Vermont Department of Health
Division of Family and Child Health

MATERNAL HEALTH INNOVATION GRANT

A qualitative study to understand health outcomes for mothers and birthing people across Vermont with substance use disorders

FINAL REPORT – MARCH 31, 2026

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ACKNOWLEDGEMENTS

We would like to thank all the people with lived experience, participants, and providers who were involved in this study. The work was strengthened by their generous collaboration, openness, and willingness to contribute their time, expertise, and knowledge.

Funding for this study was provided by the Vermont Department of Health. We are grateful for the steadfast support and guidance of Emily J. Smith, PhD, Program Evaluation Director, and Katy Leffel, RN, BSN, Nurse Program Coordinator II, both with the Division of Family and Child Health.

DISCLAIMER

This qualitative study report was prepared for the Vermont Department of Health. The findings and recommendations included in the report are solely those of the authors and do not necessarily reflect the official views or policies of the Vermont Department of Health or the Pacific Institute for Research and Evaluation (PIRE).

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EXECUTIVE SUMMARY

Pregnant and parenting people with substance use disorders (SUDs) in Vermont face complex, interconnecting challenges shaped by structural instability, stigma, fragmented systems of care, and inconsistent access to supportive services. This qualitative study, conducted from March 2025 through March 2026, explored the experiences of 11 birthing people with SUDs to identify facilitators, barriers, and opportunities to strengthen maternal health systems in the state.

Participants described how nonjudgmental, relationship-centered care—including warm handoffs, proactive communication, flexible treatment modalities, and case management—improved engagement across prenatal, postpartum, and recovery-related services. Supportive interactions with providers, peer workers, and lived-experience staff fostered trust, reduced isolation, and enhanced stability.

However, participants also reported significant barriers. Structural instability, including homelessness, poverty, transportation challenges, childcare shortages, and domestic violence, hindered consistent engagement and increased vulnerability to relapse and mental health crises. Stigmatizing or punitive interactions within healthcare, child welfare, and carceral systems further eroded trust and deterred care-seeking.

Unsafe detox attempts and inconsistent emergency department (ED) responses revealed urgent gaps in protocols for managing withdrawal during pregnancy. Participants who experienced infant loss or loss of custody described profound grief that heightened relapse risk, underscoring the need for trauma-informed grief support.

The findings align with statewide patterns documented in the 2025 and 2026 Maternal Mortality Review Panel (MMRP) Legislature Reports, reinforcing the need to address structural vulnerability, improve continuity of care, expand peer and lived-experience supports, and strengthen cross-system coordination.

Key policy recommendations emerging from this study include:

1) Strengthen cross-agency coordination to reduce fragmentation across health, social service, and justice systems.
2) Adopt standardized trauma-informed and non-stigmatizing practices across perinatal care settings.
3) Implement a 12-month perinatal SUD care pathway integrating medication for opioid disorder (MOUD), mental health services, basic needs (e.g., food assistance) and lactation support, transportation assistance, and home visiting.
4) Improve equitable access to perinatal-focused mental health and substance use services.
5) Increase access to flexible MOUD delivery, including telehealth initiation, coordinated prenatal-MOUD scheduling, and warm handoffs facilitated by Community Health Teams.
6) Expand peer recovery support, perinatal peer navigation, and SUD-trained doula services across obstetric, pediatric, MOUD, and other relevant care and service settings.

7) Establish standardized ED protocols for managing withdrawal in pregnancy, including immediate MOUD initiation and warm handoffs.

8) Develop trauma-informed grief and loss supports for those experiencing infant death or custody loss.

9) Improve prenatal and postpartum care standards within correctional settings, including anti-shackling protections and coordinated transitions post-release.

BACKGROUND

Substance use disorders (SUDs) among birthing people are a critical public health issue in Vermont. Although the rate of neonatal abstinence syndrome (NAS) in the state decreased from 33.7 to 15.5 newborns with NAS per 1,000 newborns in 2013 and 2022, respectively, likely due to an increase in access to treatment, it remains above the national average.[1] Additionally, the 2025 Pregnancy Risk Assessment and Monitoring System (PRAMS) report indicates that in 2023, 30% of people drank alcohol during the first trimester of pregnancy, with fewer (11% on average) drinking during the second and third trimesters; about 12% used cannabis during pregnancy.[2] Alcohol and cannabis use during pregnancy in Vermont are higher than the national rates.[3] [4] Moreover, the 2024 PRAMS report indicates that in 2022, about 3% of perinatal people in Vermont were enrolled in medication assisted treatment (MAT) for SUDs.[5] These trends underscore that, despite improvements, Vermont continues to face distinct and persistent challenges related to substance use in pregnancy. Understanding these issues requires attention not only to clinical indicators, but also to the social and structural conditions shaping care engagement in the state.

The purpose of this qualitative study was to better understand the barriers and facilitators affecting the use of maternal and birthing health services among individuals with SUDs. The study supports the goals of Vermont's Maternal Health Innovation (MHI) grant and aligns with the state's commitment to advancing health equity and improving access to maternal and birthing community and health services. Study findings were used to develop actionable recommendations to address gaps in birthing and postpartum health services while also strengthening approaches that promote equitable, respectful, and competent care across services settings.

Objectives

The study objectives were as follows:

1. To identify unique challenges and positive experiences encountered within the maternal healthcare and community services systems.
2. To gather insights on personal and generational impacts of these systems on birthing people with SUDs.
3. To explore experiences with health complications, stigma, and disparities in care.
4. To understand how systemic structures can both hinder and support the maternal health journey for individuals with SUDs.

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[1] Newborns Exposed to Opioids in Vermont

[2] 2023 Pregnancy Risk Assessment Monitoring System (PRAMS) Highlights

[3] Alcohol and Pregnancy in the United States

[4] Wysota, C. N., Sherman, S. E., Abroms, L. C., Ghassabian, A., Hernandez, S., Young-Wolff, K. C., & Rogers, E. S. (2026). Cannabis use in pregnancy: Key findings from 2021-2023 National Survey on Drug Use and Health data. *Addictive Behaviors*, 108621.

[5] 2024 Pregnancy Risk Assessment and Monitoring System Report

Study Questions

The study explored the following questions:

1. What are the strengths in the existing community-based and health systems, as they are related to policies and programs which support birthing people with substance use disorders?
2. What are the gaps and structural barriers in the existing systems?
3. What strategies are promising for eliminating stigma, and increasing equitable outreach, engagement, and service provision?
4. What are recommended strategic priorities for maternal health innovation programming/services in Vermont?

Pacific Institute for Research and Evaluation (PIRE; www.pire.org) was contracted by the State of Vermont, Department of Health, Division of Family and Child Health (FCH) to conduct the study. PIRE is a 501(c)(3) non-profit organization, with headquarters in Beltsville, Maryland and major research centers in North Carolina (NC), California, Kentucky, and New Mexico, as well off-site offices across the country. The project operated from PIRE's Chapel Hill (NC) Center, and the team included staff who live and work off-site in Vermont. The study was conducted from March 14, 2025, through March 31, 2026.

METHODS

Overview

In accordance with best practices in evaluation, PIRE employed a participatory, utilization-focused approach that engaged community partners and birthing people with lived experience in all phases of the study—including initial development, data collection, and interpretation of findings. Recruitment and data collection processes were trauma informed to ensure participant safety, respect, and empowerment across all study stages. Activities were equity focused, with intentional efforts to include birthing people with SUDs from across the state.

Community Engagement

Co-design partners. During the initial development phase, the PIRE team collaborated with key community members as co-design partners to shape study protocols and procedures. The team first conducted informal interviews with healthcare providers and staff from organizations serving birthing people with SUDs to identify cultural values and norms that should guide protocol development. Using these insights, the team drafted study materials and then sought feedback from individuals with lived experience, identified with help from earlier interview participants.

Data Collection

Sampling, recruitment, and informed consent. Study participants were recruited with support from providers at community organizations serving birthing people with SUDs. The PIRE team used purposive sampling techniques to identify, and screen interested individuals for eligibility (See Appendix 1). Eligible individuals were invited to participate in in-depth interviews, with informed consent obtained from all participants.

Study participants and sample size. A total of 11 individuals participated in in-depth interviews. Inclusion criteria required that individuals be 18 years or older, be pregnant or within two years postpartum, have lived in Vermont during pregnancy or postpartum, report having a SUD or being in SUD treatment, and be willing and able to provide informed consent. Individuals who did not meet all inclusion criteria were excluded.

Data collection procedures. A semi-structured guide was used to facilitate in-depth interviews. Participants were asked about their experiences with perinatal care, how they felt supported or judged by providers, negative experiences encountered when accessing services, impacts of those experiences, and potential improvements to care (See Appendix 3). Demographic information was also collected (See Appendix 2). Interviews were conducted virtually via Teams or in-person following strict protocols to ensure privacy, safety, and comfort. Participants received a $50 gift card as appreciation for their time. Each interview lasted approximately 60 minutes.

Data analysis. Each participant was assigned a unique study ID to maintain confidentiality. Interviews were recorded and auto transcribed using Teams. Dedoose software was used for thematic analysis by applying deductive codes to transcript segments based on a priori conceptual categories. Code reports for each category were generated in Dedoose and exported as Word documents. Team members then used Word, Excel, and Copilot with Enterprise Data Protection to support efficient coding based on emerging themes within each category.

RESULTS

Demographic Information

The study sample included 11 participants, all of whom identified as White and non-Hispanic. Participants represented a range of ages, with 9% (n=1) aged 18–25, 45% (n=5) aged 26–34, and 45% (n=5) aged 35 or older (Table 1). Regarding pregnancy status, 27% (n=3) were pregnant at the time of the interview and 73% (n=8) were postpartum.

Household income was generally low: 36% (n=4) reported monthly incomes below $500, 36% (n=4) between $500–999, and 27% (n=3) between $1000–1999. Educational attainment varied, with 27% (n=3) having some high school, 54% (n=6) holding a GED or high school diploma, and 9% (n=1) each completing an associate's or bachelor's degree.

Participants resided across several Vermont counties, including Chittenden, Franklin, Caledonia, Bennington, and Windham. (See Figure 1).

Figure 1. Spatial distribution of participants

Table 1. Summary of sample characteristics (N=11)

Characteristic	% (n)
Race & Ethnicity	
White, non-Hispanic	100% (11)
Age	
18-25	9% (1)
26-34	45% (5)
35 and older	45% (5)
Pregnancy Status	
Pregnant	27% (3)
Post-partum	73% (8)
Urbanicity	
Urban	45% (5)
Rural	55% (6)
Monthly household income	
$0-499	36% (4)
$500-999	36% (4)
$1000-1999	27% (3)
Education	
Some High School	27% (3)
GED/High School Diploma	54% (6)
Associates	9% (1)
Bachelors	9% (1)

Participants reported extensive lifetime exposure to multiple substances (Table 2). Nearly all participants had used prescription opioids, heroin, and fentanyl (each 91%, n=10). Use of methamphetamine was also common (82%, n=9). All participants reported lifetime use of cocaine or crack, non-prescribed buprenorphine/Suboxone/methadone, stimulants, hallucinogens, and non-prescribed tranquilizers or anxiety medications (100%). Less commonly used substances included ketamine (45%, n=5) and other substances not otherwise specified (27%, n=3). Almost all the participants (91%) reported illicit substance use during or within three months of their pregnancy. Similarly, 91% of participants reported use of tobacco or nicotine products, 82% (n=9) reported use of cannabis, and 36% reported use of alcohol.

Table 2. Substance use history (N=11)

Substance use behavior	% (n)
Lifetime Substance Use	
Prescription opioids	91% (10)
Heroin	91% (10)
Fentanyl	91% (10)
Methamphetamine such as crystal meth	82% (9)
Cocaine or crack	100% (11)
Buprenorphine, Suboxone, methadone, not prescribed to you	100% (11)
Stimulants	100% (11)
Hallucinogens	100% (11)
Tranquilizers or anxiety medications, not prescribed to you	100% (11)
Ketamine	45% (5)
Other	27% (3)
Illicit substance use while pregnant or within 3 months before becoming pregnant	
Yes	91% (10)
No	9% (1)
Non-illicit substance use while pregnant	
Alcohol	36% (4)
Tobacco or Nicotine products	91% (10)
Cannabis	82% (9)

Facilitators of Service Access

Participants described interrelated system-level factors that made it easier to engage in perinatal and recovery-related services. These facilitators centered on the quality of provider interactions, the flexibility and responsiveness of service systems, and the presence of supportive relationships that helped sustain stability during pregnancy and postpartum. Together, these elements created conditions where participants felt respected, supported, and equipped to navigate complex health and social challenges.

1) Nonjudgmental, proactive systems enable access and continuity

Participants consistently linked service engagement to provider behaviors that were nonjudgmental, proactive, and coordinated. Warm handoffs, flexible modalities (e.g., telehealth, take-home dosing), and case management that solved logistics (transportation, paperwork, housing applications) reduced friction and improved follow-through across pregnancy and postpartum as illustrated by a participant in the following quote:

> *I have WIC. I'm on Reach up. My case managers are very understanding and very kind. [My case manager] doesn't judge and listens to everything I say. A lot of funding [is] going to be cut now. So, we talked about that. There're these new rules and stuff like that. So, [case manager] is really trying to figure out how to get around some of that stuff for me. I don't have childcare. I'm looking for childcare because I've been turned down three times for disability. And so, [case manager] is trying to help me out. IDI3A*

2) Choice, timing, and trusting relationships supported uptake and retention

Access improved when systems honored client readiness, offered real choices (programs, locations, modalities), and built sustained relationships (e.g., staff who advocated and checked in with clients). Family and peer supports—including providers with lived experience—further strengthened trust and persistence in care. A participant described the critical support she and her family received from a care coordinator:

> *I'm so glad that I started working with her. She helped me get this apartment. She [vouched] for me. She gave an amazing reference. She's helped me every step of the way with everything. When my son's father finally got released from jail and got his charges dropped, because she's a family specialist, that includes him as well. [He] needed to get into a program and get clothes and she's helped with that. She's taken me voucher shopping. I tell everyone here, [they] should work with her cause she's great. IDI9A*

3) Recovery was sustained by medication for opioid use disorder (MOUD) access plus practical scaffolding

MOUD was described as pivotal for reducing use/cravings, especially when paired with practical supports (transportation, dosing flexibility, coordinated prenatal care). Pregnancy and caring for a new baby often served as strong motivators for sobriety, but participants emphasized that motivation needed system scaffolding to translate into sustained recovery. Describing herself as heavily using and on the streets, a participant offered:

> *I was very nauseous and sick and I ended up having a mental health crisis. So, I ended up in [health facility] and that's when I found out I was pregnant with my daughter and at that point wanted to get off the streets and stop using. So, I stayed there for about a month, and*

they got me connected with prenatal care. They also helped me get into the hotel voucher thing. I stayed there and got into a hotel room and from there on I slowly got off the drugs. I started up at the methadone clinic again and they take the pregnancy very seriously, you have to like go and get checked out by a doctor. And they measure your levels and stuff. So, I was being seen by them and kind of as in like the prenatal team at [health facility]. And then the people at the methadone clinic. So, I kind of had my own team of people working with me through this pregnancy. IDI6A

Supportive and Positive Experiences

Participants' supportive and positive experiences centered on the emotional impact of their interpersonal interactions within service systems. In turn, these experiences influenced how they engaged with services. The findings highlight the importance of human connection—the feeling of being supported, respected, and understood across different points of care.

1) Positive and Timely Provider Communication

Participants often emphasized the value of responsive and nonjudgmental communication from providers. Some described care teams as attentive, available, and proactive in meeting their needs. This sense of being heard and taken seriously fostered trust and reduced fears of stigma, with providers described as reliable sources of information and reassurance, contributing to a positive emotional experience during care.

If I had a question, they really had the answer. I didn't feel judged. Yeah, I had a great experience at the [health facility]. IDI11A

The doctors, the psychiatrist team and the nurses were all on top of it… I had a nurse call me almost every week until last month asking how I'm doing. IDI3A

2) Importance of Residential Programs and Stable Support

Residential programs played a critical role in helping participants rebuild stability in their lives. These settings provided structured support, opportunities to regain custody of children, and environments where participants could focus on recovery without judgment. A participant explained that having her child taken care of by a foster family facilitated her sobriety and emotional healing, and that being in a supportive residential setting enabled her to regain custody of her child:

So, I didn't have custody of him for the first, I'd say nine months of his life. And he lived with a foster family while I got sober and got my life together again, which is how we ended up at [residential facility]. I got to say, since I didn't have him with me and I only did visitations, it was a little bit easier to get through postpartum and all that since I wasn't actively taking care of him 24/7. But at the same time, mentally it was hard. But once we got to [residential facility], then it was it was so much better. You know, once he was with me, it was like everything just clicked and you know, we were able to get DCF back out of our life and now, you know, two years later, here we are. IDI9A

3) Supportive Clinical Teams and Wraparound Services

Wraparound services, especially those involving close collaboration between clinical providers, social services, and peer supports, were essential in helping participants navigate complex emotional and logistical challenges. Providers who validated participants' concerns, supported

them through interactions with child welfare agencies, and encouraged treatment (such as MAT) were described as deeply impactful. This holistic, nonjudgmental support reduced feelings of guilt, fear, and isolation. The following was noted by a participant:

> *[T]he nurses and the doctors were all like, you know, you did the best thing you could by taking MAT, you know using other things, but they were very helpful .... I do know that... [DCF] showed up at the hospital, but [the] nurses were really supportive about that as well. And they actually took the baby out of the room because I was really scared even though I was sober, I knew my boyfriend wasn't. IDI5A*

4) Trust, Empowerment, and Respectful Care

Respectful, person-centered care was linked to increased motivation to stay in recovery. When providers expressed confidence in participants' abilities, offered encouragement, and treated them with dignity, participants described feeling empowered and more willing to communicate openly. These supportive interactions contrasted with previous negative experiences, underscoring how influential relational dynamics can shape the overall quality and effectiveness of services. The following quote is from a participant whose positive experiences stemmed from respectful, supportive care she received:

> *[S]he was just always there and rooting for me. I never felt like I couldn't trust her or couldn't talk to her or anything like that. She was so fantastic and honestly, I tell everyone if I didn't have her as my caseworker I don't think I would have got him as easily as I did. You know, if I had like say the caseworker that I had the last time I had a case with my two girls, I probably would not have got him. You know, they probably never would have been OK with anything. But she was always in full support of all my decisions. And she could like see how hard I was working, despite my history. IDI9A*

5) Non-Hierarchical and Lived-Experience-Informed Care

Participants highlighted the importance of receiving care from individuals who communicated with empathy rather than authority. They valued interactions where staff talked **to** them rather than **at** them. Care that incorporated lived experience, whether from counselors or peer-informed clinical staff, was described as particularly validating and motivating. The absence of judgment and the presence of mutual understanding had strong emotional resonance for participants as illustrated by the following quote:

> *I don't know if every place is like the doctor's office here...[its] just amazing. I don't know if they're all as good. So, I would want them all to be like these people. Like none of them came at me looking at me like I was garbage, even when I was using. I knew I was pregnant. I was struggling. They didn't talk down to me. They would let me know what's going to happen if I don't stop. They've watched me go through it and then they watched me fight for my daughter and get her back. Like, so they all tell me all the time how amazing it is. IDI5A*

> *Yeah. I refuse to see a counselor, a drug counselor, unless they went through it themselves. Because until you've lived it, you cannot understand it. IDI3A*

6) Care Providers as Advocates

Some participants described providers who went beyond clinical roles to advocate for them, including offering documentation for court proceedings or providing testimony. These acts of

advocacy reinforced participants' sense of being supported and understood, strengthening trust and contributing to emotional stability during vulnerable periods. For example, a participant shared:

> *I've had a doctor one time. During my divorce, he actually came and testified on my behalf on the medical standpoint of like what I was going through. … that's kind of unheard of and helped a lot. With the judge being able to understand a little bit more with drug addiction and like the steps that I have to go through every single week and the things that I have to go through every single day in the program that I was in. IDI11A*

7) Comprehensive, Responsive, and Accessible Support

Participants appreciated providers and case workers who were consistently available, resourceful, and able to meet a wide range of practical and emotional needs. Whether assisting with paperwork, providing therapy, coordinating appointments, or helping with essential resources, these comprehensive supports created a sense of safety and reliability. Regular meetings, accessible staff, and continuity of care contributed to a feeling of being held by a supportive network.

> *I just felt like all my needs were being met. I had people to talk to. I was very busy going to the hospital and going to all my appointments. I saw a therapist too during that time. And then I had [provider]. So, I was plugged into all those places. IDI6A*

> *I mean one of the women [social worker] at [health facility] like I pretty much can call anytime and … she helps me with more than what her role is. …Well, like I could call her right now and be like, hey, I need a whole bunch of stuff printed for court. Can you help me? And I could e-mail her, and she would print them all out and I'd be able to pick it all up at our next visit…I'm homeless, I don't have access to a printer, and I don't have money to go to like a library or anything and pay $0.10 a page to print things off like that. It makes things easier. IDI11A*

> *I used to have a meeting every month. We get together like basically everybody that was my support system and we would talk about what I've done good and what I've done bad. …that helped too, just talking about everything that I've done good for the month and what I need to fix and stuff like that. IDI2A*

Summary: The Emotional Meaning of Supportive Services

Overall, the emotional tone of these supportive experiences—feeling respected, encouraged, understood, and not judged—played a central role in participants' engagement with services. The human connection, expressed through genuine care, empathy, and advocacy, emerged as a critical component of effective support. These findings underscore the powerful interpersonal dynamics that shape the recovery experience and highlight the importance of fostering environments where participants feel emotionally safe and valued.

Barriers to Service Access

Across the perinatal continuum, participants described interlocking structural constraints (housing insecurity, transportation barriers, carceral involvement), relational disruption (partner incarceration/loss, partner use), and stigmatizing or surveillance-oriented institutional responses. These forces reduced consistent access to care, increased distress during clinical encounters, and intensified postpartum demands through custody processes, logistics, and mental health strain.

1) Structural instability shaping pregnancy experiences

For some interviewees, pregnancy occurred within conditions of homelessness, partner incarceration or loss, and legal or institutional instability. These conditions produced isolation and constrained the ability to engage in routine prenatal planning or self-care. A participant who was homeless explained that her partner was incarcerated during her pregnancy, which resulted in missed prenatal visits and consequently child welfare surveillance. She said:

> *I was alone on the streets without him … I was by myself. I kept in my head saying I need to go to the hospital, I need to do this and I just, I didn't. So, two months before he was born, DCF found me. They were searching the streets for me because they knew I was homeless. So, they came and found me and like, forced me to get in the car. They took me to the hospital, and I was there for hours. They did all the ultrasounds to check on all, like that really long one where they check for the chambers of the heart and you know, all that stuff. And that's when I found out that I was having a boy. And then I didn't go again until I went into labor. IDI9A*

2) Barriers to achieving sobriety during pregnancy

Efforts to reduce or stop substance use were shaped by social context, including partner substance use and lack of clinical support, resulting in cycles of relapse and unsafe detoxing during pregnancy.

> *I was on my MAT program for the fentanyl, taking my Subutex, but I didn't stop the meth until I was four or five months pregnant, which I never thought I would do because of my other kids. Well, there's only one other kid I was actually using when I got pregnant. … And I stopped as soon as I knew I was pregnant. And this time it was a little more difficult. I think it's because with him, I was alone. But with this pregnancy, my boyfriend was still actively using so it made it harder for me. IDI5A*

> *If you give me gas money, I can get there … they didn't. They promised me they were going to get me in. I didn't know what else to do. So, I called them, they didn't do anything…. Somebody called 911 because me and [partner] were fighting. I was detoxing really bad. So, they brought me through the ambulance to the emergency room. They gave me methadone, so I was better. Well, another time I went there [the emergency room] on my own. I walked in and I said I don't feel well. And so, they told me basically that they can't give me methadone unless I get brought into the hospital through ambulance. So that frustrated me a little bit. So, I left. I didn't know what to do, but I tried really hard towards the end when [partner] went to jail to get to the clinic every time it was Friday, so I wouldn't be sick. IDI2A*

3) Carceral pregnancy and information gaps amplified stigma and uncertainty

For a participant who was incarcerated during pregnancy, prenatal care was described as minimal and not responsive to pregnancy needs. Carceral transport practices (including restraints around the abdomen) and public exposure during hospital transfers contributed to stigma and distress. Separately, the participant described uncertainty navigating complex systems (e.g., treatment court "pecking order," unclear postpartum expectations), which increased cognitive load and rumination. The following was shared by the participant:

> *They do take you to the doctors, but as far as like anything else, they don't do anything different for you… they don't feed you anything differently than any of the other inmates.*

[When being transported for care] they (and I didn't know this until I was getting ready to leave) they were not supposed to shackle you around your belly and they did the whole time I was there and it's also just like really kind of sad cause you're, you know, being pushed through the hospital by COs [correctional officers] like right out in the open with shackles and you know, everything. So it was not a pleasant experience. IDI8

There's a handful of people that work there [carceral system] and I don't know like the pecking order or who would know more than somebody else, or if there's somebody above the people that I deal with, because there hasn't really been a clear answer as to like what that's gonna look like [after delivery] other than a brief conversation…cause IOP [Intensive Outpatient Program] comes at some point after this, the Tuesday and Friday class that I take right now, and I know IOP is like a whole half of the day, twice a week at least. What's that going to look like with a newborn baby? IDI8

4) System failures and harmful responses from support agencies

Participants highlighted serious gaps in protection and accountability within support systems, particularly child welfare services. One participant described repeated reports of domestic violence being ignored by multiple agencies and individuals, leaving her without protection. Another participant shared an opposite but equally harmful experience—having her words misrepresented and distorted by a worker, leading to inaccurate assumptions about abuse.

DCF failed me because they knew what was going on and they didn't do anything to stop it… Everybody knew he was beating me up. His PO knew he was beating me up. His mom knew he was beating me up. And it's like it just got swept under the rug. IDI4A

She [service provider] basically took everything that I had said about my husband and made it seem like something more different, like that he was abusive and I never said that. She just took what I said and made it sound like that. That really bothered me. I don't like how the workers are allowed to make things up, they just take what you say and twist them. IDI2A

5) Inconsistent communication of hospital policies and documentation practices

Negative care interactions included unclear or inconsistently communicated rules, security involvement for minor issues, and distress over stigmatizing documentation in medical charts. These experiences contributed to embarrassment, mistrust, and refusal of voluntary procedures, reinforcing avoidance of formal care in future encounters.

[The nurse] saw my lighter on the little table thing by the bed when I was gone [for an ultrasound]. A security guard came and he's like, I need your lighter. I asked him where does it say I can't have a lighter? Well, there's no smoking on property. I'm like, yeah, I understand that. I go down to the sidewalk, but where does it say anywhere I can't have a lighter? I know this is your job, but this was so embarrassing that they actually had security come up. And so, they gave him the lighter. They put in my charts that that they had to have security come up and ask for my lighter when all the nurse had to do was ask for it and I would have gave it to her. She didn't have to embarrass me. And so, I was reading all they wrote and because of that, like they asked me for a voluntary UA (urine analysis) and I said no.

6) Service Access Challenges: Communication Breakdowns and System Instability

Participants described significant barriers to accessing essential services due to poor communication, non-responsiveness, and fragmented systems. They reported long wait times, difficulty reaching agencies like WIC, and inefficient phone systems that require restarting applications after minor errors. Additionally, they described rigid scheduling conflicts with obligations such as treatment court, which caused them to miss medical appointments. Participants also express anxiety about the closure of major service providers, which threatens continuity of care and leaves many without stable support.

> *I've only been to one doctor's appointment since I've been out. I've made doctor's appointments, but I have like a lot of treatment court stuff and that has come between my doctor's appointments and treatment court, unfortunately takes priority because if I don't go to treatment court, I go to jail. So, when they're making doctor's appointments for me and I don't find out until a short period before, like a day or two, I have to skip those doctor's appointments and remake them. And then when they're remaking them, they're remaking them for the following week, which again ends up being during treatment court. IDI8A*

> *So, if you miss their call, getting back to them is really, really, hard. I'd have to go through the whole application process again. They don't make it easy. They make it so that if you press one wrong number on the phone when you're trying to get through to them. That you literally have to start the whole phone call over. I was on the phone two different times now. One was a 20 minute wait, which wasn't bad, but the other was a 45 minute wait and they answered and then they said hello, hello and they couldn't hear me and they hung right up. IDI1A*

> *They're shutting down the [service facility] in Fairfax in Franklin County, Grand Isle. So, there's going to be a lot of people out at the end of December. And so, I'm freaking out about that. I'm finding a new doctor and something like [service facility] up here. There's a lot of people they are helping, and so a lot of people are not going to have any services. IDI3A*

Challenging and Disempowering Experiences

Some participants' perinatal experiences were profoundly shaped by the challenges described above and by the absence of stable support systems. These factors amplified structural, emotional, and health-related hardships and fostered a sense of disempowerment throughout the perinatal period.

1) Lack of clinical support

As noted earlier, in some cases, missed prenatal visits frequently triggered child welfare surveillance, which were experienced as coercive and destabilizing rather than supportive. Efforts to reduce or stop substance use were shaped by limited clinical support and challenging social environments, leading to cycles of relapse and unsafe detoxification attempts as described in the following quote:

> *If I didn't have my methadone, I would have to chase a high just to make myself not sick. I detoxed when I was pregnant a couple times and I can tell you I was scared that I was going to have a miscarriage because when you detox off heroin, you don't feel good. It's not something fun to feel. They told me that when I'm detoxing, my kid's detoxing three times worse than I am, and it really bothered me. IDI2A*

2) Perinatal non-attachment

Emotionally, some participants described antenatal and postnatal non-attachment as a coping response to stress, substance use, or due to postpartum depression. Birth experiences were often rapid, chaotic, and traumatic, involving minimal pain management and severe complications.

> *It happened so quick by the time we got to the hospital and of course they're like, OK, well, you need to register first. And I'm like, no, you don't understand. I cannot register. I need to go upstairs like now. So they quickly brought me up and soon as they got me into the bed I was pushing and it took a whole maybe 20 minutes for him to be born. I kept saying the whole pregnancy, to myself, I don't feel a connection to this child because of the drugs. I, you know, felt no connection. The moment he was born and I looked at him, I started bawling my eyes out saying I am so sorry and the connection hit me. They handed him to me and I just cried. IDI9A*

> *Postpartum really messed me up. I gained a ton of weight. I got really depressed. I was in bed for like 3-4 months. I couldn't function. My partner had to do everything. All the feedings, all the changings. When she was an infant, I really didn't get to connect with her the way I do now. It was completely the opposite. Like I wasn't attached to her. I was struggling with my postpartum. I couldn't stand hearing her cry. IDI6A*

3) Disengagement from services

Postpartum periods were characterized by mental health challenges, medical complications, and continued system involvement. Negative interactions, stigma, and humiliating interactions within healthcare settings, undermined trust and led to avoidance of formal care, including consideration of home birth or disengagement from services because of anticipated reporting as illustrated by the following.

> *I fell down the stairs [with baby] and she ended up with a tiny, itty bitty bruise on her cheek. No, I got hurt, but she didn't and [we] went to the hospital and they ended up reporting it to DCF because maybe I was under the influence. I'm like, are you serious? It was like 3:00 in the morning. I'm like, would you do this to like a normal mom. They don't make me feel like a normal mom, honestly. It just, it was an accident. It was so bad. Like my mom and I were both talking. We were debating whether to go into the hospital or not. Because of that, we literally were like, no matter what, they're going to call [DCF] on me. IDI3A*

In describing how she might have made different decisions had she not experienced positive support, another participant said the following:

> *I probably would have had a home birth like I did with my last child. So, because I was actively using with my daughter, I gave birth in my house, in my bed. So, I feel like if I didn't have the supports that I had and had such a positive like mindset, I would have done the same exact thing and had the same exact result. IDI4A*

4) Cognitive load of uncertainty leading to rumination and worry

Unknowns, particularly related to housing, time and mental bandwidth for some participants, crowded out attention to other needs as described in the following:

> *My main thing right now is just knowing where I'm gonna be, knowing that I have a safe place to be with the baby. If I don't figure that out, then I have no chance of getting this baby and that's scary. And that consumes a lot of my a lot of my thoughts, a lot of my time, a lot of my*

worries as to where I can't, like if there [are other things] that are on the back burner, I just haven't had time to think about them. IDI8

Unmet Needs

Consistent with earlier sections, participants identified gaps in basic resources and supports that significantly constrained their ability to maintain health, stability, and engagement in perinatal and recovery-related services. Across interviews, difficulties in securing stable housing, obtaining essential material resources, accessing transportation, arranging childcare, and ensuring personal safety emerged as chronic gaps that compounded health risks and undermined participants' capacity to navigate pregnancy, parenting, and recovery. These findings illustrate the systemic conditions that shape participants' daily realities and highlight areas where coordinated, accessible, and sustained interventions are critically needed.

1) Housing Instability

Unstable housing situations—including living outdoors, in motels, or doubling up with family—emerged as a major stressor shaping participants' health, emotional well-being, and ability to consistently access care. Participants described how the absence of basic amenities such as showers, refrigeration, and laundry services created cascading health impacts, from worsening medical conditions to repeated hospital visits. Others emphasized the chronic emotional burden of lacking a steady place to stay and the difficulty of securing housing support despite long-standing requests for assistance as illustrated in the following quotes:

I don't have access to a shower. I don't have access to a fridge to put food away. I don't have a way to wash my clothes so that I'm dirty and then that affects my wounds. Which then puts me in the hospital. IDI1A

My main thing is really just having a stable, steady place to be kind of consumes a lot of my worries and time. IDI8A

Me being a single mom and stuff, I wish there was more help out there for housing and stuff like that. I asked my court case managers for years now about that, even my parents were like, we'd really like our house back, you know? And it's going to point where I'm like, dad, you might have to write an eviction notice on me and maybe I'll get something. IDI3A

2) Lack of access to supplies for baby and mom

A few participants reported difficulty obtaining essential supplies such as diapers, wipes, formula, and clothing for themselves and their infants. Limited availability of community resources or donation programs left some parents without safe or reliable ways to meet basic needs. In moments of financial strain, lack of access to these supplies led participants to rely on unsafe strategies to get needed supplies, underscoring how unmet material needs contribute to chronic stress and instability.

I was really hoping they had like a diaper drive or something; they didn't. [W]hen times were tough, and we needed baby supplies, I hate to say this, but we stole or had to get other people to do it for us and pay them. IDI6A

Things like that they don't have that… It would be awesome if I could get like a gift card for myself and a gift card to use on the baby. IDI1A

3) Transportation barriers

As noted in earlier sections, participants described transportation challenges—such as unreliable vehicles, lack of gas money, or lack of public transit—made it difficult to attend appointments and treatment consistently. These barriers often compounded other unmet needs, contributing to missed care, increased stress, and difficulty maintaining recovery routines.

4) Limited childcare and respite support

Limited access to childcare and respite services created ongoing strain, particularly for parents balancing recovery, work, and appointments. Participants linked lack of sleep and constant caregiving demands to increased relapse risk, emphasizing the importance of reliable childcare to support both parental well-being and treatment engagement.

> *It would be awesome if they had somebody that could come and help out like respite wise…you're sleep deprived and that's when things are more apt to happen or you're more apt to be more stressed and relapse if you're in recovery. IDI1A*

> *I'm still on a wait list and I'm going to be on a wait list for a long time for this baby. There's not enough daycares, and I think 2 daycares literally shut down last summer here. IDI1A*

5) Domestic Violence and Safety Concerns

Some participants described experiencing domestic violence and facing gaps in available supports or lack of intervention from agencies. They expressed a need for coordinated responses between child welfare, domestic violence organizations, and clinical providers to ensure safety and help survivors leave harmful environments.

> *If there was a little bit more support around domestic violence and you know, I think that if maybe DCF teamed up with, you know, PAVE [Project Against Violent Encounters] … because they could have helped me get out of that situation. IDI4A*

IMPLICATIONS AND RECOMMENDATIONS

Summary of Findings

The findings from this qualitative study highlight the critical importance of nonjudgmental, proactive, and relationship-centered care in improving engagement and continuity for pregnant and postpartum people with SUDs. Warm handoffs, flexible treatment modalities such as telehealth and take-home dosing, and case management that addresses practical barriers were consistently identified as mechanisms that reduce friction and support sustained participation in care. At the same time, structural determinants—including unstable housing, limited transportation, childcare shortages, and unmet basic needs—emerged as major drivers of health outcomes, shaping participants' capacity to attend appointments, maintain recovery routines, and care for their infants. Pregnancy and the postpartum period represent pivotal windows of motivation and vulnerability; while pregnancy often catalyzed behavior change, participants emphasized that without extended postpartum support, progress is easily disrupted by compounding demands and fragmented systems. The findings also underscore the harmful effects of stigma and punitive institutional responses, which deter care-seeking and can lead to avoidance of medical settings or unsafe detox attempts. Beyond these core themes, the narratives reveal deeper implications: the need for integrated, trauma-informed models that combine clinical care with material supports; the importance of consistent, cross-agency communication to reduce cognitive burden and system confusion; and the value of peer-informed or lived experience-based care in building trust. Collectively, the implications point to a need for coordinated, family-centered approaches that bridge medical, social service, and recovery systems to support stability across the full perinatal continuum.

Study Limitations

The study's findings should be interpreted within the context of several important limitations. Recruitment was challenging due to equity concerns in accessing participants through community-based organizations, particularly because only individuals with SUDs who were pregnant or parenting children aged five or younger were eligible. Service providers also reported difficulty engaging this population consistently, often prioritizing immediate care needs over research participation. Recruitment was further constrained by fears of identification or jeopardized program access during a politically sensitive period marked by federal funding cuts in 2025. The small sample size (N=11) limits the generalizability of findings, and the lack of racial and ethnic diversity—all participants identified as White and non-Hispanic—precludes examination of racial disparities. Given the small number of participants and their geographic distribution, the risk of inadvertent disclosure remains a concern, underscoring the need for careful deidentification in public reporting. In addition, reliance on self-reported experiences introduces the possibility of recall and social desirability biases, and the absence of triangulation with provider perspectives or administrative data (such as electronic health records [EHR] or Department of Children and Families [DCF] records) limits the ability to corroborate or contextualize participant narratives.

Comparison to Available Reports and Published Literature

Despite these limitations, available state-level data indicates that our sample is representative of the broader perinatal population with SUDs in Vermont. [6] [7] [8] [9] Additionally, even with a relatively small and geographically dispersed sample, we reached thematic saturation, strengthening the robustness and credibility of our findings. Moreover, our participants' experiences align closely with those reported by others in Vermont,[10] [11] and our findings are consistent with other U.S.-based studies.[12] [13]

Of importance, the experiences described by participants in this qualitative study closely mirror the statewide patterns identified in the 2025 and 2026 Maternal Mortality Review Panel (MMRP) Legislature Reports. Across both sources, perinatal substance use is deeply intertwined with structural vulnerability, with participants navigating unstable housing, poverty, and limited access to essential resources. Both also highlight significant fragmentation across systems, leading to delayed or missed care, and emphasize how stigma and punitive interactions diminish trust and reduce care-seeking. Additionally, both identify the critical role of relationship-based supports in promoting engagement and stability, including peers, doulas, case managers, and home-visiting programs. The alignment across these findings reinforces the urgency of addressing structural barriers, enhancing trauma-informed care, expanding lived-experience supports, and strengthening coordinated statewide responses for perinatal people affected by SUDs.

Policy Recommendations

The following recommendations are offered for consideration by the Vermont Department of Health. They reflect our study findings, align with the state's current maternal health priorities, and are reinforced by recommendations in the 2026 MMRP Legislature Report.

1) Cross-Agency Coordination

Participants faced overwhelming burdens navigating DCF, treatment court, medical appointments, and other disconnected systems, highlighting the need for stronger cross-agency coordination. They also identified housing instability, childcare shortages, transportation barriers, and safety concerns as major impediments to health and recovery–structural barriers that often overshadowed their ability to engage in care. A coordinated service model can reduce fragmentation, address these structural challenges more effectively, and improve continuity of care for perinatal people with SUDs.

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[6] 2023 Pregnancy Risk Assessment Monitoring System (PRAMS) Highlights
[7] 2024 Pregnancy Risk Assessment and Monitoring System Report
[8] Maternal Mortality Review Panel 2026 Legislature Report
[9] Maternal Mortality Review Panel 2025 Legislature Report
[10] Ashlee Loyer's Story
[11] How Far Along? How Vermont Delivers Help for Pregnant Women With Opioid-Use Disorder
[12] Bosk, E. A., & Kautz, S. V. (2025). One of These Things is Not Like the Other: Parents' Experience of Family-Focused Substance Use Treatment. *Administration and Policy in Mental Health and Mental Health Services Research*, *52*(5), 999-1016.
[13] Bakos-Block, C., Nash, A. J., Cohen, A. S., & Champagne-Langabeer, T. (2022). Experiences of Parents with Opioid Use Disorder during Their Attempts to Seek Treatment: A Qualitative Analysis. *International Journal of Environmental Research and Public Health*, *19*(24), 16660.

Recommendation:

DCF, the courts, medical providers, drug treatment programs, domestic violence services, and other relevant systems of care should establish shared processes and communication pathways to break down silos. This includes aligning policies, standardizing information-sharing practices, and developing common metrics to ensure pregnant and parenting people with SUDs receive integrated and consistent services. Coordinated approaches should explicitly incorporate pathways to address key structural barriers—such as housing, transportation, childcare, and safety—which participants identified as essential to sustaining engagement in care.

2) Trauma-Informed, Non-Stigmatizing Care

Participants emphasized that stigmatizing communication, punitive documentation, and unclear policies undermined trust and discouraged care-seeking. Trauma-informed, respectful care is central to improving perinatal experiences and outcomes.

Recommendation:

As outlined in the 2026 MMRP Legislature Report, Vermont should adopt the Alliance for Innovation on Maternal Health (AIM) Substance Use bundle across all maternal health care settings. Implementing this bundle would help standardize trauma-informed practices, including respectful communication, non-stigmatizing documentation, and transparent policies throughout perinatal care.

3) Continuous Prenatal and Postpartum SUD Care

Consistent, relationship-centered care across pregnancy and postpartum was essential for participants' engagement. However, they often encountered fragmented services, missed follow-ups, and experienced unstable access to treatment. Although MOUD played a critical role in supporting recovery, access was often disrupted by transportation barriers, clinic policies, and logistical challenges. Flexible treatment models were described as improving safety and supporting sustained recovery. Strengthening continuity of care aligns with statewide maternal health priorities and existing Blueprint and Medicaid structures.[14] [15]

Recommendations:

(1) Establish a standardized 12-month perinatal SUD care pathway that integrates MOUD, mental health services, basic needs (e.g., food assistance) and lactation support, home visiting, transportation assistance, and care coordination through medical homes and Community Health Teams.

(2) Improve equitable access to perinatal-focused mental health and substance use services, as noted in the 2026 MMRP Legislature Report. This includes expanding evidence-based treatment, recovery supports, residential programs, harm reduction initiatives, and community prevention efforts.

(3) Increase access to flexible MOUD delivery, including telehealth initiation, coordinated prenatal-MOUD scheduling, and warm handoffs facilitated by Community Health Teams.

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[14] Vermont Blueprint for Health

[15] Medicaid for pregnant people in Vermont

4) Peer and Lived-Experience Support

Participants emphasized the value of peer supports (trained individuals in recovery) and lived-experience providers (staff whose own experiences inform non-judgmental care) in reducing isolation and improving engagement. Participants described these relationships as uniquely validating and motivating.

Recommendation:

Expand and sustain peer recovery support, perinatal peer navigation, and SUD-trained doula services across obstetric, pediatric, WIC, and MOUD settings. In alignment with the 2026 MMRP Legislature Report, Vermont should formalize and scale lived experience-informed roles across the perinatal continuum, ensuring these supports are embedded within clinical care teams, home visiting programs, and community-based services. Strengthening these services would help reduce stigma, increase engagement, and promote equitable, relationship-centered care for pregnant and parenting people with SUDs.

5) Emergency Department (ED) Response to Unsafe Detoxing

Participants described unsafe detox attempts and inconsistent ED responses when seeking help. Standardized emergency protocols can prevent harm and support safe stabilization.

Recommendation:

As noted in the 2026 MMRP Legislature Report, Vermont should provide ED staff and emergency medical technicians with training on pregnancy/postpartum status identification and perinatal mental health and substance use screening and referral. The state should also implement standardized ED protocols for managing withdrawal in pregnancy, including immediate MOUD initiation, warm handoffs to treatment providers, and linkage to Family Care Plan resources.

6) Trauma-Informed Grief and Loss Support

Participants who experienced infant loss or loss of custody described profound grief that increased vulnerability to relapses and disengagement from recovery services. As noted in the 2026 MMRP Legislature report, dedicated, trauma-informed grief support is needed to address this gap.

Recommendation:

Develop a trauma-informed grief support model for perinatal people with SUD, including rapid referrals after loss, routine grief screening, and cross-system coordination to ensure access to needed mental health and supportive services.

7) Correctional Setting Care Improvements

Participants who experienced incarceration described inadequate prenatal care, unsafe restraint practices, and poor transition planning. Strengthening standards can reduce harm and improve outcomes.

Recommendation:

Enforce anti-shackling protections, ensure access to MOUD and prenatal care, and establish coordinated postpartum transition planning for incarcerated pregnant people.

APPENDICES

Appendix 1

Maternal Health Innovation Interview Screening Questions

Thank you for your interest in the Maternal Health Innovation Study. [Once confirmed that they are interested in participating and all their questions have been answered]…Before we schedule you for an interview, I have just a few questions to ask you to make sure you are eligible to participate. It will take just 2 minutes. Do you have time to do that now?

1) Have you been pregnant in the past or are you currently pregnant?
    - Yes/currently pregnant
    - No

    If currently pregnant => proceed to drug use questions

    If yes to ever been pregnant => proceed to #2

2) How old is your child (are your children)?
    - 24 months or younger
    - Older than 24 months

    If youngest child is 24 months or younger => proceed to prior focus group or interview question.

    If youngest child is older than 24 months => **NOT eligible**, proceed to ineligible script.

3) Have you already participated in this maternal health innovation study, either as part of a focus group or one-on-one interview?
    - No
    - Yes

    If No => proceed to drug use questions.

    If yes => **NOT eligible**, proceed to ineligible script.

4) Drug use question:

    <u>If currently pregnant</u>:

    Have you used any substances/drugs during your pregnancy? YES NO

    Are you currently diagnosed with a substance use disorder? YES NO

    Are you currently engaged in substance use/drug treatment? YES NO

If pregnant in the past 24 months:

Did you use any substances during your pregnancy? YES NO

Are you currently diagnosed with a substance use disorder? YES NO

Are you currently engaged in substance use/drug treatment? YES NO

If yes to ANY drug use questions => **Eligible** => Schedule data collection appointment

If No to all = **Not eligible** => Read ineligibility script

Ineligibility script: Thank you for providing that information. Unfortunately, you are not eligible to participate in this study. Thank you for your time and have a nice day.

Appendix 2

Background and Demographic information Form

We have a few questions for you. Your answers will help us describe the people who took part in our study. You can skip any question you do not feel comfortable answering.

If not currently pregnant, please skip to QUESTION 3.

1. How many weeks pregnant are you?

- 1 to 13 weeks
- 14 to 27 weeks
- 28 to 40+ weeks
- Not applicable/not currently pregnant
- Prefer not to answer
- Don't know

2. Is this your first pregnancy?

- Yes
- No
- Not applicable/not currently pregnant
- Prefer not to answer

3. When did you last give birth?

- Date of birth(please enter month and year):
- Not applicable/first pregnancy
- Prefer not to answer

4. How many children have you had?

- 1 child
- 2 children
- 3 children
- 4 children
- 5 children or more
- Not applicable/first pregnancy
- Prefer not to answer

5. Where do you live in Vermont (town/county)?
- Town (please describe):
- Prefer not to answer

County:

- Windham
- Bennington
- Windsor
- Rutland
- Orange
- Addison
- Washington
- Chittenden
- Caledonia
- Lamoille
- Essex
- Orleans
- Franklin
- Grand Isle
- Prefer not to answer

6. With what race(s) do you identify?
- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White
- Prefer not to answer

7. Do you identify as Hispanic?
- Yes
- No
- Prefer not to answer
8. What language do you speak at home?
- English
- Spanish
- French
- Other (please describe):
- Prefer not to answer

9. How old are you?
- 18-19
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50+
- Prefer not to answer

10. What is your current employment status?
- Employed Full-time
- Employed Part-time
- Unemployed and currently looking
- Unemployed and not currently looking
- Self-employed
- Other (please describe):
- Prefer not to answer

11. What is your current monthly household income?
- $0-499
- $500-999
- $1000-1999
- $2000-2999
- $3000-3999
- $4000 or more
- Prefer not to answer

12. What is your highest level of education?

- Some High School
- GED/High School Diploma
- Associate’s degree
- Bachelor's degree
- Master’s degree
- Prefer not to answer

13. Do you have access to reliable transportation?

- Yes
- No
- Sometimes
- Prefer not to answer

14. What is your current housing status?

- I currently own my home
- I am currently renting my home
- I am currently staying with a friend or family member
- I am currently living/sleeping outside
- I am living at a motel
- I am living at a shelter
- I am currently living in a residential treatment home (e.g., Lund)
- Other (please describe):
- Prefer not to answer

15. Who do you currently live with (select all that apply)?

- I live alone
- My spouse or partner
- Some of my children
- All of my children
- My stepchild or stepchildren
- Other family members (like parents, siblings, cousins, etc.)
- Friends
- Other (please describe):_____
- Prefer not to answer

16. What is your marital status?

- Single
- Married
- In a domestic partnership
- Divorced
- Widowed
- Prefer not to answer

The next questions are about substances you may have used, even just once. This helps us understand how to improve care. Your answers are private, your name is not attached to your responses, and there are no right or wrong answers.

17. **Have you ever used any of the following substances?** (Check all that apply)

    - Prescription opioids (e.g., oxycodone, Vicodin) not prescribed to you
    - Heroin
    - Fentanyl
    - Methamphetamine such as crystal meth
    - Cocaine or crack
    - Buprenorphine, Suboxone, methadone, not prescribed to you
    - Stimulant medications (such as Ritalin or Adderall), not prescribed to you
    - Hallucinogens such as MDMA, mushrooms, LSD or ecstasy
    - Xylazine (Tranq)
    - Tranquilizers or anxiety medications (such as benzos or Xanax), not prescribed to you
    - Ketamine (K-hole)
    - Prescription stimulants (e.g., Adderall) not as prescribed
    - Other (please describe): _____
    - Prefer not to answer

17. **Have you used/Did you use any of these substances during this/your pregnancy or within 3 months before becoming pregnant?**

    - Yes
    - No
    - Prefer not to answer

18. During your (current or most recent) pregnancy, did you use any of the following (select all that apply)

    - Alcohol
    - Tobacco or nicotine products (e.g., cigarettes, vape)
    - Cannabis (weed, THC)
    - Prefer not to answer

Thank you very much for answering our questions.

Appendix 3

Introduction

Good morning/ afternoon. My name is _____. I am from the Pacific Institute for Research and Evaluation (or PIRE).

I'd like to begin by thanking you so much for being here today. As a reminder, you are here today to share your experiences with maternal health services in Vermont. The goal of our discussion is to learn from you so that we can improve services for pregnant people and new moms in the future. The interview will take about one hour and will be audio recorded for accuracy. You may skip any question you do not wish to answer, and you may end the interview at any time.

We will not write or record your name or any information that can be used to identify you on any study materials. Your answers will be kept confidential, they will not be shared with any of your care providers, and only summarized results will be shared. I also want to share that I am a researcher and am not a mandated reporter. The information you share with me today is kept confidential. That said, if we discuss something that leads me to believe you are in imminent and serious risk of harming yourself or your baby/child, I will connect you with a resource that can support you.

Do you have any questions before we begin? [Answer all questions] Okay, if you all are ready, we will now turn on the audio recorder and we will begin.

1. (General pregnancy): In a few words, how would you describe your current or most recent pregnancy/postpartum experience?
2. How far along was your pregnancy when you found out you were pregnant? Did you experience any health complications during pregnancy? Did you receive prenatal care?
3. If you received <u>prenatal care</u>, please start by telling me about your pregnancy experience here in Vermont in terms of where you received prenatal care.
    a. How far along was your pregnancy when you had your first prenatal appointment?
    b. How did you find your care providers?
    c. What made you choose them (if you felt you had a choice)?
4. If you did not receive prenatal care, please tell me about <u>why you did not receive care</u>.
    a. What affected your ability or choice not to engage in prenatal care (probe around substance use, stigma, partner-related issues, etc.)?
5. What were some ways you felt <u>supported, understood, and respected</u> during interactions with care providers or other community service providers during this pregnancy?
    a. How did those positive experiences influence your pregnancy and overall health?
    b. How do you think your pregnancy would have been different had you not experienced those supports and positive interactions with care or service providers?

5a. [If postpartum: What were some ways you felt supported, understood, and respected during your birth(s) specifically related to medical providers, social workers, therapists, family, any partner?

   a. What about during your postpartum hospital stay?
   b. What was the communication like between the providers who took care of you in the hospital after birth and the providers who took care of your baby(ies)?

6. What challenges have you experienced, if any, during this pregnancy/your most recent pregnancy [or in the hospital at birth and throughout your postpartum stay, if applicable]?
   a. Tell me about a time you felt judged by your providers or other health professionals because of your use of drugs.
   b. Tell me about a time you felt judged by community agencies or other service providers during your pregnancy?
   c. Tell me about a time you felt judged by family members or friends during your pregnancy?
   d. [If postpartum: If your newborn was no longer in your care, how did this impact the care you received?]
7. How have/had these challenging experiences influenced your pregnancy, [birth, if applicable], and overall health?
   a. How have these challenges impacted when you seek care or how often you attend prenatal/postnatal appointments?
   b. How have these challenges affected your ability to seek healthcare or community services after the baby is/was born?
   c. What can help/could have helped to reduce these challenges?
   d. How do you think your pregnancy/post-partum experience would have been different had you not experienced those challenges?

8. [if applicable: Did you experience any new challenges in the postpartum (*probes: mental health, custody, insurance ending, infant feeding and resources, new providers, others*)?
      a. What new services did you access or what services did you stop using? Why?
      b. When did your needs or your child's needs begin to change?

9. What other services or support outside of prenatal healthcare providers have you gotten/did you get during this pregnancy (e.g., housing support, childcare, DCF, WIC or other access to food, SUD treatment, family/friend support?)
   a. In what ways have these services met your needs and priorities?
   b. Which of your needs and priorities have not been met adequately?
   c. What were the barriers/challenges/problems you faced when trying to access these resources?
   d. What types of things made it easier for you to access these resources?
   e. What additional resources do you wish were available to you?
   f. If you have a partner or are co-parenting, did this person engage in any services or support during your pregnancy (probe around substance use)? How supportive were they of your engagement in services?
10. How prepared do/did you feel for birth and being ready to care for your baby?

    a. What are some experiences that contribute to that feeling of [being prepared/not being prepared]?
11. What would you change about the services and care you have received to help them better meet your needs and priorities?
    a. If you could create a new service or program, or make changes to an existing one, what would you do to better support pregnant individuals in Vermont?