ASTHO Brief
Exploring critical issues in state and territorial public health.
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Stigma Reinforces Barriers to Care for Pregnant and Postpartum Women with Substance Use Disorder

Overview

Substance use disorder (SUD) among pregnant and postpartum women is an increasingly pressing public health concern. Between 1999 and 2014, the number of women with opioid use disorder who gave birth increased 333 percent. Pregnant women with SUD face elevated risks of poverty, psychiatric disorders, and domestic violence. Once they give birth, they experience problems like the "relative lack of specialized and prioritized postpartum treatment resources, the stigma of having an infant exposed to substances, and postpartum depression." The social, civil, and criminal penalties for being a pregnant or postpartum woman living with SUD can be powerful enough to keep a woman away from the healthcare system altogether, putting both her and her infant's health at risk.

There is a preexisting unmet need for treatment among women of reproductive age with substance use disorders. Once these women become pregnant, it becomes substantially more difficult for them to seek and enter treatment. In one survey, 75 percent of outpatient medication-assisted treatment (MAT) providers reported that they would treat pregnant women with SUD, but only 53 percent of those providers reported accepting pregnant women as patients. Wait lists (up to 384 days long) for inpatient treatment programs and a lack of parenting support (including resources, childcare, and skill-building coaching) within SUD treatment programs discourage women with children from accessing care. For women and their families, these barriers can be insurmountable.

How Stigma Reinforces Barriers to Care

Barriers to seeking and accessing appropriate care for pregnant and postpartum women with SUD include internalized or self-stigma, gender-based discrimination, lack of provider awareness or training, and gender-specific medical problems due to the confluence of drug use patterns and risk behaviors in women that are different from those of drug-using men. For example, providers may not offer MAT to pregnant women due to personal beliefs, or may operate from the outdated and incorrect assumption that women can't receive MAT during pregnancy. Many women with SUD who become pregnant may not be able to access regular prenatal care due to lack of transportation options, unstable housing, or lack of health insurance, or may forgo it out of fear of the potential involvement of child protective services and the possibility of losing custody of their infant after birth.

In many states, the criminal justice system is ill-equipped to appropriately respond to the circumstances of pregnant and postpartum women with SUD. Many jurisdictions still respond to SUD as a criminal offense, as opposed to a medical condition. For example, 44 states will prosecute women for substance use during pregnancy, while 24 states and the District of Columbia consider prenatal substance use as child abuse or neglect. Women have been arrested or have lost custody of their children after positive preliminary drug screening results (before follow-up testing had confirmed any initial results).

Pregnant and postpartum women struggling with SUD may also avoid or delay seeking care for fear of reproductive coercion. Driven by the negative connotations of mothers who use substances, well-

meaning programs have offered women cash as an incentive to accept postpartum long-acting reversible contraception (LARC) placement or sterilization. Multiple bills—most introduced in the 1990s during the push for welfare reform—would have required women to use LARC after giving birth to an infant who displayed signs of neonatal abstinence disorder or until she had been substance-free for a minimum of six months. Although these laws were not passed, the underlying values that animated them persist.

Recommendations

Several evidence-based or promising strategies may help jurisdictions improve care and treatment for pregnant and postpartum women with SUD. Jurisdictions can expand comprehensive treatment services and improve access to care by developing detox and rehabilitation programs and policies supporting the mother-infant dad (see right column). Jurisdictions can also develop and promote contact-based training and education programs for providers, medical students, and police officers or counselors. Educating both providers and patients about SUD can reduce harm and help pregnant and postpartum women with SUD to access needed services.

States with higher incidences of SUD among pregnant and parenting populations could benefit from implementing "policies and treatment programs to target reducing concomitant opioid and benzodiazepine use; increasing access to, and utilization of, MAT; and increasing access to medical insurance." Ultimately, additional research is needed to understand and destigmatize SUD and its causes, particularly for low-income women.

Because stigma is fueled by systematic prejudice and discrimination, policymakers should take care to not further marginalize this already vulnerable population. Developing and implementing systems of care that have multiple points of entry, encouraging informed and well-equipped providers, and fostering strong multi-sector referral relationships are all potential strategies for support. While pregnant and postpartum women grappling with SUD are often enmeshed in complex psychiatric, social, and environmental factors, experts say that destigmatizing them and their conditions will improve their ability to access SUD treatment, thereby dismantling the discrimination they face and helping to develop a better-resourced and more resilient population.

Supporting Pregnant and Parenting Women with Substance Use Disorder in Colorado

The Special Connections program in Colorado's Department of Health Care Policy and Financing has been providing gender-specific care to pregnant and postpartum women with SUD. It provides case management, counseling, and health education to low-income women struggling with SUD during pregnancy and for up to one year postpartum. Established in 1991, the program is co-managed by Health First Colorado (the state Medicaid agency) and Colorado Department of Human Services' Office of Behavioral Health. Originally, the program covered women for up to 60 days postpartum, but in 1997 the program used a 1915B waiver to extend the length of coverage. The program serves 150-200 women a year.

One of the most effective ways that Special Connections has circumvented the effect of stigma is by co-locating services. The program has found that providing MAT to parents within a pediatric practice or having a substance use counselor embedded in a federally qualified health center can make it more likely that someone who qualifies for the program would access it. Co-location also communicates that a provider is friendly and that the space is "safe."

Special Connections also developed and ran an extensive public relations campaign aimed at destigmatizing and demystifying treatment while also encouraging pregnant women to enroll in the program. The program's messaging is saturated with affirming, person-centered language that emphasizes clients' self-worth and the right to pursue a better, healthier life for themselves and their families.