

PREGNANCY AND SUBSTANCE USE:

A HARM REDUCTION TOOLKIT

NATIONAL
HARM REDUCTION
COALITION



IN COLLABORATION WITH
Academy of Perinatal
Harm Reduction



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HOW TO USE
MATERIALS

QUALITY PERINATAL
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HARM REDUCTION

- ALCOHOL
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- CANNABIS
- OPIOIDS
- STIMULANTS
- TOBACCO + NICOTINE

NAVIGATING THE HEALTH
CARE + LEGAL SYSTEMS

PRENATAL CARE

LABOR + CHILDBIRTH

POSTPARTUM

CITATIONS

- All content found in this toolkit, including: text, images, and other formats were created for informational purposes only.
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- Always seek the advice of your physician or other qualified health provider or legal counsel with any questions you may have regarding a medical condition or legal situation.
- Never disregard professional medical advice or delay in seeking it because of something you have read in this toolkit.

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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 on the intersection of substance use and reproductive health.

NATIONAL
HARM REDUCTION
COALITION

www.harmreduction.org

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.

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 well-being of pregnant people who use substances and their families.

For many people, upon finding out they are pregnant, they may wonder about reducing or stopping their use. It is important to know that there are many steps that can be taken, related to substance use or not, to have a healthy pregnancy.

Pregnant people and their families can use this information to understand their rights, access services, and find high-quality, evidence-based care. This toolkit was developed in New York State, so some of the resources linked are specific to New York State.



HARM
REDUCTION
SAVES
LIVES



support
don't punish

These materials can be shared with family members and service providers in order to **start important conversations about your plans, hopes, goals, and dreams**. You can download the entire toolkit, or make your own by downloading sections individually.

This work is **written, edited, and informed by people who have lived experience** of substance use and pregnancy. **In this toolkit we use the term "pregnant people" not "pregnant women" in order to be inclusive of people of all genders who have the capacity to become pregnant.**

We know that you are the experts. We would love to hear from you. Can this toolkit be improved? Do you want to be involved in future work?

Please contact us at:
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SECTION 1

QUALITY PERINATAL CARE IS YOUR RIGHT

Pregnant and parenting people who use substances are one of the most stigmatized and demonized subsets of the population.

Experience with bias, judgment, and scrutiny - especially from healthcare workers, loved ones, family, and friends - **can isolate people and make it harder to seek 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, or their pregnancy. **That's why having even one nonjudgmental and trustworthy person to support them can make all the difference in the world.**



You deserve to have providers and support people who affirm you and your gender identity. People of all genders can become pregnant and have healthy birth outcomes.

Check out these resources for you and your providers on fertility, pregnancy, and postpartum support for trans and non-binary folks:

[Birth for Everybody](#) 

[UCSF Transgender Care](#) 

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

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 people make choices **based on their unique needs, experiences, and circumstances**. It acknowledges that everyone is different; what is right for one person may not be right for another.

When people are trusted to make their own decisions and are treated with dignity and respect, they are more likely to be honest. People will know that they will be able to get the support they need, regardless of the choices they have made.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is **a tool that can help you navigate tough conversations**. Providers can take classes in this technique in order to have better conversations about behavior change. With a little practice, this is a technique that can be easily used by anyone.

When providers use MI techniques **they should ask questions and listen to the answers**. Instead of giving directions or making accusations, they focus on **identifying your goals and listening with compassion**.

MI recognizes that **it takes time to build trust** and that you might wait to talk to them about the details of your substance use.

TRY
THIS

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

RESPECTFUL (PERSON-FIRST) LANGUAGE

Many of the words used to describe drugs and people who use them are stigmatizing. It is everyone's responsibility to try to **avoid judgmental language**. Using “person-first” language demonstrates that you value the person, and are not defining them by their drug use.

When talking about your own substance use, you can choose the language that feels right to you. But you **should never use stigmatizing terms when you talk about others** because these words shape our beliefs. Words can signal whether or not you value and respect people who use drugs and the people who care for them.

Adjusting to “**person-first**” language can be awkward at first, but it is worth it because it helps us **better serve and support** people who are often subjected to shaming and stigmatizing language.

BEST PRACTICES TO AVOID USING STIGMATIZING LANGUAGE

Don't Use	Do Use	Why
<p><i>"addict"</i> <i>"abuser"</i> <i>"junkie"</i></p>	<p><i>"person who uses heroin"</i> <i>"person with cocaine use disorder"</i></p>	<p><i>Using "person-first" language demonstrates that you value the person, and are not defining them by their drug use.</i></p>
<p><i>"got clean"</i></p>	<p><i>"not currently using drugs"</i></p>	<p><i>"Clean," implies that when someone is using they are "dirty."</i></p>
<p><i>"addicted newborn"</i> <i>"born addicted"</i> <i>"crack baby"</i></p>	<p><i>"neonatal opioid withdrawal syndrome (NOWS)"</i> <i>"neonatal abstinence syndrome (NAS)"</i> <i>"baby with prenatal cocaine exposure"</i></p>	<p><i>Infants are not addicted; they have prenatal substance exposure and/or physiological dependence.</i></p>
<p><i>"medication assisted therapy (MAT)"</i></p>	<p><i>"medication for opioid use disorder (MOUD)"</i> <i>"medication for alcohol use disorder"</i></p>	<p><i>These categories are value-neutral and precise. When discussing a specific medication, refer to it by both its generic and brand names.</i></p>

STIGMA

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** someone using the word “*junkie*”
- **institutional stigma** firing people based on a positive drug screen
- **stigma through association** when pharmacists or medical providers say, “*That’s not the population I want in my office*”
- **internalized 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 personal character flaw, stigma against people who use drugs is still **socially acceptable and commonplace.**

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

Internalized stigma is when people believe the negative messages from the outside world. Internalized stigma means that sometimes you might feel ashamed of yourself based on your substance use.

When people who use drugs accept and internalize this stigma, it can lead to anxiety, isolation, and loss of self-love.^{3, 4} If someone is told enough times that they are worthless, it can influence how they make decisions about their health and safety. **Because of this, people may accept injustice because they believe they deserve to suffer.**

When people can’t tell anyone what they use, when they use, and where they use, they are **more likely to use alone**, increasing their risk of overdose.

[BeSafe App](#) 

[Never Use Alone](#) 

(800)484-3731 

STOP the
STIGMA



www.harmreduction.org

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Stigma is amplified if a person who uses drugs becomes pregnant.^{1,2} They may become isolated even from people who knew about and accepted their substance use before pregnancy.

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 problem areas, but how to **imagine and plan for a happy future**.

Talk with them about accessing healthcare and what your hopes and concerns are. Talk with them about medications for opioid use disorder as well as **whether you envision having a family now or in the future**.

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

Ask your care providers to become familiar with "trauma-informed care."

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



TRAUMA-INFORMED CARE

CONSIDER BRINGING THIS TOOLKIT TO YOUR PROVIDER

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

- Understand that **it is not necessary for someone to disclose the specifics of their trauma** in order to receive trauma-informed care.
- Display positive and welcoming signage and **set a friendly tone** when people access services, with an integrated and consistent response from all team members, from front desk staff to direct care workers.
- Establish a comforting and welcoming **physical environment**.
- Use **strength-based, person-first language**.
- **Recognize behaviors** that providers interpret as being difficult (such as being rude, asking too many questions, or expressing frustration) as attempts to deal with negative past experiences or current stressors.
- Recognize that **some people will need more support and different types of support** than others.
- If you are a service provider, evaluate yourself and **recognize what you bring to the interaction** - your own story, family experiences, race, religion, beliefs about substance use and pregnancy, and triggers.
- **Learn how to effectively engage in therapeutic conversations** with people, including opening conversations, de-escalating when people are getting upset, helping clients in constructively interacting with healthcare 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	<ul style="list-style-type: none"> • Support clients to access organizations that can address immediate practical needs such as safe housing, food, clothing, medical concerns, leaving violent relationships, and 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 birth	<ul style="list-style-type: none"> • Consider the impact of sexual abuse and trauma on childbirth. Clients can also experience traumatic childbirth if they feel disrespected or shamed during this time.⁸ Black, Indigenous, and other people of color experience higher rates of disrespect and mistreatment in birth.⁹ • Support immediate attachment between parent and baby.¹⁰ People with histories of substance use, mental health issues, trauma and violence may have a more difficult time bonding.
Postpartum: after birth, in the hospital	<ul style="list-style-type: none"> • Keep families together as much as possible during hospital stay, including combined parent-baby care/rooming-in models, promoting early frequent skin-to-skin for bonding and other parent-baby neuropsychological benefits.^{11, 12} • Consider the relationship between trauma and breast/chestfeeding (some people refer to mammary tissue as their chest rather than their breast). The physical contact of breast/chestfeeding can be uncomfortable for some trauma survivors and trans people. There are a number of strategies to address this issue.¹³
Postpartum: in the community, through the first year after delivery	<ul style="list-style-type: none"> • Include a focus on parent-child relationships in all interventions. Clients with a history of abuse or trauma have a higher likelihood of not bonding well. However, they are able to increase attachment over time.¹ • Assess for postpartum depression and other mood disorders. Women and childbearing people with a history of trauma are more likely to develop postpartum depression.¹¹⁻¹⁴

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, and for some people it can be difficult. People can have a wide variety of emotions when they find out that they are pregnant, but **know that being on medication for opioid use disorder, or using drugs, should not be a reason you decide to have an abortion.** Though we don't often talk about it, miscarriage and pregnancy loss are common experiences. 10-20% of all pregnancies end in miscarriage, so it is important that pregnancy loss should not be blamed on substance use.¹⁵

For many, the realization that they're pregnant can be surprising and overwhelming. 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 also free resources to help you talk through this decision non-judgmentally, such as [All Options](#). [\(888\) 493-0092](tel:(888)493-0092) 📞

Your healthcare providers should never pressure you to continue or end a pregnancy.

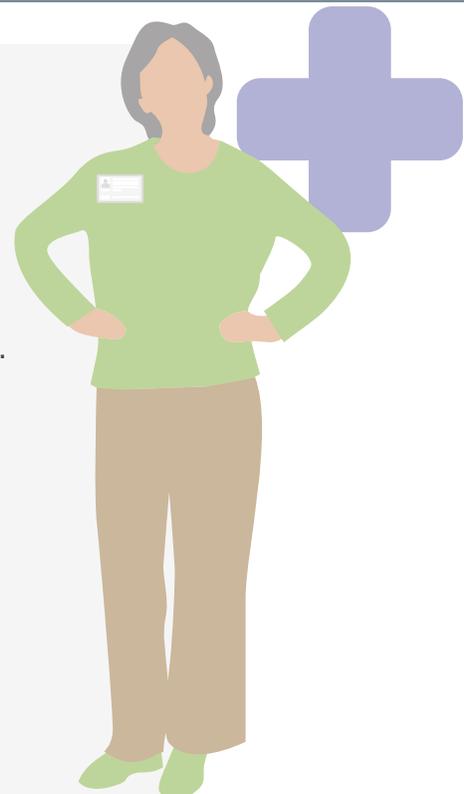
CONTINUING A PREGNANCY

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

- Identify your support system.
- Find a prenatal care provider (see page 14).
For more information, see Section 4: Prenatal Care

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.

For more information, see Section 2: Harm Reduction



ENDING A PREGNANCY

If you decide to have an abortion you should contact a healthcare provider that you trust. **There are also online resources for locating abortion providers in your area.** If you cannot afford an abortion or travel to a clinic, most clinics have connections to organizations that can help cover these costs. For more information on resources in your area see the [National Network of Abortion Funds](#) 

Of course, because both drug use and abortion are stigmatized, providers may mistreat you or refuse to care for you. **Remember that you deserve to be treated with dignity and respect.**

MEDICATION ABORTION

A medication abortion happens when you take medications that prevent a pregnancy from growing and cause your uterus to empty. This induces a process similar to a miscarriage.

Some clinics will prescribe you these medications and permit you to take them at home. Other clinics may have you take the first medication in the clinic and the second can be taken at home.

Ibuprofen is recommended for pain control, and is generally safe to take with other substances or medications you may take.

[Plan C:](#) 

[A Safe Abortion with Pills](#)

[Abortion Pill from Planned Parenthood](#) 



PROCEDURAL ABORTION

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

This procedure must be done in a clinic or hospital.

There are many options for pain control including **local anesthesia** (numbing the area with lidocaine), **minimal/moderate sedation** (usually an opioid and benzodiazepine administered by IV) and **deep sedation** (IV medications which put you to sleep).

[In-Clinic Abortion from Planned Parenthood](#) 



PAIN MANAGEMENT DURING ABORTIONS

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

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, feel free to 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.

RELIABLE PROVIDERS:

[Abortion Care Network](#) 

[National Abortion Federation](#) 

MORE ABORTION INFO:

[Reproductive Health Access Project](#) 

NEW YORK STATE:

[New York Abortion Access Fund](#) 

[Family Planning Benefit Program](#) 

[Abortion Care Policies in New York](#) 



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.
- **Obstetrician/Gynecologists (OB/GYNs)** provide comprehensive reproductive health care, whether someone is pregnant or not.
- **Maternal-Fetal 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 and pregnancy health care.
- **Midwives** provide sexual and reproductive health care. Midwives generally care for healthy, 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 and **Certified Professional Midwives (CPMs)** are licensed in 36 states. 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.

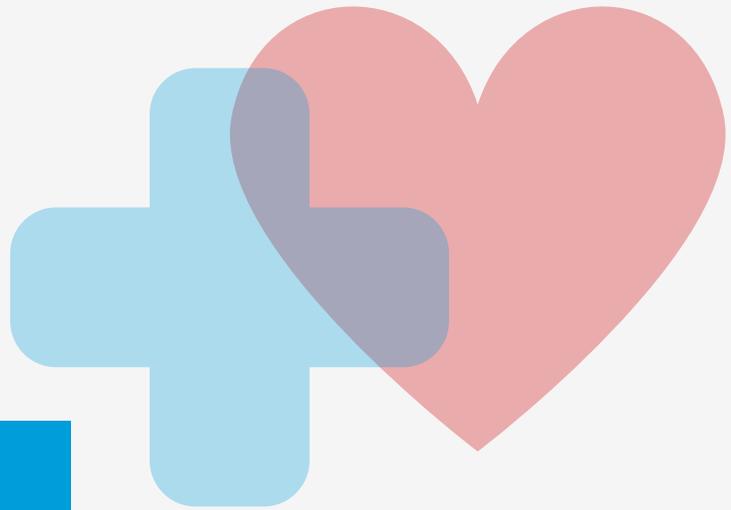
THE ROLE OF DOULAS

A doula is a support person who can be with you during pregnancy, birth, termination, 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. [New York State Doula Pilot Program - Medicaid](#) 

Doulas will typically meet with you once or twice during your pregnancy to develop a relationship with you and your support people. **During pregnancy, a doula can help you learn about your options and help you make plans** for child birth and early parenting. **During labor and birth, it is their job to care for you and advocate for you** in a non-judgmental, non-medical way, 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 people who use drugs**. If you have relationships with trusted social service providers, community health care workers, case managers, or substance use treatment providers you may ask them to help you find an experienced doula. www.perinatalharmreduction.org

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.

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 lapses 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.

Much of the research that has been conducted on pregnant people who use drugs cannot definitively state if one behavior or drug causes a bad outcome. In many cases, studies about pregnancy and substance use cannot control for other variables (such as poverty, racism, other substance use, trauma, and poor nutrition) that might lead to negative outcomes.



This information will be organized by substance. Each substance will list the most severe possible harms first, which can be rare, and then more common ones. Stopping alcohol or benzodiazepine use abruptly without the assistance of a medical professional can be dangerous. Be sure to speak with a provider if you're considering this action. Another potential danger is that street-based drug markets are unregulated. Products are mixed with fillers and other drugs, so you may not be consuming what you think you are.

TIPS FOR A HEALTHY PREGNANCY

- TAKE YOUR VITAMINS

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.

- SUPPORT YOUR BODY

Focus on staying hydrated, getting enough sleep, and eating well to help you have a healthy pregnancy.



GENERAL HARM REDUCTION STRATEGIES

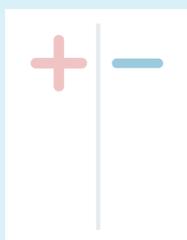
Keep track of how much you use. This may reduce your use, even if that was not your original goal.



Set limits on when and where you use, like waiting until after 5:00 to drink.



Make a list of the pros and cons of stopping and continuing to use.



Attend support groups like Moderation Management, SMART Recovery, Narcotics Anonymous, or Alcoholics Anonymous.



Avoid using opioids, benzos, alcohol, or other depressants (downers) when you are alone, if possible.



Set personal limits of how often and how much you use. For example, you won't use more than 2 bags of heroin every 8 hours.



Avoid driving or making important decisions when using drugs.



Make a parenting plan. Before any substance use - including alcohol use - arrange for childcare if necessary.



Take good care of your body in general, like eating healthy and getting enough sleep, exercise, and water.



Switch to a safer method.

See [Getting Off Right Safety Manual](#). 



ALCOHOL



ALCOHOL + PREGNANCY

Many people try to cut down or stop drinking alcohol during pregnancy. Stopping alcohol abruptly (going “cold turkey”) can be dangerous and can cause seizures, and in rare cases, even death. If you are trying to decrease your alcohol consumption, discuss this with a provider, especially if you have had seizures before.

Drinking alcohol while pregnant increases the chance of miscarriage or stillbirth.¹ Drinking alcohol while pregnant can also cause birth defects, called Fetal Alcohol Spectrum Disorder (FASD). FASD can include organ defects, limitations in thinking, reasoning and learning as well as physical effects such as abnormal facial features, low birth weight, and smaller head size.^{1,2}

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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 outcome studies of children with alcohol exposure suggest that binge drinking or severe alcohol use disorder could be associated with an increase in the child’s behavior problems or difficulty thinking (cognition) especially for children born with FASD. Studies of low to moderate alcohol consumption have not found a universally negative impact.^{3,4}

www.harmreduction.org

ALCOHOL + LACTATION

Alcohol passes into human milk and is absorbed by babies if they drink the milk. ^{4,5}**If you have plans that may include alcohol consumption, pump and store enough milk before drinking alcohol. If unable to do this, use formula.** While intoxicated, if your breasts/chest become painful, 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 okay to feed the baby, have a drink, wait a few hours, and feed the 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 there is no alcohol present in the milk, **alcohol test strips** for human milk 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:

- medications to treat alcohol use disorder
- group therapy and individual counseling
- attending 12 Step meetings such as [Alcoholics Anonymous \(AA\)](#) or other free community meetings like [Moderation Management](#), [SMART Recovery](#), or [Harm Reduction for Alcohol \(HAMS\)](#).

Sometimes, 12 Step groups can be unwelcoming and shaming towards pregnant people or people using medication for opioid use disorder, so it's important to find a group or a method that is supportive of your needs.

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 some of them are likely to be much **safer than continuing to drink**. Acamprosate is likely safe, as is naltrexone (though not recommended for opioid use disorder in pregnancy at this time), while disulfiram is not recommended. **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** such as seizures.

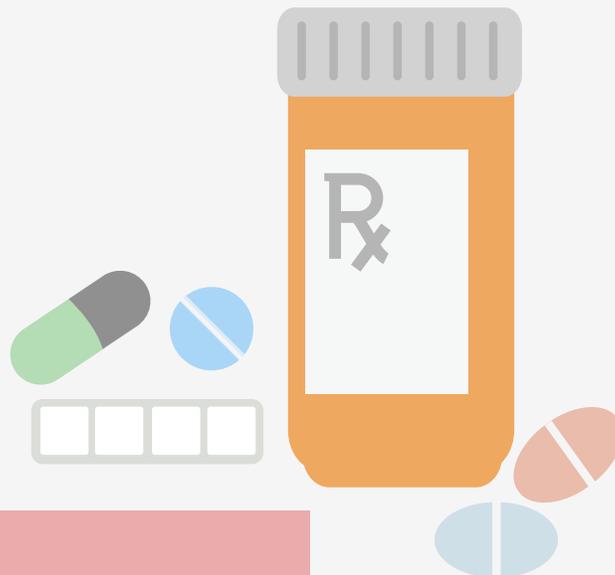
If you are **alcohol-dependent** and are trying to decrease your alcohol consumption, don't quit "cold turkey."
Work with a medical provider, especially if you have had seizures before.

In rare cases, **alcohol detox can lead to death**.
Ask for help.

www.perinatalharmreduction.org



www.harmreduction.org



BENZODIAZEPINES

BENZODIAZEPINES + PREGNANCY

Benzodiazepines are a class of medications prescribed for sleep, anxiety, and seizures. Some common ones are: lorazepam (Ativan®), diazepam (Valium®), alprazolam (Xanax®), clonazepam (Klonopin®), and chlordiazepoxide (Librium®). Benzodiazepines work in a similar way to alcohol in the brain on the same brain receptor.

If you take benzodiazepines regularly it can cause tolerance, dependence, and, if you cut down or stop your use abruptly, withdrawal symptoms. Similar to alcohol, detox or cutting back on benzodiazepines could be very harmful, as some people experience withdrawal seizures that could be deadly. It is important to talk to a provider if you want to cut back or stop benzodiazepines during pregnancy.

Benzodiazepine use might slightly increase the risk of having a baby with cleft lip or palate, but there is no link to other birth defects. Some studies found an increased risk of lower birth weight and other studies did not.⁶⁻⁸

Possible lower birth weights among people who take these medications could be related to sleep issues, and not the medications, because many people take benzodiazepines for sleep problems.⁹

Newborns exposed during pregnancy can show withdrawal symptoms after they are born; benzodiazepine use could worsen withdrawal from other substances.

BENZODIAZEPINES + LACTATION

If you are breast/chestfeeding it is important to take **as low a dose of benzodiazepines as possible** while still getting the benefits you need. Talk to your provider about the dose that is right for you.

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

See [LactMed](#). 

In small studies, **some breast/chestfed babies had low muscle tone, sedation, or difficulties breathing and feeding that resolved.**¹¹ 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 for 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 such as seizures. It's important to **decrease the dose gradually (taper off) with the help of a healthcare provider rather than stop abruptly.**¹²



CANNABIS

CANNABIS + PREGNANCY

Cannabis is a plant that can be smoked, vaped, eaten, applied topically on the skin, or ingested in other forms such as tinctures.

In some states medical cannabis is used to relieve symptoms related to glaucoma, cancer, HIV/AIDS, post-traumatic stress disorder, chronic pain and anxiety, and many other conditions. Some of the other names for cannabis are marijuana, weed, herb, mota, and hash. Some other forms are wax, dabs, oils, tinctures, and shatter.

Much of the information about effects of exposure on the fetus is conflicting and unclear, even to medical professionals. Unfortunately the

literature is inconsistent in their findings.^{13, 14} **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, or feeding problems.¹⁵ 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 tobacco and using nicotine.¹⁶

New research alert: Torres et al. (2020) 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.¹⁰

CANNABIS + LACTATION

A 2018 study of eight parents in Colorado who were exclusively breast/chestfeeding and smoking cannabis showed that cannabis does enter the milk supply, estimating it to be at 2.5% of what the parent had smoked; dosage peaked at 1 hour after smoking and decreased by 4 hours after consumption.¹⁹

Formal guidelines recommend that the safest choice is to stop recreational use completely while lactating.^{5, 15, 17, 18}



If you continue using while breast/chestfeeding, consider using harm reduction methods like pumping before using or pumping and dumping right after using. 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.^{19, 89}

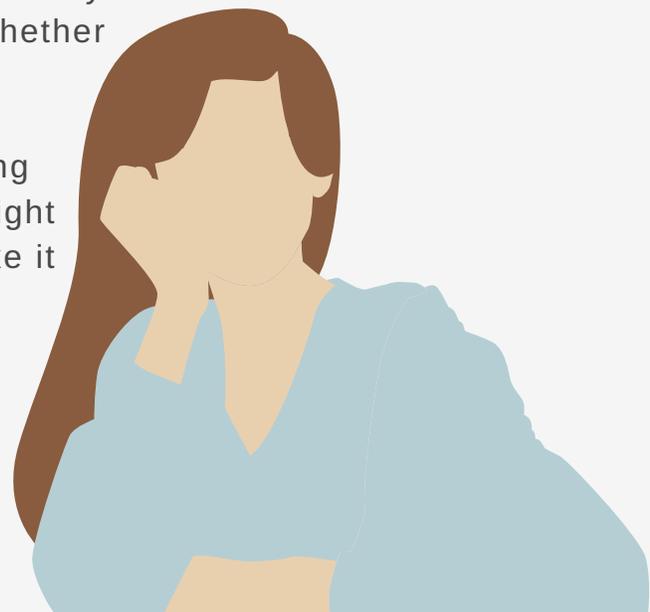
What treatment options are available for cannabis use disorder?

There is no FDA-approved medication specifically for cannabis use disorders or dependence.

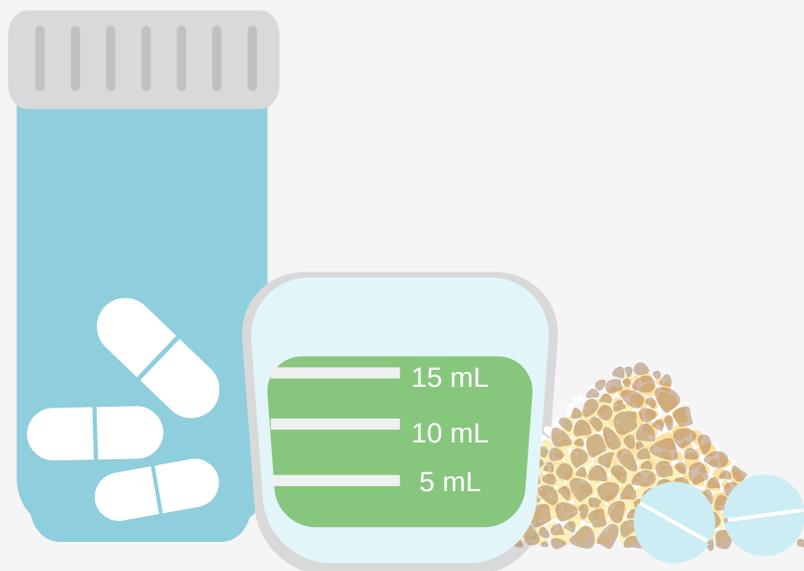
If you are using cannabis to medicate for pain, anxiety or nausea, discuss with your healthcare provider whether there is a **safer treatment method**.

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

It is not recommended to detox (or undergo medically supervised withdrawal) during pregnancy because the chances of returning to opioid use are much higher (up to 59 to 90%).²¹

The risk of overdosing is much higher after detoxing because of loss of tolerance. You can talk to your provider about medications

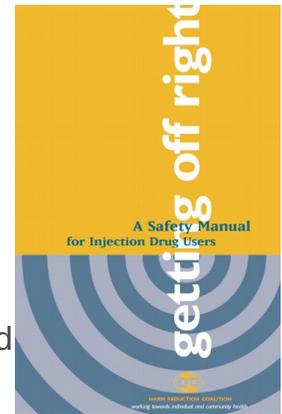
such as methadone or buprenorphine, which are the safest medications to use for opioid use disorder (OUD) in pregnancy.

Untreated opioid use disorder has associations with increased pregnancy risks such as placental abruption, preterm labor, fetal death or overdose in the parent resulting in possible death.²² Some studies find normal birth weights, and some find weights in the lower end of normal.²²⁻³⁶

Long-term outcomes are similar to other children in the same peer group if there were no birth complications.²²⁻³⁶ Opioid use (including heroin) in pregnancy is not associated with birth defects.²²⁻³⁶

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](#) 

NEONATAL ABSTINENCE SYNDROME (NAS)

For the fetus, the risks of using opioids during pregnancy are largely related to the baby experiencing neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal (NOW), which are easily treatable. NAS has many signs and symptoms that can be assessed in the hospital (many hospitals use a scoring system). 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, and diarrhea.³⁶

This can occur within 24 hours to five days after birth and is related to physiological withdrawal from any opioid (heroin, fentanyl or treatments like buprenorphine and methadone). **It is treatable with skin-to-skin contact, keeping the parent in the same hospital room as the infant, breast/chestfeeding, or also with medications such as methadone, morphine, buprenorphine or other agents as needed.**

OPIOIDS + LACTATION

It is safe to breast/chestfeed while taking medications for opioid use disorder such as methadone and buprenorphine, regardless of the dose of medication that you take.

Consult the [LactMed database](#) to learn more about the evidence on use of the medications while lactating:

- [methadone](#) 
- [buprenorphine](#) 
- [naloxone](#) 



In fact, **breast/chestfeeding can make the baby's withdrawal symptoms less severe**. Studies suggest this is because skin-to-skin contact and attachment formation help the baby feel better while breast/chestfeeding.^{30, 32}

When other opioids like methadone were studied, it was found that **only about 2% of the total dose made it into human milk**.³⁷ For buprenorphine, there are negligible amounts of buprenorphine/norbuprenorphine in human milk and infants absorb even less of this because of the way buprenorphine is broken down and metabolized (not absorbed well in the stomach).^{38, 39}

With heroin and other unregulated opioids, it is best not to breast/chestfeed, since you can't know the exact dose and it may be cut with other unknown substances and contaminants that aren't safe for the baby.

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 (Subutex®), or a buprenorphine-naloxone (Suboxone®) combination medication is safe for pregnancy and lactation and is the best treatment for pregnant people.²³

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.**

Opioid Use Disorder and Pregnancy Fact Sheets from SAMHSA



[Substance Abuse and Mental Health Administration](#)

During pregnancy, the body goes through changes that can make drugs and medications work differently. This means drugs may feel more or less strong than they used to. For example, **many people need to adjust their methadone or buprenorphine dose 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, 40-46}

There is not enough evidence to know if naltrexone (Revia®, Vivitrol®) is safe to use during pregnancy, so it is not recommended (unless it is the only thing that is working for you). An expert panel convened on this issue “did not agree on whether women [people] on naltrexone should continue to use it during pregnancy. Women **[People] stable on naltrexone can be offered treatment with buprenorphine or methadone** to prevent return to substance use if they choose to discontinue naltrexone injections. However, this transition must be carefully managed...”⁴⁷

In New York State according to the law, you have priority access to treatment if you are pregnant. This means that you are able to skip any waitlists for treatment.



[Medication-assisted Treatment](#) from the New York Office of Addiction Services and Supports

DETOX

MEDICALLY-SUPERVISED WITHDRAWAL



Medications for Opioid Use Disorder (MOUD), such as methadone and buprenorphine, should be offered as a first-line treatment for opioid use disorder.

You might 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.³⁵ Instead, the concern is that **many people relapse and have a decreased tolerance**, which could be dangerous to the parent, fetus or newborn due to risk of overdose/death.²¹

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

Detoxing and stopping MOUD, even for a short time, can lower your tolerance and make it easier to overdose on even a small amount of opioids.^{30, 35, 48} If you want to detox or decrease your dose of medication, make sure you have a careful discussion of the risks and benefits with a provider you trust. **However if you must detox, it can be safe for you and your fetus if appropriately and compassionately done.** Do not attempt detoxification at home or alone.

FIND A PROVIDER

SET YOUR GOALS TOGETHER

MAKE A PLAN TO SAFELY REACH YOUR GOALS

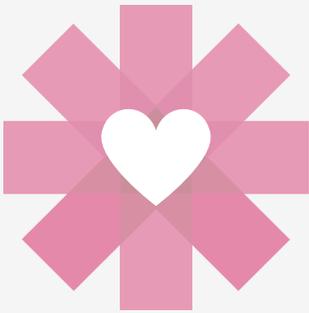


OPIOID OVERDOSE + PREGNANCY

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.

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 on opioids will not hurt them; it just won't work.



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

Get naloxone (Narcan®) training:

- [New York State's Opioid Overdose Prevention Program Directories](#) 
- [NASEN Syringe Exchange Program Map](#) 

Get naloxone (Narcan®):

- [Find a Pharmacy near you!](#) 
- [Naloxone Co-payment Assistance Program \(N-CAP\)](#) 

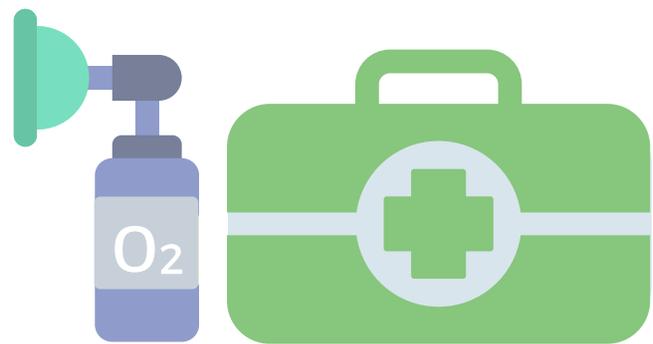


OPIOID OVERDOSE + PREGNANCY (CONTINUED)

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

However, **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.
- Many states have **Good Samaritan Laws** which may protect you from being arrested when calling for help. Look into the policies in your state.



[New York State's 911 Good Samaritan Law Protects YOU.](#) 

OPIOID OVERDOSE + PREGNANCY

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

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



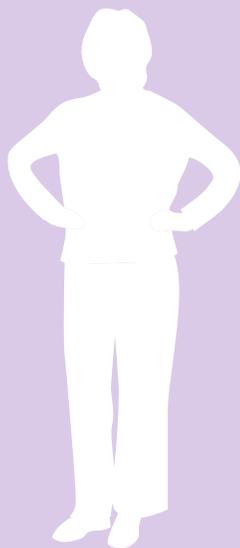
If you think they have injured their back or neck, don't move them.

Call
911

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



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



Many states have **Good Samaritan Laws** which may protect you from being arrested when calling for help.



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

STIMULANTS



STIMULANTS + PREGNANCY

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

The risks of stimulant use during pregnancy are not entirely clear, however many of the reported risks during the so-called “crack baby epidemic” of the 1980s and 1990s were incorrect. These accounts were used to punish Black parents and families and resulted in the forced separation of many families. ⁴⁹

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

Overdosing or overamping on amphetamines can stress the pregnant person’s body; **it is rare but still possible to overdose and die from methamphetamine or cocaine use as these can stress the heart and circulatory system** (often these substances are used along with many other substances, so it may be the combination that is fatal).

[Stimulant Overamping Basics](#) 

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).^{25, 50-56}

There is currently no direct link between stimulant use and placental insufficiency (lack of a good supply of nutrients and oxygen delivered to fetus through the placenta).^{25, 50-56}

Stimulants have not been linked to birth defects or placenta previa (when the placenta grows over the opening to the birth canal).^{25, 50-56}

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.^{24, 25, 50, 52, 53, 56-60}

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. Even with this link, the chance of this happening is low.^{31, 61-63, 65, 88}

Stimulants can be linked to preterm premature rupture of membranes (PPROM). PPROM occurs when the sac that contains the amniotic fluid breaks before 37 weeks of pregnancy.^{24, 25, 50-53, 55-57}

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.⁶⁶



STIMULANTS + LACTATION

Stimulant use can decrease the amount of milk you produce, and may cause the milk to dry up earlier.⁶⁷⁻⁶⁹



Up to 200 mg of caffeine per day is considered safe:^{69, 70}

- 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 and dump so that your supply does not decrease.^{32, 67, 68}

Both cocaine and methamphetamine are excreted in the human milk and there have been reports of severe infant effects from cocaine overdose, and one death after methamphetamine exposure via human milk.³²

In some states, new parents have been convicted of child endangerment or even manslaughter if the infant death was related to breast/chestfeeding and methamphetamine consumption.⁷¹

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.⁷²

[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.⁷³⁻⁷⁵ 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 there is not robust information about their health effects, but the information that exists suggests that they are less harmful for you than smoking.⁷³⁻⁷⁵

www.perinatalharmreduction.org



This is a list of tobacco and nicotine products, from most harmful to least harmful:⁷³⁻⁷⁷

- cigarettes
- cigars
- pipes
- hookah
- chewing tobacco
- snuff
- e-cigarettes and vaping *
- patches
- gum and lozenges
- no use

* What you vape matters. Some vape cartridges have very highly concentrated nicotine. Some have less - or none.

Unregulated vape products, like those containing vitamin E oil, have been associated with serious respiratory illness called e-cigarette and vaping associated lung injury.

www.harmreduction.org

TOBACCO + NICOTINE + PREGNANCY

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

Smoking cigarettes has been linked to early birth, smaller birth weight, placenta problems, birth defects, breathing problems through childhood, and even Sudden Unexpected Infant Death Syndrome/Sudden Infant Death Syndrome (SUID/SIDS) or unexpected death under one year of age.^{17, 79-81}

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.⁷⁸

Nicotine has been shown to affect the development of the baby's brain and may increase the risk of attention deficit disorders.^{17, 79-81}

Babies might experience nicotine withdrawal which makes them **irritable and hard to console**.

In addition, nicotine withdrawal has been shown to worsen neonatal withdrawal from opioids.⁸²⁻⁸³



TOBACCO + NICOTINE + LACTATION

Smoking may **decrease milk production** and/or cause the milk to **dry up earlier**.

Nicotine and other harmful substances in cigarettes can pass to the baby from human milk.^{18, 84}

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**.^{18, 85, 86}



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, colds, breathing problems (asthma, bronchitis and pneumonia), tooth decay and ongoing exposure to cancer-forming chemicals formed by cigarette smoke or vapes.⁸⁷

Children with this exposure could grow up to have increased risk of cataracts, heart and lung disease and asthma.⁸⁷

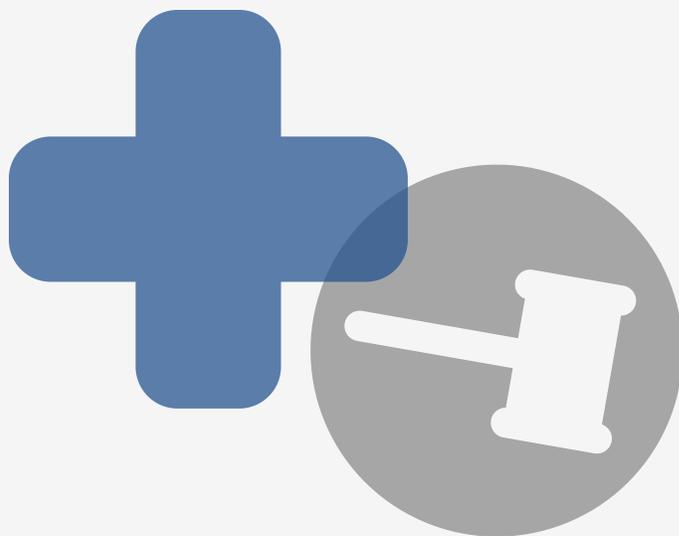
What treatment options are available for people who are pregnant?

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 bupropion (Wellbutrin®) or varenicline (Chantix®) to help their patients reduce or quit smoking. As with many other medications, these medications have not been studied in pregnant people.

SECTION 3

NAVIGATING THE HEALTH CARE + LEGAL SYSTEMS



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

You might be anxious about what may happen if you are open about your substance use.

In this section, we present you with the federal laws around this issue (as well as New York State specific laws and policies) and some information about **what might happen if you do or do not tell your provider about substance use.**

You can use this information to:

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

www.perinatalharmreduction.org

Please note that laws 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.

New York State Resources:

- [Center for Family Representation](#) 
- [Bronx Defenders](#) 
- [Brooklyn Defender Services](#) 
- [Neighborhood Defender Service](#) 

National Resources:

- [National Advocates for Pregnant Women](#) 
- [Birth Rights Bar Association](#) 

www.harmreduction.org

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. **In some states, substance use during pregnancy is so criminalized that some experts recommend consulting with a lawyer before disclosing use to a doctor.**

Having a **provider you can trust** is the first step in creating a collaborative and effective relationship.

You might need to meet with a couple of different providers before you find one that is right for you.

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

Learn About Your Treatment Options

In New York State, if you are pregnant and want to get on **buprenorphine** or **methadone** you can skip the waitlists.

For more about pregnancy and substance use treatment in New York State, visit the **Office of Addiction Services and Supports** website or call (518) 473-3460.

 oasas.ny.gov/treatment/pregnant-and-parenting

24/7 HOPEline: Call 1-877-8-HOPENY or text 467369

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 can be helpful to prepare a plan ahead of time. Preparing this plan can help to show your providers what a great parent you will be.

This "**Plan of Safe Care**" template (sample version from New York State is attached, see Appendix B for printable version) could help you think through a plan.

If you believe that a case will be opened, reach out to a legal group in your area as soon as possible.

OCF 8-2188 (05/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
PLAN OF SAFE CARE

Name of infant: _____ DOB: ____/____/____
 Admission date: ____/____/____ Discharge date: ____/____/____

Individual developing POSC:* _____ Individual monitoring POSC:* _____
 Phone: (____) _____ Phone: (____) _____
 Email: _____ Email: _____

Household Members and Affected Family or Caregivers of the Infant:

Name	Age	Relationship to infant	Name	Age	Relationship to infant
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Post-Discharge Family Strengths and Goals: (e.g., breastfeeding, housing, smoking cessation, parenting support, recovery)

Identified Supports: (e.g., stable living environment, family and friends, employment, etc.)

Safety and Protective Factors Present: (e.g., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children, etc.)

Family Is Currently Involved in the Following Services:

Service	Organization	Contact person/Phone/Email
_____	_____	_____
_____	_____	_____
_____	_____	_____

New Family Services Referred or Recommended:

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Plan of Safe Care (POSC)

Page 1 of 2

**Plan of Safe Care
 Template from New York
 State, see Appendix B
 for printable version**

OCF 8-2188 (05/2018)

Comments: _____

Signature of parent /caregiver: _____
 Date: ____/____/____ Print name: _____

Signature of staff: _____
 Date: ____/____/____ Print name: _____

Review by (Date): ____/____/____

DISCLOSURE

TALKING TO YOUR HEALTHCARE PROVIDERS ABOUT SUBSTANCE USE

It is not mandatory for New York State healthcare providers to test pregnant people for drugs or to report pregnant or parenting clients with substance use to child welfare or law enforcement agencies (see Appendix A).

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

This means that if a pregnant person tells their provider they're using drugs, it is likely this information will be shared with Child Protective Services.

A report can be made by anyone in your life, such as a nurse, doctor, lactation consultant, friend or family member or a neighbor.

In an ideal scenario, this would mean that parents are provided with resources and support for parenting and healthcare.

In many cases however, the main result is **agency surveillance** (ex: unannounced home visits, speaking with friends and family) and **removal of the baby and any other children.**

People often choose not to disclose to their provider for these and other reasons. There is often fear (from personal experiences and those of friends and family) and lack of information about what will happen to you if you access prenatal care while pregnant and using drugs.

It can be difficult to decide whether or when to tell a healthcare provider about your substance use.

If they don't know this is an issue, they cannot connect you with resources that may be helpful, and they may find out later anyway. Because of this, it might make sense to tell them about substance use early in the relationship.

Providers are more likely to be understanding if they feel they know everything going on with you from the beginning.



TYPES OF DRUG TESTING (TOXICOLOGY)

There are many ways that a provider might become aware of your substance use, including talking to you or performing tests on your hair, blood, or 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).¹⁻⁴

Substance Abuse and Mental Health Services Administration (SAMHSA), American College of Obstetricians and Gynecologists (ACOG), and other expert medical associations agree that **any positive screening result should be confirmed with a second, more accurate test** (for example, a urine test might require additional confirmatory urine and/or blood tests).^{2, 3, 5-9}

Drug screens are not good evidence and should not be used as such in legal matters.^{4, 8} 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

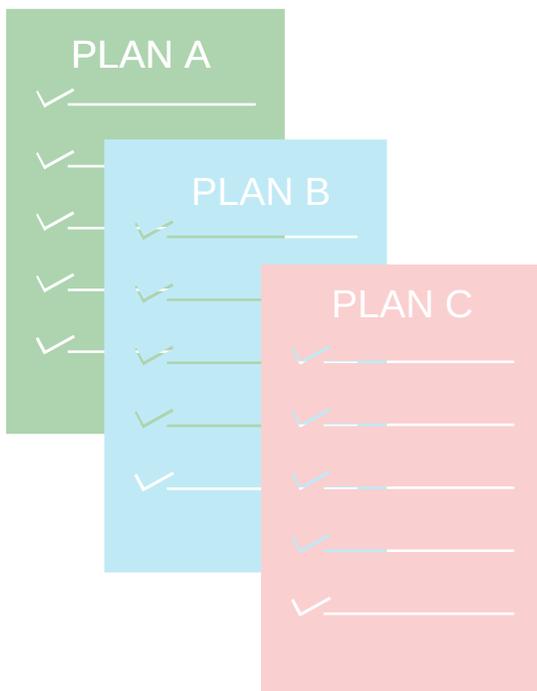


Many providers test urine or other body fluids without asking or even informing clients. This is bad practice and is not legal.

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 (alternatively they ask you for permission during a conversation, which is verbal consent).

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.



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 doula** with you to weigh these decisions. Having others join you at your appointments and labor can 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.

Check out [Birth Rights](#)  a resource from NAPW and the Birth Bar Association to help you develop a plan for your labor and birth.



FINDING OR SUSPICION



This may be based on:

- Taking opioid agonist treatment (methadone and buprenorphine)
- A record of taking controlled substances (prescribed or unprescribed)
- Diagnosis of a substance use disorder
- Positive urine or blood toxicology

DISCUSSION ABOUT YOUR USE

This is the hospital's internal process for documentation. This is among providers at the hospital. It is based on the initial finding/suspicion. They may have this conversation while filing a CPS report.

REPORT

Child Protection Services (CPS) is contacted.



DEVELOP PLAN OF SAFE CARE

Hospital staff may inform you of findings and the hospital providers' discussions. 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.



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



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



CASE WORKER ASSIGNED

IF DEEMED "UNSAFE"

A COURT 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.

INVESTIGATION BEGINS

With or without 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. Things may be presented as voluntary even though you feel like you have no choice. You may want to seek legal counsel at this stage to help you navigate this.

Many of the decisions made by people involved in these systems, such as a decision by a doctor to test someone for drugs, a nurse to call in a CPS report, a case worker to deem a situation unsafe, are up to that individual.

This means that this system, like all others, favors those with the most privilege in our society. Those who are Black and Latinx, poor, un-housed, and have familial structures deemed "untraditional" are under the most scrutiny and are most likely to be tested for substance use, have reports filed, and lose custody of their children.



IF DISAGREE TO TERMS OF PLAN

AGREE TO PLAN

Consent to supervision until the plan is completed.



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 THERE ARE PROBLEMS

If you get a result on a drug screen or any test generally that you disagree with, **you have the right to ask for a second 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 often disregarded.⁴

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 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 the facility and any patients who have experienced poor care or have a complaint.

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

To file a grievance if you have Medicaid insurance, go to the website for the [Center for Medicare and Medicaid Services](https://www.harmreduction.org/center-for-medicare-and-medicaid-services). 

See Section 4: Prenatal Care for printable sheets for easy record keeping

MY PREGNANCY

I FOUND OUT I WAS PREGNANT
DATE: _____
CONFIRMED:
 pregnancy test
 ultrasound

MY EXPECTED DUE DATE: _____

I WANT TO GIVE BIRTH AT: _____

MY FIRST APPOINTMENT WAS
DATE: _____
PROVIDER: _____

MY INSURANCE: _____

MY SUPPORT NETWORK:

IN AN EMERGENCY I WILL...
CALL: _____
GO TO: _____

MY PRENATAL CARE

APPOINTMENTS

PROVIDER: NOTES:	DATE: FOLLOW-UP:	<input type="checkbox"/> office visit	<input type="checkbox"/> call
PROVIDER: NOTES:	DATE: FOLLOW-UP:	<input type="checkbox"/> office visit	<input type="checkbox"/> call
PROVIDER: NOTES:	DATE: FOLLOW-UP:	<input type="checkbox"/> office visit	<input type="checkbox"/> call
PROVIDER: NOTES:	DATE: FOLLOW-UP:	<input type="checkbox"/> office visit	<input type="checkbox"/> call
PROVIDER: NOTES:	DATE: FOLLOW-UP:	<input type="checkbox"/> office visit	<input type="checkbox"/> call

FEDERAL LEGISLATION THAT MAY AFFECT YOU:

CHILD ABUSE PREVENTION AND TREATMENT ACT

The Child Abuse Prevention and Treatment Act (CAPTA) is a federal law directed only to states, not to hospitals or individual healthcare providers.

CAPTA requires that if states want to have the benefit of certain federal funds, they must provide an assurance that their state has a system for notifying the child protective services system of the occurrence of certain conditions in infants.

These 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.”**

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

A 2016 federal amendment passed by Congress requires that a **“Plan of Safe Care”** (See Appendix B) **must 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 who is responsible for developing and monitoring the Plan of Safe Care and may establish a reporting system 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.](#) 

New York State law does not require drug testing of pregnant/postpartum people or newborns and **does not mandate reporting of positive drug tests or evidence of prenatal exposure** to criminalized substances, alcohol, or tobacco.¹⁰

New York State does not define substance use alone as civil child abuse or neglect. But many 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.

For more information on New York State protocols, see [Plans of Safe Care for Infants and their Caregivers](#)  from the New York State Office of Addiction Services and Supports and **Appendix A** and **Appendix B**.

SUMMARY

It is a very personal decision whether you choose to share with your provider regarding your substance use. There are some drawbacks to sharing this information (your provider may make a report to their hospital or child protective services) and there may be benefits to sharing this information (your provider may connect you with important resources, appreciate your honesty and advocate for you if a report is made). The laws and protocols will differ based on where you live, so try to get in touch with local resources to get information about what you can expect about drug testing or Child Protective Services involvement. Don't forget that you do not need to make these decisions alone. Friends, family and doulas can help you make a plan for your birth, and advocate for you in the event that a report is made.

APPENDIX A:

**New York State Office of Children and Family Services
Child Protective Services Policies**

Excerpt from the [Office of Children and Family Services](#) 
[Child Protective Services Manual 2019](#) E7-8, pg. 355-356.

Parent's Drug / Alcohol Misuse

The misuse of legal or illegal drugs or alcohol by a parent or other person legally responsible for the care of a child can result in harm or imminent danger of harm to a child's physical, mental or emotional condition. The key issue to determine is whether the parent has misused a drug or drugs or alcoholic beverage to the extent that he/she loses self-control of his/her actions and is unable to care for the child, has harmed the child, or is substantially likely to harm the child. The fact that the parent or person legally responsible is voluntarily and regularly participating in a rehabilitative program is irrelevant in assessment of whether child abuse or maltreatment has occurred if the child's physical, mental or emotional condition has been impaired or is in imminent danger of impairment due to the parent's acts or omissions.

Evidence that a newborn infant tests positive for a drug or alcohol in its bloodstream or urine; is born dependent on drugs or with drug withdrawal symptoms; demonstrates fetal alcohol effect or fetal alcohol syndrome; or has been diagnosed as having a condition which may be attributable to in utero exposure to drugs or alcohol is not sufficient, in and of itself, to support a determination that the child is abused or maltreated. In addition, such evidence alone is not sufficient for a social services district to take protective custody of such a child. However, such evidence alone is sufficient to constitute reasonable cause to suspect that the child is at risk of being abused or maltreated in the future, thereby warranting a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR) and the commencement of a child protective investigation.

APPENDIX A continued

Upon the receipt of a report where parental drug or alcohol misuse is alleged, the social services district must conduct a thorough investigation to determine whether such misuse creates a risk to the child. The district must assess the ability of the parent to care for the child. The district must examine, in particular, the parent's plans for the care of the child and his/her ability to carry out those plans to determine whether the parent's drug or alcohol use creates a condition which places the child's physical, mental or emotional condition in imminent danger of becoming impaired. In the case of a newborn infant born to a drug or alcohol abusing parent, any special needs of such infant should be considered in the district's assessment of parental capability.

Immediate considerations:

- What is the child's physical, mental, or emotional condition? Has the child been harmed or in imminent danger of harm?
- What is the parent's/other person legally responsible's explanation for these conditions? Good note taking is essential. Use direct quotes.
- What are the results of medical examination concerning the parent's drug or alcohol use?
- What is the parent's/other person legally responsible's capacity to exercise a minimum degree of care to meet the child's physical, mental and emotional needs?

APPENDIX B:

Plan of Safe Care

Excerpt from the [Office of Children and Family Services](#) 
[Child Protective Services Manual 2019](#) J4-5, pg. 168-169.

Creating a Plan of Safe Care

The federal Comprehensive Addiction and Recovery Act of 2016 (CARA), which amended the Child Abuse Prevention and Treatment Act (CAPTA), tackles some of the complex issues surrounding the nation's prescription drug and opioid epidemic.

CARA places a strong emphasis on a multi-agency approach to the problem of substance abuse. CARA changed some of the requirements for developing a plan of safe care for infants exposed to substances. These changes reflect a growing body of evidence that supports a collaborative approach between various agencies and providers when responding to the challenges and complexities of dealing with substance use disorders.

The OCFS policy, 17-OCFS-LCM-03, Amendments to the Federal Child Abuse Prevention and Treatment Act by the Federal Comprehensive Addiction and Recovery Act of 2016 and Corresponding State Requirements, provides guidance to CPS on complying with the new requirements set forth in CARA for handling cases in which an infant has a positive toxicology or shows signs of withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD).

APPENDIX B continued

Requirement to Create a Plan of Safe Care

Under CARA, whenever an infant is identified as being exposed to substances, the state must provide for the development of a plan of safe care that addresses the health and substance use disorder treatment needs of both the infant and the affected family or caregiver. The plan of safe care must address not only the immediate safety needs of the affected infant, but also the health and substance use disorder needs of the affected family or caregiver. A plan of safe care should include referrals to appropriate services that support the affected infant and family or caregivers.

The plan of safe care should be developed with input from parents and caregivers, as well as from professionals and agencies involved in serving the affected infant and family. It may be written by a physician, other medical provider, CPS, social worker, or another entity.

CPS Documentation Requirements for the Plan of Safe Care

Whenever a report of suspected abuse or maltreatment involves an infant exposed to substances, CPS must document the plan of safe care in its case records. In some instances, a plan of safe care may have been developed by medical professionals and/or substance abuse treatment providers prior to the involvement of CPS. The case file should clearly document the plan of safe care, whether developed by CPS or other professionals involved.

APPENDIX B continued

A Plan of Safe Care is Not the Same Thing as a Safety Plan

A plan of safe care, as described above, is a document and plan that specifically addresses children affected by substance use and the parent/caregiver. A Safety Plan is a plan developed by an LDSS in partnership with the parent/caregiver that includes controlling interventions to address safety factors that would place a child in imminent danger of serious harm. A plan of safe care might be included as part of a Safety Plan, but is never a substitute for one. (See Chapter 6, D.2, The safety assessment process).

In 2018, OCFS issued OCFS-2196: Plan of Safe Care (see Chapter 14, Appendix), which is the required form to be used when developing a plan of safe care with a family. Completion of the OCFS-2196 should be documented in Progress Notes, including a description of how the family was involved in the creation of the plan and how the plan will be monitored and adjusted as necessary. A paper copy of the plan must be maintained in the case file.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
PLAN OF SAFE CARE

Name of infant: _____ DOB: ____/____/____
Admission date: ____/____/____ Discharge date: ____/____/____

Individual developing POSC:* _____ Individual monitoring POSC:* _____
Phone: (____) _____ Phone: (____) _____
Email: _____ Email: _____

Household Members and Affected Family or Caregivers of the Infant:

Name	Age	Relationship to infant	Name	Age	Relationship to infant
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Post-Discharge Family Strengths and Goals: (e.g., breastfeeding, housing, smoking cessation, parenting support, recovery)

Identified Supports: (e.g., stable living environment, family and friends, employment, etc.)

Safety and Protective Factors Present: (e.g., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children, etc.)

Family Is Currently Involved in the Following Services:

Service	Organization	Contact person/Phone/Email
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█

New Family Services Referred or Recommended:

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█
█	█	█

*Plan of Safe Care (POSC)

Comments: █

Signature of parent /caregiver: _____

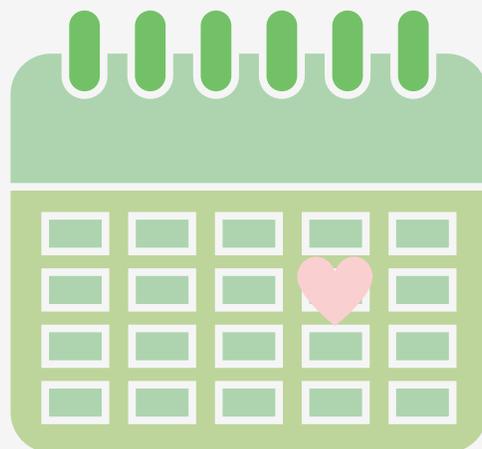
Date: █ / █ / █ Print name: █ _____

Signature of staff: _____

Date: █ / █ / █ Print name: █ _____

Review by (Date): █ / █ / █ _____

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 healthcare 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 as directed by your medical provider** and get enrolled for prenatal care with your health insurance provider as soon as possible.

Medicaid in New York State

New York State Medicaid can help you get the care you need for you and your baby.

Pregnancy care and other healthcare services are available for people who live in New York State and are eligible for Medicaid.

To see if you can access Medicaid programs for pregnant people, call the **Growing Up Healthy Hotline (800) 522-5006** or go to the website: health.ny.gov/health_care/medicaid. 

MY PREGNANCY

I FOUND OUT I WAS PREGNANT

DATE:

CONFIRMED:

- pregnancy test
- ultrasound



MY EXPECTED DUE DATE:



I WANT TO GIVE BIRTH AT:



MY FIRST APPOINTMENT WAS

DATE:

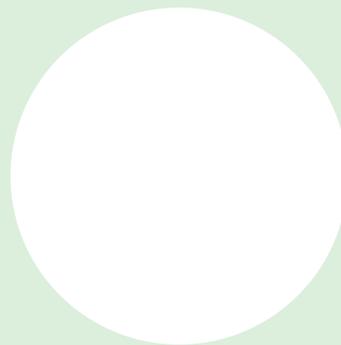
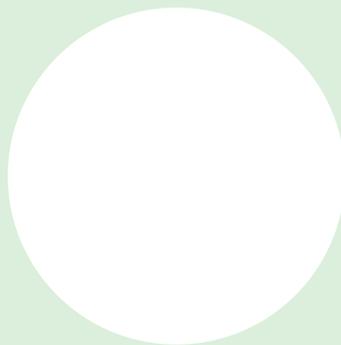
PROVIDER:



MY INSURANCE:



MY SUPPORT NETWORK:



IN AN EMERGENCY I WILL...

CALL:

GO TO:



MY PRENATAL CARE



APPOINTMENTS

PROVIDER:

DATE:

office visit

call

NOTES:

FOLLOW-UP:

PRENATAL APPOINTMENTS

PROVIDER:

DATE:

office visit

call

NOTES:

FOLLOW-UP:

PROVIDER:

DATE:

office visit

call

NOTES:

FOLLOW-UP:

PROVIDER:

DATE:

office visit

call

NOTES:

FOLLOW-UP:

REFERRALS:

I should make an appointment with...

NOTES:



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:

CARE COORDINATION

Healthcare providers in the field of obstetrics and gynecology (OB/GYN) may have not 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.

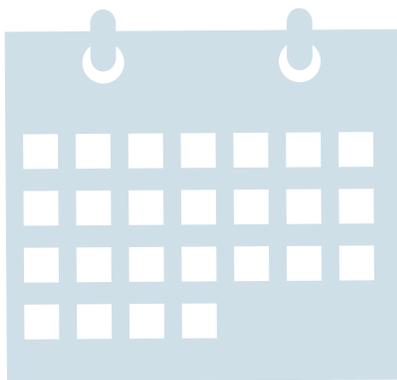
This lack of knowledge and experience can cause them to feel uncomfortable addressing or even acknowledging the impacts of health concerns outside of their area of expertise. For you, **this can result in mixed messages or lack of accurate information**.

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**.

Anyone 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.

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. We recognize that due to food deserts and prohibitive costs, not all of these options are available to everyone. As possible, 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
- low-fat dairy products
- 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 NUTRITION PROGRAMS for PREGNANCY and BEYOND

1-800-522-5006



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 your state.

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 separately.



Keep most foods chilled and refrigerated.



Cook meat and eggs all the way.



Avoid unpasteurized products.

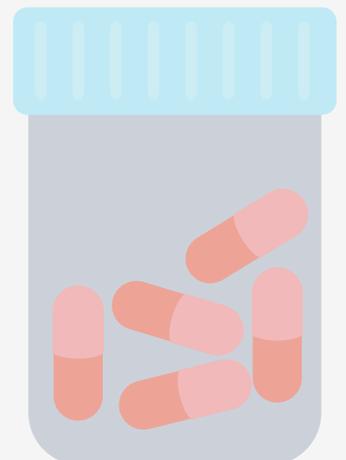


FDA

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, **folic acid** is needed to help the fetus's brain develop. It is important that you have enough calcium during your pregnancy to make sure your bones stay healthy.



People may 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 but other people have experienced increased nausea with cannabis use in pregnancy.¹⁻⁴

The safety of cannabis use during pregnancy is not agreed upon, though studies are currently being done in states where cannabis is legalized. It is safest not to use if there is an alternative.

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

See Section 2: Harm Reduction for more information

ROUTINE PRENATAL CARE

Routine prenatal care is the healthcare 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. Going to more prenatal visits as early as possible has been found to decrease the risk of premature birth, low birth weight and being small for gestational age among babies born to people who use drugs.⁵

If there are complications or your pregnancy is considered high-risk, routine prenatal care plus additional interventions are recommended. This usually involves more frequent visits, and tests that are specific to your unique medical needs. You might be referred to a specialist in Maternal-Fetal Medicine.

Conditions that Make a Pregnancy High-Risk

- Multiple gestation (twins and multiples)
- Teenage or over 35
- A history of pregnancy complications
- Chronic health conditions (e.g. hypertension, seizure disorders, diabetes, cerebral palsy, asthma, HIV)
- Using some medications (e.g. lithium, chemotherapy agents, etc.)



The earlier prenatal care is initiated, the better.

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

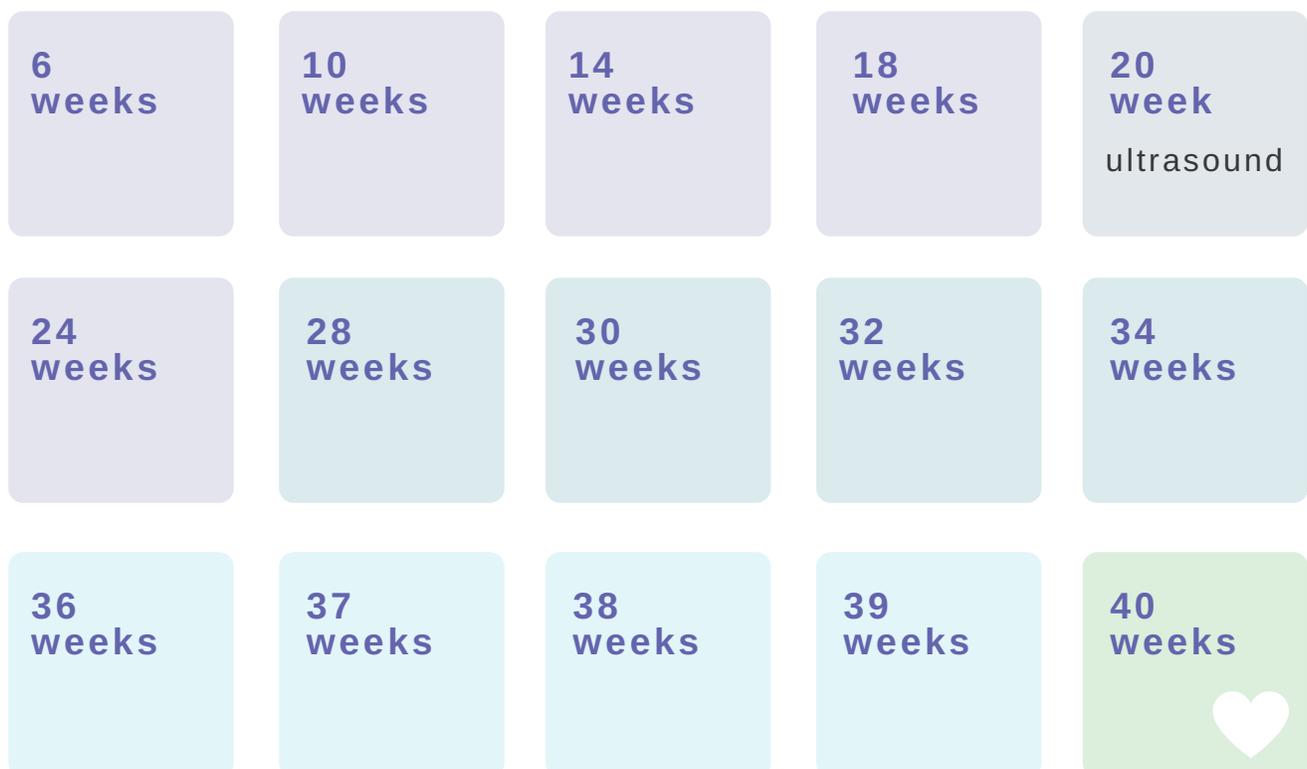
For most people, this is **around 8 weeks**, but if menstruation is not regular (as is common for people who use drugs) it may be later.

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**.



"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 Protective Services.



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

Call your prenatal care provider **IMMEDIATELY** if you experience:



- visual problems
- 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 OR PRETERM PREMATURE RUPTURE OF MEMBRANES (PPROM)

This can occur anytime 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 **backache**
- 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're 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

Preterm labor can happen any time between 20 and 37 weeks of pregnancy. 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.

PLACENTAL ABRUPTION

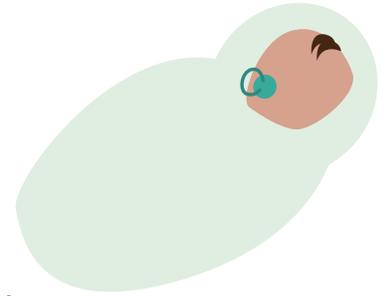
Placental abruption is when the placenta starts to detach from the uterus before the baby is born. This causes the blood vessels between the placenta and the uterus to bleed. Bleeding with pain is the most common sign of placenta abruption.

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

- www.womenshealth.gov/a-z-topics/prenatal-care
- www.plannedparenthood.org/learn/pregnancy/prenatal-care



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 at 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 and Pregnancy](#) 

[Hepatitis B and C and Pregnancy](#) 

[HIV and Pregnancy 1](#) 

[HIV and Pregnancy 2](#) 

[Preventing Parent to Child HIV Transmission](#) 

[STIs and Pregnancy](#) 

[Syphilis](#) 

SECTION 5

LABOR + CHILDBIRTH



Many people are concerned about the pain related to labor and birth.

There are many options you can discuss with your provider. **If you know more about your options, you can make decisions that make you 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 who use drugs when choosing a pain control plan.

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

We know that people who use opioids might have higher tolerance

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and require higher doses of pain medication to feel pain relief.

In addition, many people who use substances have had **negative experiences with healthcare** and may have been 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 is normal. Speak with someone in your support network about ways they can help you.**

See **Section 1: Quality Healthcare Is Your Right**, for more information on trauma-informed care and **Section 4: Prenatal Care** for information on care coordination.

www.harmreduction.org

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

Use this information 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. **You will still feel pressure and stretching, but not pain**. It is effective within 10-25 minutes, and starts to wear off mostly in a few hours, but can take up to 24 hours after the tube is removed to completely wear off.

PROS

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

CONS

- cannot walk
- will likely require a catheter
- potential for complications such as infection or nerve damage
- can slow labor and increase risk of cesarean section

SPINAL

Spinal anesthesia is usually used for cesarean section, 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

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

CONS

- cannot walk
- will likely require a catheter
- potential for complications such as infection or nerve damage

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

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

CONS

- cannot walk without assistance
- will likely require a catheter
- potential for complications such as infection or nerve damage
- 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 you will be **unconscious** and **feel nothing** during the birth.

These medications are usually given through an **intravenous tube (IV)** and/or **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 between the vulva and anus).

PROS

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

CONS

- does not numb uterine contractions

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

OPIOIDS

Injected opioids (hydromorphone, morphine, fentanyl) **do not have the same numbing effect** as the interventions listed above, but are very effective pain killers.

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
- does not fully block pain

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 cesarean section, may come with higher risk of post-operative nausea.

Vomiting after birth, especially a cesarean 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 the 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.

NITROUS OXIDE (N₂O, 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. Nitrous oxide 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 them - but are 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.

ACUPRESSURE

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.

ACUPUNCTURE

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 meditation, mindfulness or hypnosis are a 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 clients plan to use this technique during labor, instruct them to 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 ensuring 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. You may wish to use a partner or a birthing 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. You can also take a warm bath or shower.



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. Taking too much acetaminophen can cause liver problems.



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®)

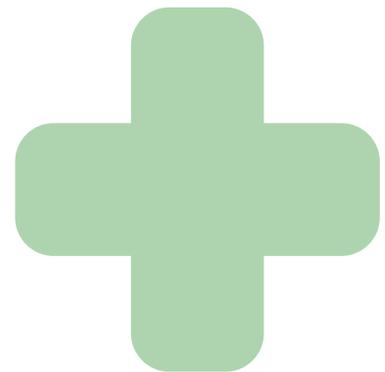
This medication is given intravenously (IV). It is a partial opioid agonist/antagonist. It can be useful for reducing pain, and reducing opioid-induced itching and/or nausea. **Nalbuphine should NEVER be used for someone who is physiologically dependent on opioids, because it can cause immediate withdrawal.**

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

These opioid medications may be used intravenously (IV) or in pill form 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 people who have cesarean sections, pressure from abdominal gas buildup after delivery can be very painful. These medications can make it easier to pass gas. 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®)

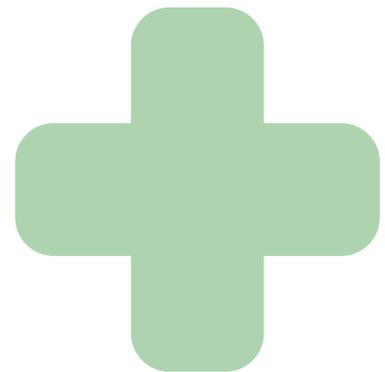
This medication may be offered as needed. It is an aerosol spray that numbs an area for about 15 minutes. Some people find it helpful for vaginal pain or hemorrhoids after delivery, or before having a bowel movement.

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

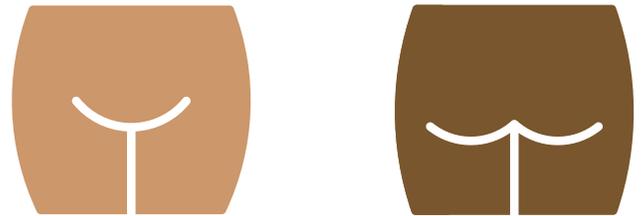
This medication can be used to reduce discomfort and/or shrink hemorrhoids. Extra strength is available only by prescription, but 1% hydrocortisone is available in drugstores.



NON-PHARMACOLOGICAL PAIN MANAGEMENT

There are many actions and products that can help with postpartum pain when opioids are not prescribed or not an option. The following interventions will be arranged by the pain source.

VAGINA, VULVA, PERINEUM, ANUS



ICE OR COLD PACKS

Ice is one of the most effective methods to ease 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. 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. Request ice packs from your provider to take home.

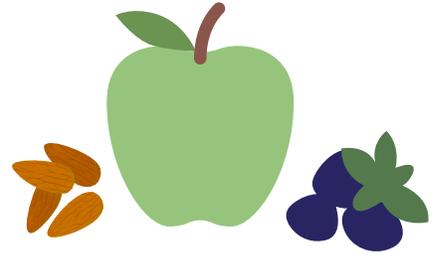
CHANGING POSITION

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:

- berries
- apples
- dried fruit (except bananas)
- whole grains
- nuts



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.

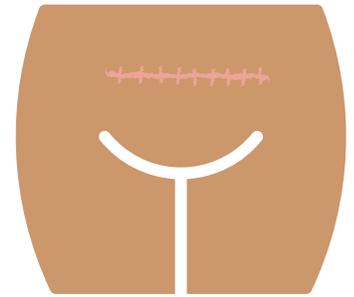
Be sure that water temperature is comfortable and not too hot.



CESAREAN 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

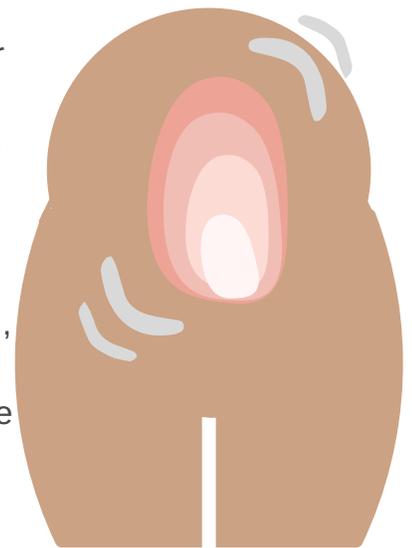
Ice or chemical cold packs can be applied to the incision for about 20 minutes at a time with breaks between applications.

BRACING WITH PILLOW

Laughing, vomiting, sneezing, and coughing 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 your fifth birth will be more intense than those following your first. Cramps are more intense during activities that release natural oxytocin, such as breast/chestfeeding, cuddling your baby, or hearing them cry. It helps to anticipate these times and use measures to decrease this pain before it starts.



FREQUENT PASSING GAS

Some of the methods of pain control can cause a decrease in passing gas. This gas can build up and cause intense pain after delivery. 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 food, 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 the baby, to avoid injury.

SECTION 6



POSTPARTUM

The first year after having a baby is physically and emotionally difficult. 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.

This section will discuss a few of the things that may come up during the first year following the birth. This includes planning to prevent overdose and finding support for common mood and anxiety disorders. It will also discuss options for contraception and, finally, how different substances impact breast/chestfeeding.

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OVERDOSE

Some people taper off of methadone or buprenorphine after their pregnancy because they or their providers think they no longer need it. 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 and 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.

[Safety Planning Resource](#) 

www.harmreduction.org

In addition, after you deliver your baby, some of the support you relied on may change. Because of insurance, you may lose access to the treatment team you had during your pregnancy.

During the postpartum period, your tolerance may fluctuate. **Remaining on medications for opioid use disorder (MOUD) after your delivery can help protect you**

from overdose given these changes in tolerance.

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



PSYCHOSOCIAL SUPPORT AND PERINATAL MOOD AND ANXIETY DISORDERS (PMADS)

Some people may be familiar with the term Postpartum Depression. For generations, we have recognized that some people become depressed after giving birth. We have realized however, that the mental health differences experienced by pregnant and postpartum people are much more varied than this. That is why we now refer to these conditions as Perinatal Mood and Anxiety Disorders (PMADs).

PMADs are fairly common, and can impact pregnant people and their partners. **These disorders can be experienced from the beginning of pregnancy through the first year after birth.**

PMADs include depression, anxiety, and psychosis. People may experience repetitive or unwelcome thoughts. For example, an image of something bad happening to the baby that comes to mind again and again, seemingly from an outside source. This is different from the mild mood swings experienced by most people after having a baby, sometimes called “baby blues.”

“Baby blues” generally come and go, but if they last two weeks or more, talk to a provider. PMADs can be unrelenting, interfere with self and baby care, and can be accompanied by thoughts of harming yourself, your baby, or others.

Factors that may increase of PMADs risk are:

- Personal or family history of other mental health problems
- Experience of trauma/ violence, especially as relates to previous pregnancy or sexual abuse
- Current or past substance use
- Post Traumatic Stress Disorder (PTSD)
- Poverty
- Isolation

Ask yourself these questions:

- How are you feeling?
- Are you having thoughts of hurting yourself or your children, even if you don't want to?
- Crying or on the verge of tears all day?
- Do you feel guilty, hopeless, angry, numb, or worthless?

Talk with your healthcare provider about how you're feeling and if you'd like a referral to mental health support. **You should tell someone right away if you have thoughts of hurting yourself or someone else.**

HELPLINES:

New York State 24-hour free help-line:

855-631-0001
631-422-2255 Hablamos Español

Postpartum Support International
24-hour hotline:

1-800-944-4773
#1 Spanish, #2 English
Text: 503-894-9453

EMERGENCY RESOURCES:

Suicide Prevention Lifeline:

1-800-273-TALK (8255)

Parental Stress Hotline –
Help for Parents:

1-800-632-8188

Crisis Text Line:

Text "Got5" to 741741

MORE INFORMATION:

[PMADs](#) 

[Learning about PMADs](#) 

[Multi-lingual Resources](#) 

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 read about the types of contraception available here:

[Planned Parenthood](#) 
[Bedsider](#) 

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, and others can last for months or years** (injections, IUDs, implant). 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, etc. **Your provider should never try and influence your decision or push you towards a method that you are not interested in.**

MORE INFORMATION:

[Postpartum Contraception](#) (ACOG) 

[Postpartum Contraception](#) (4th Trimester Project) 

NEW YORK STATE FINANCIAL SUPPORT:

[Family Planning Benefit Program](#)(NY.GOV) 

[Free Services for NYS Residents](#) (Panned Parenthood) 



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 medicine has become established, and birth more medicalized, this history has been deeply embedded in the process. 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.²⁴ In another case, 148 people incarcerated in California Women's prisons were sterilized without their consent between 2006-2010.²⁵

BREAST/CHESTFEEDING AND HUMAN MILK

Like all of the decisions outlined in this toolkit, the decision to breast/chestfeed, use formula, or both, is very personal. This section discusses how different substances affect lactation and human milk. You can find more detailed information on medications and their safety during pregnancy and lactation at [LactMed](#). If you want information on how these substances also impact fetal development and how to prevent some common harms, see **Section 2: Harm Reduction**. If you read Section 2, this information on lactation will be familiar.

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 and harm reduction practices provided through the healthcare system, not the legal or child welfare system." 



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, and your breasts/chest become painful, pump or hand express enough milk to relieve the pressure and 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 okay to feed the baby, have a drink, wait a few hours, and feed the 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 human 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

Formal guidelines recommend that the safest choice is to stop recreational use completely while lactating.^{3, 7, 8}

If you continue using while breast/chestfeeding, consider using harm reduction methods like pumping before using or pumping and dumping right after using. 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.^{9, 10}



OPIOIDS

It is safe to breast/chestfeed while taking medications for opioid use disorder such as methadone and buprenorphine, regardless of the dose of medication that you take. In fact, it can actually make the baby's withdrawal less severe. Studies suggest this is because skin-to-skin contact and attachment formation help the baby feel better while breast/chestfeeding.^{11, 12}

With heroin, it is best not to breast/chestfeed, since we can't know the exact dose and it may be cut with other unknown substances and contaminants that aren't safe for the baby. When we study other opioids like methadone, we find that only about 2% of the total dose makes it into human milk.¹³ For buprenorphine, there are negligible amounts of buprenorphine/norbuprenorphine in human milk and infants absorb even less of this because of the way buprenorphine is broken down and metabolized (not absorbed well in the stomach).^{14, 15}



STIMULANTS

Stimulants pass into human milk, and can decrease the amount of milk produced, and/or cause the milk to dry up earlier.^{16, 17, 19} Up to 200mg of caffeine per day is considered safe (one 8-oz cup of coffee contains 90-100mg caffeine, on average).^{12, 18, 19} 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).^{12, 16, 17}

Both cocaine and methamphetamine are excreted in the human milk and there have been reports of severe infant effects from cocaine overdose, and one death after methamphetamine exposure via human milk.^{12, 16} In some states, new parents have been convicted of child endangerment or even manslaughter if the infant death was related to breast/chestfeeding and substance use.²⁰



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.^{8, 26} 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.^{8, 21, 22}

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, colds, breathing problems (asthma, bronchitis and pneumonia), tooth decay and ongoing exposure to cancer-forming chemicals formed by cigarette smoke or vapes.²³ Children with this exposure could grow up to have increased risk of cataracts, heart and lung disease and asthma.

THANKS FOR READING!



HARM
REDUCTION
SAVES
LIVES



support
don't punish

Thanks for reading this toolkit. As we mentioned in the introduction, all content found in this toolkit, including: text, images, and other formats were created for informational purposes only.

This content is not intended to be a substitute for professional medical or legal advice, diagnosis, or treatment.

Always seek the advice of your physician or other qualified health provider or legal counsel with any questions you may have regarding a medical condition or legal situation.

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

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We know that you are the experts.

We would love to hear from you. Can this toolkit be improved? Do you want to be involved in future work?

Please contact us at:

pregnancy@harmreduction.org

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SECTION 5: BIRTH + LABOR

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