**Clinical Chats Official Podcast Transcript**

**Title:** Harm Reduction and Sexual and Reproductive Health for Women

**Speaker:** Mishka Terplan, MD, MPH

**Duration:** 00:39:44

**Katherine Atcheson** **(**[**00:05**](https://www.rev.com/transcript-editor/shared/qv3Iq7dDQGWNFOf_QVcyecjjMD5mPkN8f8q_DZo2v9Yyv9Sb967iEzEXcoFsy3X_Pi9IE0gODr0wNqhmET6SE8XgVvI?loadFrom=DocumentDeeplink&ts=5.04)**):**

Hello and welcome to Clinical Chats: A Podcast for Sexual and Reproductive Health Professionals. Clinical Chats, formerly known as The Family Planning Files, is a program from the Clinical Training Center for Sexual and Reproductive Health or CTC-SRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff.

**Katherine Atcheson** **(**[**00:36**](https://www.rev.com/transcript-editor/shared/9LMusWD_pCkwFpmWK32Vf2V3ZpAYTIG3iEM7x32wStuWWd-I3-xicc8_BL2G-4JizDmXtWXnV0E_h6BJJ3EKRjnY6ug?loadFrom=DocumentDeeplink&ts=36)**):**

In today's podcast, part of the October 2023 Clinician Cafe on harm reduction, we'll be discussing harm reduction counseling and women's health. With Mishka Terplan MD, MPH.

**Katherine Atcheson** **(**[**00:48**](https://www.rev.com/transcript-editor/shared/3uTz8zE3GGX27wL9MmcB281SLme4Mo_LvNVhsVbX5pYbbyfEnMUkAHGCOJ3o8XFRT53gA2btVk8qalnmgp-A-hsyD4w?loadFrom=DocumentDeeplink&ts=48.78)**):**

Dr. Terplan is board certified in both obstetrics and gynecology and in addiction medicine. He's medical director at Friends Research Institute and adjunct faculty at the University of California San Francisco, where he's also a substance use warmline clinician. Welcome to the podcast, Dr. Terplan. We're so excited to have you today.

**Mishka Terplan (**[**01:10**](https://www.rev.com/transcript-editor/shared/DzJ4rd5SC3ltTiveO5vEgkFqTdZf1MgjvuYKe_qBjXHRDgjTN7fqmE4SUQVjQW4qXMdRyHxEd7_xhir6MdGZJG06Nm0?loadFrom=DocumentDeeplink&ts=70.83)**):**

Well, thank you so much for having me. It's a real pleasure.

**Katherine Atcheson** **(**[**01:13**](https://www.rev.com/transcript-editor/shared/4xRzL1S3IymfyPF7DYnKWHFjeCeS7iZzrCNw9NAZRm2tSMUhKQfOnRaZQcCvzwuMUF5xzaNAG7_9AE8xWQFwkCepdSQ?loadFrom=DocumentDeeplink&ts=73.86)**):**

To begin with, why is substance use harm reduction an important tool in a sexual and reproductive health clinician's toolkit?

**Mishka Terplan (**[**01:23**](https://www.rev.com/transcript-editor/shared/__1Lu4ubR5EptBczTSXcaWwJ6N8rjGMtY7M-gtaAi4Kzqs0owYC_KtMZE8KgYK92Ju0K0Kjgj3A9I-ifClWlkAE6L2Y?loadFrom=DocumentDeeplink&ts=83.73)**):**

Maybe we should begin by describing or defining a little bit what harm reduction is, what we mean by that. And really, it's philosophical orientation. It's a practice. It's a way of practicing with people that recognizes a couple of fundamental things.

**Mishka Terplan (**[**01:44**](https://www.rev.com/transcript-editor/shared/LocKtfCf8-Q94YOAWlekNlmVdKCguhw6MslT4CWvVSFy1yJf4gda0vy4R57CkZU1e85kIg9C0orNJSoleJEJcLWsE4o?loadFrom=DocumentDeeplink&ts=104.82)**):**

First, it recognizes that most people use drugs, to which some people will develop an addiction. Second, it recognizes that drug use has "benefit," hence the motivation to use, but also has harms that can be associated, addiction being only one of the harms of substances.

**Mishka Terplan (**[**02:07**](https://www.rev.com/transcript-editor/shared/uM3OWqLYgbrLq8A1ZhmXR-wtje9Gyb051qF4-z071prNZ6Tx7qBNqBGPGHK9F-jpF73U-9Y4Sw97HX-BQ1TEpisc4ik?loadFrom=DocumentDeeplink&ts=127.2)**):**

But third, and this third part is oftentimes missed, harm reduction also recognizes that it's not just the drug that can cause harm, but drug policy can have harms. So the goal of harm reduction really centers on the person and the people that we serve, tries to maximize their health in concrete and rational kinds of ways. And also, so we want to not just minimize the harms of substances to a person, but we also want to minimize the harms of punitive drug policies to people in our clinical care and also in our work as I would say, public citizens.

**Katherine Atcheson** **(**[**02:53**](https://www.rev.com/transcript-editor/shared/-FkLeEo5A60ShX0pQDUEyVg9k3YKIjmNFERdtNKWMK8k6ZXQTxEkgQ7DID2vMxYAGVraVS5i5pj6K1v3LBZtUePNnaY?loadFrom=DocumentDeeplink&ts=173.13)**):**

And because the vast majority of clients in Title X settings are cis women, what factors around substance use or challenges that are unique to that population?

**Mishka Terplan (**[**03:09**](https://www.rev.com/transcript-editor/shared/XyW8e9r8-sRUan5SDEV3buUXlMnYaM69lADolZBdkZrpmXYJloz_mam6E9StNAnssLr-YvXIdkpYny4OLrLgTeANBRo?loadFrom=DocumentDeeplink&ts=189.93)**):**

So, there's a lot of resonance I think, between how sexual and reproductive health providers approach sexual and reproductive health issues and those principles of harm reduction, for men and for women, with certain unique things certainly for women.

**Mishka Terplan (**[**03:28**](https://www.rev.com/transcript-editor/shared/2rxOlmYg6UkkYls12TI6XqP-KCT-3Ie0_CUluWysel6nw1E48fvUg92DXi2FF-GoRt0rcH1Nu7HJ8IlPwB-YBlNNTb0?loadFrom=DocumentDeeplink&ts=208.14)**):**

But the paradigm of approaching "unsafe sex" is similar to the paradigm of approaching injecting drugs. We don't think people shouldn't have sex the same way we don't necessarily think people shouldn't ever use drugs. So, we approach it through that same kind of rational, humanistic lens that centers on the person.

**Mishka Terplan (**[**03:53**](https://www.rev.com/transcript-editor/shared/0Wo4mkCaR2Na8ejNCUF2ZgOblBChuMmQcyiCH1Q4XYdZIDJgfcDxZaY-mv31v3k_Uqx97u5gKp0woSh_d_ij43900rs?loadFrom=DocumentDeeplink&ts=233.01)**):**

And this resonance, you see it in some of the language even, right? There's a whole movement around non-evidence-based sexual health education that's grounded in abstinence, that word abstinence. That's actually also oftentimes the language of response to substance use, misuse, and addiction is abstinence. So, there's this abstinence parallelism in both sexual health world as well as in the substance use misuse world.

**Mishka Terplan (**[**04:22**](https://www.rev.com/transcript-editor/shared/fbWDFwEdEWSug0eY5IjQqeoFyztWDrDFZVqT1MqFjTLoo09mvftkUjVMQ0RAR9aGmhFwvq7LfltHeN5WMZdbKaxHleA?loadFrom=DocumentDeeplink&ts=262.32)**):**

And both of those are the opposite, to some extent, of harm reduction. They reflect really a moral universe and not a real universe and tend to then make care oppositional and binary. "You should do this or else. Why are you doing this thing that you know potentially is harmful?" Those are very good ways of driving people away from healthcare.

**Mishka Terplan (**[**04:49**](https://www.rev.com/transcript-editor/shared/drXvld1taIaITKl3uman9jh3qqga74nrwKNbiG9N6LKwLe1omGZYm6XQ6EWGkOCA5I8XN-0rKmnWhww2tZgnbNlKzjo?loadFrom=DocumentDeeplink&ts=289.62)**):**

So, there are gendered differences in substance use, misuse, and addiction. And maybe I'll just define those terms real briefly. By use, that should be self-evident. It means using a drug. Misuse means the prescription that's used not as intended, using a substance in a way that's causing harm. For example, being intoxicated behind the wheel of a vehicle or something like that. And then use disorder, that's a medical condition, addiction. And that's really a behavioral condition, the primary symptom being continuing to do something you know is harming yourself and others and being unable to stop doing it.

**Mishka Terplan (**[**05:31**](https://www.rev.com/transcript-editor/shared/aORERJrViolVV8hQiaaml2G5-dDMLraZtOA-kqyxEkjZqfbaxckBE4BZWh09cXM-JJbo51HUU3lWxjp9P8JhG8Hj42I?loadFrom=DocumentDeeplink&ts=331.95)**):**

So, most people, as I said, in the United States, use drugs or have used a drug in the past year. Some people will meet criteria for misuse, but it's actually a minority of people who've used a drug in the past year who meet criteria for a use disorder. It's around 25% of people who've used an opioid, including heroin or fentanyl, will meet criteria for an opioid use disorder. About 20% of people have used a stimulant, cocaine, or methamphetamine, will meet criteria for a stimulant use disorder. And maybe somewhere around 15 to 20% at the most, of people who've had a drink of alcohol will meet criteria for an alcohol use disorder. So, most people who use drugs don't develop or have a substance use disorder.

**Mishka Terplan (**[**06:20**](https://www.rev.com/transcript-editor/shared/rDhKjx_SuQkv8Kg19BbiVpnxmWNIh1ofKf37rAySr89bgQgvZfPcgxrpDH6Wq6C8svHjNvHk8_jZj8QmPc3brpSrCiA?loadFrom=DocumentDeeplink&ts=380.25)**):**

Now trajectories into use and the motivations for use do differ by gender. Men tend to initiate substance use a little bit earlier age-wise than women do. However, those that develop a use disorder, women proceed more rapidly from initial use to use disorder than men do, a phenomenon that's called telescoping. That means that life course of use is collapsed. And when women present for treatment for use disorder, they tend to present with more severe disease.

**Mishka Terplan (**[**06:57**](https://www.rev.com/transcript-editor/shared/U5DdFt5ADL5kaQrFx376GTqHcEDdzlBceSNcnjHwOyumrVUBMP-7MzuJUDFeYaWDpduCJx8rBxX2LAmG3IEgtX0WnTU?loadFrom=DocumentDeeplink&ts=417.24)**):**

There's also other maybe more specific things that relate to gender inequity, and in particular, interpersonal power dynamics. For people who inject drugs, for men, the first time they inject, they usually inject it themselves. For women, the first time they injected a drug, oftentimes it was a male partner who injected them the first time. And that sort of interdependence, an unequal interdependence can play out across the life course of use and use disorder.

**Mishka Terplan (**[**07:31**](https://www.rev.com/transcript-editor/shared/PAoUyAqA6v-9Rjj-2B7BzBuQM4zy5LdcBCP9t5E22-LFKeAhEAbqM6WIY-iLWrDUBHXmVUvayzYNFlBsdgZR8MT44DM?loadFrom=DocumentDeeplink&ts=451.83)**):**

So, there are some specific differences by gender in terms of use, pathways to use, motivations for use, and even effectiveness to some extent of medications for the treatment of addiction that are important to consider.

**Katherine Atcheson** **(**[**07:49**](https://www.rev.com/transcript-editor/shared/MIYHfqUAcOVvxcR_5WxNwWZgnCpj-Pu0QDpMhPBNjew_pO0DIokjDW3hkW945a50kxn_Xu5XHC9sJwMIGdn4Updc3ew?loadFrom=DocumentDeeplink&ts=469.11)**):**

And now that we've talked about the gender differences between substance misuse and substance use disorder, how can harm reduction and the philosophies around harm reduction specifically keep those considerations in mind when applied to women's health?

**Mishka Terplan (**[**08:08**](https://www.rev.com/transcript-editor/shared/6XAoOoS29zpGQ3z5V4rXKbqkyiWXVFFAlgo8dssIULYaJ2aLZMyfMWXXfhgh8_uS08tUD3T5YU1Hph17fhSK5N081N8?loadFrom=DocumentDeeplink&ts=488.31)**):**

Maybe I'll talk about the drug policy piece of harm reduction here because it's particularly acute. So, in general, in the United States, we see bending away from the punitive of drug policy, decriminalization of cannabis and other substances, rolling back a mandatory minimum sentencing, things like this for the last 20 years. But these are state level policies now. State policy specific to substance use in pregnancy have actually become much more punitive.

**Mishka Terplan (**[**08:45**](https://www.rev.com/transcript-editor/shared/yeyoGwT_UP7uAOG-b0NdmxEEhShwneGI49F0W18UUVdYEPOP_vlzm6gj9zSAmK9r2uUivY7g8PkID4rGOPCYxemIygw?loadFrom=DocumentDeeplink&ts=525.42)**):**

Examples of those would be mandatory reporting to child welfare for substance use or a substance exposed newborn, classifying substance use in pregnancy as child abuse within state statute. Or even in five states now, using drugs in pregnancy as being grounds for involuntary civil commitment.

**Mishka Terplan (**[**09:10**](https://www.rev.com/transcript-editor/shared/KOcdE8wpGi-5mxNq4M49Ei6rA5Gy-c7bluvwqvo0uYUUPg9vX0lT-OT5LFEAPod9nG8uAw6vjAJ01idH86nWwcrzbBA?loadFrom=DocumentDeeplink&ts=550.59)**):**

The number of states with punitive policies have become more punitive, have increased in number over the past two decades. And those policies have measurable detrimental harm on the level of the population. We know states that implement these policies. Increased rates of preterm birth, increased rates of neonatal abstinence syndrome, and decreased rates of people entering prenatal care, and/or entering prenatal care later.

**Mishka Terplan (**[**09:42**](https://www.rev.com/transcript-editor/shared/bjdV5wA9krYppor_NhSxBGzfzL0TpY_3vj0WoPjJp9SA_ExWgMpw8LFaW3fms7e2OlVEFmtljw24ohGYc4_TSldgPv8?loadFrom=DocumentDeeplink&ts=582.21)**):**

So, it's important to recognize how the drug policy environment might influence or might impact a person coming for services. In other words, it might generate what I would call legitimate mistrust in disclosure of behaviors, including drug behaviors in the context of clinical care.

**Mishka Terplan (**[**10:10**](https://www.rev.com/transcript-editor/shared/w20dc_Vn-oWv2SsOgpRj37Aw7NO_aYFzuuCslqPNGi6w5mU6XPIgKD4mpoCHrZohoGTVMih8k1LTROk2DC8b7VjYXsk?loadFrom=DocumentDeeplink&ts=610.38)**):**

For women who are mothers who are caretaking children, even if they feel like they have a problem, they might be reluctant to share that information with a healthcare provider under, as I said, legitimate concern that that information might travel from the clinical circumstance to a police and surveillance circumstance, and that they might lose their kids. So, recognizing these dynamics I think is part of harm reduction.

**Mishka Terplan (**[**10:41**](https://www.rev.com/transcript-editor/shared/p-JYtSh983CBufvrrfmFzVrhgN7OaFKRNKKTo60QqfI-2TfbB5yURv4sjRFhJh5dcdmcbZzPC4_awKhAP2PoWKIDcbA?loadFrom=DocumentDeeplink&ts=641.64)**):**

Second is to create a welcoming environment, specifically an environment where it's safe for patients to disclose information to us, where we treat as much as we can that information internally, and do not share it, do not violate their trust by oversharing health information.

**Mishka Terplan (**[**11:03**](https://www.rev.com/transcript-editor/shared/vFxcI2CPtKYNwyIjdk2y-k4KMwug8i9FW6oecQlqPJ-mtYwsI8QRMqfUVYvdEnEMcJVQTvPLOe1U93wJzHY6_OMBnJM?loadFrom=DocumentDeeplink&ts=663.84)**):**

So, in some ways even before the patient shows up, that onus is on the provider, on the clinical system to make care safe or safer, and certainly to make it welcoming.

**Katherine Atcheson** **(**[**11:15**](https://www.rev.com/transcript-editor/shared/2te9Zl33yHo6iVZZepeYD38GZS59HTprGjIGqrtZKXdS6yHpjv3BPLIV9TH0SGBmIY7ttnXWmS8nyY3trW8lK2h0BtU?loadFrom=DocumentDeeplink&ts=675.69)**):**

And that leads us really well into my next question. As we move into the clinical setting, let's say after the standard screening as part of the health appointment, a clinician sees a client who states she's currently using substances, sometimes in ways that put her health and safety at risk, but she's not interested in stopping use of those substances. What are some ways the clinician can discuss harm reduction and give specific harm reduction strategies to this patient?

**Mishka Terplan (**[**11:51**](https://www.rev.com/transcript-editor/shared/YvivXVf-s2V7ll7Me0lupCfWQzVrjFmCrIccHFJGNIaSiaG2pOxP7zqEAanaEyPklJMxVyX6Rj5O91NhD04ULmoYSLQ?loadFrom=DocumentDeeplink&ts=711)**):**

Well, I think one thing is we need to establish meaningful therapeutic alliances with the people that we serve. And that is something that sometimes can't be established in minutes, and it takes time. Trust is a function of time.

**Mishka Terplan (**[**12:07**](https://www.rev.com/transcript-editor/shared/GWSZTYWVOzFXWnb16vBRskX4lQN35FCft4m1ZDRkM1yRiGz6oxATvvZfwPJu5vysiIU_wNNE3QbiNTjRiAB6yWX1Ixo?loadFrom=DocumentDeeplink&ts=727.47)**):**

One tool that's embedded not just in harm reduction but in behavioral health interventions more generally are the idea of motivational interviewing, which is a bit of a misnomer because it's really motivational listening. And it's a way of centering the care on the people that we serve.

**Mishka Terplan (**[**12:29**](https://www.rev.com/transcript-editor/shared/NVU8v9g8ZITPwhYCdldjqQpDY-9jpn9h3nUhSwvSsIlnepbDgZ3RhLwUbDMucvAk62TqtysJXUVLIm4yqEUzPWQw86U?loadFrom=DocumentDeeplink&ts=749.7)**):**

So, one thing if you've elicited a history of substance use, is what do you like about smoking cigarettes? What don't you like about it? And then you could reflect that back. "It seems like you like the fact that it's a break in your day, it's your own time when you're on the porch, and it's the one time you have peace. On the other hand, you're worried about how the secondary smoke exposure might be affecting your infant," and you stop there. And you let them try and reconcile that difference.

**Mishka Terplan (**[**13:06**](https://www.rev.com/transcript-editor/shared/7bF-nW86pCvFC4CPO4Ow76wl9y4KPy_qG2mFhJn5Ia8L9NDG2yF_hwqunUOUrmxICTFXCYRSsIzUxUT-kmH8uwEPbYU?loadFrom=DocumentDeeplink&ts=786.18)**):**

But I think sometimes just acknowledging through asking what do you like about something you're doing, displays that you're not approaching this from a strict sort of prohibitionist, abstinence perspective only, and that you're acknowledging that their behaviors and their person, just like all of us, are complex and can contain contradictions.

**Mishka Terplan (**[**13:29**](https://www.rev.com/transcript-editor/shared/kLyKA7Du1UWBhVm__iaiMurGW1O1YfHVbbfg371mRmoSDRaGyuE4ie2bpICWJXPt1HzWEIwMTMnc2Uxw7Z0qRGI96NY?loadFrom=DocumentDeeplink&ts=809.97)**):**

I think you can also flip the script from strict diagnostic intervention kind of interactions to just say, "Do you need help with anything? And what are your goals?" Because again, that falsehood of abstinence sets up really oftentimes just two goals for people, or two options. One is continuing on this self-destructive path, and the other is completely impossible to understand at this moment in time.

**Mishka Terplan (**[**14:03**](https://www.rev.com/transcript-editor/shared/QkpgwBYlZA0tcwJsevpD0SIrPhXiT_dwtzAveNkzskzMJF7gnvmIjn4TOCz-Ppz6Ldydt64WkllJ9JZEhVdw9wQiCZw?loadFrom=DocumentDeeplink&ts=843.75)**):**

And we know that that's not how risk, putting that in quotation marks, functions. It's not binary. And for most substances, we know that cutting back can have measurable benefit. And the magnitude of quitting depends in the context, may not be quite as apparent as cutting back.

**Mishka Terplan (**[**14:24**](https://www.rev.com/transcript-editor/shared/ooJ28w8IL52gXHYeZyx5eyia0esoRVXJJRsHGcB9HFahkHYb_SeTbpnTWl-VZFGh5iRoKXrlZPlrG9gyWaPsMxdCfjE?loadFrom=DocumentDeeplink&ts=864.36)**):**

In pregnancy, even decreasing cigarette consumption by one cigarette per day meaningfully reduces the severity and duration of newborn neonatal abstinence syndrome. And so, we needn't get to abstinence in order to see an effect. And that goal, the goal really should be set by the person, and that can be elicited in that interaction, in that clinical interaction.

**Mishka Terplan (**[**14:51**](https://www.rev.com/transcript-editor/shared/Q73WizKhi5oAV10qCK_CV4nMEdW4bNiBWMLT4x_jt5x6rU0tH9Eopzw9OIXH-79ZpYZUQriMXV1TLIzh0OBQR8XLbYg?loadFrom=DocumentDeeplink&ts=891.93)**):**

There is a small role, and I want to say this, but not overstated. There is a small role for education, for dissemination of information and knowledge. That can be, we can do it as a clinician, or people can get handouts, or flyers, or things like that.

**Mishka Terplan (**[**15:08**](https://www.rev.com/transcript-editor/shared/Izx758nU-_rD-8XwBxH36TCyJNemNBYlckVWx_ln3cfwtoHseutAWf5P5Qe_txXFMABgjAPDJJL5heV40IZCAAKvDPs?loadFrom=DocumentDeeplink&ts=908.97)**):**

And so, it can be important sometimes to share things such as heavy alcohol consumption can make your blood pressure medication less effective. And that connection maybe the patient doesn't know.

**Mishka Terplan (**[**15:24**](https://www.rev.com/transcript-editor/shared/nWo1sLf4_1V2zxR-3FcnyuQIKT5GaMWtMEr8HhYh2L5vUiPQfGy9ptVpS-cUHuUfoF2nZ16VurCFUH5CyNuIwfCHxmQ?loadFrom=DocumentDeeplink&ts=924.93)**):**

But many things that we think of as education are really more moral in content, and really serve to drive people away from us and undermine what trust we might have developed. So, there's a role for education, but that tends to be the lane that we're most comfortable as providers because that's how we learned. But from a behavioral health change perspective, education does not lead to behavior change.

**Katherine Atcheson (**[**15:57**](https://www.rev.com/transcript-editor/shared/SXhkk-HEFXk2NRm-zc4FbmFaTsgq4ihToEL4cD_cBE_VUon6mwu77Sjw9t-PJd-BEoCfw8JpD-xVxvt3ovNS5uTUfrA?loadFrom=DocumentDeeplink&ts=957.84)**):**

Again, that leads us well into my next question that since one of the goals of Title X is to help achieve healthy pregnancies, are there ways to discuss and employ harm reduction for a patient who is desiring pregnancy or test positive for pregnancy, but is also using substances?

**Mishka Terplan (**[**16:17**](https://www.rev.com/transcript-editor/shared/DrARquUB9YROWBmJU2ATR8lV55ZLo1fXvASKoGah7-ngywvuo6qFtdrP6SoXvkrW9iWMVcXFObO0WjfH9qmp8e6NNV4?loadFrom=DocumentDeeplink&ts=977.94)**):**

In general, I think we as providers, but also within the public health world, and even within the scientific published literature, do a very bad job differentiating substance use disorder I.e., addiction, from untreated addiction from substance use, misuse, etc. We group everybody together who uses a drug or reports recent drug use and treat them as if they have a use disorder.

**Mishka Terplan (**[**16:44**](https://www.rev.com/transcript-editor/shared/5R53JfkYCGBxiCZzwLGrIFbSZaAqaNscW22ffjw3MaEVc76ETARl8zN19UXQmC741RIOyVm84EtdbajuzK2drG1Pimk?loadFrom=DocumentDeeplink&ts=1004.88)**):**

Now, what should follow in clinical practice, screening, using a validated instrument or having a conversation with a patient to assess recent use, type of drug, stuff like that. What should follow from that is diagnosis, right? Do they meet criteria for substance use disorder or not? Because your intervention, what you do next really differs. If somebody has a use disorder, well, they need treatment. Depends on the type of use disorder, whether or not medications are available, etc. But if they don't have a use disorder, we shouldn't be forcing treatment, which we do. It's like, what does treatment mean for somebody who does not have the condition? It's not helpful and it could be harmful.

**Mishka Terplan (**[**17:27**](https://www.rev.com/transcript-editor/shared/mFZ0x_uERTKBr2dE50acFFka3UdBt2PU6-eVQGg8Ok0gO5QbuF8If08X98m-PkkpQiktlcFhwsY7iqUxv_YFGLmzK2A?loadFrom=DocumentDeeplink&ts=1047.69)**):**

Plus, unfortunately, addiction treatment is a scarce resource. So, giving somebody who doesn't need a treatment is taking it away from somebody who does. So, it leads to inequitable distribution of healthcare resources.

**Mishka Terplan (**[**17:40**](https://www.rev.com/transcript-editor/shared/kwyLK7sUgYjvbkcCjOKCoHne9eSv1XSPc8KqVKYBhKGN-btXSPfrm-MxuQF-uv712zM0v8LVriTsFCx25scaVUoqVg0?loadFrom=DocumentDeeplink&ts=1060.47)**):**

So, I think a lot of those things I mentioned before, getting a sense of what people's goals are. What are you worried about in terms of cannabis use in pregnancy? What do you like about it? What are you worried about it, and what are your goals? "I don't want to quit now, but I want to quit in the third trimester." "Okay, how do you want to get to there? Can we set up some intermediate goals along the way? Can I check back in with you about that? If you're having trouble meeting those goals, we'll come up with something else."

**Mishka Terplan (**[**18:11**](https://www.rev.com/transcript-editor/shared/aPkMmntDUK_s1oCOfYAGmDJUFV_6hOPjOuYP8DbhSY-sUtTl1fXRZQcS2ArkfvXJejzDcddzExBHM3uUNkykyd1HQsg?loadFrom=DocumentDeeplink&ts=1091.34)**):**

So, I think there's a lot of literally negotiation that can happen around that. But as long as you set the stage of safety, and that's again, our responsibility as providers. And be clear in pregnancy around drug testing, what happens to that information, who it gets sent to, how much we can control, not control.

**Mishka Terplan (**[**18:34**](https://www.rev.com/transcript-editor/shared/AaMNy5RkEZ-sSVAmLpiWUge_4J7bJAfVR6j1hGPi1AVLO5mDZRSKAVkQSAKxc9VsGHLRjCG419JGRrwVGXlSrvtTrh8?loadFrom=DocumentDeeplink&ts=1114.47)**):**

I'll just share how I approach it, which is there's things I can control, and there's things I can't control. And I think it's important to be clear about that. Not over promise things, not say, "If you stay with me in prenatal care, you won't be reported to child welfare." I can't say that that would be false because I can say I won't report you, but I can't say you won't be reported.

**Mishka Terplan (**[**18:54**](https://www.rev.com/transcript-editor/shared/5kRE0mgsHQOEjhyO3giD1TLYFPU_YGUC69ecYIdsnXbXzOn7UEwit4NxqD9eubly3E3ijcYFp_SyGDaf4AX3jZO463o?loadFrom=DocumentDeeplink&ts=1134.78)**):**

But I can say that my responsibility for care doesn't end at the end of this visit, or when you leave this clinic or delivery, that I can pledge a responsibility regardless. So that means if you get reported to child welfare, if you end up in family court, I can be there. But I can't protect you from this part of the system completely, but I can pledge to be there in support of you throughout the process.

**Mishka Terplan (**[**19:24**](https://www.rev.com/transcript-editor/shared/C9PJZ24KqF_n4RGvCkIO7zkZGNxIdA5WXdDAW1N13szeqdGv3vKHgbLlUXM3fwzyVi2wE6wGKxVU8lUQBJ64w9tZ2YA?loadFrom=DocumentDeeplink&ts=1164.57)**):**

And I think that type of transparency that's honest, don't promise things you can't do, and follow through on the things you do say, is really helpful in making clinical care safer. It might not be safe like how we would want to see it and how our patients would want to see it, but it's realistic and moves towards there.

**Katherine Atcheson (**[**19:47**](https://www.rev.com/transcript-editor/shared/vtkkzQoLS-a5_c7Vx19J3KkzOW5NhQsHnUc_krL5F8_ceA0YN3MN8HA1IDsgDePsJnQLKnMuS4QccxdVXyln_ART5Wo?loadFrom=DocumentDeeplink&ts=1187.28)**):**

Another special population, Title X clinicians also often see adolescents for sexual and reproductive health services. Are there specific considerations for clinicians to bear in mind when discussing harm reduction strategies with these younger clients?

**Mishka Terplan (**[**20:07**](https://www.rev.com/transcript-editor/shared/zm6yD389-ABa5pkbHIROss4tis9mu-N3NwU62cQoU_p0PYFejO_1TWQAiMYAvfN_PT5jswREG0woEY0qDvGAxW1jGo0?loadFrom=DocumentDeeplink&ts=1207.08)**):**

I want to clarify that I'm not adolescent specialist, and there are people who, both reproductive health and addiction are specialists in this population. And it's a population that really deserves specialty care because there are unique considerations.

**Mishka Terplan (**[**20:25**](https://www.rev.com/transcript-editor/shared/fODG-taAzXlN24-vzomq2XnnqLF-mI9GYAMQ-XfSkh3nf1uyRAy0sPVhPttO3q6byu0jOU9b2Eb_sXvYDczuq4XGP34?loadFrom=DocumentDeeplink&ts=1225.2)**):**

I think one theme that I didn't mention before in your earlier questions, but I think bears in general, and in particular on this, is the interrelationship between sexual behaviors and drug behaviors. From a simplistic perspective of risk taking and also of risk. Not just sex, but sex while intoxicated is different. And that's something that's also common amongst adolescents, youth, and young adults. So, sort of teasing out or being sensitive or aware of the possibility of those sorts of intersections between these sorts of things.

**Mishka Terplan (**[**21:02**](https://www.rev.com/transcript-editor/shared/eNxgwP3fTv-p6HZQ0i3Su8ijmEKaWSEr37jfjRWAvx_cUfELDPuv6SaXPxvVXYSXLn4vTAVn42057d8CAkbXW8MKjCo?loadFrom=DocumentDeeplink&ts=1262.19)**):**

The second is that in our culture and in this historical period of time, drug use and what's sometimes called experimentation is normal. And normally, part of adolescence and the transition to adulthood. And yet, not everyone has the same vulnerabilities to the development of use disorders.

**Mishka Terplan (**[**21:28**](https://www.rev.com/transcript-editor/shared/VIK0bFWM26tvP2nmJ8PGcK2gn6sbHZsj0AlMpDF8aZvpc3PNl3t20Zzj7LykSnh18xsiYynSgZBQQNR1WUzVwIkqPTU?loadFrom=DocumentDeeplink&ts=1288.41)**):**

And that can be something that's hard, especially for youth who develop a use disorder or have much greater misuse than their contemporaries. That can be hard for them to understand. And teasing out, reflecting back those vulnerabilities. And those vulnerabilities would include a family history of substance use disorder, history of adverse childhood experiences. To some extent, age of first use is correlated to development of a use disorder. And trying to set that, one, accepting the normalcy of use and "experimentation." But second, trying to individualize it.

**Mishka Terplan (**[**22:10**](https://www.rev.com/transcript-editor/shared/x__iK8ASyt-4Ei24FZInrkSKzOYnJd8yQtPoa-NNM_F8H7buKflQE-wOayCZSrRYLu9_tyXJx-3iPRCEQbPcUX0VQ0I?loadFrom=DocumentDeeplink&ts=1330.89)**):**

You having three drinks is not the same as everybody else in your peer group having three drinks, because you have a greater set of vulnerabilities. And it's a good piece of information I think for that person to have. And you can think about moderating behaviors.

**Mishka Terplan (**[**22:29**](https://www.rev.com/transcript-editor/shared/7r3JYpV5t7PpcIGyts6w86U-2QNlPhGD8f4w4hM1Gfmf3XPPn632PvjNGm560ah0v1-hYt01FcLuDSeqFTF9ZXnnxVU?loadFrom=DocumentDeeplink&ts=1349.22)**):**

But the same principles of safety and disclosure, and yes, there's some issues in terms of age and what you can share and not share, but being familiar with that and respecting that. And again, not promising things you can't deliver, and following through on the things you do pledge.

**Katherine Atcheson (**[**22:46**](https://www.rev.com/transcript-editor/shared/VZHby3ug-W9lnbNvh899ysRuPUUK4tJW_jeQ3lyCHZb4JJyYs_Gh7FT-LEn_r7NmC7VCx-oLzsebo1MZOs8r65_CtlI?loadFrom=DocumentDeeplink&ts=1366.77)**):**

I'd like to change tack a little bit and talk specifically about substances themselves. While there's a lot of discussion around things like opioid or alcohol, I'd like to take a moment to discuss specifically cannabis, because it's becoming legal to use either medicinally or recreationally in more states every single year. What do we know specifically about cannabis use and misuse, and harm reduction as related to this increased legalization?

**Mishka Terplan (**[**23:20**](https://www.rev.com/transcript-editor/shared/pZcmf7eXy1q1i-Acrip81FHtkFOcnuumSWj2nzfO6yfh6qWaB2CAu_enz-pGWmuL798rqc9yfcn2I5cQQp8kmx-wttM?loadFrom=DocumentDeeplink&ts=1400.61)**):**

Cannabis is endlessly fascinating, and in particular at this historical moment. So, it remains illegal, scheduled substance without any medicinal value in federal classification. Many states have, there's medical cannabis, and many more over time where it's legal.

**Mishka Terplan (**[**23:41**](https://www.rev.com/transcript-editor/shared/hKvdkvjWT2uPop77us-FaNeTdX72NvQyLr-FwE5qxuSD6ZbmRyWMFbf7sfbNwxSXbrJbG2yW1WHtjbp_p7Xkvgc811k?loadFrom=DocumentDeeplink&ts=1421.22)**):**

This sets up just in terms of drug policy, a kind of cognitive dissonance from drug policy. Also, a particular risk that becomes gendered, certainly around reproduction, and pregnancy, and parenting. I find it helpful to have a bit of a historical lens on this.

**Mishka Terplan (**[**24:02**](https://www.rev.com/transcript-editor/shared/HjJaCFDBkd08Xr26Q1Gx_GiU6sW6xagwvhx-_Al5DPzJz6B6CFH1ExY_o8ycl01I0qgc8I-gpoO_JnlrN7epYsc9SgU?loadFrom=DocumentDeeplink&ts=1442.22)**):**

So, cannabis and cannabinoids, plant-derived cannabinoids were part of every single cultures like pharmacopeia, those that developed pharmacopeia, written documentation of medicines. And in the Victorian era and before that, but certainly in the Victorian era, cannabinoids were available primarily in tincture forms, and marketed and sold predominantly to women for the treatment of female conditions such as menstrual pain, menstrual irregularities, and might be some specific medical benefits of cannabinoids related to women's health. And there certainly are, cannabinoids have a strong therapeutic potential, some of which have been studied more than others, both in conditions and in types of cannabinoids.

**Mishka Terplan (**[**24:59**](https://www.rev.com/transcript-editor/shared/4DZidvpEBmRZCfYxU8UmS_R16yJwlm-JvpBlArmUPeNkd9GkOiT2YJ7soXKcTZ7j85QQ3u3A6EmYkXYAZ2hrsSxJ-bk?loadFrom=DocumentDeeplink&ts=1499.85)**):**

Most of that is not exactly what we call medicine. It's still plant-based care. I'm not trying to minimize its therapeutic effectiveness, but I want to mark a distinction between 20th century state controlled, bureaucratic, and pharmacologically specific medications, development, and regulation, and plant-based medicines, which are what most of human history had.

**Mishka Terplan (**[**25:26**](https://www.rev.com/transcript-editor/shared/HG-Ve0QQwF5SwJtrbNc3UGccUZwIoOq1Ht4CkcJFjTSJsRStu4pL0d7ourMjz79K1g07s71skSOQMCesBhOzjW2zznE?loadFrom=DocumentDeeplink&ts=1526.79)**):**

And so that's also a cognitive dissonance. This world of the effectiveness of smoking a plant, and/or ingesting at otherwise, or specific compounds, it doesn't align exactly with FDA randomized controlled trials and regulatory environments and designations.

**Mishka Terplan (**[**25:49**](https://www.rev.com/transcript-editor/shared/HCWEZySO-4J3xZkqxQFw2uZFtydY5sLHOPJ99caEH9uoq1WUe18jigt1zur-0CeUvt1oyJt3URRok71FjxulQyKgSoo?loadFrom=DocumentDeeplink&ts=1549.11)**):**

Doesn't mean there's not benefit. There could be that women actually, historically certainly, might have benefits from some of these sorts of things. At the same time, it's illegal federally. And if you're using it while pregnant or parenting, that information might be shared with policing agencies including child welfare.

**Mishka Terplan (**[**26:10**](https://www.rev.com/transcript-editor/shared/xBqH80hrPhzyr0y-eaGfZ9e510WOcDJ62bwivSO2JqxwNgGdvpExmosXR0rpLLNIA_THydolRdpLeKri6yz-cgiu2Jw?loadFrom=DocumentDeeplink&ts=1570.35)**):**

So, it's super, super messy. Which means, again, like that kind of harm reduction principle, the same questions around, what do you like about it? What don't you like about it? You can apply those not just to things like cigarettes or alcohol. You can also apply that to cannabis, even cannabis that's used for self-reported medical conditions.

**Mishka Terplan (**[**26:34**](https://www.rev.com/transcript-editor/shared/Dag6K_dwZECQKJZkED8vj5VsYgifMjOgGldWR0g9XPxrJVHPmvAwa3y0bbnXtFMThAhgnZzErOw-0FcJ8l5Pa9Ezamg?loadFrom=DocumentDeeplink&ts=1594.92)**):**

"How is it working?" "I use cannabis because it helps me sleep." "Okay, tell me what do you like about it? What don't you like about it? How's it working? And are there alternatives or are there things we can do at the same time that might improve the quality of your sleep?" So those kinds of considerations I think apply. That harm reduction lens is not just for drugs that are illegal or drugs that have harms, but also for things that people are using in medicinal ways.

**Katherine Atcheson (**[**27:03**](https://www.rev.com/transcript-editor/shared/Mp9Z8gX2WHUkQckojVvPJ92tZHADaHxQWEObBkkk0uN9MnPFgwXUhfQcl6QSj2ilPTTEFBTb7zbdiy9eghRiyL4pH1Q?loadFrom=DocumentDeeplink&ts=1623.81)**):**

Sort of related, you talked about how we don't know that randomized control trial evidence base FDA approval for cannabis. But what do we know about specifically how cannabis can affect women's sexual reproductive health, and pregnancy? And what can clinicians tell their patients if they ask about it, if they're providing that harm reduction counseling?

**Mishka Terplan (**[**27:30**](https://www.rev.com/transcript-editor/shared/nftOKFSwZWjBm4SY4d0nmn7hVyXpIXobbBsHtELWsDmV_ndP5Y67fik_wK7LujgoIpmPa1ZapTy4g4HJajyCratcYLQ?loadFrom=DocumentDeeplink&ts=1650.9)**):**

I think it's real important to acknowledge what we know and don't know, and to also recognize that all of us have been socialized in a particular drug policy. And in many ways, we've internalized a prohibitionist logic around substances. And that can come out in our clinical care, how we react to someone's drug test, what we recommend, etc. We have to, in many ways, at least recognize, if not try to decriminalize literally our brains. I honestly don't know the answers to this question, and I know that there are people who know more than I do.

**Mishka Terplan (**[**28:15**](https://www.rev.com/transcript-editor/shared/_VK_uXB_X8sZSEfSMPUWbiec2wK_lCFU7RM1-45CRnV9wu7Qpm4RO9YdDh3VlNiER-NtjNMOy4wigva7OS2EAYDzAE0?loadFrom=DocumentDeeplink&ts=1695.57)**):**

I will say that when we talk about cannabis, we tend to be talking about external exogenous cannabinoids. There's a whole internal endocannabinoid system. Almost every single part of the human body has cannabinoid receptors, and they're particularly concentrated within the female reproductive tract. And there are models of both endo- and exo-cannabinoids, animal models related to miscarriage, how the cilia and the fallopian tubes respond to endocannabinoids. There may or may not be something about ovulation, certainly about implantation and things like that. There's endocannabinoid mediation in all of that. I know a touch more than what I just said, but not that much more. But there's a relationship. Exactly how that translates into human health, I don't know.

**Mishka Terplan (**[**29:05**](https://www.rev.com/transcript-editor/shared/9WyO0FxjrqohBi030uK64cUXVf9tkMVmK3g4DzPpyjkncZcPvFTsdaSDF_UNjRgYOqFhIVT7PjInUc7KSpUejw6vOfY?loadFrom=DocumentDeeplink&ts=1745.37)**):**

Now in pregnancy, the concern is that you have an endogenous system, and then you've got exogenous of similar substance. And does that change? Does it override? Does it cause problems? The same questions have historically been asked about opioids. We have endogenous opioid system, and people who use opioids for whatever reason, it's an exogenous opioid on the developing embryo and fetus.

**Mishka Terplan (**[**29:32**](https://www.rev.com/transcript-editor/shared/C-0IaR1F8sHdlLl6vjo1wU62C6SXUZXFl6oJNY-xAHHp7AIAZRP4QX0N_AViscF_V8BAHQXubtg7v6IeqxsmsDkAYSo?loadFrom=DocumentDeeplink&ts=1772.55)**):**

But generally speaking, we overstate what that means, and that's a reflection of that internalization of drug policy, I would argue. We overstate the "risks" or the consequences of cannabinoid exposure.

**Mishka Terplan (**[**29:50**](https://www.rev.com/transcript-editor/shared/wrCMdftubOtXQp_EeLbNp6HhcoHbAmSVv37gMZYFya29lgTTVb-sTsVwtuD9vsJQ7k9iMQ8tjuCOvlNLNzz6-MsQUx0?loadFrom=DocumentDeeplink&ts=1790.79)**):**

What do we know at this point in time? And this is where I know more than about the sexual reproductive health question part of the cannabis. There appears to be an association between use of cannabis in pregnancy and lower birth weight, somewhere between 30-to-100-gram differences. There seems to be an association... And that's confirmed across multiple studies and seen in systematic reviews. And same with an association between cannabis exposure and admission to a neonatal intensive care unit.

**Mishka Terplan (**[**30:24**](https://www.rev.com/transcript-editor/shared/LQ_g33TAQOwNRREoPVYCqySlJHiBoDLj4tLtpHAWUbhpLb1TCKpTxM6Pi0QOwnkI1_Ju3uhpD4025NpJZnDGiN2rsU0?loadFrom=DocumentDeeplink&ts=1824.3)**):**

These studies vary a little bit in quality, and certainly don't always measure or completely measure nicotine and/or tobacco, which is known to reduce birth weight, nor do they... As you move away from nicotine, the other potential confounders are less and less measured too. But let's just assume that that is a real association. The significance, uncertain.

**Mishka Terplan (**[**30:50**](https://www.rev.com/transcript-editor/shared/rdgGKdkXkR5V0Uo1ohD-UvyxV2yqOei6SRoLN-hzp296OE79W6yyoTKapcfPP5-WSUkOxtYkJErdBHu5rJAG3AVoiAg?loadFrom=DocumentDeeplink&ts=1850.37)**):**

And then as you move along in terms of development, one thing that health professionals say that is I think false is that we don't know a lot about cannabis and child development. And it's false. We actually know a lot. The problem is we can't summarize it quickly, and certainly we can't summarize it quickly in a negative way.

**Mishka Terplan (**[**31:10**](https://www.rev.com/transcript-editor/shared/o6xcwJD5fRMYUWePD8xtjQdf3xPsChWpERlR6pUTxy2Jl9rYRhoL6DLuFzmcdfaNbWdyZ7T8QILZSkvHujCwuH9O3Ug?loadFrom=DocumentDeeplink&ts=1870.86)**):**

I can say for alcohol, it's the leading cause of preventable intellectual disability in the United States, in-utero alcohol exposure. I can't make that kind of a sentence for cannabis, because the data are mixed at best, effects are subtle when they exist at all. And what gets measured does not well control for the caregiving environment. The further we move from birth, the less of an effect we see. There are four large cohorts of cannabis exposed, what had been cannabis exposed pregnancies now are children, young adults, and even adults. And cannabis does not cause birth defects. It's unclear at best, and minimal or absent effects like probably more commonly.

**Mishka Terplan (**[**31:59**](https://www.rev.com/transcript-editor/shared/9J8-PKTo-I4oRBNPzi_L1M81CrkQJCE5r7F3yO_QcuU3IO7qDheeWRM10bO62SmdTL2Ef5NIYxEZiAU9t61EF9PKQQc?loadFrom=DocumentDeeplink&ts=1919.61)**):**

And the thing to keep in mind in this whole space too, is the organ we are concerned of when we're talking about in-utero chemical exposures, the organ we're concerned of the fetus is the brain. But the brain doesn't stop developing at birth. There's actually nothing unique that happens to the human brain at birth. The big change that happens in the brain happens around age 25 or 26. That's where the brain finally "matures" and shifts in development.

**Mishka Terplan (**[**32:30**](https://www.rev.com/transcript-editor/shared/DRgb-1dD_3FkPhqnruRlR9CjBEk0gNOpsqL37diHttW7j9LQGQJgPGO8SES7_pp4jPT9j6T3q9UzE_hnoP-uw-rwllY?loadFrom=DocumentDeeplink&ts=1950.6)**):**

And so, exposures can happen across, not just in utero, but throughout infancy, childhood, and adolescence. And probably, those exposures are more important for cannabis on development and stuff like that than the in-utero exposure was. So, we have to think about second and third hand exposure in children, and we have to think about exposure through primary use in youth and adolescents.

**Katherine Atcheson (**[**32:58**](https://www.rev.com/transcript-editor/shared/3DAu8W8te5RNc_hYHp9qzZXpv9WkzKUwez6gWZXYwwVH_ERd-br1vF9FmutByrYv2Sa7xfIy6o1oJJLYtmQddUc6T1o?loadFrom=DocumentDeeplink&ts=1978.35)**):**

Well, this has been a great discussion, but obviously there's so much more out there to learn. Where can clinicians go to learn more about harm reduction counseling and harm reduction principles? Or where can they refer their clients to learn more about implementing harm reduction?

**Mishka Terplan (**[**33:18**](https://www.rev.com/transcript-editor/shared/PdpTMdxpzOBnCVsY8gNuAbkRWpLufJdxAVb89p3BCKKrTxlkbozSYdFArVADJ21r92mXNrjc7sU3DKLHIxi2zwwePNs?loadFrom=DocumentDeeplink&ts=1998.15)**):**

In this work in general, it's super important to include and support people with "lived experience." And I can share a certain perspective. I can speak from a specific kind of authority, but it's not the primary one or the only one.

**Mishka Terplan (**[**33:39**](https://www.rev.com/transcript-editor/shared/oPSiKX40hblOV3dEzszZcuOxbhU70GeVl97QtewQw6kPpcM-_RijHr1rOe5SmK5nalvCGNSazhov_cmq1QPf6MNcacY?loadFrom=DocumentDeeplink&ts=2019.84)**):**

And generally speaking, I think the care we provide is enriched when we include the people that we serve in decision-making and in the care itself. And that means not just tokenism, that means legitimately bringing people to the table, reimbursing them, and supporting what they say, and working closely in partnership with them. Individuals, but also various community-based organizations.

**Mishka Terplan (**[**34:04**](https://www.rev.com/transcript-editor/shared/7U8S4Ycm3RmBApvjGW0PnuNzXTPbSnF4-Gjv9GUoeUXjjVrNwoktCukeq2hi5JlZaArYH0_-bzoIgkfzaCTk1ixDKEM?loadFrom=DocumentDeeplink&ts=2044.14)**):**

So, there's a ton of community-based organizations, including things such as syringe exchange services, as well as reproductive justice organizations, that include people who've been impacted by substance use. But also, I think it's important to include people who've been impacted by drug policy and that perspective. To a large extent, the harms of illegal substances are the fact that they're illegal. That's what confers the greatest risk, not the substance itself. That's true of the fetus, that's true of the pregnant person. And, generally speaking, that's true across the board.

**Mishka Terplan (**[**34:41**](https://www.rev.com/transcript-editor/shared/RNAp-gDcv3BKLDGLqRohHboxEjsK32bCUEmK1XDtxNCFuYKOHA9WZpQjOSNRjG56_2INVoJmXX306kt1t3kITV1zOOA?loadFrom=DocumentDeeplink&ts=2081.58)**):**

So, I would suggest providers getting to know their community and looking for community-based resources that can both help all of us along the path of self-discovery and learning, but also as resources for the clients that we serve.

**Mishka Terplan (**[**35:00**](https://www.rev.com/transcript-editor/shared/qYsktNchSIWHsi0cesfDrFhlPK5IOtaFyp_GA--ui1mwVhWQN7B-QT7_X49MWmgplS5Fwdb-E6LNxnedj6tc-F8lww4?loadFrom=DocumentDeeplink&ts=2100.72)**):**

There are national organizations, Harm Reduction Coalition. There's the national Academy of Perinatal Harm Reduction. There's Drug Policy Alliance. There's in the child welfare space, Movement for Family Power, JMAC for Families, and a host of other great organizations run by awesome people, many of which have resources for free on their websites.

**Mishka Terplan (**[**35:24**](https://www.rev.com/transcript-editor/shared/J7ORHFtNWQWHapcTPRkJ2CxzGt73-Ad3VTDPgg9_Oq9TfY6GrtiKFiSTPJ_cybaTWuwbj8KMyv84z1SImLNCyqpjHWY?loadFrom=DocumentDeeplink&ts=2124.12)**):**

And then the final thing, I think it's helpful for providers to have some training and certainly practice in those motivational interviewing techniques that I discussed earlier.

**Katherine Atcheson (**[**35:36**](https://www.rev.com/transcript-editor/shared/0rExWcFpOl2yHtxQwf4midbd5hXiwVSyku_Zom0PV2HLiXsihsgYf0zLF2k7J5bzb66JYVhqUGJPEUFVLiE5OJ71DAc?loadFrom=DocumentDeeplink&ts=2136.9)**):**

And before we go, one final question. What would be your top takeaway or takeaways for our listeners? The one thing you really want them to remember as they return to their practices and go forward.

**Mishka Terplan (**[**35:52**](https://www.rev.com/transcript-editor/shared/1oraQNitUqb_O_FzHc2pSzA1RjlKkHRInerBlncSSJYsGxIAkdA4oxR3hBoepkQGkzfKU3F5Yg7L8HlysCtifo7Kx-M?loadFrom=DocumentDeeplink&ts=2152.47)**):**

At its core, harm reduction is an expression of humanism. Not just medical humanism, but humanism. And really, it means treating people with dignity and respect. And for people who use drugs in particular, sometimes women who use drugs, and certainly pregnant people and parents who use drugs, they are denied that dignity. They're denied that humanity in medical encounters through the articulation of drug policies, and specifically drug policies related to pregnancy. And that means we actually have a responsibility to address those inequities that are, as I mentioned, both individual as well as structural. And one of the ways that we do that is by reflecting people's humanity back to them, and sometimes even giving them the dignity that has been denied them elsewhere.

**Mishka Terplan (**[**36:51**](https://www.rev.com/transcript-editor/shared/HDIODs1Vnus-KqdIqje6GmSBAKVqIQFPyzy3pfwLKelH3vRV3uDZ6LWl4yQGVMYEFm1vXbEumx0z__U3awYVIB-4w3w?loadFrom=DocumentDeeplink&ts=2211.06)**):**

And we do that by creating environments that are welcoming, that are safer. We do that by providing services that center on the people that we serve. We do that by including people who are impacted within the decision-making process and the delivery of healthcare services. And we do that beyond the clinic too. And that's part of the public citizenship of healthcare.

**Mishka Terplan (**[**37:15**](https://www.rev.com/transcript-editor/shared/8BWNlY1j7lqOhJy5MfvJhBwinTU5RoP6SHvjAibX9A-bNB1NrRPkMuP1qiPzwIc8YxgzFN_RVKotcRgHgqtVbs41Cno?loadFrom=DocumentDeeplink&ts=2235.24)**):**

That can mean different things at different times for different people. But this work is really more than health. It's more than wellness. It's more than drugs. It's more than sex. It's about, what is the horizon, what is the universe we would like to inhabit, and how can we get to there?

**Katherine Atcheson (**[**37:36**](https://www.rev.com/transcript-editor/shared/F0mlZdL8zgr8sCi4vhgpzwnmRkpPw8xV_IwghxYWFB3_kMox0aLlC9-3y33yh4pu5g9f3_MhmIfcYUK3uy-KdSdUWik?loadFrom=DocumentDeeplink&ts=2256.03)**):**

Well, thank you so much for joining us today, Dr. Terplan, and for sharing your time and expertise with our listeners.

**Katherine Atcheson (**[**37:43**](https://www.rev.com/transcript-editor/shared/TzOe3iUkr0JsP2vQkf5dzT1EMiPpWdpzY7UycVprxXRxfFm-jgxN2kljt06RRWVhca5m3vIT26To2WmKIs2NAfWABMA?loadFrom=DocumentDeeplink&ts=2263.89)**):**

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**Katherine Atcheson (**[**38:21**](https://www.rev.com/transcript-editor/shared/rW7YMJ9EQCuMFoEh-RA9-iq71-uBhPnCwygM7fF95_kECQMdeNBf-7AoCS3EPqnAqd7tIPqAuTlOQUu0rbBelOkOQsY?loadFrom=DocumentDeeplink&ts=2301.66)**):**

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**Katherine Atcheson (**[**38:44**](https://www.rev.com/transcript-editor/shared/EjL8rPDp2kUPGBtxgmskfoxHpzGRpb5bSSGbWIow7-f8rE3xIRX8uyr97ciXS49cM0HuzAi1JuzxVwwb7N0UKS3NKV0?loadFrom=DocumentDeeplink&ts=2324.13)**):**

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**Katherine Atcheson (**[**39:17**](https://www.rev.com/transcript-editor/shared/Gbngbn2-VwJJ9oHaFQWcLGRaHjUSLmh4hi6svtLEhkM-djDYUJS1rWQm4WW73e2JME_m4kPZ5khqF0XOnuJh0-5LCH0?loadFrom=DocumentDeeplink&ts=2357.19)**):**

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