International Journal of Drug Policy 120 (2023) 104153

Contents lists available at ScienceDirect

International Journal of Drug Policy

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

Commentary

In our responses to the overdose epidemic, we cannot forget pregnant and postpartum people

Brooke S. West [a,*], Sugy Choi [b], Mishka Terplan [c]

[a] Columbia University School of Social Work, United States
[b] Department of Population Health, New York University Langone Health, United States
[c] Friends Research Institute, United States

ARTICLE INFO

Keywords:
Maternal morbidity and mortality
Overdose
Health care providers
Stigma
Policy
Harm reduction

ABSTRACT

In 2021, there were over 100,000 drug overdose deaths in the United States (US). Death rates have increased faster among women than men, particularly among Black and Indigenous people. Although drug overdose is a leading cause of pregnancy-associated deaths, birthing people are rarely emphasized in discussions of overdose and research and services remain limited. Data show increases in drug use and deaths among women of child-bearing age, with risks continuing in the postpartum period. Harms experienced by birthing people who use drugs occur in the context of broader inequities in maternal morbidity and mortality that lead to disparate reproductive health outcomes. Shared structural antecedents (e.g. intersecting sexism and racism, stigma, and punitive policies) underlie overlapping epidemics of overdose and maternal morbidity and mortality. Here we discuss the unique challenges placed on birthing people who use drugs and make recommendations on how to mitigate harms by improving access to and delivery of quality care and addressing unjust policies and practices. We highlight the need for integrated health services, clearer guidelines rooted in equity, and the need for changes to policy and practice that support rather than punish. To better serve individuals and families impacted by substance use, we need multilevel solutions that advance gender equity and racial justice to reshape and/or dismantle the systems that undergird oppression.

Introduction

In 2021, there were over 100,000 drug overdose deaths in the United States (US) (Hedegaard, Miniño, Spencer, & Warner, 2021). Although women are less likely than men to experience overdose, death rates have increased faster among women (Scholl et al., 2019). Mortality rates were highest among Indigenous women; yet, steep increases were most pronounced for Black women, increasing 144% between 2015 and 2020 (Hedegaard, Miniño, Spencer, & Warner, 2021), highlighting stark disparities. As we grapple with how to comprehensively respond to overdose, we must pay attention to those who have been systematically left behind and/or unjustly targeted. This includes pregnant and postpartum people who use drugs. Although drug overdose is now a leading cause of 'pregnancy-associated deaths'(Campbell et al., 2021), birthing people are rarely emphasized in discussions of overdose and research and services remain limited, largely as a result of structural sexism (i.e. discriminatory beliefs and practices on the basis of gender rooted in the organization of society that lead to disparities in power, resources and opportunities (Javidan, 2021)) that is heightened during periods of reproduction (Rosenthal & Lobel, 2020).

Data show an increase in both drug use and deaths among women of child-bearing age in the US (Smith & Lipari, 2017); from 1999 to 2014, the number of people with an opioid use disorder (OUD) at labor and delivery quadrupled (Haight et al., 2018). Drug-related risks continue in the postpartum period, with overdose rates peaking 7-12 months post-delivery, even among people *without* an OUD in the year before delivery (Schiff et al., 2018). Harms experienced by birthing people who use drugs occur in the context of broader structurally-driven inequities (i.e. disparities in health that are unfair and stem from structural injustices (National Heart & Lung, 2023)) in maternal morbidity and mortality (MMM): Black women are 2-3x more likely to die of pregnancy-related causes than White women (Petersen et al., 2019) and to experience severe maternal morbidity (Admon et al., 2018). Although the prevalence of OUD at birth among Black, Indigenous and Hispanic people is a quarter to a half that of non-Hispanic White people (Admon et al., 2018), as we describe below, racist practices and policies around

* Corresponding author at: Columbia University School of Social Work, 1255 Amsterdam Ave., United States.
E-mail address: bsw2110@columbia.edu (B.S. West).

https://doi.org/10.1016/j.drugpo.2023.104153

Available online 10 August 2023

perinatal substance use primarily impact non-white individuals, creating inequities in care experiences, like perinatal care engagement and provider interactions, and outcomes, like maternal morbidity and mortality.

Shared structural antecedents, especially intersecting sexism and racism (i.e. macro-level conditions that limit opportunities, resources, power and well-being based on race and/or ethnicity (National Institute of Minority Health & Health Disparities), underlie overlapping epidemics of overdose and MMM (Drake et al., 2020; Leonard et al., 2019). Historically, the bodies of women and other birthing people have long been sites of social control, especially during pregnancy, birthing, and afterwards (Crear-Perry et al., 2021), but this is even more true for people who use drugs because they are seen as deviating from gendered expectations of motherhood (Nichols et al., 2021; Radcliffe, 2011). The use of drugs while pregnant or parenting is seen, by many, as immoral and as evidence of being "selfish" or a "bad mother" (Radcliffe, 2011), rather than deserving of support, making them subject to greater reproductive control and stigma (Nichols et al., 2021). Threats to the health and rights of perinatal people who use drugs impact access to and engagement in health and social service systems, as well as the delivery of quality care, and are deeply rooted in punitive policies and practices (Open Society Foundation, 2018). Here we discuss the unique challenges placed on birthing people who use drugs and make recommendations on how to mitigate drug-related MMM, including overdose, by centering pregnant and postpartum people.

Access to and engagement in health and social services and quality clinical care

Central to the goal of reducing drug-related MMM is improved access to and engagement in quality evidence-based substance use disorder (SUD) treatment, overdose prevention and response, and reproductive health care. Despite need, the majority of perinatal people with SUD do not receive comprehensive care (e.g. SUD treatment, medication for opioid use disorder (MOUD), behavioral health/social support services), heightening the risk for negative outcomes for parent and child (Ecker et al., 2019). The availability of SUD treatment is limited, broadly (Blevins et al., 2018), but there is a notable lack of gender-tailored services for pregnant people and people with new babies (e.g. family-based residential treatment) (Meinhofer et al., 2020; Terplan et al., 2015). Access to overdose response also differs; a study in emergency departments showed that pregnant people had lower odds of receiving naloxone compared with non-pregnant reproductive-aged women (Forbes et al., 2021). Limited access to services stems, in part, from the siloing of SUD treatment and harm reduction from reproductive health services, which prevents integrated clinical and social services (Kroelinger et al., 2019; MacAfee et al., 2020). As reproductive health care focuses primarily on the prenatal period, we also miss longer-term postnatal/parenting needs (Phillips et al., 2023), which inhibits continuity of care during a time when overdose risk is elevated.

The delivery of quality care is further hindered by limited provider time, training, and knowledge, which makes it challenging to identify people with SUD and deliver appropriate care, especially as the needs of perinatal people who use drugs can be complex (Kroelinger et al., 2019). Most health care providers do not have specialized training in addiction medicine and/or harm reduction and limited ability to access specialty services that are important for pregnant and lactating individuals (Forbes et al., 2021). Guidelines on perinatal care for people who use drugs exist (e.g. Substance Abuse and Mental Health Services Administration (Substance Abuse & Mental Health Services Administration, 2018), *American College of Obstetricians and Gynecologists* (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017)), but they are focused primarily on clinical care with less emphasis on structural needs and inequities (e.g. family separation and social/economic support), missing the longer terms needs of new parents and early child development (Guille et al., 2022).

Even when services are available, however, experiences of stigma and discrimination lead to fear and mistrust of providers, and negatively affect care engagement, especially for individuals placed in positions of marginality (Morton et al., 2023; Nichols et al., 2021; Stone, 2015). Stigma towards people who use drugs is ubiquitous and pervasive in health and social service settings (Stone, 2015; Van Boekel et al., 2013). These experiences are compounded for pregnant and parenting people due to structural sexism and racism that manifests as provider bias, discrimination, and even refusal of services, all of which affect the quality of care received and the likelihood that services are uitlized (Stringer & Baker, 2018; Van Boekel et al., 2013). For instance, in a study of providers and cannabis counseling during pregnancy, Black patients were 10 times more likely to receive punitive messages than White people (Holland et al., 2016). Due to the nature of family regulation or policing systems, which are terms used instead of "child welfare" to more accurately describe the way these unjust systems operate as tools of oppression (Roberts, 2009), providers are tasked to report patient behavior, which complicates care provision. Poor treatment, or even the expectation of stigma (Stringer & Baker, 2018), especially fears of child removal, prevents care seeking and decreases the likelihood of disclosure of substance use, increasing the risk of drug-related MMM (Morton et al., 2023; Open Society Foundation, 2018). Understanding and addressing stigma in health and social services settings is thus necessary to improve perinatal care delivery and reduce overdose.

Implementation and interpretation of punitive policies

Many of these challenges stem from punitive policies targeting perinatal people who use drugs. For instance, although drug toxicology testing is recognized as controversial by leading organizations (e.g. ASAM, ACOG) (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017), it is frequently used in perinatal health settings (Kurtz & Smid, 2022; Polak et al., 2019). Currently, there are no national guidelines around testing (Kurtz & Smid, 2022), resulting in variability in whether and how testing is implemented (e.g. with/-without informed consent) and in substantial inequities (Tiako & Sweeney, 2022): Black pregnant people and newborns, in particular, are more likely to be drug tested and tested without consent than their White counterparts (Perlman et al., 2022). This does not represent differences in drug use patterns, or harm to fetuses or children, but in who is targeted for testing, which stems from intersectional racism and sexism, stigma and mistrust of people who use drugs, staff discomfort, and insufficient staff training and/or knowledge (Roberts & Nuru-Jeter, 2012). Drug testing is ineffective in a range of ways, including that many providers do not know how to accurately interpret test results (Chua et al., 2020) and providers also report not having necessary resources for referrals and/or care coordination (Roberts & Nuru-Jeter, 2012). The result of biases in testing is differential engagement with family regulation systems and a greater likelihood of family separation (Tiako & Sweeney, 2022). If the goal of testing is to link people to services like treatment, rather than punishment, testing is not necessary to do that. Given inequities in how drug testing has been applied, and the harms it has caused (Perlman et al., 2022; Tiako & Sweeney, 2022); many states are moving towards requirements of informed consent and some are shifting their focus to universal verbal drug screening instead (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017; Roberts & Nuru-Jeter, 2012).

Many states have laws mandating that providers report perinatal drug use to child services; the number of states with such mandatory reporting laws increased in recent years (Jarlenski et al., 2017). Under these regulations, health and social service providers use results of drug screening or testing of parent or child, or their own sense of *suspected* substance use, to report individuals. However, providers have considerable discretion in reporting, so decisions may be guided by stigma, fears of liability, limited knowledge, or by a dearth of better alternatives (Jarlenski et al., 2019; Roberts & Nuru-Jeter, 2012). Black and

Indigenous individuals, in particular, are much more likely to be reported to child services (Kurtz & Smid, 2022; Roberts et al., 2015). The consequences of these reports are profound and may lead to criminal charges and/or to the removal of children (Roberts & Pies, 2011), but can also have social and economic costs (e.g. parent may end up on a state central registry for years that that can affect employment opportunities (Henry & Lens, 2021)) that prevent people from caring for their families. Child removal also has a negative impact on the health of parents (e.g. reduced access to prenatal care in subsequent pregnancies, increased risk of postpartum depression/anxiety, and avoidable mortality, including overdose and suicide) and children (e.g. lower school readiness, increased absenteeism, and poorer academic performance and social development at school) (Kenny et al., 2015; Wall-Wieler et al., 2017). Unsurprisingly, perinatal people who use drugs often fear disclosure of drug use in care settings and may opt to avoid treatment for themselves and their children (Stone, 2015; Van Boekel et al., 2013).

The reach of punitive policies associated with perinatal substance use is substantial and growing. The number of states that consider substance use during pregnancy to be child abuse under civil 'child welfare' statutes is increasing and as of 2022, 24 states and Washington DC had implemented drug-related child abuse regulations (Guttmacher). Such policies, whose stated intents are to reduce harm to fetuses or infants, instead apply a criminal frame to a public health problem, and in doing so, negatively impact both parent and child (Open Society Foundation 2018). For instance, pregnant people living in states that have more punitive drug-related policies have decreased access to MOUD (Angelotta et al., 2016). These policies also counteract supportive policies: although Medicaid expansion increased access to MOUD for pregnant people, states with punitive policies toward pregnant people who use drugs had more limited effects (Choi et al., 2021). Ultimately, policies that serve to punish perinatal people for drug use make it harder to identify and then provide health and social services to people who may really need them.

Recommendations

There is an urgent need to expand research and develop immediate programmatic and policy responses that support rather than harm perinatal people and their families during this critical period. In particular, the development and expansion of tailored SUD treatment and harm reduction programs for perinatal people is essential to increasing access to and engagement in care and mitigating overdose and other harms (MacAfee et al., 2020). This includes opportunities to advance more equitable care through the expansion of low threshold MOUD for pregnant and postpartum people (Austin et al., 2023). Expansion of MOUD has been shown to reduce overdose (Larochelle et al., 2018); however, many barriers to access exist, including that Medicaid ends 60 days postpartum in many states, which may lead to MOUD discontinutation (Frankeberger et al., 2023). The "fourth trimester" is particularly important for overdose prevention as around half of people discontinue MOUD within six months of delivery (Wilder et al., 2015). Evidence suggests that expanding postpartum Medicaid coverage to at least a year, as some states are doing, is an important tool for improving continuity of care (Daw et al., 2020), which would benefit families impacted by drug use. The expansion of MOUD is especially important for Black and Latino people who use drugs given recent data showing significant racial/ethnic differences in receipt of prenatal MOUD (Austin et al., 2023; Peeler et al., 2020).

Alongside this, allowing individuals to take home MOUD for longer periods of time, building opportunities for the delivery of medications, and increasing the availability of telemedicine (Tiako, 2021; Wang et al., 2021) could be important for new parents and for addressing inequities (Tiako, 2021). The expansion of other harm reduction tools is also essential for preventing and responding to overdose during pregnancy and postpartum (Hawk et al., 2015; Volkow, 2022; Wolfson et al., 2021). For instance, naloxone distribution or co-prescribing is standard of care recommended by Perinatal Quality Collaboratives at birthing hospital discharge (Duska & Goodman, 2022), but this is likely underutilized. Expanding naloxone distribution during prenatal and postpartum visits, which could be supported by training home visit workers, may also be beneficial (Duska & Goodman, 2022; Nidey et al., 2023).

To make these changes, however, and improve access to and engagement in services for perinatal people who use drugs, we need to reimagine how our health and social services work together while also focusing on the creation of a stronger continuum of care. Breaking down siloes around SUD treatment and reproductive health is essential (MacAfee et al., 2020), but also involves building horizontal structures, or spaces between clinical spaces, where patient navigators, peers, and/or teleservices operate to support access to comprehensive care, from pregnancy through birthing and parenting. Pregnancy and postpartum is a critical time for intervention due to increased motivation and likelihood of engagement in care; yet, our focus on pregnancy, and primarily on fetuses, misses longer-term maternal and child health (Tully et al., 2017). Extended follow-up periods of care are necessary as risk of overdose peaks 7-12 months after giving birth (Schiff et al., 2018), which is long after standard postnatal care is provided and after many supportive resources, like Medicaid, end (Daw et al., 2020). This could come in the form of home visits for new families, for example, where mental health and substance use needs are assessed and linkage to services like SUD treatment are made (O'Malley et al., 2021). Expanding the scope of care across all phases of pregnancy and parenting would decrease drug-related MMM, including overdose, by creating more touchpoints of prevention and bridges to comprehensive health and social services (Tully et al., 2017).

To facilitate the expansion of comprehensive and ethical care across the pregnancy, birthing and parenting continuum, health and social service providers are in need of additional training in harm reduction and addiction medicine (Van Boekel et al., 2013; Weber et al., 2021). This includes the development of culturally competent prevention and treatment (Marsh et al., 2009) to reduce institutional and provider racism, stigma, and discrimination and create more equitable care (Campbell et al., 2009; Tiako, 2021). Mitigating experiences of stigma and discrimination within health and social service settings as it relates to perinatal substance use will allow us to develop programs that reduce drug-related MMM, (Weber et al., 2021) particularly among Black, Indigenous and Latino populations, through improved access to and engagement in quality evidence-based addiction and childbirth services (Marsh et al., 2000). All services must also employ patient-centered and trauma-responsive approaches to support pregnant and postpartum people who use drugs (Weber et al., 2021) who often have complex trauma histories and continuing adversities from childhood through adulthood (Dansky et al., 1996).

Our responsiveness needs to be bolstered by clear guidelines that promote equity rather than unjustly target perinatal people who use drugs. For instance, there is a need for national drug testing guidelines that state testing is *only* recommended in the context of very specific protocols that delineate clinical utility (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017). Alternatively, drug screening may be employed, but there remains a need to adjust our current approaches to enhance equity and effectiveness (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017; Polak et al., 2019; Roberts & Nuru-Jeter, 2012). Drug screening that is delivered universally and in the context of trauma-informed care can set the stage for linkages to needed care (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017); however, this same goal could be achieved by simply offering treatment or other services *without* screening. Of particular importance, any testing or screening must rest on the right of refusal and providers need to be transparent about how information is shared (Commitee on Obstetric Practice, & the American Society of Addiction Medicine, 2017). Currently, a positive drug test or screen sets off a cascade of events, including reporting to child services, that can ultimately lead to family separation (Tiako &

Sweeney, 2022). This rightly leads people who use drugs to view our healthcare systems as carceral, which defeats the goals of ensuring maternal and child well-being and increases overdose risk (Austin et al., 2022; Tiako & Sweeney, 2022). We must also, therefore, shift our perspectives and policies on mandatory reporting, which ask providers to be police and to be deputized as part of these carceral family regulation systems. Part of this is creating clearer protocols clarifying that parental substance use does not equate to abuse, but this must go hand in hand with dismantling current child "welfare" systems, which act as a system of family regulation and are thus antithetical to the goals of supporting families.[72] Instead, enhancing our service capacity through integration and the expansion of specialty services could strengthen families and uphold their health and rights.

The expansion of care must also occur in the context of broad shifts in policy that move away from punitive approaches. For instance, repealing 'fetal assault' laws, which have been employed to target largely Black and Indigenous individuals, is not only just, but also results in better outcomes for perinatal people and their children (Guttmacher), including overdose prevention. More broadly, there is a fundamental need to move away from carceral systems in our responses to substance use. Legalization and regulation of all drugs could decrease the toxic drug supply that is driving the overdose epidemic and also allow for the redistribution of funding toward stronger health and service systems (Csete & Elliott, 2021; Earp et al., 2021). This would also help to reduce the stigma associated with substance use and increase care engagement for perinatal people who use drugs. As the war on drugs hinges on the tenets of anti-Black racism, directly responding to systemic racism in our health and social services is also necessary (Earp et al., 2021), which could be supported by the advancement of reproductive justice (Sister Song Women of Color Reproductive Justice, 2022). Reproductive justice involves centering the most marginalized to analyze power systems and address intersecting oppressions that undermine reproductive rights (Sister Song Women of Color Reproductive Justice, 2022), which is integral to shifting the landscape for perinatal people who use drugs.

As we struggle to get ahead of the overdose crisis, we cannot forget pregnant and postpartum people. Both overdose and MMM are largely preventable, but we are failing in our responses. To better serve individuals and families impacted by substance use, we need multilevel solutions that advance gender equity and racial justice to reshape and/or dismantle the systems that undergird oppression.

Ethics approval

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

Funding sources

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

CRediT authorship contribution statement

Brooke S. West: Conceptualization, Supervision, Writing – original draft, Writing – review & editing. **Sugy Choi:** Conceptualization, Writing – original draft, Writing – review & editing. **Mishka Terplan:** Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Admon, L. K., Winkelman, T. N., Zivin, K., Terplan, M., Mhyre, J. M., & Dalton, V. K. (2018). Racial and ethnic disparities in the incidence of severe maternal morbidity in the United States, 2012–2015. *Obstetrics & Gynecology, 132*(5), 1158–1166.

Angelotta, C., Weiss, C. J., Angelotta, J. W., & Friedman, R. A. (2016). A moral or medical problem? The relationship between legal penalties and treatment practices for opioid use disorders in pregnant women. *Women's Health Issues, 26*(6), 595–601.

Austin, A. E., Naumann, R. B., & Simmons, E. (2022). Association of state child abuse policies and mandated reporting policies with prenatal and postpartum care among women who engaged in substance use during pregnancy. *JAMA Pediatrics, 176*(11), 1123–1130.

Austin, A. E., Durrance, C. P., Ahrens, K. A., et al. (2023). Duration of medication for opioid use disorder during pregnancy and postpartum by race/ethnicity: Results from 6 state Medicaid programs. *Drug and Alcohol Dependence, 247*, Article 109868.

Blevins, C. E., Rawat, N., & Stein, M. D. (2018). Gaps in the substance use disorder treatment referral process: Provider perceptions. *Journal of Addiction Medicine, 12*(4), 273.

Campbell, C. I., Alexander, J. A., & Lemak, C. H. (2009). Organizational determinants of outpatient substance abuse treatment duration in women. *Journal of Substance Abuse Treatment, 37*(1), 64–72.

Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *Journal of Women's Health, 30*(2), 236–244.

Choi, S., Stein, M. D., Raifman, J., Rosenbloom, D., & Clark, J. A. (2021). Estimating the impact on initiating medications for opioid use disorder of state policies expanding Medicaid and prohibiting substance use during pregnancy. *Drug and Alcohol Dependence, 229*, Article 109162.

Chua, I., Petrides, A. K., Schiff, G. D., et al. (2020). Provider misinterpretation, documentation, and follow-up of definitive urine drug testing results. *Journal of General Internal Medicine, 35*, 283–290.

Commitee on Obstetric Practice, & the American Society of Addiction Medicine. (2017). *Opioid Use and Opioid Use Disorder in Pregnancy*. The American College of Obstetricians and Gynecologists (Series Editors). ACOG Committee Opinion Number, 711.

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health, 30*(2), 230–235.

Csete, J., & Elliott, R. (2021). Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction. *International Journal of Drug Policy, 91*, Article 102976.

Dansky, B. S., Brady, K. T., Saladin, M. E., Killeen, T., Becker, S., & Roitzsch, J. (1996). Victimization and PTSD in individuals with substance use disorders: Gender and racial differences. *The American Journal of Drug and Alcohol Abuse, 22*(1), 75–93.

Daw, J. R., Winkelman, T. N., Dalton, V. K., Kozhimannil, K. B., & Admon, L. K. (2020). Medicaid expansion improved perinatal insurance continuity for low-income women: Study examines the impact of state Medicaid expansions on continuity of insurance coverage for low-income women across three time points: Preconception, delivery, and postpartum. *Health Affairs, 39*(9), 1531–1539.

Drake, J., Charles, C., Bourgeois, J. W., Daniel, E. S., & Kwende, M. (2020). Exploring the impact of the opioid epidemic in Black and Hispanic communities in the United States. *Drug Science, Policy and Law, 6*. https://doi.org/10.1177/2050324520940428

Duska, M., & Goodman, D. (2022). Implementation of a prenatal naloxone distribution program to decrease maternal mortality from opioid overdose. *Maternal and Child Health Journal, 26*(5), 985–993.

Earp, B. D., Lewis, J., Hart, C. L., & Bioethicists w, Reform APfDP. (2021). Racial justice requires ending the war on drugs. *The American Journal of Bioethics, 21*(4), 4–19.

Ecker, J., Abuhamad, A., Hill, W., et al. (2019). Substance use disorders in pregnancy: Clinical, ethical, and research imperatives of the opioid epidemic: A report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology, 221*(1), B5–B28.

Forbes, L. A., Canner, J. K., Milio, L., Halscott, T., & Vaught, A. J. (2021). Association of patient sex and pregnancy status with naloxone administration during emergency department visits. *Obstetrics & Gynecology, 137*(5), 855–863.

Frankeberger, J., Jarlenski, M., Krans, E. E., Coulter, R. W., & Mair, C. (2023). Opioid use disorder and overdose in the first year postpartum: A rapid scoping review and implications for future research. *Maternal and Child Health Journal, 27*, 1140–1155.

Guille, C., Hall, C., King, C., Sujan, A., Brady, K., & Newman, R. (2022). Listening to women and pregnant and postpartum people: Qualitative research to inform opioid use disorder treatment for pregnant and postpartum people. *Drug and Alcohol Dependence Reports, 3*, Article 100064.

Guttmacher Institute. *Substance use during pregnancy*. US: Guttmacher Institute; September 1, (2022). 2022.

Haight, S. C., Ko, J. Y., Tong, V. T., Bohm, M. K., & Callaghan, W. M. (2018). Opioid use disorder documented at delivery hospitalization—United States, 1999–2014. *Morbidity and Mortality Weekly Report, 67*(31), 845.

Hawk, K. F., Vaca, F. E., & D'Onofrio, G. (2015). Focus: Addiction: Reducing fatal opioid overdose: Prevention, treatment and harm reduction strategies. *The Yale Journal of Biology and Medicine, 88*(3), 235.

Hedegaard, H., Miniño, A.M., Spencer, M.R., & Warner, M. (2021). Drug overdose deaths in the United States, 1999–2020. National Center for Health Statistics (U.S.), . https://stacks.cdc.gov/view/cdc/112340.

Henry, C., & Lens, V. (2021). Marginalizing mothers: Child maltreatment registries, statutory schemes, and reduced opportunities for employment. *CUNY L Rev, 24*, 1.

Holland, C. L., Rubio, D., Rodriguez, K. L., et al. (2016). Obstetric health care providers' counseling responses to pregnant patient disclosures of marijuana use. *Obstetrics and Gynecology, 127*(4), 681.
Jarlenski, M., Hogan, C., Bogen, D. L., Chang, J. C., Bodnar, L. M., & Van Nostrand, E. (2017). Characterization of US state laws requiring health care provider reporting of perinatal substance use. *Women's Health Issues, 27*(3), 264–270.
Jarlenski, M., Minney, S., Hogan, C., & Chang, J. C. (2019). Obstetric and pediatric provider perspectives on mandatory reporting of prenatal substance use. *Journal of Addiction Medicine, 13*(4), 258.
Javidan, P. (2021). Structural sexism: Foundations, reproduction, and responses. In: Al. WLFe, ed. *Reduced inequalities: Encyclopedia of the UN sustainable development goals*. Switzerland: Springer Nature.
Kenny, K. S., Barrington, C., & Green, S. L. (2015). "I felt for a long time like everything beautiful in me had been taken out": Women's suffering, remembering, and survival following the loss of child custody. *International Journal of Drug Policy, 26*(11), 1158–1166.
Kroelinger, C. D., Rice, M. E., Cox, S., et al. (2019). State strategies to address opioid use disorder among pregnant and postpartum women and infants prenatally exposed to substances, including infants with neonatal abstinence syndrome. *Morbidity and Mortality Weekly Report, 68*(36), 777.
Kurtz, T., & Smid, M. C. (2022). Challenges in perinatal drug testing. *Obstetrics & Gynecology, 140*(2), 163–166, 10.1097.
Larochelle, M. R., Bernson, D., Land, T., et al. (2018). Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: A cohort study. *Annals of Internal Medicine, 169*(3), 137–145.
Leonard, S. A., Main, E. K., Scott, K. A., Profit, J., & Carmichael, S. L. (2019). Racial and ethnic disparities in severe maternal morbidity prevalence and trends. *Annals of Epidemiology, 33*, 30–36.
MacAfee, L. K., Harfmann, R. F., Cannon, L. M., et al. (2020). Substance use treatment patient and provider perspectives on accessing sexual and reproductive health services: Barriers, facilitators, and the need for integration of care. *Substance Use & Misuse, 55*(1), 95–107.
Marsh, J. C., D'Aunno, T. A., & Smith, B. D. (2000). Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction, 95*(8), 1237–1247.
Marsh, J. C., Cao, D., & Shin, H-C. (2009). Closing the need—Service gap: Gender differences in matching services to client needs in comprehensive substance abuse treatment. *Social Work Research, 33*(3), 183–192.
Meinhofer, A., Hinde, J. M., & Ali, M. M. (2020). Substance use disorder treatment services for pregnant and postpartum women in residential and outpatient settings. *Journal of Substance Abuse Treatment, 110*, 9–17.
Morton, J., Vignato, J., & Anbari, A. B. (2023). Stigma experienced by perinatal women with opioid dependency in the United States: A qualitative meta-synthesis. *Western Journal of Nursing Research*. https://doi.org/10.1177/01939459231182495
National Heart, Lung, and Blood Institute. Health disparities and inequities. https://www.nhlbi.nih.gov/science/health-disparities-and-inequities#:~:text=Differences/0in/20health/20among/20population,injustice/20are/20called/20health/20inequities Accessed June 28, 2023, (2023).
National Institute of Minority Health and Health Disparities. Structural racism and discrimination. https://www.nimhd.nih.gov/resources/understanding-health-disparities/srd.html Accessed June 28, (2023), 2023.
Nichols, T. R., Welborn, A., Gringle, M. R., & Lee, A. (2021). Social stigma and perinatal substance use services: Recognizing the power of the good mother ideal. *Contemporary Drug Problems, 48*(1), 19–37.
Nidey, N., Lannon, C., Ford, S., Kaplan, H., Prasad, M., & Wilder, C. (2023). Naloxone education and receipt of kit during the perinatal period. *American Journal of Obstetrics & Gynecology, 228*(1), S208–S209.
O'Malley, D., Chiang, D. F., Siedlik, E. A., Ragon, K., Dutcher, M., & Templeton, O. (2021). A promising approach in home visiting to support families affected by maternal substance use. *Maternal and Child Health Journal, 25*, 42–53.
Open Society Foundation. (2018). *Expecting better: Improving health and rights for pregnant women who use drugs*. New York, NY: Open Society Foundations.
Peeler, M., Gupta, M., Melvin, P., et al. (2020). Racial and ethnic disparities in maternal and infant outcomes among opioid-exposed mother–infant dyads in Massachusetts (2017–2019). *American Journal of Public Health, 110*(12), 1828–1836.
Perlman, N. C., Cantonwine, D. E., & Smith, N. A. (2022). Racial differences in indications for obstetrical toxicology testing and relationship of indications to test results. *American Journal of Obstetrics & Gynecology MFM, 4*(1), Article 100453.
Petersen, E. E., Davis, N. L., Goodman, D., et al. (2019). *Vital signs: Pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017*. In . *68* p. 423).
Phillips, S. E., Celi, A. C., Wehbe, A., Kaduthodil, J., & Zera, C. A. (2023). Mobilizing the fourth trimester to improve population health: Interventions for postpartum transitions of care. *American Journal of Obstetrics and Gynecology, 229*(1), 33–38.
Polak, K., Kelpin, S., & Terplan, M. (2019).Screening for substance use in pregnancy and the newborn. Paper presented at: Seminars in Fetal and Neonatal Medicine.
Radcliffe, P. (2011). Motherhood, pregnancy, and the negotiation of identity: The moral career of drug treatment. *Social Science & Medicine, 72*(6), 984–991.
Roberts, S. C., & Nuru-Jeter, A. (2012). Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *The Journal of Behavioral Health Services & Research, 39*(1), 3–16.
Roberts, S. C., & Pies, C. (2011). Complex calculations: How drug use during pregnancy becomes a barrier to prenatal care. *Maternal and Child Health Journal, 15*, 333–341.
Roberts, S. C., Zahnd, E., Sufrin, C., & Armstrong, M. (2015). Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use? A California case study. *Journal of Perinatology, 35*(2), 146–150.
Roberts, D. (2009). *Shattered bonds: The color of child welfare*. Hachette: UK.
Rosenthal, L., & Lobel, M. (2020). Gendered racism and the sexual and reproductive health of Black and Latina Women. *Ethnicity & Health, 25*(3), 367–392.
Schiff, D. M., Nielsen, T., Terplan, M., et al. (2018). Fatal and nonfatal overdose among pregnant and postpartum women in Massachusetts. *Obstetrics & Gynecology, 132*(2), 466–474.
Scholl, L., Seth, P., Kariisa, M., Wilson, N., & Baldwin, G. (2019). Drug and opioid-involved overdose deaths—United States, 2013–2017. *Morbidity and Mortality Weekly Report, 67*(5152), 1419.
Sister Song Women of Color Reproductive Justice Collective. Reproductive Justice. (2022).; https://www.sistersong.net/reproductive-justice Accessed June 12, 2022.
Smith, K., & Lipari, R. (2017). Women of childbearing age and opioids. In *The CBHSQ report. Substance Abuse and Mental Health Services Administration (US)*.
Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice, 3*(1), 1–15.
Stringer, K. L., & Baker, E. H. (2018). Stigma as a barrier to substance abuse treatment among those with unmet need: An analysis of parenthood and marital status. *Journal of Family Issues, 39*(1), 3–27.
Substance Abuse and Mental Health Services Administration. (2018). *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
Terplan, M., Kennedy-Hendricks, A., & Chisolm, M. S. (2015). Article commentary: Prenatal substance use: Exploring assumptions of maternal unfitness. *Substance Abuse: Research and Treatment, 9*. https://doi.org/10.4137/SART.S23328
Tiako, M. J. N., & Sweeney, L. (2022). The government's involvement in prenatal drug testing may be toxic. *Maternal and Child Health Journal, 26*(4), 761–763.
Tiako, M. J. N. (2021). Addressing racial & socioeconomic disparities in access to medications for opioid use disorder amid COVID-19. *Journal of Substance Abuse Treatment, 122*, Article 108214.
Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: A critical transition period with unmet maternal health needs. *American Journal of Obstetrics and Gynecology, 217*(1), 37–41.
Van Boekel, L. C., Brouwers, E. P., Van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1-2), 23–35.
Volkow, N. D. (2022). Making addiction treatment more realistic and pragmatic: The perfect should not be the enemy of the good. *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20211221.691862
Wall-Wieler, E., Roos, L. L., Bolton, J., Brownell, M., Nickel, N. C., & Chateau, D. (2017). Maternal health and social outcomes after having a child taken into care: Population-based longitudinal cohort study using linkable administrative data. *Journal of Epidemiology and Community Health, 71*(12), 1145–1151.
Wang, L., Weiss, J., Ryan, E. B., Waldman, J., Rubin, S., & Griffin, J. L. (2021). Telemedicine increases access to buprenorphine initiation during the COVID-19 pandemic. *Journal of Substance Abuse Treatment, 124*, Article 108272.
Weber, A., Miskle, B., Lynch, A., Arndt, S., & Acion, L. (2021). Substance use in pregnancy: Identifying stigma and improving care. *Substance Abuse and Rehabilitation, 12*, 105–121.
Wilder, C., Lewis, D., & Winhusen, T. (2015). Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder. *Drug and Alcohol Dependence, 149*, 225–231.
Wolfson, L., Schmidt, R. A., Stinson, J., & Poole, N. (2021). Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. *Health & Social Care in the Community, 29*(3), 589–601.