



ASAM American Society of
Addiction Medicine

Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People

Background

The American Society of Addiction Medicine (ASAM) is deeply committed to the health and well-being of pregnant and postpartum people, their families, and communities. This includes advocating for the prevention and treatment of substance use-related harms throughout the reproductive years, with a focus on the perinatal period. Substance use disorder (SUD) is a stigmatized medical condition, and poorly understood for pregnant and postpartum people, who face discrimination accessing care and treatment.^{1,2} In areas most affected by the opioid crisis, opioid-involved pregnancies may include as many as 6 percent of childbirths.³

ASAM strongly supports reforms to reverse the punitive approach taken to substance use and SUD during and after pregnancy and respond to the shared interests of the parent-newborn dyad by providing ethical, equitable, and accessible, evidence-based care.⁴⁻⁶ Federal and state systems, healthcare institutions, and clinicians too often conflate substance use with SUD and stigmatize and equate a person with SUD as “unfit to parent” or “criminal”.⁷ As a result of the punitive approach that has permeated American public policy and practices, people who use substances while pregnant are deterred or delayed from seeking care because of fear of detection, prosecution, and punishment,⁸ and the rate of child protection system* involvement attributed to perinatal or parental substance use has doubled in recent years.⁹

Potential risks to a child growing up in a home with ongoing substance use can include risks of co-sleeping injuries while intoxicated,¹⁰ unintentional ingestions,¹¹ disruption of parenting abilities due to substance use,¹² and witnessing parental overdose.¹³ However, children impacted by family separation have worse long term outcomes in areas including education, employment, income, housing, health, substance use, and involvement with the criminal legal system, compared to their peers in the general population.¹⁴ Furthermore, child removal is associated with return to substance use among the affected parent¹⁵ (though the directionality cannot be implied based on currently available research),¹⁶ parental overdose, and higher rates of parental post-traumatic stress disorder (PTSD).^{17,18}

* The [family regulation system](#), commonly known as the child welfare system or in statute as Child Protective Services (CPS), is part of the civil legal system, thereby excepting it from constitutional provisions pertaining to police investigations. This system treats the protected privacy of family members as a risk to children, surveils and polices economically and racially marginalized families, destabilizing relationships, and increasing families’ vulnerability to state intervention. In this document, this system will be referred to as the “child protection system.”

Punitive policies and practices are disproportionately applied to and disparately affect pregnant and postpartum people of color. Despite similar rates of substance use¹⁹ and professional medical society recommendations that screening for substance use be universal,²⁰ Black parents and their newborns are 1.5 times more likely to be tested for substances as compared to non-Black parents.²¹ Black parents and their newborns are also 4 to 10 times more likely than White parents and their newborns to be reported to the child protection system at delivery.^{22,23} Black and Native American children are overrepresented in foster care at 2 to 11 times the rate of White children in the setting of parental substance use.^{1,5,24,25} Disparities in addiction care received by people of color have been documented in other ASAM statements⁶ and may be even more pronounced for people of color during pregnancy,²⁶ although this area is understudied.²⁷ For example, pregnant persons of color receive significantly lower doses of methadone at the time of delivery compared to their White counterparts.²⁸ These disparities occur in an environment where structural racism has contributed to a maternal mortality rate that is 2.9 times higher for non-Hispanic Black people than for White people.^{29,30}

Unique to the perinatal period, use of toxicology testing can have serious legal and social consequences for pregnant and postpartum people.³¹ When applied, toxicology testing should help clinicians manage addiction treatment or guide clinical management. Despite clear professional society recommendations that toxicology testing requires explicit consent—ASAM’s guidance states “pregnant women should provide explicit written consent for drug testing including during labor and delivery,”³²—testing is often done without informing patients of the risks and benefits of testing and without obtaining consent.³³ In addition, the information obtained from presumptive toxicology testing is limited by binary results and false positive results.³¹ Reliance on toxicology test results risks inaccurately equating all substance use with SUD, as substance use exists on a continuum, including, light, moderate, risky, and uncontrolled use behaviors, and may not be associated with SUD. Further, **equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons’ engagement with healthcare services.**^{34,35}

The federal Child Abuse Prevention and Treatment Act (CAPTA) is legislation that emerged in parallel with 1970s American drug policy.^{36,37} CAPTA provides funds to states to mitigate child abuse and neglect.³⁸ To receive these funds, states must implement:

“...policies and procedures (including appropriate referrals to child protection service [CPS] systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants...”³⁹

The legislation requires plans of safe care[†] be provided for infants affected by withdrawal symptoms from prenatal substance exposure and their caregivers.⁴⁰

CAPTA's overall approach and the lack of a definition of "affected by"⁴¹ in the statute has led to significant variation in how states, counties, and health care institutions implement its requirements. While CAPTA does not establish a definition of child abuse or neglect under federal law, require toxicology testing in pregnancy, or define a positive toxicology test as *per se* evidence of civil child abuse or neglect, many states have interpreted it in this way.^{38,42} CAPTA does not mandate clinicians to notify CPS of all detected substance exposures, nor does it require prosecution for any illegal action for non-prescribed substance use.³⁸

Most CAPTA funds are spent on maintaining children outside their home, only a small percentage of federal and state/local child protection system funds are spent on substance use prevention or programs that preserve or give financial assistance to families.⁴³ Additionally, CAPTA's reference to "withdrawal symptoms" is problematic, because some states have interpreted it as inclusive of legally-prescribed opioid agonist medications, an evidence-based treatment for opioid use disorder (OUD).⁴¹

The wider misunderstanding of CAPTA and its requirements has been compounded by restrictive and inequitable hospital policies. Many hospitals apply a series of unnecessary restrictions after birth when faced with a positive maternal or infant toxicology test result. These restrictions may result in a separation of the parent-newborn dyad and thus limit the implementation of evidence-based practices such as rooming-in, breast/chestfeeding, and skin-to-skin bonding.⁴⁴ Hospitals may also implement inequitable surveillance policies after substances have been detected that do not allow perinatal patients to leave inpatient units, have unsupervised visitors (including spouses and other support persons),⁴⁴ and subjects them to punitive room searches, which can lead to arrests.⁴⁵

Among pregnant and postpartum people with OUD, opioid agonist medications increase engagement in prenatal and addiction care and improve parental and child outcomes.⁴⁶

Methadone or buprenorphine remains a standard of care for OUD treatment during pregnancy, and medication doses often require titration during and after pregnancy.⁴⁷ Methadone and buprenorphine are compatible with breastfeeding, which has been shown to reduce the severity and duration of neonatal abstinence syndrome (NAS), also known as neonatal opioid withdrawal syndrome.⁴ Pregnant and postpartum people receiving opioid agonist medications for OUD face unique challenges, including limited medication availability, child protection system agency professionals' misunderstanding of those medications and possible interference in related clinical decisions, and inadequate interaction between the child protection system and clinicians.⁴⁸

Harm reduction approaches are appropriate throughout the life cycle, including during pregnancy.⁴⁹ These include access to pregnancy tests and contraception, take-home naloxone, syringe access, and use of "pump and dump" breastfeeding strategies to limit an infant's exposure to substances.⁵⁰ The use of harm reduction approaches may reduce poor obstetrical outcomes and parental mortality.⁵¹ Support provided through doula care improves maternal

[†] Individual states determine plans of safe care, and in some states, they are consistent with the kinds of plans/information given to patients before they are discharged from the hospital. Plans of safe care can be a way to communicate and link people to services that support the family.

health equity;⁵² pregnant and postpartum people with OUD who engaged with doula services perceived increased support and reduced stigma by health care providers.⁵³ In addition, paraprofessional-delivered home-visiting programs for parents and children, such as the Family Spirit intervention, improve outcomes and reduce health disparities, including reduced substance use risk.^{54,55}

Only 23% of SUD treatment facilities in 2018 offered programs specifically designed to support pregnant and postpartum people.⁵⁶ High rates of trauma and intimate partner violence (IPV) are reported by women with SUD; trauma-informed programming is necessary to support women in SUD treatment, in addition to family-friendly treatment.^{46,57,58} Among adults with unmet SUD treatment needs, parents with a child living at home were three times more likely to report treatment access barriers and four times more likely to specifically report stigma as a barrier to treatment compared to adults without a child at home.⁵⁷ Many clinicians (both obstetric and addiction medicine) have not received sufficient training in caring for pregnant people with SUD, resulting in insufficient access for pregnant people, especially when they need treatment with addiction medications,^{59,60} or on caring for people experiencing trauma and IPV.

Treatment discontinuation and overdose deaths are particularly high in the postpartum period.^{1,61,62} These poor outcomes are exacerbated by the loss of insurance coverage that many people face after giving birth, as Medicaid coverage provided during the pregnancy period traditionally expires 60 days after birth.⁶³ Access to childcare can be a barrier to treatment engagement in the post-partum period, and only 5.5 percent of specialty treatment facilities provided childcare services for patients in 2020.⁶⁴ Recovery housing for pregnant people is very limited, and few recovery homes will allow people to care for their children on premises.

American drug policy's criminalization of certain substance use has contributed to the highest rate of incarceration of women among nations; women of color bear the disproportionate burden of this response.⁶⁵ Pregnant people who are incarcerated are routinely shackled while in labor,⁶⁶ and often face difficulties in accessing SUD treatment. Although federal courts have granted injunctive relief to plaintiffs from inflexible policies that deny access to medically necessary treatment, including methadone and buprenorphine for OUD during incarceration—given likely violations of the Americans with Disabilities Act (ADA) and/or the Eighth Amendment to the U.S. Constitution's prohibition of cruel and unusual punishment,⁶⁷ lack of access to opioid agonist medications for OUD continue to be a challenge in many carceral settings.⁶⁷⁻⁷¹ One survey found 60 percent of U.S. jails reported continuing opioid agonist medication for OUD for pregnant people who had received such treatment before incarceration, but only 32 percent of jails started methadone or buprenorphine during pregnancy, and most discontinued opioid agonist medications for OUD during the postpartum period.⁷²

ASAM recognizes that the decision in *Dobbs v. Jackson Women's Health Organization* to overturn *Roe v. Wade* will bear a disproportionate burden on pregnant people who use substances.⁷³ In one estimation, 86 percent of pregnant people who used substances had unintended pregnancies.⁷⁴ The long-standing history of legislative interference with patient-clinician relationships involving patients' substance use,^{6,19} and some states' effective criminalization of substance use while pregnant or postpartum⁷⁵ has resulted in grave, disproportionate, and inequitable harm, especially to pregnant and postpartum people of color.⁷⁶ Further, where abortion bans have been enacted, they will likely intensify disparities in maternal mortality

rates³⁰ and create even more coercive conditions for pregnant people who enter jail or prison.^{77,78} In this rapidly evolving situation, ASAM reiterates that clinicians and patients must be able to make clinical decisions without legislative interference, and pregnant people must have access to life-saving medical care.

Recommendations:

The American Society of Addiction Medicine recommends:

Prevention, Screening, and Toxicology Testing

1. Addiction medicine professionals should screen all people of reproductive age for pregnancy intention, and either provide contraception if desired or refer for comprehensive family planning.
2. Addiction medicine and reproductive health professionals should work toward co-location and integration of services, including services for trauma and IPV.
3. All pregnant people should be screened with a validated instrument by their prenatal clinician to identify who may need an assessment for SUD.⁷⁹ Prenatal providers should use motivational interviewing techniques, offer medication initiation, and/or discuss referral to licensed SUD treatment services if SUD is diagnosed.¹
4. Toxicology testing during the perinatal period should be standardized in hospital policies, be used only when clinical indications suggest it is necessary, be part of a clear plan outlined by the clinician (e.g., how will the result change clinical care?), and—outside of emergency situations—obtained with informed, written³² consent to ensure risks and benefits have been reviewed given the unique legal and social consequences of testing for pregnant and postpartum people. Both clinician and patient should have clarity as to the goal of testing, who will have access to the results, and the possible ramifications of a positive test. Patients have the right of refusal and refusing a toxicology test should neither be seen as indication of use nor detract from clinical care.
5. A positive screening toxicology test result should be discussed with the patient, and a definitive test should be utilized if the patient's self-report is not consistent with the presumptive test.
6. Clinicians should not interpret a positive toxicology test result as determinative of a SUD. A positive toxicology test should result in: a) an increase in the intensity of an addiction treatment plan for patients with a SUD, b) evidence-based early intervention, and c) implementation of service-needs matching⁴¹ programs.
7. Parents should be made aware of toxicology testing of infants, and whenever possible, parental permission should be obtained. Infant meconium, umbilical cord, and cord blood testing often takes 5-7 days to result, lack clinical utility in guiding the management of hospitalized infants, and are not recommended.
8. Health care systems and hospitals should rigorously evaluate their use and applications of toxicology testing in pregnant and postpartum persons, and neonates, and examine the consequences of sharing the results of such testing outside the health care system; evaluation of such policy should be stratified by race and ethnicity. Policies that result in inequities in practice should be removed; areas where a lack of policy exists and results in inequities in practice should be addressed and rectified.

Federal and State Policy Changes and Reimagining Support

9. States with legislation defining in-utero substance exposure as child abuse or neglect should eliminate such language. This legislative effort should be informed by public health professionals, medical professional societies, substance use prevention services, child protection agencies, and people with lived experience in joint efforts with champion legislators.
10. The federal government, through CAPTA revisions and strategic guidance from federal agencies, should incentivize states to implement non-punitive, evidence-based, public health-driven approaches for SUD in pregnant and postpartum people.
 - a. A rigorous evaluation of CAPTA strategies should include linked parent-child health data to assess if the legislation is achieving its goal of improving child outcomes.⁴¹
 - b. Federal agencies should issue guidance with particular attention to how states should define the term “affected by,”⁸⁰ with clarification that addiction medications, including medications for OUD, are neither considered “prenatal drug exposure” nor should be included under any perceived CAPTA requirements. Any reauthorization of CAPTA should also include such clarification.
11. Jurisdictions and institutions should remove policies and statutes that may deter pregnant people from seeking care, including mandates to report pregnant or postpartum people to child protection systems or other governmental agencies on the sole basis of substance use or SUD.
12. Child protection system agencies should not use evidence of substance use to implement sanctions on parents, especially child removal. Such sanctions should only be made when other risk factors or harms have been assessed or identified, and there is objective evidence of abuse, neglect, or other danger to the child.
13. Jurisdictions should fund programs that focus on substance use prevention, treatment, perinatal care, and recovery supports that are culturally resonant, gender responsive, and trauma-informed, and include wrap around services for pregnant and postpartum people.
14. Federal and state agencies should fund the provision of social services and financial support to families in need.
 - a. Social service benefits and financial support should not be made contingent on toxicology testing of parents.
 - b. Federal and state agencies should prioritize funding for programs with demonstrated effectiveness, such as harm reduction programs that provide doula or paraprofessional-delivered home-visiting interventions for parents and children that reduce health disparities and risk of substance use,^{54,55} and integrated services addressing trauma and IPV.⁸¹ New interventions should be rigorously evaluated to consider both intended and unintended outcomes.
 - c. Federal and state policy should promote paid family and medical leave, thus allowing parents to fulfill caregiving responsibilities and engage in treatment services without having to forgo paid employment.

Hospital Practices Related to Substance Use

15. Hospitals should eliminate restrictive and inequitable policies that separate the parental-newborn dyad, limit the implementation of evidence-based practices, restrict patient movement or visitation, and allow for punitive room searches.
16. Hospitals should implement policies that prioritize the shared interests of the parental-newborn dyad. This includes a) coordination and communication—prior to active labor—among anesthesiology, neonatology, labor, delivery, and pediatric staff, and b) facilitating extended hospital stays for birthing parent when a neonate is being monitored or treated for withdrawal symptoms.
17. Hospitals should train staff that care for the parental-newborn dyad in the delivery of trauma-informed, respectful, comprehensive care that is patient-centered and tailored to whole person support.

Approach to Treatment in Peripartum Period

18. Pregnant and postpartum people who are stable on medication should be maintained on that medication unless there is a clear clinical rationale for discontinuation or due to patient preference.
19. Treatment decisions should be made collaboratively between a patient and their healthcare provider. Neither child protective services nor judges should make specific treatment recommendations or mandate or prohibit any particular type of treatment or peer support, but instead should know how to help patients connect with local, licensed SUD treatment providers.
20. Clinicians should make concerted efforts to communicate with social services professionals about the safety, efficacy, and importance of treatment with medications for pregnant and postpartum people with OUD.
21. Clinical protocols that result in racial inequities in treatment delivery—such as methadone dosage and buprenorphine access—should be identified and rectified.
22. Barriers to OUD treatment access and retention, including complex intake procedures, access to transportation, and childcare assistance, should be addressed.

Treatment, Harm Reduction, and Recovery Supports

23. SUD treatment services, residential treatment facilities, clinicians, and harm reduction programs should include reproductive health services, including family planning, contraception services, and pregnancy testing.
24. Peripartum people should be given priority access to SUD treatment.
25. Payment models need to ensure that SUD treatment providers can meet the specific needs of pregnant and postpartum people and their families. Such services include but are not limited to: the management of co-occurring mental health conditions, childcare, transportation, housing, nutrition, parenting skills classes, IPV counseling, and encouragement of breast/chestfeeding.
26. States should expand Medicaid and the Children’s Health Insurance Program (CHIP) to provide 12 months of coverage for postpartum care under the American Rescue Plan Act.⁸² States that have not expanded Medicaid as offered under the Affordable Care Act should do so.

27. State Medicaid programs should reimburse for the full range of prevention and treatment services during pregnancy, including screening, brief intervention, and referral to treatment (SBIRT), and IPV assessment and referral.
28. Residential treatment and recovery housing facilities should provide affordable, family housing that permits children to live on the premises with a parent receiving treatment or who is in recovery.⁸³
29. Clinicians should provide counseling regarding harm reduction strategies during and after pregnancy, including approaches to continue breastfeeding safely.
30. Clinics and hospitals should develop policies to ensure that overdose and suicide prevention is consistently offered, that naloxone kits are prescribed or dispensed, and SUD follow-up is arranged within 48 hours post-hospital discharge.
31. Harm reduction programs that provide doula, peer support services, or paraprofessional-delivered home-visiting interventions for parents and children should be further studied and those with demonstrated effectiveness for improving health equity should be replicated.

Medical Education

32. Medical education at all levels should include culturally appropriate education in the treatment and management of SUD during pregnancy and delivery, and the management of NAS; training in universal SUD screening methods, motivational interviewing, SBIRT, and training on responding to IPV. Concurrently, education on harm reduction approaches and the racist history of American drug policy should be taught.
33. Prenatal providers should be trained to care for pregnant people with SUD, including the use of methadone and buprenorphine for OUD. The American College of Graduate Medical Education program requirements should be updated to state this explicitly.⁸⁴
34. State perinatal collaboratives should train and disseminate information to prenatal and pediatric clinicians related to state and child protection system reporting/notification laws and policies.^{85,86}

Pregnant and Postpartum People Who are Incarcerated

35. The use of shackles during delivery should not be permitted; policies mandating the use of shackles or handcuffs should be eliminated.
36. Policies should support rooming-in and breastfeeding while the birthing parent is in the hospital. Telephone privileges while in the hospital should be no more restrictive than while in jail or prison.
37. Pregnant and postpartum people with SUD who are incarcerated should be able to access addiction medications, whether initiating or continuing a medication. Pregnant people with SUD who are incarcerated and in labor should be brought for appropriate medical care and permitted to continue addiction medications postpartum.
38. Policies should permit breast/chestfeeding/breast-pumping for postpartum people who are incarcerated.⁸⁷

Protecting People's Bodily Autonomy

39. It is a critical time for advocates—including clinicians—to unite in opposition to legislative interference with the patient-clinician relationship, such as abortion bans,⁸⁸ and policies

that reduce or eliminate access to voluntary, evidence-based, and in many cases, life-saving medical treatment.

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This policy statement is endorsed by the American College of Academic Addiction Medicine and the American Osteopathic Academy of Addiction Medicine.



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