her primary care provider and get a prescription for that, for that indication. Buprenorphine preparations, the name many may be familiar with this, Suboxone. It can be prescribed out of a general physician's office. And recently, it was also approved for mid-level providers, nurse practitioners, for example, to prescribe that preparation. It does require some additional training. There is an eight-hour online training that a provider needs to go through in order to get what's called the waiver or the license to prescribe that.

There is also what's called an opioid blocker or an opioid antagonist, naltrexone. That comes in a tablet. The patient can take it by mouth daily. It also comes in a monthly injection commonly known as Vivitrol. The challenge in getting folks to that medication is you can't give it to them right away when they're actively using and depending on the opioid, or it will put them right into withdrawal. And so there's some considerations there around making that happen safely. It is an option, but again, there are those difficulties. And we don't really have the data indicating that it's life-saving to the extent we do for the others. There are no FDA-approved medications for addiction to the stimulants cocaine and methamphetamine. A number of studies have been done on other categories of medications used to treat other conditions. And that might be a topic for questions.

So in wrapping up, I'd just say we want to make sure that we're addressing care needs comprehensively. We're simply focused on a single substance use and we're ignoring medical issues and mental health issues that may contribute to relapse risk, and their recovery environment, we're really not getting these women to the sort of care that they need. Really quick, there's this issue around reporting. And I'll just emphasize quickly a couple of points along those lines. I think a lot of providers get more alarmed by some of the illicit substance use where, again, it's what we were talking about a little earlier. We know that some of the legal substances actually may present greater risks to fetuses. And I just encourage you to keep that in mind. And I also made mention of the fact that really one of the most important things we can do, if not the most important thing we can do during pregnancy, is make sure the woman stays involved in prenatal care. That's really the

strongest predictor regardless of ongoing substance use, that's going to increase the likelihood of a healthier baby at the time of delivery. There are states that consider substance use during pregnancy to be child abuse under child welfare statutes, but again, reporting requirements are fairly vague. And solely substance use is rarely a mandated requirement. So there are states with mandated requirements phrased somewhat vaguely around if the woman is engaged in compulsive, habitual use and not engaging in appropriate care or positive behavior change.

Megan: Well, thank you so much, Dr. Brown, for that. I know we've put up the post-test questions, but we'd love for you to chime in on the post-test questions, but I would love to ask folks with our remaining nine minutes we have left in the webinar, please chat your questions or comments into the chat box for Dr. Brown. We'd love to hear what's on your mind about some of the content that he shared and any questions you might have. And I don't see anything in the chat box at the moment. And we can go ahead, and this will take a second, and I see folks did respond to the post-test question about... Here, I'm going to review it here.

Of the following substances listed, which has the lowest percent of women who abstain during pregnancy among women who report "risky use" before pregnancy? And as Dr. Brown shared, that was tobacco. And of the other substances, there were fairly high rates of abstaining. So many of you heard that in his presentation. And you may have heard also his remarks about the challenge with tobacco use, but he also highlighted the high rates among those that were "risky" for alcohol, cannabis, and cocaine. So let's go onto the second post-test question here. And here we are. So true or false. Reporting of substance use is not mandatory. If you'll chime in here, and as we're doing that, I'm also still monitoring the chat box. And I don't see any chatted questions or comments here for you yet, Dr. Brown.

Dr. Brown: No, I guess I did too good of a job.

Megan: You did do a great job. We'll do this post-test question here in a second. And then I'll let you do your conclusions. And we may still have time for one or more questions, if something does come to mind for someone. So folks, the majority of you see that or remarked that reporting of substance use is not mandatory, that it is true. And that is what Dr. Brown shared in his presentation. So I'll turn it back to you, Dr. Brown, for your summary slides here and the conclusion.

Dr. Brown: Great. So I think the points to really emphasize are, again, while we know some about the potential impact of substance use during pregnancy, it's been a challenge to, again, tease that apart from the impacts of the environment in which the substance use is occurring and that a nurturing parental environment can be facilitated after delivery, that may do as much as anything to ameliorate any potential harms later in life. The most harmful substances appear to be actually a couple of the things that are currently legal, including tobacco and alcohol. And again, just to re-emphasize, probably the most important thing we can do for this population is whatever we can to make sure that they continue to be engaged with appropriate prenatal care during the course of their pregnancy. That's going to be the thing most likely to positively affect the health of the newborn.

Megan: And on that topic, we did a question in, Dr. Brown. Are there any support groups or even peer support strategies that you know of that work for treatment of pregnant women?

Dr. Brown: Well, you know, that's a great question. And so far as specifically during pregnancy, I have to say I'm not completely certain. And I can get back to the group, if I can find something particular to that. There is certainly indication that groups targeting women and families that are trauma-informed are advisable, since women with that trauma history may understandably have some anxieties about participating in groups that are mixed. So I would offer that, but I can get back through our chairs here around some more particular to pregnancy, if I find that.

Megan: That would be great. And, you know, we do like to send out just a reminder slide to everybody of the key takeaways from the webinar. So I can loop back with you on that. And if you find out anything, I'll put that in our email summary of the webinar. And I did get one more question in here. So I'm going to ask you that. And then we'll do our wrap-up. So what can you share related to the federal legislation around...there's a couple of acronyms here, around CARA/CAPTA, CARA or CAPTA, and safe plans of care?

Dr. Brown: Yeah, that's something where I'm probably going to need to do a little digging on my own. I know also there are actually [inaudible 00:56:16] and funds directed to states to support some of these and nationwide in terms of efforts going on there. I need to update myself, but certainly a large number of them have been directed toward addressing opioid crisis in getting women to care for that issue, but

that's another one where I can follow up. And can you send me copies of these questions?

Megan: Sure thing. I will be happy to do that. I would be happy to send you them. Yeah. And here's one last question too. Boy, I'm glad folks, these questions are coming in here. So we have...here's one. We are in Syracuse, New York and have a centering pregnancy group for women with substance abuse history in current pregnancy. So that's more of a comment around that question around group prenatal care. So that's an interesting link that we can look back through to see centering as a model to support women in sort of peer support strategy. So maybe we can connect those folks together around that question, around group prenatal care, but a question. How much collaboration is occurring with OB-GYN practices to identify and educate and prevent substance abuse before a pregnancy occurs?

Dr. Brown: And that's something that really varies quite a bit geographically and depends on resources available there. I mean, OB-GYN is another one of those areas where providers probably need a little bit more education about that. Nationally, on average over the seven years it takes to become a physician board certified in a primary specialty, family medicine, internal medicine, OB-GYN, you've gone through seven years of training. You've gone through tens of thousands of hours. And on average, those physicians in training by the time they reach the end of all that and received eight hours or fewer of education around substance use issues, assessment, prevention, and treatment. So it's still an area where medical education needs to... So there are those in the community as they engage and practice of...they're taking an interest.

Megan: That's so interesting. Well, everyone, as we wrap up, I just want to say a huge thank you to you, Dr. Brown, for the informative presentation. And I want to let everybody know that we do have an upcoming webinar in February. I just wanted you to mark your calendars for the next "Conversations with the Division" webinar, but we may have a couple of announcements for some January webinars, but those are still being finalized. So be on the lookout for that training alert. If you're wanting to look at and see some more behavioral health-related webinars and resources, we do have a link here that I just posted in the website, I'm sorry, in the chat box on the EPIC Center. It's for the A-step team's webpage on all these resources. And all of these archived webinars are included on the EPIC Center's website. I would like to just give a moment to Janet Van Ness, who is with EPIC Center who's going

to remind folks of another training opportunity. Janet?

Janet: Hey there, Megan. Thanks, Dr. Brown. That was a great presentation. Well, first of all I wanted to reiterate something that Dawn said and that this particular topic for the webinar was directly developed as a result of the discussion sessions that we had with a wide range of grantees, with urban grantees, rural, community health center, tribal. So this is a direct result of those discussions. So thank you very much. We're actually synthesizing that second round of discussions right now. And we'll be adding to our training offerings in the next couple of months for the rest of this year. So keep your eyes open for that also. I did want to let the grantees know that, and you all likely have heard of this already, one of the things that the A-step initiative has offered us is opportunities for grantees to provide mental health first aid training as a professional development opportunity to their Healthy Start staff. And you all may know that mental health first aid for kids is an eight-hour course. It gives people skills to help someone who's developing a mental health problem or experiencing a mental health crisis.

And we offered this as an opportunity for grantees. And we've had several grantees that have taken advantage of this and have requested it. And we're helping them to identify trainers, local trainers, in their area. And we are also supporting the training by subsidizing the cost of materials and an honorarium for the trainer, if that is expected, and some room expenses and that sort of thing. We can still accommodate additional trainings. And I do want to mention that you may not realize this, but this training is not a community training. As you recall, grantees can seek out community training, but basically it's limited to one. Even if you have a community training, as you've had it or you're planning it, this is not related to that. This is a development opportunity for Healthy Start staff. So please, if you want to explore that possibility of offering it to your staff, just contact me at the EPIC Center. And Megan, if you could maybe put my email up there, it would be great. You can contact me directly.

Megan: I am doing it right now. And I'll also put that in, everybody, in the key takeaways email that we send out to everybody.

Janet: Thank you.

Megan: So thank you, Janet for that note about mental health first aid. Again, thank you to you, Dr. Brown, for the wonderful presentation. And thank you to all of you for carving out time in your busy day to participate

on the webinar. This concludes this event. And I hope you have a great rest of your day.