A Brief History of Federal Policy Regarding Maternal Mental Health and Substance Use

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Substance Use: Health Justice

Maternal Health and Substance Use

Substance use and substance use disorders (SUDs), though not new, have significantly increased in the US population over the past 3 decades. Various substances may be involved, including opioids, fentanyl, heroin, methamphetamines, and/or alcohol. Substance use in pregnancy and the postpartum period is a growing public health issue in the United States, affecting an estimated 7-10% of pregnant people and their infants. From 2010 to 2017, the number of women with opioid-related diagnoses at delivery hospitalization increased by 131%. (ACOG, 2026; CDC, 2026; Frimpons & Nketiah, 2026; SAMHSA, 2024; Hirai et al., 2021; Trost et al., 2021; Wendell, 2013)

Left untreated, SUDs increase the risk of pregnancy-related mortality and severe maternal morbidity. (Amodio et al., 2025; Declercq & Zephyrin, 2025; Sheilds et al., 2025) Overdose death rates tripled among pregnant and postpartum individuals between 2018 and 2021. (Habersham et al. 2025; Han et al., 2023) Pregnant women with SUD are also at a higher risk of developing complications related to infection, including sepsis and other infections.

Recent data reveal that drug-related deaths and suicides are among the primary causes of maternal mortality in a number of states (Goldman-Mellor and Margerison, 2019; Wallace and Jahn, 2025) Between 2018 and 2022, 19% of all deaths that occurred during pregnancy or in the year after pregnancy were attributed to substance use (referred to as pregnancy-associated overdose deaths). (Wallace & Jahn, 2025) State data shows that substance use was a *contributing factor* in 24.8 percent of pregnancy-related deaths in 2020, with wide variations among states. In 10 of 21 states reporting data on factors contributing to maternal deaths report substance use played a role in at least 40% of pregnancy-related deaths. This included 100% of pregnancy-related deaths in Wyoming, 56% in Massachusetts, 42% in Arizona, and 40% in Mississippi. Substance use or overdose was reported as the *leading cause* of pregnancy-related death in eight states, led by New Hampshire (52.4%), Ohio (44.4%), Utah (38.5%), Massachusetts (36.0%), and Delaware (33.3%). (Amodio et al., 2025)

Infants born to mothers using substances experience an array of risks, including poor fetal growth, preterm birth, stillbirth, birth defects, and neonatal abstinence syndrome. (CDC, 2026) As opioid use disorder (OUD) has grown among pregnant women, so has neonatal opioid withdrawal syndrome among infants. Across the country, both pregnant women and their newborns lack access to evidence-based SUD therapies and receive variable care. (Patrick et al., 2020; Haight et al., 2018) For infants, untreated SUD/OUD exposure is associated with an increased likelihood of preterm birth, adverse neurodevelopmental outcomes, and neonatal mortality. The challenge reaches beyond infancy. More than half a million parents with OUD are living with their children younger than 18. But fewer than one in three of these parents have received treatment for substance use disorder (SUD). (Urban Institute, 2019)

Drivers and Barriers to SUD Treatment

Stigma, fear of legal consequences, and fragmented health and social service systems create unnecessary barriers to prenatal care and SUD treatment, which contribute to the significant, rise in maternal mortality associated with SUD. (ACOG, 2025) Studies indicate that a substantial proportion of deaths related to substance use could have been avoided, were considered preventable. This includes those diagnosed with SUDs who lacked health coverage and/or treatment, were homeless, were stigmatized and/or criminalized, and/or feared legal repercussions in the child protective services or penal systems. (Blake et al., 2026; Frimpons & Nketiah, 2026; Ali et al., 2023; Morrison et al., 2023)

Pregnant women enrolled in Medicaid are both more likely than pregnant women with other forms of insurance to have SUD and more likely to receive treatment for their SUD. (MACPAC, 2020) At the same time, access to SUD treatments and related services are not uniformly available. State policy decisions and provider participation in Medicaid are key factors driving this variation.

Access to and utilization of treatment also varies by race and ethnicity. For example, a Pennsylvania study found that among Medicaid enrolled pregnant and postpartum people with a documented diagnosis of opioid use disorder (OUD), the receipt of medication for opioid use disorder (MOUD) differed significantly by race and ethnicity. Compared with non-Hispanic Whites, people of other races and/or Hispanic ethnicity were diagnosed with OUD on average 37 days later in pregnancy despite having the same or higher mean number of visits prior to diagnosis – indicating missed opportunities. During pregnancy, 61% of non-Hispanic Whites received MOUD compared with 37% of people of other races and/or Hispanic ethnicity. In the postpartum period, similar proportions received MOUD. (Gao et al., 2022)

Given the historical legacy of structural racism in the healthcare and criminal justice systems, Black, Indigenous, and Latina women have greater chances of being screened against their will, referred to child protective services, and deprived of treatment. (Braveman et al., 2021; Wang et al., 2020) Such racialized practices have often been embedded in guidelines or policy, with laws more punitive than preventive. (Frimpons & Nketiah, 2026; Carty et al., 2022) Another factor is clinicians' bias, which is associated with failure to complete recommended screening, underdiagnosis, and less effective treatment. (Hardeman et al., 2022) From an intersectional perspective, SUD magnifies other social drivers of health (SDOH) and pregnancy-related risks, including: lack of prenatal and postpartum care, racism, ableism, poverty, criminalization, and

social isolation. New ways of measuring and monitoring racism are needed. (Hardeman et al., 2022)

Fragmentation of the health care system is another barrier, with maternity care, mental health, and SUD interventions typically disconnected and leaving gaps. A study of pregnancy-associated overdose deaths—using data from Maternal Mortality Review Committees (MMRCs) in six states—found that barriers to care resulted from lack of continuity of care and care coordination between maternal health care practitioners and health care systems. Structural barriers and missed opportunities (e.g., no screening and/or no referral, no transition from emergency department) resulted in reduced access to timely and appropriate maternal health care and treatment for substance use and mental health conditions. For half of the deaths, continuity of care and care coordination were deemed contributing factors. (Blake et al., 2026)

While emergent models of integrated perinatal-SUD care (e.g., Project Nurture in Oregon) hold promise through the co-location of addiction treatment, prenatal care, and social services, such exemplary practices are few and far between. (Hall et al., 2026; Jones et al., 2021; Moss et al., 2025) Even the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is too little used; despite the fact that it has proven to be effective in prenatal and postpartum care at identifying risks and connecting people to services at an early stage. (Wouldes et al., 2021; Fitzgerald et al., 2025) Integrated and collaborative care models, along with interagency coordination and financing, are needed to effectively respond to perinatal SUD.

> "*To appropriately treat SUDs in pregnancy, clinicians, institutions, and policymakers must re-envision safety and no longer rely on punitive measures. Person-centered, trauma-informed care that incorporates a harm reduction model is imperative. Access to treatment (including but not limited to medication for addiction treatment, residential treatment, behavioral therapy, and psychosocial support) and community-based initiatives are needed. These practices should be anti-racist and focused on rehabilitation, comprehensive care, and meeting the needs of individuals. This cannot be achieved within a legal or medical climate that criminalizes substance use in pregnancy.*"
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> Society for Maternal-Fetal Medicine Position Statement: Decriminalization of substance use disorder in pregnancy. 2025.

Policies that directly and indirectly criminalize pregnant and parenting individuals take various forms, often in the name of protecting the parent and/or the child. (ACOG, 2025) Providers, health systems, and policies should treat SUD as a health condition, not a crime. People with SUD need support and care rather than punitive measures. Punishment and criminalization of substance use in pregnancy through prosecution, threats of legal action, or involvement of the family regulation system are harmful and create substantial barriers to engaging in care.

Using PRAMS data, researchers have looked at how incarceration of woman in the year before birth constituted an additional hardship. These vulnerable women were less likely to have care and support so important to maternal and infant health. Women reporting incarceration of themselves or their partners in the year before birth of a child were less likely to beginning prenatal care early, nearly twice as likely to report partner abuse, and were significantly more likely to rely on WIC and/or Medicaid during pregnancy. These associations persist after controlling for socioeconomic measures and other stressors, including homelessness and job loss. (Dumont et al., 2014)

Beyond health care, the child welfare, juvenile justice, penal, and other systems tend to punish pregnant and parenting people affected by SUD. For many decades, punitive laws and policies have disproportionately affected Black people and their reproductive decisions. Prosecution of pregnant people for substance use dramatically increased in the 1980s as part of response to the crack cocaine epidemic and the "War on Drugs," that was fueled by the stereotypes of the "pregnant addict" and "crack baby," and tropes linked to race and class. This set a policy and systems context in which the targeting and punishment of poor Black women was more common. In contrast, the opioid epidemic in the 2000s placed White women as the "new face of addiction". The drastic change in response to opioid use created a culture in which White drug use is treated as a biomedical disease.

Change in the policy and systems context is greatly needed. Taylor and others have set out a vision for how an alternative approach might be structured. It would be supportive rather than punitive. Substance use, mental and physical health treatment, and social services would be linked and/or integrated to focus on overall well-being and family preservation. Moreover, systems and providers would be held accountable for providing nonjudgmental, non-punitive, evidence-informed, culturally, and linguistically effective care. (Taylor, 2023; Taylor 2020)

What could the new way look like? One size never fits all.

– Linked Care
  - OB, SU, MH, other physical health, social services
  - Care manager across pregnancy, post-partum (though ideally even before pregnancy)

– Culturally and linguistically appropriate/effective care in all realms
  - Humility
  - Time and ability to listen
  - Flexibility to change to fit patient needs-payment that allows this

– Supportive SUD services for ALL types of substances
  - Non-punitive, community-based prevention, harm reduction, treatment (including medications as clinically appropriate), recovery services that are evidence informed

– Physical and mental health services that are accessible, affordable and effective

– Social supports and connections

– Rethinking what is available and changing to what should be available to improve health and social outcomes which benefit the individual, families and communities.

Kimá Joy Taylor. "*Equity, Autonomy and Substance Use Disorder: Lifecourse Considerations for Pregnant and Parenting People*" Boston University and Harvard University webinar. February 5, 2020

Medicaid Coverage Policy

In 1996, Congress enacted the Mental Health Parity Act (MHPA, Pub. L. 104-204), which basically required parity in mental health benefits and medical/surgical benefits for group health plans but not Medicaid. This was a major policy breakthrough.

The Balanced Budget Act of 1997 (BBA, Pub. L. 105-33) generally applied some aspects of MHPA to Medicaid Managed Care Organizations (MCOs) and Children's Health Insurance Program (CHIP) state plans.[1] These were important changes but still limited.

In addition, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub. L. 111-3) requires that CHIP plans that provide medical and surgical benefits and MH/SUD benefits comply with the parity provisions of MHPAEA. For CHIP plans, parity requirements apply to all delivery systems, including fee-for-service and managed care. To the extent that the state CHIP plan provides full coverage of the EPSDT benefit, the requirements are considered met. Otherwise, MHPAEA applies to the CHIP state plan in the same manner as group health plans. States not providing full EPSDT benefits under their CHIP state plan need to review CHIP state plans, contracts, and demonstrations/waiver projects in order to come into compliance.[1] [2]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA, Pub. L. 110-343) was enacted in 2008 to amend the existing MHPA, including parity for coverage of SUD benefits and additional financial requirements. In terms of Medicaid, MHPAEA requires states that have contracts with MCOs to meet parity requirements—such as financial requirements (e.g., co-insurance and co-pays), treatment limitations (e.g., limits on amount, duration, and scope of treatment or visits), and out-of-network coverage—consistent with those for private insurers. In addition, parity requirements apply to Medicaid Alternative Benefit Plans. Through a Medicaid rule in 2016,[3] CMS clarified that MHPAEA requires MCOs to make available upon request to beneficiaries and providers the criteria for medical necessity determinations with respect to mental health and SUD benefits. The rule also directs MCOs to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and SUD benefits. Additional guidance has been issued.[4]

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[1] Centers for Medicare and Medicaid Services (CMS). Letter to State Health Officials and State Medicaid Directors re: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans. (SHO #13-001 and ACA #24). January 16, 2013.

[2] Centers for Medicare and Medicaid Services (CMS). Letter to State Health Officials re: CHIPRA Parity Requirement. (SHO #09-114 and CHIPRA #9). November 4, 2009. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

[3] US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS). Final Rule: Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. 81 *Fed. Reg.* 18390 (March 30, 2016). (Codified at 42 CFR Parts 438, 440, 456, and 457). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of

[4] Centers for Medicare and Medicaid Services (CMS). Letter to State Health Officials and State Medicaid Directors re: Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including States' Responsibility to Comply

In 2010, the Affordable Care Act (ACA, Pub. L. 111-148) enhanced the impact of parity policy and expanded coverage for low-income people, including ACA Medicaid expansions and marketplace plans. While MHPAEA originally applied to group health plans, the ACA extended parity protections to individual and small group plans, including ACA marketplace plans.[5] For Medicaid, ACA provisions built upon MHPAEA to set out requirements for non-managed care benchmark and benchmark-equivalent plans (currently known as Medicaid Alternative Benefit Plans-ABP). In addition, ACA included mental health and substance abuse services as one of the ten required components of the Essential Health Benefit (EHB) and thus mandates mental health and SUD coverage in marketplace, small group, and individual private insurance.

Coverage and the continuity of Medicaid coverage matter. Medicaid ACA expansions to cover more low-income adults and Medicaid postpartum coverage extensions from 60 days to one full year have been shown to have increase access to treatment and improved maternal survival. (Ali et al., 2023; Lilly et al., 2019; Frank et al., 2014) Prior to 2020, most postpartum mothers lost coverage 60 days after the end of pregnancy. In 2019, more than 13% of pregnant Medicaid enrollees with SUD lost their Medicaid coverage between 60 and 90 days postpartum, with most living in states that had not adopted Medicaid ACA expansions. (Ali et al., 2023) Currently, the Medicaid postpartum extension has been adopted by all but one state. Beginning in 2021 and throughout the COVID-19 Public Health Emergency (PHE), all states opted to ensure continuous coverage for those enrolled in Medicaid. This policy again made a difference. For example, a North Carolina study found that SUD visits increased with this more continuous postpartum Medicaid coverage (2.2% for the pre-PHE cohort, 3.6% for the PHE cohort and 5.3% for the postpartum extension cohort). (Swartz et al., 2025)

Despite enhanced Medicaid coverage and growing evidence of the effectiveness of medications, integrated perinatal-SUD care models, and trauma-informed approaches, access to and utilization of these strategies is not uniform across population and geographical areas. (Frimpong & Nketiah) SUD interventions, MOUD, mental health therapy, and other supportive services are subject to coverage gaps. (Kittaneh et al, 2025; Ali et al., 2023) As noted above, the variability both in state-level Medicaid maternal health policies and in the implementation of parity legislation have resulted in a patchwork of uneven access. (KFF, 2026) More can be done.

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with Medicaid Managed Care and Separate CHIP Mental Health and Substance Use Disorder Parity Requirements. June 12, 2024. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

[5] Centers for Medicare and Medicaid Services (CMS). Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule. March 29, 2016.

What One Care Do: Use Your Gifts and Talents to Push for What is Right, to Make Change for the Better Whatever Your Role

Kimá Joy Taylor, MD, MPH, is a leader and change agent working to change how substance use services are delivered, shift punitive policies, and challenge racism that affects the health and well-being of women, children, and families. In this work she has held a remarkable variety of roles – as a pediatrician, a public health leader, Congressional staff, program director, health consultant, and scholar. She aims to weave what she has learned from all of these seemingly varied jobs, because while usually these all are siloed they ALL touch people's lives in ways that cannot be siloed.

In her own words, **Dr. Taylor is *"a health policy, clinical care and public health subject matter expert with the ability to translate complex policy and provide strategic planning to ensure positive and equitable outcomes on the ground.***" She is an experienced leader and strategist with a track record of building and stewarding strong relationships and partnerships to advance policy and programs that improve individual and community health outcomes. She is always capitalizing on strategic opportunities to not only expand access to care, but to mobilize diverse stakeholders. Her brilliance, insights, and advocacy voice are helping to change directions in policy and medicine circles.

Dr. Taylor is the founder of Anka Consulting, a health care consulting firm which focuses on expanding access to integrated primary care and behavioral health services, particularly substance use disorder services. She consults with organizations to develop policy and programmatic means to effectively and cost-effectively improve health outcomes. With her diverse professional experiences, she helps organizations find creative solutions to finance and implement innovative care strategies.

In her role at Anka Consulting, Dr. Taylor is one of the sponsors of the Medicaid Connections webinar series. But more than that, she envisioned and anchors a series of events that bring together people from various fields concerned with children and families to highlight how Medicaid policy affects the programs they care about or the justice work they pursue.

In recent years, she was a nonresident fellow at the Urban Institute, a role in which she collaborates with Urban Institute researchers on a number of topics, including analyses of racial disparities in screening and treatment practices for parents with substance use disorder, management of neonatal abstinence syndrome at hospitals, and prevention and early detection of mental and behavioral health problems among adolescents and young adults. She was part of the Urban Institute team leading and reporting on the "*Unequal Treatment at 20*" symposium in March 2023, which addressed the persistent racial and ethnic inequities in the U.S. healthcare system, two decades after the landmark National Academy of Sciences "*Unequal Treatment*" report. Her clear and penetrating briefs and reports about racism and policy go beyond theory to fostering understanding about what must change.

She previously served as the director of the Open Society Foundations' National Drug Addiction Treatment and Harm Reduction Program, where she oversaw grantmaking that supported the

expansion of access to a nonpunitive continuum of integrated, evidence-informed, and culturally effective substance use disorder services. The work leveraged Medicaid and the Affordable Care Act policies, including: support for state-level coalitions to develop community-based alternatives to incarceration for those with substance use disorders, development of pilot programs within an integrated health system, and management of a nine-state nine-demonstration project to increase access to, and sustainable funding for, high quality addiction treatment by changing public opinion. Prior to that role, she directed the Open Society Institute's Tackling Drug Addition Program, where her aim was to increase sustainable funding for addiction treatment for uninsured and underinsured residents of Baltimore City.

Before joining the Open Society Foundations, she was a leader in a large, metropolitan health department. Dr. Taylor served as Deputy Commissioner for the Baltimore City Health Department. There she led the Clinical Service, Maternal Child Health, and Chronic Disease Prevention Divisions and managed the provision of child and adult health care services to the uninsured. She also served as Baltimore's Assistant Commissioner of Health Promotion and Disease Prevention, leading programmatic efforts such as Tuberculosis Prevention, HIV/STD Prevention, Ryan White Emergency Care Act.

As a young leader, in 2004, she took on a prestigious and challenging position as the health and social policy legislative assistant for US Senator Paul S. Sarbanes (D-MD). In that role, she advised the Senator and addressed constituent concerns about legislation relevant to Social Security, Temporary Assistance for Needy Families (TANF), Aging, Pharmaceuticals, Medicare, Medicaid, women's health issues, and other health care policy. As a young, idealist she believed that policymakers just did not realize what happens when one is uninsured; however, she found that was not the only barrier to progress.

A board-certified pediatrician, Dr. Taylor has also used her skills to care for patients. From 1998 to 2002, at a community health center in Washington, DC, she provided bilingual health care for uninsured and Medicaid recipients and advocated for other life necessities, including affordable housing, improved educational opportunities and specialty appointments. As co-director of pediatrics, she supervised pediatric clinic staff including fellow health care providers, medical assistants, medical students, nurses, residents and front desk staff. Mentored and trained residents and medical students. With her boundless energy and spirit of innovation, she co-developed and staffed an Adolescent Clinic providing mental health and wellness services. She worked with other community organizations to empower youth such that they will realize their abilities, grasp opportunities, and improve the world at large.

Between 1998 and 2003, Dr. Taylor worked on children's literacy programs. Her work was based on the idea that libraries and schools in the district did not OFFER books that spoke to kids in their cultures, languages or their realities, and yet kids deserved this opportunity. Also, based on her own lived experience, she learned that books can help you feel less alone and show you can change the world even when folks say you cannot. This work started with founding Born to Read, which distributed books to clinics across the city. Then, as a founder, executive director, and board member for Reach Out and Read, she created a city-wide coalition to advance literacy in pediatric primary care across more than 20 clinics. These efforts were recognized with the Mayor's Community Service Award and were recognized by First Lady Laura Bush.

Dr. Taylor is a graduate of Brown University School of Medicine, and the Georgetown University residency program in pediatrics. In 2002, Taylor was awarded a Commonwealth Foundation minority health policy fellowship at Harvard University. Dr. Taylor received her Masters in Public Health (MPH) in Health Policy and Management from the Harvard School of Public Health in 2003.

While those are my jobs, those are far from the sum of Kima. She expressed it this way: "*I am the humble, honored daughter of amazing and strong American Descendants of Slaves who pushed systems and people, even when painful. They taught me to push for what is right, kind and just, even when there are (and there always are) consequences, even when faced with the opposite and to still hold and love myself and my ancestors in the fight—not to let people take me out. These values keep me going and I try to pass them on to my kids."* One of her favorite quotes from her mother is: *"Don't tell me what you can't do, figure out a way to get it done. If you do not want to, just say that."* Another quote from her mother, which may sound familiar to many, is: *"Just because they said it, it does not make it so. You have a brain figure out the truth."*

> *"Re-envisioning current systems to include and address the well-being and specific needs of diverse pregnant people who use drugs will help to equitably improve maternal morbidity and mortality. Policies, practices, and programs should learn how to do this and be held accountable for providing nonjudgmental, non-punitive, evidence-informed, culturally, and linguistically effective care. Substance use, mental and physical health treatment, and social services must be integrated to center well-being and family preservation."*
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> …
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> *"Throughout our country's history, we have employed a punishment system that leads to inequitable outcomes for the parent-infant dyad, especially for Black, Indigenous, and other families of color impacted by substance use. We can do better."*
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> Kimá Joy Taylor. A Different Vision: Centering Love Not Punishment for Families Affected by Substance Use. *Maternal and Child Health Journal*. 2023.

Learn more about Dr. Taylor. Select publications in the reference list have her name in bold.

To hear her voice, look at the following.

Roots of Recovery 2022: Meeting People Where They Are.
Dr. Kima Joy Taylor's Speech
https://www.youtube.com/watch?v=mkIqAl2eLYM

Urban Institute: Addressing Maternal Health Inequity During COVID-19 Pandemic
https://www.urban.org/events/addressing-maternal-health-inequity-during-covid-19-pandemic

Select Resources

- CDC: Opioid Use and Pregnancy.
- SAMHSA: A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders.
- American College of Obstetricians and Gynecologists (ACOG) Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy.
- SAMHSA: Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health]
- Medscape CDC Expert Commentary: What We Can Do About Opioid Use Disorder in Pregnancy.
- American Academy of Pediatrics: Clinical Report—Neonatal Opioid Withdrawal Syndrome
- Policy Center for Maternal Mental Health. Substance Use Disorder and Maternal Mental Health. Fact Sheet. March, 2025. https://www.doi.org/10.69764/SUDF2025

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