



# Access to Reproductive Health Care for Women in Treatment for Substance Use Disorder

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**Research has found that women\* of reproductive age (15 to 44) with substance use disorder (SUD) have lower rates of contraceptive use and higher rates of unintended pregnancy than women without SUD (Heil et al. 2011; Terplan et al. 2011).**

**Understanding the barriers to reproductive health care faced by these women is essential to meeting their health needs. In this study, we assess the reproductive health care access and needs of women in treatment for SUD through case studies conducted in Maryland and Ohio in December 2019 and January 2020, respectively. In both states, we interviewed key informants, including state Medicaid officials, policymakers, researchers, and health care and other service providers, and conducted focus groups with women of reproductive age in treatment for SUD. The key findings include the following:**

- Like women of reproductive age generally, most of the 59 women in treatment for SUD who participated in our focus groups reported that access to birth control and the ability to plan whether or when to become pregnant is very important to their lives. Many also reported wanting birth control methods that are effective and easy to use without negative side effects.

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\* This brief uses the term “women” because the participants in our focus groups self-identified as women. But we acknowledge that people who do not identify as women also need and use the reproductive health services we describe. We remain committed to using respectful, inclusive language.

- Focus group participants and key informants identified many unique reproductive health needs for women in treatment for SUD, including competing social and general health needs; histories of domestic violence, transactional sex,<sup>1</sup> and sexual trauma; and the risks of experiencing an unplanned pregnancy during the sensitive treatment and recovery periods.
- Key informants emphasized that barriers to reproductive health care access for women in treatment for SUD can include high prevalence of trauma, stigma from health care providers, distrust of the health care system, challenges planning for the future, and a perceived lack of autonomy over their reproductive decisions. Neither key informants nor focus group participants cited costs or insurance as a current barrier to reproductive health access.
- Key informants indicated that the siloed nature of the health care system, in which SUD treatment and recovery services are separated from other health care, is a serious barrier to accessing reproductive health care for women in treatment for SUD. They therefore suggested co-locating reproductive health services in SUD treatment clinics to improve access to such care. Most women we spoke with were receptive to talking about family planning with their treatment counselors and accessing reproductive health services on site.
- Both focus group participants and key informants emphasized the importance of delivering reproductive health care to women in treatment for SUD in supportive, noncoercive ways; focus group participants mentioned experiencing stigma and coercion because of their SUD when seeking family planning services previously. To build trust with these women, who might feel targeted or pressured not to have children because of their SUD, key informants suggested offering culturally effective reproductive health care as part of women's overall health and well-being, rather than as a pregnancy prevention tool.

## Background

Access to reproductive health care, including birth control, allows women and their partners to choose whether and when to have children and has broad health, social, and economic benefits for women and their families (Bailey and Lindo 2017; Johnston et al. 2017; Peters, Benatar, et al. 2019; Sonfield et al. 2013). Women recognize these benefits; in prior work, women told us birth control has a positive effect on women's lives by allowing them to pursue academic and professional goals, achieve financial stability, and maintain their mental and physical health (Peters, Benatar, et al. 2019).<sup>2</sup>

Despite these acknowledged benefits of birth control, between 11 and 18 percent of women at risk of unintended pregnancy reported using no contraception between 2006 and 2010<sup>3</sup> (Dehlendorf et al. 2014; Jones, Mosher, and Daniels 2012; Mosher, Jones, and Abma 2015). Women may not use contraception for many reasons, including preferring to avoid hormonal or invasive birth control methods, feeling ambivalent about pregnancy, and having experienced coercion and discrimination during contraceptive counseling (Dehlendorf et al. 2010). But if women desire contraception, nonuse may also reflect access barriers, such as costs, needing to travel to providers, inconvenient hours at providers' offices, prior negative health care experiences, limited awareness about birth control options,

or privacy concerns. In 2016, about one in six women reported barriers to obtaining her preferred birth control method; these barriers were more common among women with low incomes and women lacking health insurance coverage (Johnston, Courtot, and Kenney 2017).

As noted, women of reproductive age with SUD have lower rates of contraceptive use and higher rates of unintended pregnancy than women without SUD (Heil et al. 2011; Terplan et al. 2015). These differences reflect the additional barriers to accessing reproductive care facing women with SUD, including stigma; fear of criminalization; mistrust of health care providers; lack of knowledge and misinformation about contraceptive methods; misperceptions about fertility; intimate partner violence and coercive relationships; histories of sexual abuse and transactional sex; and weak support networks (Black and Day 2016; Fischbein et al. 2018; Howell and Chasnoff 1999; MacAfee, Harfmann, Cannon, Kolenic, et al. 2020; Smith, Morse, and Busby 2019). Racism and classism also pose barriers, as among women with SUD, women of color and women with low incomes have been disproportionately affected by punitive responses to substance use, such as criminalization, particularly during the perinatal period (Amnesty International 2017; Stone 2015; Terplan, Kennedy-Hendricks, and Chisolm 2015). Beyond structural barriers, women with SUD may not be supported in prioritizing family planning when their other needs, such as immediate health and safety, are not met (Tschann et al. 2019).

Women's perceptions of unplanned births vary based on their personal experiences (Johnston et al. 2017; Peters, Courtot, et al. 2019). For women with SUD, an unplanned pregnancy can be especially disruptive and may result in criminal punishment (Amnesty International 2017). In prior work exploring women's motivations about family planning, women told us their substance use shaped their perceptions of unplanned pregnancy. One woman shared, "I'm in recovery from drug addiction and [don't plan on] having another baby...You have to be more selfish when you're in recovery, because you need to work on yourself."<sup>4</sup> Another woman shared concerns about how drug and alcohol use during pregnancy might have affected the health of her baby (Peters, Courtot, et al. 2019).

Comprehensive, noncoercive contraceptive counseling that supports women's choices regarding when and whether to have children is a cornerstone of ethical reproductive health care (Brandi and Fuentes 2020; Curtis et al. 2016; Dehlendorf, Krajewski, and Borrero 2014). But some reproductive health and substance use programs and providers have promoted sterilization and long-acting reversible contraception (LARC) for women with SUD, including providing financial incentives for the use of these methods (Charron et al. 2020). Such practices raise serious ethical questions about discrimination and women's reproductive autonomy, particularly if programs target groups of women that have been historically discriminated against, including women with SUD, women with low incomes, and women of color (Amnesty International 2017; Brandi and Fuentes 2020; Gomez, Fuentes, and Allina 2014; Lucke and Hall 2012). Rather than pressure women to use birth control or a specific method, it is critical that reproductive health care for women with SUD respond to their needs and desires, as it should for all women. Further, improving access to and engagement with care will require eliminating systemic barriers, educating reproductive health and substance use providers on culturally effective reproductive health care for women with SUD, educating women with SUD about their reproductive health options, and aiding women in choosing and accessing their preferred birth control

methods and in planning for pregnancy (Black, Haber, and Lintzeris 2012; Fischbein et al. 2018; Meschke et al. 2018; Terplan et al. 2015).

Among women who can access SUD treatment, integrating family planning services into such treatment could help address their unmet reproductive health needs in an accessible and trusted setting (Heil, Melbostad, and Rey 2019; MacAfee, Dalton, and Terplan 2018; MacAfee, Harfmann, Cannon, Minadeo, et al. 2020; Klamann, Lorvick, and Jones 2019; Robinowitz et al. 2016; Terplan et al. 2015, 2016; Wright 2019). To provide high-quality, culturally effective, and responsive reproductive health care for women with SUD, the perspectives of women and their providers must be centered. We aim to do that here, using case study data from two states to examine experiences with and desires for accessing reproductive health care among women in treatment for SUD.

## Methods

This analysis draws on case studies conducted in Maryland and Ohio in December 2019 and January 2020, respectively. We interviewed 15 key informants working with women with SUD and held focus groups with 59 women in treatment for SUD. Key informants were state Medicaid officials, policymakers, researchers, addiction medicine providers, family planning providers, and staff at inpatient and outpatient SUD treatment centers. In Maryland, we conducted two focus groups with women in inpatient SUD treatment at a single program serving women who are pregnant or have young children; we also interviewed staff at the same location. Through these conversations, we learned that this program expects women to abstain from sexual activity while in residence, which may shape their reproductive health experiences.<sup>5</sup> In Ohio, we conducted two focus groups with women in outpatient SUD treatment at a single clinic serving both women and men, and we interviewed clinic staff.

Following interview protocols, we conducted semistructured interviews with key informants about access to reproductive health care for all women in the state, including family planning services and abortion, the relationship between SUD and reproductive health care, specific barriers to and facilitators of reproductive health access for women in SUD treatment, federal and state policies threatening access, and promising state and local practices to support access to reproductive health care overall and for women with SUD.<sup>6</sup> Interview protocols were tailored to each key informant based on the state policy context and the informant's position. In the focus groups, we followed moderator's guides and asked women questions on such topics as their experiences with reproductive health care; the relationship between SUD and reproductive health care; integration of reproductive health care and SUD treatment; and reproductive health care needs, access, and barriers. The Urban Institute Institutional Review Board approved this research.

Among the 30 women who participated in focus groups at the inpatient SUD treatment program in Maryland, 23 self-identified as white, 6 as Black, 1 as Hispanic, and 1 as mixed race.<sup>7</sup> Most women (23) had children, about one-third of whom had 3 or more. Twenty-two women were single, 6 were in relationships but not married, 1 was married, and 1 was separated. Among the 29 women who participated in focus groups at the outpatient SUD treatment program in Ohio, 20 self-identified as

white, 4 as Black, and 5 as mixed race. Most women (27) had children, more than half of whom had 3 or more. Nearly half of women were single (14), 8 were in relationships but not married, 5 were married, and 2 were widowed. We present combined findings for all focus group participants except when responses varied by treatment setting, in which case we differentiate between participants in inpatient and outpatient treatment.

We conducted this research as part of the larger Reproductive Health Access: Monitoring and Analysis project, a mixed-methods study carried out between 2017 and 2020. The focus groups and key informant interviews discussed here were part of a larger case study of reproductive health access that included Georgia, Missouri, and Utah. Additional project components include fielding and analysis of a nationally representative survey of women of reproductive age and secondary data analyses of federal and state surveys. Together, this work addresses the following research questions:

- What progress has been made to increase women’s access to reproductive health care?
- To what extent do women’s perceptions of and experiences with reproductive health care appear to be changing or to vary for women in different socioeconomic groups?
- What policies pose the most significant threats to reproductive health care access?
- What opportunities exist to sustain or expand access to care in the face of such threats?

## Findings

In this section, we synthesize findings from key informant interviews and focus groups by theme. For context, we summarize the state policy environments for both Maryland and Ohio in box 1. In box 2, we summarize context provided by key informants on the reproductive health and substance use treatment programs currently available in their states.

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### BOX 1

#### State Policy Context

Under the Affordable Care Act, both Maryland and Ohio expanded Medicaid eligibility to include all adults with incomes up to 138 percent of the federal poverty level. In 2017, women of reproductive age in Maryland and Ohio had lower rates of uninsurance (7.7 percent and 7.2 percent) than similar women nationwide (11.7 percent), which may be associated with better access to reproductive health care.<sup>a</sup>

In addition, Maryland has expanded eligibility for Medicaid-covered family planning services to people with incomes up to 259 percent of the federal poverty level, who are otherwise ineligible for Medicaid. Maryland also has a Medicaid demonstration waiver that expands Medicaid benefits to cover the full continuum of SUD treatment, including residential care, and to support programs integrating physical and behavioral health services. The Maryland Behavioral Health Administration supports these services through the Public Behavioral Health System for Adults, which provides inpatient and outpatient mental health and substance use treatment for Medicaid beneficiaries and others needing such services. The Behavioral Health Administration also operates the Maryland Opioid Rapid Response initiative, designed to increase access to treatment and enhance services for people with

opioid use disorder by reducing gaps in the delivery of behavioral health services. Beginning in January 2020, Maryland received funding from the Centers for Medicare & Medicaid Services to implement the Maternal Opioid Misuse model of care to improve care and service delivery to pregnant and postpartum women with opioid use disorder.

Ohio has implemented several innovative state and local programs designed to address both substance use disorder and infant mortality. Through a Medicaid demonstration waiver, it has increased funding for clinical and nonclinical recovery supports, including a behavioral health care coordination model, a mom-and-baby-dyad care model, and extension of postpartum coverage to 12 months after delivery for women with SUD. In Columbus, local initiatives to eliminate infant mortality have increased access to reproductive health services for all women, including those with SUD. These programs include women's health clinics and mobile units, funded by Title X, co-located in inpatient and outpatient substance use treatment centers and correctional facilities.

<sup>a</sup> "State-by-State Health Insurance Coverage among Women of Reproductive Age," Urban Institute, accessed November 10, 2020, <https://www.urban.org/policy-centers/health-policy-center/projects/uninsurance-among-women-reproductive-age-2017>.

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## Experiences with and Importance of Birth Control

Like the women we spoke with for prior work documenting the birth control experiences of women of reproductive age generally, the women in treatment for SUD who participated in our focus groups reported using various birth control methods throughout their lives, with both positive and negative experiences. When choosing birth control, women in the focus groups shared that they wanted an effective, easy-to-use method without negative side effects.

But women also noted that finding the right method could be a challenge, in part because they lacked good information about their birth control options. Instead, women who participated in our focus groups reported relying on information from social media and friends, even while acknowledging it can be inaccurate.

Most women we spoke with rated birth control and the ability to plan whether and when to become pregnant as extremely important to their lives, and the vast majority wanted to avoid becoming pregnant at the time of the focus group. One focus group participant emphasized this point, saying, "I would die if they said I was pregnant." Some women also placed a special value on birth control for women with SUD because of their personal experiences with transactional sex, unmet social needs, and recovery priorities. They also highlighted the importance of women's choices in their reproductive health.

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*Birth control should be a top priority [in SUD treatment] if a woman wants it. It is your choice.*

*—Focus group participant*

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A minority of focus group participants said birth control was not important to them, including women with women partners; women unable to get pregnant; and women who reported that, as long as they were in residential treatment and had agreed to abstain from sex, it was not important to them. Some women fell in the middle, including those who expressed ambivalence about pregnancy. Still others felt they did not have enough control over their lives to prevent pregnancy; one focus group participant described getting pregnant as “inevitable.”

## Reproductive Health Needs

Providers and other key informants described unique reproductive health needs for women in treatment for SUD, and focus group participants discussed many of the same needs. Key informants shared that women with SUD have significant social needs, including housing, transportation, food security, and child care. They also indicated that many have a history of or are currently experiencing domestic violence, transactional sex, sexual abuse and coercion, sex trafficking, and rape. These social and sexual health needs make the ability to access the full range of reproductive health care, including abortion, even more critical. As one focus group participant put it, “When I was using and I ran out of drugs, the only way I could get more drugs was to sell my body. So that’s why it is important to have birth control and condoms.”

Several key informants also noted that women in treatment for SUD are often accessing preventive health care for the first time after a long gap in care. One said, “When we speak to these women, most of them never had, or have not had in years, any kind of preventative [care] or Pap [test] or anything.” In some cases, key informants noted that social challenges and pressing health needs, such as uncontrolled chronic conditions and mental health concerns, monopolized their time with patients and prevented them from addressing family planning needs. As one provider put it:

There is so much going on with not being sober, or domestic violence, or housing. And then you realize, we didn’t talk about contraception yet. You are dealing with so many acute issues with this population that things get missed because of that.

Focus group participants and key informants discussed beginning SUD treatment as an opportunity for women to care for their personal health in ways they have not had the support or resources to in the past. As a focus group participant described, “Your [SUD treatment] counselor asks you what you want to accomplish while you’re here. For a lot of people that’s getting healthy, which includes getting a doctor or an OB-GYN.” While in treatment, women may have new opportunities to access health care, potentially obtaining “a [birth control] method, or delaying pregnancy, or getting that Pap smear that they put off for a very long time,” as one informant noted. But we also heard concerns about the sensitivity of recovery. One key informant explained the importance of women being able to prevent unintended pregnancies while in treatment, saying, “A big shock like [an unintended pregnancy], especially in the beginning of recovery, could derail everything.” Several focus group participants in outpatient treatment shared concerns about the challenge of an unintended pregnancy while in treatment. One noted, “Some of us are early in recovery, and the last thing you want to do is get pregnant and have to make a big decision.”

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*[Women in treatment] want to take care of themselves. Reproductive health is a big piece of that.*

*—Key informant*

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We heard different perspectives from the women who participated in our focus groups at the inpatient treatment center, who had pledged to abstain from sexual activity while in residence. These women described that family planning is not a priority while participating in residential treatment and abstaining from sex. Instead, they said family planning would become a priority when their treatment ends, as they prepare to reenter the community and potentially become sexually active again.

## **Access to Reproductive Health Services**

Our discussions with key informants and focus group participants about access to reproductive health services among women in treatment for SUD spanned three topics: barriers to accessing reproductive health care, women’s preferences for receiving such care, and opportunities to improve reproductive health care access.

### **BARRIERS**

In both Maryland and Ohio, focus group participants did not identify cost- or insurance-related concerns as barriers to accessing reproductive health services. Some women, however, had previously experienced affordability or insurance barriers and said it is important that they can now access birth control for free. Considering current access, women and key informants spoke extensively about the social and personal barriers women with SUD face. As one provider put it, “There are not physical barriers between our clients and birth control, but there definitely are social and emotional things in the way, like mental health problems and misinformation.”

Not all focus group participants agreed that they had adequate access to reproductive health care. As one put it, “I don’t think there are enough programs for before it happens. The programs we have here [are for] once you are already pregnant. We need more prevention.” Multiple providers named trauma as the biggest challenge to meeting the reproductive health needs of women with SUD, with one saying:

The longer that I’ve done this work, the more I’ve realized how much trauma women experience and how much sexual trauma women experience, and I do think when they seek [reproductive health] services that comes into play. That is a barrier for some women who have not had their trauma addressed or have not seen a provider that has recognized that or respected that.

Key informants also identified trust as a unique barrier to reproductive health services for women with SUD. As one stated, “Most of our patients have been raped, human trafficked, so they’re not



comfortable with sexual health and recovery...It's hard to build trust with women who have never trusted anyone in their whole lives...You can't do anything to jeopardize their recovery."

Focus group participants discussed their experiences with stigma and discrimination in the health care system, sharing negative experiences that often resulted in mistrust of providers. In some cases, women said they felt stigmatized when seeking health care as someone with SUD. As one woman explained, "I went to [a nearby medical center] and as soon as they found out I was in residential treatment, they spoke to me like I was incompetent. They were talking slow like I don't understand." Others said they have been frustrated with providers who they felt were not appropriately educated about SUD. "Not everyone is as educated as they need to be, especially in the medical field...I told [the provider I was seeing] I was at a methadone clinic and he didn't know what it was. He had no clue what methadone was," one woman shared. Key informants were aware of these perspectives; as one put it, "[Women with SUD] are terrified and really dislike going to medical providers because they feel that they are judged significantly."

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*Once you say you are on methadone...they look at you different and they treat you different.*  
—Focus group participant

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Key informants indicated that competing needs, histories of trauma, and distrust of medical providers resulting from discrimination and negative interactions with the health care system can prevent women with SUD from accessing reproductive health care and consistently using birth control. Multiple providers explained that their patients with SUD struggle with planning for the future and may not feel in control of their lives. One provider said of women new to recovery, "Being able to plan and having the luxury of keeping a plan and an appointment [is challenging]. If it isn't long-term birth control, then [it's] remembering to take the birth control pill every day or use a condom every day..." Providers specifically identified women's relationships as barriers; one provider noted seeing "a lot of sexual coercion and clients who are in survival sex situations, abusive relationships." That provider further explained, "So it is not as cut and dry of a decision to seek reproductive health as it might be in a typical situation. It is a power and control thing, and most of our clients don't feel very in control. It can be hard to empower them to seek control over things like that." Another key informant shared similar thoughts:

That is another thing with clients not feeling in control. They tend to just say, 'Whatever happens, happens.' Planning doesn't feel very safe. So, trying to convince people with the experience of having their plans fall through fairly consistently—it can take a lot of heat when you say, 'Let's plan something.' There is pushback on that.

Finally, at the health care system level, key informants shared that siloed care can prevent women in treatment for SUD from accessing reproductive health care. Consequently, women may need to see different providers in different offices for their SUD treatment, medical care, mental health care, and

other needs. Requiring multiple appointments to treat different needs can be a barrier to accessing care, and systems are seldom structured to provide holistic or patient-centered care. Further, siloed care can result in providers who are not trained to provide culturally effective care for women with SUD. One provider shared her frustration, saying, “Addiction treatment is over here, medical care is over here. Our patients don’t come in siloes, but it is hard to break down those siloes, both in terms of the financial structure, and also those providers will say, ‘That is not my job to take care of reproductive health.’”

Specific barriers to providing more holistic care include Medicaid reimbursement policies; limited training in reproductive health or contraception counseling among SUD treatment providers; limited training in providing culturally effective, patient-centered care for patients with SUD among reproductive health providers; high staff turnover rates at SUD treatment clinics; and a lack of shared language and vision across areas of care. Key informants noted that individual providers motivated to make change—not systemic efforts—have driven most success with integrated care models.

### CARE PREFERENCES

Most women we spoke with said they would be willing to discuss reproductive health and birth control with their SUD treatment counselors. A few women in outpatient treatment explicitly did not want to broach this topic with their counselors, and others thought it should be up to each woman to choose whether to engage with her counselor on the topic.

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*It would be really nice to have [more information] on detail about birth control methods or what’s the best fit for you.*

*—Focus group participant*

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Women consistently wanted more information, resources, and programs about family planning, and many thought it should be routinely included in their treatment programs, either in one-on-one counseling sessions or group sessions with other women. One woman in outpatient treatment shared, “I feel like we are coming in here already not 100 percent, so birth control should be a big topic here. To prevent pregnancy for a number of reasons.” A woman in the inpatient treatment program expecting residents to abstain from sex shared that she wants more information about family planning: “It’s sort of like you’re an adolescent [in the residential treatment program]. They want you to be abstinent. So they don’t even want to talk about birth control with you.”

Women were also very concerned about coercion, given their past experiences with the health care system; some reported coercive experiences with providers who do not want women with SUD to have children. One woman shared her perspective:

At the women's clinic, they want everyone to be on birth control and not have kids because we are [perceived as] junkies. That is how I feel, personally. Not at the clinic here so much, but people at other [OB-GYN provider sites], once they find out I am on methadone, they push not having a baby or being on birth control, because they know I have drug history and they don't want drug babies. That is how it comes off to me.

Another woman emphasized the need make her own decisions about using birth control, saying, "If I feel forced to do something, I am not doing it." Providers echoed the importance of choice; one said, "At some point, using drugs is not a choice—it is a disease. But there is still an opportunity to make a choice about when to have a child. So, making sure they are given that opportunity is important."

### OPPORTUNITIES FOR IMPROVEMENT

Both women in SUD treatment and providers shared that co-location of reproductive health services with high-quality, culturally effective, and evidence-informed SUD treatment could improve access to needed care. One provider shared that once services are co-located, they are easy to provide: "We can easily [meet] those [reproductive health] needs. When we're co-located with their treatment provider, those are easy services to provide." Key informants also emphasized the benefit of being able to provide services to women without asking them to come back for a separate appointment or referring them to a new location for reproductive health care. One informant stated, "You need to understand that you might never see [the patient] again, so anything you can get done right now...to help them is great." Though most conversations focused on integrating reproductive health care into SUD treatment, some key informants also shared opportunities to reach women with SUD not in treatment through mobile clinics located within correctional facilities and courts.

Some reproductive health services, such as LARC insertion and other procedures that require dedicated clinical space or stocked medical devices, likely require the use of mobile clinics or require SUD treatment counselors to refer patients to a reproductive health provider. When referrals are needed, informants emphasized the value of a warm hand-off—introducing a patient to a new provider in person rather than simply making a referral. However, key informants supported direct integration of contraceptive counseling into the curriculum provided by SUD treatment counselors. This might include training counselors to ask One Key Question,<sup>8</sup> or another validated assessment of women's pregnancy intention, and to provide comprehensive contraception counseling. One key informant shared the following experience:

What we see working best is training our addiction counselors and folks to do the initial [assessment]—whether it is the One Key Question or the counseling—having that conversation. Because at the end of the day, these women trust their counselors more than anyone. So...[the counselors] can open that conversation with them and then hand-hold them and say...'Let me introduce you to this provider.'

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## BOX 2

### Integration of Reproductive Health Care at Study SUD Treatment Programs in Ohio and Maryland

In Ohio, the SUD treatment clinic we visited had a weekly on-site women's clinic sponsored by the local health department. Women shared positive perceptions of the clinic and generally supported having access to reproductive health services where they receive SUD treatment. One woman shared, "I think it is great they have programs here and people should take advantage of it being 'one stop.'" Some women liked co-located services for their safe and trusted environment, with one woman describing the SUD treatment clinic as "one place where I don't feel judged or discriminated against." Key informants stressed that this clinic only became successful after making two changes: (1) relying on referrals from counselors and word of mouth instead of direct outreach to patients and (2) rebranding as a women's health clinic, instead of a birth control clinic. Beyond ensuring that care is noncoercive, providers also discussed the importance of ensuring integrated reproductive health services can be reimbursed and that reproductive health providers are trained to meet the unique needs of women in treatment for SUD.

Family planning is not a routine part of treatment plans at the residential SUD treatment center we studied in Maryland; instead, it might be discussed at intake; during other visits with the on-site nurses; or during a woman's discharge planning, if a woman brings it up. And though treatment includes discussions and education about parenting and pregnancy, it typically does not delve into preventing pregnancy. Women in this treatment program supported more consistent inclusion of family planning in the curriculum, and providers were open to this idea. The program currently includes education on sexually transmitted infections provided by staff at the Maryland Department of Health, and some suggested this session could be expanded to include education about pregnancy prevention and birth control. Notably, the on-site advanced practice registered nurse can already prescribe birth control; LARC methods still require referral to an outside provider.

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Beyond co-location, key informants reported that finding the right reproductive health providers for women with SUD is critical to promoting access to reproductive health care. Key informants described the right providers as having served women in SUD treatment (to reduce stigma and ensure clinical and practical knowledge of the intersection between reproductive health and SUD treatment) and being trained in trauma-informed care, good at communicating, and supportive, dedicated, and flexible. "It takes a special provider," said one key informant. We also heard the importance of having the same providers consistently available: "[Patients] need to see your face week after week, they need to know you're going to be there. They've been let down by lots of people lots of times," said one provider.

Finally, providers and other key informants emphasized the importance of presenting reproductive health care as a component of women's overall health and well-being, not specifically as a tool for pregnancy prevention. This was described as important for building trust with women who might feel targeted and pressured not to have children because they have SUD. One provider discussed framing reproductive health as "harm reduction overall," not just because someone is using substances but "because [they] are a human being that hasn't seen a doctor in five years." Another informant shared the following:

I do think that it communicates a true interest in someone's well-being to say, 'When was the last time you had a women's health appointment?' And, for us, we employ One Key Question, so we ask, 'Do you want to become pregnant in the next year?' That says a couple of things to a woman: One is, 'She [the provider] thinks I can still be a mom,' because that's a common theme for these women, that 'People think I shouldn't be a mother,' or they think, 'Look, she can offer me these services the same day.' It's really important to women to ask these questions. Some people think it's going to be prying or an invasion of privacy, but I don't find that at all, I find the opposite.

## Discussion

Like women of reproductive age generally, most of the women in treatment for SUD who participated in our focus groups reported that access to birth control and the ability to plan whether or when to become pregnant are very important to their lives. Many also wanted access to birth control methods that are effective and easy to use without negative side effects.

Both focus group participants and key informants described unique reproductive health needs for women in treatment for SUD, including risks of sexually transmitted infection and unintended pregnancy associated with transactional sex and intimate partner violence as well as competing social and general health needs. Further, focus group participants described experiences of stigma and discrimination in the health care system as barriers to reproductive health care for women in treatment for SUD, while key informants reported that barriers can include high prevalence of trauma, challenges planning for the future, and a perceived lack of autonomy over reproductive decisions.

The challenges of unintended pregnancy can cause recurrence of use for some mothers in treatment for SUD. Thus, meeting these mothers' reproductive health care needs is crucial to preventing disproportionate harm and supporting women's choices regarding when and whether to have children. To meet their needs, providers emphasize listening to women, meeting them where they are, and providing the care they need in ways that suit them.

## Limitations

Because the findings from this analysis are from case studies in two locations, they are not generalizable to the experiences of all women with SUD in Maryland, Ohio, or other states. Interviews and focus groups were conducted before the COVID-19 pandemic. Therefore, the findings from this analysis do not reflect potential challenges to accessing reproductive health care among women with SUD during the pandemic, any changes to the provision of such services during the pandemic, or other changes to the policy environment that may have occurred since January 2020.

Our conversations with women with SUD were limited to those in one residential SUD treatment program in Maryland and one outpatient SUD treatment program in Ohio. We selected these programs for focus groups based on the recommendations of key informants in each state and the organizations' willingness to participate in our case studies. Because of the limited scope of these case studies, this work does not assess the quality of SUD treatment received by women participating in our focus

groups. However, women in treatment likely have better access to health care overall, including reproductive health services, than the many women who cannot access SUD treatment (Terplan, McNamara, and Chisolm 2012): In Maryland, women discussed several barriers to treatment for SUD, including the inability to bring dependent children with them to most residential treatment centers or lack of child care in outpatient treatment; long waiting lists for treatment centers, especially those that can accommodate women with children; no treatment for co-occurring mental health disorders; and the loss of Medicaid when incarcerated. Though this study focuses on women in treatment for SUD, more work is needed to understand the experiences with and preferences for accessing reproductive health care among women with SUD who are not in treatment.

Finally, the 59 women who participated in our focus groups represent a convenience sample recruited through on-site advertising and recruitment, provider outreach, and word of mouth. Though we present participant characteristics for context, we cannot draw valid inferences about differences in women's experiences and preferences by their characteristics, including disparities by race, given the nature of the study. This is an important limitation given known inequities in access to reproductive health care and SUD treatment, as well as discrimination against women who use drugs based on one's race, ethnicity, sexual orientation, gender identity, and other characteristics (Acevedo et al. 2015; Dehlendorf et al. 2014). Future research could investigate how our study findings vary by women's characteristics and experiences, including what role racism plays in these disparities.

## Policy Implications

Key informants and focus group participants consistently reported that co-locating reproductive health services with SUD treatment services could improve access to such services for women in treatment for SUD. Importantly, offering reproductive health services where women are already in treatment can reduce stigma and discrimination; allow them to receive care from providers they already trust or through a warm hand-off to a new provider; and reduce system-level barriers, like transportation and child care, by eliminating the need for an additional visit.

However, key informants identified systemic barriers to co-locating services, ranging from Medicaid policy prohibiting reimbursement of family planning services during inpatient behavioral health stays to stigma and lack of culturally effective reproductive health care for women with SUD. Finding the special providers needed to provide co-located reproductive health and SUD treatment services will likely pose another challenge. Investments in training may be needed to ensure access to high-quality, culturally effective, and evidence-informed care. Whether SUD treatment providers start providing reproductive health care or reproductive health providers start offering SUD treatment, providers may need additional training to meet the specific reproductive health needs of women with SUD. Further, SUD treatment counselors could be trained to educate women about reproductive health services and refer them to those available on site.

These findings are consistent with studies including interviews with women in treatment for opioid use disorder in Ohio, where women reported having easy access to birth control through Medicaid

coverage but not consistently using contraception and experiencing high rates of unplanned pregnancy (Fischbein et al. 2018). Women voiced overall support for integrating reproductive health services with SUD treatment, consistent with a study in Baltimore that found clients in SUD treatment were more likely to use family planning services if they were available at the treatment site (Terplan et al. 2016).

We also heard creative local-level approaches to promoting access to reproductive health care services for women in treatment for SUD. Federal and state efforts to combat the opioid epidemic could provide a targeted funding source to begin to expand these approaches and start to address the broader health care needs of women in treatment for SUD while requiring that services provided be culturally effective. The experiences of the women in our focus groups and our key informant interviews highlight the importance of addressing discrimination against women who use drugs, particularly women with low incomes and women of color, by providing those in treatment for SUD with access to reproductive services delivered in supportive, noncoercive ways.

## Notes

- <sup>1</sup> In the brief, we use the term “transactional sex” to refer to trading sex for money, drugs, or other resources. See Decker and colleagues (2012).
- <sup>2</sup> Emily M. Johnston and Adele Shartzter, “Women Want Effective Birth Control,” *Urban Wire* (blog), Urban Institute, December 20, 2017, <https://www.urban.org/urban-wire/women-want-effective-birth-control>; Sarah Benatar, Brigitte Courtot, Ian Hill, Becky Peters, Morgan Cheeks, Jenny Markell, Emily M. Johnston, and Sophia Yin, “Women Call for More Education, Contraceptive Choices to Prevent Unplanned Pregnancy,” Urban Institute, March 7, 2019, <https://www.urban.org/features/women-call-more-education-contraceptive-choices-prevent-unplanned-pregnancy>.
- <sup>3</sup> These studies define women at risk of unintended pregnancy as those who are able to become pregnant and are not currently pregnant or seeking pregnancy.
- <sup>4</sup> Benatar, Courtot, Hill, et al. “Women Call for More Education, Contraceptive Choices to Prevent Unplanned Pregnancy.”
- <sup>5</sup> Though our study design excluded analysis of the specific programs and services at participating SUD treatment sites, women enrolled in the inpatient treatment program in Maryland frequently noted they were expected to abstain from sexual activity. Abstinence from sexual activity is not supported by evidence-based guidelines for SUD treatment (Cunningham et al. 2020; NNEPQIN 2018; SAMHSA 2018), and this program component may affect women’s reproductive health experiences (e.g., their need for and access to family planning services).
- <sup>6</sup> Although abortion was included in our definition of reproductive health care and mentioned in some interviews and focus groups, abortion was not a commonly discussed reproductive health care topic.
- <sup>7</sup> Counts sum to 31 because one participant selected multiple responses.
- <sup>8</sup> **One Key Question** is a tool used by health care and social service providers to begin a conversation about family planning by asking women, “Would you like to become pregnant in the next year?”

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