ASAM
American Society of Addiction Medicine

Public Policy Statement on Women, Alcohol and Other Drugs, and Pregnancy

Background

The American Society of Addiction Medicine (ASAM) is deeply committed to the prevention of alcohol and other drug-related harm and to the health and well-being of mothers and their children, including the prevention of addiction in women. For the pregnant woman with a substance use disorder (SUD), ASAM also recognizes that the SUD is typically well established prior to conception. Although addiction in women occurs in all ethnic groups and social classes, it frequently occurs in the complex context of psychiatric co-morbidity, interpersonal violence, poverty, poor nutrition, inadequate health care and stressful life experiences.

Because of the potential risk of adverse effects on fetal development following exposure to alcohol and other drugs (including nicotine, cocaine and other stimulants, marijuana, and opioids), the woman who uses drugs or alcohol and who is pregnant or may become pregnant is an especially important candidate for intervention, education, and treatment as may be indicated. As the threshold for harm is lower during pregnancy, efforts should be made to identify, educate, and treat, if indicated, even the casual user of drugs, including alcohol and nicotine, if she is pregnant or may become pregnant.

To effectively minimize the risk of fetal exposure to drugs or alcohol, substance abuse prevention programs should target all women of childbearing age. Similarly, women of reproductive age in treatment for substance use disorders should receive education about the effects of alcohol and drugs on reproduction and pregnancy and should receive counseling regarding the importance of pregnancy planning. These women should be appropriately referred for contraceptive or pregnancy planning services.

ASAM recognizes that substance-related disorders occurring during pregnancy are best addressed by a comprehensive treatment approach that addresses the woman's, the child's, and society's interests. ASAM supports treatment of the pregnant woman with substance use disorders rather than criminalization of prenatal substance use, whenever possible. Incarceration of pregnant women as a means of preventing fetal exposure to alcohol and other drug use may compromise both maternal and fetal health and inhibit the pregnant woman’s opportunity to receive effective treatments to address her long-term recovery from her substance-related disorder.

This statement addresses three aspects of substance use and addiction in women of childbearing age, with an emphasis of the potential adverse effects of substance use and substance use disorders during pregnancy. The first section highlights the harms that alcohol and other drugs may cause to the woman and her developing fetus. The second section provides policy recommendations. The final section provides a summary statement regarding the use of alcohol during pregnancy.

I. Mechanisms of Harm Due to Alcohol and Other Drugs during Pregnancy

Alcohol and other drugs ingested by a pregnant woman may cause harm to the woman and to her developing fetus by a variety of mechanisms:

1. Teratogenesis:

Teratogens can induce either embryopathy or fetopathy. The embryonic period from two to eight weeks gestation is the period of organ development (organogenesis) and is the period of maximum sensitivity for malformations due to toxic exposures. Exposure to teratogens during the ninth week through delivery can cause alterations in the structure and function of organs that initially developed normally during organogenesis. Alcohol and other drugs cross the placenta and enter the fetal circulation, thus potentially interfering with both physical and neurologic fetal growth and development, and may cause reduced birth weight, birth defects, learning and behavior disorders, and mental retardation. Alcohol is a particularly potent teratogen and may cause Fetal Alcohol Syndrome (FAS), the criteria of which are facial malformations, growth deficits, and lifelong neurodevelopmental disabilities. Alcohol may also cause Fetal Alcohol Spectrum Disorders (FASD) which can involve physical, mental, behavioral, and learning disabilities. Fetal exposure to alcohol is the most common cause of non-genetic mental retardation and the most common preventable cause of mental retardation and birth defects.

2. Obstetrical complications:

The fetus is dependent on normal utero-placental function. Disruption to the utero-placental unit can be catastrophic for both mother and fetus. Alcohol and other drugs and their associated withdrawal syndromes during pregnancy may cause constriction of uterine blood vessels, thus leading to utero-placental insufficiency or catastrophic events such as abruptio placenta as well as premature labor. These events increase the risk of fetal loss, prematurity, stillbirth, and obstetrical complications such as maternal hypertension or hemorrhage which may threaten both maternal and fetal health.

3. Intoxication risk:

Acute intoxication due to alcohol or other drugs during pregnancy is associated with impairment and poor judgment which may increase the risk of violence, suicide, motor vehicle accidents, falls, drowning, burns or other trauma to the mother and the fetus.

4. Behavioral effects:

Substance-related disorders, including alcohol and other drug addiction during pregnancy, interfere with interpersonal, occupational, and social functioning. The pregnant woman with substance use disorders, alcoholism, or drug addiction may suffer from poor self-care, including the ability to maintain adequate nutrition to support her pregnancy. There is often lack of early and regular prenatal care due to both non-compliance and fear of reporting to legal authorities or child welfare by health care providers. Substance-related disorders, including alcohol and other drug addiction, are often associated with family dysfunction and compromise of parent-infant bonding, and may be associated with child neglect or child abuse.

5. Drug culture involvement:

The drug culture associated with illicit drug use may result in women resorting to various dangerous methods to support themselves or to obtain alcohol, drugs, or the funds to procure them. These methods may include prostitution, theft, selling drugs, and trading sex for drugs. There is a risk of exposure to other hazardous situations such as sexual abuse, emotional abuse, and violence, domestic or otherwise. This in turn may lead to increased risk of sexually transmitted diseases, unintended pregnancy, and legal consequences such as criminal charges or child custody issues.

6. Withdrawal syndromes:

Physical dependence on alcohol or certain other drugs is associated with periods of intoxication that alternate with periods of withdrawal. Maternal withdrawal from alcohol and other sedatives may be life-threatening if untreated and is associated with fetal stress and distress. Withdrawal from opioids during pregnancy may not be fatal to the mother but can lead to intrauterine demise of the fetus. Physical dependence on alcohol or other drugs at the time of delivery may lead to a neonatal withdrawal syndrome in the newborn infant, as well as to a postpartum withdrawal syndrome in the mother, if left untreated.

II. Policy Recommendations

In order to prevent harm to mothers and infants, ASAM recommends the following:

1. Widespread and continuing programs to educate the public about the effects of alcohol and other drugs, including tobacco, during pregnancy. These programs should include:

a. Age-appropriate health education in elementary and secondary schools, colleges, graduate and professional schools, based on the best available scientific knowledge.
b. Patient and family education in medical settings including prenatal education about alcohol and other drugs for all pregnant women and significant others, as part of adequate prenatal care. Age-appropriate adolescent education should also be provided in medical settings regarding the effects of alcohol and drugs on general health as well as on unintended pregnancy rates and pregnancy outcomes.
c. Culturally competent public prevention programs to educate all members of the public about the realistic dangers of alcohol and other drug use during pregnancy and lactation, and ways to optimize the health of all women and children. These programs should include prominent and easily understood warning labels on alcoholic beverages, nicotine-containing products, over-the-counter medications, and prescription medications along with warning posters at the point of sale for these products.

2. Education and training of health care providers about the effects of alcohol and other drugs, including tobacco, during pregnancy. These programs should include:

a. Professional education for all physicians and other health care professionals in the care and management (including identification, intervention, treatment, and referral) of women of reproductive age who show evidence of risky use, harmful use, or addictive use of alcohol, nicotine, or other drugs. In particular, health care providers should receive appropriate professional education regarding pregnancy planning, pre-conception planning, prenatal, peri-partum, and post-partum care, including breast feeding, for these women.
b. Professional education for all providers of newborn and infant care regarding the identification and management of infants exposed to alcohol or drugs in-utero, including improved recognition of alcohol and other drug withdrawal syndromes in the newborn as well as appropriate management of neonatal opioid withdrawal syndrome and other neonatal withdrawal syndromes.
c. Professional education for all providers of medical and clinical services for infants, children, and adolescents regarding the identification and management of potential sequelae to in-utero exposure to alcohol and drugs, as well as the concurrent risks of family dysfunction related to ongoing use of alcohol and drugs by parents.

3. Early intervention, case finding, and consultation programs specifically designed to reach parents or potential parents who manifest risky use, harmful use, or addictive use of alcohol, nicotine, or other drugs, as is well established in the SBIRT (Screening, Brief Intervention, and Referral to Treatment) model:

a. Universal screening, using validated screening tools, to identify women “at risk” for substance use disorders or substance-related medical problems, women

already experiencing alcohol or drug-related harms, and women with addiction, in all medical settings--including obstetrical and gynecologic settings.

b. Repeated follow-up assessments to assure adequate identification based on universal screening of these same populations of women.
c. Appropriate intervention and referral services for these same populations of women, especially during pregnancy.

4. Substance use disorder treatment services able to meet the specific needs of women, including pregnant and parenting women, and their families:

a. The treatment of choice for women who are dependent on illicit opioids and who become pregnant is opioid agonist treatment (OAT). Women who are already on opioid agonist treatment and become pregnant should be advised to continue OAT throughout their pregnancy.
   In order to respect patient autonomy, there should be documentation of appropriate informed consent in every possible situation regarding the risks and benefits of OAT regarding pregnancy outcomes as well as neonatal abstinence syndrome and its treatment. If the woman who is already on OAT chooses discontinuation of treatment after informed consent, she should be advised to undergo a medically supervised withdrawal during the second trimester when the risk of complications is lowest.
   For a pregnant woman in the first trimester, who is using illicit opioids and who refuses OAT after a thorough discussion of risks and benefits, the ideal time for her to undergo withdrawal is the second trimester but a medically supervised withdrawal (MSW) may need to be scheduled during the first trimester if she is unwilling to accept interim maintenance treatment.
   If a pregnant woman using illicit opioids presents during the third trimester and refuses OAT, then MSW will need to be performed during the third trimester with appropriate informed consent because the alternatives will be ongoing illicit opioid use or a potentially dangerous unsupervised withdrawal.
b. Ready access to available, affordable, high-quality substance-related disorder and addiction treatment for all pregnant women. Pregnant women should be given highest priority for admission to available treatment slots; priority for admission should also be considered for their partners who need addiction treatment. Clinically available services should include education for all domestic partners and fathers and evaluation and treatment for domestic partners and fathers, as indicated. Services should also include evaluation and case management of all substance-exposed children. Programs should ideally develop and make available addiction treatment services for the family as a unit, when appropriate. Studies have shown that keeping women and their children together, even while the mother is receiving drug treatment, leads to better outcomes for the children and to increased likelihood of success in treatment for the mother.
c. Childcare and transportation should ideally be provided when necessary to enable women to engage in needed treatment.

d. Adequate and appropriate facilities for the outpatient and continuing care phases of treatment for women with substance-related disorders and addiction, consistent with models of chronic disease management.
e. Adequate perinatal care for women in addiction treatment that is non-judgmental and sensitive to their special needs.
f. Appropriate and judicious determination of when women are unable to fulfill the parental role and when alternative arrangements need to be made on a temporary or a permanent basis, keeping in mind that maintaining the family unit and/or the mother-child unit is the desirable goal. Every effort should be made to facilitate this goal.
g. Adequate, safe, and appropriate child protection services to provide alternative placement for infants or children of persons with active substance use disorders who are unable to function as parents independently, in cases where there is an absence of others who are able to fulfill the parental role.
h. Development of close working relationships among primary care, obstetric, family medicine, and midwife practices, and alcohol and other drug addiction treatment services, including services for nicotine dependence. Collaborative interdisciplinary models should be developed through joint educational and training modalities to foster consultations among specialties involved in the care of pregnant women with substance use disorders.
i. Preservation of the physician-patient relationship, so that laws or regulations should not require physicians to violate confidentiality by reporting their pregnant patients with current or past history of substance use to legal authorities and/or child welfare services in the absence of evidence of child abuse or neglect.
j. For all women entering addiction treatment, screening for co-occurring mental illness, any personal history of prenatal alcohol exposure, and any personal history or Fetal Alcohol Spectrum Disorder (FASD) or Fetal Alcohol Syndrome (FAS). Treatment plans and long-term, intensive case-management planning should be developed accordingly for women with such co-morbid conditions.

5. Research:

a. Increased public and private support for research regarding the clinically important questions about the effects of alcohol, tobacco, and other drugs, and how biological, genetic, psychological and social factors exacerbate and mitigate these effects on the pregnant woman, on her pregnancy, and on fetal development; this includes research to examine the potential intergenerational effects of in utero exposure to alcohol and drug use.
b. Research to determine which types of programs and/ or components of programs result in the best outcomes for mothers with substance-related disorders and their children.
c. Research regarding the rates of unintended pregnancy and pregnancy termination among women with substance use disorders. Research regarding the effectiveness of reproductive, contraceptive, and pregnancy planning education and counseling provided in the context of treatment for substance-related disorders in reducing the rates of unintended pregnancy and rates of pregnancy

termination among women with substance use disorders. Research regarding the effects of substance use disorder treatment itself on pregnancy rates, intended or unintended.

6. Reproductive and contraceptive counseling:

a. All women of reproductive age at risk for or suffering from substance-related disorders should receive information regarding the effects of drugs, including alcohol and nicotine, on the course of pregnancy and the health of the developing fetus.
b. All women of reproductive age entering treatment for a substance-related disorder should receive counseling regarding the effects of drugs, including alcohol and nicotine, on reproductive function.
c. All women of reproductive age entering treatment for a substance-related disorder should receive basic counseling regarding pregnancy prevention and planning, with referral to appropriate providers for specific contraceptive or pregnancy planning services.
d. Educational materials regarding reproduction and pregnancy prevention and planning designed specifically for the woman with substance use disorders should be developed and made available in substance use disorder treatment facilities.

III. ASAM Summary Statement Regarding the Use of Alcohol During Pregnancy

Alcohol is a legal and commonly used substance. There is no absolutely safe time or safe amount of alcohol to use during pregnancy. ASAM supports the recommendation from the Centers for Disease Control and Prevention (CDC), the National Institutes on Alcohol Abuse and Alcoholism (NIAAA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetrics and Gynecology (ACOG), the American Medical Association (AMA), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the National Organization on Fetal Alcohol Syndrome (NOFAS), and the Office of the Surgeon General that <u>all women should completely abstain from alcohol during pregnancy and preconception planning</u>.

ASAM concurs with the prevention recommendations published by the CDC in December 2008 in the document “Reducing Alcohol-Exposed Pregnancies: A Report of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effects”.

ASAM also recognizes the need to partner with relevant governmental and professional organizations in order to further research, education, identification, treatment, and prevention of substance-related disorders during pregnancy, addiction, FAS (fetal alcohol syndrome), and FASD (fetal alcohol spectrum disorders).

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