ASTHO Brief
Exploring critical issues in state and territorial public health.
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Evidence-Informed Substance Use Disorder Policies for Maternal and Child Populations

The unintended consequences of substance use disorder policies can be significant for women with and families impacted by substance use disorders (SUD). Much of the current federal and state approach to substance use policy is still informed by the most recent period of the "war on drugs," beginning in the 1970s. Policies such as mandatory minimum sentencing, prosecution of low-level substance use offences, increased conviction and incarceration of individuals with SUD, and the general criminalization of substance use and mental illness led to soaring imprisonment rates, especially for Black and Latina populations.

Within the broader community hardships brought by these policies, women and children have been disproportionately impacted and burdened. Because of the different and gendered ways that men and women seek out, acquire, and use substances, women have been more likely to be involved with the criminal/legal system through charges of conspiracy, accomplice liability, and constructive possession. When someone is incarcerated, they are also more likely to lose custody of their children or have their parental rights terminated. In 2017 alone, over 500,000 parents (who were disproportionately Black and Latina women) were deemed by the criminal/legal system to have maltreated their children.

Substance use policies affect women with SUD and their families uniquely, as the following examples show:

- "Research has shown that [mothers who use substances] who had a child removed from their care were twice as likely to have a subsequent birth, and three times as likely to have a subsequent alcohol- or drug-exposed birth." As such, child removal may exacerbate the harms of substance misuse by increasing rates of unintended pregnancy, fetal alcohol syndrome, and neonatal abstinence syndrome.
- The criminalization of substance use may increase the likelihood of women struggling with SUD to isolate themselves from others, skip medical appointments, or avoid the healthcare system to try and reduce their risk of detection by health or criminal/legal authorities.
- Routine urine drug screening may exacerbate racial and ethnic health disparities through perpetuating stereotyping and stigma. (This is distinct from universal verbal screening for SUD with a validated tool, which is recommended early in pregnancy and in partnership with the patient.)
- Women with opioid use disorder who live in states with prenatal child abuse laws (also referred to as fetal endangerment laws) are less likely to receive medications for opioid use disorder or access prenatal care, leading to poorer birth outcomes and increased fetal and infant deaths.

The above examples highlight the necessity of connecting policy development with lessons learned from previous SUD policy implementation, and not mistaking the intent of a policy for its impact.

Considerations for Crafting and Implementing Comprehensive SUD Policy

When drafting policy interventions for women who use substances, consider:

1) **Promoting holistic, team-based SUD treatment and mental health services.** Comprehensive and accessible care that includes intensive case management and motivational interviewing can greatly improve outcomes for women with SUD. This multifaceted care can better address the social determinants of health, recognize the value of all health profession disciplines, and provide continuity of care during the transition from residential treatment to the community, (i.e., inpatient treatment followed by outpatient aftercare) to help patients develop a recovery-oriented support network, prevent relapse, and maintain recovery. Vermont's Care Alliance for Opioid Addiction's "hub and spoke" model is a well-known example of this kind of interconnected care.

Key Resources

1) Ending the Opioid Crisis: A Practical Guide for State Policymakers
2) Coalitions and Community Health: Integration of Behavioral Health and Primary Care
3) Building Recovery: State Policy Guide for Supporting Recovery Housing

2) **Engaging non-traditional partners or systems, such as transportation, housing, information technology, and education sectors.** Partners in the child welfare systems, for example, could be approached about implementing policies to help parents maintain custody of their children or, for parents whose children have already been removed, to bolster supports to help families reunify safely. Sufficient substance use treatment, along with other services and supports that promote a parent's keeping their child or successfully reunifying, increases the possibility of the parent being able to care for the children they may already have. Huntington, West Virginia's Quick Response Team exemplifies innovative partnership and collaboration in response to substance use disorder.

3) **Developing certification guidelines and oversight mechanisms for peer recovery coaches, recovery housing, recovery schools, and other such entities.** Auxiliary services like these can help prevent patients from relapsing by teaching important life skills and meeting patient needs like childcare and vocational training. However, without proper certification and oversight, these services can vary significantly in quality. Providing certification pathways and formal oversight of such services can help strengthen the SUD treatment services system and improve population health. For example, Arizona leveraged its Medicaid program to include and formalize the role of peer recovery coaches.

4) **Examining and confronting systemic racism in assessment, treatment, and recovery services provision.** People of color still face "more barriers to treatment engagement, completion, and satisfaction than their White counterparts" when attempting to access behavioral health services. Requiring cultural humility and/or implicit bias training for all staff involved in SUD treatment is just the first of many steps to addressing and finally reducing race-based disparities.