



ASAM American Society of
Addiction Medicine

Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids

Background

The American Society of Addiction Medicine (ASAM) is deeply committed to the health and well-being of mothers and children. This includes advocating for prevention and treatment of substance-related harm throughout a woman's reproductive years, with a particular focus on addiction and substance use during and following pregnancy.

Risks associated with substance use during and following pregnancy apply to the developing fetus, the newborn infant, and the mother. Data on fetal consequences from direct substance exposure are more robust for alcohol and nicotine than for other substances. Pregnancy complications can occur with exposure to a number of licit and illicit substances, including, but not limited to alcohol, nicotine, cocaine, amphetamines, opioids, and benzodiazepines. For example, alcohol-related neurodevelopmental disorders are the leading cause of preventable intellectual disability in the US. Opioid-related overdose not only threatens the life of the mother, but also can lead to fetal demise. Opioid withdrawal may threaten the viability of the fetus through an increased potential for spontaneous abortion.

Untreated substance misuse and addiction can lead to subsequent medical sequelae for the fetus, child, and mother. Substance misuse and addiction are associated with behaviors that increase the risk of maternal and fetal acquisition of sexually transmitted infections (STIs) such as HIV and hepatitis C and B. Women with substance use disorders (SUD) have high rates of unmet reproductive health needs. Whereas 50% of pregnancies in the United States are unplanned (defined as a woman not attempting pregnancy at the time of conception), the rate may be as high as 80% among women with SUD.¹ Short intervals between pregnancies may be disruptive to a woman's ongoing treatment and recovery and carry their own inherent risk. Inadequately treated SUDs are associated with poor adherence to prenatal care, poor attention to maternal nutrition, and worsening of co-occurring psychiatric illness. Although co-occurring disorders are common among all individuals with SUD, pregnant women with SUD are even more likely to have a co-occurring psychiatric illness, and postpartum depression (PPD) is more common among women with SUD compared to those without SUD.²

Pregnant women with SUD and their children are also more vulnerable to psychosocial problems. Women with SUD have higher rates of exposure to potentially traumatic childhood events (including sexual and/or physical abuse), and are more likely to be in a current or recent violent relationship.³ Substance-affected home environments of pregnant and postpartum women and their children can also complicate or contribute to poor health and compromised well-being. Some pregnant women with SUDs

experience housing and food insecurity for themselves as well as children in their care. Child protective services (CPS) involvement may need to occur, but can disrupt important maternal attachment, especially with her newborn child.

All pregnant women are motivated to adopt, or change, lifestyle behaviors to optimize their health and therefore that of their baby-to-be. Due in part to concerted efforts over decades to raise public awareness of substance-related risks during pregnancy, most women quit or cut down substance use during this time. Motivation to change is inherent in pregnancy. The American Congress of Obstetricians and Gynecologists (ACOG) recommends universal screening for substance use using a validated instrument at the first prenatal visit and periodically thereafter.^{4,5} Professional guidelines make clear that urine drug testing is not an adequate assessment of whether an individual has a substance use disorder.⁶ Positive results of a urine drug test do not establish a diagnosis of addiction; a woman with a positive urine drug test requires further, comprehensive assessment. However, women who cannot completely quit or cut down use during pregnancy in spite of trying are likely to have an SUD. For the pregnant woman with an SUD, the condition almost never arises *de novo* during her pregnancy, but rather developed prior to conception. Often, however, the SUD is first diagnosed during pregnancy. Thus, pregnancy offers a window of opportunity for case finding, diagnosis, treatment entry and initiation of recovery. The professional societies of clinicians involved in the care of women and children, including ACOG and ASAM, stress the importance of working with a pregnant woman to facilitate her quitting or at least reducing substance use during pregnancy, and engaging in addiction-related treatment if necessary. These professional societies oppose criminalizing and other punitive approaches to substance use during pregnancy as they turn women away from prenatal care, thus compromising maternal and fetal well-being.

For pregnant women with opioid use disorder, opioid agonist pharmacotherapy is the standard of care; the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use recommends that pregnant women who are physically dependent on opioids receive treatment using methadone or buprenorphine monopreparation rather than withdrawal management to abstinence.⁷ The preponderance of evidence supports initiation or maintenance of opioid agonist therapy during pregnancy. Medication withdrawal remains highly associated with relapse and its attendant risks. These risks include overdose, death, and HIV and hepatitis C infection. The scientific evidence clearly supports that individuals receiving opioid agonist pharmacotherapy should continue their usual medication dose and that their usual dose should be considered their baseline in terms of subsequent analgesic need, e.g., during a delivery. Methadone or buprenorphine doses may need to be adjusted during pregnancy and in the postpartum period. Women receiving opioid agonist pharmacotherapy are likely to respond less to parenteral opioid analgesia and may have a need for higher dose of analgesics to achieve adequate pain control. Therefore, multi-modal pain therapy, including the use of regional anesthesia during delivery is recommended. The method of a baby's delivery should be determined by obstetric indications only; addiction and/or active drug use are not, in and of themselves, criteria for cesarean delivery.⁸ Breastfeeding is to be encouraged and supported for women on opioid agonist therapy as both breastfeeding and skin-to-skin contact can reduce the severity and duration of neonatal abstinence syndrome (NAS).

The first year after delivery is stressful; with stress being a known relapse risk factor, women are at increased risk of relapse and overdose at that time. After delivery, the previous close contacts with the prenatal care provider ceases. Therefore, the SUD treatment provider may be the sole provider of continuity during this critical time.

Unfortunately, pregnant and postpartum women with SUD frequently experience stigma and discrimination from healthcare providers, as well as the public at large. Recently, public concern for preventing fetal harm has resulted in some states implementing punitive measures against pregnant or postpartum women. These measures have included incarcerating pregnant women to keep them abstinent and criminally prosecuting mothers for taking drugs while pregnant. Punishing pregnant women impedes proper medical care and the promotion of public health. However, since its adoption in 2010, the federal Child Abuse Prevention and Treatment Act (CAPTA) requires all states to have policies and procedures in place to notify child protective service agencies of substance-exposed newborns. The assumption is that substance use in itself is “reportable” because it is *de facto* evidence of a child in potential need of protective services.

It is inappropriate to reflexively move from the possibility to an alleged certainty of defective parenting or danger to the child simply based on evidence of substance use. Note that states differ on which substances constitute a “reportable” exposure and whether the exposure constitutes child abuse,⁹ but it is unfortunate that in some states, such reporting requirements have led to punitive consequences. It is important to recognize again that drug testing can provide evidence on the presence or absence of a compound in urine, but does not diagnose addiction or define an impairment in the individual’s ability to carry out life functions at work or at home. Sanctions against parents under child protective services interventions should be made only when there is objective evidence of danger, not simply evidence of substance use.

Given the complex needs of pregnant and postpartum women and their children, and the number of systems they encounter during critically important periods in their lives, ASAM’s policy recommendations on substance use, misuse, and SUDs during and following pregnancy fall into several categories.

Recommendations:

The American Society of Addiction Medicine recommends:

1. Screening/Prevention

- a. At SUD treatment intake, all women of reproductive age should be screened for pregnancy intention in the next 12 months and offered referrals to comprehensive family planning services, including contraception. Interest in family planning should also be addressed during the pregnancy, reinforced prior to discharge from the hospital and implemented in the postpartum period.
- b. During prenatal care, all pregnant women should be screened for substance use and SUD using a validated instrument. Brief interventions should be delivered for those women who continue to use substances and referrals to treatment provided for those who meet criteria for SUDs.
- c. Screening for depression and other co-occurring psychiatric illness should be included as part of prenatal and postpartum visits and during SUD treatment for all pregnant and postpartum women with SUD.
- d. Excluding emergency circumstances, pregnant women should provide explicit written consent for drug testing including on labor and delivery. This informed consent should include an understanding of the possible consequences of test results. A positive result of a drug test is not in itself a diagnostic criterion for an SUD, although it should prompt a

- conversation between clinician and patient about the patient's substance use. Depending on how it is conducted, this conversation may be an important factor in motivating the patient to make beneficial changes in drug use. An approach based on motivational interviewing and Screening and Brief Intervention model is recommended.
- e. As part of informed consent for SUD treatment with an opioid agonist, all pregnant women with opioid use disorder should be made aware of the possibility that their infants may develop neonatal abstinence syndrome (NAS) and they should be offered education regarding the manifestations and reassurance that NAS is not associated with documented functional impairments in the short term or developmentally.
 - f. Pregnant women diagnosed with addiction involving opioids and pregnant women prescribed methadone or buprenorphine for a diagnosed case of addiction should receive overdose training and co-prescribing of naloxone as the standard of care.

2. Treatment

- a. Given the importance of SUD treatment during pregnancy, pregnant women should be given priority access to treatment.
- b. SUD treatment services must be able to meet the specific needs of women, including pregnant and parenting women, and their families. Components of such services include but are not limited to: management of co-occurring disorders (including post-traumatic stress disorder), childcare, transportation, reproductive health, nutrition and parenting.
- c. Breastfeeding should be encouraged unless there are specific contraindications (active untreated substance use; HIV). Arrangements should be made to encourage and enable breastfeeding while the woman is attending SUD treatment services.
- d. For women with opioid use disorder, an opioid agonist medication, either buprenorphine or methadone, in conjunction with behavioral therapies, is the standard of care.
- e. Pregnant women who are stable on either methadone or buprenorphine during pregnancy and postpartum should be maintained on that particular medication and not changed to the other without clear clinical rationale. Medication should be continued through the postpartum period.
- f. Medically supervised withdrawal ("detoxification") is not recommended as it may lead to adverse fetal outcomes and is associated with a high rate of relapse and risk of overdose.
- g. During treatment, urine drug testing may be valuable as an indicator of illness severity.
- h. It is important that clinician and patient be clear on how drug testing will be implemented, on the goals of testing, and who will have access to testing results.
- i. SUD treatment providers caring for pregnant women should work closely with the woman and her other healthcare providers to coordinate care after appropriately signing the release of information forms. This includes prior to labor so accurate medication information, if needed, can be shared with labor and delivery staff.
- j. Obstetrical and labor and delivery providers caring for pregnant women with opioid use disorder should coordinate and communicate with pediatric staff versed in the care of neonates with neonatal abstinence syndrome. This communication ideally occurs before the woman enters the hospital in active labor
- k. Naltrexone should be studied in pregnancy and postpartum; at this point, naltrexone has not been well-studied during pregnancy and further research is needed before recommendations can be made.

3. Education

- a. Scientifically accurate, culturally competent, and non-judgmental messaging about the harms of substance use in pregnancy and the benefits of quitting or cutting down should be disseminated to both providers and the public at large.
- b. Product labeling on alcoholic beverages, nicotine-containing products, over-the-counter medications, and prescription medications should be evidence-based, prominently displayed and easily understood.
- c. Age-appropriate health education in schools based upon best available scientific knowledge should be provided. Starting in adolescence, this education should include not just the effects of substances on general health but also on unintended pregnancy rates and pregnancy outcomes as well.
- d. Law enforcement, lawyers, medical providers, and social workers should be educated regarding addiction as a disease and the negative impact on both maternal and child health of punitive approaches to women who use substances during pregnancy.
- e. Medical education, including at the medical school and relevant residency levels, should include culturally-appropriate education in the management of SUD during pregnancy and delivery, and in the care of infants born to such women, including management of the neonatal abstinence syndrome.
- f. Educational efforts that target a reduction of stigma related to the diagnosis and treatment of addiction should be implemented.

4. Regulatory and Law Enforcement

- a. State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as "child abuse or maltreatment," and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women.
- b. Pregnant women with SUD who are incarcerated and in labor should be promptly brought for appropriate medical care.
- c. Providers should be aware of state statute and local child welfare reporting requirements.
- d. Sanctions against parents under child protective services interventions should be made only when there is objective evidence of danger to a child, not simply evidence of substance use.
- e. The presence of a positive result on a urine drug test should be used to increase the intensity of the pregnant woman's addiction treatment plan. It should not be used as a basis for termination of treatment services or as the basis for arrest, incarceration, or as a *prima facie* basis for reflexive revocation of probation or parole, particularly in this vulnerable population.
- f. Pregnant women should provide explicit written consent for drug testing both during prenatal care and labor and delivery, particularly given the potential legal consequences.

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