The Dual Burden of Unmet Reproductive Health Care Needs among Women with Substance Use Disorder in Ohio
The Dual Burden of Unmet Reproductive Health Care Needs among Women with Substance Use Disorder in Ohio

Center for HOPES Issue Report | October 2022

Lisa A. Frazier, PhD, MPH
Anne Trinh, MPH
Kyle J. Moon
Saira Nawaz, PhD, MPH
## Table of Contents

- The ‘dual burden’ of unmet need ........................................................................3
- Complex health care needs and services ...............................................................4
- Who’s at risk for the dual burden in Ohio ............................................................5
- Structural barriers to accessing SUD and reproductive health in Ohio .............7
- Consequences of the dual burden .........................................................................12
- Implications for public health policy & practice in Ohio ....................................16
- Summary ..............................................................................................................19
- Endnotes ...............................................................................................................19
Nearly 200,000 women* of reproductive age in Ohio live with a substance use disorder. This population systematically faces barriers to essential health care that leads to poor outcomes for themselves, their families, and Ohio’s communities.

What is the ‘dual burden’ of unmet need?

The dual burden refers to the joint problem of unmet reproductive health and addiction care needs among women* with substance use disorder (SUD). While all people face a range of reproductive health needs throughout their lives, women and people with female reproductive organs experience unique reproductive health care needs related to both biological and socio-cultural factors based on their sex and gender.

People with SUD have long-term health care needs similar to those associated with management of other chronic conditions. While access to appropriate and quality health care is a concern for everyone, women with SUD bear a dual burden of complex structural barriers to access including lack of coverage, cost, supply of providers, and pervasive social stigma and criminalization related to both reproductive health and addiction. In addition to the personal costs of unmet need for women with SUD, the dual burden imposes costs for families, loved ones, and society at large, making it a matter of public health and public concern, not just individual health care.

* Not all people with female reproductive organs are women, nor do all women have female reproductive organs. The data sources we draw on for this report use binary sex categories, we are thus limited to those categories and default to use of the term “women”. Nonetheless, we hope that readers will take special note that all people need reproductive health care, and that women, transgender people, and gender non-binary people are likely to experience the unmet health care needs discussed in this report, and likely many more.
Complex health care needs and services

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that more than 7.5 million women and girls in the United States ages 12 and older are living with substance use disorder.\(^1\) The lifetime prevalence of alcohol and drug use disorders in women is 19.5\% and 7.1\%, respectively.\(^2\) Substance use disorder is defined by the recurrent use of a substance that causes clinically significant impairment and distress including health problems, inability to reduce use, physiological tolerance for the substance, and failure to meet major responsibilities at work, school, or home.\(^3,4\)

A chronic brain disease with complex etiology, substance use disorder creates long-term, evolving health care needs for affected individuals. Prevention and treatment approaches for addiction are generally as successful as those for other chronic diseases; adherence to treatment and relapse rates are similar to those for asthma, hypertension, and diabetes.\(^5,6\) In addition to counseling and social support, *medications for addiction treatment* (MAT, also referred to as medication-assisted therapy) are essential elements of treatment and improve recovery outcomes. For example, buprenorphine and methadone are widely effective treatments, including for pregnant people and infants; MAT induction is associated with lower rates of overdose death, low birthweight, preterm delivery, and neonatal withdrawal.\(^7\)

Although the rate of SUD in women is lower than in men,\(^8\) women face unique sex- and gender-based challenges. Women are more likely than men to report use of addictive substances to cope with physical and emotional pain and trauma, including domestic or sexual violence, divorce, loss of child custody, or death of a partner or child.\(^9\) While men are more likely to use addictive substances,\(^10\) substance use in women tends to progress into addiction more quickly (in part due to higher sensitivity to the intoxicating effects of some drugs), and women are thus just as likely to develop SUD as men.\(^11\)

Evidence suggests that women are at higher risk of opioid use disorder (OUD) specifically because they are prescribed medications for chronic pain management at higher levels than men, and women are at higher risk of death from opioid overdose because they are less likely to be administered naloxone than men.\(^12\) Therefore both physiological and cultural factors drive the need for increased socio-behavioral supports and family- or community-based counseling for women with SUD.\(^13\)

Women with SUD also face sex- and gender-specific health care needs across their reproductive life course, from menstruation through menopause.\(^14,15\) Women with SUD are less likely than those without SUD to have consistent and reliable access to menstrual hygiene products,\(^16\) contraception and sexually transmitted infection (STI)
prevention, and essential gynecological and obstetric care. They are also more likely to have been victims of domestic or sexual violence.

Who’s at risk for the dual burden in Ohio?

On average, women’s reproductive window lasts about 35 years. There are approximately 2.5 million females of reproductive age (15-49) in Ohio and 75 million nationally, constituting about 43% and 45% of the total female population, respectively.

According to data from the Behavioral Risk Factor Surveillance System (BRFSS), nearly 70% of Ohio women ages 18-49 at risk of pregnancy use any contraceptive.

Use of Contraceptives | Ohio women 18-49

- **No method**
  - 50.1%

- **Unspecified**

- **Least effective method**
  - condoms, diaphragm, cervical cap, sponge, rhythm method, natural family planning, withdrawal, spermicide, EC

- **Moderately-effective method**
  - injectables, pills, patches, vaginal rings

- **Highly-effective method**
  - male or female sterilization, IUDs, implants

Source: 25

---

Dual Burden Issue Report | u.osu.edu/hopes
Rates of **substance use** in women and girls in Ohio are comparable to the national average. Women accounted for 32.5% of all overdose deaths in Ohio in 2018, compared to 31% nationally; 7.6% of women and girls in Ohio have a substance use disorder, compared to 7.4% nationally.

**Substance Use | Women & Girls 12+ | Ohio | U.S.**

<table>
<thead>
<tr>
<th></th>
<th>Illicit drugs in past month</th>
<th>Alcohol in past month</th>
<th>Binge alcohol use in past month</th>
<th>Tobacco in past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ohio</strong></td>
<td>11.7%</td>
<td>51.3%</td>
<td>24.8%</td>
<td>27%</td>
</tr>
<tr>
<td><strong>U.S.</strong></td>
<td>12.3%</td>
<td>50.9%</td>
<td>24.2%</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

Source: 27

Significant proportions of Ohio’s women and children report **traumatic experiences** that increase their risk for substance use and misuse. Those who have experienced high levels of childhood trauma (five or more **adverse childhood events** or ACEs) are three times more likely to abuse prescription painkillers, and five times more likely to inject drugs. Eighty percent (80%) of those seeking opioid use disorder treatment report at least one ACE.

**Ohio ranks among the worst – 46th of 51 nationally – for kids with 3+ ACEs**

<table>
<thead>
<tr>
<th></th>
<th>49% of kids with at least 1 ACE</th>
<th>1/7 kids with 3+ ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nationally, Black</strong></td>
<td>61%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>51%</td>
<td>30%</td>
</tr>
<tr>
<td>children are more likely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to have had at least 1 ACE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>compared to White children</td>
<td>(40%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: 30

35.6% of Ohio **women** and 30% of Ohio **men** experience **intimate partner physical violence**, intimate partner rape, and/or intimate partner stalking in their lifetimes.

Source: 31
What are the structural barriers to accessing SUD and reproductive health care in Ohio?

Women of reproductive age with SUD, particularly pregnant people, face a number of structural barriers to accessing health care. In Ohio and nationally, the story of those barriers is dominated by a landscape of racial, gender, and geographic inequities.

**Lack of Health Insurance Coverage**

Due to the cost of care, insurance coverage is essential in facilitating access to health care. Ohio expanded Medicaid through the Affordable Care Act in 2013, which has reduced uninsured rates and increased coverage through Medicaid, though significant shortfalls remain. For example, women of color are still more likely to be uninsured than White women (see below). Lack of eligibility is not the primary barrier for many of those who remain uninsured; 76% of Ohio’s uninsured are eligible for Medicaid or for federal subsidies to purchase a marketplace insurance plan. Thus, while expansion of Medicaid eligibility is an important pathway to insurance, it has not resulted in universal coverage.

Compared to women with insurance, uninsured women are less likely to report having a regular source of care and have lower use of preventive services such as cancer and STI screenings, blood pressure checks, and use of effective contraception. In addition to inadequate access to health care, uninsured women
receive a lower standard of care and have poorer health outcomes than insured women, on average.

Inequitable Supply of Providers & Services

Uneven and inadequate access to providers poses challenges for Ohio women with SUD seeking health care. While Ohio’s supply of obstetricians and gynecologists (OB/GYNs), certified nurse midwives, women’s health nurse practitioners, and women’s health physician assistants is projected to match demand by 2030, the distribution of providers is concentrated in metropolitan areas, making access to reproductive care for all rural women more difficult.34

An important challenge for people seeking SUD care is that addiction treatment is provided mainly in specialty facilities and by specialists, rather than in primary care settings. In 2017, there were just over 15,000 addiction specialty facilities and 3,600 physicians board-certified in addiction medicine, nationally.35 According to the 2018-2019 National Survey on Drug Use and Health, 7% of women in Ohio needing treatment at a specialty facility for substance use in the past year did not receive it.36

Nationally, only 4% of all physicians had undergone the training required to prescribe buprenorphine in 2017.37 In addition, access to buprenorphine is highly segregated: buprenorphine prescribing capacity is higher in majority White areas while methadone prescribing capacity is higher in majority Black and Latinx areas.38 Researchers are investigating the extent to which any of the recent efforts to expand capacity for buprenorphine and other medications for addiction treatment (e.g., the Comprehensive Addiction and Recovery Act of 2016) have improved access or addressed inequities.

Ohio has a relatively robust supply of primary care physicians (178.2 per 100,000 people39), who are the providers most likely to have contact with someone struggling with substance use. People prefer to enter treatment through primary care settings (37.3%) rather than specialty addiction treatment centers (24.6%), making well-women’s care an opportune place for screening and intervention.40 But lack of training, insufficient reimbursement, and lack of confidence in knowing how best to treat individuals with SUD inhibit primary care engagement. The isolation of addiction treatment from primary care has also contributed to stigma among health care professionals about providing SUD care. Recovery-related discrimination – receiving inferior treatment and less respect compared to other patients – is commonly-reported and particularly high among SUD patients of color in both primary and addiction specialty settings.41
**Integration of Services**

The health care needs of women with SUD are complex in part because the systems with which they may interact – including health care, social services, and criminal justice – are poorly integrated, creating an ineffective patchwork of services.\(^4^2\)

Access to integrated care is limited but essential for maternal, fetal, and child health. Only 23% of SUD treatment facilities have programs for pregnant and postpartum people.\(^4^3\) Providers of buprenorphine and methadone are less likely to accept and treat pregnant patients, who are more likely to experience long wait times if accepted for care.\(^4^4, 4^5\) Black women are less likely than White women to access medications for addiction treatment during pregnancy.\(^4^6\) Additionally, pregnant people and parents seeking SUD treatment require access to a wide range of wrap-around services, including advisory legal services, child care, basic needs (e.g., food), education, domestic safety, housing, transportation, vocational, and other health services that facilitate success of treatment, but rarely receive support in these areas.\(^4^7\)

Incarcerated women face particularly high barriers to integrated care for reproductive and substance use treatment needs and are at high risk for poor outcomes. The majority of incarcerated women are parents and are of reproductive age; 70% have SUD.\(^4^8\) While incarcerated people have a constitutional right to medical care, there are no regulations or oversight for quality or breadth of care. Few carceral institutions make contraception, menstrual hygiene products, STI screening or treatment, or prenatal care available.\(^4^9\) Access to abortion care, already tenuous for much of the incarcerated population, has been eliminated or further restricted in many states since the Supreme Court’s 2022 decision on *Dobbs v. Jackson Women’s Health Organization*.\(^5^0\) The 26% of pregnant women admitted to prison and 14% admitted to jail who have opioid use disorder are often denied essential services (such as buprenorphine) and receive substandard care (e.g., are required to go through withdrawal, contrary to medical advice).\(^5^1\) Because health insurance benefits are suspended or surrendered while incarcerated, health care financing is the responsibility of the jail, prison, or detention facility and thus depends on local funds, legislative appropriations, and individual out-of-pocket spending.\(^5^2\)

**Public Policies & Funding**

Federal and state policies do not necessarily support the delivery of evidence-based reproductive health or SUD treatment care in Ohio. A range of educational standards, funding, insurance coverage, and criminal justice decisions ultimately limit access for all those experiencing the dual burden but are particularly damaging to people of color. System-level recovery-related discrimination manifests in the structural violation of rights
– including restricted access to health care, education, social services, and increased rates of arrest and incarceration – that people of color are more likely to experience.\textsuperscript{53, 54}

**Sexual Education & Family Planning**

Ohio Revised Code Sections 3313.60 and 3313.6011 require that sexual education emphasizing abstinence is taught in schools. Ohio law prohibits the State Board of Education from adopting or setting a standard health education curriculum. There is no standard regarding medically accurate or comprehensive information (e.g., instruction on sexual orientation or gender identity, consent, healthy relationships) and schools are required to provide an opt-out for parents to excuse their student from any or all instruction. The variation in content, quality, and accuracy of sex education disproportionately harms those in resource-poor and unstable family situations and other marginalized youth (e.g., LGBTQ+) who are also at higher risk for substance use and risky sexual behaviors.\textsuperscript{55}

Between 2010 and 2015, funding for reproductive health and family planning in Ohio through Title X decreased by 43% -- more than $3 million.\textsuperscript{56} That amounts to serving 15,000 fewer patients per year, a 24% decrease in network capacity for family planning services.

**Insurance Coverage**

Medicaid is the largest public funder of family planning services and largest overall funder of SUD treatment services in Ohio.\textsuperscript{57, 58} Adults with incomes up to 138% of the federal poverty level are eligible for Ohio Medicaid, which covers most forms of prescription contraceptives, including long-acting reversible contraception and emergency contraception.\textsuperscript{59} By law, pregnancy-related services are covered without cost-sharing; Medicaid finances 42% of all Ohio births.\textsuperscript{60} Ohio Medicaid has also expanded coverage of SUD treatment services to include inpatient settings, medications for addiction treatment, and care coordination across inpatient and outpatient settings through its Behavioral Health Redesign.

Per the Affordable Care Act (ACA), all marketplace health plans must cover a range of preventive services (including breast and cervical cancer screenings, well woman visits, prenatal visits, prescribed contraceptives, breastfeeding supplies, and STI services), as well as maternity care and SUD treatment services.\textsuperscript{61} The ACA also prohibits health plans from excluding potential beneficiaries based on preexisting conditions, including prior SUD treatment.

However, access to reproductive health and SUD care in Ohio remains limited in important ways. Medicaid quantity limits on services and prescriptions
and other utilization controls on contraception apply to many beneficiaries, and a 2018 Trump administration rule widened the employer-based insurance contraception exclusion.\textsuperscript{62} Abortion is not covered in Medicaid or marketplace plans except in cases of rape, incest, or imminent life endangerment, and various regulations on providers and gestational limits restrict the provision of abortion care.\textsuperscript{63} In practice, many SUD treatment providers do not accept insurance (including Medicaid), meaning that patients who can pay cash have the best chance of accessing treatment.\textsuperscript{64} These high out-of-pocket costs contribute to making SUD treatment access in Ohio highly inequitable.\textsuperscript{65}

Criminal Justice

Health care providers in Ohio are legally required to encourage and facilitate drug counseling for pregnant people, and pregnant people are given priority access to treatment programs and are protected from discrimination in publicly funded programs.\textsuperscript{66}

However, Ohio considers substance use during pregnancy to be child abuse under child welfare statutes and requires that health care professionals report suspected prenatal drug use.\textsuperscript{67} This policy has particularly damaging effects for Black women, who are 10 times more likely to be reported to social services during pregnancy drug screenings compared to other racial groups.\textsuperscript{68,69} Policies that criminalize substance use have been shown to deter women from seeking treatment for SUD and do not reduce neonatal substance exposure.\textsuperscript{70,71} Punitive policies are also associated with large increases in infant maltreatment reports, indicating higher levels of postpartum child welfare system involvement in states with such policies.\textsuperscript{72}
What are the consequences of the dual burden?

The dual burden imposes a range of human, social, and economic costs on women with SUD and their loved ones, as well as on communities and societal systems more broadly. Despite the resources spent on those experiencing the dual burden (the National Institute of Drug Abuse estimates that substance misuse alone costs the nation $600 billion annually in health and social costs\(^73\)), outcomes for this population are poor.\(^74\) The burdens of unmet health care needs and poor outcomes fall particularly heavily on Ohio’s women of color.

*Unmet Family Planning Needs*

Unintended pregnancy is much more common for women with unmet reproductive health needs, particularly for those with SUD. Consistent with the national level, 46% of Ohio women having a live birth report their pregnancy as unintended.\(^75\) Black non-Hispanic and Hispanic women are three and two times as likely, respectively, to experience an unintended pregnancy as non-Hispanic White women.\(^76\) Among women with substance use disorder nationally, the proportion of pregnancies that are unintended exceeds 80%.\(^77\)

Among those not trying to become pregnant, 38% of Ohio women report using contraception at time of conception.\(^78\) Contrary to racist narratives, women of color are *more* likely to report using contraception when they become pregnant: 44.5% of Black women and 46.8% of Hispanic women compared to 34.6% of White women.\(^79\) Effectiveness of contraceptive method may be one explanation: nearly 20% of Ohio women report using a method that is not moderately- or highly-effective.\(^80\) The 25% who report not using their preferred contraceptive method are more likely to be Hispanic, have low socio-economic status, and be dissatisfied with their medical care.\(^81\) Access to and use of emergency contraception (EC) has increased since its over-the-counter FDA approval in 2006 (11% in 2008 to 23% in 2015, nationally\(^82\)).

Ohioans have increasingly limited access to abortion care. In 2017, there were 14 abortion facilities in Ohio, nine of which were stand-alone clinics.\(^83\) In 2022, after the *Dobbs* decision, only 9 clinics providing abortion services remain. Ohio Senate Bill 123, which bans abortion after embryonic cardiac cell activity is detected, went into effect on June 24, 2022, thus limiting provision of abortion care to six weeks from last menstrual period.\(^84\)
Unmet Perinatal Care Needs

Lack of access to reproductive health care and care for SUD has significant negative consequences for prenatal, birth, and delivery outcomes. Substance use during pregnancy is linked to preterm birth, low birthweight, and maternal mortality. 85

15.2% of people in Ohio having a live birth had inadequate prenatal care

6.1% had late or no prenatal care, 2017-2019
- 9.8% | AIAN
- 9.3% | Black
- 8.9% | Hispanic
- 6.5% | API
- 5.1% | White

Sources: 86, 87

Preterm Birth
10.4% of Ohio live births, 2017-2019
- 14.1% | Black
- 13.1% | AIAN
- 10.4% | Hispanic
- 9.5% | White
- 9.1% | API

8.6% of Ohio births were moderately or very low birthweight in 2019

Source: 88, 89

In Ohio, 2018:
- 14.1 maternal deaths / 100,000 live births
- Black women in Ohio are 2.6x more likely to experience pregnancy-related death than their White peers

Ohio has the 10th highest infant mortality rate in the U.S.
- 6.9 infant deaths / 1,000 live births
- The rate is 2.6x higher for Black infants compared to White

Sources: 90, 91, 92, 93
The use or misuse of some drugs while pregnant, especially opioids, can cause a newborn infant to experience withdrawal symptoms (a condition known as Neonatal Abstinence Syndrome), and is also associated with higher rates of maternal death.

Nationally, prenatal maternal opioid use increased from 1.19 per 1,000 hospital births per year in 2000 to 5.63 per 1,000 per year in 2009.

Opioid use disorder during pregnancy associated with a 4.6x increase in maternal death.


Sources: 94,95,96

Overdose

In 2018, Ohio had the second highest unintentional overdose death rate among the 50 U.S. states. Opioids were involved in 86% of Ohio's 3,700 unintentional overdose deaths in 2018, significantly higher than the national level of 69.5%.

NAS rate higher in Ohio than nationally
15.9 per 1,000 newborn hospitalizations | Ohio
7.0 per 1,000 | U.S.

NAS is more common in rural areas

Sources: 97,98,99
Cycle of Marginalization

Lack of access to health care is one manifestation of how people with substance use disorder are marginalized and stigmatized. However, lack of access to care further isolates and harms people with SUD. These effects are amplified for people of color with SUD, for whom structural racism compounds stigma and barriers to access. Researchers have found evidence of recovery-related discrimination, including denial of insurance coverage and claims, suspension of student financial aid, welfare (SNAP, Medicaid, etc.) exclusions, job loss and denial, housing loss and denial, loan denial, denial of voting, unfair treatment by police, and unfair treatment by providers. These systemic forms of discrimination, which are more commonly experienced by people of color, are associated with more psychological distress, lower quality of life, and fewer resources to support ongoing recovery.
Implications for public health policy & practice in Ohio

The scope, structural drivers, and deleterious social and human consequences of the dual burden make addressing the unmet health care needs of women with SUD a significant public health and public policy issue for the state of Ohio. Addressing the dual burden requires acknowledging the complexity of the problem and the complexity of the health care needs of affected and at-risk populations. Because those experiencing complex health needs tend to cycle through multiple systems without lasting improvements, policy and practice must facilitate adaptive, evidence-based, integrated care across health and social service networks.  

Provision of Care

Given the supply-side barriers that women of reproductive age and those with SUD face in accessing health care, the provision of evidence-based, accessible, quality reproductive health and SUD care in Ohio is essential to addressing the dual burden. Providing care that prioritizes sexual and reproductive health and autonomous decision making, for example through access to STI screening, long-acting reversible contraception, abortion care, and broader family planning services, improves reproductive health outcomes for women of reproductive age.  

The prevalence, consequences, and complex health care needs of women with SUD make universal screening for SUD in primary care settings a key strategy for facilitating access to treatment. Evidence is clear that treatments that utilize harm reduction strategies, such as medications for addiction treatment (MAT), improve outcomes for individuals with substance use disorders. Medications such as buprenorphine, methadone, naloxone, naltrexone, disulfiram, and nicotine replacement should therefore be included in standard provision of care for women with SUD. Expanding and desegregating access to MAT is particularly important in addressing racial and geographic inequities in care. Removing or relaxing the physician requirement to apply for an “X-waiver” to prescribe buprenorphine is one step in the process. However, improving provider education and training regarding SUD and its treatment are also essential to building capacity and reducing stigma.
Integration of Care

Improving the provision of care for those experiencing or at risk of experiencing the dual burden requires integrating health care and social support services. An important step in integrating care is to train and educate more primary care providers and women’s health specialists (e.g., OB/GYNs) in addiction medicine, thus expanding SUD screening and services to women throughout their reproductive life course.115

Expanding quality treatment programs for pregnant people is an area of particularly high need. Pregnant people can safely stop drug use when they have access to medication, counseling, prenatal care, and support services such as child-care, parenting classes, job training, and postpartum care. Integrated Care Models (ICMs) are so named because they co-locate and integrate reproductive health and substance use treatment services.116 ICMs typically provide access to contraception in voluntary, patient-centered, non-coercive ways; have special SUD treatment groups for pregnant people, people with children, and families; hold couples counseling for both family planning and SUD treatment; provide child-care services for women receiving MAT; and provide focused postpartum care, including through home visitation.

Several other integrated models apply social justice and harm reduction principles, centering the needs, goals, and circumstances of patients in providing care. Hub-and-spoke models refer to special arrangements of addiction treatment facilities (hubs) for specialized treatment of complex patients and primary care providers (spokes) willing to provide medications to those with less complex needs.117 Open Door group clinics have been used at federally-qualified health centers to provide counseling and medications for addiction treatment in group settings.118 The Low-Threshold approach has been employed to encourage people to seek treatment by providing an initial screening and a one week prescription for buprenorphine-naloxone. Participants are encouraged but not required to receive counseling, and treatment is not automatically suspended if they fail a subsequent substance screening.119

Medications such as methadone and buprenorphine, combined with the services described above, can improve outcomes for pregnant people. While some infants may still require treatment for withdrawal symptoms, outcomes are generally better under use of MAT than if the pregnant person continues to use opioids.120

Public Health Policy

Because the dual burden is a complex phenomenon, improving health care provision and integration must be supported through public policies and funding decisions consistent with public health principles of harm reduction and autonomy. These principles are
particularly important to addressing racial inequities arising from discriminatory policies and structures. Public health-oriented policy actions include:

- Increase funding and access to comprehensive sexual education and reproductive health services, including contraception, abortion, and STI testing\(^{121,122}\)
- Improve data collection and reporting on relevant health outcomes (e.g., maternal mortality), particularly by race, ethnicity, and neighborhood\(^{123}\)
- Improve use of telehealth services to facilitate access to care\(^{124}\)
- Fund public prenatal health clinics in resource-poor areas of the state staffed by professionals that provide accurate information, resources, and services to pregnant people\(^{125}\)
- Build on Medicaid coverage expansion by increasing provider reimbursement rates (particularly for SUD care), reducing cost barriers to MAT, taking up the federal Medicaid family planning program, and extending coverage to one year postpartum\(^{126}\)
- Require accreditation of health care in carceral settings to provide appropriate care during incarceration, including access to contraception and perinatal services and prohibiting use of restraints or solitary confinement for pregnant people\(^{127}\)
- Permit access to or use of health insurance coverage (e.g., Medicaid) during incarceration\(^{128}\)
- Decriminalize substance use during pregnancy and increase compliance with Child Abuse and Neglect Prevention and Treatment Act (2010)\(^{129}\)

Many of these public health investments would contribute to building a more robust social services and social safety net in Ohio. Strong social supports have positive implications for racial equity and improved outcomes among marginalized populations, including people with SUD.\(^{130}\)
Summary:
Structural barriers to access contribute to unmet health care needs for women with SUD in Ohio

In addition to having reproductive health care needs throughout their lives, millions of women and girls in Ohio may require care for substance use or substance use disorder. For these individuals, the intersecting problem of unmet reproductive and addiction care needs creates a dual burden on their long-term health and recovery. Limitations on health insurance coverage, the supply of qualified and willing providers, availability and integration of services, and public policy decisions that restrict or fail to fund access to care, or that criminalize health care needs, all contribute to the magnitude of burden experienced by women of reproductive age with SUD. Taking steps to reduce the dual burden in Ohio would have positive effects on key population health outcomes, including unintended pregnancies, infant and maternal morbidity, and overdose deaths.

Learn more about the dual burden issue by visiting the Center for Health Outcomes and Policy Evaluation Dual Burden page or watching our Advancing Equity webinar series.

---

1 Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). Results from the 2012 National Survey on Drug Use and Health: Detailed tables. – needs updated to at least 2018.


7 Patrick, S. W., Richards, M. R., Dupont, W. D., McNeer, E., Buntin, M. B., Martin, P. R., ... & Cooper, W. O. (2020). Association of pregnancy and insurance status with treatment access for opioid use disorder. *JAMA network open*, 3(8), e2013456-e2013456.


20 World Health Organization standard categorization.


22 March of Dimes Peristats. [www.marchofdimes.org/peristats](http://www.marchofdimes.org/peristats)


37 Hostetter, M. & Klein, S. (September 2017). In Focus: Expanding access to addiction treatment through primary care [Brief]. The Commonwealth Fund. [Link](https://www.commonwealthfund.org/publications/2017/sep/focus-expanding-access-addiction-treatment-through-primary-care#3)


42 Patrick, S. W., Richards, M. R., Dupont, W. D., McNeer, E., Buntin, M. B., Martin, P. R., ... & Cooper, W. O. (2020). Association of pregnancy and insurance status with treatment access for opioid use disorder. JAMA network open, 3(8), e2013456-e2013456.


44 Patrick, S. W., Martin, P. R., Scott, T. A., Michael Richards, M. D., & Cooper, W. O. (2018). Barriers to accessing treatment for pregnant women with opioid use disorder in Appalachian states. Substance abuse.

45 Patrick, S. W., Richards, M. R., Dupont, W. D., McNeer, E., Buntin, M. B., Martin, P. R., ... & Cooper, W. O. (2020). Association of pregnancy and insurance status with treatment access for opioid use disorder. JAMA network open, 3(8), e2013456-e2013456.


65 Patrick, S. W., Richards, M. R., Dupont, W. D., McNeer, E., Buntin, M. B., Martin, P. R., ... & Cooper, W. O. (2020). Association of pregnancy and insurance status with treatment access for opioid use disorder. *JAMA network open*, 3(8), e2013456-e2013456.


Atkins, D. N., & Durrance, C. P. (2020). State Policies That Treat Prenatal Substance Use As Child Abuse Or Neglect Fail To Achieve Their Intended Goals: Study examines the effect of state policies that treat prenatal substance use as child abuse or neglect on the incidence of neonatal abstinence syndrome and other factors. Health Affairs, 39(5), 756-763.


National Center for Complex Health & Social Needs. https://www.nationalcomplex.care/about/who-we-serve/


We recognize that the term Hispanic is problematic because it by-and-large is not used by members of the Latinx or Spanish-speaking communities. However, the sources we draw from in this overview collect their data using this category, which necessitates its use for the sake of fidelity.


Power to Decide. (n.d.) Access is power: Opioid use disorder and reproductive health. [Powertodecide.org](http://powertodecide.org).


Author Contributions

Lisa Frazier conducted the research and wrote the manuscript. Anne Trinh gathered foundational research and organized and drafted a review of the relevant literature. Kyle Moon provided preliminary research support. Saira Nawaz developed the initial idea and framework for this line of work. All authors have reviewed the final manuscript and take responsibility for its accuracy and completion.

Acknowledgements

We thank Sarah Hayford, Kristin Harlow, and Lenisa Chang for their review and feedback on earlier drafts of this report.

Suggested citation for this issue brief


https://u.osu.edu/hopes/
@CenterforHOPES