

Dr. Stephen Taylor: Welcome. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Dr. Stephen Taylor, and I'm gonna start us off today with a little excerpt from the New York Times.

Kim waited in the doctor's exam room on an icy day in February, exhausted from the first trimester of pregnancy and trembling in withdrawal from methamphetamine, alcohol, Xanax, and Klonopin. This was Kim's second pregnancy with the Great Moms Clinic at the Corewell Health Medical Center in Grand Rapids, Michigan. One of the rare programs for a population of patients who are among the most reviled in society, pregnant women and new mothers who were addicted to drugs and alcohol. Kim, 32, had first come to the clinic in the fall of 2022 and, in April 2023, gave birth to a healthy, drug-free boy. But within months, she relapsed, and child protective services placed the baby in foster care. Her despair drove her further into addiction.

Now, pregnant again, she had returned to the one place she believed was her best shot at staying sober and raising this new baby. Dr. Cara Poland walked into the exam room. "I'm so thankful that you made your way back to us." She said to Kim. Dr. Poland, an addiction medicine specialist who founded the clinic, was not like any Dr. Kim had ever met. She did not wear a white coat. At their first appointment back in 2022, Dr. Poland plopped down cross-legged on the floor of the exam room and smiled up at her new patient. Kim, a petite woman who had been hunching inward as if braced for dismissive contempt, was startled.

Dr. Poland, an associate professor at the Michigan State University College of Human Medicine, then introduced a gaggle of students who accompanied her. She told Kim, "it's your job to teach them how to not be assholes to people who have addiction." Kim laughed, thinking, she later recalled, "I can vibe with this lady for sure."

Reducing the prejudice and shame felt by addicted patients is Dr. Poland's calling. She spearheaded a program that trains doctors in other disciplines to treat addiction, a chronic brain disorder that alters circuits involving brain reward and self-control. So today, folks, I think you know who our guest is gonna be.

It's that lady that we're all gonna get a chance to vibe with and learn from as well. Dr. Cara Poland, the Vice President of ASAM, and my guest today to talk about women with addiction, particularly those who are pregnant. Dr. Poland, welcome.

Dr. Cara Poland: Thank you so much for having me.

Dr. Stephen Taylor: I am super excited to have you here on our podcast to talk about these topics.

Almost as excited as I am to have you as my vice president at ASAM. And so, let's go on ahead and get started. I have some questions for you. We all need to get to vibe with you and learn from you today. Can you start out by talking a little bit about what

you're seeing in terms of substance use and overdose risk during pregnancy and the postpartum period?

How has the landscape shifted over the past few years?

Dr. Cara Poland: The landscape shifted a lot over the last few years. It's not unlike what has happened in other areas of addiction care, right? It's the same drug supply. People are using; they get pregnant; they continue to use the same substances. So, we're seeing a lot more stimulant use.

We're seeing a lot more fentanyl use. And so, with those higher risk fentanyl analogs, we're seeing more overdose, higher risk patients that come in to see us in our clinics. And that's really important to remember because it only makes providing evidence-based care to pregnant people, providing them with the opportunity to engage with your clinic, with your treatment team, offering medications, that much more important.

Dr. Stephen Taylor: Yeah, that's absolutely true. And talk to me about stigma. To me, this is a topic we need to get into as early in this particular episode as possible. Stigma can be a huge barrier to care. And, as the New York Times article referenced, there's probably no group of people who are more stigmatized and more reviled to use the word used in the article than pregnant patients who have addiction. What are some of the most damaging ways stigma shows up for these folks in healthcare settings, and what advice do you have for providers on how to actively counter it? You know, break down what it means to not be assholes to these patients.

Dr. Cara Poland: [Laughter] Well, I think it's coming up and being your authentic, real self. Right?

A lot of times in medicine, we're taught to put up this barrier, that we have to have this professionalism barrier, and sometimes it can lead to these kind of stilted, false interactions with our patients, and our patients are other humans, right? They feel that when you walk in the room. Also, I think we have to recognize and honor the fact that one of the biggest contributors to stigma from a patient perspective is the healthcare system.

So, when they walk into the room, frankly, we've taught them as a healthcare system – hopefully, not too many of our addiction colleagues – but we've taught them as a healthcare system to expect us to be rude, to expect us to be mean, to expect us to be assholes. And so, when we walk in the room, we have to remember that we need to disarm these patients.

We have to pull it back. When I walk into the pediatrician's office for the well child visits, for my 11 and 13-year-old, healthy children, that I get a little nervous. And I work in healthcare, right? I know who the MA is. I have their pediatrician's cell phone

number, for goodness' sake. There's no reason for me to get nervous, but still, I get nervous.

What if he finds something? What if I'm a terrible physician, doctor, mom? Even though I'm not even a pediatrician, like, I have no business being my kid's doctor. What if I've missed something? And the pediatrician, like the expert, is gonna point that out. Like that could be awful, right? And so, I get a little nervous, I get a little elevated, and I have no reason to.

Now just imagine what it's like to be in that vulnerable position. Imagine what it's like to not really have the same amount of knowledge and reserve that we have as physicians about what the healthcare system looks like. Then they walk into the room and they're expecting us not to be mean, and their fight or flight is elevated.

And, people who have a history of a substance use disorder, we know that they're 12 times more likely to develop a substance use disorder if they have an ACE score of four or above. So, we know they're more likely than the average patient that walks into a healthcare system to have had traumatic experiences in the past.

And we put that all together, and it's no wonder they're nervous. I just had a second-year EM resident with me yesterday, and I said, "Why don't you go see this new patient yourself?" And he said, "What should I do? What do I do first?" He pulled my template up and I said, "When you walk in the room, tell the patient thank you for coming to see me. And then tell 'em who you are."

And I think if we can think about it like that, when was the last time I walked into my doctor's office and the first thing out of their mouth was, "thank you for coming in to see me today." I've never experienced that, and I think it just flips the tone. And you know the part about me sitting down. Kim's petite.

I'm petite. I almost hit five feet tall. I promise one day I will grow tall enough to hit that high bar. But I still make it a point to make sure I'm smaller than my patient, that I'm sitting in that chair. That, if the patient's looking down and I can't make eye contact, that's when I sit down on the floor because they can't not make eye contact when I'm sitting there looking like with 3-year-old up at them. But it disarms them, 'cause they're not expecting that, and it loosens them up. And then when I tell people that I need their help training the next generation, it empowers them as a patient. And so, kind of just breaking down all of those pieces and watching the patient as you do that, like you will see them go from tense, shoulders up, curled in on themselves, and, you'll physically, you can watch them relax their body. And they're not thinking about it. Right? And that's when you can start really asking the questions and getting the information from them.

And I think that when you add that layer of pregnancy on it... when the reporter from the New York Times and I were talking about this article, she really was very sensitive

about wanting to make it not sound like pregnant people who use drugs are bad people and – because that's what the ethos is out there in so many environments.

So, reminding them that they're making the best choices that they can. That they have this terrible disease that is making it really hard for them to stop using something that is harming them and potentially affecting their pregnancy. It is really a powerful place to be. And one of the great things about pregnancy is that desire to change.

Dr. Stephen Taylor: Pregnancy is often a motivator for change, as you point out. So, what does an effective support system look like? And that could be from partners and family to community programs, including us, addiction specialty physicians, who partner with OBGYNs and maternal health providers. What does that effective support system look like for this person who now has maybe a heightened motivation to change?

Dr. Cara Poland: It looks like meeting them where they are. I have a certain support system. I think many of our listeners probably are aware that I've had some loss in my family. So, my brother died, my mother died. And so, my support system looks different than somebody who has a parent who's still alive, right? Just by definition.

So, really finding out from the patient who is available for them in the community and what are the gaps and what do they need. And I always tell people that my job is to give you the menu of options. I can look at the ASAM criteria, and I can say, "According to that ASAM Criteria, you qualify for this level of care."

But if that's not practical for that person, they're not going to do it. I will tell people that I can tell you what the statistics say. I can tell you that the vast majority, in the 90 percents, in some studies, show that people who try to go abstinence-based during pregnancy will return to using. But what I can't do is I don't have a magic wand that tells me if you're gonna be in that 10% that's successful.

So, if you say you really want to try an abstinence-based program, I'm gonna say let's try an abstinence-based program. I'm going to ask that I can also remind you that I'm here to support you, and if that abstinence-based program isn't going the way you want it to, that we should revisit it. If the buprenorphine isn't going the way you want it to, we should revisit it."

Just in that same way, to me, a lot of it is about hearing from your patient and finding out what's important to them. And I often get confused for an OBGYN. I like to remind people that I've had multiple pregnancies, but they were both over a decade ago. So, my information's a little outdated as a formerly pregnant person, but that's where my expertise in OBGYN ends.

So, we should probably pull in somebody who actually knows what they're talking about. But I think as an addiction specialty physician, it's a lot of fun to be part of that

team-based care, right? To pull in the recovery coach and find out what they've learned about the patient and what supports they might be seeing from their lens that might be helpful for that patient.

It's a lot of fun to bring together all of those players to find out what are the unique things that this individual might need to be the most successful that they can with their pregnancy.

Dr. Stephen Taylor: That is so true. Part of the fun of us working in this field and being addiction specialist physicians is that we generally tend to work as part of a team.

Very often part of a multidisciplinary team, because the disease for which we are treating our patients tends to be a multimodal and multifaceted disease. And so, it's so important for us to be able to work as part of the team. And I also wanted to go back and give you a shout-out for the very important points you made about making your patient feel comfortable. I remember back in medical school, I had one of my attendings who was grilling us medical students on rounds about what is the single most important first thing you have to do with your patient when you're first taking a history and first starting the evaluation of the patient. And everybody had a number of different guesses of what that might be.

And he said, "Okay, you're all wrong. The single most important, first thing you have to do is get your patient to like you." And so, I thought, "Yeah, how about that?" Because if they like you, they are gonna be able to be more relaxed. They are gonna recognize that you're not judging them and that this is a place where they can speak freely and trust you and talk to you.

And if you accomplish that, then half the battle is won. If you fail to accomplish that, you get nothing done. So, I just wanted to give you a shout-out for that really awesome approach. And it was important to hear that everything you did was strategic. I mean, the sitting on the floor and getting the patient to understand that they're helping you to train the next generation to know how to take care of folks and how to treat folks.

That was just awesome. I must say, though, that, yeah, we may be part of a team, but we also, as addiction specialist physicians, have some unique knowledge, of course, that we want to impart to our patients and some unique expertise that we want to provide for our patients. And so, when it comes to some of our tools in our toolbox, like what you mentioned, buprenorphine and even methadone, we know that those medications can save lives. We know that. But we also know that they're still underused in general and particularly in pregnancy. So why do you think prescribers hesitate to start or continue these medications during pregnancy? And what guidance can you offer to help them feel more confident in starting or continuing MOUD in patients who are pregnant?

Dr. Cara Poland: Well, I mean, the obvious answer is stigma, right? We can talk about stigma the whole time. But the other answer, I think, is the lack of understanding and training. There's a lot of myths about what happens at a methadone clinic. What does it mean to prescribe buprenorphine? Am I at more medical-legal risk if I take on these patients than if I don't take on this patient population?

So, there's a lot of kind of myths swirling around in this space, particularly around pregnant people that have a substance use disorder. And then there's variability across the nation in terms of the legal infrastructure and the reporting infrastructure. And so, you have to know what your micro location expectations are as well.

And that can feel really overwhelming to, particularly a generalist physician, but also to us as addiction specialty physicians if we don't treat a lot of pregnant people. But I think ultimately our responsibility as addiction specialty physicians [is] to be the experts in addiction, inclusive of what to do when somebody's pregnant.

And we know that these medications are the best way to improve outcomes for that dyad, the pregnant person and that baby. And so, I think I encourage people to just remember that it's not that different than prescribing in a non-pregnant person. The one big thing to remember is that quite a significant number of people require either split dosing for methadone and or higher doses for both buprenorphine and methadone because they start breaking down the medication more quickly. I always tell my patients, like, "your body's a little machine and it ramps up during your pregnancy so that it can do all sorts of really good things - pulling more nutrients out of your food; making a human, right? This is like crazy that our bodies can do this in the first place. But one of the things that it does that isn't so great is, you know, when it's pulling out all that extra nutrition, it makes your constipation worse.

That's not fun. The swelling that you get in your ankles, also not fun. Also, your body's breaking things down at a different rate, and, for the majority of people, over half of patients will need more medication during their pregnancy." So not being scared. I think for the addiction specialty physician of going up on the dose of medication during pregnancy is really important to remember.

I always frame it to my patients as, "I want you on the lowest possible effective dose." So, we don't want you on too much medication. We don't want you on too little medication. We want you on the lowest possible effective dose. The other kind of key fact to give patients is that it's not the dose of medication that is the best predictor for withdrawal in that newborn.

So, we believe it's based on the amount of aromatase that mom's placenta creates, so the dose of the medication doesn't impact the baby's risk of withdrawal. So, I think that's a really key fact for people to be able to share with their patients and for us to know, so that we feel reassured in going up on that dose based on their clinical presentation.

Dr. Stephen Taylor: That is awesome. Very valuable information. The idea that you gotta be careful on the dose and you gotta stay low with the dose when, in fact, pregnant people tend to need higher dosages and there are very legitimate physiological reasons why that's the case. So, that's very helpful. The postpartum period, let's talk about that for a minute. Because that carries some of the highest overdose risk. And as we talked about before, the importance of getting patients engaged and getting them to trust us and be comfortable enough and relaxed enough to work with us.

What about the strategies that you might suggest for keeping folks engaged, particularly in the postpartum period when you wanna keep a person on MOUD during this high overdose risk period of time, postpartum? What are some strategies you can offer to some of our listeners regarding keeping folks engaged and supported and safe during this time?

Dr. Cara Poland: The biggest thing is to remember that this is a really hard time. As a parent myself, I feel like those first, I don't know, 18 months of my kids' lives were kind of a blur, right? I'm getting lack of sleep, my body's stressed, and my brain is stressed from not getting sleep. So, it's physically destabilized. It's actually, I mean, it's a beautiful, wonderful, delightful time of my life, but I never wanna go back to it, to be perfectly honest.

Like, I would do it again to have my two children. Absolutely. Would I volunteer to do it today? No. It was really hard, right? It's hard to be a parent, and that added stress physically on the brain of lack of sleep really can contribute to destabilizing some of the functionality that is going on in our brains, no matter who we are.

And when we add that onto a substance use disorder, and sometimes one of the gains of using a substance is that extra energy, right? That's sometimes why somebody started using in the first place. Kind of that anticipatory guidance coming up, but not only with safe care plans for what to do if you're having a craving, but safe care plans for what to do if you need a break. You know, who's going to be your relief plan? Do you have another adult that lives in the home with you or do you not? Who are your resources to pull on when you need a little bit of extra support because you just need to take that nap or take that shower, fold that load of laundry, have something other than macaroni and cheese for dinner, right?

Those are real things that happen when you're postpartum, no matter who you are. And I think that's really relatable, and I think normalizing that the postpartum period is just hard for everyone, and that we're here to support you and we're here to provide you with ongoing care.

Traditionally, in the OB world, it's that six-week postpartum visit, and then, like, see you later. We did a two-week postpartum visit, that's almost more of a check-in. And if the patient would prefer to do that over the phone, we will do an over-the-phone call or a virtual call or maybe a check-in with the social worker or the recovery coach.

Like, we kinda leave that one up to the patient, what type of follow-up they want. And then we have our traditional, six-week follow-up. And I think part of it is the engagement with the medication, right? They would like their buprenorphine medication. But I like to think some of it is we're just nice in our clinic.

And so, our postpartum follow-up, our six-week follow-up, rate is usually average is in the low 80s. You know, we dipped down to 78 at one point and I nearly cried. But that follow up is really key. And then walking with that patient for the first year postpartum to find what is the sweet spot for them.

If you don't do long-term care, if you focus on the pregnant and postpartum population, then what is the right time for that person to transition to a new provider? I mean, I've had patients who are like, "I saw Dr. Taylor for five years before I was pregnant. He made me come see you while I was pregnant.

And now I wanna go back and see Dr. Taylor because he's the nicer doctor." And I'm like, "Great, if that's what works for you, I just need to see you at six-weeks for the pregnancy part of it." I don't actually, the midwife I work with, she's the one who does the postpartum check. But "We wanna see you for that six-week and then we'll make that appointment with Dr. Taylor. We'll make sure you have enough medication to get to him. If something happens – the kid doesn't sleep, you get sick, Dr. Taylor ends up having to cancel the appointment – you're welcome to come back until we make sure you get there." We talk about warm handoffs in medicine. I tell people that in the postpartum period...

I mean, I wish everywhere we could think of it like this, I don't want a warm handoff. I want like an, I'm putting my hand in a 350-degree oven and I'm gonna burn my hand off. That's the type of handoff I want. So, I want the patient to know that they're safe and secure during that process. That if they're ready to go see their next provider, they've got that appointment, they are good to go, that they can go see them. But, if something happens, that we're still here to backfill that. And, also, somebody's going to see a new provider, maybe they just started MOUD during their pregnancy, and they're no longer eligible for your clinic, making sure you have some flexibility.

So, if that first referral isn't a love match, they don't connect with that clinic the way that you thought they would, that they can bounce back and try someplace else without feeling stuck. So, really just making it as warm and cuddly and as all-inclusive as possible is what I try to do.

Dr. Stephen Taylor: You know, I've had experiences with this as well.

Obviously, never been pregnant, never given birth. But I do remember very clearly when my daughter was born, the first of our two children, and I was doing my internship at that time, and my internship was in pediatrics. So, I'd come home after a long day of taking care of children and babies, and my wife, who was postpartum during that period, as soon as I walked in the house, she would hand my daughter to

me and say, "Here, she's yours. Now I gotta go take care of me for a change." And I got it. I absolutely got it. It made perfect sense because that's one of the challenges of this postpartum period is that it's all about the baby. It's all about the baby in so many people's minds and in the mind of the mother. And we really forget to focus on taking care of that mother during that postpartum period of time. And so, it's so important that that is emphasized in taking care of folks with OUD who are in that postpartum period. And then again, professionally during my – 'cause the first two years of my residency were in pediatrics and I'm actually a trained pediatrician, but I don't talk about that much 'cause I don't do pediatrics anymore.

But yeah, from our perspective, it's all about the baby. Again, you talked about the two-week visit that you folks have and then the six-week visit. In that period of time, in that postpartum period, mom's gotta bring that baby in for the three-week checkup on the baby and then the two-month visit to start the shots and all of that.

And we pediatricians, I will tell you, from having worked in the pediatrics clinic as an intern. It's all about the baby. Rarely do we ask about how the mom is doing. In many cases, many of us may not even be aware that the mom is in treatment for an OUD or for an SUD because it's all about the baby. And so, it's so important that you have that focus on the well-being and the care of the mother during that postpartum period.

So, you're absolutely right. It's all about being as cuddly and as warm and as careful and as focused on that person's care as possible. Do you have any clinical pearls? And then this may touch on some things that you've already said, but I just gotta ask this because there are some of our listeners who, even though they may be addiction specialist physicians, they don't necessarily take care of pregnant persons.

And so, you might have someone among our listeners who is gonna be evaluating their very first pregnant person with an opioid use disorder. Do you have any clinical pearls for those folks? To help them feel a little less nervous, because I think that is an issue for some of our colleagues.

Dr. Cara Poland: I think the only other place that I sometimes feel like there are snafus is this idea that going into withdrawal to get on buprenorphine is risky for the pregnancy.

And we've gotta remember that in all likelihood, if somebody's using illicit opioids, they're going in and out of withdrawal, likely even multiple times a day. That risk is less relevant, clinically, than I think from the hypothetical standpoint. I still know that there are OBs that will say, "Oh, you have to put the patient in the hospital to start them on buprenorphine."

I'm like, "No, we don't need to do that." So, I think remembering that if they're actively using illicit opioids in particular, [they] are likely going in and out of withdrawal. So, getting them on buprenorphine where they're gonna be the most

successful. So, for me, I usually ask my patients, "What's your preference? Do you wanna do it in your home where you have your own bed and, if you're uncomfortable, you can manage those symptoms yourself." Particularly in people who have been on buprenorphine products previously, [that] is often their preference. And so, not being scared of that, I think, is a key fact.

Dr. Stephen Taylor: That's great. So, we've spent a lot of time talking about opioid use disorder and, of course, that makes sense. We understand we're still in the middle of an overdose epidemic. But we also understand that few patients use only opioids. And in fact, even Kim, in that New York Times article that we referenced at the top, was in withdrawal from methamphetamine, alcohol, Xanax, and Klonopin. So, I think it makes sense for us to also think about alcohol use disorder, for example, and some of these other drugs.

And, Cara, let me ask you, what are some pearls that you could share with our listeners regarding patients, for example, who are pregnant or postpartum, who have an alcohol use disorder?

Dr. Cara Poland: I think it's really important to remember what you're saying, which is that polysubstance use is sort of the norm, right?

And I like to remind my patients with illicit substance use that their drug dealer is not following OSHA safety protocols and ensuring the separation of the methamphetamine from the fentanyl. So, that is a fact, right? And so, we see sometimes unexpected results in our toxicology screens because a patient truly doesn't know that they're using that substance. In terms of treating alcohol use disorder, we do have medications that can be used in pregnancy.

Of course, Acamprosate is one of them. And that one is a little easier to use in pregnancy, if only because naltrexone is an opioid antagonist. So, if we start that medication, then we have to know that that person at the end of their pregnancy is going to potentially need to pause that medication for a period of time.

Stop an injectable about six weeks ahead of time, stop oral about two weeks ahead of their due date. Of course, babies sometimes come when they're not expected to come. They sometimes come early. So, that can be an added challenge of Naltrexone use during pregnancy, but offering medications where appropriate is certainly something that can be done during pregnancy to treat alcohol use disorder.

And again, as with opioid use disorder, I think a lot of the principles of kind, compassionate care are universal. I think that, also, we've seen some amount of this, what I find unusual, normalization of alcohol use, that maybe a little bit of alcohol use is okay during pregnancy in the broader public, which we know, as physicians, is false. No amount of alcohol used during pregnancy is safe. So, we are fighting this upstream battle around the normalization of alcohol use more broadly. And so, that increases the stigma of coming to see somebody and asking, "How do I stop using alcohol?"

Because there's this added layer of "I should just be able to quit because I'm pregnant, because I know 10 other people who were pregnant and just stopped drinking alcohol." So, adding those safe questions, creating safe spaces that will allow people to have that conversation with you. Look, we know that about 1 in 20 kids has the effects of an alcohol use during pregnancy. So, somewhere on the fetal alcohol spectrum, they're falling, right?

Which, if you think about it, that's one kid in every kindergarten classroom, which is huge, right? And we're not talking about it, and we're not identifying it. So, I think if I had a pearl for alcohol use disorder, it would be to make sure we're talking about alcohol use in pregnancy. To make sure that there's some amount of universal screening for that for all pregnant people, and to honor the stigma difference between alcohol and other substances, because of that sort of normalization in the nation.

Dr. Stephen Taylor: That's so important. You're so right. And alcohol's always been a challenge because it's the most socially acceptable of all of the drugs that our patients deal with. And so, it makes sense that we're in a period of trying to normalize its use, and at the same time, as we are increasingly seeing research in the medical literature talking about the carcinogenic effects of alcohol. And again, in the general population, not just in pregnant and postpartum people. And the notion that there's really no amount of alcohol that is necessarily safe for anyone.

And the fact that is changing messaging that used to be delivered to people a couple of decades ago, about possibly moderate use of alcohol, potentially even being beneficial from a healthcare standpoint. And so, that is a particular challenge that I would expect that we would have many of our pregnant and postpartum patients coming in with just plain confusion about what should be their relationship with alcohol. What's true, what's not true.

And I would imagine that a good bit of the work we need to do is just basic education, even as we're trying to help people be more relaxed and be more comfortable to talk with us.

Dr. Cara Poland: Absolutely. I sometimes laugh because I tell patients, "We're gonna have a history lesson today." And I talk about water sanitization, and that we used to be actually safer in some places to drink beer than it was to drink water because of the lack of sanitation. And so, I'll go into that with patients, and I'll say, "so this is something that we've had a relationship with as humans for a long time." And that also allows me to segue into the higher potency kind of craft beers and how the supply has changed, right?

What they were drinking a hundred years ago, because beer was safer than water, in some regards, right, is different than what we have today on the market. I'm in Grand Rapids, Michigan. We are self-proclaimed beer city, USA. We have a ton of that kind of, you know, come in for the flights and billboards for different breweries all over.

You know, I feel like it's in my face in a different way, and so it has to feel the same way for my patients, right?

Dr. Stephen Taylor: Yeah. And particularly those who have an alcohol use disorder. "Why can't I be normal like everybody else? Look at all these billboards saying that this is perfectly fine and enjoyable. Look at all these people around me who are able to enjoy this and not have a problem. Why do I have to stop?" So, yeah, I hear that a lot from many of my patients. Again, not just those who are pregnant and or postpartum. So, very important topic to touch on. And then, in general, what would be the top three takeaways that you wanna leave with our listeners from this discussion when they go forth and take care of pregnant and postpartum people with SUD?

Dr. Cara Poland: Well, you know, the first one is always don't be an asshole. Right? Think about how you can create the warm, cuddly feeling in your clinic and with your patients, and being a partner in developing that plan for that individual centered on what is going to work for them in their life right now. And being flexible over time with that.

The second one I would say is, don't be scared of prescribing medications, referring to methadone clinics, and even starting medications for alcohol use disorder. Make sure that you are offering the medications that are safe and appropriate during pregnancy. And I'd say that the third one is to honor that time in somebody's life and recognize that I have yet to meet a pregnant person that doesn't wanna change something to improve their healthcare and honor the fact that for some of our patients, it's just that they wanna stop using heroin. And it's that they wanna stop using methamphetamine, and they're doing the best that they can. Even if they aren't totally successful with their treatment, the fact that they're coming up to you and your office, that they're showing up for that appointment, means some part of them wants to change. And let's support them in leading the healthiest life that they can in that moment.

Dr. Stephen Taylor: Wow. There it is. One, two, and three. That's very nicely summarized for us. Dr. Cara Poland. Vice President of ASAM. The lady that we can all vibe with and learn from. Thank you so very much for joining us today on our podcast and sharing your wisdom and your experience. This has been an incredibly fun discussion and a very helpful discussion.

Thank you to my listeners for listening to ASAM Practice Pearls. For more information about women's care and addiction treatment, check out the ASAM Clinical Tip series on Women in Addiction. This free micro-learning video series covers key topics including pregnancy and substance use disorder, substance use in the aging female population, addressing motivated behaviors in women, and engaging families and care providers in women's SUD treatment. Don't forget to subscribe and share this episode with colleagues who may find this information helpful. Finally, with season one starting to wrap up, we'd love to hear from you. What topics would you

be interested in hearing more about in season two? Take our survey, which can be found in today's show notes, or email us at education@asam.org.

Thanks for listening. We'll see you next time on ASAM Practice Pearls for our season one finale.