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Commentary

Structural Factors That Affect Life Contexts of Pregnant People With Opioid Use Disorders: The Role of Structural Racism and the Need for Structural Competency

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ABSTRACT

This article is a commentary on Preis et al.'s (2020) article "Improving Assessment, Treatment, and Understanding of Pregnant Women With Opioid Use Disorder: The Importance of Life Context." Here I discuss the importance of structural racism in any evaluation of the life context of people of color in the United States. The recent "crack baby" epidemic provides an example of the impact of structural racism on the assessment and treatment of pregnant women of color. Structural analysis is often missing from medical education and training. I argue that physicians' structural competence is necessary for reproductive justice.

KEYWORDS

Opioid use disorder; pregnancy; reproductive health; structural racism; structural competency; medical education

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Preis et al. (2020) provided an informative summary of the literature on the challenges that many pregnant women with opioid use disorder (OUD) face when seeking care. The authors underscored the importance of an increased understanding of women's "life context" to improve a range of reproductive health outcomes, including access and utilization of medication-assisted treatment (MAT) and perinatal care. According to the authors, "[l]ife context includes women's personal and medical history; their currently available mental, social, and physical resources; and their cultural and biomedical needs"(p. 154). The authors drew on life course theory, which emphasizes the "role of social, environmental, and financial determinants of health" to advocate for how an increased "understanding of the life context of pregnant women with OUD can improve prenatal care, increase adherence to and the success of substance use treatment, and improve perinatal outcomes" (p. 154). They proposed that improvements in the clinical assessment of life context can fill critical gaps in our understanding of the reproductive health trajectories of pregnant women with OUD and briefly described the Profile for Maternal Opioid Treatment Effectiveness (PROMOTE) assessment developed by their multidisciplinary team as one potentially efficacious assessment tool that has yet to be formally evaluated.

I heartily agree that attention to life context is essential to improving the care and potentially reducing multiple forms of stigma that persons with opioid use disorders frequently experience

(Tsai et al., 2019). In this commentary, I would like to offer a humble extension to the framing of "life context" provided by the authors that situates the factors shown to constitute life context beyond the interpersonal and social domains to elucidate the larger structural factors that influence those social contexts. If can we agree, as many social scientists and Preis et al. (2020) themselves have argued, that behavior is situated in life contexts, then we must also interrogate how those life contexts are shaped, positively and negatively, by structural factors in order to engage fully in the "socioecological, woman-centered research and practice approach" that the authors endorsed (p. 153). Structural factors are defined as policies, economic systems, and institutions (e.g., policing and judicial systems, welfare entitlements, schools) that can produce and maintain social equities or inequities, often along the lines of such social categories as race/ethnicity, class status, gender identity, sexuality, and ability(Metzl & Hansen, 2014; Neff et al., 2017). Here I introduce two structural factors that I think are currently missing from Preis et al.'s framing of life context, and I outline existing scholarship that associates these factors with poor health and reproductive health outcomes for persons with OUD. These factors are: (1) structural racism, and (2)lack of structural analysis in medical education that highlights the potential benefit of a structural competency approach to education in addiction medicine and obstetrics/gynecology.

Structural racism is defined as the societal systems, social forces, institutions, and ideologies that perpetuate racial inequities (Bailey et al., 2017; Gee & Ford, 2011; Paulet al., 2019). There is a well-known body of scholarship in the history of medicine that describes the relationship between the founding of the field of obstetrics/gynecology and coerced experimentation on slave women in the United States (e.g., Owens, 2017;Washington, 2006) and the lengthy historical periods of forced sterilization of women of color, indigenous, and poor women that extended well into the 20th century(Obasogie, 2013; Stern, 2005). The historical connection between structural racism and reproductive health care in the United States can be a critical lens through which we can better understand later efforts to pathologize the African American family, and African American motherhood specifically, in the era of the social construction of the "crack-baby" epidemic (Staples, 2018). Although this is not the earliest example of con-tested and conflictual relationships between women with substance use disorders (SUD)and their clinical care providers in the United States (Campbell, 2000), the experiences of public vilification, criminalization, and child welfare adjudication that followed in the wake of the "crack-baby" epidemic has had a devastating and long-lasting impact on clinical interactions and reproductive health outcomes for vulnerable pregnant people(Knight, 2015; Knight et al., 2019).

Legal scholar Dorothy E. Roberts (1991, 1997, 2001) has published extensively to demonstrate the roles that drug policy, health-care institutions, and welfare reforms have played in producing poor health and social outcomes for African American individuals and families. Medical anthropologist and addiction medicine psychiatrist Helena Hansen (Hansen & Netherland, 2016; Hansen et al., 2013, 2016) extended this work to examine racialized disparities in access to methadone and buprenorphine treatment for persons with OUD and the wider public discourse related to race and opioids. Carolyn Sufrin (2017) and Kimberly Sue (2019), both physician anthropologists, have addressed the complex relationship between the incarceration, the criminalization of substance use, and pregnancy and parenting; they drew on the work of Michelle Alexander (2010)that charted the intersecting impacts of structural racism, federal drug policies, and mass incarceration. The current crises of racialized disparities in U.S. maternal mortality(Centers for Disease Control and

Prevention, 2019; McLemore, 2019) and racialized dis-parities in postpartum pain management (Badreldin et al., 2019) underscore the need to elevate a reproductive justice framework that acknowledges the role of structural racism and discrimination in the life context of pregnant women of color (Davis, 2019; Ross & Solinger, 2017). There is a need to integrate reproductive justice and harm-reduction frameworks to address productively the multiple forms of stigma that pregnant people with substance use disorders experience, particularly those who are caught in webs of incarceration, criminalization, housing insecurity, and child welfare system involvement(Biancarelli et al., 2019; Knight et al., 2019; Pantell et al., 2019; Premkumar, Kerns, & Huchko, 2020; Wright et al., 2012). Research and care models that incorporate the perspectives of people with lived experience of SUD, pregnancy, and family adjudication are necessary to initiate dialogue about how structural vulnerability should be assessed for pregnant people with OUD in clinical care settings and how care interactions and systems can be improved (Altman et al., 2019; Knight et al., 2019; Scott et al., 2019).

Ethnographic research has documented that pregnant women with substance use disorders often avoid prenatal care because they fear experiencing discrimination and stigma due to their substance use, and/or perceived race/ethnicity or class status, and/or because they fear that they will lose custody of their children if their substance use is revealed (Knight,2015). Larger sociological studies have documented the criminalization of pregnant women who use or who are suspected of using illicit substances (Campbell, 2000; Flavin, 2009;Flavin & Paltrow, 2010). In a recent repeated cross-sectional analysis of the potential association between punitive or required reporting state policies related to substance use during pregnancy and neonatal abstinence syndrome (NAS), Faherty et al. (2019) compared 4.6million births in eight U.S. states. They found that “policies that criminalized substance use during pregnancy, considered it grounds for civil commitment, or considered it child abuse or neglect were associated with significantly greater rates of NAS in the first full year after enactment and more than 1 full year after enactment” (p. 1). Collectively, these anthropo-logical, sociological, and epidemiological data suggest that the larger structural stigmas perpetuated by punitive and criminalizing policies are associated with poor prenatal care and birth outcomes for women who use substances. Alternatively, a systematic review and meta-analysis (MacMillan et al., 2018) conducted to examine the associations between NAS outcomes and “rooming-in” (i.e., allowing a women and her neonate to remain together immediately postpartum while the neonate is being assessed and/or treated for NAS)showed reduced likelihood of treatment with pharmacotherapy and reduced length of hospital stay compared to neonates treated in a neonatal intensive care unit. The results of these studies suggest that non-criminalizing, non-punitive policies may hold promise in promoting improved birth outcomes for pregnant women with substance use disorders(Goodman et al., 2019; Paltrow & Flavin, 2013).

Tsai et al. (2019) recently published an article that outlines the detrimental role multiple forms of stigma play in undermining appropriate and humane public health responses to the opioid crisis. They wrote: “Public stigma and enacted stigma can become structural stigma when they become encoded in cultural norms, laws, and institutional policies. Collectively, these forms of stigma run at cross purposes to—and reduce public support for—public health–oriented policies to address the opioid over-dose crisis” (p. 1). In the case of pregnant people with OUD, research has shown that public stigma generated through unsympathetic, and sometimes demonizing, media portrayals

of pregnant women with OUD (Allen, 2016; Copeland, 2014; De La Cruz, 2016;Farberov, 2016) can influence reproductive and substance use disorder treatment care environments and care professionals, thus increasing the likelihood of biased or dis-criminatory interactions (i.e., enacted stigma; Knight, 2015, 2017; Sufrin, 2017). Together, public stigma and enacted stigma influence policy-making, institutional organization, and funding allocation for pregnant people with OUD (Flavin & Paltrow,2010; Guttmacher Institute, 2017). This evidence suggests that people seeking care for pregnancy and OUD should receive assessment not only about their social and interpersonal relationships and housing status, but also about the ways in which they experience and internalize multiple stigmas, particularly the structural stigma so commonly reported by people with opioid use disorders in health-care settings (Wakeman & Rich,2017). With this additional lens, care professionals might gain knowledge about and validate the structural etiologies of relevant behaviors, such as return to substance use, avoidance of prenatal care, and nonadherence to MAT regimens, as well as the interpersonal and personal-psychological dimensions that often shape the experience of sub-stance use disorders (American College of Obstetricians and Gynecologists' (ACOG)Committee on Health Care for Underserved Women, 2011).

One clinical implication of these findings relates directly to Preis et al.'s (2020) recommendations for better assessment, treatment, and understanding of pregnancy with co-occurring substance use. Rather than assessing life context independent of the above-mentioned larger policy contexts, an assessment that captures and then provides counseling about risks for adjudication and poor outcomes in more punitive environments is merited. This type of clinical interaction or assessment would be deemed structurally competent. A structural competency framework can help to provide an extension of a life-context assessment that addresses the frequent lack of structural analysis in medical education. Structural competency is an emergent framework in medical education that seeks to "shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions" (Metzl & Hansen, 2014, p. 126). It is part of a national effort to train health professionals to recognize and respond to structural factors in clinical settings, factors that have been demonstrated to be particularly cogent to the opioid crisis and to patients with OUD (Dasgupta et al., 2018; Knight et al., 2017).

At my home institution, the University of California–San Francisco, we have introduced structural competency into the medical education curriculum in the preclinical and clerkship years, as a result of the Bay Area Structural Competency Working Group's curriculum development and evaluation efforts (Donald et al., 2019; Neff et al.,2017, 2019). In the MS1 year, we offer two lectures that link behavior, social context, and structural factors: "Structural and Cultural Competency" and "Understanding Addiction: Insights from Medicine, Law, and the Social Sciences." "Understanding Addiction" is designed to increase students' awareness of the historic and current sources of public, enacted, and structural stigma that people with substance use disorders experience, particularly in health-care settings. The following year, in a small-group format, we offer "Addiction Medicine and Structural Competency" to all students during their Ob/Gyn clerkship rotation. This consists of an interactive education about (1)how to screen for, diagnose, and treat a pregnant patient with OUD and (2) the history of the "crack-baby" epidemic and how structural racism played a role in the care and treatment of women during that era. Students read a case (Knight et al., 2019) in which structural racism and discrimination against patients with OUD while pregnant play a role

in poor reproductive health outcomes, and then identify solutions to reduce stigma and bias and to promote policy and funding changes to improve care.

By focusing attention on the role structural racism has historically played in disadvantaging women of color, particularly those who reported or who were suspected of substance use while pregnant or parenting, clinicians can better understand how public, enacted, and structural stigmas contribute to poor reproductive health outcomes. A structural analysis during medical training that addresses the intersection of obstetrics/gynecology and addiction medicine is necessary to recognize and respond to the aspects of patients' life context in which the conditions of possibility for behavioral changes are structurally constrained. A structural competency framework is one route to training clinicians to identify and endorse solutions to complex health and social problems such as opioid use disorder in pregnancy; it acknowledges both the personal and interpersonal experiences of patients and the policy and institutional changes necessary to reduce stigma and promote health.

Disclosure statement

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