

Table Two: Hazards of Stigma, Myths, and Stereotypes for Women Seeking or Receiving Opioid Agonist Treatment

Stigma-Related Policy-Level Errors	Clinical Errors	Consequences for the Woman, Fetus, and Child
Reluctance to provide or fund services for pregnant women with SUD, and policies designed to justify rejecting these women, resulting in a significant shortage of programs that can treat pregnant women—and have the specialized training necessary to do so	Rejecting pregnant women who apply for admission	These women are not properly treated for their OUD; they and their unborn children may suffer repeated withdrawal episodes and the full consequences of the SUD; and they might never be connected with prenatal care or help with neonatal withdrawal.
Rejection of potential harm-reduction policies	Rejecting clinical approaches that reflect a harm-reduction approach, focusing instead on approaches that require greater readiness for abstinence	Women who cannot achieve abstinence receive fewer needed services and support, with greater harm to the woman, her fetus, and her newborn child.
State laws criminalizing substance use during pregnancy		Fear of criminal justice or child welfare involvement keeps many women from seeking needed services and support, often prolonging active SUD and resulting in greater harm to the woman, fetus, and child.
Policies requiring that providers report neonatal withdrawal, but not making it clear whether withdrawal from an agonist medication should be reported	Reporting neonatal withdrawal from an agonist medication the same way they would report withdrawal from an illicit substance	Women who have been following the best medical advice to protect their children are penalized, labeled “bad mothers,” and may lose their children, all for doing the right thing.
Myths and Stereotypes	Clinical Errors	Consequences for the Woman, Fetus, and Child
The myth that pregnant women need to take as little medication as possible, not realizing that opioid agonist medication is the best thing for the fetus as well	Withholding opioid agonist treatment	This lessens the likelihood that women will receive effective, evidence-based treatment (e.g., buprenorphine, methadone) for opioid use disorders.
The myth that opioid agonist medications are “substitute drugs” that prolong the physical destabilization of the fetus from opioid use	Mistaking an evidence-based medicine for an illicit drug; misinterpreting the need to stabilize the fetal environment as a need to help the woman reach abstinence as soon as possible	The developing fetus is endangered from immediate, simultaneous discontinuation of all substances, followed by greater instability if the woman—with a 90% chance of relapse—cannot remain abstinent.
The myth that withdrawal from opioid agonist medications will be “worse” or more dangerous than withdrawal in utero (when studies show that it is not)	Withdrawing pregnant women from agonist medication when it is not medically necessary, putting the fetus at risk and generating a 90% risk that the mother will relapse and discontinue treatment and prenatal care	If the mother relapses, the fetus may continue to experience multiple episodes of withdrawal in utero; delay of prenatal care or treatment for SUD until women are close to delivery or in labor brings

		increased risk of pre-term delivery, low birthweight, and transmission of HIV SAMHSA to the newborn.
The myth that women with OUD or history of SUD are drug-seeking if they ask for pain relievers; The myth that African American women do not experience pain the same as White women, even during labor	Denying or minimizing standard-of-care pain relief, even during labor, leading to uncontrolled pain and diminishing trust; Harsh, suspicious, or judgmental treatment of women assumed to be “drug-seeking”	Traumatization from uncontrolled pain or harsh treatment by staff may lead women to leave the care setting prematurely, avoid recommended aftercare, and miss well-baby exams and post-partum appointments.
Sources of Content: Kaltenbach, 2017; Center for Substance Abuse Treatment, 2018; and Weber et al., 2021.		