PREGNANCY AND SUBSTANCE USE

A HARM REDUCTION TOOLKIT

NATIONAL HARM REDUCTION COALITION

Academy of Perinatal Harm Reduction

ARBOR PLACE

OD reversal
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SCAN ME

RELEASED JULY 9, 2025

ABOUT

Vision for WISCONSIN toolkit:

This toolkit is a resource for all in Wisconsin who are affected by substance use disorders - and those who care for them.

Collectively, we hope to dismantle the stigma and discrimination around substance use in pregnancy.

For nearly half a century, Arbor Place has served the Western Wisconsin region, helping countless people on their path to recovery. Let us help you too. Healing is possible, and it's just a phone call away.

The mission of Arbor Place, Inc. is to provide prevention, treatment, and renewal opportunities to individuals, families, and communities impacted by substance use and mental health disorders.

Let's start the conversation.

ARBOR PLACE

This project was paid for by Arbor Place, Inc., utilizing grant funding from the Advancing a Healthier Wisconsin Endowment.
www.ahwendowment.org

If you are interested in adapting this publication for where you live, contact

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- 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 legal or medical 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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NOTES:

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**. A provider can be a midwife, physician assistant, doctor, or nurse practitioner. Whoever manages your care is your provider.

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

Most people use substances. And when they find out they are pregnant, most people think about stopping or reducing their substance use. It is important to remember that there are many things you can do to have a healthy pregnancy - including changing how you use.

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

These materials can be shared with family members and service providers to help you **start important conversations about your plans, hopes, goals, and dreams**.

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

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

Please contact us at:
info@arborplaceinc.org or
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MY CARE TEAM

My Medical Providers

Work with me to make informed decisions about my care

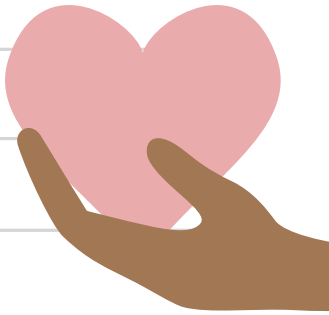
My Doula

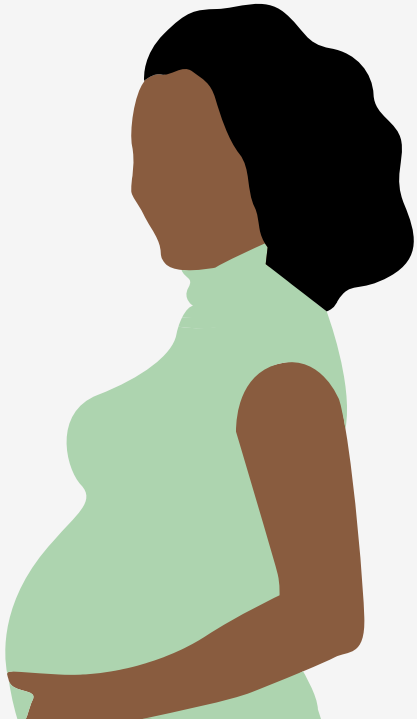
Advocates for me with my providers - especially during childbirth

My Peer Support Specialist

Knows what it's like to navigate pregnancy and parenting when you're a person who uses drugs (PWUD)

NOTES:





QUALITY PERINATAL CARE IS YOUR RIGHT

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

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

People don't go to places where they don't feel welcomed. They may fear for their safety - or the safety of their family and children. They may be worried about being coerced into treatment that isn't right for them. **That's why having kind, smart, trustworthy, nonjudgmental, people to support them and advocate with them can make all the difference in the world.**

SUBSTANCE USE

is not the same as a

SUBSTANCE USE DISORDER

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

www.samhsa.gov

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

Substance use disorders (SUDs) are **common**, **recurrent**, **treatable**.

SHOWING POSITIVE REGARD

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

Demonstrating unconditional positive regard starts with the belief that **people are inherently good**.

Communicating unconditional positive regard means that when you talk to someone about their healthcare needs, you **recognize the whole person.** You see them as someone with a full range of needs - instead of just focusing on their substance use.

When you have unconditional positive regard for someone:

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

WHY IT MATTERS

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

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

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

MOTIVATIONAL INTERVIEWING

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

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

Part of motivational interviewing is understanding that **it takes time to build trust.** People may choose to wait to talk to you about the details of their substance use until they believe that you can be a reliable partner and ally.

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.. How did your last pregnancy go? What are your goals for this pregnancy?

MOTIVATIONAL INTERVIEW METHODS

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

RESPECTFUL LANGUAGE

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

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

Another strategy is for dismantling stigma is adopting "**person first language**." This means **using words that recognize people's humanity - and that don't define them solely by their condition.** Adjusting to person first language can be awkward at first, but it is worth it if it helps us **better serve and support** people who have been subjected to shaming and stigmatizing by others.

BEST PRACTICES TO AVOID USING STIGMATIZING LANGUAGE

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

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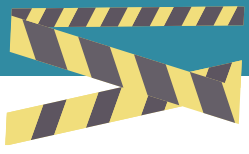


Micro-aggressions are forms of discrimination that are common and subtle insults toward marginalized groups and people.

STIGMA AND PRIDE

Stigma is made worse by policies that discriminate against people who use drugs and push them to the margins of society. There are many forms of stigma, such as:

- **stigma from individuals** who use words like *“junkie” or "pillhead"*
- **institutional stigma** like instituting policies for firing people based on positive urine drug screens
- **stigma by association** when pharmacists or medical providers say, “I don't want people like that around my patients and staff”
- **self-stigma** when you believe you deserve judgement, pain, and suffering because you use drugs

Stigmatizing language is written into our laws, child welfare policies, and provider education. Despite widespread acceptance that substance use is a health condition - and not a character flaw - stigma against people who use drugs is still **socially acceptable and commonplace**.

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

Sometimes people might feel like they should be ashamed of themselves based on what substances they use or the circumstances in which they use them.

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

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

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

We recommend these 24h safety lines:

Never Use Alone
(877) 696-1996
(800) 484-3731

Safe Spot
(800)972-0590

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

DIGNITY + PRIDE

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

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

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

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

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

ACOG Committee Opinion:
Caring for Patients Who Have Experienced Trauma

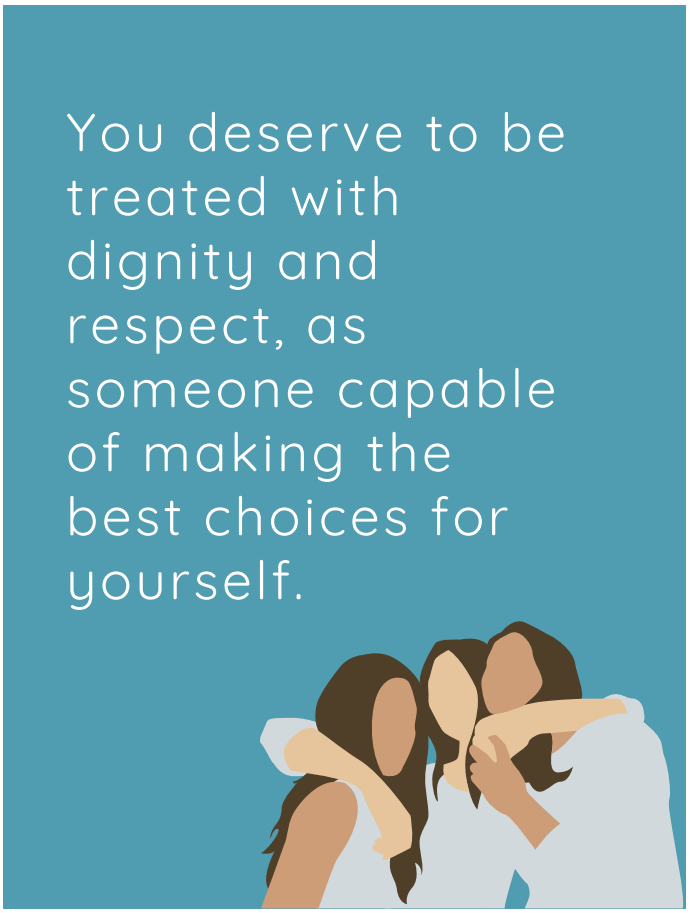
Ask your care providers if they know about - and provide - trauma-informed care.

TRAUMA-INFORMED CARE

An essential component of respectful reproductive health care is what is known as "**trauma-informed care**."

Trauma-informed care is health care that recognizes the impact of negative life experiences.

Living with the effects of things like poverty, racism, scarcity, child welfare services involvement, incarceration, and the loss of loved ones affects our health. Being exposed to emotional, verbal, sexual, financial abuse, and unhealthy relationships contributes to poor outcomes.



TRAUMA-INFORMED CARE

Consider sharing this toolkit with your Midwife, Doctor, Nurse Practitioner, Physician Assistant. Pharmacist, or other healthcare provider. We will refer to these folks as “providers”.

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

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

GENDER-INCLUSIVE CARE

Everyone deserves respectful, gender-affirming care.

Parents of all genders can get pregnant, give birth, and feed their babies. And families may include one, two, three, or more parents.

As care becomes more comprehensive and inclusive, more people who are LGBTIQA+ and trans & gender diverse (TGD) will feel empowered to advocate for the care they need - and deserve.

Understanding perinatal care from new perspectives improves and enriches pregnancy and postpartum care for all families - and builds healthier communities.

RESOURCES WE ♥ :

- Trans and Gender Diverse Parents Guide from Rainbow Families
- Birth for Every Body
- Planned Parenthood of Wisconsin - Gender Affirming Hormone Therapy
- La Leche League (LLL) - Support for Transgender & Non-Binary Parents
- Trans Fertility co. - healthcare provider trainings
- Centerlink - LGBT Centers for health, legal, and social support
- FORGE - training, technical assistance, and community building

PARENTS

LACTATION

SHE HE THEY XI

PARTNERS

PERINATAL

LANGUAGE MATTERS

The words we use to talk about gender, pregnancy, giving birth, parenting, and feeding our babies are changing and expanding.

Don't assume you can understand someone's gender or identity just by looking at them.

Ask people about the words they use to describe their gender, their bodies, and their parenting.

TRAUMA-INFORMED CARE PRACTICES

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

TO BIRTH OR NOT TO BIRTH

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

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

There are free, non-judgmental resources and services that can help you talk through your decision, such as All-Options:

www.all-options.org (888) 493-0092

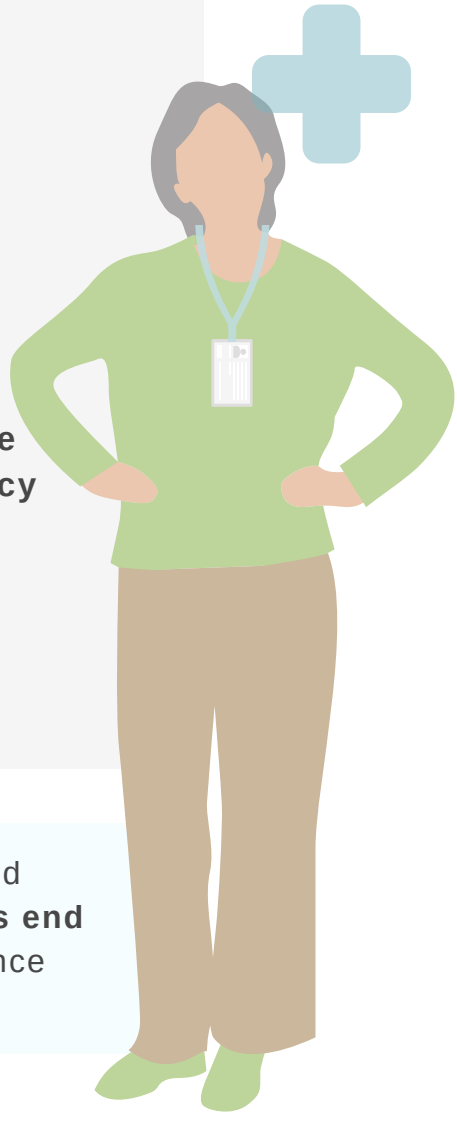
CONTINUING A PREGNANCY

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

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

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

If this is a desired pregnancy, being on medications for opioid use disorder or using drugs should never be the only reason for you to decide to have an abortion.



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

TYPES OF PREGNANCY PROVIDERS

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

THE ROLE OF

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

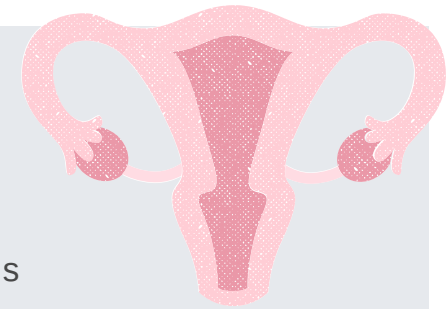
Doulas will meet with you once or twice during your pregnancy to develop a relationship with you and your support person. **During pregnancy, a doula can help you learn about your options and help you make plans** for childbirth and early parenting. **During labor and birth, it is their job to care for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

Doulas are not mandated reporters, but employers may have a reporting policy. Always ask before sharing sensitive info.

When searching for a doula, get as much information about them as possible. Ask them if they provide **trauma-informed care** or have **experience with caring for people who use drugs**. If you have relationships with trusted social service providers, community health care workers, case managers, or treatment providers you may ask them to help you find an experienced doula. Find a doula on page 94.

NOTES:

ENDING A PREGNANCY



If you decide to have an abortion, the next step is contacting a trusted healthcare provider. Planned Parenthood and Affiliated Medical Services provide abortion care in Wisconsin.

- Planned Parenthood Wisconsin or (844) 493-1052
- Affiliated Medical Services or (414) 253-6400
- Pregnancy Options in Wisconsin pregnancyoptionswi.org

YOUR OPTIONS

ABORTION PILLS

Also called: medication abortion or self-managed abortion

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

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

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

You can get these medications online using telehealth services, at a clinic, or by prescription. Wisconsin law requires that you take the medicine in the presence of the provider who wrote the prescription.

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

IN-CLINIC ABORTION

Also called: surgical abortion or procedural abortion

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

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

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

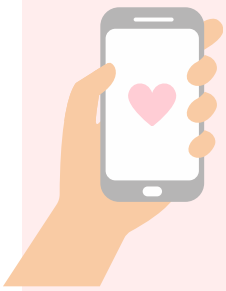
- In-Clinic Abortion from Planned Parenthood
- Abortions Welcome

RELIABLE INFORMATION

- Reproductive Health Access Project reproductiveaccess.org
- Abortion Care Network abortioncarenetwork.org 202-419-1444
- National Abortion Federation prochoice.org 1-800-772-9100
- Speak to a lawyer at reprolegalhelpline.org 844-868-2812

PAYING FOR THE ABORTION CARE YOU NEED

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



PROTECTING YOUR PRIVACY

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

We like the resources at the Digital Defense Fund.

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

BADGERCARE+ DOES NOT COVER MOST ABORTIONS

In the state of Wisconsin, Medicaid (BadgerCare+) does not cover the cost of abortion care unless it is a medical emergency OR the pregnancy is the result of sexual assault or incest AND a police report has been made.

Learn more about your options for paying for abortion care:

Wisconsin Abortion Support Network - Get Support

Indigenous Women Rising - Rain Fund or (505) 398-1990

Midwest Access Coalition - Get Support or call/text (847) 750-6224

ABORTION CARE in YOUR COMMUNITY

Nationwide protections for abortion ended with the overturning of Roe v. Wade in 2022, and **the legality of abortion in Wisconsin has changed several times since then**. The law may have changed again by the time you read this. For up-to-date information, **talk with a lawyer for free at Repro Legal Helpline**: (844) 868-2812 | ReproLegalHelpline.org

Abortion is legal in Wisconsin right now... At the time of writing, people in Wisconsin can have an abortion **up to 21 weeks and 6 days** gestation. An ultrasound and 24 hour waiting period are required between appointments, although **there is no medical reason** for this.[13-16]

If you are **under 18 years old** and need an abortion in Wisconsin, the law requires permission from a parent, legal guardian, or other family member who is over the age of 25. Or you can travel to a nearby state where abortion is legal and does not require parent permission, like Illinois or Minnesota. If none of these options works for you, you can ask a judge for permission.
Jane's Due Process - Judicial Bypass or call/text (866) 999-5263

At the time of writing, **Wisconsin has 3 abortion clinics and 93 anti-abortion centers**, **whose purpose is to prevent people from having abortions**.[11] These places look like legitimate medical clinics, but most do not provide medical care and they are **not required to follow safety, privacy, and ethics standards**.[11] These centers **spread false information** about abortion and contraception, use deceptive practices to **delay or prevent access to abortion and prenatal care**, and **collect and share patient information** freely,[12] including on a database that is accessible to thousands of partner centers worldwide. This is legal because they are not regulated as medical clinics.

Check your clinic before you go: Wisconsin Fake Clinics

MEDICATION ABORTION IN WISCONSIN

The abortion pill is a safe and effective way of ending an early pregnancy. Wisconsin law requires that the physician who provides medications for abortion must be in the same room when patients take them. **Medication abortion is indistinguishable from natural miscarriage**, and after care is the same.

Some people in Wisconsin receive **abortion medications by mail** through websites like Aid Access, Plan C Pills, or I Need An A. **It is not a crime to take these medications.** Wisconsin law says "No penalty may be assessed against a woman to whom an abortion-inducing drug is given". § 253.105(3)

PAIN MANAGEMENT + ABORTION CARE

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

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

Pain can feel more intense when we're emotional or nervous. Consider having a plan. Practice breathing exercises, bring calming music to listen to, or learn other relaxation techniques.

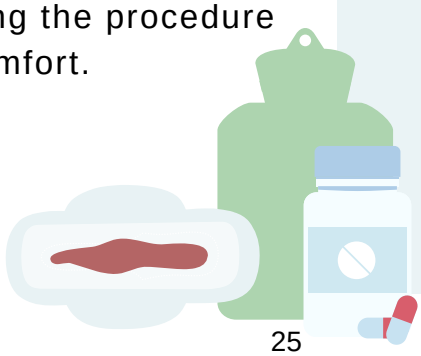
If you take a medication for opioid use disorder, you need accurate information about pain control and how to get it. **If you are taking buprenorphine (Suboxone) or methadone, take your regular dose**. If you are considering mild or deep sedation - and feel safe enough to tell the team of folks performing your abortion about your medications - they may be able to increase the dose of opioids they give during the procedure to help with any discomfort.

Some abortion providers are not comfortable with managing pain in patients who take buprenorphine. If you feel safe doing so, ask them to reach out to your buprenorphine provider for guidance. Many abortion providers are willing to be vague about the type of procedure you will be having. We suggest this language: "Your patient is at my facility today for a minor procedure for which we'd like to offer minimal sedation..."

If you have any concerns about urine drug screens at your buprenorphine or methadone provider's office, **ask your abortion provider for a note** explaining the medications you were administered or prescribed. Again, most abortion providers are willing to be vague about the type of procedure you had. Only you should decide if you want your buprenorphine or methadone provider to know about your abortion.

AFTER YOUR ABORTION

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



RESOURCES in YOUR COMMUNITY

HEALTH INSURANCE

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

BadgerCare+ covers healthcare while you are pregnant and for 60 days after the baby is born. BadgerCare Plus includes both outpatient healthcare, and inpatient hospital care, including labor and delivery, primary and specialty care, and prescription drugs.

You may be eligible for coverage of meals, dental, transportation, home nurse visits, childcare, utility bills, and more through ForwardHealth.

Apply for all Wisconsin benefits online: download the app ACCESS
Apply by phone or in person: DHS + Tribal Agency Contact Information

Children's Health Insurance Program (CHIP)
Wisconsin children may be eligible for BadgerCare+, and several other programs depending on their age, family status, and healthcare needs.
InsureKidsNow.gov

Wisconsin Wayfinder is a resource for caregivers of children with special health care needs to get help finding and using all of the services and resources available. Although most prenatal substance exposures do not cause of disability or delay, substance exposure qualifies your child for extra services, so be sure to use what you need.
Apply: 877-WISC-WAY

CONSUMER GUIDE TO HEALTH CARE

The Wisconsin Department of Health Services assists consumers to access health care services and insurance benefits. The department also assists healthcare consumers with problems and complaints, and educates consumers about their rights.

Visit dhs.wisconsin.gov/guide/index.htm

RESOURCES in YOUR COMMUNITY

FOOD AND NUTRITION ASSISTANCE

WIC (Women, Infants, & Children) program provides nutritious food, education, referrals, and breast/chest feeding support for pregnant people and parents of young children. Visit www.wicstrong.com/about/eligibility Services are provided in communities throughout the state, and most counties have their own Women, Infants and Children office. Make an appointment and find out what papers or documents you need to bring with you. APPLY HERE
If you need assistance, contact the **State WIC Office by phone 800-642-7837 or text 608-360-9328**.

SNAP is the Supplemental Nutrition Assistance Program, which Wisconsin calls FoodShare. FoodShare helps people buy the food they need for good nutritional health. The goal of this program is to stop hunger.

Before applying, check if your income makes you eligible: Monthly Income Level

- Apply for this and all benefits in one place: **ACCESS**

FoodShare WISCONSIN
A Recipe for Good Health

USING YOUR BENEFITS

If you qualify for FoodShare, you will get a Wisconsin Quest card. Each month, the amount of your benefits will be added to your Quest Card account, and you can use it like a debit card to pay for food at most grocery stores.

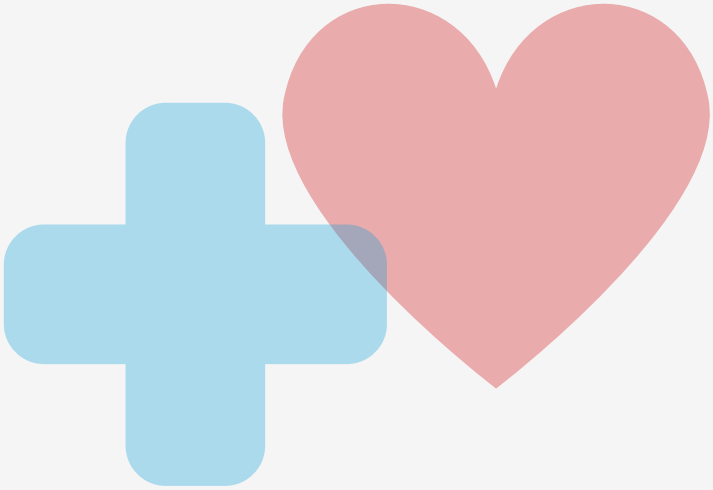
IF YOU NEED HELP

If you are having trouble with your benefits, you can get help from the ACCESS Help Center. Learn how to set up your account, search help topics, and find a specialist to answer your questions by talk or text.

HMO enrollment specialist 800-291-2002 | Member Services 800-362-3002

NOTES:

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.

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**.

Most of the problems our society links with drug use are not caused by drug use. For example, crime, violence, and damaging health effects are not directly caused by substance use. They are caused by medical neglect and our racist criminalization of certain types of use.[118-128]

Abstaining from all recreational substance use during pregnancy and breast/chestfeeding is the safest option for most people. But it's important to understand that some people have trouble achieving abstinence. Or don't want to stop using all substances. Those that want to stop or cut down but cannot may or may not have a substance use disorder (SUD).

Whether or not you're using, your health matters! And you deserve high-quality pregnancy care.

Substance use is just one of many things that influence our 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 substances.

Most people use substances at different times and in different ways during their lives. And most people try several times before they stop using a substance they've become dependent on. **A good healthcare provider will continue to work with people who are unable - or unwilling - to quit using substances**, rather than dropping them as patients.

It's ok to make missteps on your path to healthier use or recovery. Relapses are an expected part of everyone's journey. If a treatment does not work, try something else. **Remember**: The treatment failed, not you.

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

Please remember that much of the research that has been applied to pregnant people who use drugs is problematic. Studies seldom control for all the things that might lead to negative outcomes, such as poverty, racism, trauma, poly-substance use, poor nutrition, or other conditions.

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.

- **MAKE HEALTHY CHOICES**

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

HARM REDUCTION
strategies for parents

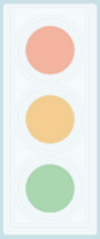
Record how much you use. This can help you reduce your use, even if that was not your original goal.

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

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

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

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



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

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

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

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

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

NATIONAL HARM REDUCTION COALITION

Academy of Perinatal Harm Reduction

harmreduction.org

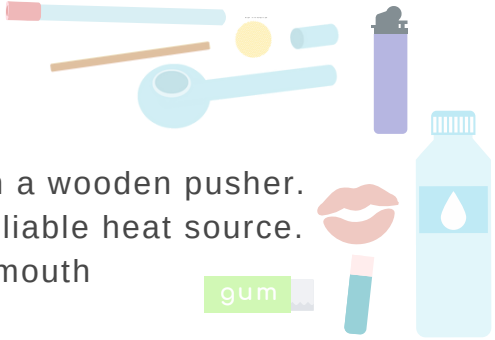
perinatalharmreduction.org

TIPS FOR SAFER USE

Empower yourself and the people you care about.
Learn what you can do to reduce the risk - and
increase the benefits - associated with substance use.

- **Know where what you're using came from**. Ask questions.
- **Don't use alone**. Use with someone you trust.
- **Use in a safe place**, like at home or at an overdose prevention clinic.
- **Take control** of what you use, how much you use, and how you use it.
- **Learn how to test** powders and pressed pills for **fentanyl and xylazine.**
- **Start with a small amount. Start Low. Go slow.**
- **Rest, stay hydrated, eat healthy.**

If you are smoking with a glass pipe, please remember:



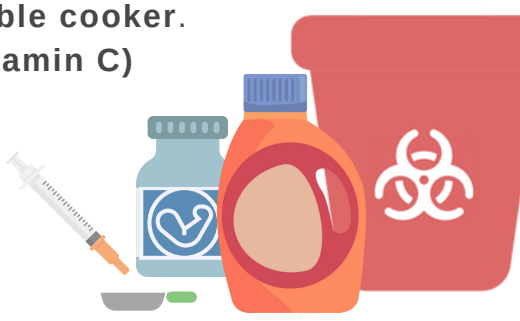
- **Use your own mouthpiece or pipe** to prevent infections.
- Keep particles out of your lungs. **Put filters in place** with a wooden pusher.
- **Use PYREX® blend (borosylicate) pipes** and a good, reliable heat source.
- **Drink water**, **use lip balm**, and **chew gum** to keep your mouth and lips moist and to help prevent cracks or blisters.

If you are snorting, please remember:

- Look at your drugs. Do they **smell, feel, and taste** like they should?
- Snort off of a fresh, **clean surface**.
- **Use a clean, new, disposable straw or spoon** - don't share.
- **Rinse your nostrils**. If they get irritated use lip balm or vitamin E oil.

If you are injecting, please remember:

- **When possible, learn how to safely** inject on your own so you don't have to depend on someone else to inject you.
- **Wash your hands** with soap and water for 20+ seconds.
- **Clean the skin** before every injection.
- Use **clean, sterile water**, a **cotton filter**, and a **disposable cooker**.
- If you need to dissolve your drugs, **use as little acid (vitamin C) as possible**.
- Use a **new syringe for each injection**.
- Use your own equipment. **Don't share**.
- Put used syringes in a biohazard container. (or other thick, plastic container with a wide mouth)



Always store your substances and equipment safely and securely away from children.

SAFE STORAGE

Learn how to securely store your medications and substances.

Keep them up and away - and out of children's sight and reach.

* Ask everyone around you to do the same.

MEDICATIONS

- Keep prescription medications in their **original, childproof containers**.
- Store methadone take-homes in their **lock box**.
- Keep a **count** of what you have.

ALCOHOL

- Keep alcoholic beverages **up, away, and out of sight**.
- **Store drinks in their original containers**,
- Don't leave **open containers** or **drinking cups** unattended.
- Lock up booze in a **liquor cabinet** or use **bottle locks**.

TOBACCO AND NICOTINE

- **Nicotine is toxic** - Keep nicotine products out of reach of kids and pets. Contact Poison Control in an emergency.
- Don't keep **nicotine gum** in your purse. Keep it in a **child-resistant container**.
- Keep vape juice and nicotine cartridges in their **child-proof packaging**.

CANNABIS PRODUCTS

- Keep your weed locked up. **Buy a box** or **bag** with a **combination lock**.
- Keep **vape cartridges** in child-proof containers between uses.
- Label **edibles** and store them **up**, **away**, and **out of sight**.
- Keep products you've bought from a **dispensary** in their original **child-resistant packaging**.

Put your medicines up AND away and out of sight

upandaway.org

In an **EMERGENCY**:

(800) 222-1222

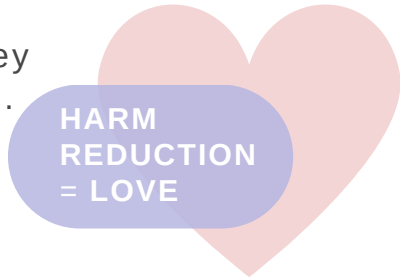
Text **POISON** to (301) 597-7137

Academy of Perinatal Harm Reduction

www.perinatalharmreduction.org

HARM REDUCTION RESOURCES in YOUR COMMUNITY

NeverUseAlone.com
Operators stay on the phone with you while you use. They can call for help if you overdose. Free, anonymous, 24/7.
800-484-3731 | 877-696-1996



Vivent Health Lifepoint Syringe Services and Naloxone Access
Mobile vans, and delivery to your home. Case management, primary care, referrals.
10 locations - www.viventhealth.org/locations

Naloxone/Needle Exchange Locator
211wisconsin.communityos.org/addiction-helpline-guided-search

Healing Hearts, Healthy Starts at Arbor Place - Menomonie
Even with the nation's focus on the overdose epidemic, there continue to be barriers to treatment. Those barriers are often even greater for pregnant and postpartum people. The barriers to treatment may be substantial, but together, we can help pregnant people with opioid use disorder prepare for a safe and healthy pregnancy, delivery, and postpartum period.
www.arborplaceinc.org/health-disparities-in-pregnant-parenting-women

CAYA Clinic - Madison
CAYA uses evidence-based harm reduction therapy techniques to reduce harm associated with the war on drugs, including overdose death. We promote Any Positive Change for people who use drugs. We provide services to all regardless of health insurance. Care plans integrate harm reduction supplies, licensed therapists, and peer services. CAYA serves marginalized communities through programs created and staffed by people from their own communities.
www.cayaclinic.com/home
608-844-8473 | admin@cayaclinic.com

Bad River Harm Reduction - Odanah + NEXT Distro Mail Order
Access is not limited to tribal members. If you need supplies, we'll work to get you supplies. Given the fact that people who use drugs are typically generous with each other and have formed community around providing access to harm reduction supplies without regard to race, gender or political status, it makes sense for us to mirror this approach.
www.badriverharmreduction.org
www.nextdistro.org/widistro

NOTES:

ALCOHOL

ALCOHOL + PREGNANCY

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

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

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

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

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

Some of the **potentially permanent effects of FASD** include organ defects, limitations in thinking, reasoning, and learning.

ALCOHOL + LACTATION

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

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

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

ONE SERVING OF ALCOHOL

12 oz
BEER

8-9 oz
MALT LIQUOR

5 oz
WINE

1-2 oz
LIQUOR

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

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

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

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

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

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

ALCOHOL WITHDRAWAL

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

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

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

RESOURCES AND TOOLS

Sunnyside: Alcohol Tracker app

Sunnyside is a free alcohol tracking, planning, and coaching app focused on mindful drinking and moderation, not sobriety. It can help you reframe your relationship to alcohol by helping you set your goals around alcohol use, make a personal plan, track your drinking, and get support.

www.sunnyside.com

Moderation Management (MM)

Moderation Management is a not-for-profit alternative to 12-step groups offering advice and support to those seeking to limit, moderate, or abstain from alcohol usage.

www.moderation.org

ReThinking Drinking

At the time of writing, National Institute on Alcohol Abuse and Alcoholism is one of several agencies which are planned to be absorbed into the proposed Administration for a Healthy America (AHA). There is no website for AHA, and the timeline of changes is unknown.

www.rethinkingdrinking.niaaa.nih.gov

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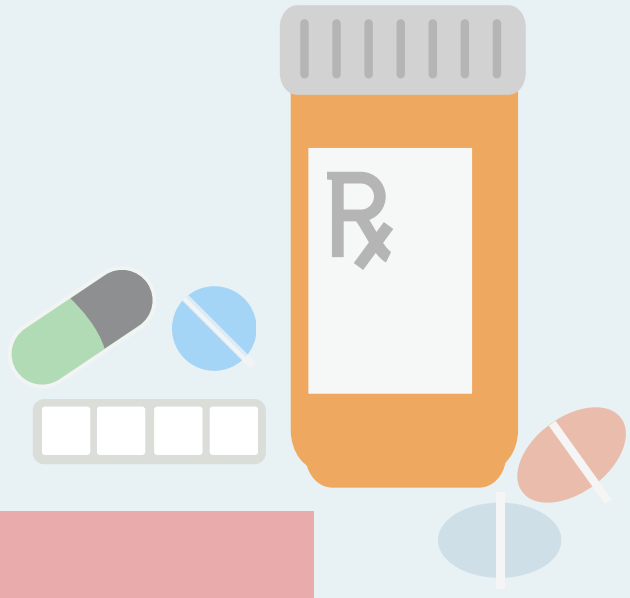


BENZODIAZEPINES

BENZODIAZEPINES + PREGNANCY

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

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

Possible lower birth weights among people who take these medications could be related to sleep deprivation, and not the drugs.

Because people use benzodiazepines for sleep problems it's difficult to know for sure. [9]

Newborns who are given benzodiazepines in the NICU have shown withdrawal signs.

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

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

BENZODIAZEPINES + LACTATION

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

Not all benzodiazepines are the same. Some are safer than others while breastfeeding. For example, lorazepam is safer than diazepam. See LactMed.

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

What treatment options are available for dependence on benzodiazepines?

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

If you are using benzodiazepines 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. Some people have withdrawal symptoms like seizures.[11] So it's important to **decrease the dose gradually (taper off) with the help of a healthcare provider**.

CANNABIS

CANNABIS + PREGNANCY

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

For example, some studies find mild negative effects on newborn development while others find mild positive effects. And some find no effects.[12, 13] **Long term outcomes for babies exposed to cannabis appear similar to other children** in the same peer group.

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

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

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 other factors, including smoking.[16]

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

CANNABIS + LACTATION

Roughly 1% of the cannabis you consumed passes into your milk.[17, 18] Infant absorption is poor, so infants only absorb about 1% of that through their digestive system.[18, 19] This means the dose infants gets is roughly one thousand times less than the parents' dose. However, even that small of an exposure **can still be enough to cause a positive result on a urine drug screen**.

Experts agree that the safest choice is to stop recreational use completely while lactating.[5, 14, 20-22] If you use cannabis while chestfeeding, use harm reduction methods like using less, vaping or edibles instead of smoking, and making sure there's someone to help watch the baby if you're intoxicated.[13, 23]

Human milk is made for babies and is better for them than formula. The **best** option is to stop using cannabis while lactating. The **better** option is to breastfeed. **"Least preferable is continuation of marijuana use in conjunction with (formula) bottle-feeding."**[19] There are many reasons you may use formula, but concern about medical complications of cannabis exposure should not be one of them.

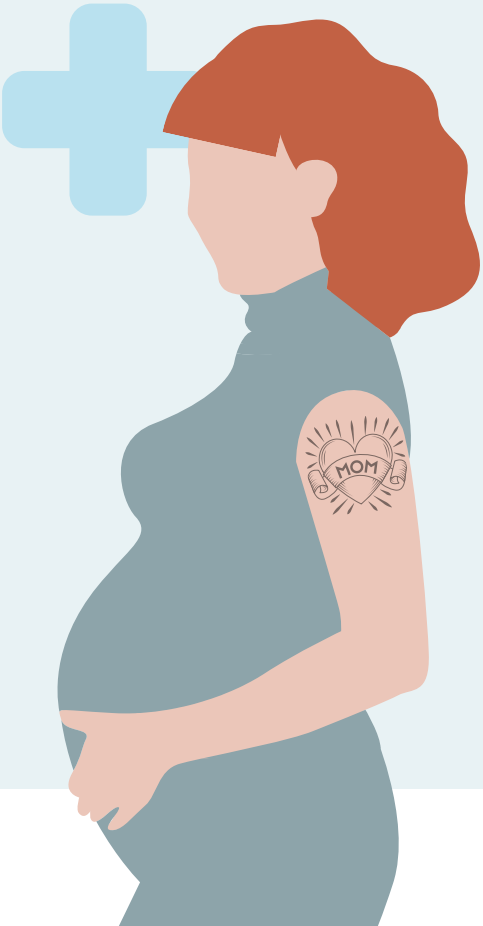
What treatment options are available for cannabis use disorder?

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

If you were using cannabis to medicate for pain, anxiety, or nausea discuss with your healthcare provider whether or not there is a **safer method for treatment**.

Many people who continue to use cannabis during pregnancy - including those who use it daily - may 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 any formal treatment, but others have found **counseling** or **group therapy** to be helpful.



CANNABIS LAW IN WISCONSIN

Cannabis use is criminalized in Wisconsin. There is no exception for medical use.

The law specifically prohibits “tetrahydrocannabinols”, commonly known as THC. However, medical use of pharmaceutically processed cannabidiol, or CBD, is allowed when taken as prescribed by a doctor. § 961.14(4)(t) & 961.01(14)

Since 1965, citizens have voted to decriminalize cannabis all over the state. Many of these laws change the penalty from arrest and imprisonment to a fine, similar to a parking ticket. In recent years, voters in many parts of Wisconsin have disputed cannabis criminalization by setting the fine at $5 or less.

A 2024 poll[129] of Wisconsin voters found that 86% were in favor of medicinal use and 63% were in favor of recreational use. It is unknown when and if Wisconsin lawmakers will enact a change in the laws regarding cannabis use.

WHEN YOU'RE PREGNANT

The American College of Obstetricians and Gynecologists (ACOG) says, "Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties for marijuana use, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing"[14] and recognizes that "...patients should also be informed of the potential ramifications of a positive screen result, including any mandatory reporting requirements."[14] Regardless, testing, reporting, and subsequent punishment are standard practice not only in Wisconsin, but even in legal states.

IF YOU'RE A PARENT

Wisconsin law defines prenatal alcohol, cannabis or other criminalized drug exposure as child abuse. There is no requirement to prove harm. A positive maternal or infant urine test is enough to a activate the chain of events that starts with a report and often ends with child removal. § 961.14(4)(t) Changing the law is a necessary step, but even in legal states, people who use cannabis are vulnerable to losing their housing, jobs, and children. To stop the harm, we must challenge and reject the assumption that the contents of someone’s urine is an accurate measure of their parenting ability.

RESOURCES AND TOOLS

SAMHSA: Marijuana and Pregnancy - Know the Risks

This website can give you insights into how you may be counseled by some providers if you disclose your cannabis use. SAMHSA models their recommendations after the American Academy of Pediatrics guideline.[129] These resources are examples of how many people understand and interpret the evidence about cannabis use while pregnant or parenting.

www.samhsa.gov/substance-use/learn/marijuana/pregnancy

American Academy of Pediatrics: Marijuana Use During Pregnancy and Breastfeeding - Implications for Neonatal and Childhood Outcomes

Previous guidelines from AAP included cannabis in a general prohibition of “street drugs”. This guideline continues to recommend prohibition of cannabis and other criminalized substances.

publications.aap.org/pediatrics/article/142/3/e20181889/38625/

Elephant Circle is a reliable source of accurate information. These publications by Heather Thompson, MS, PhD, molecular and cellular biologist, clinical researcher, birthworker, and queer parent:

- 10 Facts to Know about Cannabis and Human Milk
- Molecules 101: The Molecules involved in Cannabis Ingestion, Metabolism, and Detection
- Fetal Exposure to Cannabis: A Review of the Literature

www.elephantcircle.net/dataresearch

NOTES:

OPIOIDS

OPIOIDS + PREGNANCY

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

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

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

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

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

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

OPIOIDS + LACTATION

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

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

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

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

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

- methadone
- buprenorphine
- naloxone
- naltrexone

INFORMATION ON MEDICATIONS, PREGNANCY, AND LACTATION

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

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

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

Treatment for opioid use disorder with **methadone, buprenorphine, or a buprenorphine-naloxone combination medication is safe for pregnancy and lactation** and is the first-line standard of care treatment for pregnant people. All of the different forms of buprenorphine are safe for treatment of pregnant people.[40-43]

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

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

SEE the section on naltrexone for more information.

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

Starting buprenorphine or methadone during pregnancy can vary by state and region. Some healthcare providers might require you to **go to the hospital for monitoring** and others might make a plan with you for **microinduction it at home**.

NALTREXONE

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

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

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

Naltrexone is less likely to be effective in reducing substance use than methadone and buprenorphine and comes with side effects, including **increased vulnerability to death by overdose**.[44-46] Starting naltrexone requires a person to detox completely before the first dose to avoid severe precipitated withdrawal.[45, 47] Some people with OUD find naltrexone to be helpful, but many others have a hard time sticking with this treatment.[45] Long-acting opioid blockers (such as Vivitrol) can be a problem for anesthesia and pain control during unexpected surgeries such as a C-section for premature labor, because many anesthesia medications are opioids.[45-47, 5, 55] N**altrexone lowers people's tolerance for opioids, so they have increased risk for overdose if they use opioids**. Some people may try to overcome the opioid-blocking effects of naltrexone by taking larger doses of opioids, which also increases their risk for overdose.

NALTREXONE (CONTINUED)

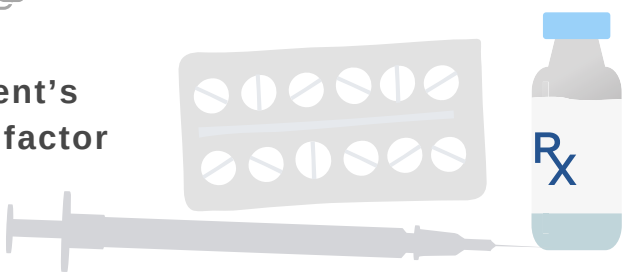
It is not recommended to start treatment with naltrexone during pregnancy.[45] If a patient with OUD becomes pregnant before seeking treatment, agonist treatment should be offered as the first-line gold standard, and naltrexone should only be available after a thorough risk/benefit discussion with a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

Providers should work with pregnant patients to **frequently re-assess satisfaction with treatment** and evaluate whether a switch to an agonist medication would be beneficial.

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

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

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



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

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

NEONATAL OPIOID WITHDRAWAL (NOW)

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

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

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

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

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

DETOX

MEDICALLY-SUPERVISED WITHDRAWAL

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

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

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

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

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

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

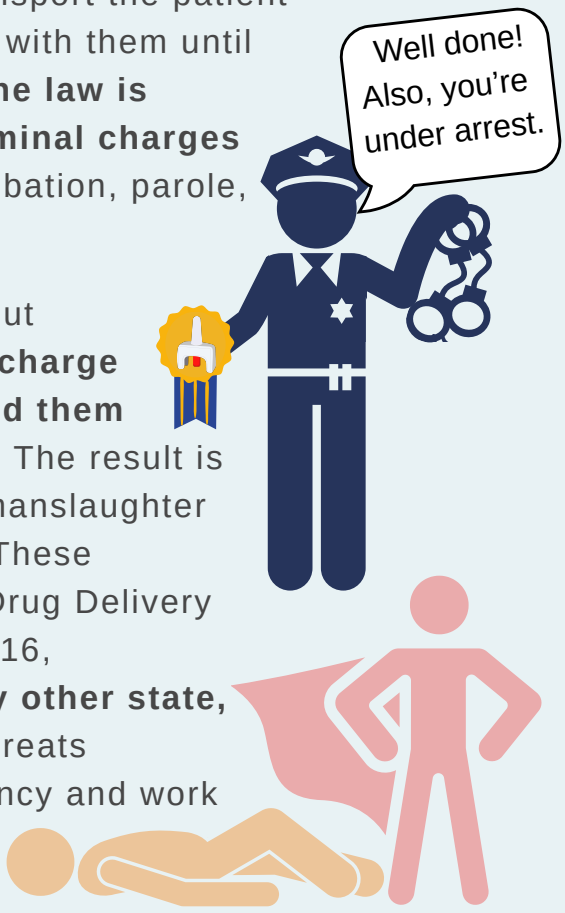
NOTE: *Opioid agonist therapy (OAT) is one type of medication for opioid use disorder (MOUD). You may see either term being used.*

Good Samaritan Laws: Immunity From Certain Drug Charges for Overdose Responders

These laws are intended to encourage people to call for help when someone has an overdose. Many people who use drugs avoid calling 911 because of justified fear of criminalization when dispatchers send police instead of or in addition to Emergency Medical Services. To be effective, these laws would need to protect not only against drug charges, but for all acts, omissions, or associations that could result in targeting for punishment from the state.

Good Samaritan Laws in Wisconsin Wis. Stat. Ann. § 961.443

For the rescuer or "aider", Wisconsin's Good Samaritan law protects **only** from prosecution for possession, paraphernalia, and masking agents, but **does not protect from arrest or criminal charges,** and does not protect against arrest, charges, or prosecution related **to a warrant,** a charge other than possession, paraphernalia, or masking agents, and other forms of state violence, such as threats to child custody, housing, immigration status, or employment. **There are no protections in the law for the person who overdoses**. To access immunity, the aider must do at least one of the following three things: 1. Call 911; 2. summon a law enforcement officer or healthcare provider; or 3. transport the patient to a healthcare facility. Ideally, the aider would stay with them until help arrives. However, because **protection under the law is incomplete, they are vulnerable to arrest and criminal charges** if they have drugs in or on their body, a warrant, probation, parole, other supervision, or a criminal record.



Unfortunately, Wisconsin sends mixed messages about saving a life. There is law that allows prosecutors to **charge anyone who gave, sold, shared, prepared or helped them get or take the drugs they used prior to overdose**. The result is that friends and family are sometimes charged with manslaughter or murder for common behaviors like sharing drugs. These charges are called Drug Induced Homicide (DIH) or Drug Delivery Resulting in Death (DDRD). Every year from 2011-2016, **Wisconsin charged more people with DIH than any other state, and many were imprisoned for decades.**[132] These threats discourage people from calling for help in an emergency and work against the goals of the Good Samaritan law.

Naloxone (Narcan®) is a medicine that reverses overdose from opioids including heroin, fentanyl, 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.

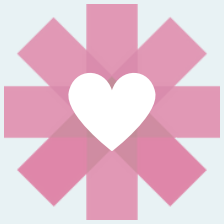
OPIOID OVERDOSE + PREGNANCY (CONTINUED)

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.

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

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



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

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

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

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

  You do not need to tell them that this may be a drug poisoning or overdose. If you do they may send police officers.
- **Stay with the person** or find someone who can.
- **Tell the responders that the person takes opioids** and may have taken too much and overdosed.

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

NOTES:

If I have to use opioids alone...

I will call this person or hotline to make sure I don't overdose

I prefer my naloxone to be given by: Nasal Spray | Muscle Injection

I keep my naloxone and other overdose prevention supplies:

The instructions for using it are kept:

Look at the next page for instructions on how to save my life - and my baby's life - if I overdose.

I may have them on the phone already, but if not, you can call for help administering the naloxone.

- 800-484-3731 | 877-696-1996

OPIOID OVERDOSE + PREGNANCY

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

1. NARCAN 2. RESCUE BREATHS 3. GET HELP

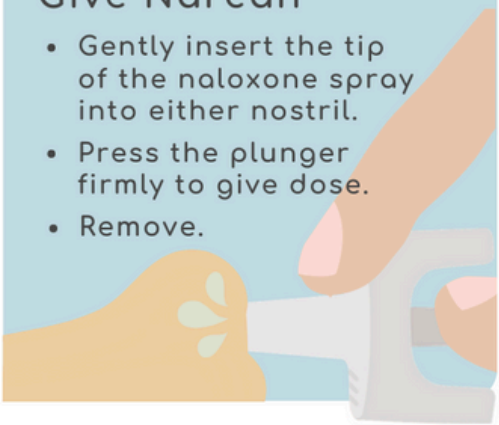
An overdose slows or stops breathing and keeps oxygen from getting to the body and brain.

Check for breathing

* Give rescue breaths.

Give Narcan

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



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

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

Get Naloxone www.naloxoneforall.org

Call 911

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

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

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

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

When help arrives...

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

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

Academy of Perinatal Harm Reduction

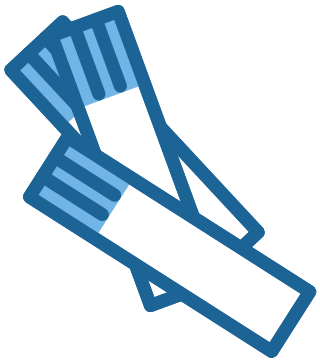
www.harmreduction.org

www.perinatalharmreduction.org

NATIONAL HARM REDUCTION COALITION

CONTAMINATION

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



FENTANYL AND CARFENTANYL

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

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

XYLAZINE

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

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

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

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

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

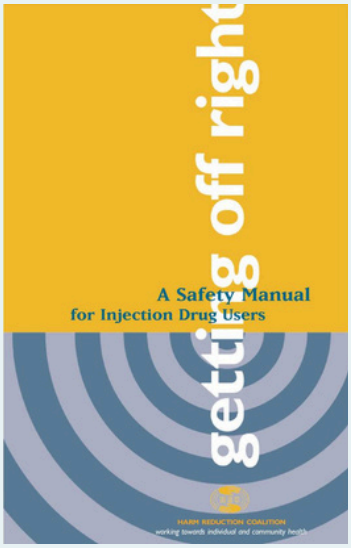
IF YOU SUSPECT AN OVERDOSE

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

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

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

TAKE STEPS TO PROTECT YOUR HEALTH



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

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

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

RESOURCES AND TOOLS

Wisconsin 211 Hotline 24/7

Call, text, or online chat 24/7. Whether you're seeking a food pantry, utility assistance, substance use services, housing help, mental health supports, a safe haven from intimite partner violence, or other local services, 211 operators can help. Our specialists are good listeners, offering a friendly ear, information, and local referrals so you can accomplish your goals.

Text your zip code to **898211**
Call 211
Chat 211wisconsin.communityos.org/

SAMHSA's National Helpline

SAMHSA's National Helpline is a free, confidential, 24/7 service in English and Spanish for people facing mental and/or substance use disorders.

www.samhsa.gov/find-help/national-helpline
1-800-662-4357

NeverUseAlone.com operators stay on the phone with you while you use. They can call for help if you stop responding. Free, anonymous, 24/7.

Call: 800-484-3731 | 877-696-1996

Naloxone Administration Training Videos from NEXTDistro.org

Español
Intramuscular | Intranasal

English
Intramuscular | Intranasal

NOTES:

STIMULANTS

STIMULANTS + PREGNANCY

While all of the risks associated with stimulant use during pregnancy are not entirely clear, we do know that they haven't been communicated accurately. Much of the reporting during the so-called “crack baby epidemic” of the 1980s and 1990s was incorrect, racist, and destructive. These stories were used to justify **disproportionately targeting and criminalizing Black parents** and families and **resulted in the forced separation** of parents and children. [70]

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

Overdosing or overamping on amphetamines can stress pregnant people's bodies. While it is rare, it is possible to die from cocaine or methamphetamine use because these drugs can cause stress to the heart. **The risks associated with stimulant use are greater when they are used in combination with other substances.** Polysubstance use - using more than one substance at a time - greatly increases the risk of overdosing.

Responding to Stimulant Overamping

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

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

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

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

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

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

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

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

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

HIGH BLOOD PRESSURE

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

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

.

STIMULANTS + LACTATION

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

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

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

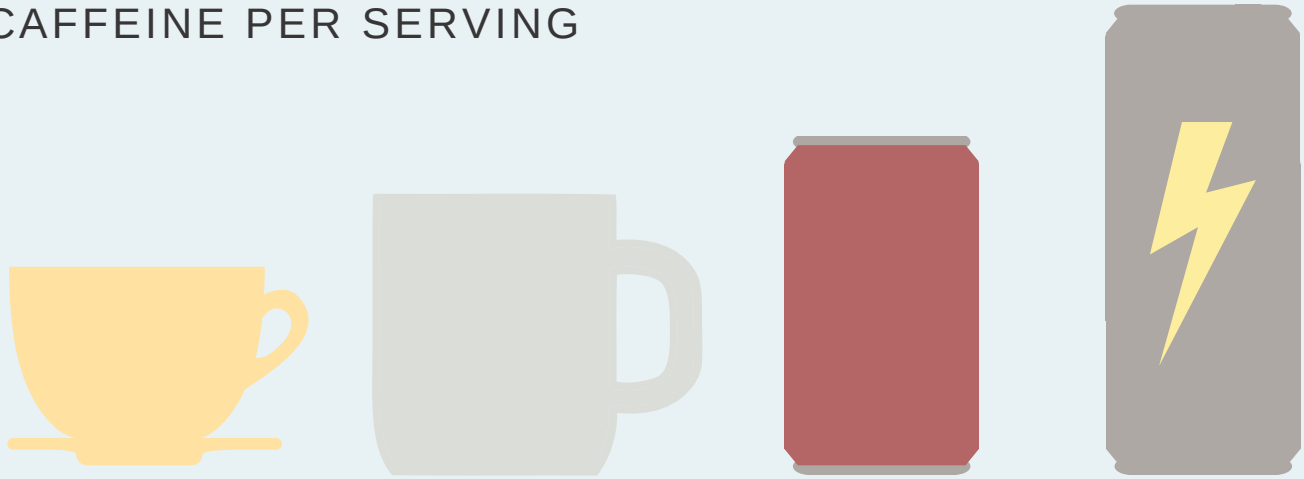
- 1 to 2 cups of regular coffee (8 oz)
- 5 cans of soda (12 oz)
- 2 cans of energy drink (250 mL)

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

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

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

CAFFEINE PER SERVING



8 oz black tea
50-70 mg

8 oz coffee
100-200 mg

12 oz soda
40-100 mg

250 mL
energy drink
100+ mg

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

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

However there are some "off label" uses of medications that may be helpful. **The off-label use of medications is common and is the norm for medication taken during pregnancy and lactation because few drugs are tested on pregnant and lactating people.** Off-label prescribing is when a physician gives you a drug that the U.S. Food and Drug Administration (FDA) has approved to treat a condition different than your condition or a drug that has been approved for your condition - but not 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.[95]

Connections is an app from Arbor Place and CHESS Health supports recovery through human connections, skill building, and contingency management.

Android | Apple

Contingency Management

RESOURCES AND TOOLS

SAMHSA's National Helpline

SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.

www.samhsa.gov/find-help/national-helpline

1-800-662-4357

NEXT Distro

NEXT Distro is an online and mail-based harm reduction platform designed to reduce drug overdose death and drug-related health issues in rural and suburban communities.

www.nextdistro.org/getnext

Here to Help

Find mental health and substance use information you can trust from the BC Partners for Mental Health and Substance Use Information.

www.heretohelp.bc.ca/methamphetamine

NOTES:

TOBACCO + NICOTINE

TOBACCO + NICOTINE + PREGNANCY

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

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

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

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

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

✳ What you vape matters.

Make sure your vaping products come from a reliable source. Unregulated cannabis vape juices contaminated with vitamin E acetate were strongly associated with serious lung injury starting in 2019.[117]

TOBACCO + NICOTINE + PREGNANCY

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

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

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

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

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

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

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

TOBACCO + NICOTINE + LACTATION

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

Nicotine and other harmful substances in cigarettes can be passed to the baby through human milk.[21, 106]

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

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

CHILDREN + SMOKE EXPOSURE

Children who are exposed to second-hand or third-hand smoke (residue left on clothes or surfaces in the home) can have increased risks of ear infections, coughs, colds, breathing problems (asthma, bronchitis and pneumonia), and tooth decay. Ongoing exposure to the cancer-forming chemicals in cigarette smoke or vapor can also increase risks for breathing difficulties.

Children with these exposures may grow up to have increased risk of cataracts, heart and lung disease, and asthma.

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

What treatment options are available for people who are pregnant?

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

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

SMOKING CESSATION: HELP QUITTING

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

Smokefree Women

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

Smokefree: Pregnancy and Motherhood

- Quitting While Pregnant
- Smokefree Motherhood

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

LIVE CHAT ON WEBSITE

More support:

Quash
A logical plan for quitting

Kwit
#1 stop smoking app

EX
Free, 24/7 support

Not on Tobacco (N-O-T)
Teen Cessation Program

HARM REDUCTION: VAPING + E-CIGARETTES

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

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

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

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

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

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

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

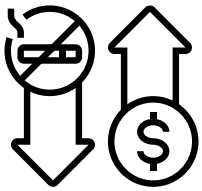
RESOURCES AND TOOLS

Wisconsin Tobacco Quitline

quitline.wisc.edu

You're in control. We go at your pace. Just want info? Want to just cut down? We got you. Open to Wisconsin residents 13 and older.

Adults over 18 can get **free medications** in the mail for up to 12 weeks. Options include **gum, patches, or lozenges**.



- Quit coaches **available 24/7**: 1-800-QUIT-NOW (1-800-784-8669)
- En Español: 1-877-266-3863
- Text READY to 34191

American Indian Quitline

1-800-7AI-QUIT (1-888-724-7848)

Coaches have a deep understanding of **native culture and commercial tobacco.**

Freedom From Smoking

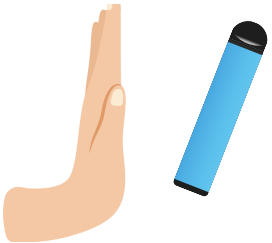
Freedom From Smoking® is a flexible online course by the American Lung Association. They provide workbooks, resources, and support groups to help you reach your goals.

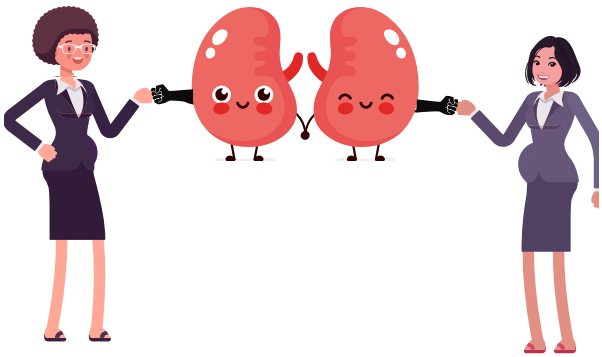
1-800-586-4872
www.freedomfromsmoking.org

Live Vape Free

livevapefree.com

This program offers judgement-free support and powerful resources for young people 13-26.



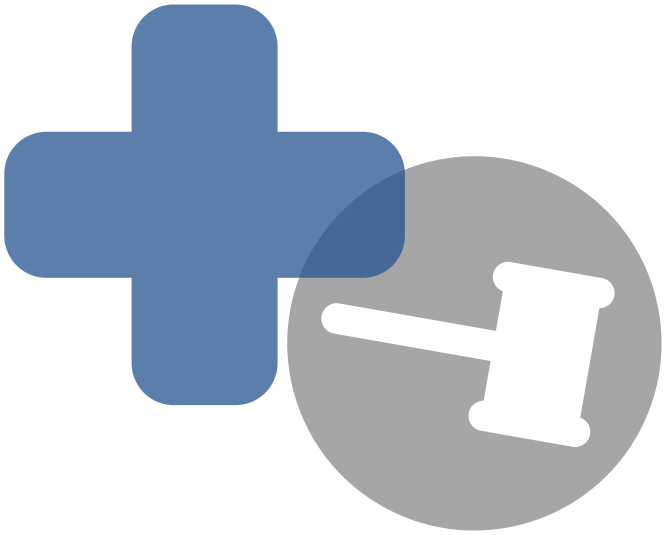


Smokefree: Pregnancy and Motherhood

www.women.smokefree.gov/pregnancy-motherhood

Quitting at any stage of your pregnancy is the best thing that you can do for you and your baby. Being prepared can help you succeed.

SECTION 3



NAVIGATING THE HEALTH CARE + LEGAL SYSTEMS

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

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

You may be worried about **what could happen if you are open and honest with your providers about your substance use.** Telling providers about your substance use can begin a reporting process that ends in family separation.

On the other hand, **you might be worried that if you don't disclose your use, someone may find out anyway.**

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

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

Please understand that laws and statutes will **vary widely by state** and some providers, hospitals, and agencies might **interpret the law differently than it is written**. Please **consult with local agencies** that have expertise in how things work where you live.

You can use this information to:

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

GATHERING INFORMATION

If you decide to call a hospital, treatment center, or CPS office for information:

- They can only make a report if you give your name and details about your pregnancy or children.
- If you call “about a friend”, and do not give them a name, they will not be able to make a report. **You may consider calling from a public phone** or a number that is not linked to your name.
- **Ask for information about their policies on testing/reporting, what services they offer, and how many babies go home with their parents.** These policies are different in each county and even between each facility in the same county.

IF YOU ARE BEING INVESTIGATED:

See page 89 to find legal help in Wisconsin

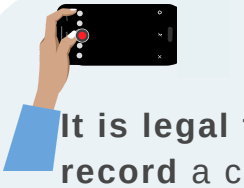
- Ask what the allegations are against you and if you are being investigated for "abuse" or "neglect"
- Ask when and how you are alleged to have abused or neglected a child
- Be polite and courteous, but **say as little as possible** - Don't help the investigators - Don't say more than you need to
- **Never invite a CPS social worker or investigator into your home** unless they have a warrant or court order - If someone insists on searching, say "I do not consent to a search."
- **Do not open the door** and allow the CPS worker to look into your home. If you do they may say that they see something that creates an “emergency situation” even if it is not true - If you invite an investigator into your home, you have just waived your federally-protected fourth amendment constitutional protection to be free from unreasonable searches.
- Record your interactions with CPS, and take notes each time - ask your friends, family members, and providers to do the same - This is especially important for any conversations CPS has with your children - Provide your own recorder and keep your own copy.

While you can refuse to talk to CPS investigators, it may hurt your case if you are labeled “non-cooperative.”

IF YOU ARE BEING INVESTIGATED CONT.

If you are being accused of medical neglect or physical abuse, have your child's pediatrician or other medical providers do a thorough exam of your baby and children.

If you allow your child to be interviewed, **they have the right to have someone present** when the investigator interviews them if it will make them feel more comfortable.



It is legal to record a conversation in Wisconsin **only if you are part of the conversation**. You are not required to ask or tell the other person in most cases, but it is the courteous thing to do. If you want to record a conversation you are not a part of, you need to ask permission.

You should provide any and all information that supports your case. This includes information from your medical providers and support team. **CPS has a constitutionally mandated duty to gather and consider all available evidence in your favor**. To ensure CPS meets this duty, you can provide any evidence you might have that may help to show you did not abuse or neglect a child. You are entitled to provide the contact information for people you think can support your case. CPS investigators are required to speak to at least two people who you identify as character witnesses before making a decision in your case.

If you become involved in juvenile or family court proceedings:

- Ask who your assigned public defender is and contact them.
- Before agreeing to a CPS Service Plan or Safety Plan, be sure to speak with your attorney, even if they say the plan is “voluntary”.

Many families have reported that they have had challenges with receiving their CPS service plan in a timely fashion, understanding the requirements, obtaining the appropriate referrals to service providers, and reaching their caseworkers. This has sadly resulted in family separation or in delays in reunifying with their children. Don’t wait until the last minute; contact your worker early and often. If they don’t answer, leave a message, write down the date and time you called, and keep it with your records.

GETTING PRENATAL CARE SHOWS YOU CARE

Getting prenatal care improves outcomes for both you and your baby. Ideally, every healthcare decision you and your providers make - you make together. And you make them with your best interest in mind.

We know that substance use and dependence can cause health problems that may or may not be obvious. We believe that a provider that is informed about all aspects of your health - including your substance use - is better able to provide the care that is most appropriate for you. But you need to trust each other.

If your provider understands your substance use they may be able to provide support, offer you better care, connect you with services, and help you reach your goals.

For example, if you're dependent on opioids, you may be ready to start treatment with methadone or buprenorphine which can help keep you safe from risks of illicit use.

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

NOTES:

DRUG TESTING + INFORMED CONSENT

Some 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 they're being done, and how the results will be used.

Ideally, you should be given a written document to sign before any tests are done. Then you should be able to ask questions and get answers.

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.

Your newborn may be legally tested without your consent if they suspect that the baby could experience negative effects from substance exposure. **Reasons for doing the test without parental consent should be documented in the baby's health record.**

Patient gave informed consent.

Drug screen was discussed.

WHAT THE TEST DETECTS:

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

TYPES OF DRUG TESTING (TOXICOLOGY)

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

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

The Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetricians and Gynecologists (ACOG), and other expert medical associations agree that any rapid (1-4h) screening result is considered unconfirmed, or “presumptive”, and **should be confirmed** with a 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 and 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

DISCLOSURE:

TALKING TO YOUR HEALTHCARE PROVIDERS ABOUT SUBSTANCE USE

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

90
for mandatory reporting guidelines.

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

This means that if a pregnant client tells their provider they’re using drugs, there’s a chance this information will be shared with Child Protective Services (CPS) or even law enforcement without their consent. And unfortunately, anyone can make a report to CPS - even if they are not directly involved in your care. This includes nurses, doctors, lactation consultants, friends, family members, neighbors, or strangers.

Sometimes people make reports because they think it will help.

DISCLOSURE

Ideally, a report should lead to parents being provided with extra resources and support. However, that's not what typically happens.

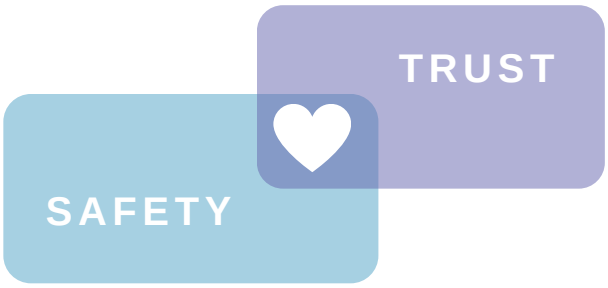
In most cases the result is agency surveillance (for example: unannounced home visits, speaking with friends and family) and removal of the baby and any other children from the parent's custody. **THIS CAUSES HARM.**

Because of this, **people often choose not to disclose** their substance use to their providers.

Instead of building confidence and trust, our past experiences, the experiences of our friends and family, and media stories lead us to **fear for our safety** and mistrust healthcare systems.

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

Some providers say they are more likely to be helpful, supportive, and understanding when you tell them about your substance use. Others distrust people who use drugs and treat them poorly no matter how they find out about your substance use.



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 only you can make based on how you think your provider will respond.

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

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

If a report is made and it becomes an investigation, **your prenatal providers could be required to talk** about your substance use. But this can also be an opportunity for them to advocate for you.

A good provider will talk about **your strengths, share your successes, and collaborate with you** to help you plan for your and your family's safety.

See page **87** for information about **Plans of Safe Care**

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

AFTER YOUR BABY IS BORN

Once your baby is born, if any of the providers suspect the baby might be substance exposed, **they may legally test the baby without informing you** - even though this is unethical. If your baby's bodily fluids or tissues test positive for a substance, it could be used against you.

FREE DOWNLOAD

My Birth Plan

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

perinatalharmreduction.org/create-a-birth-plan

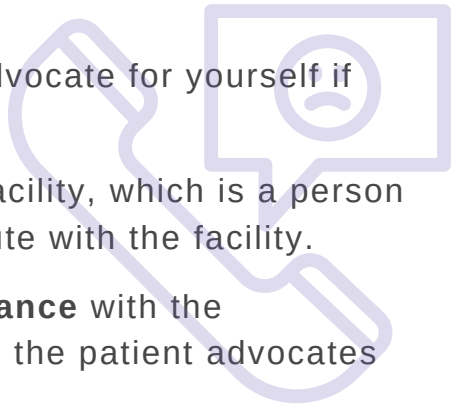
IF THERE ARE PROBLEMS

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

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

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

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



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

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

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

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

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

Find legal help on **page 89**

NOTES:

FEDERAL LEGISLATION THAT MAY AFFECT YOU:

CHILD ABUSE PREVENTION AND TREATMENT ACT

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

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

But some child welfare workers may open a case and start an investigation based solely on use of criminalized substances and not because there is evidence of abuse or neglect.

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

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

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

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

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

If a report is made to child welfare, it should be done with your consent and your participation - and it should highlight your strengths.

ADVOCATING FOR YOURSELF

We believe that people who use drugs (PWUD) love their children and deserve the same rights as any other parent, including:

- the **right to bodily autonomy** - to have power and agency over how we use our bodies
- the **right to have children**
- the **right not to have children**
- the **right to parent in a safe and healthy environment** that we choose

www.sistersong.net

We believe these rights are not conditional; **we don't lose these rights because of what we put in our bodies.** A drug test is not a parenting test.

You deserve to be seen as whole person who is worthy of dignity and respect - and you deserve a supportive community. That is the basis of Reproductive Justice.

PLANS OF SAFE CARE

If you have used substances during your pregnancy, it helps to build a **supportive network of people who can help you navigate both the legal and family surveillance systems**. This can include friends and family, social service providers who work with people who use drugs, as well as doulas and birth workers.

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 of Safe Care before delivery.

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

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

If you believe that a report will be made and a case will be opened, **reach out to a legal group in your area to get connected to a lawyer**.

NOTE: A Plan of Safe Care (POSC) is different from a CPS Safety Plan which is made when you are being investigated for child neglect or abuse.

Learn more and create your own POSC on **page 90**.

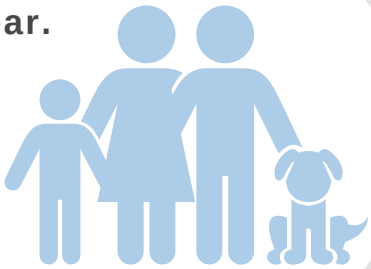
WISCONSIN LAW

See: docs.legis.wisconsin.gov/

Wisconsin Act 292: Loertscher v. Anderson

In 2017, Tammy Loertscher **was arrested and jailed for 18 days** under Act 292* because she refused to go to a drug treatment facility and was accused of endangering her “unborn child”. She refused, saying that she didn’t need treatment because **she had stopped using drugs** as soon as she found out she was pregnant, which was onfirmed by urine testing.

After baby Harmonious was born, Tammy and her family moved away from Wisconsin, partly because she was unable to find work as a nursing assistant because her name was on the child abuse registry. A little while after Harmonious’ first birthday, the **Wisconsin Supreme Court decided that the law was unconstitutional**. but because Tammy now lived out of state, the case was declared to be “moot”, or no longer relevant. Eight years later, there **are still 400 Wisconsin families investigated every year.**



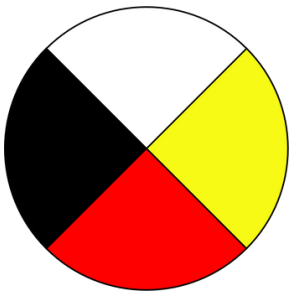
Wisconsin law calls a fertilized egg, embryo, or fetus an “unborn child” from “the time of fertilization”. We understand that this is a loaded term which is **often used to take human rights away from pregnant people** or even those who might become pregnant in the future. We will always strive to use words which are scientifically accurate, precise, and affirming to human rights, but when we are directly quoting the law or other documents, you may see some of this language.

It is difficult to know exactly what is prohibited by Act 292. The decision to open a case can be made by anyone “whose responsibilities include investigation or treatment of child abuse” and has completed 4 hours of training. The state gives these workers “**the power of police officers**” to **take physical custody of the pregnant person**. They **do not have to prove that someone used a substance**. If they believe that there is risk from suspected substance use, that is enough. Unlike the criminal system, parents **do not have the right to a lawyer in the family court system**. But there are lawyers who can help. See **page 89** for legal aid.

Loertscher v. Anderson continued

Tammy Loertscher was imprisoned under Act 292, and she appealed (requested to change) the decision all the way up to the state supreme court, which found that the **law was unconstitutional because people couldn't know what was expected of them**. But because the family had moved away, the process couldn't be finished. That is why **the law is still enforced**. **Even though it is unconstitutional,** it can still be used to open a case or take custody of pregnant people and hold them in jail or treatment, and control their decisions until they give birth.

The Indian Child Welfare Act (ICWA)



In the late 1800s, after the US failed to fully conquer Indigenous nations through war, they turned to more insidious tactics, including cultural genocide by way of forced child removal[21] and assimilation. The founder of one of the first Indian residential schools expressed the goal of "killing the Indian in him and save the man".[20]

By the late 1960s, this pattern had resulted in roughly **⅓ of Indian children taken from their families** in the name of child welfare.[22] ICWA was passed in 1978 to correct this injustice, and WICWA was passed in 2009 to facilitate and encourage compliance with ICWA.[19] Indigenous children remain 2.7x more likely than whites to be taken from their families.

Learn about ICWA from Indigenous Sources:

The Association on American Indian Affairs is the oldest national Native non-profit protecting sovereignty, preserving culture, educating youth, and building capacity.

ICWA procedures are considered the "gold standard" in child welfare. It requires the state to:

1. Look into the enrollment status of a Native child
2. Provide Tribes and parents notice in child welfare proceedings
3. Ensure that Tribes are given the opportunity to intervene
4. Transfer jurisdiction to the Tribal court.

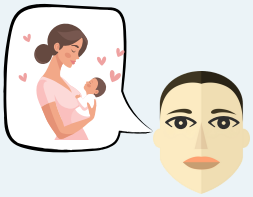
NEXT GENERATIONS Program - www.indian-affairs.org/nextgenerations.html

National Indian Child Welfare Association (NICWA) is a nonprofit uniting tribal nations, individuals, and organizations to protect Native children and families.

Podcast: This Land by Rebecca Nagle crooked.com/podcast-series/this-land
How a string of custody battles over Native children became a federal lawsuit that threatens everything from tribal sovereignty to civil rights. Season 2 does a deep dive into the 2023 United States Supreme Court case ***Haalund v Brakeen.***

Even though the law is unclear, **it's important to know what it says** - and **there are things you can do** to prepare, including collaborating with your support team to make a plan.
Create a Plan of Safe Care on page 90

A note on visuals:



Explanations of the law that are not on a legal notepad, like the paragraph above, are in our own words.

Text shown on a legal notepad is the law exactly as it is written, like the paragraph below.
In legal writing, when you are referencing a particular part of the law, the “section” sign followed by a number is used.

§ You can use this number to find the full text on the government website, or in the statute book, which can be found in a public library or government office.

Wisconsin Definitions

Child abuse is defined as non-accidental injury, emotional damage, sexual assault, exploitation, or trafficking, manufacturing meth near a child or on the same property where a child lives, and drug use while pregnant.

(1)(am) When used to refer to an unborn child, (abuse means) serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree.

Wis. Stat. Ann. § 48.02

(12g) “Neglect” means failure, refusal or inability on the part of a caregiver, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child.

Wis. Stat. Ann. § 48.02

A drug test on a pregnant or birthing person is NOT required by law. If verbal screening indicates the need for a drug test, providers should ask for and get informed consent prior to drug testing a pregnant or birthing person.

Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals - www.ifwhenhow.org

No physician may test an expectant mother without first receiving her informed consent to the testing.

Wis. Stat. Ann. § 146.0255(2)

This means that you have the right to understand the reasons for any tests done on you (urine, hair, placenta, etc.), the right to understand what will happen if you test positive, and the right to refuse testing.

We have heard from families in Wisconsin that **CPS sometimes requests to see past drug test results or requires you or your children to be randomly tested** during an investigation.

Although the law says you have the right to refuse, **many people report that they were tested without their knowledge or consent**, or that refusing to test can be treated the same as a positive test by some providers, judges, and CPS workers. Ask what tests are being done on you and how the results will be used.

The **physician may test the infant** … if the physician determines that there is a **serious risk** that there are controlled substances or controlled substance analogs in the bodily fluids of the infant … and that **the health of the infant … may be adversely affected** by the controlled substances or controlled substance analogs.

Wis. Stat. Ann. § 146.0255(2)

This means that hospital workers can legally test a newborn without the parent's consent if they suspect that the baby could experience negative effects from substance exposure. They should always inform you. **Reasons for doing the test without parental consent should be documented in the baby's health record.**

Tammy reported that she was told in jail that they **would not allow her to take her thyroid medicine or see a doctor unless she gave a urine sample**.

Mandated Reporting

Wisconsin requires many kinds of workers to be mandated reporters, including doctors, nurses, social workers, teachers, and so on.

Remember, **anybody can make a report.** The messaging from most employers, governmebr agencies, and other organizations tends toward “when in doubt, report”, so non-mandated professions (all adults really) can be considered “encouraged” reporters. Just be thoughtful about who you share information with.

CPS policy says that **mandated reporters cannot report anonymously**, and must give their name. Other reporters can be anonymous, such as a neighbor or family member.

Testing on a newborn is only required by law if a hospital employee, social worker, or intake worker who provides health care suspects that an infant has a fetal alcohol spectrum disorder.”

A physician **must report** a FASD diagnosis to the Department of Children and Families. This is not a child abuse or neglect report.

If a pregnant person is drug tested and the result is positive, **a child abuse report is required** by state law **only** if there is:

“Serious physical harm inflicted” on a fetus or, “ the risk of serious physical harm” to the child at birth “caused by the habitual lack of self-control” of the expectant parent “in the use of alcohol beverages, controlled substances, or controlled substance analogs, exhibited to a severe degree.”

Because the law only requires reports for a “habitual lack of self-control” and “severe degree” of use, prescription medication used as prescribed, such as **methadone, buprenorphine, or medical cannabis, would NOT require a report.**

Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals
www.ifwhenhow.org

1997 Wisconsin Act 292: "Unborn Child Protection Act"

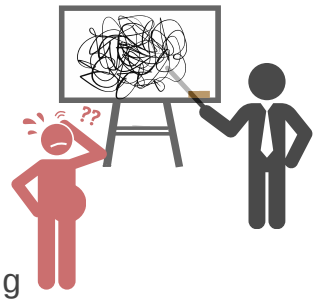
Act 292 is the law mentioned on page 80 that was found to be unconstitutionally vague, but is still in effect.

The court has exclusive original jurisdiction over an **unborn child alleged to be in need of protection** or services which can be ordered by the court whose expectant **mother habitually lacks self-control** in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a **severe degree**, to the extent that there is a **substantial risk** that the physical health of the unborn child, and of the child when born, will be **seriously affected or endangered** unless the expectant mother receives prompt and adequate treatment for that habitual lack of self-control. The **court also has exclusive original jurisdiction over the expectant mother** of an unborn child described in this section.

Wis. Stat. Ann. § 48.133

This means... **nobody's really sure** what it means. **The state does not need to prove that the person has a substance use disorder** or that harm has occurred. Phrases like "habitual lack of self-control" and concern that the future child will be born "endangered" allow plenty of room for interpretation, and **the law is often applied when a child is born healthy**.

Families, peers, and healthcare workers have reported that when the state takes custody of a pregnant person, they are given only a short time to choose between jail and inpatient drug treatment.



Whether in jail or treatment, mothers have reported that **the state controlled their healthcare decisions**, including the decision to birth or seek an abortion.

It is impossible to understand who the law applies to and when. **Any pregnant person is vulnerable** if they are suspected of using alcohol, criminalized substances, or unprescribed medications.

Although it is difficult to defend yourself when the accusation is not defined. We know that **it is important to begin your Plan of Safe Care** (see page 90) as soon as you find out you are pregnant.

You can start on your own and add your healthcare and legal teams once you are able to **get prenatal care and legal aid**. If you seek drug treatment and other healthcare on your own, it may decrease the likelihood that the state will take away your freedom. Remember, there are no guarantees, but **there are things you can do** to improve your health and decrease the chances of state intervention. **Find Legal help on the next page.**

FINDING HELP WHERE YOU LIVE

WISCONSIN

If you believe that a report will be made to DCFS or a case will be opened, **you should reach out to a legal group** in your area to get connected to a lawyer.

Wisconsin Law Help www.wislawhelp.org

In this page, find lists of organizations or clinics available in your county, along with statewide and nationwide sources for further help.

Wisconsin Law Library wilawlibrary.gov/topics/assist.php

Answer a few questions and our Find Legal Help tool will match you with legal organizations that fit your needs.

Free Legal Answer wi.freelegalanswers.org

Answer a few questions to see if you qualify to use this service. You'll receive an email telling you when your question receives a response. Log back in: See the response to your question; ask more questions.

Wisconsin Bar Association

Search for an attorney
Call (800)362-9082 www.wisbar.org/forpublic/ineedalawyer

Judicare www.judicare.org/

Judicare Legal Aid provides free civil legal services to low-income persons living in Northern Wisconsin and Native Americans statewide.

PLANS OF SAFE CARE

A Plan of Safe Care (POSC) is a **plan designed to ensure the safety and well-being of an infant with prenatal substance exposure** following their release from the care of a healthcare provider by **addressing the health and substance use treatment needs of the infant and affected family** or caregiver.

Ideally a Plan of Safe Care is created **to ensure that you and your family have the support you need** to not just keep your family together - but to thrive.

A good plan is created by you and people you trust, like family or care providers.

Your plan should:

- be created by **you and your care team** reflect your **goals, values, and preferences**
- be **family-centered**
- outline **your strengths as a parent**
- document **what you have done to care for yourself and your baby** during your pregnancy
- describe **your support network** of family and community members
- include a **plan of care for you and your baby** at home
- include **services** for you and your baby after discharge
- help you get **appropriate, evidence-based treatment** for substance dependence or substance use disorders
- be monitored by a **provider, agency, or community-based program** you have a relationship with and are comfortable with
- be **voluntary**, not coercive

Some states have sample plans. Our favorite is from Michigan:

English

Español

(Arabic) عربي

Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families

A resource from the National Center on Substance Abuse and Child Welfare:

www.childwelfare.gov/resources/plans-safe-care-infants-prenatal-substance-exposure-and-their-families/

PLANS OF SAFE CARE (POSC) IN WISCONSIN

The **POSC can be used instead of a CPS-enforced safety plan** for infants. For older children, you will be required to follow a CPS-enforced safety plan, but you can still use the POSC to keep track of your progress and steps you are taking to keep your family safe. **Preparing this plan early in your pregnancy** demonstrates the steps you have taken to be a great parent. It can also **provide the evidence needed to reassure them that they do not need to open a case** with CPS.

Unfortunately, many providers still mistakenly believe that reporting you to CPS will lead to you and your family getting services and support.

Your Plan of Safe Care is proof that you already have a plan in place for getting what you need and that you are making progress toward reaching your goals.

Wisconsin definitions: who needs a Plan of Safe Care?

This policy **applies to an infant born with controlled substances** or controlled substance analogs in his or her system as determined by a physician pursuant to s. 146.0255, Stats., when **information does not indicate that the child has been abused or neglected** or threatened with abuse or neglect. [17]

This means that **a POSC can be used in place of a CPS-enforced safety plan for infants who have no safety risks** other than exposure to substances before they were born.

This policy does not apply to an infant born with controlled substances or controlled substance analogs in his or her system where **there are reports of alleged maltreatment** to the infant subsequent to birth. Such cases are to be handled as reports of alleged maltreatment under s. 48.981, Stats. [17]

This means that **a POSC cannot be used in place of a CPS-enforced safety plan if there is evidence of abuse or neglect** that happened after the child was born.

What's UCHIPS?

The process below is for babies and children who have been born. **Wisconsin allows CPS to open a case for an embryo or fetus, which is unusual in the United States**. These are called UCHIPS cases, or "unborn child in need of protection or services". **CPS does not describe the process for UCHIPS cases**. What we know is that **the state can take custody of your fetus, which means they can take custody of you**. For example, they may **force you to live in a treatment facility or be put in jail until you give birth**. Creating a Plan of Safe Care (POSC) and **contacting a lawyer** can help you protect yourself.

CPS Policy

Child protective services (CPS) will accept **reports of an infant identified at birth as having controlled substances** or controlled substance analogs in his or her system pursuant to s. 46.238, Stats., and assess the safety of the infant. **CPS will develop a plan of care** that reduces risk to the child and supports a safe environment, either an agency-managed safety plan or a referral to appropriate preventive community services, **or determine that the family has in place a Plan of Safe Care for the infant.** [17]

The report is screened in as a child welfare services intake, and **no decision regarding substantiation is made**, as the report is made under s. 46.238, not under s. 48.981. [Note: If a report of a drug-affected infant contains information that the child has been abused or neglected or is threatened with abuse or neglect, the report should be screened in.

If the referral is accepted for assessment under s. 46.238, **the following information must be gathered and documented:**

- The infant's **general functioning and development**, including the effects of the illegal substances on the infant.
- The **parents' individual functioning** (communication, coping, problem solving, life management, control of emotions, **use of alcohol or other substances, mental health functioning, sociability, relationships with others, self-concept, etc.,)**. As the fact that the mother has used illegal substances is apparent, the assessment must include a **special focus on her current use of illegal substances** and the impact that will have on the infant's care. [17]

The process: CPS Policy continued

I**f the referral is accepted** for assessment under s. 46.238, **the following information must be gathered** and documented:

The parents' **parenting practices**, if there are **other children in the home** (discipline, nurturing, understanding of child's needs and capabilities, expectations of child, satisfaction with parenting role, etc.) If there are no other children in the home, gather and document information about the **parents' capacity and commitment to parent** (understanding of infant's special needs and plans already made to address them, general day-to-day plan for caring for the infant, etc.)

The **family's functioning, strengths, and current stresses** (roles and boundaries, communication, decision making, relationships, integration into community, power distribution, presence/absence of domestic violence, organization and stability, demographics, etc.)

The **above information must be used to assess safety**. Safety must be assessed and **documented using the safety assessment instrument** in the Wisconsin Model/WiSACWIS.

17

This means that **all reports of substance exposure during pregnancy are investigated**. According to WI policy, **if the only concern is exposure to substances** before birth, the report will result in services provided to the family and **the Plan of Safe Care (POSC) can be used instead of a safety plan.** If there is evidence of abuse or neglect that happened after birth (or risk of abuse or neglect), then CPS requires a safety plan.

CPS workers do not need very much evidence to say that there is risk, and families report that their assessments and requirements can change over time or can be different for each worker. For example, **some CPS workers can find evidence of risk in things that are normal** for most families, like kids with no shirt or shoes on a hot day, or if they visit when you're behind on cleaning or grocery shopping. **Making a POSC can help decrease your chances of a safety plan,** but there are no guarantees.

If the report is accepted as a referral under s. 46.238 but **the family refuses to be interviewed**, the agency must **determine if available information supports a concern of alleged maltreatment or threatened maltreatment** under s. 48.02(1) or s. 48.981(1)(d) and, **if it does, pursue the initial assessment** under the Parent Standard.[17]

Plan of Safe Care or Safety Plan?

A **Plan of Safe Care (POSC) is made by you and your care team before CPS is involved.** It can be used for infants with substance exposure when there is no evidence of other abuse or neglect.

A **Safety Plan is made and enforced by CPS** when they think there is evidence of abuse, neglect, or risk of abuse/neglect of an infant.

This means that if you are reported as having no other risk factors except substance exposure during pregnancy, but you refuse to be interviewed, **CPS can escalate the type of report.** If they think there is reason for concern, **they can change the report from offering services up to suspected investigating for abuse or neglect.**

If the infant is determined to be unsafe, the agency must develop a safety plan with the family, using the Safety Analysis and Plan in the Wisconsin Model, and adhere to the CPS Ongoing Services Standards and Practice Guidelines for cases opened for ongoing services."

If the infant is determined to be unsafe and the family refuses services, the agency must **make every reasonable attempt to file a petition** under s. 48.13 to assure needed protection and services for the child. Those efforts must be documented in the case record.[17]

This means that **CPS can take custody of your child if they think there is reason to believe that the child is not safe** with you. They may place the child with relatives, foster care, or a group setting.

If the infant is determined to be safe, the agency should refer the family to appropriate community resources and **assist the family in accessing those resources** unless the family refuses such assistance. The activities associated with referral to community resources should be documented in the case record.[17]

This means that if **CPS is not concerned for your child's safety, they will refer your family for community resources** and help you access those resources.

CPS does not describe what types of resources they mean. These resources **should be based on your family's needs** and include things like healthcare, mental health services, childcare, food assistance, and more.

If you decline voluntary services, CPS may escalate the report. Services are not voluntary when you must submit or face punishment. It can be frustrating to be forced to spend time doing things that are not helpful, but **many people choose to accept services they do not need rather than risk escalation.**

Investigation Process

I**nitial Assessment** is the stage of the process where local and tribal child welfare **agencies perform interviews with the child(ren), parent(s), Indian custodian(s), and other adults who are in contact with the child,** such as doctors and educators, and visit the home. Using this information, they determine child safety, whether additional services may be needed, and **if maltreatment occurred.**

How long is the initial assessment?
Child welfare professionals have **60 days to complete their assessment**. In some cases, it will take less time, and in rare circumstances it can take longer than 60 days. This can be due to case complexity or other unforeseen circumstances.

What can I expect during an assessment?
A child welfare professional will have **conversations with you, your child, and other persons** to help identify your family's **strengths and assess some of the challenges** you may be facing.[18]

Investigation Process continued

You can **expect that the child welfare professional will**:

- Talk with **your child**
- Talk with **you, siblings, and other household members**
- Learn about your family, help you **provide safety** for your children
- Gather **information about the suspected abuse or neglect**
- Ask questions about your **family strengths and needs**
- **Observe the family home**
- **Speak with** other persons, such as **doctors and teachers**

The child welfare professional will then **write a report** that explains what was done and the information gathered.

Will my child be removed from the home?

County and tribal child welfare agencies strive to keep families together. **Most children and families receive services within their home.** However, sometimes these services cannot be provided within the home. When this occurs, **the child welfare professional will talk with your family to:**

- Find a **temporary safe place for your child to stay; with relatives or friends** or in a foster home
- **Arrange for you to see your child**
- Connect you and your child to **supportive services with the goal of reunification**

In an emergency, **a child may be placed outside your home without permission.** A court **hearing must be held within 48 hours** of when the decision was made to remove your child. At this Temporary Physical Custody (TPC) hearing, **the court decides whether your child should remain living outside your home**. You will be told of when and where the hearing will be, and **you are encouraged to attend** to tell the court how you see the situation.

What are the different outcomes of the assessment?

There are **two decisions** that are made in an initial assessment - **whether a child was maltreated and whether they are safe.**

Maltreatment decision

The determination of whether child maltreatment has occurred (substantiated) or not (unsubstantiated). **This finding is not connected to safety decisions** and does not determine if services will be offered.

Investigation Process continued

Safety decision

Based on the safety of the child, **there are multiple outcomes that can occur:**

- **Safe - Case Closed**: The child welfare professional **provides the family with information on how to access community resources**, if needed, and the case is closed.
- **Safe - Case Open with Voluntary Services**: The child welfare professional **offers voluntary child welfare services to the family and keeps the case open** to check in periodically and see if further assistance is needed.
- **Unsafe - Case Open with Protective/Safety Plan:** The child welfare professional **works with the family to develop a protective or safety plan** that helps ensure safety in the home. The family may also be offered **voluntary or court-ordered child welfare services**.
- **Unsafe - Case Open with an Out-of-Home Placement**: If the child welfare professional determines that a child needs to be removed in order to ensure safety, **the child is removed and placed in out-of-home care,** preferably with **someone they already have a relationship with, such as a relative or family friend**. A Child in Need of Protection and Services (CHIPS) order may be filed. **Services are provided** to the child and family with the **goal of reunification.**

CPS does not describe what types of services they provide. These services **should be based on your family's needs** and include things like healthcare, mental health services, childcare, food assistance, and **not just drug testing and unscheduled home inspections.**

What if I disagree with the decision?

If you have been **substantiated for abuse or neglect, and would like to appea**l that determination, you may follow the process outlined in your determination letter, or visit our Child Protective Services Appeal Process page.

Please note that determination **appeals are time sensitive** and are not part of the general complaint process.
The case will then transition to the third stage of the child welfare system - Ongoing.

Investigation Process continued

The Ongoing stage is where services are provided based on the initial assessment and conversations with the family. Services may vary based on the needs, strengths and goals of the family. Child welfare professionals will work with the family to **establish goals that achieve measurable outcomes** and build a safe, stable home for children.

It is important to note that **no two child welfare cases are the same** as family dynamics and stressors vary. **A child can be removed at any time** if deemed unsafe. Additionally, **when a child is safe, a case can be closed at any step of the process.**

What can I expect in this process?

A child welfare professional will sit down with you to:

- **Develop measurable goals** to enhance your protective capacity
- **Confirm any specific needs and strengths** and how those will be addressed
- **Identify change strategies** to assist you in **achieving stability and safe case closure**
- Find **culturally appropriate services and activities** that are easily accessible and **meet your needs**
- **Involve non-custodial or absent parents and relatives** as resources for children

Using this information, the child welfare professional will **develop the safety/protective plan and share it with you** for your review and agreement.

18

If you don't agree with the safety plan, you can ask for changes. CPS should try to make a plan that you agree with, but **they can enforce it whether you agree or not.** Many people choose to **accept services they do not need rather than risk escalation.**

How will this impact my family life?

The level of involvement, frequency of contact, and types of services depend on variety of factors, including:

- The **needs of your child and family**
- Results of **the assessment**
- The **potential for further child maltreatment**
- **What has been court-ordered**
- Evaluation of **progress toward goals**

Can a safety / protective plan change?

Yes, **a safety/protective plan can be changed** based on new information or progress. For example, changes could be **more or less of current services or the addition of a new service.**

What happens when I meet all of the plan goals?

Your child welfare professional will talk with you about your progress and ensure your home is safe and stable. Prior to the case being closed, the child welfare professional will also sit down with you to help you determine **how your family's needs will be met after agency involvement ends** and the **date of when ongoing services will end.**

18

Wisconsin is not clear about what makes a "safe and stable" home. We can all agree about basic needs like heat, food, water, adult care and supervision, and a safe place to sleep. Beyond the basics, **each person can have a different understanding** of what a "safe and stable" home is. For example, some CPS workers might want **your kitchen to be spotless** all the time, and some may have **more realistic expectations of housekeeping** with small children. **Make sure that you understand the requirements of your particular CPS worker.**

It is important to note that no two child welfare cases are the same as family dynamics and stressors vary. A child can be removed at any time if deemed unsafe. Additionally, when a child is safe, a case can be closed at any step of the process.

18

Child Protective Services Appeal Process

Child Protective Services (CPS) agencies investigate reports of child abuse or neglect. **If they decide child abuse or neglect happened, they will "substantiate."** The agency may say who caused the abuse or neglect. **CPS calls the person who abused or neglected the child(ren) the "maltreater."** Wisconsin State law provides definitions of child abuse and neglect. If CPS "substantiates," or in other words, decides that you did abuse or neglect a child:

You will get a letter with this decision. The letter explains **how to try to change this decision.**

If you would like to appeal the decision

- **Tell the CPS agency** you want to try to change the decision **within 15 days of the date on the letter.**
- **CPS will set up a meeting** with you and send you **a letter with the time of the meeting.**
- At the meeting, **you can say why the decision should change**. You can hire a lawyer.
- **You will get another letter** that will tell you the appeal decision and how to change the decision.

If you disagree with the upheld decision and would like to try to change the decision

- **You send an appeal** form to the Division of Hearing and Appeals (DHA) **within 10 days.**
- DHA will set up a meeting within 90 days and you will get a letter with the time of the meeting.
- At the meeting, **you can say why the decision should change. You can hire a lawyer.**
- **You will get a letter** in 60 days with the Division of Hearing and Appeals (DHA) decision

If the decision is upheld **you may still submit an application for rehabilitation review**. A rehabilitation review allows **a person with substantiated maltreatment to provide proof of counseling or improvement classes.**

The Caregiver Law and Rehabilitation Review

Wisconsin's Caregiver Law may require that a person be barred from operating, working or residing in a licensed or certified facility because of certain crimes, acts or offenses.

Generally, the Caregiver Law applies to:

- Any adult convicted of a serious crime.
- Any juvenile adjudicated delinquent for committing a serious crime.
- Anyone found to have abused or neglected a child.
- Anyone found by a unit of government or a state agency to have abused or neglected a client.
- Anyone found by a unit of government or state agency to have stolen the property of a client.

Individuals with a bar may be banned from:

- Receiving a child care license or certification.
- Receiving a shelter care, child placing agency, group home, residential care center for children and youth or foster home license.
- Working or residing at any of the above facilities.

For some offenses, a person will be permanently barred. For other offenses, a person will be barred unless they request and undergo a rehabilitation review.

The rehabilitation review allows a caregiver or resident to give evidence that:

- The person is not likely to do what led to the conviction(s) or finding(s) again,
- And clients will be safe under the person's care.

A successful rehabilitation review removes the bar and gives the person the chance to be considered for a license or certification, or to be allowed to work or reside at a facility. It does not guarantee that a person will be hired, licensed or certified. A rehabilitation review will appear on a person's future Caregiver background checks.

A successful rehabilitation review does not remove the conviction or finding from a person's record.

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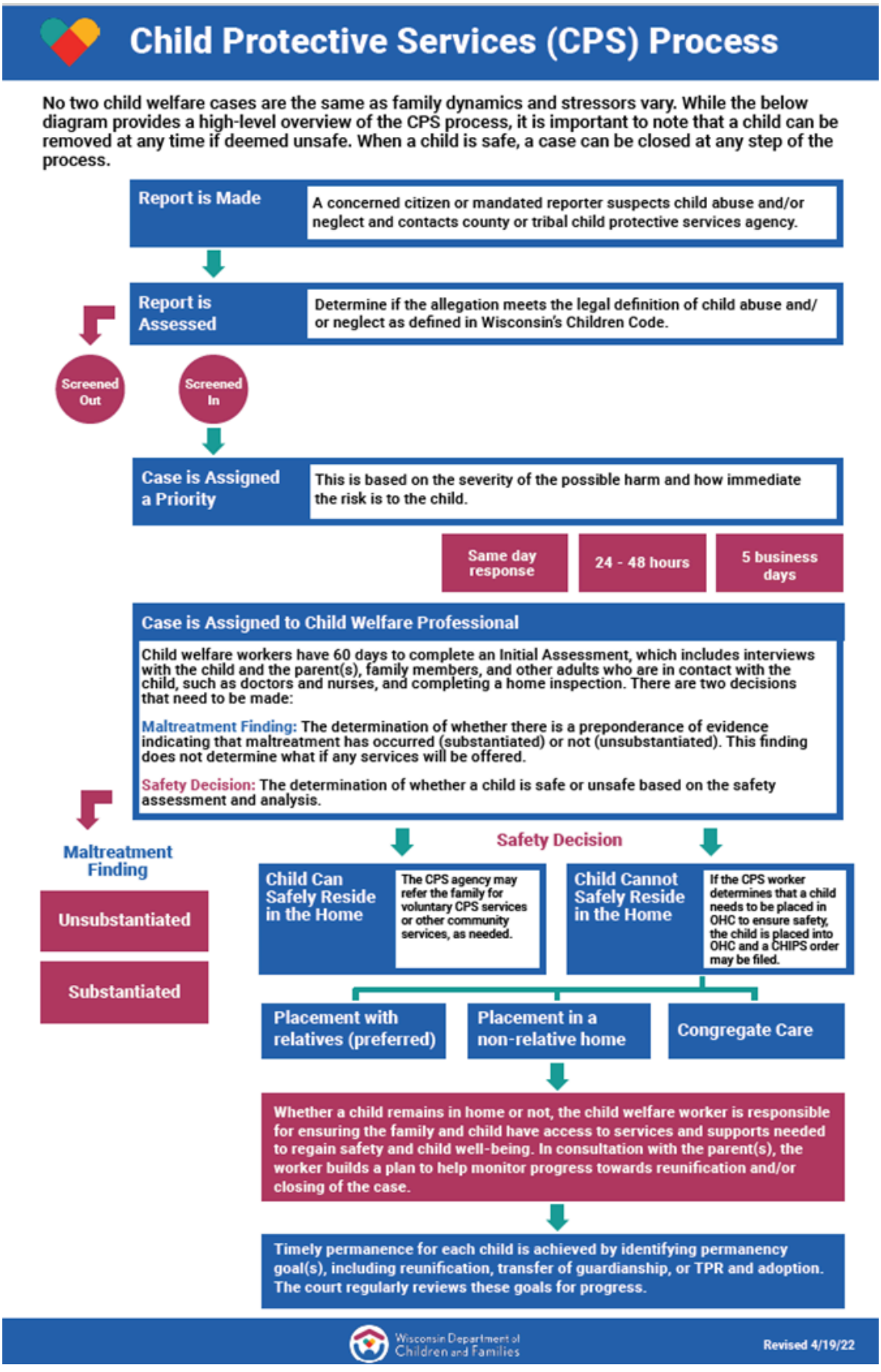
This is the process that prohibited Tammy Loertscher from working as a nurse's aid in Wisconsin. If you are banned from working in your industry, you can appeal to have the ban lifted, but even if it is lifted, you cannot remove it from your record. Ask a lawyer to help you prepare for the review presentation. You can also contact APHR to talk about your case and see if we can support you in any way!

Joelle@perinatalharmreduction.org

This flowchart from CPS shows how a case moves through the system from report to closure of the case

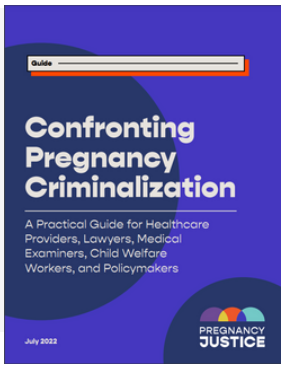


NOTES:

We recommend reading:

Confronting Pregnancy Criminalization: A Practical Guide for Healthcare Providers, Lawyers, Medical Examiners, Child Welfare Workers, and Policymakers

www.pregnancyjusticeus.org/confronting-pregnancy-criminalization/



SECTION 4

PRENATAL CARE

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

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

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

The next pages include a template you can print out to keep track of this information.

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

Get Health Insurance

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

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

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

RESOURCES in YOUR COMMUNITY

HEALTH INSURANCE

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

BadgerCare+ covers healthcare while you are pregnant and for 60 days after the baby is born. BadgerCare Plus includes both outpatient healthcare, and inpatient hospital care, including labor and delivery, primary and specialty care, and prescription drugs.

You may be eligible for coverage of meals, dental, transportation, home nurse visits, childcare, utility bills, and more through ForwardHealth.

Apply for all Wisconsin benefits online: download the app ACCESS
Apply by phone or in person: DHS + Tribal Agency Contact Information

Children's Health Insurance Program (CHIP)
Wisconsin children may be eligible for BadgerCare+, and several other programs depending on their age, family status, and healthcare needs.
InsureKidsNow.gov

Wisconsin Wayfinder is a resource for caregivers of children with special health care needs to get help finding and using all of the services and resources available. Although most prenatal substance exposures do not cause of disability or delay, substance exposure qualifies your child for extra services, so be sure to use what you need.
Apply: 877-WISC-WAY

CONSUMER GUIDE TO HEALTH CARE

The Wisconsin Department of Health Services assists consumers to access health care services and insurance benefits. The department also assists healthcare consumers with problems and complaints, and educates consumers about their rights.

Visit dhs.wisconsin.gov/guide/index.htm

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 PROVIDERS:

IN AN EMERGENCY I WILL...

CALL:

GO TO:

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

MY PRENATAL CARE

APPOINTMENTS

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

FOLLOW UP:

After this appointment I will...

REFERRALS:

I should make an appointment with...

NOTES:

PRENATAL APPOINTMENTS

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

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DATE:

☐ office visit ☐ call

PROVIDER:

DATE:

☐ office visit ☐ call

REFERRALS:

MY POSTPARTUM CARE

6-WEEK APPOINTMENT

PROVIDER:

DATE:

If I have questions I can

CALL:

MY PLAN

My goal for another pregnancy is:

My choice for birth control is:

MY GOALS

MY HOPE FOR THIS PREGNANCY IS...

MY HOPE FOR MY BABY IS...

MY HOPE FOR MYSELF IS...

MY NEEDS:

I WILL FEED MY BODY...

I WILL REST AND SLEEP...

MY MEDICATIONS

MEDICATION:

DOSE:

WHAT TO WATCH FOR:

IF...

THEN...

DURING PREGNANCY:

POSTPARTUM:

LACTATING:

MEDICATION:

DOSE:

DURING PREGNANCY:

POSTPARTUM:

LACTATING:

WHAT TO WATCH FOR:

MY MEDICATIONS

MEDICATION:

DOSE:

WHAT TO WATCH FOR:

IF...

THEN...

DURING PREGNANCY:

POSTPARTUM:

LACTATING:

MEDICATION:

DOSE:

DURING PREGNANCY:

POSTPARTUM:

LACTATING:

WHAT TO WATCH FOR:

MY PLAN

THINGS I'M DOING TO CARE FOR MYSELF...

THINGS I'M DOING TO PREPARE FOR MY BABY...

MY SUPPORT NETWORK:

WHEN I NEED EXTRA HELP AND SUPPORT...

I CAN CALL:

I CAN VISIT:

NOTES:

TYPES OF PREGNANCY PROVIDERS

There are two things that can directly affect the **quality of care you get** and whether or not **you and your baby have the best possible outcomes.** The first is **where you give birth** and the second is **the providers you have.**

When choosing a provider, be sure to ask them where they deliver their patients' babies (where they have "privileges") and if they have experience with the type of care you need. **All of these types of providers can deliver high-quality pregnancy care**:

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

I WANT A PROVIDER WHO...

THE ROLE OF DOULAS

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

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

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

DOULA CARE IN WISCONSIN

Birth Outcomes Made Better (BOMB) Doula Program
city.milwaukee.gov/Health/Services-and-Programs/MCH/BOMB

Pregnancy Options Wisconsin: Education, Resources and Support Inc.
www.pregnancyoptionswi.org/doulas

DoulaMatch.net - With over 4,000 doulas, you'll find the right one for you.
doulamatch.net

African American Breastfeeding Network - WeRISE Doula Program
wpp.med.wisc.edu/funded-project/werise-community-doula-program
(312) 793-1476

Wisconsin Prison Doula Project – Free Services in Prisons
Contact: cheri@wiprisonbirthproject.com

CARE COORDINATION

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

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

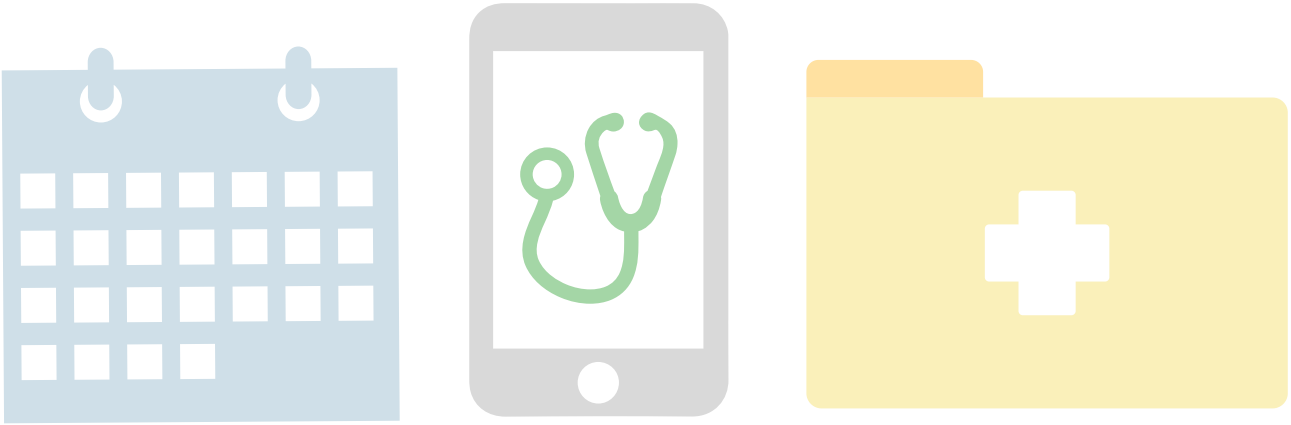
This **lack of knowledge and experience can cause them to feel uncomfortable** addressing or even acknowledging the impacts of health concerns outside of their area of expertise. For you, **this can result in mixed messages or lack of accurate information.**

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

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

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

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



NOTES:

NUTRITION

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

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

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

FOOD and NUTRTION PROGRAMS for PREGNANCY and BEYOND

WIC (Women, Infants, & Children) program provides food, education, referrals, and breastfeeding support for pregnant people and parents of young children. Visit dhs.wisconsin.gov/wic/income-guidelines.htm
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 Wisconsin.

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

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

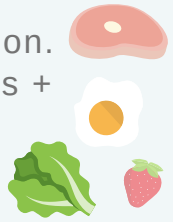
Although fish is very healthy, it's important to be careful about how much and which kinds of fish you eat during pregnancy because of the risk for mercury contamination. **Mercury can cause irreversible fetal brain damage.**

FOODBORNE ILLNESSES

BE FOOD SAFE.

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

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



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

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

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

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

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

CANNABIS

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

The **safety of cannabis use during pregnancy is not well understood**, though studies are currently being done in states where cannabis is legalized. Talk to your provider about the safety of other nausea medications.

It is **safest not to use cannabis during pregnancy and breastfeeding**. This is not for any medical reason. It is because **cannabis may be detectable in your urine, breastmilk, and other body tissues for several weeks.**

ROUTINE PRENATAL CARE

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

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

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

Conditions that Make a Pregnancy High-Risk

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

The earlier prenatal care is initiated, the better.

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

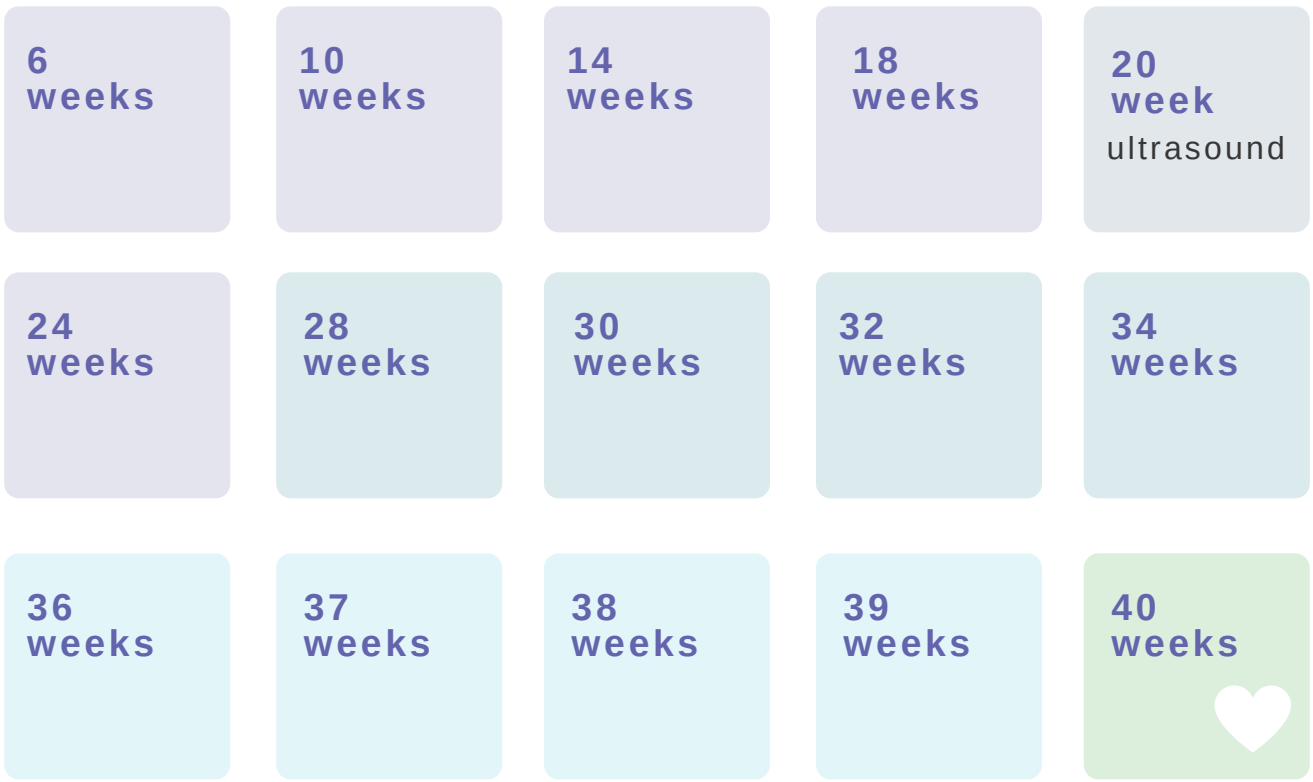
For most people, this is **around 8 weeks**, but if menstruation is not regular (as is not uncommon for people who use drugs) it may be later.

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

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

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

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



"LATE TO CARE"

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

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

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

WARNING SIGNS

See your prenatal care provider

IMMEDIATELY

if you experience:

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

WARNING SIGNS

PRETERM LABOR
PREMATURE RUPTURE OF MEMBRANES (PPROM)

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

Symptoms to watch out for are:

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

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

CALL YOUR PROVIDER

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

TELL SOMEONE ELSE WHAT'S HAPPENING

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

GO TO THE EMERGENCY ROOM

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

CALL 911

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

EMERGENCY COMPLICATIONS

PRETERM LABOR

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

PLACENTA PREVIA

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

PLACENTA ABRUPTION

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

UTERINE RUPTURE

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

PARENT-TO-CHILD DISEASE TRANSMISSION

Some infections pose serious risks to the fetus/newborn, so testing for them is part of normal prenatal care for everyone. These tests will be conducted on your first prenatal visit so that treatment or other steps can be taken to decrease or eliminate risks.

TORCH infections stands for: **T**oxoplasmosis, **O**ther, (syphilis, etc), **R**ubella, **C**ytomegalovirus, and **H**erpes.
TORCH Infections: Syndrome, Causes, Risks & Treatment
my.clevelandclinic.org/health/diseases/23322-torch-syndrome

About Sexually Transmitted Infections (STIs) and Pregnancy
www.cdc.gov/sti/about/about-stis-and-pregnancy.html

Syphilis In Wisconsin: **1,450%** increase in 5 years
www.dhs.wisconsin.gov/std/syphilis.htm

Mother to Baby Fact sheet: Syphilis
www.mothertobaby.org/fact-sheets/syphilis/pdf

About Congenital Syphilis | CDC
www.cdc.gov/syphilis/about/about-congenital-syphilis.html

Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Syndrome (AIDS)

Preventing HIV Transmission During Infant Feeding | NIH OAR HHS
clinicalinfo.hiv.gov/en/guidelines/perinatal/preventing-transmission-infant-feeding

National Clinician Consultation Center: Perinatal HIV/AIDS
www.nccc.ucsf.edu/clinician-consultation/perinatal-hiv-aids

HIV and Pregnancy | ACOG
www.acog.org/womens-health/faqs/hiv-and-pregnancy

Criminalization of HIV status in Wisconsin
www.hivlawandpolicy.org/sites/default/files/Wisconsin

People Living With HIV Demand Human Rights
The Denver Principles - 1983
www.poz.com/blog/how-the-denver-princ

PARENT-TO-CHILD DISEASE TRANSMISSION

Hepatitis B and C

Hepatitis B and Hepatitis C in Pregnancy | ACOG
www.acog.org/womens-health/faqs/viral-hepatitis-in-pregnancy

Hepatitis B or C Infections and Breastfeeding | CDC
www.cdc.gov/breastfeeding-special-circumstances/hcp/illnesses-conditions/hepatitis-b-c.html

Hepatitis B Foundation www.hepb.org

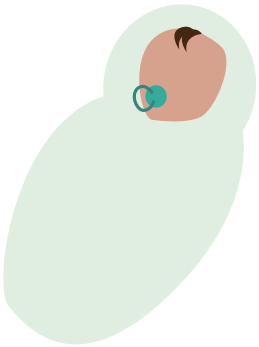
Pregnancy and Hepatitis B Fact Sheet: www.hepb.org/assets/Uploads/Pregnancy-and-Hepatitis-B-Fact-Sheet-final.pdf

ECHO from Hep B Foundation www.youtube.com/@HepBFoundation
Free webinar recordings, made for clinicians, **open to everyone**
Perinatal Hepatitis B Foundations Perinatal Hepatitis B Intensive

COVID-19, Pregnancy and Breastfeeding: Answers From Ob-Gyns
www.acog.org/womens-health/faqs/coronavirus-covid-19-pregnancy-and-breastfeeding

Frequently Asked Questions: Can I breastfeed my baby if I'm sick with coronavirus? lllusa.org/coronavirus-and-breastfeeding

ROUTINE TESTS



Learn more about routine tests...

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

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

SECTION 5

LABOR + CHILDBIRTH

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

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

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

See the sections on
- Care Coordination page 116
- Trauma Informed Care page 16

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

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

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

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

Consider planning ahead for pain management., and bringing a written plan you can share with your care team.

- download "My Birth Plan"
- download "My Pain Management Plan"

REMEMBER: While more and more providers are learning how to provide trauma-informed, respectful, patient-centered care, very few have experience supporting people who are substance dependent. **They may not understand how to deliver the care you need,** especially if you are taking medications for opioid use disorder (MOUD).You and your support team will need to **be prepared to advocate for the care you need.**

The National Clinician Consultation Center (NCCC) consultation with experts in the field. This line is **for clinicians, by clinicians**. Ask your provider to call: M-F 9am-8pm PT: **(844) ASK-NCCC | (844) 275-6222**

nccc.ucsf.edu/

ADDRESSING BIAS AND STIGMA

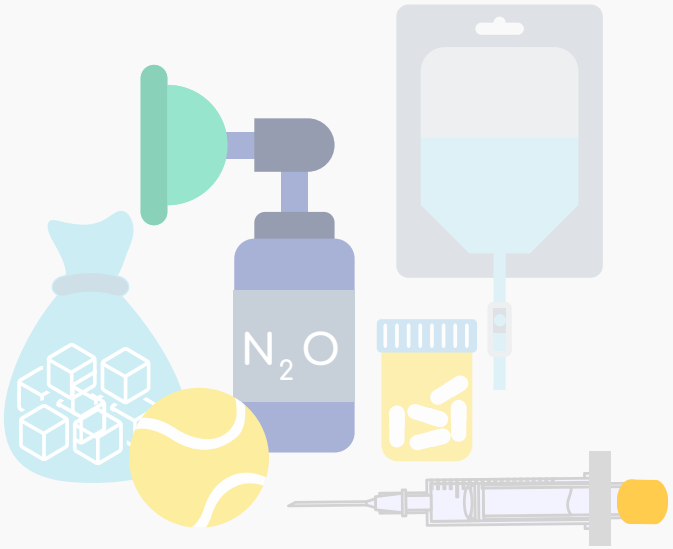
If something during your labor or postpartum recovery doesn't feel right to you, SPEAK UP. ASK for HELP. You deserve to feel safe, respected, and heard.

If you have a doula, birth advocate, or family support person with you, **you can work together to advocate** for you during the labor and delivery process. They can help you:

- communicate your needs
- clarify your expectations
- guard against bias and stigma
- protect your rights

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

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



EPIDURAL

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

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

An epidural works by almost completely blocking nerve function below the level of the injection. **Patients will still feel pressure and stretching, but not pain**. It is effective within a 10-2 minutes, wears off mostly in a few hours, but continues to wear off for up to 24 hours after the tube is removed.

PROS

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

CONS

- cannot walk
- cannot pee
- potential for complications

SPINAL

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

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

PROS

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

CONS

- cannot walk
- cannot pee
- potential for complications

COMBINED EPIDURAL OR "WALKING EPIDURAL"

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

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

PROS

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

CONS

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

GENERAL ANESTHESIA

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

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

PROS

- patients experience no pain
- works immediately

CONS

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

LOCAL

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

PROS

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

CONS

- does not numb uterine contractions

MEDICATION-INDUCED NAUSEA

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

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

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

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

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

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

- mint chewing gum

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

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

PUDENDAL

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

PROS

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

CONS

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

INTRAVENOUS (IV) INTRAMUSCULAR (IM) OPIOIDS

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

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

PROS

- works quickly
- has a calming effect

CONS

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

NITROUS OXIDE (N_2O, laughing gas)

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

PROS

- very short-acting
- does not cause sedation

CONS

- does not fully block pain

COMPLEMENTARY + ALTERNATIVE MEDICINE INTERVENTIONS

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

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

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

PERINEAL MASSAGE

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

TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION)

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

Do NOT use TENS:

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

LOW-TECH INTERVENTIONS

BREATHING

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

POSITIONING

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

For positioning suggestions:

- www.thebump.com/a/birthing-positions
- www.babycenter.com/0_positions-for-labor-and-birth_1030907.bc

HEAT + ICE

Heat and ice can be applied to ease muscle pain, especially in the lower back. you can use ice packs, wet towels, warm blankets or hot water bottles - or even take warm or cool showers or baths.

POSTPARTUM PAIN MANAGEMENT

MEDICATIONS

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

ACETAMINOPHEN (TYLENOL®)

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

Know how much acetaminophen you're taking:

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

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

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

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

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

NALBUPHINE (NUBAIN®)

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

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

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

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

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

SIMETHICONE (MYLICON®, GAS-X®)

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

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

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

BENZOCAINE SPRAY (DERMOPLAST®)

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

WITCH HAZEL PADS (TUCKS®)

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

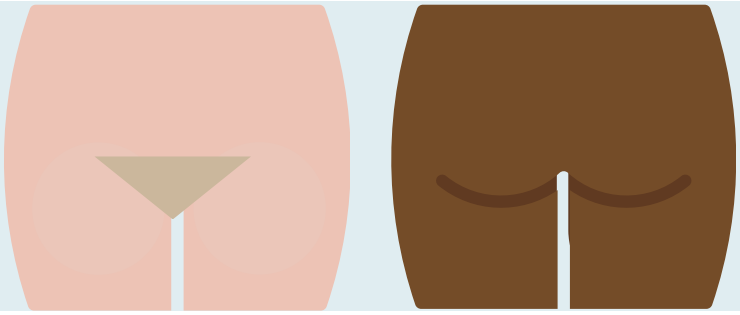
HYDROCORTISONE CREAM

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

NONPHARMACOLOGICAL PAIN MANAGEMENT

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

VAGINA
VULVA
PERINEUM
ANUS (HEMORRHOIDS)



ICE OR COLD PACKS

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

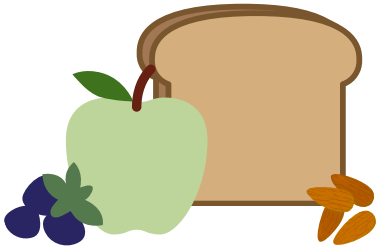
CHANGING POSITION

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

HIGH FIBER DIET

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

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



SITZ BATH OR PERINEAL CARE BOTTLE (“PERI” BOTTLE)

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

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

C-SECTION INCISION PAIN

ABDOMINAL BINDER

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

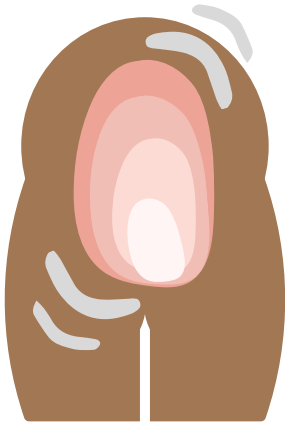
ICE

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

BRACING WITH PILLOW

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

ABDOMINAL PRESSURE AND UTERINE CRAMPS



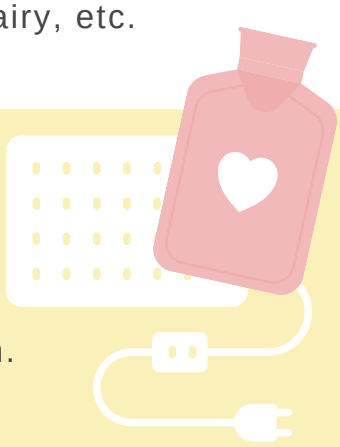
Uterine cramping continues for several days to weeks after birth as the uterus shrinks back down to its usual size. They are usually only bothersome for a few days, and then barely noticeable. These cramps increase in intensity with each birth, so the cramps following the fifth birth will be more intense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

FREQUENT PASSING GAS

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

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

HEAT



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

NOTES:

SECTION 6

POSTPARTUM CARE

The first year after having a baby can be an exciting time. It can also be difficult - physically and emotionally. Your body is healing and adjusting and you may have new stressors in your life. Most people maintain their goals, but some people who stopped using drugs during pregnancy start again after giving birth. A few find themselves using more chaotically.

THE RISKS OF OVERDOSE

After giving birth, many people taper off medications they've been using such as methadone or buprenorphine because they or their doctors think they are able to manage without the medication. However, this is sometimes dangerous and increases risks of relapse, overdose and death.

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

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

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

We like this Safety Planning Resource from NYSDH.

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

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

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

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

MEDICAL RACISM

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

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

Many Black, Indigenous, 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 obtain informed consent and the researchers were later denounced for their colonialist, racist, and unethical research practices.[22]

In a more recent case, 148 people incarcerated in California Women's prisons were sterilized without their consent between 2006-2010.[23]

BREAST/CHESTFEEDING AND HUMAN MILK

ALCOHOL

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

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

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

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

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

BENZODIAZEPINES

It is important to take as low a dose of benzodiazepines as possible to get the benefits you need. All benzodiazepines are not equally safe while breast/chestfeeding (for example. lorazepam is safer than diazepam. Talk to your doctor about which medication you take and at what dose. Work together to find what's right for you.[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, the results cannot be assumed to apply to other groups.

CANNABIS

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

OPIOIDS

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

STIMULANTS

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

TOBACCO + NICOTINE

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

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

Drug Use and Human Milk: Legal and Child Welfare Considerations

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

NOTES:

CONTRACEPTION OPTIONS

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

There are many options to consider around when and what kind of contraception to use if you do not want to have another pregnancy within the next year.

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

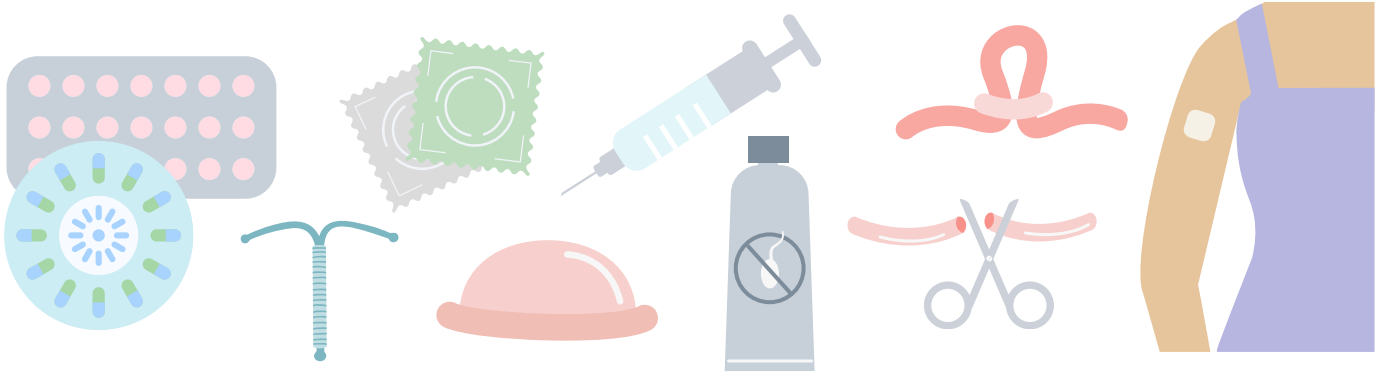
Some you may take daily, such as the pill. Others can last for months or years, like injections, IUDs, and implants.

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

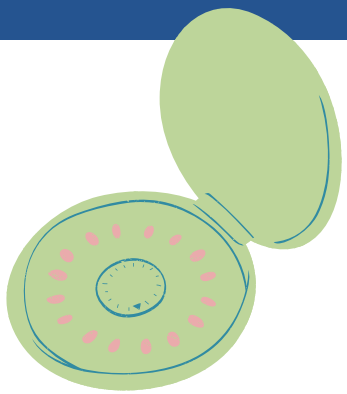
You should discuss with your doctor if you have any concerns such as heavy period, cramping, weight issues, or mood issues.

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

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



CONTRACEPTION COVERAGE



In Wisconsin you can **get birth control at no cost** if you qualify for one of the health coverage programs below:

Family Planning Services Only Program - Covers Reproductive Care
www.dhs.wisconsin.gov/fpos/index.htm

Planned Parenthood - Quarterly Contraceptive Kits (QCK)
www.plannedparenthood.org/planned-parenthood-wisconsin/patients/QCK

BadgerCare+ - Pregnancy healthcare up to 60 days after birth
www.dhs.wisconsin.gov/medicaid/pregnant-women.htm

Children's Health Insurance Program (CHIP)
www.dhs.wisconsin.gov/medicaid/pregnant-women.htm

OPill: Order birth control through the mail without a prescription
www.opill.com/products/opill

Power To Decide - State Policy
www.powertodecide.org/what-we-do/state-policy

As we write, there are efforts underway to increase AND decrease access to healthcare, including contraception. There are also efforts to extend Medicaid coverage to 12 months after birth instead of just 2. By the time you read this, things may have changed for better or worse. For up-to-date information, check in with:
plannedparenthoodaction.org/planned-parenthood-advocates-wisconsin/issues

2023 Study
Primary and reproductive healthcare access and use among reproductive aged women and female family planning patients in 3 states

- 33% of people could not afford desired contraception
- 33% of those who couldn't afford it blamed lack of health insurance
- 15%reported logistical difficulties (distance, time, transportation)
- 10% reported that they couldn't get to a facility when it was open

pubmed.ncbi.nlm.nih.gov/37224157

FAMILY LEAVE IN WISCONSIN

Everyone needs time to take care of themselves when they're pregnant, recovering from giving birth, and bonding with their new family. Unfortunately, there are few benefits and protections for most working people. Whether or not you can take paid or unpaid time away from work depends upon:

- who you work for
- where you work
- how long you have worked there
- how many hours you typically work
- the number of people employed at your place of work

Learn more:

Family Medical Leave Act (FMLA) dwd.wisconsin.gov/er/civilrights/fmla

The Family Medical Leave Act (FMLA) provides unpaid leave for Wisconsin employees' serious health conditions, the serious health condition of a parent, child or spouse, or for the birth or adoption of a child.

Wisconsin does not guarantee bereavement leave. Some employers may offer it voluntarily. Common reasons to take bereavement leave are death in the family or pregnancy loss.

PREGNANCY RIGHTS IN WISCONSIN

Pregnant Workers Fairness Act (PWFA)

The Federal Pregnant Workers Fairness Act and The Wisconsin bans discrimination based on pregnancy, childbirth and related medical conditions, and requires employers to make reasonable accommodations for pregnant people.

www.eeoc.gov/statutes/pregnancy-discrimination-act-1978
dwd.wisconsin.gov/eworkboard/fair-employment

The Center for Work-Life Law Helpline is for workers and students who have questions about their rights during pregnancy and postpartum.

hotline@worklifelaw.org | (415) 703-8276

PSYCHOSOCIAL SUPPORT AND PERINATAL MOOD AND ANXIETY DISORDERS (PMADS)

Perinatal Mood and Anxiety Disorders are common and treatable.

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

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

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

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

In an EMERGENCY call: 988

or 1-800-273-8255 (TALK)

988lifeline.org

In an EMERGENCY text "Home" to 741741 to reach a Crisis Counselor

www.crisistextline.org/text-us

NEW National Maternal Mental Health Hotline

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

Call or text 1-833-TLCMAMA

TTY users can use a preferred relay service
or dial 711 and then 1-833-852-6262.

Counselors also have access to interpreter services who can support
60 other languages 1-833-852-6262

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

TTY users can use a
preferred relay service
or dial 711 and then 1-833-852-6262.

HELP from POSTPARTUM SUPPORT INTERNATIONAL

POSTPARTUM SUPPORT INTERNATIONAL

www.postpartum.net

PSI Helpline:
1-800-944-4773

PRESS
1 English
2 Spanish

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

MENTAL HEALTH SUPPORT

Postpartum Support International (PSI) of Wisconsin
www.psichapters.com/wi

PSI Online FREE Support Groups
postpartum.net/get-help/psi-online-support-meetings

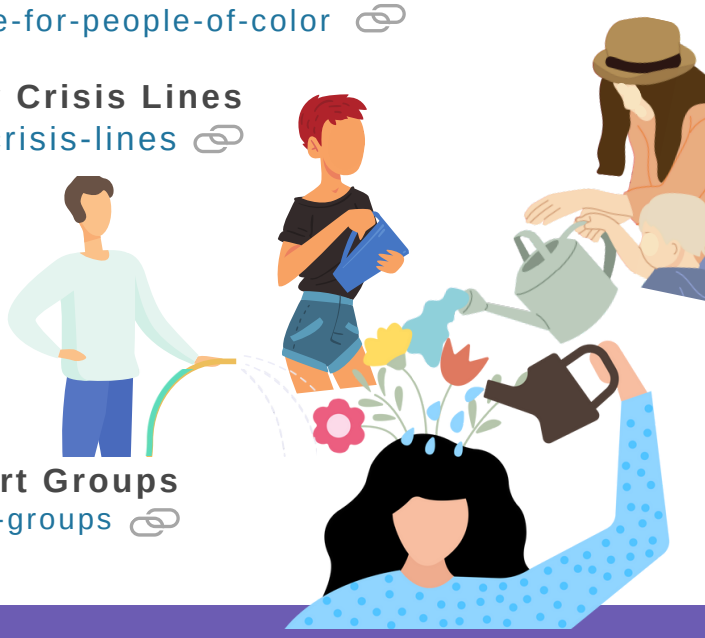
Perinatal Mental Health Alliance for People of Color (PMHA-POC)
postpartum.net/perinatal-mental-health-alliance-for-people-of-color

Prevent Suicide Wisconsin - List of County Crisis Lines
www.preventsuicidewi.org/county-crisis-lines

Moms Mental Health Initiative - Milwaukee
www.momsmentalhealthinitiative.org

Department of Human Services Helpline
1-800-843-6154 or 1-800-447-6404

National Alliance on Mental Illness - Support Groups
namiwisconsin.org/support-and-education/support-groups



NOTES:

REFERENCES

SECTION 1: QUALITY PERINATAL CARE IS YOUR RIGHT

1.Cleveland, L. M., Bonugli, R. J., & McGlothen, K. S. (2016). The Mothering Experiences of Women With Substance Use Disorders. ANS. Advances in nursing science, 39(2), 119–129. https://doi.org/10.1097/ANS.0000000000000118

2.Torchalla, I., Linden, I. A., Strehlau, V., Neilson, E. K., & Krausz, M. (2015). "Like a lots happened with my whole childhood": violence, trauma, and addiction in pregnant and postpartum women from Vancouver's Downtown Eastside. Harm reduction journal, 11, 34. https://doi.org/10.1186/1477-7517-11-34

3.Cunningham, J. A., Sobell, L. C., & Chow, V. M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. Journal of studies on alcohol, 54(6), 693–699. https://doi.org/10.15288/jsa.1993.54.693

4.Pauly B. (2008). Harm reduction through a social justice lens. The International journal on drug policy, 19(1), 4–10. https://doi.org/10.1016/j.drugpo.2007.11.005

5. British Columbia Provincial Mental Health and Substance Use Planning Council. (2013). Trauma-Informed Practice Guide. https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

6.Poole, N., & Greaves, L. (2012). Becoming trauma informed. Centre for Addiction and Mental Health.

7.Nathoo, T., Poole, N., Bryans, M., Dechief, L., Hardeman, S., Marcellus, L., ... Taylor, M. (2013). Voices from the community: Developing effective community programs to support pregnant and early parenting women who use alcohol and other substances. First Peoples Child Family Review, 8(1), 93–106. https://doi.org/10.7202/1071409AR

8.Beck, C. T., Driscoll, J., & Watson, S. (2013). Traumatic childbirth. Routledge.

9.Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq, E., & GVtM-US Steering Council (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive health, 16(1), 77. https://doi.org/10.1186/s12978-019-0729-2

10.Abrahams, R. R., Kelly, S. A., Payne, S., Thiessen, P. N., Mackintosh, J., & Janssen, P. A. (2007). Rooming-in compared with standard care for newborns of mothers using methadone or heroin. Canadian family physician Medecin de famille canadien, 53(10), 1722–1730.

11.Moore, E. R., Anderson, G. C., Bergman, N., & Dowswell, T. (2012). Early skin-to-skin contact for mothers and their healthy newborn infants. The Cochrane database of systematic reviews, 5(5), CD003519. https://doi.org/10.1002/14651858.CD003519.pub3

12.Pepler, D. J., Motz, M., Leslie, M., Jenkins, J., Espinet, S. D., Reynolds, W. (2014). The Mother-Child Study: Evaluating Treatments for Substance-using Women. Mothercraft Press.

13.Kendall-Tackett K. A. (2007). Violence against women and the perinatal period: the impact of lifetime violence and abuse on pregnancy, postpartum, and breastfeeding. Trauma, violence & abuse, 8(3), 344–353. https://doi.org/10.1177/1524838007304406

14.Seng, J. S., Sperlich, M., Low, L. K., Ronis, D. L., Muzik, M., & Liberzon, I. (2013). Childhood abuse history, posttraumatic stress disorder, postpartum mental health, and bonding: a prospective cohort study. Journal of midwifery & women's health, 58(1), 57–68. https://doi.org/10.1111/j.1542-2011.2012.00237.x

SECTION 2: HARM REDUCTION

1. Centers for Disease Control and Prevention. (2021, December 14). Alcohol use during pregnancy. Centers for Disease Control and Prevention. Retrieved October 2, 2022, from https://www.cdc.gov/ncbddd/fasd/alcohol-use.html
2. Riley, E. P., Infante, M. A., & Warren, K. R. (2011). Fetal alcohol spectrum disorders: an overview. Neuropsychology review, 21(2), 73–80. https://doi.org/10.1007/s11065-011-9166-x
3. Centers for Disease Control and Prevention. (2021, May 14). Key findings: The effects of alcohol use during pregnancy and later developmental outcomes: An analysis of previous studies. Centers for Disease Control and Prevention. Retrieved October 2, 2022, from https://www.cdc.gov/ncbddd/fasd/features/key-finding-acer.html
4. Academy of Breastfeeding Medicine (ABM). (2023) Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder. Breastfeeding medicine. 18(10), 715–733.
5. National Institute of Child Health and Human Development (LactMed). (2025). Drugs and Lactation Database: Alcohol. Available from: https://www.ncbi.nlm.nih.gov/books/NBK501469/
6. Ogawa, Y., Takeshima, N., & Furukawa, T. A. (2018). Maternal exposure to benzodiazepine and risk of preterm birth and low birth weight: A case-control study using a claims database in Japan. Asia-Pacific psychiatry : official journal of the Pacific Rim College of Psychiatrists, 10(3), e12309. https://doi.org/10.1111/appy.12309
7. Okun, M. L., Ebert, R., & Saini, B. (2015). A review of sleep-promoting medications used in pregnancy. American journal of obstetrics and gynecology, 212(4), 428–441. https://doi.org/10.1016/j.ajog.2014.10.1106
8. Zwink, N., & Jenetzky, E. (2018). Maternal drug use and the risk of anorectal malformations: systematic review and meta-analysis. Orphanet journal of rare diseases, 13(1), 75. https://doi.org/10.1186/s13023-018-0789-3
9. Reichner C. A. (2015). Insomnia and sleep deficiency in pregnancy. Obstetric medicine, 8(4), 168–171. https://doi.org/10.1177/1753495X15600572
10. Iqbal, M. M., Sobhan, T., & Ryals, T. (2002). Effects of commonly used benzodiazepines on the fetus, the neonate, and the nursing infant. Psychiatric services (Washington, D.C.), 53(1), 39–49. https://doi.org/10.1176/appi.ps.53.1.39
11. Soyka M. (2017). Treatment of Benzodiazepine Dependence. The New England journal of medicine, 376(24), 2399–2400. https://doi.org/10.1056/NEJMc1705239
12. Fried P. A. (1995). Prenatal exposure to marihuana and tobacco during infancy, early and middle childhood: effects and an attempt at synthesis. Archives of toxicology. Supplement. = Archiv fur Toxikologie. Supplement, 17, 233–260. https://doi.org/10.1007/978-3-642-79451-3_21
13. Day, N. L., Richardson, G. A., Geva, D., & Robles, N. (1994). Alcohol, marijuana, and tobacco: effects of prenatal exposure on offspring growth and morphology at age six. Alcoholism, clinical and experimental research, 18(4), 786–794. https://doi.org/10.1111/j.1530-0277.1994.tb00041.x
14. Braillon, A., & Bewley, S. (2018). Committee Opinion No. 722: Marijuana Use During Pregnancy and Lactation. Obstetrics and gynecology, 131(1), 164. https://doi.org/10.1097/AOG.0000000000002429
15. Torres, C. A., Medina-Kirchner, C., O'Malley, K. Y., & Hart, C. L. (2020). Totality of the Evidence Suggests Prenatal Cannabis Exposure Does Not Lead to Cognitive Impairments: A Systematic and Critical Review. Frontiers in psychology, 11, 816. https://doi.org/10.3389/fpsyg.2020.00816

SECTION 2: HARM REDUCTION

16. Corsi, D. J., Walsh, L., Weiss, D., Hsu, H., El-Chaar, D., Hawken, S., Fell, D. B., & Walker, M. (2019). Association Between Self-reported Prenatal Cannabis Use and Maternal, Perinatal, and Neonatal Outcomes. JAMA, 322(2), 145–152. https://doi.org/10.1001/jama.2019.8734
17. Bertrand, K. A., Hanan, N. J., Honerkamp-Smith, G., Best, B. M., & Chambers, C. D. (2018). Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk. Pediatrics, 142(3), e20181076. https://doi.org/10.1542/peds.2018-1076
18. Perez-Reyes, M., & Wall, M. E. (1982). Presence of delta9-tetrahydrocannabinol in human milk. The New England journal of medicine, 307(13), 819–820. https://doi.org/10.1056/NEJM198209233071311
19. Hill, M., & Reed, K. (2013). Pregnancy, breast-feeding, and marijuana: a review article. Obstetrical & gynecological survey, 68(10), 710–718. https://doi.org/10.1097/01.ogx.0000435371.51584.d1
20. Section on Breastfeeding (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827–e841. https://doi.org/10.1542/peds.2011-3552
21. Reece-Stremtan, S., & Marinelli, K. A. (2015). ABM clinical protocol #21: guidelines for breastfeeding and substance use or substance use disorder, revised 2015. Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine, 10(3), 135–141. https://doi.org/10.1089/bfm.2015.9992
22. Metz, T. D., & Stickrath, E. H. (2015). Marijuana use in pregnancy and lactation: a review of the evidence. American journal of obstetrics and gynecology, 213(6), 761–778. https://doi.org/10.1016/j.ajog.2015.05.025
23. Baker, T., Datta, P., Rewers-Felkins, K., Thompson, H., Kallem, R. R., & Hale, T. W. (2018). Transfer of Inhaled Cannabis Into Human Breast Milk. Obstetrics and gynecology, 131(5), 783–788. https://doi.org/10.1097/AOG.0000000000002575
24. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. (2017). Obstetrics and gynecology, 130(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235
25. Dickmann, L. J., & Isoherranen, N. (2013). Quantitative prediction of CYP2B6 induction by estradiol during pregnancy: potential explanation for increased methadone clearance during pregnancy. Drug metabolism and disposition: the biological fate of chemicals, 41(2), 270–274. https://doi.org/10.1124/dmd.112.047118
26. Hepburn, M. (2004). Current Obstetrics and Gynaecology, 14(6), 419–425. https://doi.org/https://doi.org/10.1016/j.curobgyn.2004.07.006
27. Kashiwagi, M., Arlettaz, R., Lauper, U., Zimmermann, R., & Hebisch, G. (2005). Methadone maintenance program in a Swiss perinatal center: (I): Management and outcome of 89 pregnancies. Acta obstetricia et gynecologica Scandinavica, 84(2), 140–144. https://doi.org/10.1111/j.0001-6349.2005.00497.x
28. Pace, C. A., Kaminetzky, L. B., Winter, M., Cheng, D. M., Saia, K., Samet, J. H., & Walley, A. Y. (2014). Postpartum changes in methadone maintenance dose. Journal of substance abuse treatment, 47(3), 229–232. https://doi.org/10.1016/j.jsat.2014.04.004
29. Shiu, J. R., & Ensom, M. H. (2012). Dosing and monitoring of methadone in pregnancy: literature review. The Canadian journal of hospital pharmacy, 65(5), 380–386. https://doi.org/10.4212/cjhp.v65i5.1176v
30. Wolff, K., Boys, A., Rostami-Hodjegan, A., Hay, A., & Raistrick, D. (2005). Changes to methadone clearance during pregnancy. European journal of clinical pharmacology, 61(10), 763–768. https://doi.org/10.1007/s00228-005-0035-5

SECTION 2: HARM REDUCTION

31. Wong, S., Ordean, A., Kahan, M., & Society of Obstetricians and Gynecologists of Canada (2011). SOGC clinical practice guidelines: Substance use in pregnancy: no. 256, April 2011. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 114(2), 190–202. https://doi.org/10.1016/j.ijgo.2011.06.001
32. Behnke, M., Smith, V. C., Committee on Substance Abuse, & Committee on Fetus and Newborn (2013). Prenatal substance abuse: short- and long-term effects on the exposed fetus. Pediatrics, 131(3), e1009–e1024. https://doi.org/10.1542/peds.2012-3931
33. Lind, J. N., Interrante, J. D., Ailes, E. C., Gilboa, S. M., Khan, S., Frey, M. T., Dawson, A. L., Honein, M. A., Dowling, N. F., Razzaghi, H., Creanga, A. A., & Broussard, C. S. (2017). Maternal Use of Opioids During Pregnancy and Congenital Malformations: A Systematic Review. Pediatrics, 139(6), e20164131. https://doi.org/10.1542/peds.2016-4131
34. Bada, H. S., Das, A., Bauer, C. R., Shankaran, S., Lester, B. M., Gard, C. C., Wright, L. L., Lagasse, L., & Higgins, R. (2005). Low birth weight and preterm births: etiologic fraction attributable to prenatal drug exposure. Journal of perinatology : official journal of the California Perinatal Association, 25(10), 631–637. https://doi.org/10.1038/sj.jp.7211378
35. Cleary, B. J., Eogan, M., O'Connell, M. P., Fahey, T., Gallagher, P. J., Clarke, T., White, M. J., McDermott, C., O'Sullivan, A., Carmody, D., Gleeson, J., & Murphy, D. J. (2012). Methadone and perinatal outcomes: a prospective cohort study. Addiction (Abingdon, England), 107(8), 1482–1492. https://doi.org/10.1111/j.1360-0443.2012.03844.x
36. Cleary, B. J., Donnelly, J. M., Strawbridge, J. D., Gallagher, P. J., Fahey, T., White, M. J., & Murphy, D. J. (2011). Methadone and perinatal outcomes: a retrospective cohort study. American journal of obstetrics and gynecology, 204(2), 139.e1–139.e1399. https://doi.org/10.1016/j.ajog.2010.10.004
37. Hulse, G. K., Milne, E., English, D. R., & Holman, C. D. (1997). Assessing the relationship between maternal cocaine use and abruptio placentae. Addiction (Abingdon, England), 92(11), 1547–1551.
38. Wurst, K. E., Zedler, B. K., Joyce, A. R., Sasinowski, M., & Murrelle, E. L. (2016). A Swedish Population-based Study of Adverse Birth Outcomes among Pregnant Women Treated with Buprenorphine or Methadone: Preliminary Findings. Substance abuse : research and treatment, 10, 89–97. https://doi.org/10.4137/SART.S38887
39. Center for Substance Abuse Treatment. (2005). Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Substance Abuse and Mental Health Services Administration (US).
40. National Library of Medicine. (n.d.). Drugs and lactation database (lactmed) - NCBI bookshelf. LactMed. Retrieved October 2, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK501922/
41. Montgomery, A., Hale, T. W., & Academy Of Breastfeeding Medicine (2012). ABM clinical protocol #15: analgesia and anesthesia for the breastfeeding mother, revised 2012. Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine, 7(6), 547–553. https://doi.org/10.1089/bfm.2012.9977
42. Ilett, K. F., Hackett, L. P., Gower, S., Doherty, D. A., Hamilton, D., & Bartu, A. E. (2012). Estimated dose exposure of the neonate to buprenorphine and its metabolite norbuprenorphine via breastmilk during maternal buprenorphine substitution treatment. Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine, 7, 269–274. https://doi.org/10.1089/bfm.2011.0096
43. Lindemalm, S., Nydert, P., Svensson, J. O., Stahle, L., & Sarman, I. (2009). Transfer of buprenorphine into breast milk and calculation of infant drug dose. Journal of human lactation : official journal of International Lactation Consultant Association, 25(2), 199–205. https://doi.org/10.1177/0890334408328295

SECTION 2: HARM REDUCTION

44. Kelty, E., & Hulse, G. (2017). A Retrospective Cohort Study of Obstetric Outcomes in Opioid-Dependent Women Treated with Implant Naltrexone, Oral Methadone or Sublingual Buprenorphine, and Non-Dependent Controls. Drugs, 77(11), 1199–1210. https://doi.org/10.1007/s40265-017-0762-9
45. Wachman, E. M., Saia, K., Miller, M., Valle, E., Shrestha, H., Carter, G., Werler, M., & Jones, H. (2019). Naltrexone Treatment for Pregnant Women With Opioid Use Disorder Compared With Matched Buprenorphine Control Subjects. Clinical therapeutics, 41(9), 1681–1689. https://doi.org/10.1016/j.clinthera.2019.07.003
46. Ward, E. N., Quaye, A. N., & Wilens, T. E. (2018). Opioid Use Disorders: Perioperative Management of a Special Population. Anesthesia and analgesia, 127(2), 539–547. https://doi.org/10.1213/ANE.0000000000003477
47. Jones, H. E., Chisolm, M. S., Jansson, L. M., & Terplan, M. (2013). Naltrexone in the treatment of opioid-dependent pregnant women: the case for a considered and measured approach to research. Addiction (Abingdon, England), 108(2), 233–247. https://doi.org/10.1111/j.1360-0443.2012.03811.x
48. Chan, C. F., Page-Sharp, M., Kristensen, J. H., O'Neil, G., & Ilett, K. F. (2004). Transfer of naltrexone and its metabolite 6,beta-naltrexol into human milk. Journal of human lactation: official journal of International Lactation Consultant Association, 20(3), 322–326. https://doi.org/10.1177/0890334404266881
49. Hulse, G. K., O'Neill, G., Pereira, C., & Brewer, C. (2001). Obstetric and neonatal outcomes associated with maternal naltrexone exposure. The Australian & New Zealand journal of obstetrics & gynaecology, 41(4), 424–428. https://doi.org/10.1111/j.1479-828x.2001.tb01322.x
50. Hulse, G., & O'Neil, G. (2002). Using naltrexone implants in the management of the pregnant heroin user. The Australian & New Zealand journal of obstetrics & gynaecology, 42(5), 569–573. https://doi.org/10.1111/j.0004-8666.2002.548_14.x
51. Hulse, G. K., O'Neil, G., & Arnold-Reed, D. E. (2004). Methadone maintenance vs. implantable naltrexone treatment in the pregnant heroin user. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 85(2), 170–171. https://doi.org/10.1016/j.ijgo.2003.10.001
52. Jones, H. E., Chisolm, M. S., Jansson, L. M., & Terplan, M. (2013). Naltrexone in the treatment of opioid-dependent pregnant women: the case for a considered and measured approach to research. Addiction (Abingdon, England), 108(2), 233–247. https://doi.org/10.1111/j.1360-0443.2012.03811.x
53. Kelty, E., & Hulse, G. (2017). A Retrospective Cohort Study of Birth Outcomes in Neonates Exposed to Naltrexone in Utero: A Comparison with Methadone-, Buprenorphine- and Non-opioid-Exposed Neonates. Drugs, 77(11), 1211–1219. https://doi.org/10.1007/s40265-017-0763-855
54. Coluzzi, F., Bifulco, F., Cuomo, A., Dauri, M., Leonardi, C., Melotti, R. M., Natoli, S., Romualdi, P., Savoia, G., & Corcione, A. (2017). The challenge of perioperative pain management in opioid-tolerant patients. Therapeutics and clinical risk management, 13, 1163–1173. https://doi.org/10.2147/TCRM.S141332
55. Harrison, T. K., Kornfeld, H., Aggarwal, A. K., & Lembke, A. (2018). Perioperative Considerations for the Patient with Opioid Use Disorder on Buprenorphine, Methadone, or Naltrexone Maintenance Therapy. Anesthesiology clinics, 36(3), 345–359. https://doi.org/10.1016/j.anclin.2018.04.002
56. Jansson, L. M. (n.d.). UpToDate. Retrieved October 2, 2022, from https://www.uptodate.com/contents/neonatal-abstinence-syndrome

SECTION 2: HARM REDUCTION

57. Bell, J., Towers, C. V., Hennessy, M. D., Heitzman, C., Smith, B., & Chattin, K. (2016). Detoxification from opiate drugs during pregnancy. American journal of obstetrics and gynecology, 215(3), 374.e1–374.e3746. https://doi.org/10.1016/j.ajog.2016.03.015
58. Chhabra, N., Mir, M., Hua, M. J., Berg, S., Nowinski-Konchak, J., Aks, S., Arunkumar, P., & Hinami, K. (2022). Notes From the Field: Xylazine-Related Deaths - Cook County, Illinois, 2017-2021. MMWR. Morbidity and mortality weekly report, 71(13), 503–504. https://doi.org/10.15585/mmwr.mm7113a3
59. Zibbell, J. E., Clarke, S. D., Kral, A. H., Richardson, N. J., Cauchon, D., & Aldridge, A. (2022). Association between law enforcement seizures of illicit drugs and drug overdose deaths involving cocaine and methamphetamine, Ohio, 2014-2019. Drug and alcohol dependence, 232, 109341. https://doi.org/10.1016/j.drugalcdep.2022.109341
60. Moss, M. J., Warrick, B. J., Nelson, L. S., McKay, C. A., Dubé, P. A., Gosselin, S., Palmer, R. B., & Stolbach, A. I. (2017). ACMT and AACT Position Statement: Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders. Journal of medical toxicology : official journal of the American College of Medical Toxicology, 13(4), 347–351. https://doi.org/10.1007/s13181-017-0628-2
61. Attaway, P. R., Smiley-McDonald, H. M., Davidson, P. J., & Kral, A. H. (2021). Perceived occupational risk of fentanyl exposure among law enforcement. The International journal on drug policy, 95, 103303. https://doi.org/10.1016/j.drugpo.2021.103303
62. Del Pozo, B., Sightes, E., Kang, S., Goulka, J., Ray, B., & Beletsky, L. A. (2021). Can touch this: training to correct police officer beliefs about overdose from incidental contact with fentanyl. Health & justice, 9(1), 34. https://doi.org/10.1186/s40352-021-00163-5
63. Ruiz-Colón, K., Chavez-Arias, C., Díaz-Alcalá, J. E., & Martínez, M. A. (2014). Xylazine intoxication in humans and its importance as an emerging adulterant in abused drugs: A comprehensive review of the literature. Forensic science international, 240, 1–8. https://doi.org/10.1016/j.forsciint.2014.03.015
64. Torruella R. A. (2011). Xylazine (veterinary sedative) use in Puerto Rico. Substance abuse treatment, prevention, and policy, 6, 7. https://doi.org/10.1186/1747-597X-6-7
65. Rodríguez, N., Vargas Vidot, J., Panelli, J., Colón, H., Ritchie, B., & Yamamura, Y. (2008). GC-MS confirmation of xylazine (Rompun), a veterinary sedative, in exchanged needles. Drug and alcohol dependence, 96(3), 290–293. https://doi.org/10.1016/j.drugalcdep.2008.03.005
66. Friedman, J., Montero, F., Bourgois, P., Wahbi, R., Dye, D., Goodman-Meza, D., & Shover, C. (2022). Xylazine spreads across the US: A growing component of the increasingly synthetic and polysubstance overdose crisis. Drug and alcohol dependence, 233, 109380. https://doi.org/10.1016/j.drugalcdep.2022.109380
67. Reyes, J. C., Negrón, J. L., Colón, H. M., Padilla, A. M., Millán, M. Y., Matos, T. D., & Robles, R. R. (2012). The emerging of xylazine as a new drug of abuse and its health consequences among drug users in Puerto Rico. Journal of urban health : bulletin of the New York Academy of Medicine, 89(3), 519–526. https://doi.org/10.1007/s11524-011-9662-6
68. Philadelphia Department of Public Health. (2022). Risks of xylazine use and withdrawal in people who use drugs in Philadelphia. PDPH-HAN_Alert_1_Xylazine_03.16.2022.pdf (hip-production-philly-private-assets.s3.amazonaws.com)
69. McNinch, JR; Maguire, M; Wallace, L. A CASE OF SKIN NECROSIS CAUSED BY INTRAVENOUS XYLAZINE ABUSE. Abstract published at SHM Converge 2021. Abstract 559 Journal of Hospital Medicine. https://shmabstracts.org/abstract/a-case-of-skin-necrosis-caused-by-intravenous-xylazine-abuse/. June 15th 2022.

SECTION 2: HARM REDUCTION

70. The New York Times Editorial Board. (2018, December 28). Slandering the unborn. The New York Times. Retrieved October 2, 2022, from https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html
71. Committee Opinion No. 479: Methamphetamine abuse in women of reproductive age. (2011). Obstetrics and gynecology, 117(3), 751–755. https://doi.org/10.1097/AOG.0b013e318214784e
72. Andrade C. (2018). Risk of Major Congenital Malformations Associated With the Use of Methylphenidate or Amphetamines in Pregnancy. The Journal of clinical psychiatry, 79(1), 18f12108. https://doi.org/10.4088/JCP.18f12108
73. Forray, A., & Foster, D. (2015). Substance Use in the Perinatal Period. Current psychiatry reports, 17(11), 91. https://doi.org/10.1007/s11920-015-0626-5
74. Gorman, M. C., Orme, K. S., Nguyen, N. T., Kent, E. J., 3rd, & Caughey, A. B. (2014). Outcomes in pregnancies complicated by methamphetamine use. American journal of obstetrics and gynecology, 211(4), 429.e1–429.e4297. https://doi.org/10.1016/j.ajog.2014.06.005
75. Huybrechts, K. F., Bröms, G., Christensen, L. B., Einarsdóttir, K., Engeland, A., Furu, K., Gissler, M., Hernandez-Diaz, S., Karlsson, P., Karlstad, Ø., Kieler, H., Lahesmaa-Korpinen, A. M., Mogun, H., Nørgaard, M., Reutfors, J., Sørensen, H. T., Zoega, H., & Bateman, B. T. (2018). Association Between Methylphenidate and Amphetamine Use in Pregnancy and Risk of Congenital Malformations: A Cohort Study From the International Pregnancy Safety Study Consortium. JAMA psychiatry, 75(2), 167–175. https://doi.org/10.1001/jamapsychiatry.2017.3644
76. Shah, R., Diaz, S. D., Arria, A., LaGasse, L. L., Derauf, C., Newman, E., Smith, L. M., Huestis, M. A., Haning, W., Strauss, A., Della Grotta, S., Dansereau, L. M., Roberts, M. B., Neal, C., & Lester, B. M. (2012). Prenatal methamphetamine exposure and short-term maternal and infant medical outcomes. American journal of perinatology, 29(5), 391–400. https://doi.org/10.1055/s-0032-1304818
77. Wright, T. E., Schuetter, R., Tellei, J., & Sauvage, L. (2015). Methamphetamines and pregnancy outcomes. Journal of addiction medicine, 9(2), 111–117. https://doi.org/10.1097/ADM.0000000000000101
78. Good, M. M., Solt, I., Acuna, J. G., Rotmensch, S., & Kim, M. J. (2010). Methamphetamine use during pregnancy: maternal and neonatal implications. Obstetrics and gynecology, 116(2 Pt 1), 330–334. https://doi.org/10.1097/AOG.0b013e3181e67094
79. Nguyen, D., Smith, L. M., Lagasse, L. L., Derauf, C., Grant, P., Shah, R., Arria, A., Huestis, M. A., Haning, W., Strauss, A., Della Grotta, S., Liu, J., & Lester, B. M. (2010). Intrauterine growth of infants exposed to prenatal methamphetamine: results from the infant development, environment, and lifestyle study. The Journal of pediatrics, 157(2), 337–339. https://doi.org/10.1016/j.jpeds.2010.04.024
80. Richardson, G. A., & Day, N. L. (1994). Detrimental effects of prenatal cocaine exposure: illusion or reality?. Journal of the American Academy of Child and Adolescent Psychiatry, 33(1), 28–34. https://doi.org/10.1097/00004583-199401000-00005
81. Richardson, G. A., Hamel, S. C., Goldschmidt, L., & Day, N. L. (1999). Growth of infants prenatally exposed to cocaine/crack: comparison of a prenatal care and a no prenatal care sample. Pediatrics, 104(2), e18. https://doi.org/10.1542/peds.104.2.e18
82. Shankaran, S., Lester, B. M., Das, A., Bauer, C. R., Bada, H. S., Lagasse, L., & Higgins, R. (2007). Impact of maternal substance use during pregnancy on childhood outcome. Seminars in fetal & neonatal medicine, 12(2), 143–150. https://doi.org/10.1016/j.siny.2007.01.002

SECTION 2: HARM REDUCTION

83. La Leche League International. (2021, June 1). Breastfeeding and caffeine. La Leche League International. Retrieved October 2, 2022, from https://www.llli.org/breastfeeding-info/caffeine/
84. Chasnoff, I. J., Burns, K. A., & Burns, W. J. (1987). Cocaine use in pregnancy: perinatal morbidity and mortality. Neurotoxicology and teratology, 9(4), 291–293. https://doi.org/10.1016/0892-0362(87)90017-1
85. Mastrogiannis, D. S., Decavalas, G. O., Verma, U., & Tejani, N. (1990). Perinatal outcome after recent cocaine usage. Obstetrics and gynecology, 76(1), 8–11.
86. Slutsker L. (1992). Risks associated with cocaine use during pregnancy. Obstetrics and gynecology, 79(5 (Pt 1)), 778–789.
87. ACOG Practice Bulletin No. 102: management of stillbirth. (2009). Obstetrics and gynecology, 113(3), 748–761. https://doi.org/10.1097/AOG.0b013e31819e9ee2
88. Little, B. B., Snell, L. M., Trimmer, K. J., Ramin, S. M., Ghali, F., Blakely, C. A., & Garret, A. (1999). Peripartum cocaine use and adverse pregnancy outcome. American journal of human biology : the official journal of the Human Biology Council, 11(5), 598–602. https://doi.org/10.1002/(SICI)1520-6300(199909/10)11:5<598::AID-AJHB3>3.0.CO;2-L
89. Aghamohammadi, A., & Zafari, M. (2016). Crack abuse during pregnancy: maternal, fetal and neonatal complication. The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians, 29(5), 795–797. https://doi.org/10.3109/14767058.2015.1018821
90. Hulse, G. K., Milne, E., English, D. R., & Holman, C. D. (1997). Assessing the relationship between maternal cocaine use and abruptio placentae. Addiction (Abingdon, England), 92(11), 1547–1551.
91. Eze, N., Smith, L. M., LaGasse, L. L., Derauf, C., Newman, E., Arria, A., Huestis, M. A., Della Grotta, S. A., Dansereau, L. M., Neal, C., & Lester, B. M. (2016). School-Aged Outcomes following Prenatal Methamphetamine Exposure: 7.5-Year Follow-Up from the Infant Development, Environment, and Lifestyle Study. The Journal of pediatrics, 170, 34–8.e1. https://doi.org/10.1016/j.jpeds.2015.11.070
92. Bartu, A., Dusci, L. J., & Ilett, K. F. (2009). Transfer of methylamphetamine and amphetamine into breast milk following recreational use of methylamphetamine. British journal of clinical pharmacology, 67(4), 455–459. https://doi.org/10.1111/j.1365-2125.2009.03366.x
93. Cressman, A. M., Koren, G., Pupco, A., Kim, E., Ito, S., & Bozzo, P. (2012). Maternal cocaine use during breastfeeding. Canadian family physician Medecin de famille canadien, 58(11), 1218–1219.
94. Temple, J. L., Bernard, C., Lipshultz, S. E., Czachor, J. D., Westphal, J. A., & Mestre, M. A. (2017). The Safety of Ingested Caffeine: A Comprehensive Review. Frontiers in psychiatry, 8, 80. https://doi.org/10.3389/fpsyt.2017.00080
95. Rawson, R. A., Gonzales, R., & Brethen, P. (2002). Treatment of methamphetamine use disorders: an update. Journal of substance abuse treatment, 23(2), 145–150. https://doi.org/10.1016/s0740-5472(02)00256-8
96. Farsalinos, K. E., & Le Houezec, J. (2015). Regulation in the face of uncertainty: the evidence on electronic nicotine delivery systems (e-cigarettes). Risk management and healthcare policy, 8, 157–167. https://doi.org/10.2147/RMHP.S62116

SECTION 2: HARM REDUCTION

97. Foulds, J., Ramstrom, L., Burke, M., & Fagerström, K. (2003). Effect of smokeless tobacco (snus) on smoking and public health in Sweden. Tobacco control, 12(4), 349–359. https://doi.org/10.1136/tc.12.4.349
98. Royal College of Physicians. (2007, October). Harm reduction in nicotine addiction: Helping people who can't quit. RCP London. Retrieved October 2, 2022, from https://shop.rcplondon.ac.uk/products/harm-reduction-in-nicotine-addiction-helping-people-who-cant-quit?variant=6509405637
99. Narahashi, T., Fenster, C. P., Quick, M. W., Lester, R. A., Marszalec, W., Aistrup, G. L., Sattelle, D. B., Martin, B. R., & Levin, E. D. (2000). Symposium overview: mechanism of action of nicotine on neuronal acetylcholine receptors, from molecule to behavior. Toxicological sciences : an official journal of the Society of Toxicology, 57(2), 193–202. https://doi.org/10.1093/toxsci/57.2.193
100. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on the Review of the Health Effects of Electronic Nicotine Delivery Systems, Eaton, D. L., Kwan, L. Y., & Stratton, K. (Eds.). (2018). Public Health Consequences of E-Cigarettes. National Academies Press (US).
101. Law, K. L., Stroud, L. R., LaGasse, L. L., Niaura, R., Liu, J., & Lester, B. M. (2003). Smoking during pregnancy and newborn neurobehavior. Pediatrics, 111(6 Pt 1), 1318–1323. https://doi.org/10.1542/peds.111.6.1318
102. Stroud, L. R., Paster, R. L., Papandonatos, G. D., Niaura, R., Salisbury, A. L., Battle, C., Lagasse, L. L., & Lester, B. (2009). Maternal smoking during pregnancy and newborn neurobehavior: effects at 10 to 27 days. The Journal of pediatrics, 154(1), 10–16. https://doi.org/10.1016/j.jpeds.2008.07.048
103. Committee Opinion No. 721: Smoking Cessation During Pregnancy. (2017). Obstetrics and gynecology, 130(4), 1. https://doi.org/10.1097/AOG.0000000000002353
104. Einarson, A., & Riordan, S. (2009). Smoking in pregnancy and lactation: a review of risks and cessation strategies. European journal of clinical pharmacology, 65(4), 325–330. https://doi.org/10.1007/s00228-008-0609-0
105. Office of the Surgeon General (US), & Office on Smoking and Health (US). (2004). The Health Consequences of Smoking: A Report of the Surgeon General. Centers for Disease Control and Prevention (US).
106. Napierala, M., Mazela, J., Merritt, T. A., & Florek, E. (2016). Tobacco smoking and breastfeeding: Effect on the lactation process, breast milk composition and infant development. A critical review. Environmental research, 151, 321–338. https://doi.org/10.1016/j.envres.2016.08.002
107. Dorea J. G. (2007). Maternal smoking and infant feeding: breastfeeding is better and safer. Maternal and child health journal, 11(3), 287–291. https://doi.org/10.1007/s10995-006-0172-1
108. Grana, R., Benowitz, N., & Glantz, S. A. (2014). E-cigarettes: a scientific review. Circulation, 129(19), 1972–1986. https://doi.org/10.1161/CIRCULATIONAHA.114.007667
109. Centers for Disease Control and Prevention. E-cigarettes and pregnancy. Atlanta, GA: CDC; 2019. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/e-cigarettes-pregnancy.htm Retrieved August 22, 2022
110. Spindel, E. R., & McEvoy, C. T. (2016). The Role of Nicotine in the Effects of Maternal Smoking during Pregnancy on Lung Development and Childhood Respiratory Disease. Implications for Dangers of E-Cigarettes. American journal of respiratory and critical care medicine, 193(5), 486–494. https://doi.org/10.1164/rccm.201510-2013PP

SECTION 2: HARM REDUCTION

111. Whittington, J. R., Simmons, P. M., Phillips, A. M., Gammill, S. K., Cen, R., Magann, E. F., & Cardenas, V. M. (2018). The Use of Electronic Cigarettes in Pregnancy: A Review of the Literature. Obstetrical & gynecological survey, 73(9), 544–549. https://doi.org/10.1097/OGX.0000000000000595
112. McDonnell, B. P., Dicker, P., & Regan, C. L. (2020). Electronic cigarettes and obstetric outcomes: a prospective observational study. BJOG : an international journal of obstetrics and gynaecology, 127(6), 750–756. https://doi.org/10.1111/1471-0528.16110
113. Wang, X., Lee, N. L., & Burstyn, I. (2020). Smoking and use of electronic cigarettes (vaping) in relation to preterm birth and small-for-gestational-age in a 2016 U.S. national sample. Preventive medicine, 134, 106041. https://doi.org/10.1016/j.ypmed.2020.106041
114. Shittu, A., Kumar, B. P., Okafor, U., Berkelhamer, S., Goniewicz, M. L., & Wen, X. (2021). Changes in e-cigarette and cigarette use during pregnancy and their association with small-for-gestational-age birth. American journal of obstetrics and gynecology, S0002-9378(21)02583-7. Advance online publication. https://doi.org/10.1016/j.ajog.2021.11.1354
115. Bowker, K., Ussher, M., Cooper, S., Orton, S., Coleman, T., & Campbell, K. A. (2020). Addressing and Overcoming Barriers to E-Cigarette Use for Smoking Cessation in Pregnancy: A Qualitative Study. International journal of environmental research and public health, 17(13), 4823. https://doi.org/10.3390/ijerph17134823
116. DeVito, E. E., Fagle, T., Allen, A. M., Pang, R. D., Petersen, N., Smith, P. H., & Weinberger, A. H. (2021). Electronic Nicotine Delivery Systems (ENDS) Use and Pregnancy I: ENDS Use Behavior During Pregnancy. Current addiction reports, 8(3), 347–365. https://doi.org/10.1007/s40429-021-00380-w
117. Rebuli, M. E., Rose, J. J., Noël, A., Croft, D. P., Benowitz, N. L., Cohen, A. H., Goniewicz, M. L., Larsen, B. T., Leigh, N., McGraw, M. D., Melzer, A. C., Penn, A. L., Rahman, I., Upson, D., Crotty Alexander, L. E., Ewart, G., Jaspers, I., Jordt, S. E., Kligerman, S., Loughlin, C. E., ... Witek, T. J., Jr (2023). The E-cigarette or Vaping Product Use-Associated Lung Injury Epidemic: Pathogenesis, Management, and Future Directions: An Official American Thoracic Society Workshop Report. Annals of the American Thoracic Society, 20(1), 1–17. https://doi.org/10.1513/AnnalsATS.202209-796ST
118. Coles, C., et al. (2018). Gestational age and socioeconomic status as mediators for the impact of prenatal alcohol exposure on development at 6 months. Birth defects research. 1-8. https://doi.org/10.1002/bdr2.1408
119. Schempf, A. H. et al. (2008). Illicit drug use and adverse outcomes: Is it drugs or context?. Journal of urban health. 85(6). 858-873.
120. Dreher, M. C., Hayes, J. S., Nugent, J. K. (1988). Newborn outcomes with maternal marihuana use in jamaican women. Periatric nursing. 14(2). 107-110.
121. Frank, D. A. et al. (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure a systematic review. Journal of the American medical association. 285(12). 1613-1625.
122. Fried, P. A. (1995). The Ottawa prenatal prospective study (OPPS): Methodological issues and findings – it's easy to throw the baby out with the bathwater. Life Sciences. 56(23-24). 2159-2168.
123. Scott, K. A. et al. (2019). The ethics of perinatal care for black women. J perinat neonat nurs. 33(2). 108-115.
124. Mayne, G., Buckley, A., & Ghidei, L. (2023). Why Causation Matters: Rethinking "Race" as a Risk Factor. Obstetrics and gynecology, 142(4), 766–771. https://doi.org/10.1097/AOG.0000000000005332

SECTION 2: HARM REDUCTION

125. Braveman P. (2023). The Black-White Disparity in Preterm Birth: Race or Racism?. The Milbank quarterly, 101(S1), 356–378. https://doi.org/10.1111/1468-0009.12625
126. Beldon, M. A., Clay, S. L., Uhr, S. D., Woolfolk, C. L., & Canton, I. J. (2025). Exposure to Racism and Adverse Pregnancy Outcomes for Black Women: A Systematic Review and Meta-Analysis. Journal of immigrant and minority health, 27(1), 149–170. https://doi.org/10.1007/s10903-024-01641-2
127. Saiyed, N. S., Bishop-Royse, J. C., Smart, B. P., Leung, A., & Benjamins, M. R. (2025). Black:white inequities in infant mortality across the 69 most populous US cities, 2018-2021. Frontiers in public health, 13, 1484433. https://doi.org/10.3389/fpubh.2025.1484433
128. Saiyed, N. S., Bishop-Royse, J. C., Smart, B. P., Leung, A., & Benjamins, M. R. (2025). Black:white inequities in infant mortality across the 69 most populous US cities, 2018-2021. Frontiers in public health, 13, 1484433. https://doi.org/10.3389/fpubh.2025.1484433
129. Franklin, C. (2024). Marquette Law School Poll: A Comprehensive look at the Wisconsin vote January 24-31, 2024. Marquette Law School Poll. https://law.marquette.edu/poll/
130. Mendelson, J. H. Mello, N. K. Elingboe, J. (1985). Acute effects of marihuana smoking on prolactin levels in human females. Journal of Pharmacology and Experimental Therapeutics. 232(1). 220-222.
131. Ryan, S. A., Ammerman, S. D., O'Connor, M. E., COMMITTEE ON SUBSTANCE USE AND PREVENTION, & SECTION ON BREASTFEEDING (2018). Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes. Pediatrics, 142(3), e20181889. https://doi.org/10.1542/peds.2018-1889
132. An overdose death is not murder: Why drug-induced homicide laws are counterproductive and inhumane. Drug Policy Alliance (DPA). (2017, November 6). drugpolicy.org/resource/an-overdose-death-is-not-murder-why-drug-induced-homicide-laws-are-counterproductive-and-inhumane

SECTION 3: NAVIGATING THE HEALTHCARE + LEGAL SYSTEMS

1. Vincent, E. C., Zebelman, A., Goodwin, C., & Stephens, M. M. (2006). Clinical inquiries. What common substances can cause false positives on urine screens for drugs of abuse?. The Journal of family practice, 55(10), 893–897.
2. Lester, B. M., Andreozzi, L., & Appiah, L. (2004). Substance use during pregnancy: time for policy to catch up with research. Harm reduction journal, 1(1), 5. https://doi.org/10.1186/1477-7517-1-5
3. McMillin, G. A., Slawson, M. H., Marin, S. J., & Johnson-Davis, K. L. (2013). Demystifying analytical approaches for urine drug testing to evaluate medication adherence in chronic pain management. Journal of pain & palliative care pharmacotherapy, 27(4), 322–339. https://doi.org/10.3109/15360288.2013.847889
4. Clinical Drug Testing of Pregnant People and Newborns. Pregnancy Justice. (2024, February). https://www.pregnancyjusticeus.org/resources/clinical-drug-testing/
5. Committee opinion no. 633: Alcohol abuse and other substance use disorders: ethical issues in obstetric and gynecologic practice. (2015). Obstetrics and gynecology, 125(6), 1529–1537. https://doi.org/10.1097/01.AOG.0000466371.86393.9b
6. Bell S. G. (2016). Drug Screening in Neonates. Neonatal network : NN, 35(5), 321–326. https://doi.org/10.1891/0730-0832.35.5.321
7. Kohsman M. G. (2016). Ethical Considerations for Perinatal Toxicology Screening. Neonatal network : NN, 35(5), 268–276. https://doi.org/10.1891/0730-0832.35.5.268
8. Substance Abuse and Mental Health Services Administration. (2017, January 23). The Federal Register. Federal Register :: Request Access. Retrieved October 2, 2022, from https://www.federalregister.gov/documents/2017/01/23/2017-00979/mandatory-guidelines-for-federal-workplace-drug-testing-programs
9. Terplan, M., & Minkoff, H. (2017). Neonatal Abstinence Syndrome and Ethical Approaches to the Identification of Pregnant Women Who Use Drugs. Obstetrics and gynecology, 129(1), 164–167. https://doi.org/10.1097/AOG.0000000000001781
10. New York Consolidated Laws, Family Court Act. FCT §§ 412(1), 413; N.Y. Family Court Act §1012(f) (i)(B).
11. ACOG Government Affairs. (2022, October). Issue Brief: Crisis Pregnancy Centers. Crisis Pregnancy Centers: Issue Brief. https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-crisis-pregnancy-centers
12. Center For Countering Digital Hate. (2023, June 15). Profiting From Deceit. Profiting From Deceit: How Google Profits From Anti-Choice Ads Distorting Searches For Reproductive Health Care. https://counterhate.com/wp-content/uploads/2023/06/Profiting-from-Deceit-CCDH-FINAL.pdf
13. Ralph, L. J., Baba, C. F., Biggs, M. A., McNicholas, C., Hagstrom Miller, A., & Grossman, D. (2024). Comparison of No-Test Telehealth and In-Person Medication Abortion. JAMA, 332(11), 898–905. https://doi.org/10.1001/jama.2024.10680
14. Duncan, C. I., Reynolds-Wright, J. J., & Cameron, S. T. (2022). Utility of a routine ultrasound for detection of ectopic pregnancies among women requesting abortion: a retrospective review. BMJ sexual & reproductive health, 48(1), 22–27. https://doi.org/10.1136/bmjsrh-2020-200888
15. Williams, S. G., Roberts, S., & Kerns, J. L. (2018). Effects of Legislation Regulating Abortion in Arizona. Women's health issues : official publication of the Jacobs Institute of Women's Health, 28(4), 297–300. https://doi.org/10.1016/j.whi.2018.02.002
16. Morse, J. E., Charm, S., Bryant, A., Ramesh, S., Krashin, J., & Stuart, G. S. (2018). The Impact of a 72-hour Waiting Period on Women's Access to Abortion Care at a Hospital-Based Clinic in North Carolina. North Carolina medical journal, 79(4), 205–209. https://doi.org/10.18043/ncm.79.4.205

SECTION 3: NAVIGATING THE HEALTHCARE + LEGAL SYSTEMS

17. Assessing the safety of drug-affected infants: Addendum to the child protective services access and initial assessmentstandards. Wisconsin Department of Children and Families. (2004, June 25). https://dcf.wisconsin.gov/files/cwportal/policy/pdf/dai-addendum.pdf
18. Initial assessment: What happens when a family receives a visit. Wisconsin Department of Children and Families. (n.d.). https://dcf.wisconsin.gov/cps/overview/ia
19. Indian Child Welfare Act, 25 U.S.C. §§ 1901-1963 (1978)
20. Pratt, R. H. (1892). The advantages of mingling Indians with Whites. In I. C. Barrows (Ed.), Proceedings of the National Conference of Charities and Correction (pp. 46–59). Press of Geo. H. Ellis.
21. United States. Congress. Senate. Committee on Foreign Relations. (1982). The Genocide Convention : hearing before the Committee on Foreign Relations, United States Senate, Ninety-seventh Congress, first session on Ex. O, 81-1, the Convention on the Prevention and Punishment of the Crime of Genocide, adopted unanimously by the General Assembly of the United Nations in Paris on December 9, 1948, and signed on behalf of the United States on December 11, 1948. Washington :U.S. G.P.O.,
22. Association on American Indian Affairs. (n.d.). Indian Child Welfare Act. Association on American Indian Affairs. https://www.indian-affairs.org/icwa.html#history
23. The Caregiver Law and Rehabilitation Review. Wisconsin Department of Children and Families. (n.d.). https://dcf.wisconsin.gov/rehab-review

SECTION 4: PRENATAL CARE

1.Hayes, J. S., Dreher, M. C., & Nugent, J. K. (1988). Newborn outcomes with maternal marihuana use in Jamaican women. Pediatric nursing, 14(2), 107–110.
2.Westfall, R. E., Janssen, P. A., Lucas, P., & Capler, R. (2006). Survey of medicinal cannabis use among childbearing women: patterns of its use in pregnancy and retroactive self-assessment of its efficacy against 'morning sickness'. Complementary therapies in clinical practice, 12(1), 27–33. https://doi.org/10.1016/j.ctcp.2005.09.006
3.Alaniz, V. I., Liss, J., Metz, T. D., & Stickrath, E. (2015). Cannabinoid hyperemesis syndrome: a cause of refractory nausea and vomiting in pregnancy. Obstetrics and gynecology, 125(6), 1484–1486. https://doi.org/10.1097/AOG.0000000000000595
4.Roberson, E. K., Patrick, W. K., & Hurwitz, E. L. (2014). Marijuana use and maternal experiences of severe nausea during pregnancy in Hawai'i. Hawai'i journal of medicine & public health : a journal of Asia Pacific Medicine & Public Health, 73(9), 283–287.
5.El-Mohandes, A., Herman, A. A., Nabil El-Khorazaty, M., Katta, P. S., White, D., & Grylack, L. (2003). Prenatal care reduces the impact of illicit drug use on perinatal outcomes. Journal of perinatology : official journal of the California Perinatal Association, 23(5), 354–360. https://doi.org/10.1038/sj.jp.7210933

SECTION 5: LABOR + CHILDBIRTH

None

SECTION 6: POSTPARTUM CARE

1. Schiff, D. M., Nielsen, T., Terplan, M., Hood, M., Bernson, D., Diop, H., Bharel, M., Wilens, T. E., LaRochelle, M., Walley, A. Y., & Land, T. (2018). Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. Obstetrics and gynecology, 132(2), 466–474. https://doi.org/10.1097/AOG.0000000000002734
2. Academy of Breastfeeding Medicine (ABM). (2023) Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder. Breastfeeding medicine. 18(10), 715–733.
3. National Institute of Child Health and Human Development (LactMed). (2025). Drugs and Lactation Database: Alcohol. Available from: https://www.ncbi.nlm.nih.gov/books/NBK501469/
4. Sachs, H. C., & Committee On Drugs (2013). The transfer of drugs and therapeutics into human breast milk: an update on selected topics. Pediatrics, 132(3), e796–e809. https://doi.org/10.1542/peds.2013-1985
5. Iqbal, M. M., Sobhan, T., & Ryals, T. (2002). Effects of commonly used benzodiazepines on the fetus, the neonate, and the nursing infant. Psychiatric services (Washington, D.C.), 53(1), 39–49. https://doi.org/10.1176/appi.ps.53.1.39
6. Bertrand, K. A., Hanan, N. J., Honerkamp-Smith, G., Best, B. M., & Chambers, C. D. (2018). Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk. Pediatrics, 142(3), e20181076. https://doi.org/10.1542/peds.2018-1076
7. Perez-Reyes, M., & Wall, M. E. (1982). Presence of delta9-tetrahydrocannabinol in human milk. The New England journal of medicine, 307(13), 819–820. https://doi.org/10.1056/NEJM198209233071311
8. Hill, M., & Reed, K. (2013). Pregnancy, breast-feeding, and marijuana: a review article. Obstetrical & gynecological survey, 68(10), 710–718. https://doi.org/10.1097/01.ogx.0000435371.51584.d1

SECTION 6: POSTPATRTUM CARE

9. Braillon, A., & Bewley, S. (2018). Committee Opinion No. 722: Marijuana Use During Pregnancy and Lactation. Obstetrics and gynecology, 131(1), 164. https://doi.org/10.1097/AOG.0000000000002429
10. Section on Breastfeeding (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827–e841. https://doi.org/10.1542/peds.2011-3552
11. Reece-Stremtan, S., & Marinelli, K. A. (2015). ABM clinical protocol #21: guidelines for breastfeeding and substance use or substance use disorder, revised 2015. Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine, 10(3), 135–141. https://doi.org/10.1089/bfm.2015.9992
12. Metz, T. D., & Stickrath, E. H. (2015). Marijuana use in pregnancy and lactation: a review of the evidence. American journal of obstetrics and gynecology, 213(6), 761–778. https://doi.org/10.1016/j.ajog.2015.05.025
13. National Library of Medicine. (n.d.). Drugs and lactation database (lactmed) - NCBI bookshelf. LactMed. Retrieved October 2, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK501922/
14. Dashe, J. S., Jackson, G. L., Olscher, D. A., Zane, E. H., & Wendel, G. D., Jr (1998). Opioid detoxification in pregnancy. Obstetrics and gynecology, 92(5), 854–858. https://doi.org/10.1016/s0029-7844(98)00312-3
15. Bartu, A., Dusci, L. J., & Ilett, K. F. (2009). Transfer of methylamphetamine and amphetamine into breast milk following recreational use of methylamphetamine. British journal of clinical pharmacology, 67(4), 455–459. https://doi.org/10.1111/j.1365-2125.2009.03366.x
16. Cressman, A. M., Koren, G., Pupco, A., Kim, E., Ito, S., & Bozzo, P. (2012). Maternal cocaine use during breastfeeding. Canadian family physician Medecin de famille canadien, 58(11), 1218–1219.
17. Temple, J. L., Bernard, C., Lipshultz, S. E., Czachor, J. D., Westphal, J. A., & Mestre, M. A. (2017). The Safety of Ingested Caffeine: A Comprehensive Review. Frontiers in psychiatry, 8, 80. https://doi.org/10.3389/fpsyt.2017.00080
18. La Leche League International. (2021, June 1). Breastfeeding and caffeine. La Leche League International. Retrieved October 2, 2022, from https://www.llli.org/breastfeeding-info/caffeine/
19. Napierala, M., Mazela, J., Merritt, T. A., & Florek, E. (2016). Tobacco smoking and breastfeeding: Effect on the lactation process, breast milk composition and infant development. A critical review. Environmental research, 151, 321–338. https://doi.org/10.1016/j.envres.2016.08.002
20. Dorea J. G. (2007). Maternal smoking and infant feeding: breastfeeding is better and safer. Maternal and child health journal, 11(3), 287–291. https://doi.org/10.1007/s10995-006-0172-1
21. Vennemann, M. M., Bajanowski, T., Brinkmann, B., Jorch, G., Yücesan, K., Sauerland, C., Mitchell, E. A., & GeSID Study Group (2009). Does breastfeeding reduce the risk of sudden infant death syndrome?. Pediatrics, 123(3), e406–e410. https://doi.org/10.1542/peds.2008-2145
22. Blakemore, E. (2018, May 9). The first birth control pill used Puerto Rican women as guinea pigs. History.com. https://www.history.com/articles/birth-control-pill-history-puerto-rico-enovid
23. Johnson, C. G. (2013, July 7). Female inmates sterilized in California prisons without approval. Reveal. https://revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/

NOTES:

IMPORTANT

- 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 with any questions you may have regarding a medical condition.
- Never disregard professional medical advice or delay in seeking it because of something you have read in this toolkit.

NATIONAL HARM REDUCTION COALITION

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

www.harmreduction.org

Academy of Perinatal Harm Reduction

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

www.perinatalharmreduction.org