PREGNANCY AND SUBSTANCE USE

A HARM REDUCTION TOOLKIT

NATIONAL
HARM REDUCTION
COALITION

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- Never disregard professional medical advice or delay in seeking it because of something you have read in this toolkit.

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HOW TO USE THESE MATERIALS

This information is intended for use by **pregnant and parenting people who use drugs**, **their loved ones**, and their **service providers**.

Our goal is to promote the overall health and wellbeing of pregnant people who use substances and their families.

Most people use substances. And when they find out they are pregnant, most people think about stopping or reducing their substance use. It is important to know there are many things you can do, related to substance use or not, to have a healthy pregnancy.

We believe in informed decision-making. We hope that pregnant people and their families can use the information in this toolkit to understand their rights, access services, and find high-quality, evidence-based care.

These materials can be shared with family members and service providers in order to **start important conversations about our plans, hopes, goals, and dreams**.

This work is **written, edited, and informed by people who have lived experience** of substance use and pregnancy. We use the words "pregnant people" and "parents" to be inclusive of everyone who has the capacity to be pregnant, parent, and care for children - including those who are trans and gender non-conforming.

We know that you are the experts. So we would love to hear from you. Can this work be improved? Do you want to contribute to future versions? Tell us.

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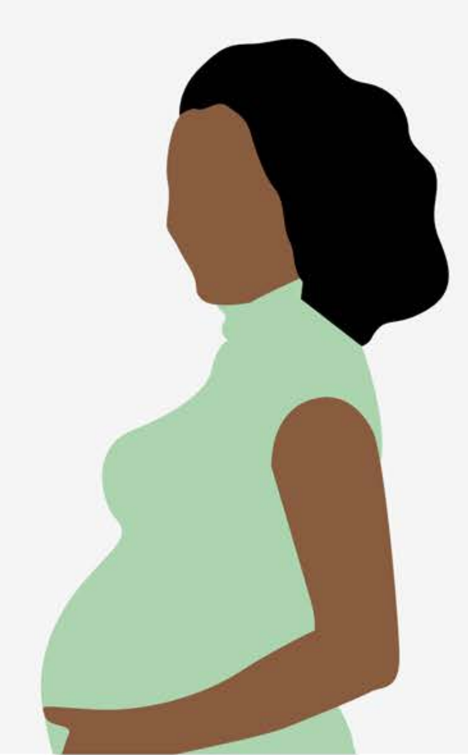
SECTION 1

QUALITY PERINATAL CARE IS YOUR RIGHT



Pregnant and parenting people who use substances face tremendous stigma and judgement when they seek medical care.

Experience with bias, judgement, and scrutiny - especially from healthcare workers, loved ones, family, and friends - **can isolate people and make it harder to get prenatal care, mental health counseling, social services,** and **community support.** [1, 2]

People don't like to go to places where they don't feel welcomed. They may fear for their safety or the safety of their children. **That's why having having even just one kind, smart, nonjudgmental, trustworthy person to support them and advocate with them can make all the difference in the world.**

Please understand that while **many people are able to quit or cut back on their use during pregnancy**, those who want to stop, but can't stop need support. They may have a substance use disorder.

SUBSTANCE USE

is not the same as a

SUBSTANCE USE DISORDER

*When we talk about substance use disorder we mean,"use that causes **clinically significant impairment**, including health problems, disability, and failure to meet our responsibilities at work, school, or home."*

www.samhsa.gov

COMMON, RECURRENT, TREATABLE

POSITIVE REGARD

Unconditional positive regard can be a great tool for boosting people's self-esteem and showing them you believe that they can be good parents.

The concept of unconditional positive regard assumes that **people are inherently good**.

It means that when you talk to someone, you address the **whole person**, instead of just focusing on their substance use.

When you have unconditional positive regard for someone:

- **You respect their right to make important decisions** about their body and their health.
- **You want what is best for them.**
- **You believe that they are competent and capable** of choosing what is right for them based on their unique circumstances.

WHY IT MATTERS

Unconditional positive regard is useful both in the **clinical setting** and in **everyday life**. And it is an essential tool in **harm reduction**.

It appreciates that we all make choices **based on our unique needs, experiences, and circumstances**. It acknowledges that everyone is different; what is right for you may not be right for me.

Positive regard helps us to make new **choices that are different from the ones we've made before**. When we know that people respect us as someone who is capable of making their own choices, **we feel safer** discussing the choices we are making. We know that even if we change our minds or make a mistake, **we will still be able to get the support we need**.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is **a tool that can help you navigate tough conversations**. To be effective, MI requires that you have empathy, self-awareness, and the ability to partner with someone in your care.

When you use MI techniques **you ask questions** and **listen to the answers.** Instead of giving directions or making accusations, you focus on **identifying choices** and **looking for solutions**. With a little practice, this is a technique that can be easily used by anyone in any setting.

As you use motivational interviewing you will start to understand that **it takes time to build trust** and that people may wait to talk to you about the details of their substance use until they know that you are a reliable ally.

Instead of saying... Now that you're pregnant you need to stop smoking.

Say... What do you think about your smoking now that you're pregnant?

Instead of saying... If you loved your children you'd stop using.

Say... I know you love your children. What can we do to help you parent them the way you want to?

See SAMHSA's resources and guide.

Instead of saying... You'll probably lose custody of this baby too.

Say... What was it like when you lost your child?

MOTIVATIONAL INTERVIEW METHODS

ASK	PERMISSION	*Can we talk about...*
	OPEN QUESTION	*What do you think about...*
	CLOSED QUESTION	*Would you want to...*
TELL	EDUCATION	*We know that...*
	INFORMATION	*Some of the choices are...*
	RECCOMENDATIONS	*You might want to...*
LISTEN	APPRECIATE	*You know what you...*
	REFLECT	*You want to, but...*
	SUMMARIZE	*So your plan is...*

RESPECTFUL LANGUAGE

Many of the words we use to describe substances, their use, and the people who use them are stigmatizing. It is our responsibility to our partners, family, and friends to do our best to **avoid judgmental and stigmatizing language**.

When talking about their own substance use, people can choose the language that feels right to them. But we should never use stigmatizing terms or labels when we talk about others. Because the **words we use to describe people who use drugs, their children, and substance use shape our beliefs**. The words we choose demonstrate whether or not we value and respect people who use drugs - and the people who care for them.

Another strategy is adopting "**person first language**." This means **recognizing the humanity of a person - and not defining them solely by a condition.** Adjusting to person first language can be awkward at first, but it is worth it if it helps us **better serve and support** people who may have been subjected to shaming and stigmatizing language by others.

BEST PRACTICES TO AVOID USING STIGMATIZING LANGUAGE

Don't Use	Do Use	Why
"addict" *"abuser"* *"junkie"*	*"person who uses heroin"* *"person with cocaine use disorder"*	*Using "person-first" language demonstrates that you value the person, and are not defining them by their drug use.*
"got clean"	*"no longer uses drugs"*	*"Clean," although a positive word, implies that when someone is using they are "dirty."*
"addicted newborn" *"born addicted"*	*"newborn opioid withdrawal (NOW)"* *"baby with prenatal cannabis exposure"*	*Infants are not addicted; they have prenatal substance exposure and/or physiological dependence.*
"medication replacement therapy (MRT)" *"medication assisted therapy (MAT)"*	*"opioid agonist therapy (OAT)"* *"medication for opioid use disorder (MOUD)"* *"medication for alcohol use disorder"*	*These categories are value-neutral and precise.* *When discussing a specific medication, refer to it by both its generic and brand names.*

CAUTION: Micro-aggressions are forms of discrimination that are common and subtle insults toward marginalized groups and people.

STIGMA AND PRIDE

Stigma is a process that discriminates against people who use drugs and pushes them to the margins of society. There are several forms of stigma, such as:

- **stigma from individuals** using the word *"junkie" or "pillhead"*
- **institutional stigma** firing people based on a positive drug screen
- **stigma through association** when pharmacists or medical providers say,"That's not the population that I want in my office"
- **self-stigma** believing you deserve pain or suffering because you use drugs

Stigma toward people who use drugs is written into our laws, child protective service and social service systems. Despite widespread acceptance that substance use is a health condition and not a character flaw, stigma against people who use drugs is still **socially acceptable and commonplace**.

STOP the STIGMA

Widespread stigma creates significant barriers to accessing what people need to survive and thrive, such as care, housing, income and social services.

Self-stigma means that sometimes you might feel like you ought to be ashamed of yourself, based on what substances you use or the circumstances in which you use them.

When people who use drugs accept and internalize this stigma, it can lead to **anxiety, isolation, and loss of self-love**.[3, 4]

Stigma **robs people of their dignity and autonomy**. It punishes and it creates barriers. People accustomed to **mistreatment and abandonment** learn to live in fear. If someone is told enough times that they are worthless, **it changes how they make decisions about their health and their safety**.

When people can't tell anyone who loves them what they use, when they use, and where where they use, they are **more likely to use alone**, increasing their risk of overdose.
We recommend these resources:
Never Use Alone (800) 484-3731
The Brave App

Stigma is amplified if a person who uses drugs becomes pregnant. [1,2] They may even become isolated from people who knew about and accepted their substance use before they got pregnant.

DIGNITY + PRIDE

It is important that you and your support system build up your self-esteem and hope for your future.

You have many positive qualities and deserve to be your best self.

You deserve to be treated with dignity and respect, as someone capable of making the best choices for yourself.

You deserve to be surrounded with people that help you **identify, grow, and celebrate your strengths**.

You deserve to talk with people not only about how to work on your current problems, but how to **imagine and plan for a happy future**.

Parents of all genders can be pregnant, give birth, feed their babies. Everyone deserves respectful, gender-affirming care.

See Trans and Gender Diverse Parents Guide from Rainbow Families
and Birth for Everybody

Part of respectful health care is **trauma-informed care**. Trauma-informed care is health care that recognizes the impact of negative life experiences such as poverty, racism, scarcity, incarceration, loss of loved ones, as well as emotional, verbal, sexual abuse, and unhealthy intimate relationships.

Ask your care providers if they know about - and provide - "trauma-informed care."

LEARN MORE...

ACOG Committee Opinion:

Caring for Patients Who Have Experienced Trauma

You deserve to be treated with dignity and respect, as someone capable of making the best choices for yourself.

TRAUMA-INFORMED CARE

Consider sharing this toolkit with your providers.

Some basic strategies for providing trauma-informed care across the perinatal and postpartum continuum are:

- Understand that **it is not necessary for someone to disclose the nature of their trauma** in order to provide trauma-informed care.
- Display positive and welcoming signage that **sets a friendly tone** when families access services, with an integrated and consistent response from all team members - from the front desk staff to direct care workers.
- Establish a **comforting, welcoming, and accessible** physical environment.
- Use **strengths-based, person-first language.** Don't describe people as being controlling, manipulative, non-compliant, unreliable, uncooperative, immature, attention-seeking, drug-seeking, or a bad parent. Especially in their medical record or any documentation shared with others.
- **Recognize that behaviors** that providers might interpret as being difficult (such as expressing anger or frustration) **are often attempts to cope** with negative past experiences or current stressors.
- Recognize that care must be individualized and person-centered. **Some people will need more support** and **different types of support** than others.
- **Know yourself.** If you are a service provider **recognize what you bring to the interaction.** Confront your own beliefs and biases about substance use and pregnancy. Acknowledge your own story, history, and beliefs.
- **Learn how to effectively engage in therapeutic conversations.** Practice how to open conversations and de-escalate when people are escalating in emotions. Know your own triggers and vulnerabilities. Help clients constructively interact with health care providers who are not trauma-informed.
- **Give choices** to participants and clients **that empower** them to set boundaries and determine the pace of physical assessments in the clinical setting.

TRAUMA-INFORMED CARE PRACTICES

When	Intervention or Action
Prenatally: before birth, during pregnancy	• Support clients to access organizations that can address immediate practical needs such as safe housing, food, clothing, medical concerns, leaving violent relationships, transportation. [5,6] • Develop approaches to providing prenatal services that are integrated and coordinated across health and social systems, including child welfare.[7]
Peripartum: during childbirth	• Consider the impact of sexual abuse and trauma on childbirth. Clients can also experience traumatic childbirth if they feel disrespected, shamed and a lack of dignity during this time. [8] • Support immediate attachment between mother and baby. People with histories of substance use, mental health issues, trauma and violence are at higher risk of impaired attachment. [9]
Postpartum: during your stay	• Keep families together as much as possible during hospital stay, including combined mother-baby care/rooming-in models [10], promoting early frequent skin-to-skin for bonding and other mother-baby neuropsychological benefits. [11] • Consider the relationship between trauma and breast/chest-feeding (some people prefer to call their mammary tissue as their chest rather than their breast). The physical contact of chestfeeding can be uncomfortable for trauma survivors. There are a number of strategies to address this issue.[12]
Postpartum: in the community, first 6 weeks after birth	• Include a focus on parent-child relationships in all interventions. Clients with a history of abuse or trauma have a higher likelihood of attachment impairment. However, they are able to increase attachment over time.[1] • Assess for postpartum depression. Women and childbearing people with a history of trauma are more likely to develop postpartum depression. [11, 12, 13, 14]

TO BIRTH OR NOT TO BIRTH

Deciding whether to carry a pregnancy to term and deliver a baby is a very personal decision. For some people, the decision is easy. For some people, it can be more difficult. **Remember: Any of the feelings you have about your pregnancy are ok.** It's normal to have conflicting emotions. For example, you might be scared and excited at the same time.

Some people find it helpful to talk to their partners, friends and family - but only you can make this personal decision.

There are free, non-judgemental resources and services that can help you talk through this decision, such as All-Options. www.all-options.org (888)493-0092

CONTINUING A PREGNANCY

If you choose to continue your pregnancy, the **next steps** are to:

- Start taking **prenatal vitamins**.
- Find a prenatal **care provider**.
- Build your **support network**.

It is important to remember that **using substances before you realized you were pregnant - or during your pregnancy - does not mean that your baby will be harmed**.

If this is a desired pregnancy, being on medications for opioid use disorder or using drugs should not be a reason for you decide to have an abortion.

NOTE: While we don't often talk about it, miscarriage and pregnancy loss are common. **10-20% of all pregnancies end in miscarriage**. It is important to remember that substance use should not be blamed for pregnancy loss.

TYPES OF PREGNANCY PROVIDERS

- **Family Medicine Physicians** and **Primary Care Providers** offer comprehensive health care services for people of all ages. They also provide care for low-risk pregnancies and births.
- **Obstetricians and Gynecologists (OB/GYNs)** provide comprehensive reproductive health care, whether someone is pregnant or not.
- **Maternal-Metal Medicine Specialists (MFMs),** also called **Perinatologists**, have special training in handling complicated and high-risk pregnancies.
- Obstetrics and Gynecology **Nurse Practitioners** (NPs or OGNPs) have special training in providing reproductive, pregnancy, and gender-specific health care.
- **Midwives** provide sexual and reproductive health care. Midwives generally care for people with low-risk pregnancies but they can consult with specialists if there are any problems. **Certified Nurse Midwives (CNMs)** are licensed to provide care everywhere in the country. There are other types of midwives who are not required to be licensed, but their services may not be covered in your state or by your insurance. Check with your provider.

THE ROLE OF DOULAS

A doula is a professional support person who can be with you during pregnancy, birth, abortion, miscarriage, or the postpartum period (also called the 4th trimester). They can be licensed or unlicensed. **Doulas advocate for you, help you make decisions,** and **provide general support.** Some provide their services at low to no-cost. Some provide services that are covered by health insurance and Medicaid.

Doulas will typically meet with you once or twice during your pregnancy to develop a relationship with you and your support person. **During pregnancy, a doula can help you learn about your options and help you make plans** for childbirth and early parenting. **During labor and birth, it is their job to care for you and advocate for you** in non-judgmental, non-medical ways - especially during stressful situations.

When searching for a doula, get as much information about them as possible. Ask them if they provide **trauma-informed care** or have **experience with caring for people who use drugs**. If you have relationships with trusted social service providers, community health care workers, case managers, or treatment providers you may ask them to help you find an experienced doula.

ENDING A PREGNANCY

If you decide to have an abortion, the next step is contacting a trusted healthcare provider.
If your provider does not provide abortion care, they should refer you to someone who does.
Ask them for a referral. Or use these tools to find care:

- How to Access an Abortion in Each State
- I Need an A

YOUR OPTIONS

ABORTION PILLS

Also called: medication abortion or self-managed abortion

There are medications you can take that will prevent a pregnancy from growing and cause your uterus to empty.

These medications are mifepristone and misoprostol. They are FDA-approved and extremely safe.

Abortion pills work best in the first 11 weeks of pregnancy.

You can get these medications from a healthcare provider online using telehealth services or at an office visit. Then you can use them safely at home.

- Plan C: A Safe Abortion with Pills
- Hey Jane

IN-CLINIC ABORTION

Also called: surgical abortion or procedural abortion

A healthcare provider can perform a simple surgical procedure that removes a pregnancy from your uterus.

This simple, safe, and common procedure can be done in-office or at a clinic. While your appointment may take a few hours, the procedure itself only takes 5-10 minutes.

You can often get an in-clinic abortion as soon as you have a positive pregnancy test, but some providers prefer to wait until 5-6 weeks after the first day of your last period.

- In-Clinic Abortion from Planned Parenthood
- Abortions Welcome

RELIABLE INFORMATION

- Reproductive Health Access Project reproductiveaccess.org
- Abortion Care Network abortioncarenetwork.org 202-419-1444
- National Abortion Federation prochoice.org 1-800-772-9100

PAYING FOR THE ABORTION CARE YOU NEED

If you need financial assistance there are organizations that can help. For more information on resources in your area see the National Network of Abortion Funds

PROTECTING YOUR PRIVACY

While using our phone and looking for information online feels private, many apps and websites actually watch what we do online and use our phones to track where we go. There are steps you can take to protect your privacy,

We like the resources at the Digital Defense Fund.

Your healthcare providers should never pressure you to have a baby or an abortion.

RESOURCES for PREGNANCT PEOPLE and PARENTS

HealthCare.gov Health coverage if you're pregnant, plan to get pregnant, or recently gave birth healthcare.gov
1-800-318-2596

Children's Health Insurance Program (CHIP)
InsureKidsNow.gov

WIC (Women, Infants, & Children) program provides nutritious food, education, referrals, and breast/chest feeding support for pregnant people and parents of young children. Visit www.wicstrong.com/about/eligibility

PAIN MANAGEMENT + ABORTION CARE

For medication abortions, people will experience bleeding and some people may have intense cramping and gastrointestinal discomfort (vomiting and diarrhea).

For in-clinic abortions, most people who are awake for the procedure describe the discomfort as intense period cramps. In most cases, the procedure lasts less than five minutes, although your appointment may be for a few hours.

Since pain can be made more intense by certain emotions or nervousness, consider having a plan for breathing exercises, bringing calming music to listen to, or using pressure points.

If you take a medication for opioid use disorder, you may not receive accurate information about pain control or adequate pain control. If you are taking buprenorphine (Suboxone) or methadone, take your regular dose. If you are considering mild or deep sedation and feel safe enough to tell the team of folks performing your abortion about your medications, they may be able to increase the dose of opioids they give during the procedure to help with discomfort.

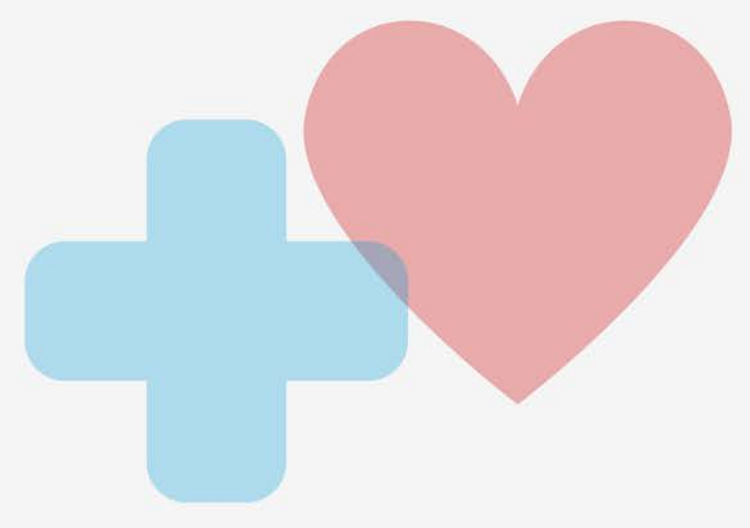
Some abortion providers are not comfortable with managing pain in patients who take buprenorphine, so you can ask them to reach out to your buprenorphine provider for information if that feels safe to you. Many abortion providers would be willing to be vague about the type of procedure you will be having if you suggest language like "they are at my facility today for a minor procedure for which we'd like to offer minimal sedation..."

If you have any concerns about urine drug screens at your buprenorphine or methadone provider's office, **ask your abortion provider for a note** about the medications you were administered or prescribed. Again, most abortion providers are willing to be vague about the type of procedure you had if you would like your buprenorphine or methadone provider to not know about your abortion.

AFTER YOUR ABORTION

- What can I expect after having an in-clinic abortion? from Planned Parenthood
- What can I expect after I take the abortion pill? from Planned Parenthood

SECTION 2



HARM REDUCTION

Harm reduction is a radical change from the way society has historically responded to substance use.

Harm reduction is the idea that since we cannot completely eliminate risk and harm, we should do our best to minimize them.

Most of the problems our society links with drug use are not caused by use. For example, disease, crime, and violence are not actually related to substances themselves, but to structural racism and criminalization.

Some examples of risk reduction in our daily lives are wearing seatbelts, using condoms, and getting enough sleep.

The most important and radical part of harm reduction is to demonstrate with our words and actions that we respect and love people who use drugs.

Abstaining from all recreational substance use during pregnancy and breast/chestfeeding is the safest option. It is important to understand that some people have trouble achieving abstinence, or simply don't want to. Those that want to stop or cut down but cannot may have a substance use disorder.

Whether or not you're using, your health and pregnancy matter!

Substance use is just one of many things that influence health and pregnancy outcomes. This section will give you the tools you need to be as healthy as possible, whether or not you're using.

www.harmreduction.org

www.perinatalharmreduction.org

Most people try several times before they can stop using. **A good healthcare provider will continue to work with people who are unable or unwilling to stop using**, rather than dropping them as clients. Multiple relapses are an expected part of just about everyone's journey. If a treatment does not work, try something else.
Remember: The treatment failed, not you.

The following sections will give you the **tools you need to help you have a healthy pregnancy and stay safe** for as long as you use drugs - whether or not you are trying to cut back or stop.

Much of the research that has been conducted on pregnant people who use drugs is problematic. It is difficult determine if a single behavior or drug causes a poor outcome. In many cases, studies around pregnancy and substance use do not control for other variables that might lead to negative outcomes, such as poverty, racism, poly-substance use, trauma, poor nutrition, or other conditions.

Prenatal vitamins provide you with the extra minerals and nutrients you need to protect your health and ensure your baby's healthy development.

- **GET GOOD PRENATAL CARE**

This is the most important thing you can do. Getting care early and often reduces your risks for most complications.

- **MAKE HEALTHY CHOICES**

Use fewer substances less often while increasing your healthy behaviors like getting more sleep, eating better, and drinking more water.

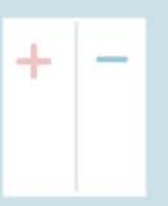
HARM REDUCTION

strategies for parents

Record how much you use. This can help you reduce your use, even if that was not your original goal.

Set limits on when and where you use, like waiting until after 5:00 to drink or only using at home or with a trusted friend.

Make a list of the risks and benefits of stopping and continuing to use. Think about where you're at or who you're with when you use.



Avoid using opioids. alcohol, or other depressants (downers) when you are alone or feeling vulnerable.

Switch to a safer method - which might be different for each substance. For example, taking a pill is safer than injecting heroin, but it is easier to control your dose of cannabis with smoking rather than eating edibles.

Set personal limits on what you use, when you use, and how much you use. For example, don't combine substances, or plan to have no more than 3 drinks over 2 hours.

Make a safety plan before you use. For example, arrange transportation so you don't need to drive.

Make a parenting plan before any substance use - including alcohol use. Arrange for help with childcare. Know what you'd do in an emergency.

Attend support groups like Moderation Management, SMART Recovery, NA, or AA. Look for peer support.

Take good care of your body and mind. Eat healthy foods. Get enough sleep. Exercise. Drink water.

NATIONAL HARM REDUCTION COALITION

harmreduction.org

perinatalharmreduction.org

ALCOHOL

ALCOHOL + PREGNANCY

"There is no known safe amount of alcohol use during pregnancy or while trying to get pregnant. There is also no safe time during pregnancy to drink. All types of alcohol are equally harmful, including all wines and beer. FASDs are preventable if a woman does not drink alcohol during pregnancy." CDC

Drinking alcohol while pregnant may increase the chance of **miscarriage** or **stillbirth**.[1] Pregnant people who drink a lot of alcohol during pregnancy are at higher risk of having a baby with symptoms of **Fetal Alcohol Spectrum Disorder (FASD)** which include characteristic facial features, smaller head size, lower birth weight, and intellectual disabilities.[1, 2]

No one knows exactly how much alcohol is safe to drink during pregnancy and it is probably different for each person.

Not every person who consumes alcohol during pregnancy will give birth to a child with symptoms of Fetal Alcohol Spectrum Disorder.

Long-term studies of children with alcohol exposure suggest that binge drinking or severe alcohol use disorder may be associated with behavior problems. Studies of low to moderate drinking have not found a universally negative impact.[3]

Some of the **permanent effects of FASD** include organ defects, limitations in thinking, reasoning, and learning. In addition, there are physical effects such as low birth weight, smaller head size, and temporary abnormal facial features.

ALCOHOL + LACTATION

Alcohol passes into human milk and is absorbed by babies if they drink that milk.[4, 5] **If you have plans that may include alcohol consumption, pump and store enough milk beforehand to feed the baby a couple of feedings or plan to use formula.** While intoxicated, if your breasts become painful or engorged, pump or hand express enough milk to relieve the pressure. Then discard it.

Recommendations for the time it takes for your milk to be safe for the baby range from **2-4 hours per drink**.[4, 5] If you are only going to have one standard drink, it is ok to feed the baby, have a drink, wait a few hours, and feed baby again without doing anything special.

If you still feel drunk or hungover - even if the recommended time has passed - wait until you feel better before providing milk to your baby. If you want to be 100% sure it's safe to give your baby your milk, you can use **alcohol test strips** for breast milk that are available in drugstores.

ONE SERVING OF ALCOHOL

12 oz BEER

8-9 oz MALT LIQUOR

5 oz WINE

1-2 oz LIQUOR

What treatment options are available for people with alcohol use disorder who are pregnant?

There are many approaches to treatment for people who want to **change their drinking** or **stop drinking** completely. A few common ways are:

- attending 12 Step meetings such as Alcoholics Annonymous (AA) or other free community meetings like Moderation Management, SMART Recovery, or Harm Reduction for Alcohol (HAMS).
- group therapy, individual counseling, hypnotherapy
- using medications prescribed by a doctor to treat cravings

The medications available for the treatment of alcohol dependence are naltrexone tablets or injections (Vivitrol®), acamprosate (Campral®), disulfiram (Antabuse®) and gabapentin (Neurontin®).

We don't have good information on how safe these medications are during pregnancy, but they are likely to be much **safer than continuing to drink**.

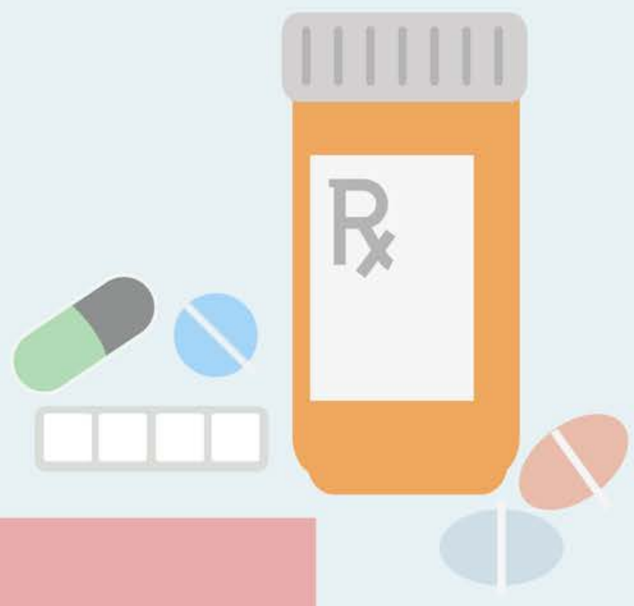
Consult with a provider before taking any of these medications while pregnant.

ALCOHOL WITHDRAWAL

In some cases alcohol dependency and withdrawal are associated with serious complications like seizures.

If you are alcohol-dependent and are trying to decrease your alcohol consumption, don't quit "cold turkey." Work with a medical provider, especially if you have had seizures before.

In rare cases, alcohol detox can lead to lethal complications. Ask for help.



BENZODIAZEPINES

BENZODIAZEPINES + PREGNANCY

Benzodiazepines are a class of medications prescribed for sleep, anxiety, and seizures. Benzodiazepines work in a similar way to alcohol in the brain on the same brain receptors. Their use might slightly increase the risk of having a baby with **cleft lip** or **palate**, but there is no link to other birth defects.[6, 7, 8]

Some studies have found an increased risk of **lower birth weight**, and other studies did not.

Possible lower birth weights among people who take these medications could be related to sleep deprivation, and not the drugs because many people take benzodiazepines for sleep problems[9]. Newborns who are given benzodiazepines in the NICU have shown withdrawal signs.

Long term outcomes are thought to be similar to other children in the same peer group.

Benzodiazepines are a class of medications prescribed for sleep, anxiety, and seizures.
Some common ones are: lorazepam (Ativan®), diazepam (Valium®), alprazolam (Xanax®), clonazepam (Klonopin®).

BENZODIAZEPINES + LACTATION

Because they have side effects, including tolerance and dependence, is important to take **as low a dose of benzodiazepine as possible** to get the benefits you need if you're breast/chestfeeding. Talk to your provider about the dose that is right for you.

Not all benzodiazepines are the same in regard to their safety and breastfeeding. For example, lorazepam is safer than diazepam. See LactMed.

In small studies, **some breastfed babies have low muscle tone, sedation, or difficulties breathing** and feeding that resolved[10]. A problem with small studies is that because they include fewer people, their findings are difficult to generalize.

What treatment options are available for dependence on benzodiazepines?

There are no FDA-approved medications that can help with benzodiazepine dependence. However, doctors can prescribe medications that can ease uncomfortable symptoms.

If you are using them to help with anxiety, depression, or insomnia **there may be medications that are safer to use while pregnant or lactating**. Seek medical advice.

Stopping use without help can be dangerous because of withdrawal symptoms like seizures. So it's important to **decrease the dose gradually (taper off) with the help of a healthcare provider**.[11]

CANNABIS

New research alert! Torres et al. (2020) [15] conducted a systematic review of prenatal cannabis exposure on cognitive functioning, finding that children with cannabis-exposure predominantly fell within the normal range, refuting many significant misunderstandings about cannabis and cognitive functioning.

CANNABIS + PREGNANCY

Most information about effects of exposure to cannabis on the fetus or newborn is conflicting and confusing.

For example, some studies find mild negative effects on newborn development, some find mild positive effects, and some find no effects. [12, 13]

Long term outcomes appear similar to other children in the same peer group.

There is no evidence to suggest that cannabis is related to stillbirth, preterm labor, significantly low birth weight, birth defects, cancer, or feeding problems. [14]

There is some recent evidence (2019) that shows that cannabis users had higher rates of preterm birth than nonusers (12.0% compared to 6.1%) but like most studies on pregnancy and cannabis it was unable to control for many other factors, including smoking. [16]

Cannabis is a plant that can be smoked, vaped, eaten, or ingested in other forms such as tinctures. It is used for relaxation, pain, anxiety, glaucoma, and many other things. Some of the other names for cannabis are marijuana, weed, herb, mota, and hash. Some other forms are wax, dabs, oils, tinctures, and shatter.

CANNABIS + LACTATION

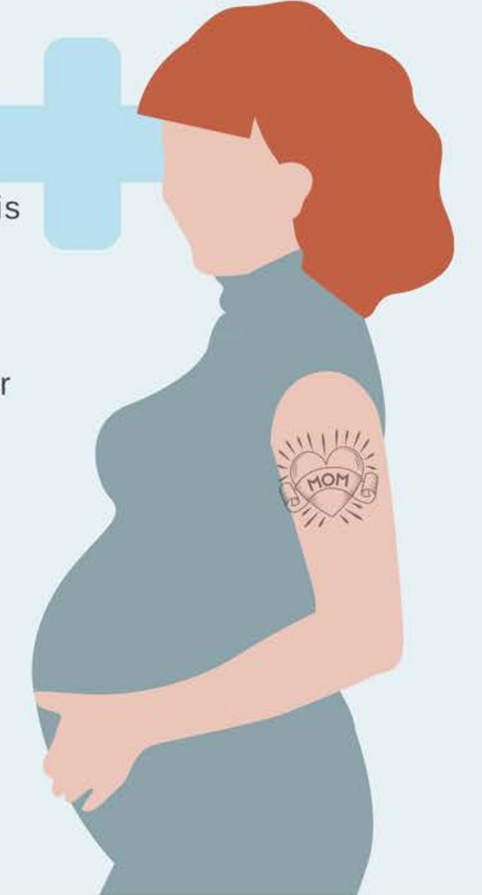
Roughly 1% of the cannabis consumed passes into your milk. [17, 18] Infant absorbtion is poor, so infants only absorb about 1% of that, making the absorbed dose roughly one thousand times less than the parents's dose.[18, 19] **This can still be enough to cause a positive result on a urine drug screen**.

Experts agree that the safest choice is to stop recreational use completely while lactating. [5, 14, 20-22]

If you continue using while breast or chestfeeding, use harm reduction methods like pumping before using or pumping and dumping right after using. [22, 23]

Human milk is made for babies and is better for babies than formula. The benefits of breastfeeding your baby outweigh the risks of them being exposed to cannabis in your milk.

What treatment options are available for cannabis use disorder?



There is no treatment medication specifically for cannabis use disorders or dependence.

If you were using cannabis to medicate for pain, anxiety or nausea, discuss with your healthcare provider whether there is a **safer treatment method**.

Many people who continue to use cannabis during pregnancy - including those who use it daily - might have a **cannabis use disorder** which might make it **more difficult for them to stop**.

Most people who want to quit cannabis do so without formal treatment, but others have found **counseling** or **group therapy** helpful.

OPIOIDS

OPIOIDS + PREGNANCY

Opioids are substances that work on the opioid receptors in the body. **Opioids are prescribed for pain management or for treatment of opioid use disorder** (opioid agonist therapy, or OAT).

During pregnancy, the body goes through changes that can make **drugs work differently**. This means opioid medications may feel stronger or less strong than they used to.[24-31]

Because of these changes that happen during pregnancy, **your opioid doses may need to be adjusted**. Otherwise there can be risks for withdrawal symptoms or over-sedation.[24-31]

Opioid use (including heroin) in pregnancy is not associated with birth defects.[24, 32, 33]

Some studies find normal birth weights, and some find weights at the lower end of normal.[34-38] **Long term outcomes are similar to other children** in the same peer group.[24, 39]

Opioids include heroin, morphine, hydromorphone (Dilaudid®), fentanyl, hydrocodone (Vicodin®, Norco®), oxycodone (Percocet®), oxycontin, tramadol, buprenorphine (Subutex®, Suboxone®), nalbuphine (Nubain®), methadone, and meperidine (Demerol®).

OPIOIDS + LACTATION

It is safe to breastfeed/chestfeed on opioid use disorder treatment medications such as methadone and buprenorphine, regardless of the dose of medication that one takes.[40-43]

In fact, **if a baby is showing signs of withdrawal breast/chestfeeding appears to make them less severe**. This may be because skin-to-skin contact and attachment formation help the baby feel better while breast/chestfeeding.

When we study other opioids like methadone, we find that **only about 2% of the total dose makes it into human milk**.[41] For buprenorphine, there are negligible amounts of buprenorphine/norbuprenorphine in breast milk and infants absorb even less of this because of the way buprenorphine is broken down and metabolized (not absorbed well in the stomach).[42, 43]

With heroin, it is best not to breastfeed, since we can't know the exact dose and it may be cut with other unknown substances that aren't safe. **It's not the heroin itself, but the other factors that makes safety an unknown.**

Consult the LactMed database to learn more about the evidence on use of the medications while lactating:

- methadone
- buprenorphine
- naloxone
- naltrexone

INFORMATION ON MEDICATIONS, PREGNANCY, AND LACTATION

If you are looking for reliable information on medications and evidence-based guidance for their use during pregnancy and lactation, we recommend these resources:

- MotherToBaby from the Organization of Teratology Information Specialists
- Drugs and Lactation Database (LactMed) from the National Library of Medicine

What treatment options are available for opioid use disorder during pregnancy?

Treatment for opioid use disorder with methadone, buprenorphine, or a buprenorphine-naloxone combination medication is safe for pregnancy and lactation and is the first-line standard of care treatment for pregnant people. Both buprenorphine-naloxone (Suboxone®) and buprenorphine (Subutex®) are safe for treatment of pregnant people.[40-43]

During pregnancy, the body goes through changes that can make drugs work differently. This means drugs may feel stronger or less strong than they used to. **Many people need to adjust their methadone or buprenorphine doses during pregnancy** because they start to experience withdrawal symptoms or feel overly-sedated. Report any withdrawal, cravings, or changes in sleep patterns to your doctor. **You might need to split your dose of medication into twice a day or three times a day** instead of once a day.[24-31]

There is emerging evidence suggesting that naltrexone (Vivitrol®) is safe to continue for people who are already using it when they become pregnant. Experts agree that it is better to use methadone or buprenorphine for people who are not already being treated with medications when they become pregnant.

SEE the section on naltrexone for more information.

Women who are being treated with naltrexone can be offered treatment with buprenorphine or methadone if naltrexone is no longer working for them. However, it is important to be cautious when changing medications because patients using long-acting naltrexone have decreased opioid tolerance. As the naltrexone wears off, smaller and smaller doses will have larger and larger effects, increasing risk for death from overdose.

Buprenorphine and methadone initiation during pregnancy can vary by state and region. **Some healthcare providers might require you to go inpatient to get monitoring on the OB-GYN floor** and **others might feel comfortable with you doing it as an outpatient**.

NALTREXONE

Naltrexone (Vivitrol®, Revia®) is another medication that can be used for treatment of opioid use disorder (OUD). It is different from methadone and buprenorphine because **it is an antagonist, rather than an agonist**. Instead of activating the endorphin receptor, it blocks it. This means that opioids will not work until the naltrexone has worn off. Where methadone and buprenorphine can be thought of as a key that opens a lock, naltrexone can be thought of as shoving chewing gum into the lock. It is similar to the overdose reversal medication naloxone (Narcan) but takes longer to wear off.

Naltrexone can be taken as a daily tablet or "as needed". Naltrexone is also available as a monthly intramuscular injection called Vivitrol. With injected Vivitrol, it can take a month or more for the opioid blockade to wear off, and as it wears off, the person's opioid tolerance gradually becomes lower and lower. **Use of unprescribed opioids during this time is very dangerous because of risk of death by overdose**.[44-46]

Naltrexone is not a controlled substance and does not cause physical dependence. There is no withdrawal associated with naltrexone in adults or infants. A naltrexone overdose would require such large doses that it is practically impossible.[47] There are no reports of any effect on infants exposed to naltrexone during pregnancy or lactation.[48, 49-53]
Roughly 1% of a parent's dose is transferred into human milk.[45, 48]

Naltrexone is less likely to be effective in reducing substance use than agonist medications (methadone and buprenorphine) and comes with side effects, including increased vulnerability to death by overdose.[44-46] Starting naltrexone requires a person to detox completely before the first dose to avoid severe precipitated withdrawal.[45, 47] Some people with OUD find naltrexone to be helpful, but many others have a hard time sticking with this treatment.[45] Long-acting opioid blockers (such as Vivitrol) can be a problem for anesthesia and pain control during unexpected surgeries such as a C-section for premature labor, because many anesthesia medications are opioids.[45-47, 54, 55] **Because naltrexone use lowers people's tolerance for opioids, they are at increased risk for overdose if they resume their opioid use**. Some people may try to overcome the opioid-blocking effects of naltrexone by taking larger doses of opioids, which also increases their risk for overdose.

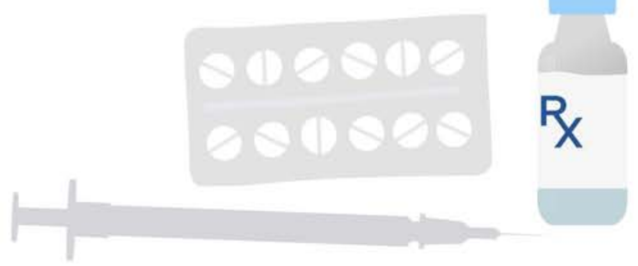
NALTREXONE (CONTINUED)

It is not recommended to start treatment with naltrexone during pregnancy.[45] If a patient with OUD becomes pregnant before seeking treatment, agonist treatment should be offered as the first-line gold standard, and naltrexone should only be available after a thorough risk/benefit discussion with a treatment provider familiar with pregnancy and OUD.[47] **If someone who is stable on naltrexone becomes pregnant and desires to continue using the medication, it is considered safe to do so**.[47] Providers should work with pregnant patients to frequently re-assess satisfaction with treatment and evaluate whether a switch to an agonist medication would be beneficial.

Many pregnant people will choose naltrexone over opioid agonist therapy (OAT) because it eliminates the risk of withdrawal in newborns. This is because there are legal and child custody implications in many states for parents of an infant who experiences Neonatal Opioid Withdrawal (NOW), even if it is a result of taking medication as prescribed. **Nobody should ever have to make a healthcare choice under coercion**. The care plan for every pregnant patient taking any Medication for Opioid Use Disorder (MOUD) requires inclusion of a thorough discussion of the local legal landscape and referrals to legal aid, if desired. **Ethical providers work with patients to minimize the individual harm done by these laws and policies, and work to change such laws and policies where they exist**.

Laws and policies that seek to punish pregnant people for having a substance use disorder or seeking treatment are harmful to individual and public health. These laws and policies are opposed by the American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), the American Society of Addiction Medicine (ASAM), and more. A full list can be accessed here **Medical Groups Oppose prosecution** at nationaladvocatesforpregnantwomen.org

Whatever medication is chosen, the **parent's stable recovery is the most important factor** influencing short- and long-term health outcomes for pregnancy and beyond.



Consult these publications from the Substance Abuse and Mental Health Administration (SAMSHA) www.samhsa.gov

- Opioid Use Disorder and Pregnancy Fact Sheets
- Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants

NEONATAL OPIOID WITHDRAWAL (NOW)

The risks of using opioids during pregnancy are largely related to the baby experiencing **neonatal opioid withdrawal (NOW),** previously known as **neonatal abstinence syndrome (NAS).** Neonatal opioid withdrawal is easily treatable.

NOW has **many signs and symptoms** that can be assessed in the hospital. Some of these signs and symptoms include: irritability, tremors, jitteriness, sleep/wake disturbances, sweating, sneezing, yawning, nasal congestion, overstimulation, difficulty feeding, poor weight gain, gassiness, vomiting, diarrhea.[56]

These symptoms can occur within 24 hours to five days after birth and are related to physical withdrawal from any opioid (heroin, fentanyl or treatments like buprenorphine and methadone).

Withdrawal symptoms are treatable with skin-to-skin contact, rooming-in (the parent staying in the same room as infant), breastfeeding/chestfeeding, or also with medications such as methadone, morphine, buprenorphine, or other agents as needed.

Not all babies who are exposed to opioids will develop signs of withdrawal, but it is good to know what to watch for and have a plan.

DETOX

MEDICALLY-SUPERVISED WITHDRAWAL

Opioid agonist therapy (OAT) should be offered as a first line treatment for opioid use disorder.

If you want to detox during pregnancy, you should only do it with supervision from a healthcare provider because detoxing can be stressful and dangerous, for both you and the fetus. **Detoxification is NOT recommended by experts on opioid use and pregnancy for this reason.**

No one should ever be pressured or coerced into detox, especially when pregnant.

Detoxing and stopping OAT, even for a short time, can lower your tolerance for opioids and make it easier to overdose the next time you use because of decreased tolerance.

Some people have heard that it is not safe to detox during pregnancy because the distress on the parent puts distress on the fetus, leading to possible negative outcomes (fetal death or preterm delivery), however, this has not been found in more recent short-term studies.[57]

If you want to detox or decrease your dose, make sure you have a careful discussion of the risks and benefits with a provider you trust. **Do not attempt detoxification at home or alone.**

NOTE: *Opioid agonist therapy (OAT) is one type of medication for opioid use disorder (MOUD). You may see either term being used.*

FIND A PROVIDER

SET YOUR GOALS TOGETHER

MAKE A PLAN TO SAFELY REACH YOUR GOALS

OPIOID OVERDOSE + PREGNANCY

Anyone who uses opioids is at risk for opioid overdose.

This is especially true during and immediately after pregnancy because of the changes that happen to your body. Changes in your weight, body mass, metabolism, and hormones will affect the dose of opioids you need to get the desired effect and how much you can tolerate.[24-31]

Naloxone (Narcan®) is a medicine that reverses overdose from opioids including heroin, prescription pain pills, and fentanyl. If you think it is possible someone has overdosed, give naloxone. Giving naloxone to someone who has not overdosed will not hurt them; it just won't work.

- If you use opioids, get naloxone.
- If you love someone who uses opiods, get naloxone.
- If you suspect an overdose, give naloxone.

Get naloxone (Narcan®) training:

- www.getnaloxonenow.org/#gettraining
- www.naloxoneforall.org from NEXT Distro

Get naloxone (Narcan®):

- Prevent & Protect: Where to Get Naloxone
  - CVS
  - Walmart
  - Walgreens
  - Rite-Aid

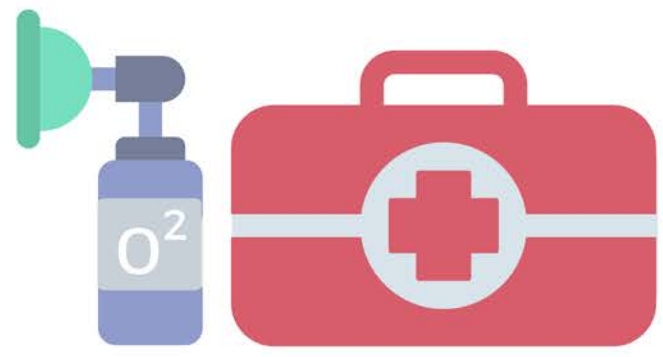
Good Samaritan laws are in place in most states to protect those who are overdosing and anyone assisting them in an emergency from arrest, charges, or a combination of these. **Learn about the laws in your state**.

OPIOID OVERDOSE + PREGNANCY (CONTINUED)

Because overdose reversal with naloxone induces immediate withdrawal, **it is possible that both overdose and overdose reversal could cause stress to your pregnancy and increase your risk of complications.**

However, even though there is a risk of distress for you or the developing fetus, **the risks posed by oxygen deprivation or even death from overdose outweigh the possible risk of fetal distress** from overdose reversal.

We recommend responding to overdose in a pregnant person exactly the same as for anyone else.



Although there is no research on overdose reversal in pregnant people, there are things you can do to protect the pregnant person and their fetus during a suspected overdose:

- Place the person in the **recovery position** on their **left side** to improve the blood flow to the placenta.
- Call **911**

  Tell the dispatcher that you are with **a pregnant person who is not breathing** and you **need paramedics.**

  You do not need to tell them that this may be a drug poisoning or overdose. If you do they may send police officers.

- **Stay with the person** or find someone who can.
- **Tell the responders that the person takes opioids** and may have taken too much and overdosed.

Good Samaritan laws in most states protect those who are overdosing and anyone assisting them in an emergency from arrest, charges, or a combination of these. **Learn about the laws in your state**.

OPIOID OVERDOSE + PREGNANCY

When overdoses happen, giving naloxone (Narcan®) saves lives - including the lives of pregnant people and their babies

1. NARCAN **2.** RESCUE BREATHS **3.** GET HELP

An overdose slows or stops breathing and keeps oxygen from getting to the body and brain.

Check for breathing

* Give rescue breaths.

Give Narcan

- Gently insert the tip of the naloxone spray into either nostril.
- Press the plunger firmly to give dose.
- Remove.

Place the person in the recovery position on their left side to improve blood flow to the placenta.

If you think they have injured their back or neck don't move them.

Get Naloxone www.naloxoneforall.org

Call 911

Tell the dispatcher that you are with a pregnant person who is not breathing and you need paramedics.

You do not need to tell them that this may be a drug poisoning or overdose. If you do, they may send police officers.

Stay with the person or find someone who can until paramedics arrive.

"Good Samaritan" laws and statutes protect people who help those who may be experiencing an overdose.

When help arrives...

Tell the responders that the person takes opioids and may have taken too much and overdosed.

Respond to overdose in a pregnant person exactly the same as you would for anyone else.

www.harmreduction.org

www.perinatalharmreduction.org

NATIONAL HARM REDUCTION COALITION

CONTAMINATION

Some of the greatest risks people who use drugs face are the result of a poisoned and contaminated drug supply. When substance use is prohibited, the result is an unregulated drug supply. This means that it is often impossible for people to know for certain what they are using - and whether or not the amount they are using is safe.

FENTANYL AND CARFENTANYL

Since 2016, **contamination of the drug supply with fentanyl (and its analogues like carfentanyl) has resulted in an increased risk of overdose for people who use illicit drugs**.[58] Fentanyl is a potent synthetic opioid and has similar pregnancy effects to other opioids. It can be injected, smoked, swallowed, or inhaled. Contamination is not limited to opioids, but has also been reported in cocaine, methamphetamine, pressed pills, and other substances.[59]

There is no risk of overdose from touching fentanyl or being near it. Fentanyl does not absorb through the skin and does not aerosolize well, meaning that it is impossible to accidentally inhale enough to cause any effect.[60] Reports of first responders overdosing in these ways are not backed by evidence and can be attributed to fear, misinformation, and panic attacks.[61, 62]

XYLAZINE

Xylazine is another substance which is being found increasingly in the unregulated drug supply in the continental United States.[58] It is also known as Rompun, Anased, Sedazine, Chanazine, anestesia de caballo, or simply anestesia.[63, 64] It has been identified as an adulterant in Puerto Rico for about 15 years.[64, 65] Some people choose to use xylazine because it is said to lengthen and enhance the fentanyl high.[66]

Xylazine is a veterinary sedative, and is **not approved for human use**. It can be injected, snorted, or swallowed.[67] Its effects are reported to last about 4 hours, but could be up to 72 hours with extremely large doses.[63] It belongs to the class of alpha-adrenergic medications, which cause **sedation, low blood pressure, slowed heartbeat and breathing**.[67] Xylazine causes physical dependence and withdrawal independently from opioids.[67, 64] People in withdrawal from xylazine experience heightened anxiety and general discomfort. There is growing guidance from doctors on how to treat physical dependence and withdrawal caused by xylazine independently from opioids.[68]

There is no published evidence about pregnancy and xylazine, but other alpha-adrenergic medications such as clonidine are used with caution in pregnancy and lactation due to concerns about heart rate and blood pressure changes in the pregnant person, fetus, and breastfed infant.

While xylazine can cause overdose death by itself, it is usually found in combination with other drugs such as heroin, fentanyl, and cocaine.[63-65, 67] Since xylazine is not an opioid, when it is present in a multi-substance overdose, naloxone (Narcan) may not be enough to reverse the overdose, but should still be given to reverse the effects of any opioids. **Rescue breathing and supplemental oxygen are critical in responding to overdoses associated with xylazine.**[58]

If there are reports of xylazine in your area, try to use with other people and keep an eye on people who are nodding for longer than usual. If possible, put people in recovery position. If that's not possible, make sure to check their breathing regularly and move them every hour in order to prevent injury. **Remember to use naloxone in any presumed overdose to reverse possible opioid overdose effects.**

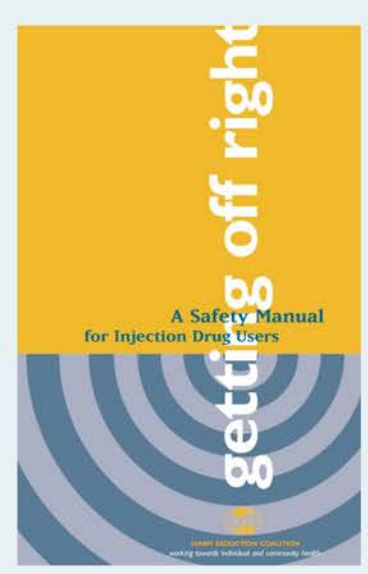
IF YOU SUSPECT AN OVERDOSE

- Give naloxone There might be opioids in what they took
- IMPORTANT Give rescue breaths or supplemental oxygen
- Put them in the recovery position, lying on their side

Xylazine is associated with increased risk of severe skin ulcers, which are large wounds that can resemble burns, often with areas of black necrotic (dead) tissue. An ulcer is not the same thing as an abscess, but it looks similar to most people. These ulcers are thought to be related to decreased blood flow to skin caused by xylazine. **They may appear at injection sites or elsewhere on the body**. Xylazine ulcers are far more severe than typical abscesses associated with injection drug use. There are reports of ulcers reaching the bone and causing bone thinning in healthy young people.[64, 65, 67, 69] **Good wound care (with the help of a nurse if possible) is essential for taking care of people with xylazine wounds**. These ulcers can take months or years to heal.

Many people who inject drugs can identify xylazine contamination by its appearance, smell, taste, and the way it makes users' body fluids smell. Some people report that it crystalizes after mixing and before injection.[64, 67] However, **when researchers test used syringes, they find xylazine in many of the syringes of people who don't think they're using it** and alternatively, they do not find it in all of the syringes of people who report that they are using it.[65]

TAKE STEPS TO PROTECT YOUR HEALTH



If you are continuing to use, and/or are injecting opioids or other substances (meth, cocaine, etc.), **please do not share your supplies**, **wash your hands with soap and water**, and **clean the site before every injection** with an alcohol pad.

Rates of skin and soft tissue infections, blood-borne bacteria - which can lead to infection of the heart valves (endocarditis)- are rising among people who inject drugs and sterile hygiene can prevent many of these infections.

See **Getting Off Right: A Safety Manual for Injection Drug Users**

STIMULANTS

STIMULANTS + PREGNANCY

Risks associated with stimulant use during pregnancy are not entirely clear. However, many of the reports during the so-called "crack baby epidemic" of the 1980s and 1990s were incorrect. These accounts were used to **disproportionately target black parents and families and resulted in the forced separation** of many families.[70]

The risks of using stimulants during pregnancy are now better understood.

Overdosing or overamping on amphetamines can stress the pregnant person's body. While it is rare, it is possible to die from methamphetamine or cocaine use because they can **stress the heart and circulatory system**.

The risks associated with stimulants are higher when they are used in combination with other substances. Polysubstance use - using more than one substance at a time - greatly increases the risk of overdosing.

Responding to Stimulant Overamping

Prescribed stimulants include methylphenidate (Ritalin® and Concerta®) and amphetamines (Adderall® and Dexedrine®). Caffeine, cocaine, amphetamines, and methampethamines are commonly used without a prescription.

Stimulants may cause decreased blood flow to the placenta. They can also **increase blood pressure** which increases the risk of preeclampsia, a dangerous condition in pregnancy which can cause seizures, heart attack, stroke and pulmonary edema (fluid in the lungs).[32, 71-77]

There is currently no direct link between stimulant use and placental insufficiency (lack of a good supply of nutrients and oxygen delivered to baby through the placenta).[32, 71-77]

Stimulants have not been linked to birth defects or placenta previa (when the placenta grows over the opening to the birth canal).[32, 71-73, 75-78,]

Stimulants may cause decreased birthweight, but the evidence is not clear, because other factors such as cigarette smoking and poor diet can also cause low birth weights.[32, 34, 71, 73, 74, 77, 79-82]

Placental abruption (the separation of the placenta from the uterine wall) has not been linked to caffeine or methamphetamine, but there is evidence linking it to cocaine. However, this evidence is of very poor quality and does not adequately control for confounding factors.[83-90]
Even with this link, the chance of this happening is low.

www.harmreduction.org

www.perinatalharmreduction.org

Stimulants can be linked premature rupture of membranes (PPROM). PPROM occurs when the sac that contains the amniotic fluid breaks before 37 weeks of pregnancy.[32, 34, 71-73, 76, 77, 79]

There is **no evidence of stimulant withdrawal** in infants with prenatal exposure.

Long-term outcomes are similar to other children in the same peer group. One study that followed meth exposure during pregnancy and outcomes in children 7.5 years later found there may be an increased risk of the child having behavior issues, however poverty and negative childhood experiences had significant effects as well.[91]

HIGH BLOOD PRESSURE

Hypertension during pregnancy is both common and dangerous. It affects up to 10% of pregnant people. Get your blood pressure checked regularly and watch for signs like:

- trouble breathing
- headaches
- swelling
- vision problems
- stomach pain, nausea, vomitting

STIMULANTS + LACTATION

Stimulants pass into human milk. So the safest choice is to not use them.

Cocaine or Amphetamine use can decrease the amount of milk you produce, and may cause the milk to dry up earlier.[92, 93, 94]

Up to 200 mg of caffeine per day is considered safe: [83, 94]

- 1 to 2 cups of regular coffee (8 oz)
- 5 cans of soda (12 oz)
- 2 cans of energy drink (250 mL)

It is recommended to discard milk for **24 hours after cocaine use**, and **48 hours after methamphetamine use**. During this time, continue to pump or express milk so that your supply does not decrease.[40, 92, 93]

Both cocaine and methamphetamine are excreted in the breastmilk.[92, 93] There have been reports of severe infant effects.[40]

In some states, new parents have been charged with or convicted of child endangerment and manslaughter because it was thought that their infant's death was related to breastfeeding/chestfeeding and stimulant use, although there is no definitive evidence to support these charges.

CAFFEINE PER SERVING

8 oz black tea
50-70 mg

8 oz coffee
100-200 mg

12 oz soda
40-100 mg

250 mL
energy drink
100+ mg

What treatment options are available for stimulant use disorder during pregnancy?

Currently, there are **no FDA-approved medications** for the treatment of stimulant use disorder.

However there are some "off label" uses of medications that may be helpful. **The off-label use of medications is common and is the norm for medication taken during pregnancy and lactation because few drugs are tested on pregnant and lactating people.** Off-label prescribing is when a physician gives you a drug that the U.S. Food and Drug Administration (FDA) has approved to treat a condition different than your condition or approved for your condition when someone is not pregnant or lactating.

Topiramate (Topamax®), modafinil (Provigil®), ondansetron (Zofran®), and prescription stimulants - amphetamine (Adderall® and Dexedrine®), dextroamphetamine and dexedrine (Dexedrine®, Spansule®, ProCentra®, and Zenzedi®), atomoxetine (Strattera®), methylphenidate (Ritalin® and Concerta®) - have been studied in non-pregnant people and have been helpful in some cases but not all.

Some people find that **group or individual therapy** is helpful - especially when done with those who understand substance use and substance use disorders. Others use **12 step or mutual support programs** such as Cocaine Anonymous (CA)
or Narcotics Anonymous (NA)
but these can sometimes be stigmatizing or shaming to pregnant people.

Contingency management (the use of variable rewards for having negative urine toxicology) has been shown as useful in the treatment of people with stimulant use and other substance disorders.[95]

UptoDate: Contingency management for substance use disorders

TOBACCO + NICOTINE

TOBACCO + NICOTINE + PREGNANCY

Tobacco is a leafy plant that contains large amounts of nicotine, a chemical that affects the brain.

Most of the health problems associated with tobacco products are thought to be the result of smoking, and not related to the nicotine. [96-98] That's why smokeless nicotine delivery systems like gum, patches, and e-cigarettes are considered to be less harmful.

E-cigarettes (vapes) have only been around for a few years, so we don't have very good information about their health effects, but the information we do have suggests that they are less harmful for you than smoking.

Every person is different, but in general, this is a list of tobacco and nicotine products, from most harmful to least harmful: [96-100]

- cigarettes
- cigars
- pipes
- hookah
- chewing tobacco
- snuff
- e-cigarettes and vaping *
- patches
- gum and lozenges

What you vape matters.

Some vape juices have very highly concentrated nicotine. Some have less - or none. Make sure to use juices that come from a reliable source to avoid dangerous contamination.

TOBACCO + NICOTINE + PREGNANCY

Most of the research regarding tobacco, nicotine and pregnancy is conducted with pregnant people who smoke cigarettes.

The effects of nicotine on pregnancy may be similar to the effects of other stimulants. Babies might experience nicotine withdrawal which might make them irritable and hard to console.[101, 102]

Next to getting good prenatal care, quitting smoking may be the single best thing you can do to have a healthy pregnancy. Ask for help.

Smoking cigarettes has been linked to **early birth**, **lower birth weight**, **placenta problems**, **birth defects, and breathing problems** for the child as they grow up. Smoking is also linked with Sudden Unexpected Infant Death Syndrome/Sudden Infant Death Syndrome (SUID/SIDS) or unexpected death under one year of age.[20, 103-105]

People who are able to reduce their smoking or quit during pregnancy decreased the risk of SUID by 12 to 21 percent, so it is recommended to smoke as few cigarettes as possible.[103]

Nicotine has been shown to affect the development of the baby's brain and may increase the risk of attention deficit disorders.[20, 103-105]

Smokefree: Pregnancy and Motherhood
www.women.smokefree.gov/pregnancy-motherhood

TOBACCO + NICOTINE + LACTATION

Smoking may **decrease milk production** and/or cause the milk to **dry up earlier**.[20, 106]

Nicotine and other harmful substances in cigarettes can pass to the baby from human milk.[21, 106]

Nicotine and other harmful substances are thought to pass to the baby from human milk after vaping.

It's important to remember that even though there are risks from smoking and breast/chestfeeding, it is still considered **better to breast/chestfeed and smoke than to formula feed and smoke.**[21, 106, 107]

CHILDREN + SMOKE EXPOSURE

Children that are exposed to second-hand or third-hand smoke (residue left on clothes or surfaces in the home) can have increased risk of ear infections, coughs cold, breathing problems (asthma, bronchitis and pneumonia), tooth decay and ongoing exposure to cancer-forming chemicals formed by cigarette smoke or vapes.

Children with this exposure could grow up to have increased risk of cataracts, heart and lung disease and asthma.

Source: American Academy of Pediatrics. *"How Parents can Prevent Exposure to Thirdhand Smoke."* 2017.

What treatment options are available for people who are pregnant?

There are many different options to help people reduce or quit smoking. You can get patches, gum, lozenges, or e-cigarettes without a prescription. Insurance may cover gum, patches, or lozenges with a prescription from a healthcare provider.

Healthcare providers can also prescribe **nicotine nasal sprays**, **inhalers**, or **medications** like buproprion (Wellbutrin®) or varenicline (Chantix® and Champix®) to help their patients reduce or quit smoking. These medications have not been approved for use during pregnancy, but they may be **safer than continuing to smoke** and **should be discussed with your doctor**.

SMOKING CESSATION: HELP QUITTING

"Quitting smoking is one of the best things you can do for a healthy pregnancy and a healthy baby. But that doesn't make quitting easy. Whether before, during, or after baby, we have the tools and support to help you quit and stay quit."

Smokefree Women

- Smokefree texting program
- Build Your Quit Plan
- Using Medications to Help You Quit
- Smokefree Apps

Smokefree: Pregnancy and Motherhood

- Quitting While Pregnant
- Smokefree Motherhood

Smokefree: This Free Life

1-800-QUIT-NOW
(1-800-784-8669)
1-877-44U-QUIT
(1-877-448-7848)

LIVE CHAT ON WEBSITE

HARM REDUCTION: VAPING + E-CIGARETTES

Cigarette smoking causes significant health problems for both people who are pregnant and those who are not. While using e-cigarettes is not as safe as quitting, **switching to exclusive vaping is a healthier choice than exclusive cigarette smoking**.[108]

Scientists still need to collect more information about e-cigarette use in pregnancy. **The nicotine in both cigarettes and e-cigarettes has the potential to cause harm to a fetus, however, e-cigarettes lack the harmful products related to combustion** that are present in standard cigarettes.

The evidence is clear that exclusively using e-cigarettes is safer than smoking cigarettes in pregnant people.[109-114] In the UK, the national health service encourages pregnant people who smoke to switch to e-cigarettes, even providing them with equipment and supplies! [115]

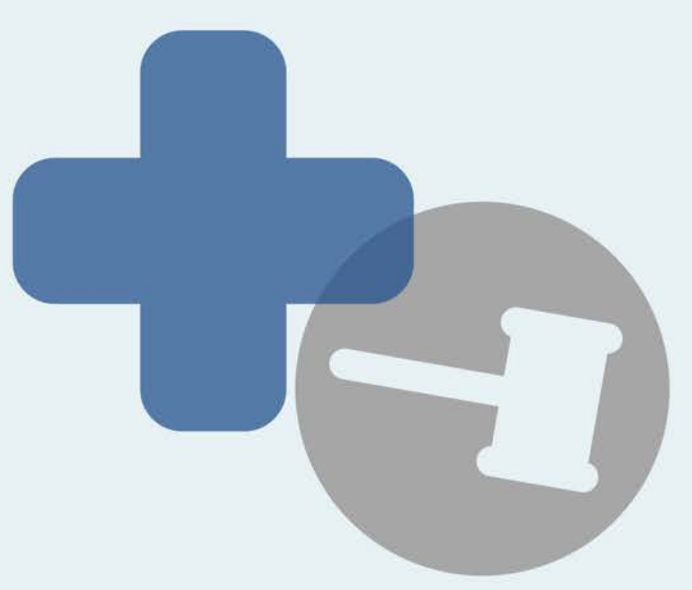
It is unclear whether smoking and vaping is healthier for pregnancy than just continuing to smoke without vaping, even if you use fewer cigarettes.[112]

Most people who quit smoking with e-cigarettes are not able to switch completely right away, and many experience a period of weeks, months, or even years of using both.[114, 116] Whether or not it is healthier for you probably depends on your patterns and amount of use, but scientists aren't sure yet.

When making the decision about whether to quit smoking with the help of a vape, it's important to consider what it would mean for you - not just during your pregnancy, but for the rest of your life. **Quitting smoking is one of the best things you can do for yourself, your pregnancy, and your future.** If you have tried quitting before, but other quit methods didn't work for you, vaping might help. The hierarchy of risk for quit methods is:

- **Safest**: Quitting nicotine and tobacco use altogether
- **Safer**: Quitting with therapies like gum, patches, or bupropion
- **Safer**: Quitting using an e-cigarette
- **Least safe**: Continuing to smoke

SECTION 3



NAVIGATING THE HEALTH CARE + LEGAL SYSTEMS

We believe seeking pregnancy care and treatment for substance use disorders should never be dangerous. But we know it can be.

Substance use during pregnancy is a complicated medical and legal situation to navigate.

You may be worried about **what could happen if you are open and honest with your providers about your substance use.**

You might be worried that if you don't disclose your use, someone may find out anyways.

And if you have a history of substance use, you know that providers' attitudes and biases can affect the sort of care you get. You may have experienced discrimination - or worse.

In this section, we talk about the federal laws around pregnancy, parenting, and substance use. We will also share some information about what might happen if you do or do not tell your provider about substance use.

Please note that statutes will **vary widely by state** and some providers and agencies might **interpret the law differently than it is written**. So please **consult with local agencies** that have expertise.

You can use this information to:

- understand the risks
- weigh the benefits
- make a plan

BUILDING A RELATIONSHIP

Ideally, healthcare decisions are made collaboratively between a patient and a medical provider/team.

A provider that is informed about all aspects of your health is better able to provide the care that is most appropriate and refer you to needed services.

Having a **provider you can trust** is the first step in creating a collaborative and effective relationship. **You can tell your provider that this is the type of care you want - and need**.

Getting prenatal care can improve birth outcomes like making sure the baby is full-term and a healthy size.

Substance use can cause health problems that may or may not be obvious. For pregnant people, there are some potential risks that a provider can help with if they are informed of the whole picture.

Starting treatment with **methadone** or **buprenorphine** can help **reduce many of the risks** of illicit opioid use while **improving both maternal and infant outcomes**.

DRUG TESTING + INFORMED CONSENT

Many providers test urine or other body fluids without asking or even informing clients. This is bad practice and is **not legal**.

You have a right to know what tests are being performed on you, why, and how the results will be used.

Ideally, they will give you a written document to sign before performing any tests (less ideal is verbal informed consent where you give permission during a conversation).

You have the right to decline any test or procedure. But if you decline a drug screen (test), some providers will assume it would be positive. This can lead to biased treatment.

Urine screen was discussed.

Patient gave informed consent.

TYPES OF DRUG TESTING (TOXICOLOGY)

There are many ways to test if somebody has used drugs including taking a verbal history or performing other tests (hair/blood/urine).

The most common is a **urine drug screen**. Most drug screens work by checking for the byproducts of drug metabolism. **These tests can sometimes be inaccurate** (false positives or false negatives, meaning the test might show a substance when none was actually taken or might not show a substance even if one was present).[1, 2, 3, 4, 5]

Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetricians and Gynecologists (ACOG), and other expert medical associations agree that **any positive screening result should be confirmed with a more accurate test** (for example, a urine test might require additional confirmatory urine and/or blood tests).[6, 7, 8, 9, 10]

Drug screens are not good evidence and should not be used as such in legal matters.[4, 9] Despite this, they are often held against people – whether or not confirmatory results have been completed. A confirmatory test takes longer, costs more, but is more accurate than a screening test.

- ACOG Committee Opinion: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist
- SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants

URINE DRUG TESTING

What the test detects:

- A urine drug screen doesn't detect psychoactive substances directly.
- It looks for their metabolites.
- False positive and negative results are common.
- If it is positive, confirmatory tests must be done.

DISCLOSURE

TALKING TO YOUR HEALTHCARE PROVIDERS ABOUT SUBSTANCE USE

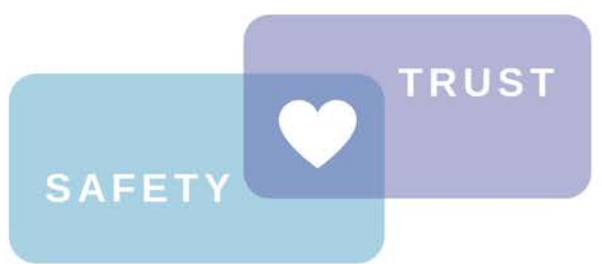
It is not mandatory for healthcare providers to test pregnant people for drugs. In most states, it is not mandatory to report pregnant or parenting clients' substance use to child welfare or law enforcement agencies.

However, **many healthcare providers are poorly informed about the laws** around mandatory reporting or they are following guidelines developed by their hospital which are not based on the law.

This means that if a pregnant client tells their provider they're using drugs, there's a chance this information will be shared with child protective services.

A report can be made by anyone, including a nurse, doctor, lactation consultant, friend, family member, or a neighbor.

In an ideal scenario, a report would lead to parents being provided with resources and support for parenting and health care.



In many cases however, the main result is **agency surveillance** (for example: unannounced home visits, speaking with friends and family) and **removal of the baby and any other children** from the parent's custody without much support.

People often choose not to disclose to their provider for these and other reasons. There is often fear and lack of information about what will happen to you if you access prenatal care while pregnant and using drugs (media stories, past experiences, and accounts from friends can lead to fear or mistrust of the healthcare system).

It can be difficult to decide when and if you want to tell a healthcare provider about your substance use.

If they don't know about it, they won't connect you with resources that may be helpful - and they may find out anyway. Because of this, it may be easier to tell them about your history of substance use up front.

Some providers say they are more likely to be helpful and understanding if they know the whole truth from the beginning.

MAKING A PLAN

You can make a plan with your support system before engaging in care and decide the pros and cons of sharing information about your substance use with your provider. This is a case-by-case decision that you can make based on how you think your provider will respond.

In situations like this, it is especially helpful to have a **friend, family member, or trusted advocate** with you to weigh these decisions. If they can be with you during your appointments and labor it may also help to **demonstrate that you have a strong support system.**

It is important to note though, that **your prenatal provider may not be the provider that is present during your labor**. Any member of the team could file a report, even if other providers on your team do not want a report filed.

If a report was made and it becomes an investigation, your **prenatal provider could be required to speak** about your discussions regarding your substance use and any safety plans you had shared with them.

Deciding whether to consent to a drug test is a very personal decision and there is no right or wrong answer.

AFTER YOUR BABY IS BORN

Once your baby is born, **if the providers suspect the baby might be substance exposed, they may legally test the baby without informing you**. If the baby tests positive for a substance, it could be used against you.

It is important to think about this decision before birthing in a hospital. **During labor it can be very difficult to have these conversations** with wellness providers, or to even remember that this may occur.

FREE DOWNLOAD

My Birth Plan

You can print this worksheet that we created or use it to start building your own unique plan

perinatalharmreduction.org/create-a-birth-plan

www.harmreduction.org

www.perinatalharmreduction.org

FEDERAL LEGISLATION THAT MAY AFFECT YOU:

CHILD ABUSE PREVENTION AND TREATMENT ACT

"The Child Abuse Prevention and Treatment Act (CAPTA) is the key Federal legislation addressing child abuse and neglect. CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects."

Many states' laws does not require drug testing of pregnant/postpartum people or newborns and **do not mandate reporting of positive drug tests or evidence of prenatal exposure** to criminalized substances, alcohol, or tobacco.

But some child welfare workers may open a case based on use of criminalized substances.

If you have already had **children in the system**, or if you were **involved in the system as a child**, it may be more likely that a case will be opened based on your substance use.

CAPTA is a federal law directed only to states - not to hospitals or individual healthcare providers.

There is no federal law requiring all pregnant people be tested for drugs.

CAPTA requires that states have a mechanism for notifying child protective services when babies are born with certain conditions if they want federal funds. Those conditions are:

- when Infants are born **"affected by substance abuse"** (a term not defined in the statute).
- when infants have **"withdrawal symptoms resulting from prenatal drug exposure."**
- when infants are diagnosed with **"a Fetal Alcohol Spectrum Disorder."**

See Plans of Safe Care for Infants and their Caregivers from the New York Office of Addiction Services and Supports.

A plan of safe care can be developed for all infants with these conditions. These plans must include the needs of the affected family and/or caregiver.

States can decide where reports are directed, as well as what entity is responsible for developing and monitoring the plan of safe care. States may establish a reporting pathway that **does not make families vulnerable to allegations of or investigations** for child abuse or neglect.

For more information about how CAPTA relates to you, please see the fact sheet from National Advocates for Pregnant Women: Understanding CAPTA and State Obligations.

"This fact sheet addresses common misconceptions about what states are required to do to comply with the federal Child Abuse Prevention and Treatment Act (CAPTA), with regard to newborn infants' prenatal drug exposure." - National Advocates for Pregnant Women

SELF-ADVOCACY

If you have used substances during your pregnancy, it is beneficial to build a **supportive network to help navigate these systems**. This can mean friends and family, social service providers who work with people who use drugs, as well as doulas.

Deciding to disclose your substance use to your provider is a personal decision. **Your healthcare provider may become aware of your substance use even if you don't share this information with them**, so it is can be helpful to prepare a Plan of Safe Care before delivery.

This plan outlines your **strengths as a parent** and your **plans for once your baby is born**.

Preparing this ahead of time can help to show your providers what a great parent you will be and can help to **provide evidence that they do not need to open a report**.

If you believe that a case will be opened, **reach out to a legal group in your area to get connected to a lawyer**. This is a resource that will vary by location.

IF THERE ARE PROBLEMS

If you get a result on a drug screen or any test that you disagree with, **you have the right to ask for a confirmatory test**.

If the results of the test are to be used in legal matters, such as criminal prosecution or child custody, **the test should be a forensic test**. A forensic test is more accurate and every step of the process is documented. This is the only kind of test which technically can be used as evidence, but unfortunately this is routinely disregarded.[8]

If you are concerned that you are being mistreated, it is important to keep records of your **appointment dates**, the **names of your providers**, and **what happened at each appointment**.

It can be helpful to have another person present with you throughout this process to help advocate.

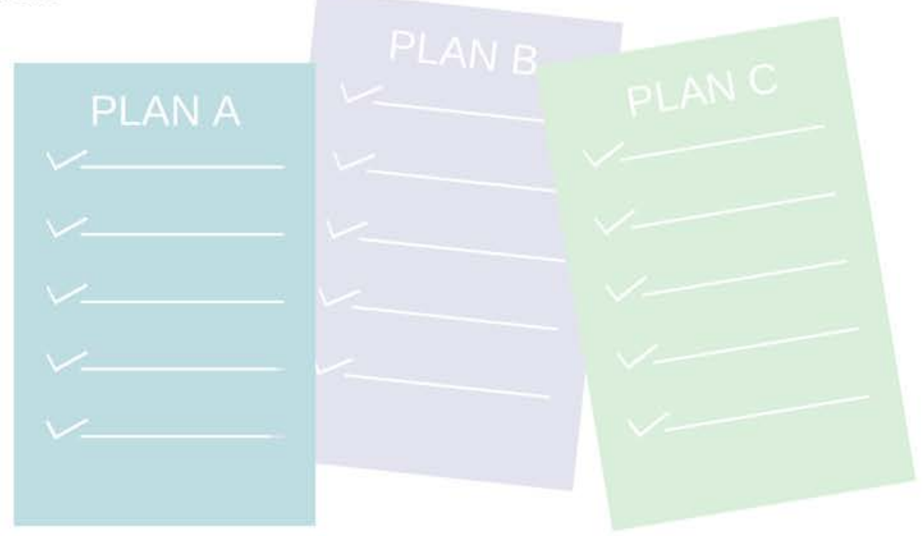
Having a **record of what happened** will help you advocate for yourself if your rights have been violated.

Contact the **patient advocate** associated with the facility, which is a person whose job is to assist patients when there is a dispute with the facility.

If your concern is not resolved, you can **file a grievance** with the government or the facility. Though many people find the patient advocates and the grievance process to be unsatisfying.

To file a grievance if you have Medicaid insurance, go to the website for the **Center for Medicare and Medicaid Services**:

www.cms.gov/Medicare/Appeals-and-grievances/MMCAG/Grievances.html



PATHWAYS FOR CHILD PROTECTIVE SERVICES INVOLVEMENT

FINDING OR SUSPICION

This may be among providers at the hospital. It is based on the initial findings. They may have this conversation *while* filing a CPS report.

DISCUSSION ABOUT YOUR USE

- self disclosure
- receiving treatment
- using medications
- getting opioid agonists treatment

- + urine screening
- + blood test
- "profiled"
- subjective
- subject to bias

This is the hospital's internal process for documentation.

REPORT

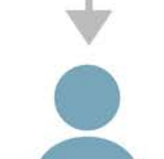
Child Protection Services is contacted.

DEVELOP PLAN OF SAFE CARE

Hospital staff may inform you of findings and the hospital providers' discussions.
May include:
Consent to supervision until the plan is completed.
Child Protection Services (CPS) is contacted.
Federal law requires states to make sure infants identified as being affected by substance use have a Plan of Safe Care (PSC). You are entitled to help create the plan and to see it.

WARNING: AT ANY TIME

The hospital may keep your baby or give them to a family member.



CASE WORKER ASSIGNED

DEEMED "UNSAFE"

This determination is made solely by the CPS case worker. It is up to their discretion - and subject to bias.

- *This is a time when racism can most influence what happens next.*

INVESTIGATION BEGINS

With your permission CPS will talk with family, friends, and providers about you and your parenting ability. There will be home visits. * Now is the time for your support system to advocate for you.

If your child is out of your custody for 15 out of 22 months, your parental rights may be terminated.
- ASFA
(Adoption and Safe Families Act)

A CASE IS OPENED

This is when court proceedings begin. You will need a lawyer. The court will appoint you one but they may not be an expert in this kind of advocacy. There may be an organization in your area who can provide you with free legal counsel.

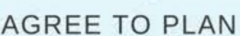
CONDITIONAL PLAN

May include:

- attending a treatment program
- going to parent-infant classes
- getting medical care
- consenting to unannounced "check-ins" and home visits

If you have previously had your parental rights terminated, CPS may remove this child or another child without completing the process again.

AGREE TO PLAN



Consent to supervision until the plan is completed.

ASFA = Adoption and Safe Families Act
CPS = Child Protective Services
PSC = Plan of Safe Care for infants and their caregivers

SECTION 4

PRENATAL CARE

Accessing prenatal care is the single most important thing you can do, not only for parental, fetal, and infant health, but also to prepare for any legal challenges that may occur.

If you are labeled by healthcare providers as **"late to care" (seeking care after 20 weeks of pregnancy)** you can face additional barriers when seeking quality health care and are more likely to be referred to child welfare.

Be prepared to advocate for yourself and your family. Keep records of phone calls, appointments, and any other information relating to your prenatal care.

The next page has a template you can print out to keep track of this information.

Be sure to start taking **prenatal vitamins** and get enrolled for prenatal care with your health insurance provider as soon as possible.

Get Health Insurance

Medicaid can help you get the care you need for you and your baby.
Complete pregnancy care and other health care services are available for people who are eligible for Medicaid. www.healthcare.gov/what-if-im-pregnant-or-plan-to-get-pregnant

If you don't qualify for Medicaid you can still get health coverage by visiting HealthCare.gov Health coverage if you're pregnant, plan to get pregnant, or recently gave birth healthcare.gov 1-800-318-2596

All Health Insurance Marketplace® and Medicaid plans cover pregnancy and childbirth. This is true even if your pregnancy begins before your coverage starts.

MY PREGNANCY

I FOUND OUT I WAS PREGNANT

DATE:

CONFIRMED:

- ☐ pregnancy test
- ☐ ultrasound

MY FIRST APPOINTMENT WAS

DATE:

PROVIDER:

MY EXPECTED DUE DATE:

I WANT TO GIVE BIRTH AT:

MY INSURANCE:

MY SUPPORT NETWORK:

IN AN EMERGENCY I WILL...

CALL:

GO TO:

DOWNLOAD this and other tools at www.perinatalharmreduction.org/make-a-plan

MY PRENATAL CARE

APPOINTMENTS

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

FOLLOW UP:

After this appointment I will...

REFERRALS:

I should make an appointment with...

NOTES:

DOWNLOAD this and other tools at www.perinatalharmreduction.org/make-a-plan

PRENATAL APPOINTMENTS

PROVIDER:
DATE:
☐ office visit ☐ call

PROVIDER:
DATE:
☐ office visit ☐ call

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DATE:
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REFERRALS:

MY POSTPARTUM CARE

6-WEEK APPOINTMENT

PROVIDER:
DATE:

If I have questions I can
CALL:

MY PLAN

My goal for another pregnancy is:

My choice for birth control is:

DOWNLOAD this and other tools at www.perinatalharmreduction.org/make-a-plan

CARE COORDINATION

Healthcare providers in the field of obstetrics and gynecology (OB/GYN) have not historically received much **training about substance use** and other **mental health issues**.

In addition, providers in the fields of substance use and mental health do not receive much training about pregnancy.

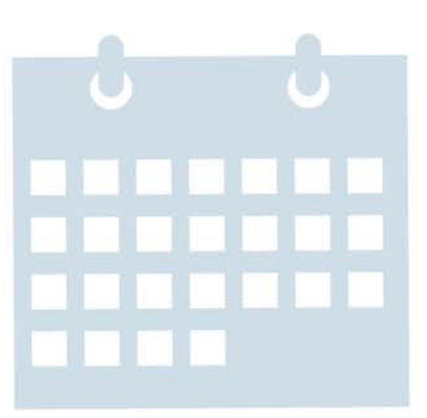
This lack of knowledge and experience can cause them to feel uncomfortable addressing or even acknowledging the impacts of health concerns outside of their area of expertise. For you, this can result in mixed messages or lack of accurate information.

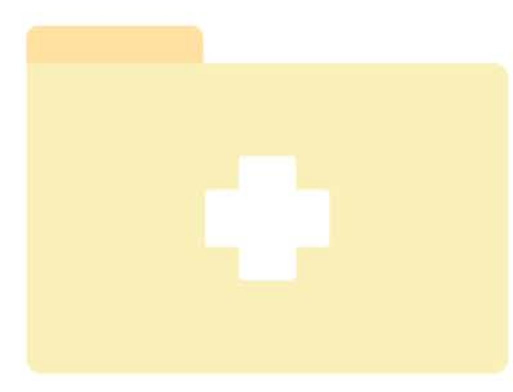
It can be frustrating to work with providers who are uninformed or who might seem uninterested.

If it seems that services provided to your family overlap with or contradict another part of your treatment plan, **ask for a care conference or for someone to be designated as your care coordinator**.

You - or anyone else you feel comfortable with knowing your healthcare information - can step into the role of **care coordinator**.

Keep in mind that **effective communication between providers can ease the workload on everyone** and avoid duplicate interventions or tests.





NUTRITION

During pregnancy, **good nutrition supports the healthy development of the fetus and increases the chances of delivering on time, without complications.** Good nutrition also protects your health during pregnancy and delivery, reducing the risk of nutritional deficits and serious complications like preeclampsia and excessive bleeding during delivery.

Eating a lot of **fruits, vegetables, whole grains, and lean protein** is the foundation of good nutrition for anyone, but especially when you are pregnant. Eat lots of foods that are high in nutrients needed in pregnancy like:

- leafy greens like kale and spinach
- carrots, beets, turnips
- brussels sprouts, cabbage
- broccoli, cauliflower
- sweet potato, yams, plantains
- pumpkin, squash
- tomatoes, cucumbers, eggplant
- avocados
- onions, garlic
- daikon, radish, parsnips
- cantaloupe, melon
- mango, papaya, passion fruit
- apricots, plums, peaches
- oranges, lemons, limes, grapefruit
- nuts, seeds, rice
- peas, beans, lentils, chickpeas
- soy, edamame, tofu
- eggs, chicken, turkey, duck
- beef, pork, goat, lamb
- fish, shellfish, shrimp (in moderation)

FOOD and NUTRTION PROGRAMS for PREGNANCY and BEYOND

WIC (Women, Infants, & Children) program provides nutritious food, education, referrals, and breastfeeding support for pregnant people and parents of young children. Visit www.wicstrong.com/about/eligibility
Use the pre-screening tool at wic.fns.usda.gov/wps/pages/preScreenTool.xhtml

You can also apply for **Supplemental Nutrition and Assistance Program (SNAP)**. Visit www.fns.usda.gov to find out what is available in Tennessee.

There are some foods you should avoid, due to the risk of infections or contamination. These foods include:

- **Unpasteurized** (raw) dairy products and juices
- **Raw sprouts** (like alfalfa, clover, radish, and mung bean sprouts)
- Certain **seafood that is high in mercury** (like shark, swordfish, king mackerel, tilefish, bigeye tuna, marlin, and orange roughy)

Although fish is very healthy, it's important to be careful about how much and which kinds of fish you eat during pregnancy because of the risk for mercury contamination. Mercury can cause irreversible fetal brain damage.

FOODBORNE ILLNESSES

BE FOOD SAFE.

Wash your hands, utensils, and surfaces you prepare food on.

Stop cross contamination. Store and prepare fruits + vegetables, meat, and eggs seperately.

Keep most foods chilled and refridgerated.

Cook meat and eggs all the way.

Avoid unpasteurized products.

FDA

PRENATAL VITAMINS

Even with a healthy, balanced diet, most pregnant people still need prenatal vitamins to get enough of the most important nutrients.

For example, without enough **vitamin B9** (**folic acid**), the baby's brain might not grow right. It is important that you have enough calcium during your pregnancy to make sure your bones stay healthy.

People usually have some nausea and even vomiting during pregnancy. For most people, it is in the morning, but it can happen at any time. If you experience "morning sickness," drink fluids and eat bland foods, including whatever sounds good and stays down.

Other strategies to minimize nausea are eating many small meals throughout the day and taking vitamin B6 supplements. There are also anti-nausea medications that are considered safe in pregnancy that can be prescribed by your doctor.

For most people, morning sickness is an unpleasant, but not dangerous experience, but for some it can become severe and even life threatening.

Hyperemesis gravidarum is nausea and vomiting so severe that you are unable to eat or drink anything, even water. It is very dangerous because it can cause severe dehydration and loss of nutrients and electrolytes. If you think you may be experiencing hyperemesis gravidarum, see a provider right away.

CANNABIS

Some people find that cannabis helps them with nausea during pregnancy[1, 2] but other people have experienced increased nausea with cannabis use in pregnancy.[3, 4]

The safety of cannabis use during pregnancy is not well understood, though studies are currently being done in states where cannabis is legalized, and it is safest not to use it if there is an alternative.

Talk to your provider about the safety of other nausea medications.

ROUTINE PRENATAL CARE

Routine prenatal care is the health care that every pregnant person should get during the normal course of their pregnancy. In other words, it is the standard for clients with no complications or known risk factors.

Prenatal care increases the chance of having a healthy pregnancy, delivery, and baby. In fact, accessing prenatal care is the single most important thing you can do to have a healthy pregnancy. In a study of pregnant people in Washington DC in 1996, 13% of pregnant people in the study were identified as people injecting drugs or with a history of injecting drugs which is associated with increased risks of prematurity, low birth weight and being small for gestational age. Going to more prenatal visits and going as early as possible in pregnancy decreased the risks of these outcomes happening.

If there are complications or your pregnancy is considered high-risk, routine prenatal care with additional interventions are recommended This usually involves **more frequent visits, and tests that are specific to your unique medical needs**.

Conditions that Make a Pregnancy High-Risk

- Multiple gestation (twins and multiples)
- Being a teenager or over the age of 35
- A history of pregnancy complications
- Chronic health conditions (e.g. hypertension, seizure disorders, diabetes, cerebral palsy, asthma, HIV)
- Using some medications (for example: lithium, chemotherapy agents)

The earlier prenatal care is initiated, the better.

Ideally, everyone should see a provider for **pre-pregnancy planning**, but most people schedule their first visit when they first suspect they're pregnant.

For most people, this is **around 8 weeks**, but if menstruation is not regular (as is not uncommon for people who use drugs) it may be later.

For **first-time, low-risk pregnancies** the usual prenatal care schedule is:

- **every 4 weeks** until 28 weeks of pregnancy
- **every 2 weeks** from 28-36 weeks
- then **every week** until the baby is born

Those who are high-risk should be seen more often.

Following this schedule, a person with a low-risk pregnancy who sees a provider for the **first visit at 6 weeks and the last visit at 40 weeks** will have **15 prenatal care visits**.

6 weeks	10 weeks	14 weeks	18 weeks	20 week ultrasound
24 weeks	28 weeks	30 weeks	32 weeks	34 weeks
36 weeks	37 weeks	38 weeks	39 weeks	40 weeks

"LATE TO CARE"

One of the risks pregnant people face is being labeled as **"late to care"** or having received **"inadequate care."** These patients are more likely to be drug tested and/or reported to child welfare agencies.

Prenatal care is considered to be late if **started after 20 weeks of pregnancy**. It is considered inadequate if clients **miss over 20% of appointments**.

If possible, **go early in pregnancy and go often**. This shows your providers that you care about the health of your pregnancy.

WARNING SIGNS

See your prenatal care provider

IMMEDIATELY

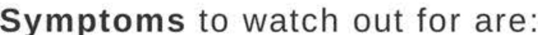
if you experience:

- visual disturbances
- severe abdominal pain
- shortness of breath
- vaginal bleeding
- leaking amniotic fluid (water breaking)
- preterm labor contractions
- severe, persistent headache
- the baby moves a lot less
- the baby stops moving
- severe nausea

WARNING SIGNS

PRETERM LABOR
PREMATURE RUPTURE OF MEMBRANES (PPROM)

This can occur any time during pregnancy and is dangerous if it happens before 37 weeks.



Symptoms to watch out for are:

- vaginal **bleeding**
- **leaking** of amniotic fluid (some people think they are wetting their pants)
- lower **back ache**
- feeling of pelvic **pressure**
- **contractions** (may feel like menstrual cramps or the urge to have a bowel movement)

IF YOU'RE HAVING ANY OF THESE SYMPTOMS OR IF SOMETHING "JUST DOESN'T FEEL RIGHT" YOU CAN:

CALL YOUR PROVIDER

- Tell them what you're feeling.
- Describe what you're seeing.

TELL SOMEONE ELSE WHAT'S HAPPENING

- Don't wait.
- Don't hesitate.
- It's ok to be worried.
- You are not alone.

GO TO THE EMERGENCY ROOM

- Tell them you are pregnant.
- Ask for help.

CALL 911

- Tell them you're pregnant and that you need help.
- Stay on the phone until help arrives.

EMERGENCY COMPLICATIONS

PRETERM LABOR

Premature/preterm labor can happen any time. Preterm labor can be dangerous for you or the baby. Signs of preterm labor are leaking of fluid from your uterus through your vagina, or contractions. It can be difficult to tell if preterm labor is really happening, so see a healthcare provider right away if you are not sure.

PLACENTA PREVIA

Placenta previa is when the placenta grows over the opening of the uterus. Usually if this happens, it moves out of the way as the pregnancy progresses and the uterus stretches. Your healthcare provider can see on the ultrasound if this is happening. If the placenta remains over the opening, it can cause bleeding when labor starts and prevent the baby from coming out through the vagina. Bleeding without pain is the most common sign of placenta previa.

PLACENTA ABRUPTION

Placenta abruption is when the placenta starts to detach from the uterus before the baby is born. This causes the blood vessels between the placenta and the uterus to bleed. Bleeding with pain is the most common sign of placenta abruption.

UTERINE RUPTURE

Uterine rupture is when the uterus tears. This can cause fluid to leak into the abdomen, endangering the pregnant person and the baby. The signs of uterine rupture may include chest or belly pain, bleeding, dizziness, difficulty breathing, or fainting.

ROUTINE TESTS

Learn more about routine tests...

- Prenatal care | Office on Women's Health (womenshealth.gov)
- What Is Prenatal Care? | Health Care During Pregnancy (plannedparenthood.org)

* You have the right to decline any test for yourself, but in most states, once the baby is born, providers do not need your consent to test the baby and they don't have to inform you of any infant testing. It is best practice for providers to work collaboratively with parents regarding any tests or interventions the infant receives.

PARENT-TO-CHILD DISEASE TRANSMISSION

Testing for HIV, Hepatitis B, and TORCH infections (Toxoplasmosis, Other, [syphilis, varicella, parovirus, etc], Rubella, Cytomegalovirus, and Herpes)

These infections pose serious risks to the fetus/newborn, so testing for them is important. These tests will be conducted on your first prenatal visit, and if any of them are positive, treatment or other steps can be taken to decrease or eliminate risks. There is a lot of information on these conditions accessible online from experts in these fields.

- Hepatitis B Foundation: Pregnancy and Hepatitis B (hepb.org)
- Hepatitis B and Hepatitis C in Pregnancy | ACOG
- HIV and Pregnancy | ACOG
- Pregnant People | HIV by Group | HIV | CDC
- Detailed STD Facts - STDs & Pregnancy (cdc.gov)
- Congenital Syphilis - STI Treatment Guidelines (cdc.gov)
- TORCH Infections: Syndrome, Causes, Risks & Treatment (clevelandclinic.org)

LABOR + CHILDBIRTH

One of the biggest concerns of any pregnant person is possible pain related to labor and birth.

There are many options you can discuss with your birth provider. **If you are aware of some of the options, you can make decisions that reflect your personal values and feel more confident and safe as labor approaches.**

You may also share this information with your provider who may not be familiar with the specific issues faced by people with substance use when choosing a pain control plan. .

See the sections on

- Care Coordination
- Trauma Informed Care

For people with a history of substance use, pain control can be more complicated.

We know that people who use drugs (opioids) might have higher tolerance and require higher doses of pain medication to feel pain relief.

In addition, many people who use substances have had **negative experiences with health care** during which they were disrespected, labeled as “drug-seeking” and **denied pain relief** based solely on their status as a person who uses substances.

These past traumas can lead to fear and anxiety as the due date approaches.

This section provides a brief overview of some of the more common pain control methods used for labor.

Use it to start a conversation about your care with your team.

EPIDURAL

The epidural is the most well-known form of labor pain control.

It is considered **regional anesthesia** because it makes a **large portion of the body numb**. Usually it is an **anesthetic combined with an opioid** administered through a **soft flexible tube** inserted between the layers of the **spinal cord** sheath in the lower back.

An epidural works by almost completely blocking nerve function below the level of the injection. **Patients will still feel pressure and stretching, but not pain**. It is effective within a 10-25 minutes, wears off mostly in a few hours, but continues to wear off for up to 24 hours after the tube is removed.

PROS

- excellent pain control
- long lasting
- pregnant person stays alert
- does not pass to baby

CONS

- cannot walk
- cannot pee
- potential for complications

SPINAL

Spinal anesthesia is usually used for C-Sections, unless an epidural is already in place. It is similar to an epidural, except that the medications are injected inside the spinal cord sheath, rather than between its layers. This results in faster pain control, within a few minutes.

The other difference is that the tube is not left in place, and the pain relief wears off in a few hours, depending on which medication was used. Spinal anesthesia can take up to 24 hours to wear off completely.

PROS

- excellent, fast pain control
- long lasting
- pregnant person stays alert
- does not pass to baby

CONS

- cannot walk
- cannot pee
- potential for complications

COMBINED EPIDURAL OR "WALKING EPIDURAL"

A combined spinal epidural (aka “Walking Epidural”) can be used to **decrease pain without interfering as much with movement**. Despite the name, most people will not be able to walk safely without assistance, but they will be able to move more than if they received a standard epidural.

Most patients report that pain is **not eliminated but is decreased to a tolerable level**. An epidural catheter is placed and much lower dose of medication than traditional epidural is injected. **Pain control is achieved within a few minutes**.

PROS

- excellent, fast pain control
- long lasting
- pregnant person stays alert
- does not pass to baby
- allows more movement

CONS

- cannot walk without assistance
- cannot pee
- potential for complications
- less complete pain control than traditional epidural

GENERAL ANESTHESIA

This is not typically used unless there is an emergency, because there are **increased risks for the pregnant person as well as the baby**. General anesthesia means that the patient will be **unconscious** and **feel nothing** during the birth.

These medications are usually given through an **intravenous tube (IV)** as well as **inhaled through a mask**. This type of anesthesia **requires a breathing tube** to be inserted into the lungs. Pain control is achieved immediately.

PROS

- patients experience no pain
- works immediately

CONS

- passes to baby
- sore throat from breathing tube
- more risk for complications
- unconscious during birth
- longer recovery

LOCAL

Local anesthesia means that just one part of the body is numb. This is achieved by injecting medicine into or near the desired area. This can be used during or immediately after labor to numb the vagina, vulva (vaginal opening), or perineum (the area including the vulva and anus).

PROS

- no opioid medication used
- works within minutes
- minimal risk of side effects

CONS

- does not numb uterine contractions

MEDICATION-INDUCED NAUSEA

Most people will not have side effects from anesthesia, but some may experience nausea and vomiting.

Higher doses, such as those used in general or spinal anesthesia for a C-section, may come with higher risk of post-operative nausea.

Vomiting after birth, especially a C-section, can be extremely painful and cause increased pain medication requirements.

There may not be a way to eliminate nausea, but the following interventions can help:

- aromatherapy with mint, lemon, or ginger
- cool wet cloth on face and neck
- mint or ginger tea

Check with provider to be sure consumption of clear liquids is allowed.

- mint chewing gum

Check with provider. Do not use until sedation is worn off to avoid choking.

- Avoid looking at things close to the face for prolonged periods of time. This can cause dizziness.
- When nursing or holding baby, be sure to look up for a few seconds every few minutes.
- Brace incision with a pillow and/or abdominal binder during vomiting to decrease pain.
- Rinse mouth or wipe with oral swabs after vomiting. Ask provider for oral swabs (aka toothettes) if available. Oral swabs can be purchased at drugstores.

PUDENDAL

This is a form of **local anesthesia**. It is accomplished by injecting medication into the vaginal wall. **It is useful right before birth**, if forceps or a vacuum extractor is used, or right **after birth** during stitching of a tear or episiotomy. It **numbs** the perineum between the vulva and anus. Pain relief is achieved within a few minutes and lasts about an hour.

PROS

- no opioid medication used
- works within minutes
- minimal risk of side effects

CONS

- does not numb uterine contractions
- sometimes it only works on one side

INTRAVENOUS (IV) INTRAMUSCULAR (IM) OPIOIDS

Injected opioids **do not have the same numbing effect** as the interventions listed above, but they can **take the edge off pain**, or at least make the patient **less anxious about the pain**.

Depending on the medication used, they kick in within a few minutes and last from about 30 minutes to 3 hours. **They should only be used early in labor because they pass to the baby and can cause sedation after birth.**

PROS

- works quickly
- has a calming effect

CONS

- causes sedation
- passes to baby
- may trigger substance use disorder
- does not fully block pain

NITROUS OXIDE (N_2O, laughing gas)

Nitrous oxide is **inhaled** through a **mask that the laboring person holds in their hand and only breathes from when needed**. Despite the name, it will not make patients laugh, but can make them feel a little silly for a few seconds. N2O just takes the edge off and does not block pain or cause sedation. It works within seconds and wears off within seconds.

PROS

- very short-acting
- does not cause sedation

CONS

- does not fully block pain

COMPLEMENTARY + ALTERNATIVE MEDICINE INTERVENTIONS

Complementary and Alternative Medicine Interventions (CAM) can be very helpful for patients who desire to use it - but is not likely to be sufficient for surgical or complicated birth.

If you plan to use only CAM for pain relief, it is important that you be flexible and acknowledge that the birthing process is unpredictable.

ACCUPRESSURE

Some people find relief if pressure is applied to certain pressure points. Common points for labor pain are the forehead between the eyes or the low back just above the pelvis.

ACCUPUNCTURE

Be sure to use a licensed professional if using acupuncture during labor and clear it with the birth provider in advance.
To learn more about acupressure or acupuncture visit aobta.org

REFLEXOLOGY

Reflexology is a technique of pressure applied with the provider's fingers to the patient's feet, hands, or face. To learn more about reflexology visit reflexology-usa.org

HYPNOSIS + MEDITATION

If hypnosis or meditation are part of your life, you may find it helpful and centering to use these techniques during labor.

PERINEAL MASSAGE

Perineal massage with water soluble lubricant during labor probably does not reduce the risk of tearing, but can feel good. Have someone with clean hands and short fingernails massage the lower part of the vaginal opening for a minute or two, then insert their index fingers about an inch into the vagina. Then they apply gentle pressure down and to the side in a U-shaped motion.

TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION)

This technique involves electrodes placed on the back connected to a machine that can be used to deliver small electrical pulses. If you plan to use this technique during labor, try it out beforehand and get trained on how to use it by a healthcare provider.

Do NOT use TENS:

- during water birth or in the shower
- if it is interfering with fetal monitoring or other equipment

LOW-TECH INTERVENTIONS

BREATHING

Breathing exercises have been practiced by laboring people for generations and can help with pain during labor while assuring that the laboring person and fetus get enough oxygen. For more information visit www.lamaze.org

POSITIONING

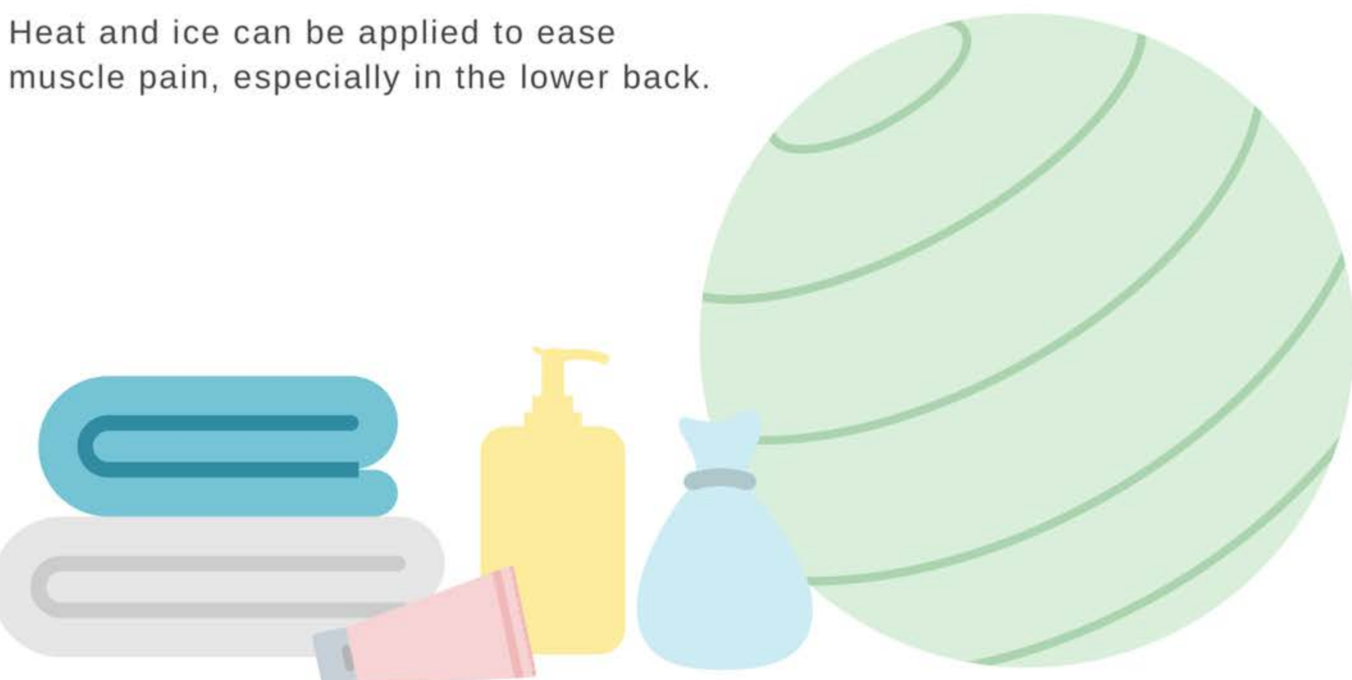
Position changes can be helpful for relieving pressure during early labor. It can be helpful to practice prior to labor onset. Clients may wish to use their partner or a birthing ball (large inflatable ball) for support and balance.

For positioning suggestions:

- www.thebump.com/a/birthing-positions
- www.babycenter.com/0_positions-for-labor-and-birth_10309507.bc

HEAT + ICE

Heat and ice can be applied to ease muscle pain, especially in the lower back.



POSTPARTUM PAIN MANAGEMENT

MEDICATIONS

Birth providers will not offer any medication that could be harmful to human milk or nursing babies, unless the benefit outweighs the risks. You should always consult your provider before taking any medication or herbal supplement. More information can be found at National Institutes of Health database on medications and human milk safety, LactMed

ACETAMINOPHEN (TYLENOL®)

This medication can be taken every 4-8 hours after birth, depending on dose and provider orders. It is administered intravenously (IV) or orally (pills). It is especially helpful when taken in combination with other medicines.

Know how much acetaminophen you're taking:

Acetaminophen is also in medications such as Norco®, Percocet®, and Vicodin®. Do not take additional acetaminophen while taking these medications.

IBUPROFEN (MOTRIN®, ADVIL®) AND KETOROLAC (TORADOL®)

These medications can be taken every 6-8 hours after birth, depending on dose and provider orders. Ketorolac is usually given intravenously (IV), and ibuprofen is given orally (pills). These medications help reduce or prevent swelling and inflammation as well as pain.

HYDROCODONE (NORCO®, VICODIN®) AND **OXYCODONE** (PERCOCET®, PERCODAN®, ROXICODONE®)

These are the most common opioid medications offered to postpartum patients. They can be taken on a schedule or only as needed, depending on dose and provider orders. Often, they will be offered as combined pills with acetaminophen (see box above). They can cause constipation, drowsiness, and pass into human milk, so doses should be as minimal as possible.

NALBUPHINE (NUBAIN®)

This medication is given intravenously (IV). It is a partial opioid agonist/antagonist. It can be useful for reducing pain, and reducing opioid-induced itching and/or nausea. Nalbuphine should **NEVER** be used for someone who is physiologically dependent on opioids, because it can cause immediate withdrawal.

MORPHINE, **HYDROMORPHONE** (DILAUDID®), **MEPERIDINE** (DEMEROL®)

These opioid medications may be used intravenously (IV) or as pills if other medications are not sufficient. They are stronger than hydrocodone and oxycodone and cause more severe side effects. Their use should be limited if possible.

PROMETHAZINE (PHENERGAN®) AND **HYDROXYZINE** (VISTARIL®)

These medications may be given with opioids in order to reduce the required dose.

SIMETHICONE (MYLICON®, GAS-X®)

For many C-section patients, pressure from abdominal gas buildup after delivery can be more painful than surgery itself. See the passing gas section below for more tips.

STOOL SOFTENERS AND LAXATIVES (DOCUSATE, SENNA, COLACE®, SENOKOT®)

For people who deliver vaginally, having a bowel movement after birth can be scary and painful. These medications work either by softening the stool, or stimulating the bowel to push out the stool.

BENZOCAINE SPRAY (DERMOPLAST®)

This medication may be offered as needed. It is an aerosol spray that numbs an area for about 15 minutes. Some people find it helpful for vaginal pain or hemorrhoids after delivery, or before having a bowel movement.

WITCH HAZEL PADS (TUCKS®)

Witch hazel is an herb which is thought to help with pain and itching. These pads can be placed on top of ice packs for vulva application, between the buttocks for hemorrhoid application, or both. They are available at drugstores.

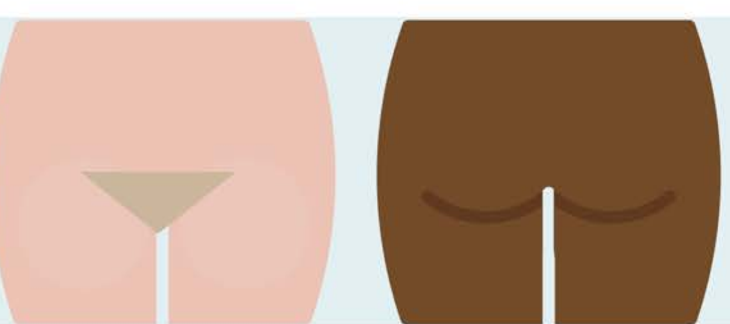
HYDROCORTISONE CREAM

This medication can be used to reduce pain and/or shrink hemorrhoids. Extra strength is available only by prescription, but 1% hydrocortisone is available in drugstores.

NONPHARMACOLOGICAL PAIN MANAGEMENT

There are many actions or products that can help with postpartum pain for folks for whom opioids are not a good option, due to tolerance or provider reluctance to prescribe adequate doses. The following interventions will be arranged by the pain source.

VAGINA
VULVA
PERINEUM
ANUS (HEMORRHOIDS)



ICE OR COLD PACKS

Ice is one of the most effective methods to ease this kind of pain. Crushed ice can be put inside of a disposable baby diaper or a non-latex glove wrapped in soft disposable dry wipes and placed in the underwear. Chemical cold packs attached to absorbent pads are also available. Partners and support people can ask staff to show them how to make ice packs so that they are more readily available. Ice should be used for about 20 minutes at a time with breaks in between applications. Ice not only reduces pain, but also swelling and inflammation.

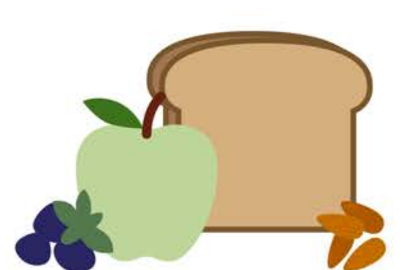
CHANGING POSITION

Sitting for prolonged periods of time can put pressure on the perineum. Changing position and frequent walking helps decrease this pressure. After delivery, it is safe to sleep in any comfortable position.

HIGH FIBER DIET

To help decrease hemorrhoid pain with bowel movements, eat foods that soften stools:

- whole grains
- nuts
- beans
- peas
- berries
- apples
- dried fruit
- popcorn



SITZ BATH OR PERINEAL CARE BOTTLE ("PERI" BOTTLE)

These items are available at drugstores or from some hospitals. They are used to run warm water or prescribed medications over the vulva.

This is a more comfortable method of cleansing than wiping with toilet paper. The same effects can be accomplished with a removable shower head and a shower chair.

C-SECTION INCISION PAIN

ABDOMINAL BINDER

Abdominal binders should be worn snugly and to comfort. They do not help with losing weight or shrinking the stomach after birth. It is possible that they protect the incision, but their main purpose is to decrease pain

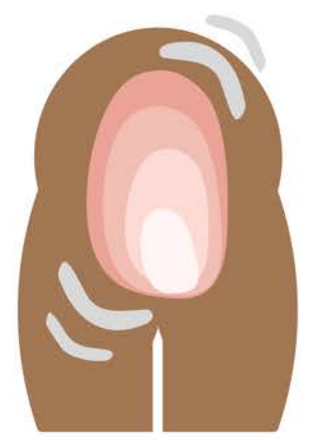
ICE

Ice or chemical cold packs can be applied to the incision for about 20 minutes at a time with breaks between applications.

BRACING WITH PILLOW

Anytime someone laughs, vomits, sneezes, or coughs, it can cause incision pain. It can help to brace the incision with a pillow before any of these actions.

ABDOMINAL PRESSURE AND UTERINE CRAMPS



Uterine cramping continues for several days to weeks after birth as the uterus shrinks back down to its usual size. They are usually only bothersome for a few days, and then barely noticeable. These cramps increase in intensity with each birth, so the cramps following the fifth birth will be more intense than those following the first. Cramps are more intense during activities that release natural oxytocin, such as breast- and chestfeeding, cuddling baby, or hearing her cry. It helps to anticipate these times and use measures to decrease this pain before it starts.

FREQUENT PASSING GAS

Most of the methods of labor and birth pain control cause a decrease in passing gas. This gas can build up and cause intense pain. Some people feel gas pain in the ribs or shoulders. To avoid gas build-up:

- walk frequently
- decide not to be embarrassed about passing gas
- ask for privacy or pass gas in a warm/hot shower
- minimize opioid pain medications
- avoid foods that cause gas, like fried things, beans, dairy, etc.

HEAT

Heat can relax muscles and ease cramping pain. Ask for a warm blanket or heating pad to place on the abdomen. This can be used simultaneously with incision ice if necessary. Remove the heating pad when nursing or holding baby, to avoid overheating.

POSTPARTUM CARE

The first year after having a baby can be difficult, physically and emotionally. Your body is still re-adjusting and there can be a lot of stress in your life. Some people who stop using drugs during pregnancy start again after birth, and some find themselves using more chaotically after having a baby while dealing with these changes.

OVERDOSE

Many people taper off medications they used during pregnancy such as methadone or buprenorphine because they or their doctors think they are able to do without the medication. However, this is often dangerous and increases risks of relapse, overdose and death.

In one study in Massachusetts, **overdose rates were highest among people 7-12 months after delivery of a baby.** [1]

It can be hard to talk with loved ones about your substance use, and sometimes you might feel like you're letting people down if you start using after taking a break.

Try to find someone you can trust, a family member or friend, a counselor or provider, and discuss a plan for how you can cope with triggers and stay safe if you use.

We like this Safety Planning Resource from NYSDH.

In addition, after you deliver your baby, some of the support you relied on may change. Sometimes providers who supported you getting on buprenorphine or methadone (OAT) while you were pregnant may be less concerned about continuing treatment.

Just like being pregnant, **having a baby can change your tolerance.**

Remaining on OAT after your delivery can help keep you safer as your tolerance changes and as you are coping with changes in your life.

It is recommended by many experts to stay on OAT as long as you need to stay healthy and able to parent; some people stay on it for life.

MEDICAL RACISM

It is important to understand that the origins of gynecology and obstetrics are tied to racism and the abuse of Black and Brown birthing people.

As the field of medicine became established - and birth became more medicalized - racism shaped institutions and became embedded in medical education. The licensing and certification process that have been put in place have further reinforced White Supremacy and taken choices away from pregnant and birthing people - making the choice to have a baby more dangerous.

Many Black and Latinx people experienced reproductive coercion and violence, and the movement around contraceptive services has often been exploited by those with xenophobic and racist ideologies.

One example of this is the human trials of the oral contraceptive pill conducted in Puerto Rico on poor women of color in 1956. These trials did not have informed consent and the researchers were later denounced for colonialism, racism and unethical research practices. In another case, 148 people incarcerated in California Women's prisons were sterilized without their consent between 2006-2010.

BREAST/CHEST-FEEDING AND HUMAN MILK

ALCOHOL

Alcohol passes into human milk and is absorbed by babies.[2, 3]

If you have plans that may include alcohol consumption, **pump and store enough milk** beforehand to feed the baby, or plan to use formula.

While drinking/intoxicated, if your breasts become painful or engorged, pump or hand express enough milk to relieve the pressure. Then discard it. You do not need to fully empty, because the body continually filters alcohol out of milk, just like it does with blood, so when you sober up, the milk does too.

Recommendations for the time it takes for your milk to be safe for the baby range from **2-4 hours per drink**.[2, 3] If you are only going to have one standard drink, it is ok to feed the baby, have a drink, wait a few hours, and feed baby again without doing anything special.

If you still feel drunk or hungover, even if the recommended time has passed, **wait until you feel better before providing milk to the baby**. If you want to be 100% sure, alcohol test strips for breast milk are available in drugstores.

BENZODIAZEPINES

It is important to take as low a dose of benzodiazepines as possible if breast/chestfeeding. Not all benzodiazepines are the same in regard to safety and breast/chestfeeding (lorazepam is safer than diazepam, for example). Talk to your doctor about which medication you take and at what dose.[4]

In small studies, some babies have low muscle tone, sedation and/or difficulties breathing at delivery and also at breast/chestfeeding.[5] One problem with many of these studies is that because they have a small number of participants, their findings can be difficult to generalize.

CANNABIS

Roughly 1% of the cannabis consumed passes into your milk.[6, 7] Infant absorbtion is poor, so infants only absorb about 1% of that, making the absorbed dose roughly one thousand times less than the parents's dose.[7, 8] This can still be enough to cause a positive result on a urine drug screen. Experts agree that the safest choice is to stop recreational use completely while lactating.[3, 9-12] If you continue using while breast or chestfeeding, use harm reduction methods like pumping before using or pumping and dumping right after using.[12 13]

OPIOIDS

It is safe to breastfeed on prescribed opioids, including opioid use disorder treatment medications such as methadone and buprenorphine. In fact, it can actually make baby's withdrawal less severe. We are not sure whether this is related to the opioids passed into human milk, or the fact that baby feels better and closer to you while breastfeeding, or both![13, 14] With heroin, it is best not to breastfeed, since we can't know the exact dose and there may be other substances cut into street drugs that are not safe.

STIMULANTS

Stimulants pass into human milk, and can decrease the amount of milk produced, and/or cause the milk to dry up earlier.[15-17] Up to 200mg of caffeine per day is considered safe. [13, 17, 18] After illicit stimulant use, it is recommended to discard milk for 24 hours for cocaine, and 48 hours for methamphetamine use.[13, 15] During this time, continue to pump or express milk so that your supply does not decrease.

TOBACCO + NICOTINE

Smoking may decrease the amount of milk produced, and/or cause the milk to dry up earlier. Nicotine and other harmful substances in cigarettes can pass to the baby from human milk.[11, 19]

It's important to remember that even though there are risks from smoking and breastfeeding, it is still much better to breastfeed and smoke than to formula feed and smoke![11, 20, 21]

Drug Use and Human Milk: Legal and Child Welfare Considerations

"We believe that breast/chest feeding families who use substances are best served by evidence-based, harm reduction practices provided through the healthcare system, not the legal or child welfare system."

NOTES:

CONTRACEPTION OPTIONS

Many people may not realize it is possible to become pregnant in the year after having a baby. Some people may want to avoid this because they do not want to have another baby right now, while others may be excited at the prospect of having a large family with children close in age.

There are many options to consider around when and what kind of contraception to use if you do not want to have another pregnancy within the next year. You can **ask a medical provider** before leaving the hospital or in a doctor's visit after.

There are many kinds - such as the IUD, oral contraception pills, patches, rings, or injections - and **they all have their own benefits**.

Some you may take daily, such as the pill. Others can last for months or years, like injections, IUDs, and implants.

You can ask your medical provider for one of these forms of birth control before leaving the hospital, or get it at a doctor's visit later.

You should discuss with your doctor if you have any concerns such as heavy period, cramping, weight issues, or mood issues.

Your provider should never try and influence your decision or push you towards a method that you are not interested in.

You can read about the types of contraception available at PlannedParenthood.org and Bedsider.org.

PSYCHOSOCIAL SUPPORT AND PERINATAL MOOD AND ANXIETY DISORDERS (PMADS)

Perinatal Mood and Anxiety Disorders are common and treatable.

By some estimates, 1-2 out of every 10 pregnant people and their partners will have some kind of mood disorder during, right after pregnancy, or during the first year postpartm. Self-harm, overdose, and suicide are common causes of maternal death in the United States.

Rates may be higher for people who use drugs because they are more likely to have history of mental or mood disorders - and to be caught in punitive legal or family surveillance systems.

If you or your partner are having thoughts about hurting yourself or someone else, you can call 911 or see a healthcare provider right away.

The National Suicide Prevention Lifeline is now the 988 Suicide and Crisis Lifeline.

In an EMERGENCY call: 988

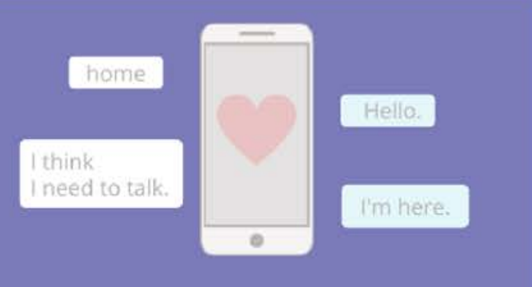
or 1-800-273-8255 (TALK)

988lifeline.org

In an EMERGENCY text "Home" to

741741 to reach a Crisis Counselor

www.crisistextline.org/text-us



NEW National Maternal Mental Health Hotline

24/7 Free Confidential Hotline for
Pregnant and New Moms
in English and Spanish

Call or text 1-833-9-HELP4MOMS

TTY users can use a preferred relay service
or dial 711 and then 1-833-943-5746.

Counselors also have access to interpreter services who can support 60 other languages 1-833-9-HELP4MOMS

- Arabic
- Creole
- French
- German
- Italian
- Hebrew
- Hmong
- Mandarin
- Polish
- Portuguese
- Tagalog
- Vietnamese

TTY users can use a preferred relay service or dial 711 and then 1-833-943-5746.

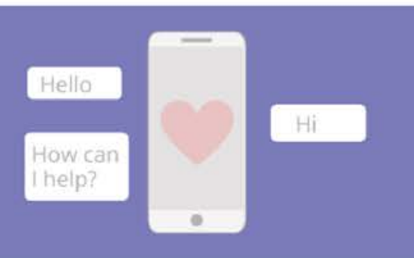
HELP from POSTPARTUM SUPPORT INTERNATIONAL

PSI Helpline:

1-800-944-4773

PRESS
1 English
2 Spanish

Text PSI:
503-894-9453
Text en Español: 971-203-7773



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SECTION 5: LABOR + CHILDBIRTH

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- Never disregard professional medical advice or delay in seeking it because of something you have read in this toolkit.

NATIONAL HARM REDUCTION COALITION

Harm Reduction Coalition is a national advocacy and capacity-building organization that works to promote the health and dignity of individuals and communities who are impacted by drug use - including pregnant and parenting people.

www.harmreduction.org

The Academy of Perinatal Harm Reduction provides evidence-based, inclusive, affirming education for parents and providers. Our work is informed by lived experience and is focused of the intersection of substance use and reproductive health.

www.perinatalharmreduction.org