TEMPLE UNIVERSITY

Center for Public Health Law Research

EXPLORING POLICY SURVEILLANCE

Part 4 — Policy Surveillance for Research

April 9, 2019, 1:00 p.m.-2:30 p.m. ET

Presented by

THE POLICY SURVEILLANCE PROGRAM

A LawAtlas Project

How to use WebEx Q&A

1. Open the Q&A panel by clicking the "…" button on the bottom of the screen and selecting "Q&A"
2. Select "All Panelists"
3. Type your question
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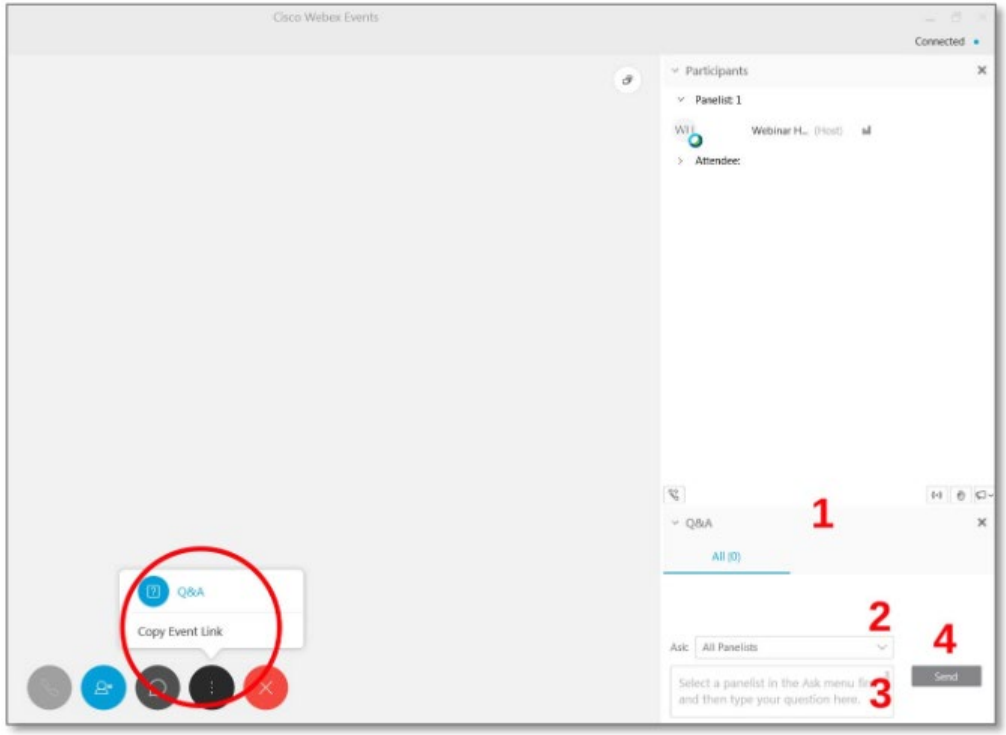

Moderator

Heidi Grunwald, PhD

Co-Director, Center for Public Health Law Research
Director, Institute for Survey Research

Presenters

Aaron Gilson, MS, MSSW, PhD

Health Policy Research Scientist, Senior Scientist
Sonderegger Research Center, University of Wisconsin-Madison School of Pharmacy

Presenters

Kelli Komro, PhD, MPH

Professor, Behavioral Sciences/Health Ed.
Director at Large, RISE Center for Reproductive Health Research in the Southeast

Presenters

Sue Thomas, PhD

Senior Research Scientist, PIRE

State Laws and Other Regulatory Policies Related to Pain Care

Policy Surveillance Webinar

Policy Surveillance for Research

April 9, 2019

Aaron M. Gilson, MS, MSSW, PhD

Health Policy Research Scientist / Senior Scientist

Sonderegger Research Center
SCHOOL OF PHARMACY
UNIVERSITY OF WISCONSIN–MADISON

Policy Surveillance Project
Purpose

Compile, code, and analyze state-level laws and other regulatory policies that govern chronic pain treatment, including for palliative care and end-of-life care

- this is a legal content review based only on observable features (keyword search)
- all 50 states & DC
- policies effective through December 31, 2017

Policy Surveillance Project
Procedure

- Controlled Substances Acts & regulations
- Medical Practice Acts & regulations
- Medical Board guidelines
- Osteopathic Practice Acts & regulations
- Osteopathic Medical Board guidelines
- Pharmacy Practice Acts & regulations
- Pharmacy Board guidelines
- practice standards for healthcare facilities
- Prescription monitoring programs statutes and regulations

Policy Surveillance Project
Procedure

- Conduct background research
- Use Lexis Academic to identify legal text
- Redundant coding (2 raters)
  - conducted in Batches (n=5)
- Calculate divergence rates
  - < 5% divergence (range = 0% to 4.00%; mode = 1.60%)
- Enter policy language into MonQcle
- Create Master Sheets
- Develop LawAtlas resources (e.g., Research Protocol, Landing Text, Codebook)

Model Polices Informing Coding Questions

- Federation of State Medical Boards *Essentials of a State Medical and Osteopathic Practice Act* & *Guidelines for the Chronic Use of Opioid Analgesics*
- the Joint Commission on Accreditation of Health Care Facilities facility standards
- National Alliance for Model State Drug Laws *Model Prescription Monitoring Program Act*
- National Association of Boards of Pharmacy *Model State Pharmacy Act* and Model Rules & *Model Prescription Monitoring Program Act*
- National Association of State Controlled Substances Authorities *Model Prescription Monitoring Program Act*
- National Conference of Commissioners on Uniform State Laws *Uniform Controlled Substances Act*
- current Federal statutes (Controlled Substances Act)
- current Federal regulations (Code of Federal Regulations)

Coding Questions
Domain 1:
Policy Definitions

1. Does the practice of medicine include the treatment of pain?

- ○ Yes
- ○ No

2. Does the policy define addiction not based solely on physical dependence or tolerance?

- ○ Yes
- ○ No

2.1. Is there a statement that physical dependence or tolerance are not considered addiction?

- ○ Yes
- ○ No

3. Does the policy define a maximum amount for a prescription of a controlled substance?

- ○ Yes
- ○ No

3.1. What is the maximum amount for a prescription of a controlled substance?

- ○ 7-day supply
- ○ 30-day supply
- ○ 30-day supply, 100 MME
- ○ 31-day supply
- ○ 31-day supply or 100 dosage units, whichever is greater
- ○ 1 month supply
- ○ 34-day supply
- ○ 90-day supply

4. Does the policy define a duration for which a prescription for a controlled substance is valid?

- ○ Yes
- ○ No

4.1. What is the duration for which a prescription for a controlled substance is valid?

- ○ 3 days
- ○ 7 days
- ○ 14 days
- ○ 21 days
- ○ 30 days
- ○ 60 days
- ○ 90 days
- ○ 120 days
- ○ 6 months

5. Does the policy define "unprofessional conduct" to include excessive prescribing?

- ○ Yes
- ○ No

5.1. Does the policy include factors determining "excessive prescribing"?

- ○ Yes
- ○ No

Coding Questions
Domain 2:
Establishing a Context for Pain Treatment

6. Does the policy state the need to reduce harms from controlled substances while maintaining patient care?

- ○ Yes
- ○ No

7. Does the policy establish that a regulatory board will use individual case characteristics to judge the validity of pain treatment?

- ○ Yes
- ○ No

8. Does the policy establish an education course for practitioners or pharmacists to improve pain treatment?

- ○ Yes
- ○ No

9. Does the policy establish methods for healthcare facilities to improve pain treatment?

- ○ Yes
- ○ No

Coding Questions
Domain 3:
Practitioner Expectations for Pain Treatment

10. Are practitioners expected to consider integrative care during pain treatment?

- ○ Yes
- ○ No

11. Are practitioners expected to provide individualized care during pain treatment?

- ○ Yes
- ○ No

12. Are practitioners expected to assess patient functioning during pain treatment?

- ○ Yes
- ○ No

13. Are practitioners expected to engage in shared decision-making with patients when considering pain treatment options?

- ○ Yes
- ○ No

14. Are practitioners expected to assess or discuss patient benefits and/or risks before initiating pain treatment?

- ○ Yes
- ○ No

15. Are practitioners expected to monitor patient benefits and/or risks during pain treatment?

- ○ Yes
- ○ No

Coding Questions
Domain 4:
PMP-Related Content

16. Does the policy require a timeframe in which dispensing data is submitted to the PMP after dispensing?

- ○ Yes
- ○ No

16.1. What is the timeframe in which dispensing data must be submitted to the PMP after dispensing?

- ☐ Real time
- ☐ 24 hours
- ☐ Daily
- ☐ 1 business day
- ☐ Next business day
- ☐ 72 hours
- ☐ 3 business days
- ☐ 7 days
- ☐ Weekly
- ☐ 8 days
- ☐ Monthly

17. Does the policy authorize the PMP to share data with other state PMPs?

- ○ Yes
- ○ No

18. Are practitioners required to register with the PMP?

- ○ Yes
- ○ No

19. Are practitioners required to check the PMP before initially prescribing a controlled substance?

- ○ Yes
- ○ No

20. Does the policy require teaching practitioner or pharmacist users about the PMP?

- ○ Yes
- ○ No

21. Does the policy require the PMP governing agency to review program information to identify inappropriate use of monitored medications?

- ○ Yes
- ○ No

Policies Affecting Pain Management

THE POLICY SURVEILLANCE PROGRAM
A LawAtlas Project

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Home / Topics / State Laws and Other Regulatory Policies Related to Pain Care

State Laws and Other Regulatory Policies Related to Pain Care

Healthcare practice in the United States is governed at the state level. All 50 states and the District of Columbia have laws and other regulatory policies that address pain management for patients. Policies related to pain care, palliative care, or end-of-life care provide standards of practice influencing the way pain management is provided for all patients with chronic diseases or conditions, including those with cancer and those who are now cancer-free but are experiencing other chronic painful conditions. These policies also have been used as a tool to curtail the opioid epidemic. As a result, the policies are often designed to maintain access to pain management services while also reducing medication misuse.

This dataset explores important features of state pain care-related laws and other regulatory policies. It includes laws and policies that address prescribing of controlled substances (specifically, Schedule II opioid analgesics); definitions creating parameters for healthcare practice; standards for evaluating and improving pain treatment, including practitioner expectations for treatment; practice requirements; and characteristics of state prescription monitoring programs (PMPs).

This map identifies and displays key features of more than 700 laws and other regulatory policies across all 50 states and the District of Columbia, in effect as of December 31, 2017.

CREATED BY: Sonderegger Research Center, University of Wisconsin–Madison School of Pharmacy
MAINTAINED BY: Sonderegger Research Center, University of Wisconsin–Madison School of Pharmacy
VALID FROM: December 31, 2017
UPDATED THROUGH: December 31, 2017

Data Codebook Protocol Summary Report

Filter | Explore | Reset

1. Does the practice of medicine include the treatment of pain?
- Yes
- No

2. Does the policy define addiction not based solely on physical dependence or tolerance?
- Yes
- No

2.1. Is there a statement that physical dependence or tolerance are not considered addiction?
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3.1. What is the maximum amount for a prescription of a controlled substance?
- 7-day supply
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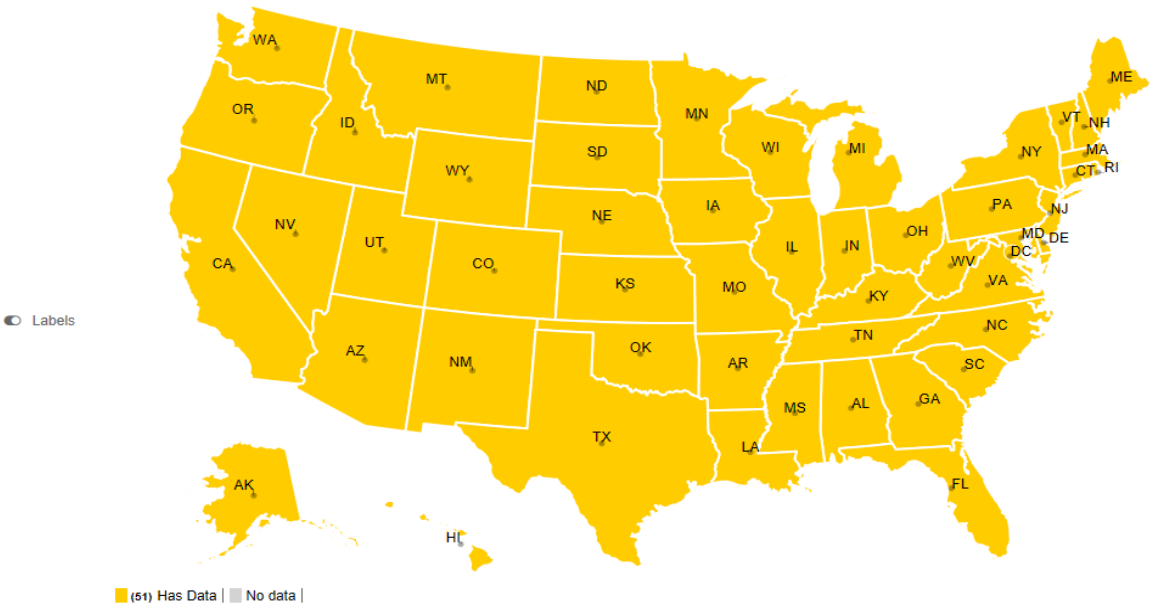
- 30-day supply, 100 MME
- 31-day supply
- 31-day supply or 100 dosage units, whichever is greater

Map Profiles

Help Share

(51 jurisdictions)



THE POLICY SURVEILLANCE PROGRAM
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| Criteria:
17. Does the policy authorize the PMP to share data with other state PMPs?
Yes | ✖

16.1. What is the timeframe in which dispensing data must be submitted to the PMP after dispensing?

- [ ] Real time
- [ ] 24 hours
- [ ] Daily
- [ ] 1 business day
- [ ] Next business day
- [ ] 72 hours
- [ ] 3 business days
- [ ] 7 days
- [ ] Weekly
- [ ] 8 days
- [ ] Monthly

17. Does the policy authorize the PMP to share data with other state PMPs?

- (•) Yes
- ( ) No

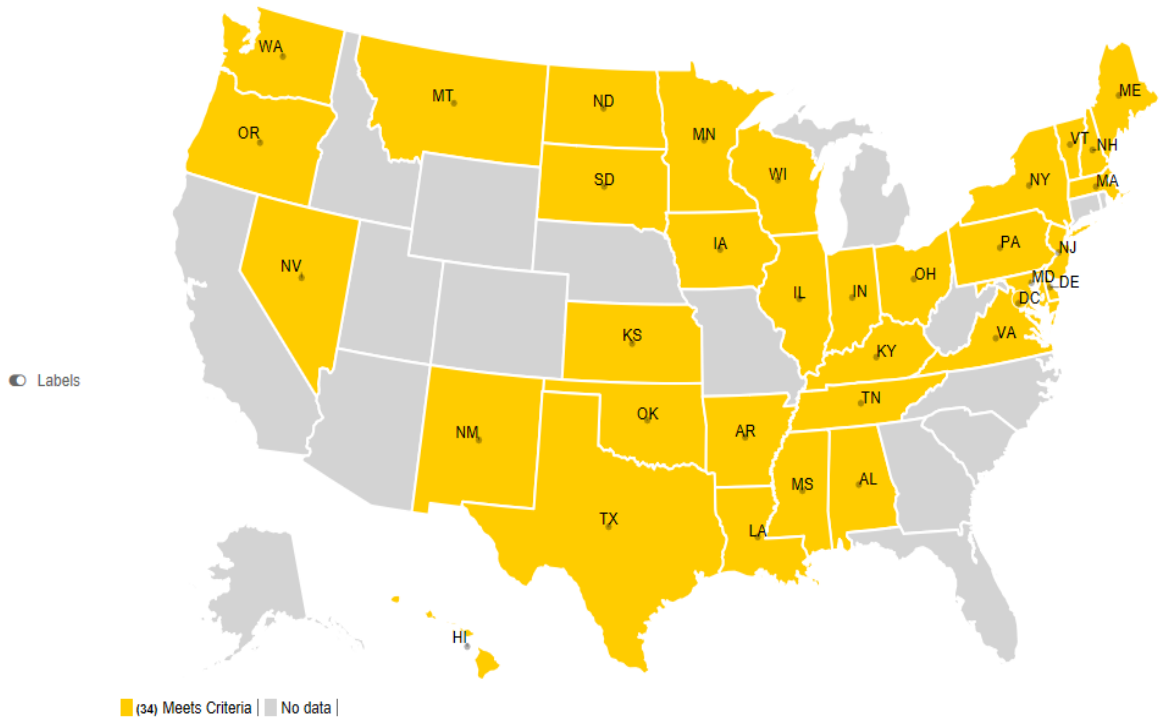
18. Are practitioners required to register with the PMP?

- ( ) Yes
- ( ) No

Map | Profiles

Help | Share

(34 jurisdictions)



Download Table

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- ☐ Monthly

17. Does the policy authorize the PMP to share data with other state PMPs?

- ◉ Yes
- ○ No

18. Are practitioners required to register with the PMP?

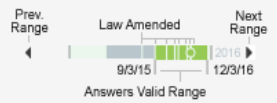
- ○ Yes
- ○ No

Map | Profiles

Citations

× Wisconsin

1 results



Does the policy authorize the PMP to share data with other state PMPs?

Wisconsin

17. Does the policy authorize the PMP to share data with other state PMPs?

Yes

Citations:

Wis. Adm. Code CSB 4.14

...

The board may exchange monitored prescription drug history reports and PDMP data with a prescription monitoring program operated by a relevant agency in another state or jurisdiction if the prescription monitoring program satisfies all of the following conditions:(a) The prescription monitoring program is compatible with the program.(b) The relevant agency operating the prescription monitoring program agrees to exchange similar information with the program. §§

...

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UNIVERSITY OF WISCONSIN-MADISON

Research Protocol for State Laws and Other Regulatory Policies Related to Pain Care

Prepared by the Sonderegger Research Center, University of Wisconsin-Madison School of Pharmacy

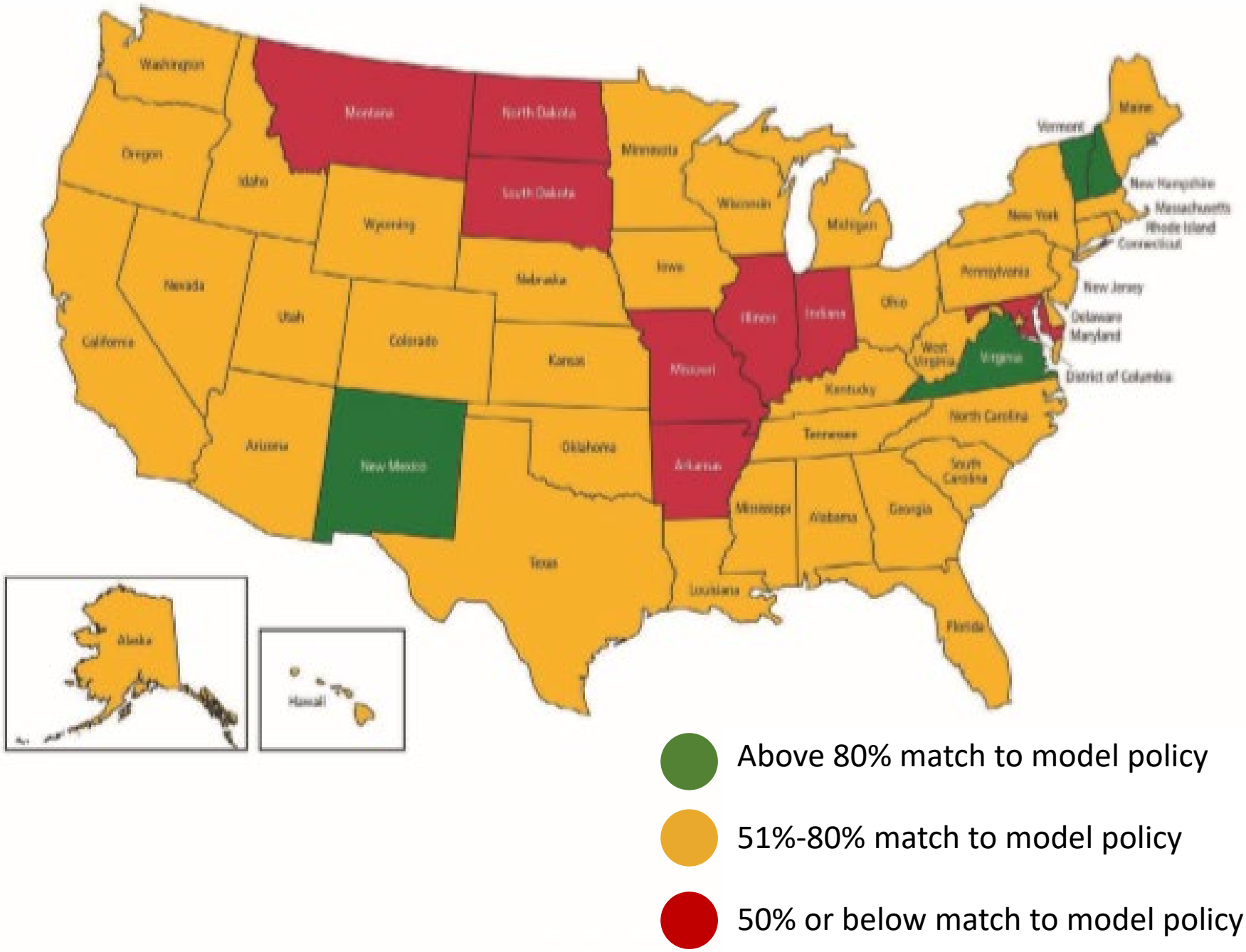
December 2017

Policies Affecting Pain Management
Use by Others

PRESCRIPTION MONITORING PROGRAMS	
Establishes timeframe for submitting dispensing data *RED =* > next business day after dispensing	next business day
Authorizes data sharing with other states PMPs	√
Requires practitioners to register with the PMP	√
Requires checking PMP before initially prescribing	--
Requires teaching practitioners	--
Requires review to identify inappropriate medication use	--
	Domain points: 3

Achieving Balance in State Pain Policy

A Report Card


Above 80% match to model policy
51%-80% match to model policy
50% or below match to model policy

Pain Policy Report Card 2018

Vermont

Green

Pain Policy in Vermont

Cancer patients, cancer survivors and other patients with serious illness often need pain treatment. State laws, policies and regulations can affect whether patients get the treatment they need, and the quality of that treatment. The American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN), working with the University of Wisconsin, have graded state pain policies as of December 31, 2017. The following are results for our state.

	Points
Policy Definitions & Prescription Limits	**5 out of 6**

Vermont does well in this category acknowledging that standard medical practice does include the proper treatment of pain but does have a maximum prescription validity period of 7 days in place which can be problematic for the elderly, the underserved and individuals who live in rural areas.

Efforts to Assess & Improve Pain Treatment	**6 out of 6**

Vermont does very well in this category recognizing the need to reduce potential medication harms while maintaining patient care. Individual case characteristics dictate pain care and practitioner education is in place to improve pain treatment.

Requirements for Treating Pain	**6 out of 6**

Vermont does very well in this category regarding integrative, individualized patient care while prioritizing the assessment of benefits/risks before treatment and monitoring benefits/risks during treatment.

Prescription Monitoring Programs (PMP)	**5 out of 6**

Vermont has become a leader in regards to state prescription monitoring programs requiring submission of data within 24 hours, or one business day, of dispensing. A state strategy to systematically review program data to identify inappropriate medication use could be beneficial.

Total points	**22**

Green – Matches model policy Yellow – Making progress toward model policy Red – Matches 50% or less of model policy

Policy Surveillance
Challenges

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities

Policy Surveillance
Future?

Depends on…

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities

Policy Surveillance
Future?

Needs…

- Enhanced awareness
- Impact policy decisions
- Funding opportunities
- Links to quantitative outcomes
  - Use of longitudinal policy data

Acknowledgements

This research was supported by the American Cancer Society and the American Cancer Society Cancer Action Network

Contact Information

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School of Pharmacy

University of Wisconsin - Madison

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Effects of EITC on Birth Outcomes: Research Findings

KA Komro, PhD, S Markowitz, PhD, MD Livingston, PhD, & AC Wagenaar, PhD

Emory University Rollins School of Public Health & Dept of Economics

S Burris, JD, & L Cloud, JD, Temple University Beasley School of Law

EMORY UNIVERSITY

ROLLINS SCHOOL OF PUBLIC HEALTH

Special Section Article

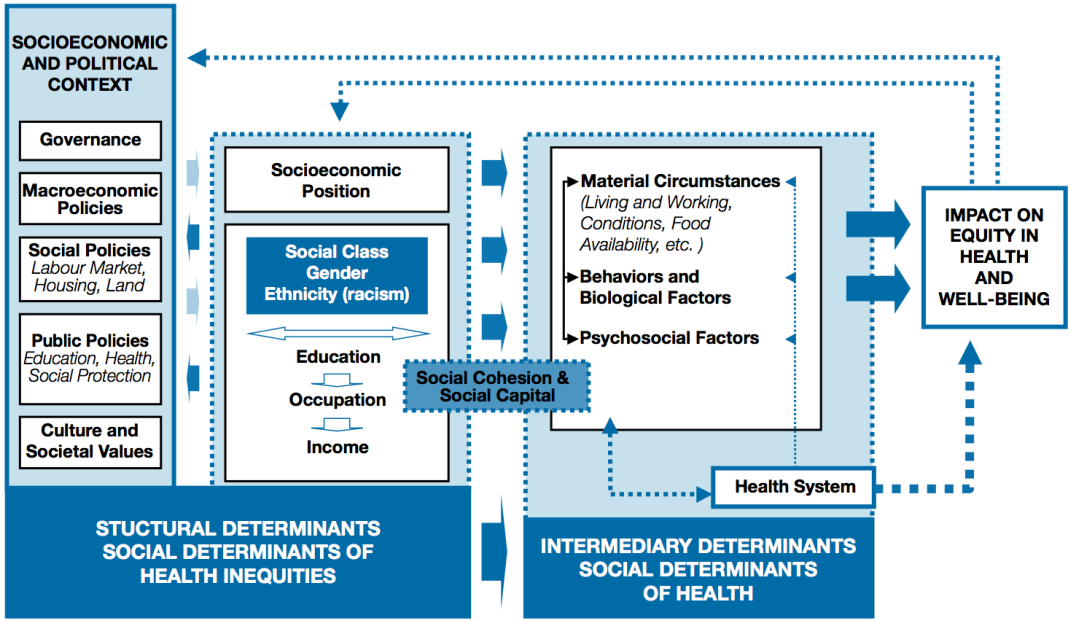
25 Years of Complex Intervention Trials: Reflections on Lived and Scientific Experiences

Research on Social Work Practice
2018, Vol. 28(5) 523-531

DOI: 10.1177/1049731517718939
journals.sagepub.com/home/rsw
SAGE

Kelli A. Komro[1,2]

Figure A. Final form of the CSDH conceptual framework



WHO Commission on Social Determinants of Health (CSDH, 2010)

Family Economic Security Policy: Effects on Infant and Child Health Disparities

1. Minimum Wage Laws
2. Earned Income Tax Credit (EITC)
3. Unemployment Insurance
4. Temporary Assistance for Needy Families (TANF)

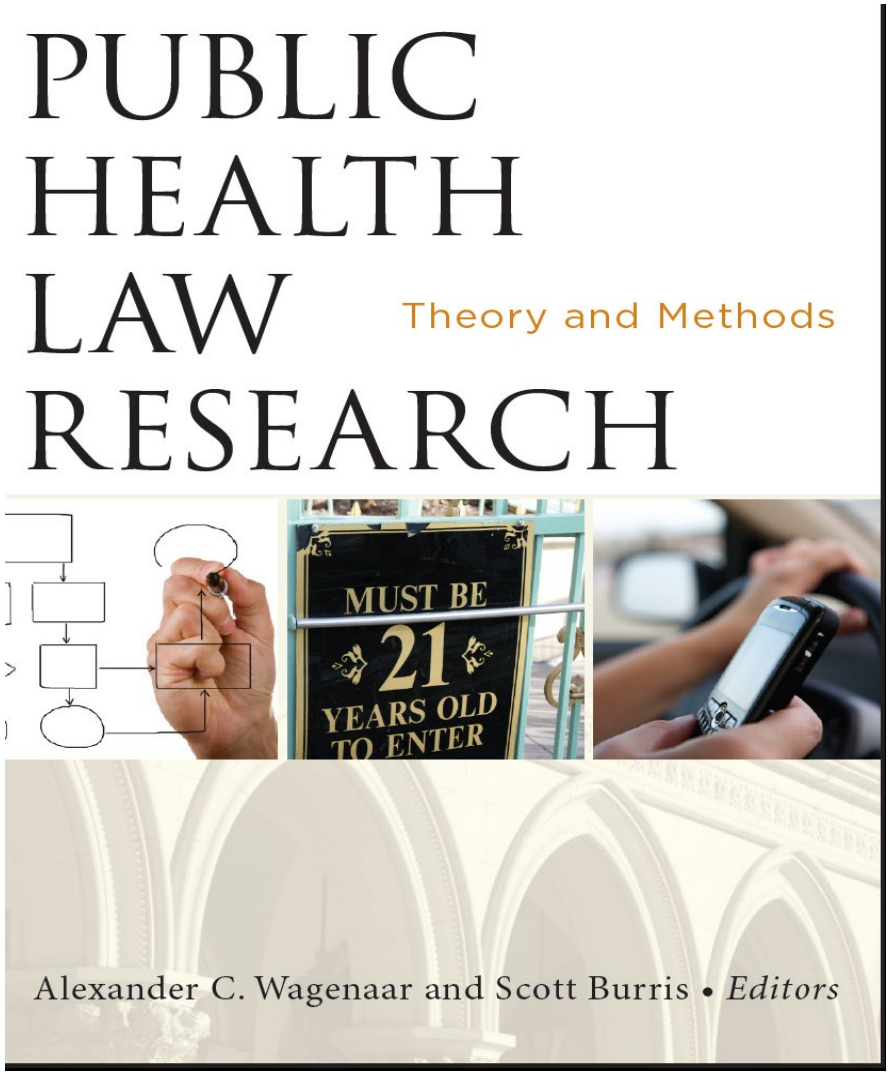
R01 funded by the National Institute on Minority Health and Health Disparities, 2015-2019

Initial policy surveillance and pilot studies funded by the Robert Wood Johnson Foundation Public Health Law Research program, 2012-2015

Understanding How Law Affects Health

Scientific Contributions from Multiple Disciplines

- Law
- Social & Behavioral Sciences
- Epidemiology
- Economics
- Statistics

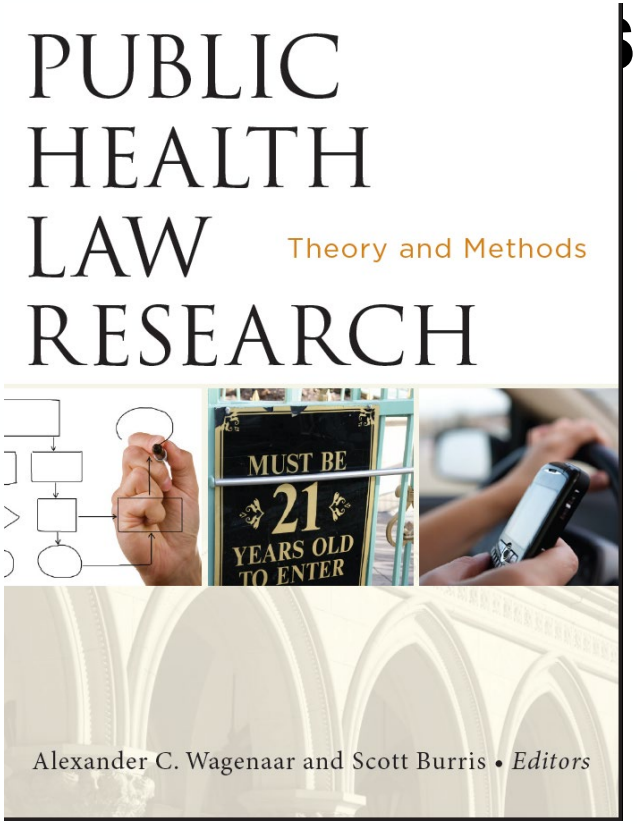


- Framing
- Theories
- Legal Coding
- Research Designs
- Design Elements
- Cost Analysis

Chapter 3. Understanding how law influences environments and behavior: Perspectives from public health. Komro, O'Mara & Wagenaar.

Chapter 14. Natural experiments: Research design elements for optimal causal inference without randomization. Wagenaar & Komro.

http://publichealthlawresearch.org/theory-methods



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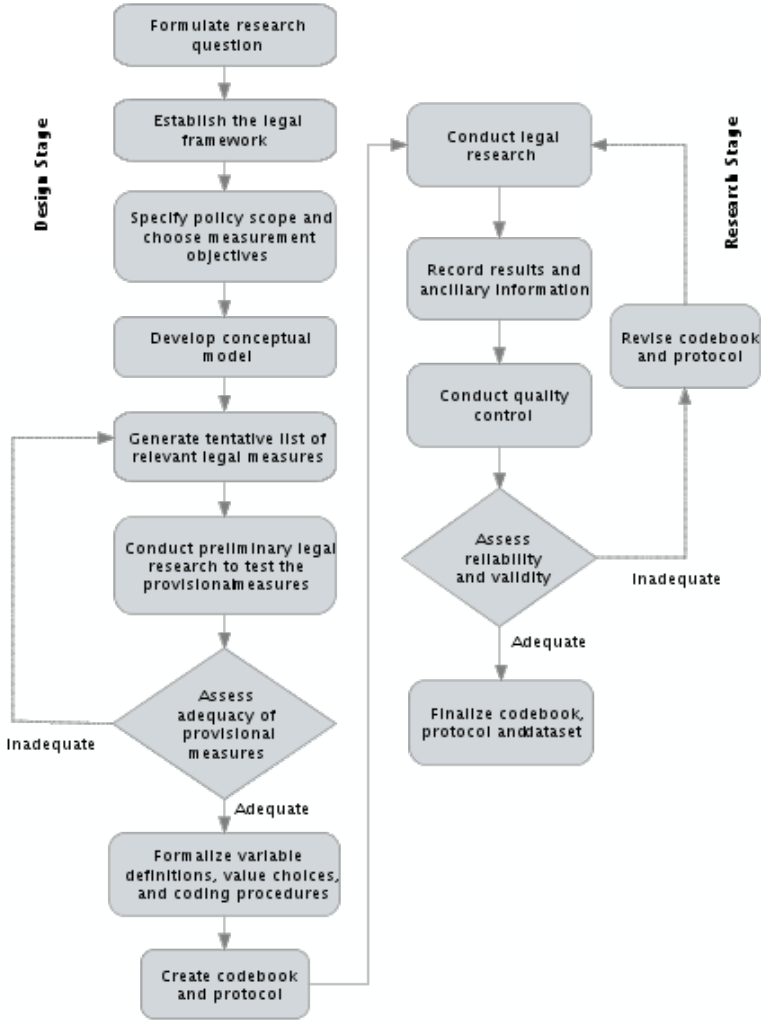
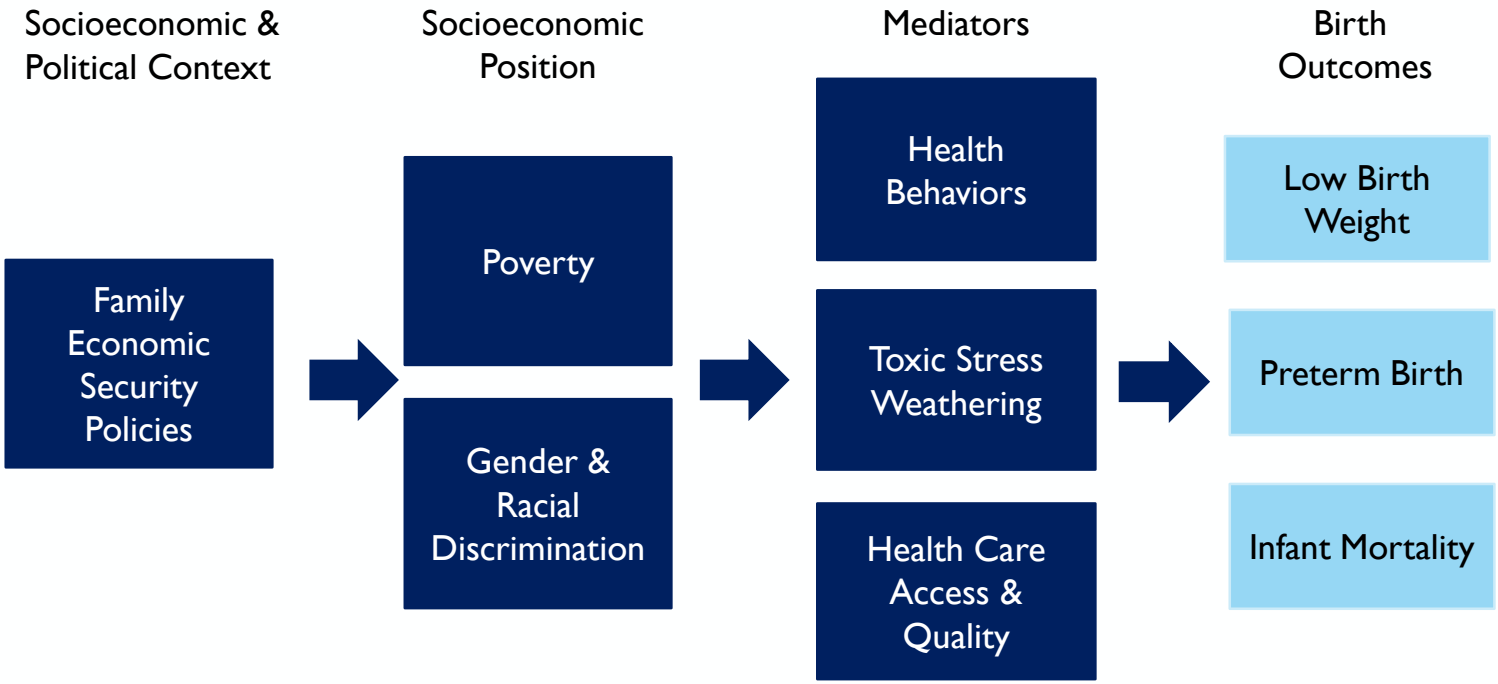


Social Determinants of Birth Outcomes Conceptual Framework



Social Science & Medicine 194 (2017) 67–75

Contents lists available at ScienceDirect

Social Science & Medicine

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

Effects of state-level Earned Income Tax Credit laws in the U.S. on maternal health behaviors and infant health outcomes

Sara Markowitz[a], Kelli A. Komro[b,*], Melvin D. Livingston[c], Otto Lenhart[d], Alexander C. Wagenaar[b]

Contribution

1. Strong quasi-experimental and longitudinal design
   - state-level EITCs
   - multiple policy changes over 20 years
2. Presence and generosity of state EITCs
   - infant health outcomes
   - possible mechanisms via maternal health behaviors

State EITC

- In 1994, 5 states had an EITC → In 2013, 26 states had an EITC
- State-specific EITC ranges from 3.5% to 40% of the federal amount, varies by number of children and refundability

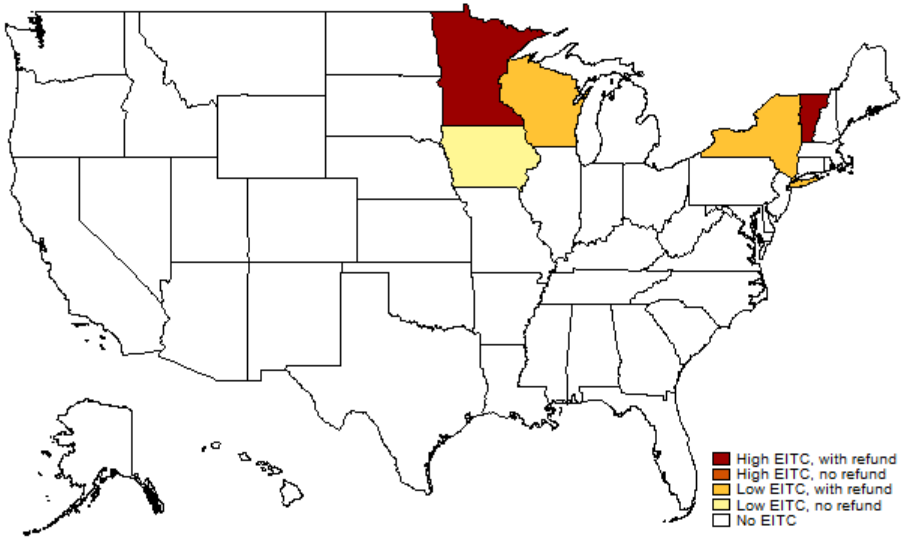
EITC summary measure

least generous → most generous

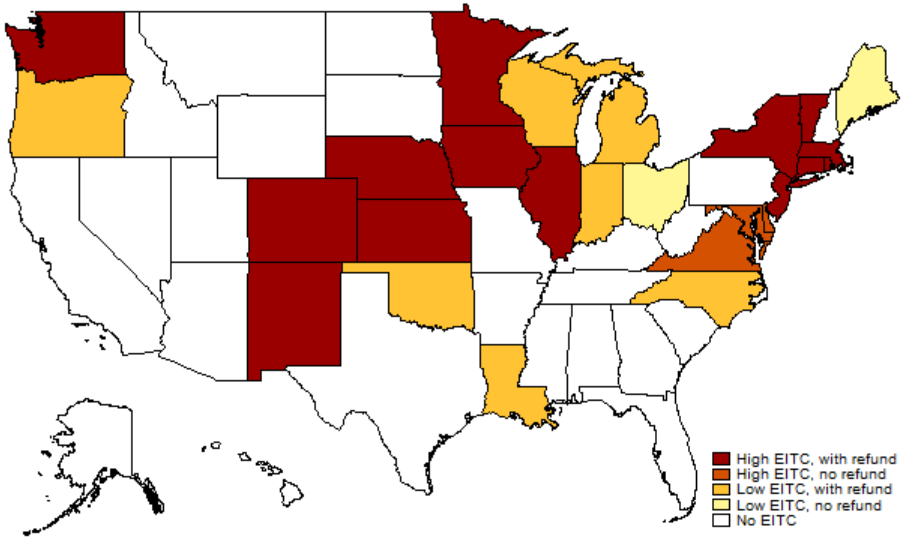
States with **no EITC**	States with an EITC, **nonrefundable** payments, and payments **less than 10%** of the federal amount	States with an EITC, **refundable** payments, and payments **less than 10%** of the federal amount	States with an EITC, **nonrefundable** payments, and payments **10% or more** of the federal amount	States with an EITC, **refundable** payments, and payments **10% or more** of the federal amount

Generosity of State EITCs
Families with One Child

1994



2013



Birth Outcome Results

	Dependent Variables		
	Birth Weight in Grams	Birth Weight <2500g	Gestation Weeks
Low EITC No Refund	**9.44**	**-0.003**	0.05
Low EITC With Refund	**16.85**	**-0.005**	0.03
High EITC No Refund	**12.68**	**-0.003**	**0.17**
High EITC With Refund	**27.31**	**-0.008**	**0.08**

Quantile Regression Results

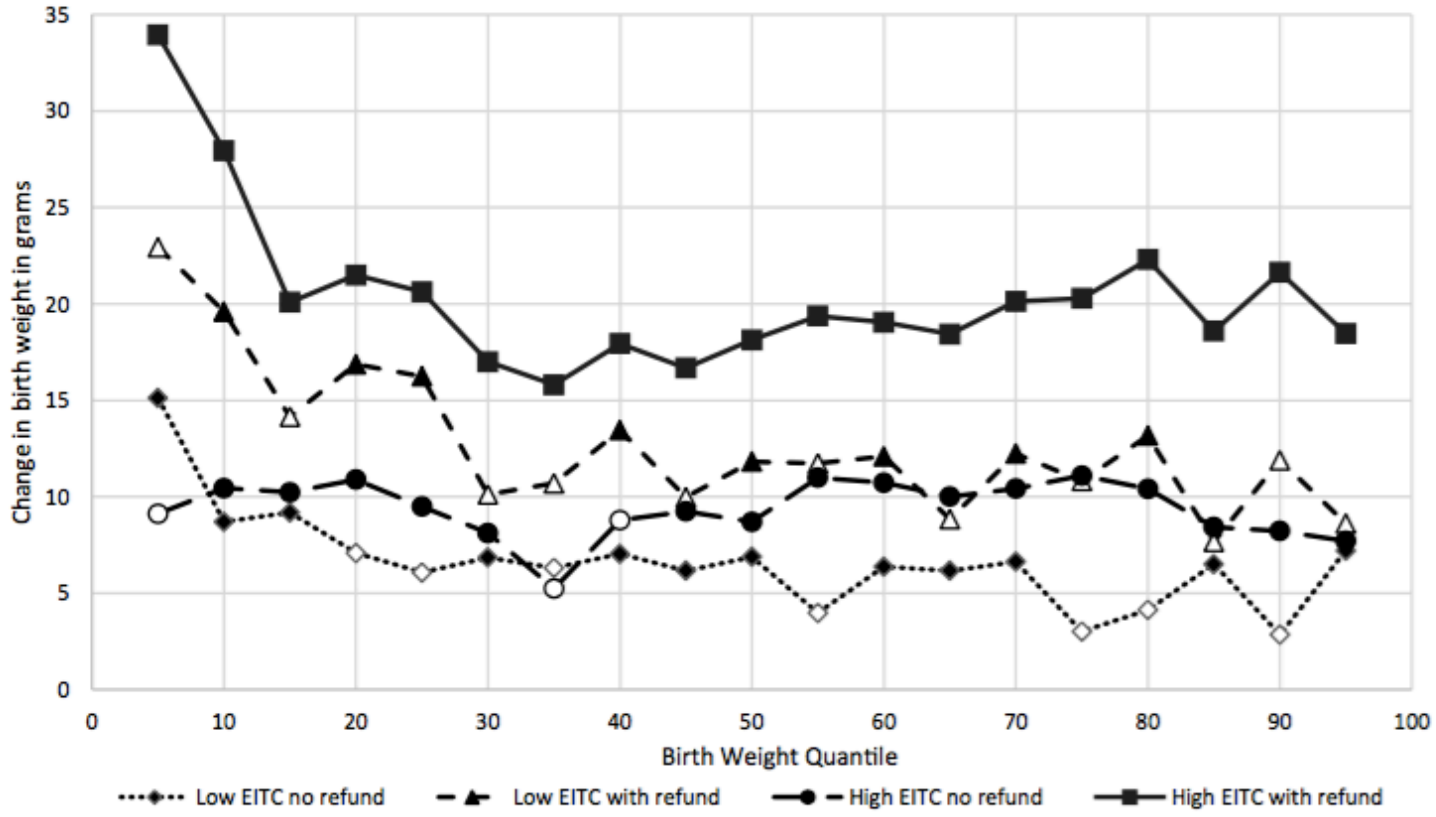


Fig. 2. Effects of EITC Generosity on Birth Weight Using Unconditional Quantile Regression at 5th through 95th Quantiles.
Note: N = 30,780,950. Solid marker indicates point estimate is statistically significant at the 5% level.

Conclusions

- More generous EITCs associated with reductions in *probability of LBW*
  - 0.3 to 0.8 percentage-point reductions
  - 4% to 11% reductions
  - 4,300 to 11,850 fewer babies born LBW *every year* among women with high school education or less

- If Georgia implemented a refundable EITC at 10% or more of the federal, based on results we estimate
  - 1,047 fewer LBW babies per year in Georgia

SSM - Population Health 7 (2019) 100356

Contents lists available at ScienceDirect

SSM - Population Health

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

Short Report

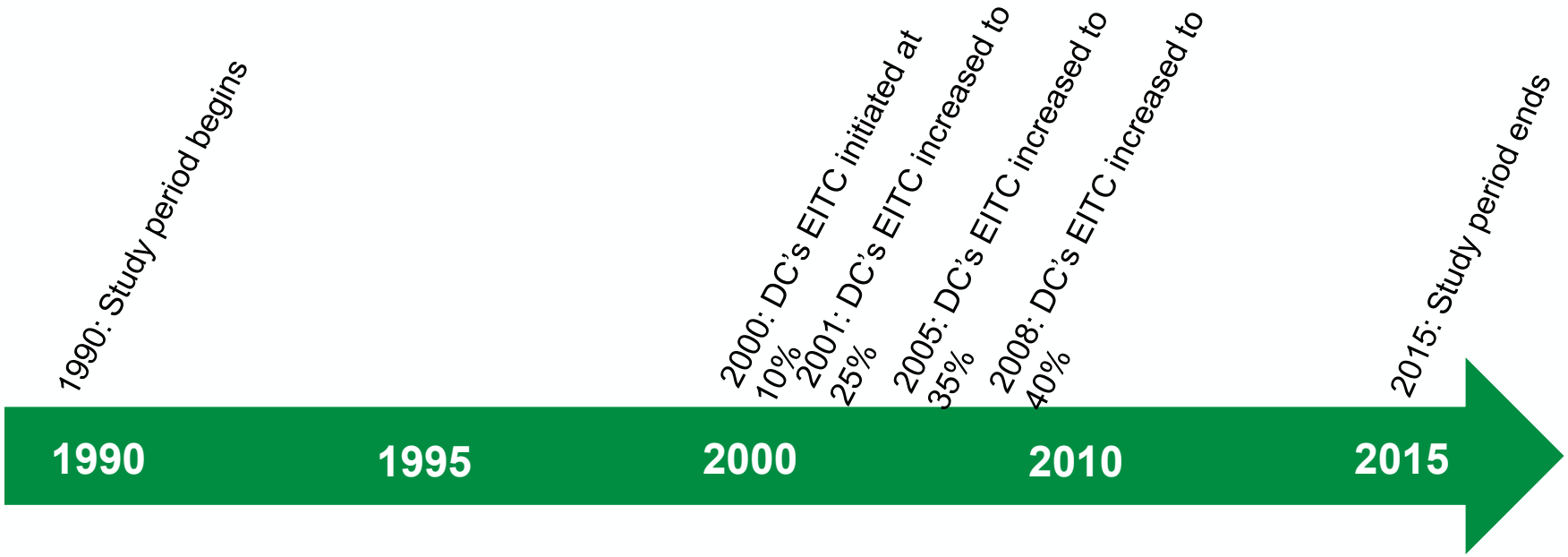
Effects of changes in earned income tax credit: Time-series analyses of Washington DC☆

Alexander C. Wagenaar[a,*], Melvin D. Livingston[a], Sara Markowitz[b], Kelli A. Komro[a]

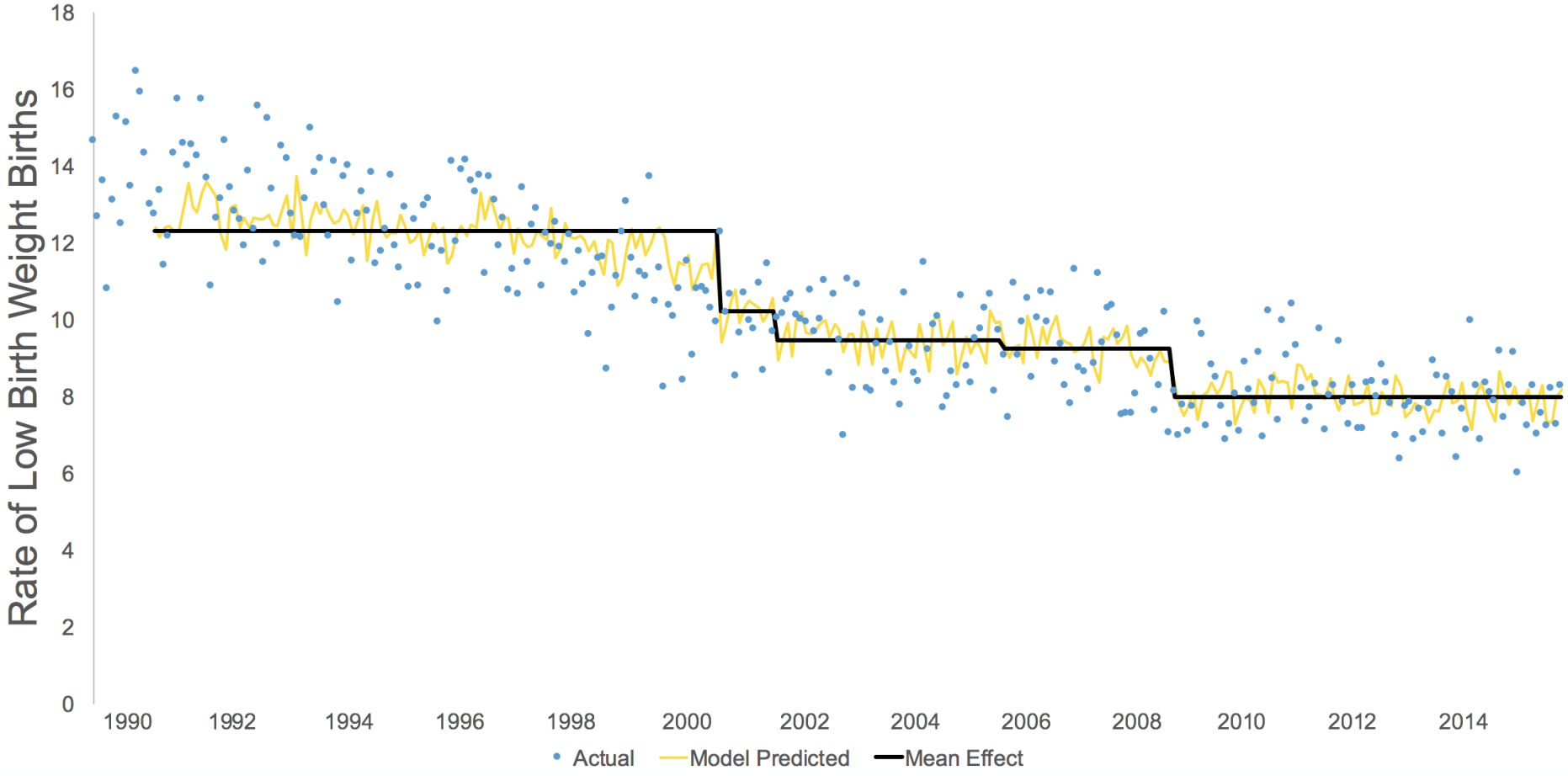
[a] Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, 1518 Clifton Road, NE, GCR 556, Atlanta, GA 30322, USA
[b] Department of Economics, Emory University, Atlanta, GA, USA

EITC in DC

- **Four distinct policy changes over 8 year period**
- **Percentage of the federal EITC, fully refundable**



Effects of EITC on Low Birth Weight



Bottom Line: Effects in DC

- 40% tax credit → 40% decrease in low birth weight births from baseline
- Prevents an estimated 349 low-weight births per year in DC

Health Equity
Volume 3.1, 2019
DOI: 10.1089/heq.2018.0061

Health Equity

Mary Ann Liebert, Inc. publishers

ORIGINAL ARTICLE

Open Access

Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity

Kelli A. Komro,[1,2,*] Sara Markowitz,[3] Melvin D. Livingston,[1] and Alexander C. Wagenaar[1]

Health Inequities

- Health inequities in birth outcomes by mother's income, education level and race
  - Percent low birth weight births (2016)
    - Hispanic women: 7% to 9.5%
    - non-Hispanic white women: 7%
    - non-Hispanic black women: nearly 14%
- Caused by a complex set of social factors across the life course
  - income inequality
  - education achievement gaps
  - residential segregation
  - toxic environment exposures

Results

- Larger beneficial effect among black mothers compared with white mothers for the probability of low birth weight and gestation weeks

- No significant differences in birth outcomes between Hispanic and white mothers

15 FORWARD GBPI

Bigger State Earned Income Tax Credits Lead to Healthier Babies

Some 1,047 babies in Georgia a year can be saved from low birth weight if lawmakers pass a Georgia Work Credit, according to Emory University researchers. A new study finds that state tax credits to support low-income working families are linked to better health outcomes for babies.

The research builds on a robust body of evidence that already highlights many health and economic benefits from the federal Earned Income Tax Credit (EITC).

Georgia lawmakers came close to passing a state tax credit to help working families earlier this year, and this move remains on the table for 2018. Lawmakers can still support working families and boost the health of babies statewide.

EITC Funders Network

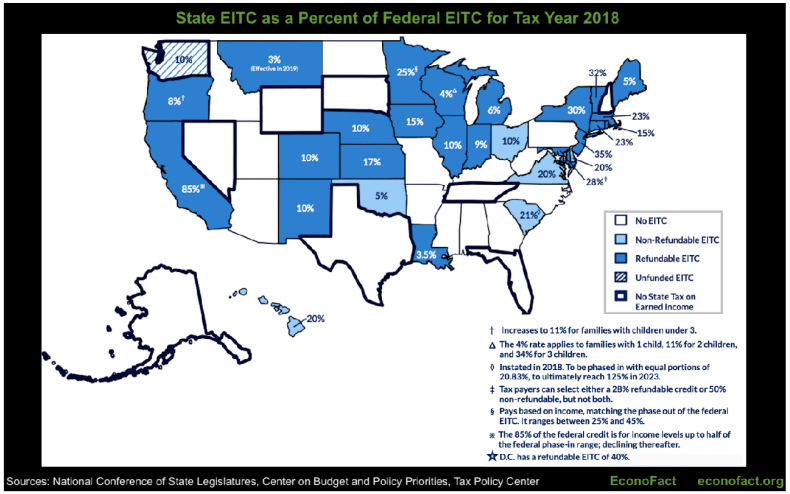
GRANT MAKERS IN HEALTH

ECONOFACT THE ECONOFACT NETWORK IN THE

EARNED INCOME TAX CREDIT

The Potential of State Earned Income Tax Credits

By Kelli Komro and Sara Markowitz · March 14, 2019
Emory University



We Concur: Gilson's Policy Surveillance Challenges

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities

We're Just Getting Started

- Minimum wage and EITC interactive effects
- Minimum wage and EITC optimum legal constructions
- TANF effects on maternal, infant and child outcomes
- Exploring differential effects by race/ethnicity
- Additional health outcomes
- Additional policies affecting social determinants
- Continued monitoring and coding of legal changes

Thank You! Kelli

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Substance Use During Pregnancy Policy

A Report on State-level Alcohol/Drug & Pregnancy Policies

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Project Objectives

- Status and trends of state policies targeting alcohol and drug use during pregnancy
- Assess effects of state-level policies targeting alcohol use during pregnancy as measured by prenatal care use and birth outcomes
- Assess effects of alcohol use based on SES and race

Context

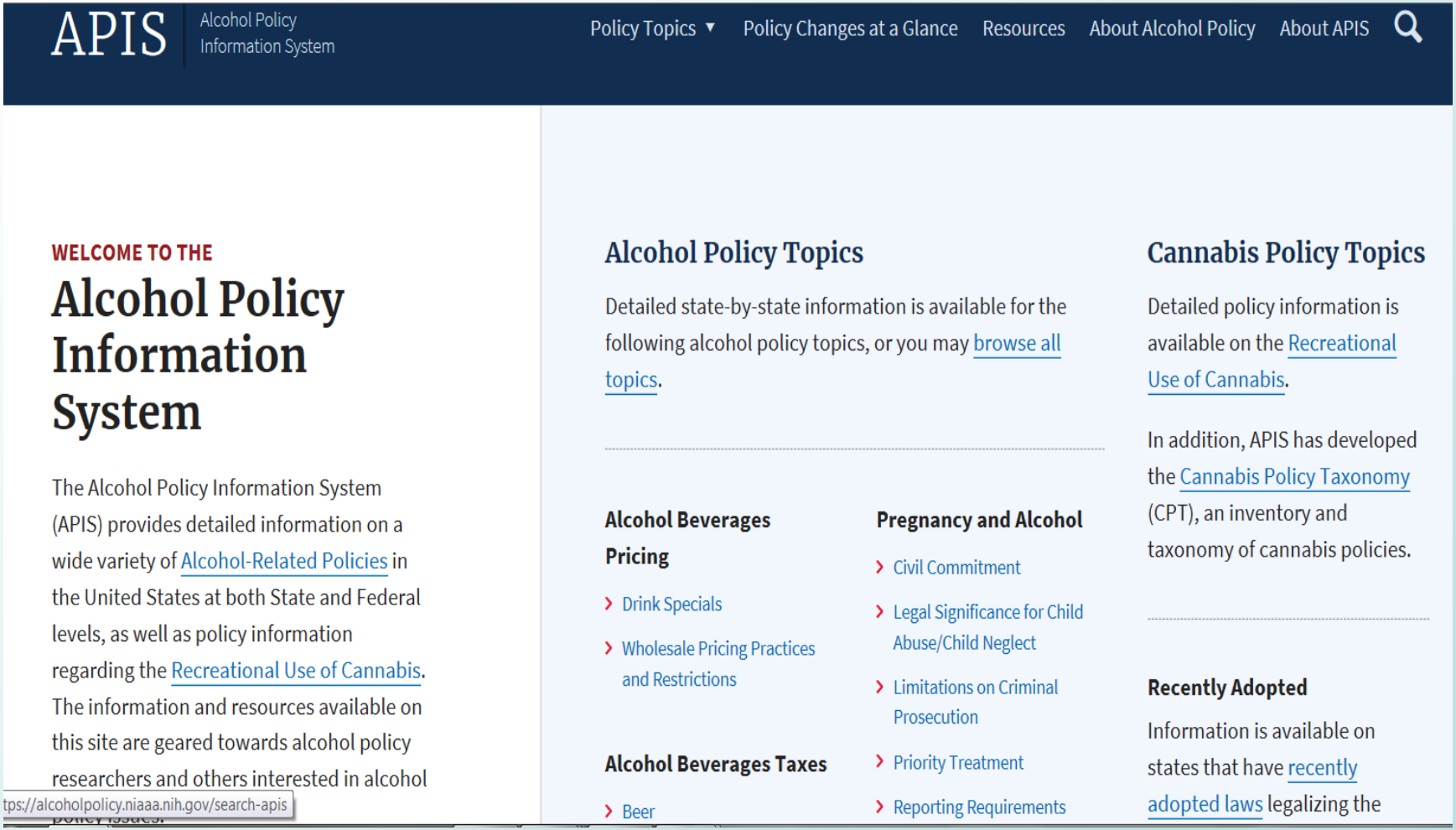
- Extant research lacks quantitative, longitudinal data/analysis on the effects of policies, their specifics & whether they accomplish their purposes
- Understanding the effects of these policies is crucial to our ability to adopt/implement policies to improve health.

Project Data

For this research, we use:

- An original dataset (based on NIAAA's APIS) that covers 1970 - 2016 - the entirety of state-level legislation in this policy domain (46 years)
- More than 30 years of alcohol use during pregnancy survey data from the Behavioral Risk Factor Surveillance System (57,955 pregnant women between 1985-2016)
- More than 40 years of birth outcomes and prenatal care data from Vital Statistics records (148,048,208 singleton births between 1972-2013)

The Alcohol Policy Information System (APIS)
https://alcoholpolicy.niaaa.nih.gov/



Legal Methods – Alcohol Dataset

Data from APIS & original legal research

- Identified relevant statutes and regulations on each of six alcohol/pregnancy policy topics tracked in APIS
- Identified effective dates for each statute and regulation not available on APIS – HeinOnline, StateScape
- Coded statutes and regulations, including ensuring inter-rater reliability
- Quality control steps to compare results to those available from secondary sources

Legal Methods- Drug Dataset

Data from APIS & original legal research

- Relied on Westlaw, HeinOnline, and StateScape
- Started with relevant statutes and regulations from alcohol/pregnancy database (derived from APIS) including effective dates data
- Searched Westlaw for additional drug/pregnancy statutes and regulations on each policy topic
- Coded drug/pregnancy statutes and regulations, including inter-rater reliability checks
- Quality control step to compare results to those available from secondary sources – Guttmacher Institute data

Data Gathering Challenges

- Tools – databases
- Longitudinal data gathering for regulations
- Recodifications and tracking back to a single (new) effective date.
- Comprehensive session laws
- Lack of redlining in session laws
- Staff training
- Quality control

Alcohol & Drug Use During Pregnancy Policy Data

Mandatory warning signs	Require that notices about alcohol/cannabis use during pregnancy are posted in medical/recreational marijuana dispensaries as well as retail outlets selling or serving alcohol. The warning language must warn of the risks.
Priority treatment	Mandate priority access to substance abuse treatment for pregnant + postpartum women.
Prohibitions against criminal prosecution	Prohibits use of results of medical tests, such as prenatal screenings or toxicology tests, as evidence in the criminal prosecutions of women who may have caused harm to a fetus or a child.
Reporting requirements	Mandated or discretionary reporting of suspicion of or evidence of alcohol/drug use or abuse by women during pregnancy to either CPS or to a health authority. Evidence: screening and/or toxicological testing of pregnant women or of infants after birth. Reporting may be for child abuse/neglect investigation, provision of health services or for data gathering.
Child abuse/child neglect	The legal significance of a woman's conduct prior to birth + of damage caused in utero. In some cases, defines alcohol/drug use during pregnancy as child abuse or neglect.
Civil commitment	Mandatory involuntary commitment of a pregnant woman to treatment or mandatory involuntary placement in protective custody of the state for the protection of a fetus from prenatal exposure to alcohol/drugs.

Policy Categories

- **Supportive policies**: provide information, early intervention, and treatment or services to pregnant women
- **Punitive policies**: seek to control pregnant women's behavior by civilly committing them, mandating reporting to law enforcement and/or child welfare agencies, and initiating child welfare proceedings or using the threat of such actions to compel behavior change

Policies by Category

Child Abuse/Child Neglect	Punitive
Civil Commitment	Punitive
Reporting Requirements	Punitive if referral to CPS
Reporting Requirements	Supportive if for data gathering purposes or referral to treatment
Mandatory Warning Signs	Supportive
Prohibitions Against Criminal Prosecution	Supportive
Priority Treatment – Pregnant Women & with Children	Supportive

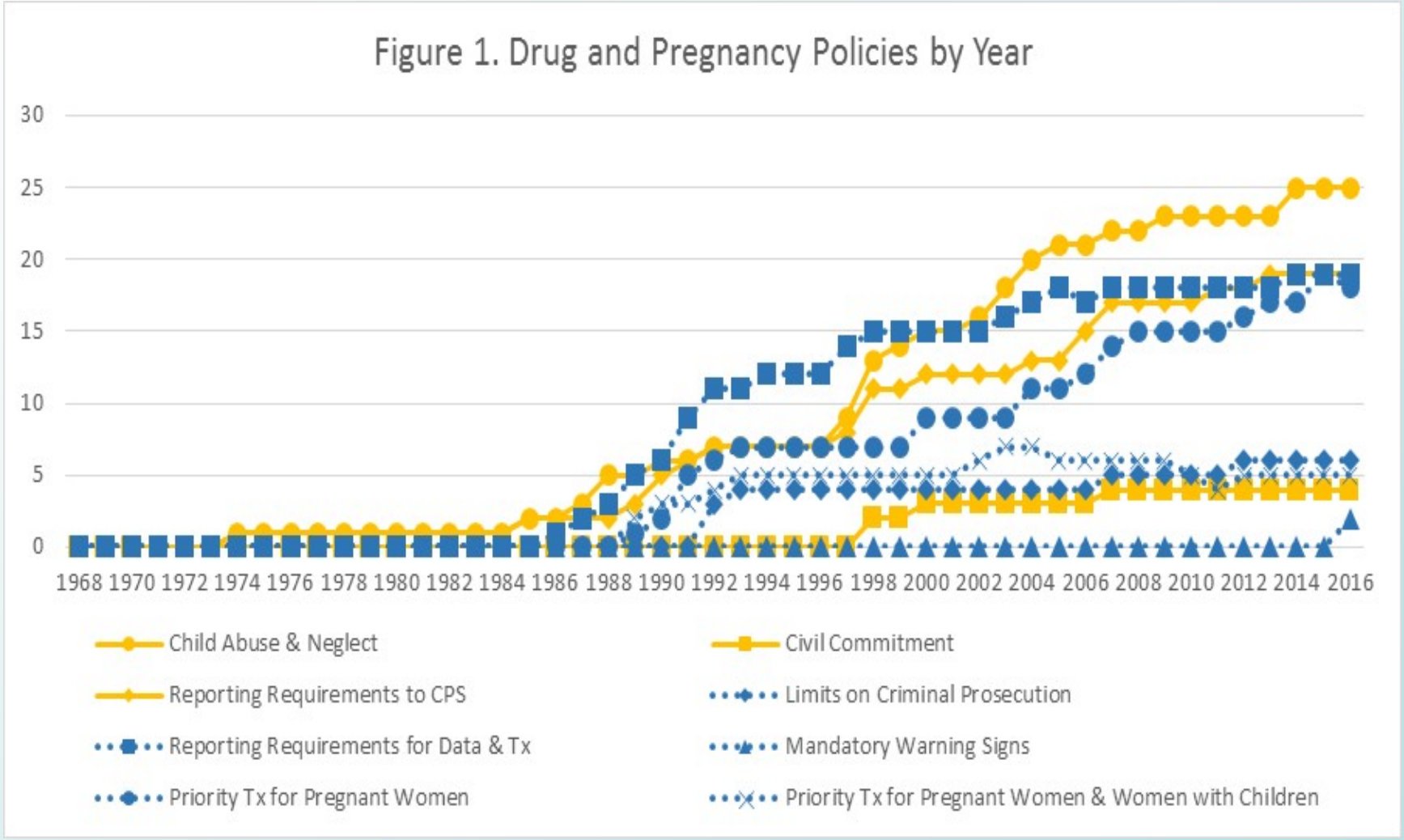
Drug Policy Status & Trends Article

Thomas, S., Treffers, R., Berglas, N.F., Drabble, L. and Roberts, S.C., 2018. **Drug Use During Pregnancy Policies in the United States From 1970 to 2016**. *Contemporary Drug Problems*, *45*(4), pp.441-459.

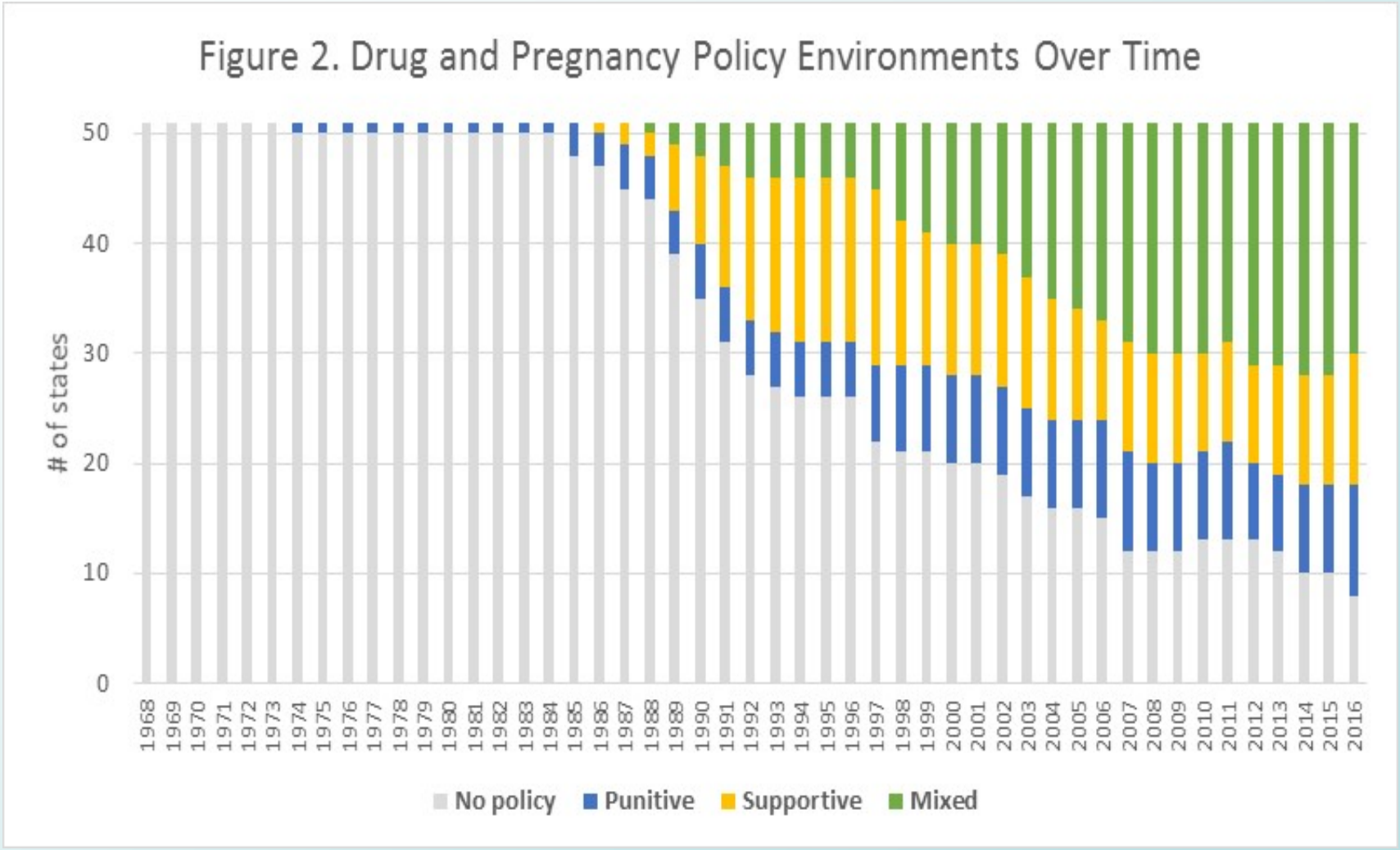
Status & Trends of Drug/Alcohol & Pregnancy Policy

- # of states with at least 1 alcohol/pregnancy policy &/or at least 1 drug/preg. policy – dramatic increase since 1970.
- Most states have at least 1 alcohol/pregnancy or drug/pregnancy policy:
  - **More common**: Mandatory Warning Signs (MWS) for alcohol, Reporting Requirements- Data & Treatment & CPS, Child Abuse/Neglect
  - **Less common**: Civil Commitment, Priority Treatment, Prohibitions on Criminal Prosecution, MWS- drugs
- With exception of MWS, policies related to alcohol/pregnancy also address drugs/pregnancy
- Alcohol/pregnancy & drug/pregnancy policy environments are becoming increasingly punitive.

Individual Policy Trends



Policy Environmental Trends



Findings: Alcohol

- Most policies targeting alcohol/ pregnancy – MWS, CACN, CC, PCP, RR-DATA, and PT-PREG appear associated with increased adverse birth outcomes
- **State-level policies targeting alcohol use during pregnancy at best do not improve birth outcomes and, at worst, associated with increases in adverse birth outcomes and can lead women to avoid prenatal care**
- Generally applicable policies that lead to decreased population-level consumption might improve birth outcomes

Project Conclusions: Alcohol

- Overall, findings indicate that policies punishing alcohol use during pregnancy are associated with increased adverse birth outcomes and may lead to avoidance of prenatal care
- Findings do not support hypotheses that the more supportive policies – including Mandatory Warning Signs – are associated with decreased adverse birth outcomes

Explanations of Findings

Pregnant women report:

- Bureaucratic and logistical barriers
- Fear of having harmed baby
- Belief that it is necessary to stop using before going to the doctor
- Fear of being reported to Child Protective Services, losing children, and going to jail

Partial List of Project Publications

- Drabble, L., Thomas, S., O'Connor, L. and Roberts, S.C., 2014. State responses to alcohol use and pregnancy: Findings from the alcohol policy information system. *Journal of social work practice in the addictions*, *14*(2), pp.191-206.
- Roberts, S.C., Thomas, S., Treffers, R. and Drabble, L., 2017. Forty Years of State Alcohol and Pregnancy Policies in the USA: Best Practices for Public Health or Efforts to Restrict Women's Reproductive Rights?. *Alcohol and Alcoholism*, *52*(6), pp.715-721.
- Subbaraman, M.S., Thomas, S., Treffers, R., Delucchi, K., Kerr, W.C., Martinez, P. and Roberts, S.C., 2018. Associations Between State-Level Policies Regarding Alcohol Use Among Pregnant Women, Adverse Birth Outcomes, and Prenatal Care Utilization: Results from 1972 to 2013 Vital Statistics. *Alcoholism: Clinical and Experimental Research*, *42*(8), pp.1511-1517.
- Thomas, S., Treffers, R., Berglas, N.F., Drabble, L. and Roberts, S.C., 2018. Drug Use During Pregnancy Policies in the United States From 1970 to 2016. *Contemporary Drug Problems*, *45*(4), pp.441-459.
- Roberts, S.C., Mericle, A.A., Subbaraman, M.S., Thomas, S., Treffers, R.D., Delucchi, K.L. and Kerr, W.C., 2018. Differential Effects of Pregnancy-Specific Alcohol Policies on Drinking Among Pregnant Women by Race/Ethnicity. *Health equity*, *2*(1), pp.356-365.

Project Team

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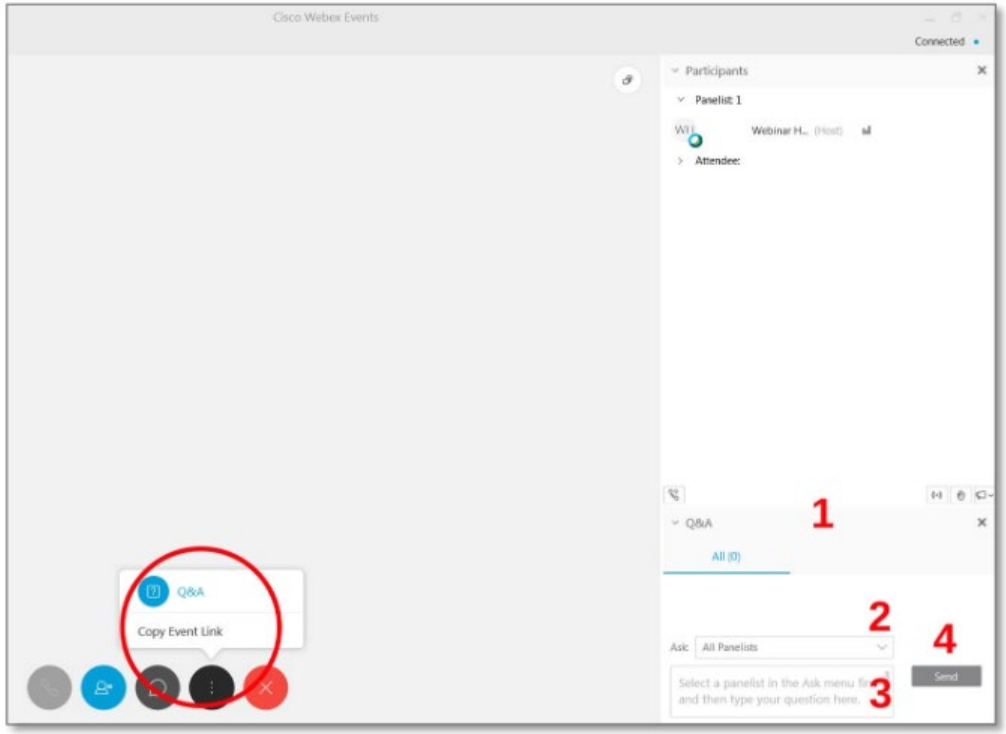

Thank You!

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Policy Surveillance for Policymaking

Register at **bit.ly/ExplorePS19**