Access Is Power:
Opioid Use Disorder and Reproductive Health

Background

Opioid use and abuse in the United States has rapidly increased over the past two decades, leading to a public health crisis. The prevalence of opioid use disorder (OUD) among pregnant women doubled between 1998 and 2011 (from 1.7 per 1,000 delivery admissions to 3.9 per 1,000).[1]

As the incidence of OUD in pregnancy has increased, so too has the number of infants born with neonatal abstinence syndrome (NAS). The incidence of NAS in the United States quadrupled from 1999 to 2013 (from 1.5 per 1,000 births to 6.0 per 1,000).[2] NAS refers to the withdrawal symptoms exhibited by infants who are exposed to substances (such as opioids, benzodiazepines, and methamphetamines) in utero. These symptoms include irritability, poor sleeping and feeding, high-pitched cry, diarrhea, and seizures. Though rarely fatal, NAS can lead to significant distress, extended hospital stays, and prolonged treatment with medications including methadone and morphine.[3] These medications and prolonged hospitalizations, often in the neonatal intensive care unit, have a large financial impact. In 2012, an infant with NAS had an average hospital stay of 17 days and an average bill of $66,700 (compared to 2.1 days and $3,500 for a healthy term infant). The medical bills for all infants treated for NAS that year totaled $1.5 billion, 80 percent of which was financed by Medicaid.[4]

In addition to medical and economic costs, substance use disorder (SUD)[i] has negative social outcomes for families as well. From 2012 to 2016, there was a 10-percent increase in the number of children entering foster care nationally, which has been largely attributed to the opioid epidemic. For the average county, a 10 percent rise in drug overdose deaths between 2011 and 2016 was correlated with a 2.2 percent increase in maltreatment reports and a 4.4 percent increase in foster care placements.[5] While Child Protective Services aims to keep families intact, foster placements occur when parents are unable to balance caring for their children and successfully treating their addiction. Many of these children have

[i] Though SUD and OUD are not interchangeable terms, they are both used here because substance use disorder is the broader category of which opioid use disorder is a specific type, and many people who have OUD use and abuse additional substances including methamphetamines, cocaine, tobacco, marijuana, and alcohol.

behavioral and mental health concerns due to experiencing abuse and/or neglect prior to placement, as well as being separated from their parents. The increase in children entering foster care also puts strain on state child welfare systems that are already struggling to meet the needs of the families they serve.

Among all women of childbearing age, 45 percent of pregnancies are unplanned;[6] however, as many as 86 percent of pregnancies among women with OUD are reported as unplanned.[7] Given the increased risk of unplanned pregnancy in this population, one primary prevention strategy for reducing the incidence of NAS and utilization of the foster system that states and communities should consider is to address the reproductive health needs of individuals with SUD.[8] For women not in recovery, many barriers including cost, fear of mistreatment, and lack of transportation, contribute to a high rate of unplanned pregnancy. Even for those in recovery, barriers remain.

Substance Use Treatment and Reproductive Health

In 2018, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) issued *Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants* that underscores the importance of health care professionals discussing various forms of contraception with all women, including those with OUD, before they are discharged from the hospital. This is critical to preventing unplanned pregnancies and reducing the incidence of infants born with NAS. The SAMHSA guidelines advise providers to encourage pregnant women in treatment to consider planning future pregnancies with the support of the health care team.

> "At a minimum, women should receive non-coercive contraceptive counseling and the option to leave the hospital with a prescription for contraception, contraceptive supplies, or a contraception plan."[i]

For women who have just given birth in the hospital, SAMHSA recommends "Each new mother should have the option to receive a long-acting reversible contraceptive (LARC) prior to leaving." This is in accordance with the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, and other nurse professional societies that recommend offering immediate postpartum LARC to reduce unintended or short-interval pregnancy. "At a minimum," SAMHSA advises that "women should receive *non-coercive* contraceptive counseling and the option to leave the hospital with a prescription for contraception, contraceptive supplies, or a contraception plan [emphasis added]."[9]

However, evidence suggests that these vital conversations are not yet a common practice between providers and women with SUD, including for women and their providers in treatment facilities. For example, in one study, women in treatment for

SUD identified myriad barriers to accessing reproductive health services, including not being asked about family planning, being unable to fill prescriptions for birth control, having difficulty making and getting to appointments with outside doctors, and not knowing they could discuss reproductive health with the staff at their drug treatment program.[10] In another study, of those in SUD treatment, 53 percent and 60 percent of sexually active women and men respectively were using any form of contraception, with 20 percent of women and 14 percent of men using a highly reliable form of contraception. Also, 83 percent of women and 58 percent of men in the same study said they would be more likely to use reproductive health services *if they were offered* through their treatment program.[11]

While Congress has so far not addressed this primary prevention strategy in legislation, states and communities are leading the way with innovative approaches to increase knowledge about, and access to, reproductive health services for women with SUD. Several of those initiatives are highlighted below.

State and Community Initiatives at a Glance

Florida

The Healthy Start Coalition of Bay, Franklin, & Gulf Counties is working to increase access to contraception for women with OUD in Bay County, Florida. They are offering services to women in treatment at a local methadone clinic and the Bay County jail. With a grant from the Bay Health Foundation, Healthy Start has partnered with a free clinic in Panama City to provide contraceptive counseling and IUD placements for those who desire them.[i]

Maryland

Efforts in Baltimore have focused on reaching high-risk populations who are not yet in recovery as well as incorporating reproductive health into substance use treatment. One initiative used the Health Department's needle exchange mobile vans to go into the city's "red light district" and provide exotic dancers with services including pregnancy and STI testing and contraception counseling and provision. From October 2009 to June 2011, there were 220 visits to the vans. Staff provided contraception, including the pill and depo shot, at 63 percent of the visits.[12] The vans served a clear need, as 75 percent of the women who visited them were not receiving contraceptive care elsewhere at that time.

After years of formative research, the Baltimore City Health Department's Bureau of Maternal and Child Health and Behavioral Health System Baltimore launched the Baltimore Reproductive Health Initiative pilot project (RHI) in 2016. RHI was designed to integrate screening, education, and on-site service delivery into substance use treatment programs. Patients were screened on their family planning needs through a modified One Key Question® guide at intake, educated on reproductive health and contraception through a six-week curriculum, and offered a full range of on-site reproductive services, including all contraceptive methods.[13] Staff also received extensive training and technical assistance. Private foundation and Title X funds helped support these services. Originally integrated into three

treatment sites, on-site reproductive health services continue to be offered at two sites. More than 500 clients have been served to date.

Ohio

Pilot programs in Cleveland and Columbus are using Title X funding to increase access to birth control, STI testing, and other services for women in treatment.[14] In Cleveland, the efforts are organized by the County Board of Health Title X Reproductive Health Clinic in coordination with the Cuyahoga County Opiate Task Force and the Better Birth Control NEO initiative. They have been working with women's recovery houses in the county to collaborate on ways to increase access to reproductive health services for women in recovery.[15] In the first year, 122 clients at treatment centers received education on a variety of health topics and 60 women opted to come in for an office visit where they received a well-woman exam and other services. Of the women seeking contraception, 42 percent chose an IUD or implant, and there were no unplanned pregnancies.

At the CompDrug treatment facility in Columbus, there is a clinic operating one half day a week to provide women with contraception counseling, reproductive life planning, and same-day access to birth control, including LARC (IUDs and implants).[16] By offering walk-ins and same-day method provision, this program reduces the barriers of time, transportation, and difficulty making and following through on appointments. Women can learn about their contraceptive options when they come for their drug treatment services, and if they want to, also receive their desired method. Since the clinic opened in February of 2018, there have been 35 visits. Patients received same-day contraception at 24 of these visits, and 11 (46 percent) patients chose to start a LARC method.

Tennessee

In an effort to reduce the rate of NAS in the state through primary prevention, the Tennessee Department of Health has worked with the justice system to develop pilot programs in county jails. These efforts began in the East Region, in Sevier and Cocke counties, in 2014. Programs provided inmates with health education sessions on NAS and ways to prevent it. Those who desired more reproductive health counseling were transported to their local health department for family planning services, including LARCs if desired. In 2015, a year after the pilot program in Sevier County began, the county noted a 57 percent reduction in NAS cases compared to the previous year. Given the success in these pilot counties, the programs were expanded to other counties across the state and as of January 2017, 41 jails were offering similar programs.[17] From January 2014 to 2017, 5,847 women in the East Region attended these education sessions, 1,012 of the women requested referrals for further services, and 935 (92.4 percent) of those women selected a method from the full range of options, ranging from the birth control pill and the shot to the IUD and the implant.

Washington

As a part of Medicaid transformation, Washington has created regional opioid treatment services with nine regional Accountable Communities of Health, or ACHs. Several of these ACHs are starting to incorporate reproductive health into their

substance use treatment efforts. In Pierce County, the ACH is doing this by encouraging providers to use One Key Question®[18] to help men and women in substance use treatment assess their goals with respect to having children, in order to help tailor care to their specific needs.

West Virginia

The West Virginia Bureau for Public Health, Office of Maternal, Child and Family Health, Family Planning Program (WV Family Planning Program) is the state's sole Title X grantee. The WV Family Planning Program has contacted every harm-reduction clinic in the state to ensure that staff are aware of the full range of contraceptive methods and to encourage the provision of family planning services simultaneously during harm-reduction clinics. Additionally, the West Virginia Family Planning team started training staff at the family planning clinics on appropriate provision of care for women with SUD.

In 2018, the legislature provided additional funds to the WV Family Planning Program to ensure that more women with substance use disorder have access to the full range of contraceptives (including LARC) and that they are provided in a non-coercive environment. The WV Family Planning Program will facilitate and oversee increased access to contraception at harm reduction clinics, hospitals (immediately post-partum), and correctional facilities where contraception will be offered to women who are about to be released.

Recommendations

While there are a number of promising efforts around the country, there is still much room for program development, improvement, evaluation, and expansion. Stakeholders, including policymakers, can help to support and expand these initiatives. Many programs need increased funding to be able to offer services during more hours of the day and more days of the week. Also, many of the efforts are focused on specific populations such as those in the justice system or those in treatment facilities, and are only in one or a few communities. Through policies, funding, and collaboration, services could be expanded to more women of reproductive age with SUD across each state.

Any efforts to expand access to contraception, especially among vulnerable populations including women with SUD, should be voluntary and non-coercive, patient-centered, and provide the full range of contraceptive options, including but not limited to LARC.[19]

There is also opportunity for states and communities to incorporate reproductive health into existing programs for women and their infants. The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), a federal program that was reauthorized for five years in February 2018, provides funding to states for evidence-based home visiting programs in high-need areas. In 2016, 3,282 local programs in 56 states and territories reached 239,662 families through 2,066,227 home visits.[20] Of these, 37.5 percent of enrollees had substance abuse problems and 26 percent stopped using alcohol and illicit drugs through their program

involvement.[21] With these home visiting programs already reaching and helping families struggling with SUD, expanding services so that more home visiting programs include comprehensive contraception counseling and referral would more fully meet the needs of parents with OUD and their children.

> Any efforts to expand access to contraception, especially among vulnerable populations including women with SUD, should be voluntary and non-coercive, patient-centered, and provide the full range of contraceptive options, including but not limited to LARC.

If your state is not mentioned above, find out if there are any initiatives to meet the reproductive health needs of women experiencing SUD. If there aren't any, talk to other stakeholders to start laying the groundwork for such efforts. Opioid and other substance use disorders are prevalent throughout the United States, and lack of access to appropriate reproductive health services for women has profound consequences for women, families, communities,[22] and taxpayers.

Conclusion

Many public health efforts to improve pregnancy planning and prevention among women with SUD are motivated by a desire to improve the overall health and well-being of families. Women in substance use treatment programs have acute mental health needs, but also reproductive health needs that are often not addressed to ensure they have equitable access to these services. By providing women with comprehensive, non-judgmental information on, and access to, the full range of contraceptive options, as well as STI and prenatal care, we can empower them to decide if, when, and under what circumstances to become pregnant.

---

[1] Ko, J.Y., Wolicki, S., Barfield, W.D., Patrick, S.W., Broussard, C.S., Yonkers, K.A., Iskander, J. (2017). CDC Grand Rounds: Public Health Strategies to Prevent Neonatal Abstinence Syndrome. *Morbidity and Mortality Weekly Report,* 66(9), 242-245. http://dx.doi.org/10.15585/mmwr.mm6609a2

[2] Ko, J.Y., Patrick, S.W., Tong, V.T., Patel, R., Lind, J.N., & Barfield, W.D. (2016). Incidence of Neonatal Abstinence Syndrome - 28 States, 1999–2013. *Morbidity and Mortality Weekly Report,* 65(31), 799–802. http://dx.doi.org/10.15585/mmwr.mm6531a2

[3] Kocherlakota, P. (2014). Neonatal abstinence syndrome. *Pediatrics, 134*(2), e547–e561. Retrieved from http://pediatrics.aappublications.org/content/pediatrics/134/2/e547.full.pdf

[4] Ko, J.Y., Wolicki, S., Barfield, W.D., Patrick, S.W., Broussard, C.S., Yonkers, K.A., Iskander, J. Public Health Strategies.

[5] Radel, L., Baldwin, M., Crouse, G., Ghertner, R., & Waters, A. (2018). Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study (ASPE Research Brief). Retrieved from https://aspe.hhs.gov/system/files/pdf/259241/MethodologicalDetailsMixedMethods.pdf

[6] National Data. (n.d.). *Power to Decide*. Retrieved from https://powertodecide.org/what-we-do/information/national-state-data/data

[7] Heil, S. H., Jones, H. E., Arria, A., Kaltenbach, K., Coyle, M., Fischer, G., Martin, P. R. (2011). Unintended Pregnancy in Opioid-abusing Women. *Journal of Substance Abuse Treatment*, 40(2), 199–202. http://doi.org/10.1016/j.jsat.2010.08.011

[8] Ko, J.Y., Wolicki, S., Barfield, W.D., Patrick, S.W., Broussard, C.S., Yonkers, K.A., Iskander, J. Public Health Strategies.

[9] U.S. Substance Abuse and Mental Health Services Administration. (2018). *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf

[10] Robinowitz, N., Muqueeth, S., Scheibler, J., Salisbury-Afshar, E., & Terplan, M. (2016). Family Planning in Substance Use Disorder Treatment Centers: Opportunities and Challenges. *Substance Use & Misuse*, 51(11), 1477–1483. http://doi.org/10.1080/10826084.2016.1188944

[11] Terplan, M., Lawental, M., Connah, M. B., & Martin, C. E. (2016). Reproductive Health Needs Among Substance Use Disorder Treatment Clients. *Journal of Addiction Medicine*, 10(1), 20–5. https://doi.org/10.1097/ADM.0000000000000175

[12] Moore, E., Han, J., Serio-Chapman, C., Mobley, C., Watson, C., & Terplan, M. (2012). Contraception and clean needles: feasibility of combining mobile reproductive health and needle exchange services for female exotic dancers. *American Journal of Public Health*, 102, 1833-6. http://doi.org/10.2105/AJPH.2012.300842

[13] Terplan, M., Kirschner, J., Muqueeth, S., & Dineen, R. (2017). The Baltimore Reproductive Health Initiative: Bringing Family Planning to Women in Treatment. *Drug and Alcohol Dependence*, 171, e201. https://doi.org/10.1016/j.drugalcdep.2016.08.550

[14] Pryce, D. (2018, February 25). A missing piece in our fight to combat the opioid epidemic. *Cleveland.com.* Retrieved from www.cleveland.com/metro/index.ssf/2018/02/a_missing_piece_in_our_fight_t.html

[15] Cuyahoga County Board of Health. (2016). *Cuyahoga County Opiate Task Force Report 2016*. Retrieved from http://www.ccbh.net/wp-content/uploads/2017/07/2016-CCOTF-Annual-Report.pdf

[16] *Holmes, D. (2018, February 27). Columbus Clinic Aims to Prevent Pregnancy While Addicted Women Recover.* WOSU Public Media. *Retrieved from http://radio.wosu.org/post/columbus-clinic-aims-prevent-pregnancy-while-addicted-women-recover#stream/0*

[17] Scott, M. (2017, January 30). Long-acting contraception now offered at 41 Tennessee jails. *WBIR.* Retrieved from https://www.wbir.com/article/news/local/long-acting-contraception-now-offered-at-41-tennessee-jails/51-394541994

[18] *Tarico, V. (2018, May 22). Almost 1 Percent of Washington Newborns go Through Withdrawal from Opioids: Integrated reproductive health and opioid treatment services empower prospective moms, provide best starts for babies.* Siteline Institute*. Retrieved from www.sightline.org/2018/05/22/almost-1-percent-of-washington-newborns-go-through-withdrawal-from-opioids*

[19] Bishop, D., Borkowski, L., Couillard, M., Allina, A., Baruch, S., & Wood, S. (2017). *Bridging the Divide White Paper: Pregnant Women and Substance Use: Overview of Research & Policy in the United States* [White Paper]. Retrieved from http://hsrc.himmelfarb.gwu.edu/sphhs_centers_jacobs/5

[20] The Dalton Daley Group. (2018). *MIECHV Reauthorization: Combating the Opioid Epidemic Through Evidence Based Home Visiting*. Washington, DC: The Dalton Daley Group. Retrieved from www.thedaltondaleygroup.org/Publications.html

[21] Ibid

[22] *Pryce, D. "A missing piece in our fight to combat the opioid epidemic: Deborah Pryce." Cleveland Plain Dealer. 25 February 2018. Retrieved from https://www.cleveland.com/metro/index.ssf/2018/02/a_missing_piece_in_our_fight_t.html.*