TABLE 1 Barriers across the stigma action framework

		Study included
Individual level of stigma—person who experiences individual stigma (i.e., unfair treatment, internalized stigma and anticipated stigma that inhibits accessing support)	Fear or mistrust of the child welfare system	Baskin et al. (2015); Blakey and Hatcher (2013); Carlson et al. (2006); Elms et al. (2018); Falletta et al. (2018); Howell and Chasnoff (1999); Jessup et al. (2003); Kruk and Banga (2011); Radcliffe (2009); Roberts and Nuru-Jeter (2012); Rockhill et al. (2008); Taylor and Kroll (2004)
	Internalized stigma (limiting self-esteem/capacity to seek support)	Blakey and Hatcher (2013); Carlson et al. (2006); Elms et al. (2018); Feder et al. (2018); Radcliffe (2009); Rockhill et al. (2008); Salmon et al. (2000); Smith (2006); Stringer and Baker (2018)
	Fear of failing to reduce substance use	Elms et al. (2018); Jessup et al. (2003); Kruk and Banga (2011); Radcliffe (2009); Rockhill et al. (2008); Salmon et al. (2000)
	Trauma history	Carlson et al. (2008); Kenny and Barrington (2018)
	Previous substance use treatment attempts	Green et al. (2006)
	Fear of prenatal care	Jessup et al. (2003)
	Fear of prosecution due to substance use	Bessant (2003); Jessup et al. (2003)
Interpersonal level of stigma—from friends, family, service providers, social/work networks (i.e., derogatory language, intrusive questions and hate crimes)	Partner's/family influence on treatment access	Bessant (2003); Carlson et al. (2006); Comfort and Kaltenbach (2000); Howell and Chasnoff (1999); Jessup et al. (2003); Rockhill et al. (2008); Tuten et al. (2003)
	Stigma (substance use, mothering, pregnancy)	Bessant (2003); Carlson et al. (2006); Elms et al. (2018); Feder et al. (2018); Kenny and Barrington (2018); Radcliffe (2009); Rockhill et al. (2008); Stringer and Baker (2018)
	Having to restore trust and rebuilding relationships with children	Carlson et al. (2008); Kenny and Barrington (2018)
	Belief from providers that substance use results in an inability to parent	Drabble (2007); He et al. (2014)
	Lack of trusting and respectful relationships with service providers	Grosenick and Hatmaker (2000); Salmon et al. (2000)
	External expressions of trauma	Blakey and Hatcher (2013)
Institutional level of stigma—organizational (i.e., being made to feel less than, longer wait times, non-inclusive physical environment and institutional policies that cause harm)	Lack of coordination across service providers	Drabble (2007); Falletta et al. (2018); Haller et al. (2003); Henry et al. (2018); Howell and Chasnoff (1999); Kovalesky (2001); Lussier et al. (2010); Marcenko et al. (2011); Roberts and Nuru-Jeter (2012); Robertson and Haight (2012); Smith and Testa (2002); Smith (2006); Taylor and Kroll (2004)
	High expectations placed on women who use substances to meet an unrealistic number of tasks (including administrative tasks)	Baskin et al. (2015); Carlson et al. (2006, 2008); Elms et al. (2018); Falletta et al. (2018); He et al. (2014); Jessup et al. (2003); Lewis (2004); Radcliffe (2009); Roberts and Nuru-Jeter (2012); Rockhill et al. (2008); Smith (2002)
	Institutional stigma due to low socioeconomic status or interpersonal resources (i.e., housing and food)	Bessant (2003); Carlson et al. (2008); Comfort and Kaltenbach (2000); Henry et al. (2018); Lean et al. (2013); Lussier et al. (2010); Marcenko et al. (2011); Rockhill et al. (2008); Tuten et al. (2003)
	Institutional stigma due to pregnancy or mothering status	Bessant (2003); Falletta et al. (2018); Howell and Chasnoff (1999); Jessup et al. (2003); Kruk and Banga (2011); Radcliffe (2009); Smith (2002, 2006)
	Lack of outreach/ability to access harm reduction and treatment programs	Bessant (2003); Elms et al. (2018); Green et al. (2006); Howell and Chasnoff (1999); Kruk and Banga (2011); Rockhill et al. (2008)
	Lack of gender- and trauma-informed programming	Bessant (2003); Grosenick and Hatmaker (2000); Kruk and Banga (2011); Lewis (2004); Tuten et al. (2003)

(Continues)

TABLE 1 (Continued)

		Study included
	Geographic and transportation barriers to visitation (particularly in relation to substance use treatment programs)	Kovalesky (2001); Letourneau et al. (2013); Marcenko et al. (2011); Smith and Testa (2002)
	Impact of child welfare system (e.g. distracting mothers from reducing their substance use or increased substance use after apprehension)	Carlson et al. (2008); Jessup et al. (2003); Rockhill et al. (2008, 2015); Smith and Testa (2002); Smith (2002)
	Proof of treatment completion and abstinence from substances	Carlson et al. (2006); He et al. (2014); Robertson and Haight (2012); Taplin and Mattick (2015)
	Reunification timelines (mothers' readiness for reunification in relation to how long a child can be in foster care before parental rates are terminated)	Carlson (2006); Carlson et al. (2008); Kenny and Barrington (2018)
	Lack of financial support for programs (including allied services)	Carlson et al. (2006); Robertson and Haight (2012); Taylor and Kroll (2004)
	Wait times to access substance use services	Green et al. (2006); Kruk and Banga (2011); Rockhill et al. (2008)
	Lack of family-centred programming	Carlson (2006); Kruk and Banga (2011)
	Lack of control over visitation rights and schedule	Kovalesky (2001); Smith and Testa (2002); Smith (2002)
	Lack of information sharing (with women and across staff)	Letourneau et al. (2013); Salmon et al. (2000)
	Staff turnover	Kruk and Banga (2011); Taylor and Kroll (2004)
	Insurance acceptability	Angelotta et al. (2016)
	Different perceptions of the impact of substance use across fields	Drabble (2007)
	Institutional barriers due to use of methadone maintenance	Lean et al. (2013)
Population level of stigma—mass media, policies, law (i.e., stereotypes, negative portrayals in media, discriminatory policies and laws and inadequate legal protections)	Discrimination due to mental health status	Brown et al. (2016); Carlson et al. (2008); Henry et al. (2018); Lean et al. (2013); Marcenko et al. (2011); Marshall et al. (2011); Smith and Testa (2002)
	Discrimination due to substance use	Baskin et al. (2015); Carlson et al. (2006); Kenny and Barrington (2018); Smith (2002); Taylor and Kroll (2004)
	Punitive approaches, including prenatal child welfare laws and apprehensions at birth	Angelotta et al. (2016); He et al. (2014); Roberts and Nuru-Jeter (2012); Robertson and Haight (2012)
	Discrimination due to intergenerational involvement with child welfare	Blakey and Hatcher (2013); Marshall et al. (2011)
	Racism	Blakey and Hatcher (2013)
	Historical trauma	Baskin et al. (2015)

the need to access substance use treatment, and that when women engaged with child welfare services, the topic of substance use dominated discussions (Radcliffe, 2009). Where women were able to access child welfare services, they expressed a lack of confidence from social workers with their ability to remain abstinent (Kenny & Barrington, 2018) or to parent (Kruk & Banga, 2011). These interactions limited information sharing between women and service providers, contributing to a lack of trusting and respectful relationships (Grosenick & Hatmaker, 2000; Letourneau et al., 2013; Salmon et al., 2000).

In an outpatient substance use treatment programe, Salmon et al. (2000) found that only 45% of pregnant women felt physicians/nurse practitioners provided adequate medical support and the majority of women felt providers did not give substantive information on substance use in pregnancy or when parenting. This could be in part due to discrimination related to pregnancy/mothering and substance use or the lack of tailored services for pregnant women and mothers in substance use treatment and harm reduction programmes (Elms et al., 2018; Howell & Chasnoff, 1999; Jessup et al., 2003; Radcliffe, 2009). Fewer women access treatment compared to men, and parents with children are less able to access harm reduction services or treatment compared to those without children (Feder et al., 2018; Stringer & Baker, 2018). Though this could be reflective of institutional and population levels factors, the identifiable gender differences in how women access harm reduction services or treatment can be reinforced on an interpersonal level.