

***Accessing Medication-Assisted Treatment While Pregnant  
in Baltimore City: “She wouldn’t do well here”***

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## Preface

While people who are pregnant do not have different rates of illicit drug use across racial categories, most of our public rhetoric and cultural imagination would have us believe otherwise. This public rhetoric would also have us believe that parents or pregnant people who use drugs are to be punished and are not worthy of family connections. This idea is largely applied to Black parents and families and is thus a horrifying example of the structural racism in U.S. society.

Service-provision from prenatal care to early childhood education is often expected to be punitive--this is particularly true for patients from historically oppressed communities. The service recipient is in constant threat of being labeled "non-compliant" or making choices that are "against medical advice" or otherwise a "danger" to their child. This labeling and subsequent actions ignore the danger that the system, and sometimes that the provider herself, puts the person or family in. Students of reproductive justice will recognize the ways in which these labels are used to take away the rights of individuals and communities, the consequences of which ripple into future generations.

I continue to be dismayed at what I perceive to be a disconnect between harm reduction, 'recovery,' and reproductive justice movements, organizations, and advocates. Within reproductive justice work, people who use drugs are most often mentioned in conversations of abortion and contraception access, yet they are largely absent from discussions of pregnancy and fertility services. Mention of abortion care within 'recovery' and harm reduction spaces often sparks discomfort and fertility services are rarely up for discussion at all. In all of these arenas, touching on the overlap of drug use and pregnancy often makes us squirm—we can feel our largely unexplored judgments surfacing and thus we shut the conversation off. I imagine this disconnect and sense of taboo topics is largely to do with the intensity of moral judgment we are encouraged to foster around drugs and pregnancy or parenting.

I hope that we can have these necessary conversations, and move towards having a comprehensive care landscape that benefits the residents of Baltimore who have been abused by systems of care for generations. This is part of the reason why we—at BHRC—wanted to explore access to MAT services in Baltimore City for people who are pregnant. This is a small way to better understand how to improve our City for people who use drugs and are otherwise targeted by the racist war on drugs. Access to these services does not ensure compassionate, helpful, and appropriate care once enrolled, nor does it tell us much about how various services overlap and cooperate. This is a sliver of the exploration needed to fully honor the needs of oppressed and stigmatized people and to repair the system to do better for generations to come. The role of racism, classism/capitalism, sexism and other oppressions in the care of people who are pregnant and use drugs is not well-explored in this brief analysis of the Baltimore City MAT landscape. It is crucial that we (and others) explore this more as discussion deepens and moves towards action.

Our intention is to focus on a concrete and relatively narrow piece of the puzzle. This will inform what we explore next and how we can collectively build more demand for a deep, honest, and meaningful move towards reparations for harm perpetrated. We can and must build new ways of caring for each other that are resourced and honorable.

Many thanks to Dr. Dorothy Roberts and Mamas of Color Rising for their thought-work and action.

- Harriet Smith, Baltimore Harm Reduction Coalition

## Introduction

Accessing medication-assisted treatment (MAT) during pregnancy and while parenting young children can be challenging due to a variety of barriers, including provider biases, provider and system obstacles, lack of child care services, and the social expectations of pregnancy and parenting—including social stigma that gets internalized. In creating this report, we hope to better understand these barriers hindering access to medication assisted treatment (also known as medication assisted recovery or opioid replacement therapy). We hope to mobilize providers, community members, and other stakeholders to consider their roles in creating or limiting this access and to keep asking ourselves: How can we better support pregnant and parenting individuals who use drugs?

In this report we have tried to pay specific attention to the language used to discuss pregnancy and reproductive health. It is typical for discussions about pregnancy and parenting to include gendered language—'women,' 'maternal,' 'mothers,' etc. While most people who become pregnant identify as women, there are transmen, non-binary, genderqueer, and other trans people who do get pregnant, give birth, and become parents. There is little formal 'counting' or research on people who become pregnant but do not identify as women. We do our best in this report to use gender inclusive language—such as 'people who are pregnant,' 'parents,' and 'birth parent'—even though health services and healthcare research about pregnancy are gendered.

We include the following sections in our report:

- *Looking at history: What informs our understanding of pregnancy and parenting?*
- *Substance Use and Pregnancy*
- *Importance of MAT Accessibility*
- *What stands in the way of accessing MAT?*
- *Digging Deeper: Cold Calling Services in the City*
- *Reflections*
- *Conclusions*
- *Acknowledgments*
- *Glossary of Acronyms*
- *Bibliography and Further Reading*

### **Looking at history: What informs our understanding of pregnancy and parenting?**

To better understand what informs our present day views on pregnancy and parenting, we will be offering a brief overview of relevant history and cultural shifts. Since we will be skimming a very deep, complicated history, we encourage you to look deeper into how systems of oppression continue to define and shape the healthcare field—affecting everyday protocols, patient hesitancy towards seeking out care, and the struggle of advocating for oneself as a patient.

Racist ideas surrounding pregnancy and parenting in the United States came to life during the colonization of this land and during times of enslaving Afrikan people. Enslaved Black mothers were seen as nurturers only when under the supervision and control of white enslavers, particularly the white wives of plantation owners. The mythology of Black mothers as negligent and careless took root in this time period and continues today. This framework hopes to blame Black childrens' poor health on parental

carelessness instead of on the physical and mental traumas of slavery and continued racial violence from then to the present.<sup>1</sup> The very ideal of motherhood—staying at home, caring for one’s children, and relying on the husband’s wages—was created with white, middle-class women in mind. As Dorothy Roberts writes, “The ideal of motherhood confined to the home and opposed to wage labor never applied to Black women and made them appear deviant and neglectful.”<sup>2</sup> The very structure of the devaluation of the labor of Black people often prohibits a two parent household from having only one wage earner. While views about the ideal mother have changed some, the notion of neglectful Black families has stuck. Thus, while white parents may sometimes have the freedom to be seen and judged for who they are, Black parents are held to impossible standards. Policy decisions are made from these assumptions—even policies that never mention race. Coded language may take the place of more explicit language, but the impacts are nevertheless felt.

We can see how the notion of the ‘careless Black mother’ still carries weight in how pregnancy and parenthood are treated today for Black people. One pervasive example of this is the trope of ‘crack mothers’ and ‘crack babies’. This myth resulted from the 1980s crack-cocaine media frenzy and political rhetoric from the Reagan-Bush era. Crack-cocaine became almost exclusively linked to Black people and then sensationalized by the media as a plague on modern American society.<sup>3</sup> In 1986, six of the largest U.S. news sources published over 1,000 stories about crack cocaine, three major TV networks ran 74 stories about crack cocaine in 6 months, and 15 million Americans watched the CBS documentary “48 Hours on Crack Street.”<sup>4</sup> Preliminary reports on the effects of crack cocaine were misleading, particularly those focusing on the long-term effects of prenatal exposure to crack cocaine on childhood outcomes.<sup>5</sup> Much of this research has since been disproven, but did little to reverse the portrayal of ‘crack babies’ as permanently damaged and unloved, and the portrayal of pregnant women who use drugs as “depraved, inner-city African-American women who voluntarily ingested crack to poison their children.”<sup>6</sup> Thus, hysteria over crack cocaine overlapped with the ‘fetal-rights’ movement, which sought to end legal abortion and criminalize parents and pregnant people.<sup>7</sup>

During this era, women became subject to increased policymaker interest in reproductive health, stemming from the belief that they were causing harm to a fetus. Heightened focus on substance use during pregnancy often exaggerated the effects of such drug use on children’s fetal and childhood development. In the US, many children who test positive for certain drugs at birth were deemed abused by their parents, leading local authorities to remove children from parental custody.<sup>8</sup> Drug testing newborns and their parents is more likely to be conducted on Black families and families receiving some form of public assistance.<sup>9</sup> This disparity in who is suspected is the norm despite similar rates of illicit and illicit substance use among Black and white pregnant people (we have less data on people of other races).<sup>10</sup> The public fear of ‘crack babies’ combined with the cultural vitriol surrounding Black women—especially those that may use substances—created the public perception that all pregnant people who use substances are Black and that Black pregnant people should be suspected of substance use.

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<sup>1</sup> Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (New York: Basic Civitas Books, 2002)

<sup>2</sup> *Ibid.*, pg. 62

<sup>3</sup> Craig Reinerman and Harry G. Levine, *Crack in America: Demon Drugs and Social Justice* (Berkeley: University of California Press, 1997)

<sup>4</sup> *Ibid.*

<sup>5</sup> Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997)

<sup>6</sup> Drew Humphries, “Crack Mothers at 6: Prime-Time News, Crack/Cocaine, and Women,” *Violence Against Women* 4, no. 1 (February 1998): 45-61. <https://doi.org/10.1177/1077801298004001004>

<sup>7</sup> Laura Gómez, *Miscegenating Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure* (Philadelphia: Temple University Press, 1997)

<sup>8</sup> *Ibid.*, pg. 50

<sup>9</sup> Roberts, *Shattered Bonds*

<sup>10</sup> Gómez, pg. 63

Ever increasing unpopularity of government programs seeking to benefit poor people, amongst white and wealthier constituents, was stoked by racial integration of the social welfare system in the 1970s. This continues to affect federal and state policy, as well as cultural notions of good and bad parenting. Both maltreatment of and lack of resources for children are often seen as an individual failing of parents, rather than a societal failure. This and other beliefs play into the stereotype of the ‘welfare queen,’ which relies on the assumption that welfare recipients—assumed only to be poor Black mothers—cannot be trusted to spend their meager financial assistance well. This trope was used as a tactic to erode social safety net services and led to a policy shift that placed even more children in the foster care system. This significant increase in punitive involvement via child welfare agencies targeted Black families, placing scores of Black youth into foster care as their parents were deemed ‘unfit’ to provide for them. According to a report published by the Administration for Children and Families in 2000, 42% of all children in foster care are Black, though Black youth make up only 17% of the national population.<sup>11</sup> The impact of centuries of violence perpetrated on Black families and after emancipation the subsequent policies that aimed to continue disrupting Black familial relationships is devastating.

The racist impact of these systems is bolstered by assumptions about drug use and criminalization of a number of substances. Since laws began punishing pregnant people for fetal harm, there have been hundreds of documented arrests for prenatal drug exposure. Most of these arrests are of low-income women of color.<sup>12</sup> Healthcare staff use intensified scrutiny to monitor and surveil Black patients (particularly women) during routine and specialty care. To this day, many hospitals continue to operate under selective policies in which they test only Black infants for signs of exposure to substances during pregnancy or childbirth.<sup>13</sup> Despite little difference between providers identifying substance use during pregnancy for Black and white women, Black newborns are four times more likely than white newborns to be reported to Child Protective Services (CPS) at delivery.<sup>14</sup> Reporting disparities persist despite the adoption of prenatal substance use protocols—a 2015 study found that a hospital protocol was not reducing reporting disparities, since nearly five times more Black newborns were reported to CPS than white newborns.<sup>15</sup> This monitoring occurs post-pregnancy, as well.

As we have briefly touched on here, seeking out public services, particularly substance use treatment services and prenatal care, opens a door for heightened scrutiny and surveillance of family life, including questions of parental ‘fitness.’ By acknowledging that parents living in poverty and parents of color—particularly Black parents—are already hyper-surveilled by public institutions, we must also recognize the potential harms that come with self-identifying as a pregnant or parenting woman who uses drugs. Reaching out for substance use treatment services can result in intervention of child welfare services at or following birth, increasing the risk of losing children to the foster care system, and/or the possibility of criminal charges.

The historical trauma of the racist and classist ideals of motherhood and the violence faced by Black families in the U.S., during and after legal enslavement policies, continue to affect individual

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<sup>11</sup> Cited in Roberts, *Shattered Bonds*, pg. 8

<sup>12</sup> Flavin, Jeanne and Lynn M Paltrow, “Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense,” *Journal of Addictive Diseases* 29, no. 2 (2010): 231-44, accessed February 2020, <https://doi.org/10.1080/10550881003684830>

<sup>13</sup> Roberts, *Shattered Bonds*, pg. 72

<sup>14</sup> Roberts, Sarah CM and Amani Nuru-Jeter, “Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting,” *Journal of Behavioral Health Sciences & Research* 39, no.1 (2011): 3-16, accessed February 2020, <https://doi.org/10.1007/s11414-011-9247-x>

<sup>15</sup> Roberts, Sarah CM, Elaine Zahnd, Carolyn Sufrin, and Mary Anne Armstrong, “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, no. 2 (2015): 146-50, accessed February 2020, <https://doi.org/10.1038/jp.2014.168>

willingness to seek out support. We hope that providers of MAT and other substance-related services keep this historical and current context in mind. Identifying and addressing entrenched beliefs and deeply held biases—affecting how we act and how we make policies—is the starting point and a point we need to continually examine if we are to better support people who are pregnant, parents, and other caregivers, in a holistic manner.

## Substance Use and Pregnancy

The following paragraphs will briefly overview the research focused on the side effects of fetal exposure to commonly-used substances. However, we ask that you keep in perspective that many societal concerns with substance use during pregnancy have undoubtedly been shaped by racist and classist narratives, like those discussed above.

**Alcohol** use during pregnancy can lead to Fetal Alcohol Spectrum Disorders (FASD) that cause physical and mental ailments that range in severity.<sup>16</sup> Thus, abstaining from alcohol is recommended for people who are pregnant or trying to become pregnant.<sup>17</sup> **Tobacco/nicotine** is another legal drug that can cause health concerns during pregnancy. Nicotine readily crosses through the placenta and can have consequences for the fetus—exposure can increase risk of stillbirth, miscarriage, and low birth weight.<sup>18</sup> **Cannabis** use during pregnancy has been studied, but very few conclusions have been made. Erring towards caution, many medical professionals recommend that people who are pregnant abstain from using cannabis.<sup>19</sup>

**Stimulants**, such as cocaine and methamphetamine, used during pregnancy can have consequences for the pregnant person. Cardiovascular changes are expected in pregnancy, and stimulant use can intensify these changes, increasing the likelihood of preeclampsia, placental abruption, miscarriage, preterm labor, and related concerns.<sup>20</sup> **Caffeine** use during pregnancy is safe at moderate levels, around 1 - 2 cups of coffee a day.<sup>21</sup>

Fewer than 10% of **prescription medications** have enough information to accurately determine fetal risk, as people who are pregnant are rarely, if ever, included in trials to determine the safety of medications before approved.<sup>22</sup> Yet, 9 out of 10 people who are pregnant in the U.S. take a prescription medication<sup>23</sup>, many of whom receive recommendations from medical professionals to discontinue their medications for the benefit of the developing fetus. For mental health patients who are pregnant, this leads to relapse (return of severe symptoms) rates of 68% for those with major depressive disorder, 81-85% with bipolar disorder, and 50% with schizophrenia.<sup>24</sup> Not all medications, psychiatric or otherwise, lack sufficient research on fetal or maternal health outcomes. Selective serotonin reuptake inhibitors (SSRIs) are more widely studied and not recommended to use during pregnancy due to increased risk of miscarriage, preterm birth, and low birth weight.<sup>25</sup> Ultimately, given the variety of

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<sup>16</sup> National Institute on Drug Abuse (NIDA), *Substance Use in Women*, Rockville, MD: NIDA, 2018, accessed July 2019, <https://www.drugabuse.gov/node/pdf/18910/substance-use-in-women>

<sup>17</sup> Centers for Disease Control and Prevention, "Alcohol Use in Pregnancy," cdc.gov, CDC, March 2018, accessed July 2019, [https://www.cdc.gov/ncbddd/fasd/documents/fasd\\_alcoholuse.pdf](https://www.cdc.gov/ncbddd/fasd/documents/fasd_alcoholuse.pdf)

<sup>18</sup> NIDA, *Substance Use in Women*

<sup>19</sup> The American College of Obstetricians and Gynecologists (ACOG), *ACOG Committee Opinion 722: Marijuana Use During Pregnancy and Lactation*, Washington DC: ACOG, 2017, accessed July 2019, <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/10/marijuana-use-during-pregnancy-and-lactation>

<sup>20</sup> NIDA, *Substance Use in Women*

<sup>21</sup> Sara Morgan, Gideon Koren, and Pina Bozzo, "Is caffeine consumption safe during pregnancy?," *Canadian Family Physician* 59, no.4 (2013): 361-362, accessed July 2019, <https://www.cfp.ca/content/59/4/361.long>

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> Margaret Chisolm and Jennifer Payne, "Management of psychotropic drugs during pregnancy," *BMJ* 2016, 352: h5918, accessed July 2019, <https://doi.org/10.1136/bmj.h5918>

<sup>25</sup> Ibid.

pharmaceuticals available, the best practice is coordinated care between any prescribing physicians and an obstetrician.

The use of both prescription and illicit **opioids** during pregnancy is associated with a variety of outcomes depending on factors such as frequency of use and dosage during use. Fluctuating in and out of withdrawal, a common experience for people who experience opioid dependency (given often inconsistent availability) can negatively impact the pregnancy, especially placental functionality.<sup>26</sup> Consequently, medical professionals across specialty recommend the sole best practice for pregnant people using opioids is to begin treatment with suboxone or methadone to stabilize levels of opioids in the blood and prevent withdrawal.<sup>27</sup> Newborns who were exposed to opioids while in utero can experience neonatal abstinence syndrome (NAS).<sup>28</sup> NAS is a treatable, temporary condition in which the infant experiences withdrawal symptoms that can be eased with medication.<sup>29</sup> NAS is not life threatening and research suggests that infants recover significantly more quickly when they are breastfed, receive skin-to-skin contact, and medical care in the same hospital suite as their parent(s), also known as 'rooming in.'<sup>30</sup>

As stated before, **all** research on prenatal drug exposure is limited by confounding variables like sample size, access to prenatal care, malnutrition, other drug use, trauma, and many other factors.<sup>31</sup> Ultimately, the key piece of medical advice is that if you are pregnant, it is typically better to abstain from using drugs.

### Importance of MAT Accessibility

For pregnant and postpartum patients who use opioids, medication-assisted treatment with methadone or suboxone is the standard of care.<sup>32</sup> It is far worse for the developing fetus to experience the stress of withdrawal that comes with detoxification and abstinence-based treatment than to treat that patient with medication. Detoxification while pregnant can result in preterm labor, fetal distress or demise, in addition to increasing the risk of relapse and maternal overdose.<sup>33</sup> Adhering to a methadone or suboxone regimen while pregnant eliminates withdrawal's negative impacts on the fetus and provides stability to the parent during their pregnancy.

The Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>34</sup>, National Institute on Drug Abuse<sup>35</sup>, Department of Health and Human Services: Office of Women's Health<sup>36</sup>, World Health Organization<sup>37</sup>, American College of Obstetricians and Gynecologists<sup>38</sup>, American Society of Addiction

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<sup>26</sup> The National Institute on Drug Abuse, *Treating Opioid Use Disorder During Pregnancy*, Rockville, MD: NIDA, July 2017, accessed July 2019, <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy>

<sup>27</sup> Ibid.

<sup>28</sup> NIDA, *Substance Use in Women*

<sup>29</sup> Ibid.

<sup>30</sup> NIDA, *Treating Opioid Use Disorder During Pregnancy*

<sup>31</sup> ACOG, *ACOG Committee Opinion 722: Marijuana Use During Pregnancy and Lactation*

<sup>32</sup> NIDA, *Treating Opioid Use Disorder During Pregnancy*

<sup>33</sup> Stephen Patrick, Davida Schiff, and the Committee on Substance Use and Prevention, "A Public Health Response to Opioid Use in Pregnancy," *Pediatrics* 139, no.3 (2017):1-7, accessed July 2019, [https://pediatrics.aappublications.org/content/pediatrics/early/2017/02/16/peds.2016\\_4070.full.pdf](https://pediatrics.aappublications.org/content/pediatrics/early/2017/02/16/peds.2016_4070.full.pdf)

<sup>34</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*, HHS Publication No. 18-5054, Rockville, MD: SAMHSA, January 2018, accessed July 2019, <https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>

<sup>35</sup> NIDA, *Treating Opioid Use Disorder During Pregnancy*

<sup>36</sup> US Department of Health and Human Services Office on Women's Health, *Final Report: Opioid Use, Misuse, and Overdose in Women*, Washington DC: Office on Women's Health, July 2017, accessed July 2019, <https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf>

<sup>37</sup> World Health Organization (WHO), *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*, NLM WQ210, Geneva, Switzerland: WHO, 2014, accessed July 2019, [https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731\\_eng.pdf;jsessionid=0146B810F4BB96C617D3D40F9B7D3545?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf;jsessionid=0146B810F4BB96C617D3D40F9B7D3545?sequence=1)

<sup>38</sup> ACOG, *ACOG Committee Opinion 722: Marijuana Use During Pregnancy and Lactation*

Medicine<sup>39</sup>, American Academy of Pediatrics<sup>40</sup>, American Psychological Association<sup>41</sup>, American Nurses Association<sup>42</sup>, and the National Perinatal Association<sup>43</sup> all support the use of MAT for opioid dependent pregnant individuals and denounce the practice of detoxification. Outside of the rigorously proven physical benefits, medication-assisted treatment improves maternal social support by establishing relationships and opportunities to receive care beyond the realm of substance use. MAT clinics are often one of the few spaces available to pregnant and parenting people who want to talk to someone about their substance use without facing stigma, at least in theory.

## What stands in the way of accessing MAT?

Despite widespread institutional and professional support for ensuring and improving access to MAT for pregnant patients, this much needed service still remains elusive to many individuals who need it. On the surface level, barriers related to protocol and logistics play a major role in the accessibility of MAT for all people, not just pregnant and parenting people. Identification requirements, insurance coverage, long intake appointments and assessments, limited hours, and rules that mandate sobriety or participation in groups and other activities commonly stand in the way of patients receiving MAT. For parents, the absence of childcare or a child play area can make accessing a routine appointment exponentially more difficult.

The stigma of MAT as an intervention in general also increases the difficulty of getting patients into treatment, since providers must adhere to a variety of strict regulations to offer MAT in the first place. Simply receiving approval to prescribe medications for addiction treatment is complicated and time consuming. Interested providers—if allowed by their place of employment—must complete an approved training, provide evidence of their referral capacity, and submit a formal application to SAMHSA.<sup>44</sup> Once approved, prescribers receive a special license number from the Drug Enforcement Agency (DEA) that is subject to periodic audits and intensified scrutiny from law enforcement.<sup>45</sup> This arduous process acts as a deterrent to practitioners interested in becoming MAT providers—even if the prescriber is motivated, they usually need to ensure that any cross-covering or supervisory staff also becomes approved. These federal regulations are intended to reduce the risk of medication ‘diversion’; instead, research suggests that these regulations contribute to illegal buprenorphine markets, as those denied treatment are at an increased risk of seeking medication in the underground economy.<sup>46</sup>

Often, these heightened regulations lead to heightened stringency by providers, which is exacerbated due to the history of racism and sexism within the United States. The stigma of substance use during pregnancy contributes heavily to its underreporting by pregnant and parenting individuals, leading to ineffective or delayed treatments and thus increased fetal risk.<sup>47</sup> For instance, a patient who delivers without ever receiving prenatal care is more likely to have a history of substance use than

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<sup>39</sup> American Society of Addiction Medicine (ASAM), *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, Rockville, MD: ASAM, 2015, accessed July 2019, <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>

<sup>40</sup> Stephen Patrick, Davida Schiff, and the Committee on Substance Use and Prevention, “A Public Health Response to Opioid Use in Pregnancy”

<sup>41</sup> American Psychiatric Association (APA), *Position Statement: Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders*, Washington DC: APA, 2016, accessed July 2019, <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Position-2016-Pregnant-Addiction.pdf>

<sup>42</sup> American Nurses Association (ANA), *Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders*, Silver Spring, MD: ANA, March 2017, accessed July 2019, <https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/nonpunitive-treatment-pregnant-breastfeeding-women-sud.pdf>

<sup>43</sup> National Perinatal Association, “Perinatal Substance Use,” [nationalperinatal.org](http://www.nationalperinatal.org/Substance_Use), National Perinatal Association, 2017, accessed July 2019, [http://www.nationalperinatal.org/Substance\\_Use](http://www.nationalperinatal.org/Substance_Use)

<sup>44</sup> Kevin Fiscella, Sarah Wakeman, and Leo Beletsky, “Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver,” *JAMA Psychiatry* 76, no.3 (2019):229-230, accessed July 2019, <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2719455>

<sup>45</sup> Ibid.

<sup>46</sup> Michelle Lofwall and Sharon Walsh, “A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World,” *J Addict Med* 8, no.5 (2014): 315-326, accessed July 2019, <https://doi.org/10.1097/ADM.0000000000000045>

<sup>47</sup> NIDA, *Treating Opioid Use Disorder During Pregnancy*

pregnant patients who have received prenatal care.<sup>48</sup> Patients are more likely to initiate and remain in treatment if staff are non-judgemental and use trauma-informed care approaches.<sup>49</sup> Any reluctance to provide MAT to pregnant patients is scientifically unfounded and dangerous for the fetus and the pregnant person.

Furthermore, punitive policies and criminalization of substance use during pregnancy results in incarceration, loss of parental rights, or loss of personal autonomy. These are all significant deterrents in seeking prenatal care, with no proven benefits for infant health.<sup>50,51</sup>

## Digging Deeper: Cold Calling Services in the City

We want to better understand the experiences of pregnant and parenting people seeking entry into treatment for opioid use, sparking this report. We have wondered: What barriers in Baltimore City are pregnant people experiencing that hinder their access to the healthcare services they need, when they need it most?

Accessing appropriate treatment services can be a life-saving and family-preserving measure. In Maryland, unintentional drug overdose has been the leading cause of pregnancy-associated death for four consecutive years<sup>52</sup>, and prevalence of opioid use disorder during delivery hospitalizations is the 5th highest in the United States.<sup>53</sup> Furthermore, 27% of children in foster care in Maryland list parental substance use as their reason for entry.<sup>54</sup> This makes improving the accessibility of medication-assisted treatment an absolute priority. As a recipient of SAMHSA block grants, the state of Maryland is federally required to prioritize admission into treatment facilities for pregnant people to comply with United States Code.<sup>55</sup> Despite this, we know that people who are pregnant continue to struggle to find appropriate treatment for substance use concerns—especially opioid use.

Having accepted that we are not practiced researchers, we approached this question from the most direct route available to us: calling treatment providers and asking about availability. Using a short script and a list of MAT providers, we conducted ‘secret-shopper’ calls using a scenario based on our executive director’s experiences as a case manager. We used those calls as a snapshot to develop the analysis and recommendations that follow.

## Secret-Shopper Script

*Introduction:* “Hi, my name is \_\_\_\_\_. I’m calling for my client. She uses heroin daily and sometimes other drugs (marijuana and crack cocaine and K2) and she would like to get on methadone (or suboxone). She just found out that she’s pregnant and we wanted to know if you take women who are pregnant in your center/clinic.”

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<sup>48</sup> Stephen Patrick, Davida Schiff, and the Committee on Substance Use and Prevention, “A Public Health Response to Opioid Use in Pregnancy”

<sup>49</sup> National Perinatal Association, “Perinatal Substance Use”

<sup>50</sup> Stephen Patrick, Davida Schiff, and the Committee on Substance Use and Prevention, “A Public Health Response to Opioid Use in Pregnancy”

<sup>51</sup> Sarah Roberts and Amani Nuru-Jeter, “Women’s perspectives on screening for alcohol and drug use in prenatal care,” *Women’s Health Issues* 20, no.3 (2011): 193-200, accessed July 2019, <https://doi.org/10.1016/j.whi.2010.02.003>

<sup>52</sup> Maryland Department of Health, *Maryland Maternal Mortality Review 2018 Annual Report*, Baltimore, MD: MDOH, December 2018, accessed July 2019, <http://healthymaryland.org/wp-content/uploads/2019/01/Health-General-Article-%C2%A713-1207-2018-Annual-Report-Maryland-Maternal-Mortality-Review.pdf>

<sup>53</sup> Sarah Haight, Jean Ko, Van Tong, Michele Bohm, and William Callaghan, “Opioid Use Disorder Documented at Delivery Hospitalization -- United States, 1999-2014,” *CDC Morbidity and Mortality Weekly Report* 67, no.31 (2018): 845-849, accessed July 2019, <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6731a1-H.pdf>

<sup>54</sup> ChildTrends, “Foster Care,” *childtrends.org*, ChildTrends, 2015, accessed July 2019, [https://www.childtrends.org/wp-content/uploads/2017/01/Maryland-Foster-Care-Factsheet\\_2015.pdf](https://www.childtrends.org/wp-content/uploads/2017/01/Maryland-Foster-Care-Factsheet_2015.pdf)

<sup>55</sup> U.S. Constitution art. 42, §300x-27

*If Yes.*

- “That’s great, what requirements do you have for people receiving methadone (or suboxone)?”
- “Are there ID/documentation requirements? Prenatal care requirements? Behavioural (sobriety) requirements?”
- *Follow-Up:* “I forgot to mention she has a 2 year old, would it be okay if she brought her child to appointments, or do you have childcare there?”

*If Maybe.*

- “Can you tell me more?”
- “Is there someone else I should ask?”
- “Is there any kind of approval or referral we’d need?”

*If No.*

- “Can you tell me why that is?”
- “Do you have any suggestions of places I could call instead?”

*Closing:* “Thanks for answering my questions. I’ll talk this over with my client and we’ll be in touch.”

### **Results of Secret-Shopper Calls:**

We called 39 different medication-assisted treatment centers that accept female clients in Baltimore City using our ‘secret shopper’ script. We were unable to connect with 8 of those treatment centers because the line was always busy when we called, staff were unavailable, or they did not return voicemails. This leaves 31 programs for which we have some information.

84% (26 of 31) of the programs stated they would accept pregnant clients, although many were hesitant. Some preferred not to have pregnant patients even though it was not explicitly against their program’s policies. 16% (5 of 31) programs explicitly did not accept pregnant clients.

*“She can come here, but why is she not going to Bayview?”  
- treatment service staff member, Baltimore, MD 8/13/19*

*“She wouldn’t do well here in the outpatient program”  
- treatment service staff member, Baltimore, MD 8/13/19*

Among the 26 providers who would accept pregnant clients, we observed significant barriers to care, including unclear provider policy, lack of childcare, pre-screening or evaluation needed before intake, and requiring forms of identification and proof of insurance. 19% (5 of 26) acknowledged these possible barriers to care during the call and offered reference to other providers.

- *Hesitancy/Unclear Policy:* 12% (3 of 26) needed to ask other staff members or their supervisors prior to confirmation. Though they were directly answering clients’ calls, they were unsure if pregnant people could be accepted.

- *Lack of Childcare*: Only 15% (4 of 26) provided childcare for their clients. 85% (22 of 26) did not.
- *Requiring Insurance, ID, SSN*: 81% (21 of 26) required ID of some kind and 70% (18 of 26) required an insurance card for intake. 8% (2 of 26) required a social security number for intake.
- *Prescreening or Evaluation*: 23% (6 of 26) had pre-screening or evaluation requirements before intake, many of which were hours-long (with the longest being an all-day evaluation).

Focusing on the 5 providers who would not accept pregnant clients, a majority (4 of 5) referred the client to what they believed to be a more suitable program. However, all of those references were to the same provider. Additionally, 2 of the 5 providers suggested detoxification due to their facility not being set up to support pregnant people who use drugs.

## Reflections

We were pleased to find that the majority of treatment providers utilizing suboxone and/or methadone do not deny services to potential clients because they are pregnant. Nevertheless, some providers have specific stipulations and additional restrictions for pregnant patients that differed from their other patients, which could serve as barriers. Additionally, we did not account for the common-place barriers people seeking MAT face regardless of pregnancy status. These include inability to show government issued ID, housing instability, interruptions in care due to imprisonment, enrollment in health insurance, long waitlists, young age, requirements to attend daily group sessions, detoxification and ‘black out’ requirements, lack of childcare, limited options for non-English speakers, and discrimination based on gender and sexual identity (most especially providers’ perception of gender and/or sexual identity).

Nevertheless, we are glad that dozens of providers are willing to accept pregnant patients in need of MAT. There is also always work to be done to make improvements and we should continue to strive for the greatest access and highest quality services. Through conversations with colleagues and using our own experiences, we know that the landscape of treatment provision in Baltimore has greatly expanded and improved. We are looking forward to strategizing for this continued effort. The following are topics for improvement that we found in much of the academic literature and governmental agency documents we explored. They are coupled with some of our own thoughts and reflections.

- **Provider-bias Reduction Efforts:** *In 2017, Baltimore City Health Department officials made the formal recommendation to “Provide training to prenatal care providers to improve knowledge, attitudes, and beliefs related to pregnancy and substance use; reduce stigma; and improve quality of care.”*<sup>56</sup>

There is also a need for substance use treatment providers (along with perinatal care providers) to reduce stigma and provider-bias. This is true for biases (unconscious or not) towards many groups of highly stigmatized and marginalized patients, including pregnant and postpartum patients. Provider-bias is a concern in all care settings, and in our society at large. Just as stigma

<sup>56</sup> Baltimore City Child Fatality Review Team Subcommittee on Child Abuse and Neglect, *Eliminating Child Abuse and Neglect Fatalities in Baltimore City*, Baltimore, MD: Baltimore City Health Department, 2017, accessed July 2019, <http://healthybabiesbaltimore.com/uploads/files/Initiatives/Baltimore%20City%20CFR%20Child%20Abuse%20Report%20January%202017.pdf>

exists on the perinatal care side towards people who use drugs, so does stigma towards pregnant people in treatment programs. When we allow the idea that some patients are ‘too difficult’ or a ‘liability risk’ (both conclusions that we have heard) to receive care, we enforce their marginalization and the isolation they may already be experiencing. Further education, beyond a single-session training, is needed to improve access to care.

- **Prioritization Through Action:** *“While pregnant substance abusing women are given priority when requesting substance abuse treatment in Maryland, many treatment providers do not feel comfortable providing services for pregnant women.”*<sup>57</sup>

If pregnant patients are to be prioritized when seeking treatment, this should be more widely publicized and assistance offered to providers who want to make this change. Presently, we have been unable to locate a formal memorandum or other announcement from the Maryland Department of Health about this priority. It is mentioned briefly in the 2014 Maternal Mortality Report<sup>58</sup>, and is an agreed upon requirement within MDH’s SAMHSA block grant applications for the last decade.<sup>59</sup> A more public declaration could go a long way in letting providers and the public know about the urgency of providing and seeking treatment. Documents could include explicit encouragement and concrete tools for both perinatal and MAT providers, highlighting best practices when assisting pregnant patients with concerns about their drug use. Additionally, this would be an appropriate time to review whether or not MDH’s assessment of the impact of SAMHSA block grant funding is accurate with the experience of pregnant people seeking MAT. Continuously investigating whether funding is allocated efficaciously is a cornerstone of government work. For example, funding was recently awarded to Baltimore City to open a detoxification center that serves and houses women with children.<sup>60</sup> This center will help many people, but it will not help pregnant people who need MAT.

- **Focusing on Families:** *“Sorry, the facility is not set up to take women who are expecting” - treatment service staff member, Baltimore, MD 8/12/19*

Most of the resources available to individuals do not address the individual as a part of a family or parent-child pair. Most of us do not exist only as single adults with no care-giving relationships. Services that do not allow patients to bring children or engage other members of the household are missing an opportunity. This is, nevertheless, considered a niche service area, rather than a regular part of doing business as a MAT provider. The fact that childcare, children’s play areas, and other family support was rarely offered to our callers leads us to believe that it must be an approach to treatment that is socially and/or financially discouraged. We hope to encourage prioritizing of the care relationships people are in, particularly when considering broadening and improving the treatment resource landscape in Maryland

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<sup>57</sup>Maryland Department of Health, *Maryland Maternal Mortality Review 2014 Annual Report*, Baltimore, MD: MDOH, 2015, accessed July 2019, [https://phpa.health.maryland.gov/mch/Documents/MMR\\_2014\\_FINAL\\_Approved\\_1-8-15.pdf](https://phpa.health.maryland.gov/mch/Documents/MMR_2014_FINAL_Approved_1-8-15.pdf)

<sup>58</sup> Ibid.

<sup>59</sup> Maryland Department of Health, *Uniform Application FY 2009 Substance Abuse Prevention and Treatment Block Grant*, Baltimore MD: Center for Substance Abuse Treatment, Division of State and Community Assistance, March 2009, accessed July 2019, [https://bha.health.maryland.gov/OPERATIONS/Documents/GRANTS/Maryland2009\\_BG\\_Application\\_3\\_17\\_09.pdf](https://bha.health.maryland.gov/OPERATIONS/Documents/GRANTS/Maryland2009_BG_Application_3_17_09.pdf)

<sup>60</sup> Kathleen Rebbert-Franklin and Marian Bland, “Maryland’s Behavioral Health System: An Overview of Prevention, Treatment, and Recovery Efforts to Address the Opioid Epidemic,” Presentation, Baltimore, MD, November 2018, accessed July 2019, [https://www.marylandpatientsafety.org/documents/rebbertfranklin\\_and\\_bland.pdf](https://www.marylandpatientsafety.org/documents/rebbertfranklin_and_bland.pdf)

## **Conclusion**

In closing, we hope this report will validate that most MAT providers in Baltimore City do serve pregnant patients. That being said, this report confirms that MAT providers still need support and assistance from larger institutions to increase the accessibility of MAT, especially in integrating a family-focused approach to service provision. Continuing these conversations moving forward with the inclusion of service providers and the women who have experience trying to access these services is a necessary next step moving forward.

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## Glossary of Acronyms

BCHD: Baltimore City Health Department

CAPTA: Child Abuse Prevention and Treatment Act

DEA: Drug Enforcement Agency

FASD: Fetal Alcohol Spectrum Disorders

*a class of conditions that can occur in a person born to a parent that consumed alcohol during pregnancy*

MAT: Medication-Assisted Treatment

*the use of opioid-agonist medication, such as methadone, to treat opioid use disorder*

MDH: Maryland Department of Health

NAS: Neonatal Abstinence Syndrome

*a class of conditions that can occur when an infant experiences withdrawal symptoms from exposure to substances during pregnancy*

OTP: Opioid Treatment Program

*a federally accredited medication-assisted treatment program*

OUD: Opioid Use Disorder

*a pattern of behavior regarding opioid use that causes significant distress or impairment and meets 2 or more DSM-5 criteria*

SAMHSA: Substance Abuse and Mental Health Services Administration

SEN: Substance-Exposed Newborn

*an infant that was exposed to drugs and/or alcohol in the womb*

SUD: Substance Use Disorder

*a "pattern of behavior" regarding substance use that "causes significant distress or impairment" and meets 2 or more DSM-5 criteria*

## Bibliography

1. The American College of Obstetricians and Gynecologists. *ACOG Committee Opinion 722: Marijuana Use During Pregnancy and Lactation*. Washington DC: ACOG, 2017. Accessed July 2019. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/10/marijuana-use-during-pregnancy-and-lactation>
2. American Nurses Association. *Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders*. Silver Spring, MD: ANA, March 2017. Accessed July 2019. <https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/nonpunitivetreatment-pregnantbreastfeedingwomen-sud.pdf>
3. American Psychiatric Association. *Position Statement: Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders*. Washington DC: APA, 2016. Accessed July 2019. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Pregnant-Addiction.pdf>
4. American Society of Addiction Medicine. *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*. Rockville, MD: ASAM, 2015. Accessed July 2019. <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>
5. Baltimore City Child Fatality Review Team Subcommittee on Child Abuse and Neglect. *Eliminating Child Abuse and Neglect Fatalities in Baltimore City*. Baltimore, MD: Baltimore City Health Department, 2017. Accessed July 2019. <http://healthybabiesbaltimore.com/uploads/files/Initiatives/Baltimore%20City%20CFR%20Child%20Abuse%20Report%20January%202017.pdf>
6. Centers for Disease Control and Prevention. "Alcohol Use in Pregnancy." Cdc.gov. CDC, March 2018. Accessed July 2019. [https://www.cdc.gov/ncbddd/fasd/documents/fasd\\_alcoholuse.pdf](https://www.cdc.gov/ncbddd/fasd/documents/fasd_alcoholuse.pdf)
7. ChildTrends. "Foster Care." Childtrends.org, ChildTrends, 2015. Accessed July 2019. [https://www.childtrends.org/wp-content/uploads/2017/01/Maryland-Foster-Care-Factsheet\\_2015.pdf](https://www.childtrends.org/wp-content/uploads/2017/01/Maryland-Foster-Care-Factsheet_2015.pdf)
8. Chisolm, Margaret and Jennifer Payne. "Management of psychotropic drugs during pregnancy." *BMJ* 2016, 352:h5918. Accessed July 2019. <https://doi.org/10.1136/bmj.h5918>
9. Fiscella, Kevin, Sarah Wakeman, and Leo Beletsky. "Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver." *JAMA Psychiatry* 76, no.3 (2019): 229-230. Accessed July 2019. <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2719455>
10. Flavin, Jeanne and Lynn M Paltrow. "Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense." *Journal of Addictive Diseases* 29, no. 2 (2010): 231-44. Accessed February 2020. <https://doi.org/10.1080/10550881003684830>
11. Gómez, Laura. *Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure*. Philadelphia: Temple University Press, 1997.
12. Haight, Sarah, Jean Ko, Van Tong, Michele Bohm, and William Callaghan. "Opioid Use Disorder Documented at Delivery Hospitalization -- United States, 1999-2014." *CDC Morbidity and Mortality Weekly Report* 67, no.31 (2018): 845-849. Accessed July 2019. <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6731a1-H.pdf>

13. Humphries, Drew. "Crack Mothers at 6: Prime-Time News, Crack/Cocaine, and Women." *Violence Against Women* 4, no. 1 (1998): 45-61. Accessed July 2019. <https://doi.org/10.1177/1077801298004001004>
14. Lofwall, Michelle and Sharon Walsh. "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World." *J Addict Med* 8, no.5 (2014): 315-326. Accessed July 2019. [doi.org/10.1097/ADM.0000000000000045](https://doi.org/10.1097/ADM.0000000000000045)
15. Maryland Department of Health. *Maryland Maternal Mortality Review 2014 Annual Report*. Baltimore, MD: MDOH, 2015. Accessed July 2019. [https://phpa.health.maryland.gov/mch/Documents/MMR\\_2014\\_FINAL\\_Approved\\_1-8-15.pdf](https://phpa.health.maryland.gov/mch/Documents/MMR_2014_FINAL_Approved_1-8-15.pdf)
16. Maryland Department of Health. *Maryland Maternal Mortality Review 2018 Annual Report*. Baltimore, MD: Maryland Department of Health, December 2018. Accessed July 2019. <http://healthymaryland.org/wp-content/uploads/2019/01/Health-General-Article-%C2%A713-1207-2018-Annual-Report-Maryland-Maternal-Mortality-Review.pdf>
17. Maryland Department of Health. *Uniform Application FY 2009 Substance Abuse Prevention and Treatment Block Grant*. Baltimore MD: Center for Substance Abuse Treatment, Division of State and Community Assistance, March 2009. Accessed July 2019. [https://bha.health.maryland.gov/OPERATIONS/Documents/GRANTS/Maryland2009\\_BG\\_Application\\_3\\_17\\_09.pdf](https://bha.health.maryland.gov/OPERATIONS/Documents/GRANTS/Maryland2009_BG_Application_3_17_09.pdf)
18. Morgan, Sara, Gideon Koren, and Pina Bozzo. "Is caffeine consumption safe during pregnancy?." *Canadian Family Physician* 59, no.4 (2013): 361-362. Accessed July 2019. <https://www.cfp.ca/content/59/4/361.long>
19. The National Institute on Drug Abuse. *Substance Use in Women*. Rockville, MD: NIDA, 2018. Accessed July 2019. <https://www.drugabuse.gov/node/pdf/18910/substance-use-in-women>
20. The National Institute on Drug Abuse. *Treating Opioid Use Disorder During Pregnancy*. Rockville, MD: NIDA, July 2017. Accessed July 2019. <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy>
21. National Perinatal Association. "Perinatal Substance Use." [Nationalperinatal.org](http://www.nationalperinatal.org/Substance_Use). National Perinatal Association, 2017. Accessed July 2019. [http://www.nationalperinatal.org/Substance\\_Use](http://www.nationalperinatal.org/Substance_Use)
22. Patrick, Stephen, Davida Schiff, and the Committee on Substance Use and Prevention. "A Public Health Response to Opioid Use in Pregnancy." *Pediatrics* 139, no.3 (2017):1-7. Accessed July 2019. <https://pediatrics.aappublications.org/content/pediatrics/early/2017/02/16/peds.2016-4070.full.pdf>
23. Rebbert-Franklin, Kathleen and Marian Bland. "Maryland's Behavioral Health System: An Overview of Prevention, Treatment, and Recovery Efforts to Address the Opioid Epidemic." Presentation, Baltimore, MD, November 2018. Accessed July 2019. [https://www.marylandpatientsafety.org/documents/rebbertfranklin\\_and\\_bland.pdf](https://www.marylandpatientsafety.org/documents/rebbertfranklin_and_bland.pdf)
24. Reinerman, Craig and Harry G. Levine. *Crack in America: Demon Drugs and Social Justice*. Berkeley: University of California Press, 1997.
25. Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Pantheon Books, 1997.
26. Roberts, Dorothy. *Shattered Bonds: The Color of Child Welfare*. New York: Civitas Books, 2002.

27. Roberts, Sarah CM and Amani Nuru-Jeter. "Universal screening for alcohol and drug use and racial disparities in child protective services reporting." *Journal of Behavioral Health Services & Research* 39, no. 1 (2011): 3-16. Accessed February 2020. <https://doi.org/10.1007/s11414-011-9247-x>
28. Roberts, Sarah CM and Amani Nuru-Jeter. "Women's perspectives on screening for alcohol and drug use in prenatal care." *Women's Health Issues* 20, no.3 (2011): 193-200. Accessed July 2019. <https://doi.org/10.1016/j.whi.2010.02.003>
29. Roberts, Sarah CM, Elaine Zahnd, Carolyn Sufrin, and Mary Anne Armstrong. "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, no. 2 (2015): 146-50. Accessed February 2020, <https://doi.org/10.1038/jp.2014.168>
30. Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. HHS Publication No. 18-5054. Rockville, MD: SAMHSA, January 2018. Accessed July 2019. <https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>
31. US Department of Health and Human Services, Office on Women's Health. *Final Report: Opioid Use, Misuse, and Overdose in Women*. Washington DC: Office on Women's Health, July 2017. Accessed July 2019. <https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf>
32. World Health Organization. *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. NLM WQ210. Geneva, Switzerland: WHO, 2014. Accessed July 2019. [https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731\\_eng.pdf;jsessionid=0146B810E4BB96C617D3D40F9B7D3545?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf;jsessionid=0146B810E4BB96C617D3D40F9B7D3545?sequence=1)

## Further Reading

### Amnesty International

- [Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA](#)

### **Black Mamas Matter Alliance**

#### *Resource List*

- [Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities](#) (Ancient Song Doula Services, Village Birth International, Every Mother Counts)
- [Race & Maternal Mortality Are Linked and Black Mother Are Paying the Price](#) (Morgan Brinlee)
- [To Prevent Women from Dying in Childbirth, First Stop Blaming Them](#) (Monica McLemore)
- [Uplifting Birth Justice Through Doula Care!](#) (Birth Justice Network, Forward Together)

#### *Toolkit*

- [Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care](#)

### Journal Articles

- [Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health](#) (Lynn M Paltrow and Jeanne Flavin, *Journal of Health Policies, Policy, and Law*)

- The Detention and Forced Medical Treatment of Pregnant Women: A Human Rights Perspective (Cynthia Soohoo and Risa E Kaufman, American Constitution Society for Law and Policy)
- The War on Drugs and the War on Abortion: Some Initial Thoughts on the Connections, Intersections, and the Effects (Lynn M Paltrow, Southern University Law Review)

## **Mamas of Color Rising**

### **National Advocates for Pregnant Women**

#### *Fact Sheets*

- Birth Justice as Reproductive Justice
- Clinical Drug Testing of Pregnant Women and Newborns
- Don't Judge Pregnant Drug-Using Women Based on Junk Science
- How We Know That Criminal Abortion Laws Don't Protect Women from Violence
- Medical and Public Health Group Statements Opposing Prosecution and Punishment of Pregnant Women
- Prenatal Exposure to Illegal Drugs and Alcohol: Media Hype and Enduring Myths Are Not Supported by Science
- Rights Over My Birth
- Trumpcare's Uncaring Impact on Pregnant Women
- Understanding CAPTA and State Obligations
- Understanding Opioid Use During Pregnancy

#### **New York Times**

- "A Woman's Rights" interactive series

### **SisterSong: Women of Color Reproductive Justice Collective**

- Reproductive Injustice: Racial and Gender Discrimination in US Healthcare (written with National Latina Institute for Reproductive Health and the Center for Reproductive Rights)