

Chapter 1 : Substance Use While Pregnant and Breastfeeding | National Institute on Drug Abuse (NIDA)

Abuse, whether emotional or physical, is never okay. Unfortunately, some women experience abuse from a partner. Abuse crosses all racial, ethnic and economic lines. Abuse often gets worse during pregnancy. Almost 1 in 6 pregnant women have been abused by a partner. Abuse can come in many forms. An.

Adolescents and young adults are biologically wired to take risks and experiment with tobacco, alcohol, prescription pills, and illicit drugs. This puts women of childbearing age at an increased risk of addiction. Studies show that pregnant teens are more likely to abuse drugs compared to older women. Unplanned pregnancies are a risk factor for exposure to drugs and alcohol due to a late recognition of pregnancy and delayed access to antenatal care. When a pregnancy is unplanned, the woman may continue risky consumption of alcohol and drugs without realizing she is carrying a baby. In pregnant women, treatment with any medication needs to be carefully monitored to ensure the mother does not become dependent and no harm is caused to the baby. They realize that quitting tobacco, alcohol, or drugs is an important step towards a healthy birth. Yet, changing behaviors is not easy. Not all women are able to stop smoking, drinking, or using drugs when they find out they are expecting. Women who are daily smokers, heavy drinkers, and long-term drug abusers find it the hardest to quit. Abstinence rates for alcohol and illicit drugs are slightly more encouraging, but relapse rates in the postpartum period remain high. However, not every woman who is expecting understands the risks of tobacco, alcohol, and drug abuse for herself and her baby. Some women are under the false impression that light drinking is okay, believing that only binge drinking is harmful to the baby. Many expectant mothers are aware of the risks of drugs and alcohol but avoid seeking treatment for their addiction because they are afraid of the legal ramifications. Some women fear they will be judged and criticized by friends, family, and healthcare providers. Some women are afraid they may lose custody of their children or be evicted from their home if their addiction is discovered. The threat of institutionalization or incarceration keeps many pregnant women from seeking treatment for substance abuse. Many women struggle to cope with and adapt to the new phase of their lives and suffer from depression as a result. Postpartum depression, commonly known as baby blues, affects an estimated 15 percent of new mothers. Feelings of anxiety, sadness, and exhaustion make it difficult for the mother to care for herself and her baby. Studies show that women with postpartum depression are at a high risk of substance abuse. In fact, substance abuse and depression are risks for each other and both have a substantial negative impact on maternal and infant health. Substance Use Disorders in Pregnancy: A Statistical Overview Substance abuse in pregnancy is associated with a number of serious maternal and fetal health consequences. Nearly 90 percent of female drug abusers are of reproductive age. In pregnant teens age 15 to 17, the rate of drug abuse is much higher at almost 15 percent. More than 8 percent of women report current alcohol use and nearly 3 percent are binge drinkers. Tobacco use is also prevalent during pregnancy and 1 in 14 pregnant women smokes cigarettes. It is evident that substance use disorders are rampant during pregnancy. The study found that the prevalence of tobacco use is highest in the years age group. American-Indians and Alaskan Natives have the highest incidence of tobacco abuse at almost 17 percent. Smoking during pregnancy is highest in West Virginia more than 25 percent and Kentucky nearly 19 percent. Smoking during pregnancy is harmful to both mother and baby. For women who are trying to conceive, tobacco use makes it harder to become pregnant. Miscarriages are more likely in smokers and there is an increase in abortion rate by 33 percent. The risk of stillbirth increases by 23 percent in smokers. The risk of infections is higher in the unborn child if the mother is a smoker. Smoking is associated with placental problems such as early separation from the womb the placenta is the source of oxygen and nutrition to the baby. Maternal tobacco abuse can lead to the baby being born prematurely or having a low birth weight and health problems, requiring a longer hospital stay. Maternal smoking is also a risk factor for SIDS sudden infant death syndrome. Birth defects such as cleft lip and cleft palate are more likely in babies born to mothers who smoked while they were expecting. More than 50 percent of women report drinking alcohol in the three months prior to conceiving. Nearly 7 percent of mothers report using alcohol during the last three months of their pregnancy. In women above the age of 30, the percentage of alcohol drinkers in the last trimester is

higher at 10 percent. Interestingly, drinking during the last trimester is more common in mothers who are more highly educated. Women who are risky drinkers more than 7 drinks per week or more than 3 drinks on one occasion are less likely to achieve abstinence when they are pregnant. The good news is that alcohol consumption by pregnant women seems to be on the decline. Drinking alcoholic beverages during pregnancy has a number of harmful consequences including preterm labor. Fetal alcohol syndrome, a condition in which the baby suffers brain damage, malformations, and growth retardation, is a well-established consequence of maternal alcohol abuse and is present in 1 in live births every year. Interestingly, the jump is even more substantial in women under the age of 18, increasing from The number of pregnant women seeking treatment for marijuana abuse has also increased. According to one study , about 20 percent of pregnant women under the age of 24 tested positive on drug testing for marijuana.

Chapter 2 : Alcohol Abuse During Pregnancy - Alcohol Rehab Guide

While pregnancy can bring out a new or renewed tenderness in many relationships, it rocks others with emotions that play out in the form of domestic violence against both the mother and her unborn baby. Domestic violence also known as domestic abuse or intimate partner violence can.

Accepted May This article has been cited by other articles in PMC. Abstract Prenatal substance use is a critical public health concern that is linked with several harmful maternal and fetal consequences. The most frequently used substance in pregnancy is tobacco, followed by alcohol, cannabis and other illicit substances. Unfortunately, polysubstance use in pregnancy is common, as well as psychiatric comorbidity, environmental stressors, and limited and disrupted parental care, all of which can compound deleterious maternal and fetal outcomes. There are few existing treatments for prenatal substance use and these mainly comprise behavioral and psychosocial interventions. Contingency management has been shown to be the most efficacious of these. The purpose of this review is to examine the recent literature on the prenatal use of tobacco, alcohol, cannabis, stimulants, and opioids, including the effects of these on maternal and fetal health and the current therapeutic options. Furthermore, women are at highest risk for developing a substance use disorder during their reproductive years 18–44, especially ages 18–29. This means that women who are pregnant or soon to become pregnant are at increased risk for substance abuse. According to a national survey conducted in the United States in 2005, 5. Similar patterns of use have been observed in Europe 4, 5 and Australia 6. The most commonly used substance in pregnancy is nicotine, followed by alcohol, marijuana and cocaine 7, 8. Recently, there has been an increase in opiate use in pregnancy. There is little information available on the extent of substance use, other than tobacco, among pregnant women in low-income and middle-income countries. The overall prevalence of tobacco use in these countries is 2. While data on illicit substance use in pregnancy is lacking for most middle- and low-income countries, according to the World Health Organization, cannabis is the most common illicit drug worldwide, followed by amphetamine-type stimulants and opiates 14, and, as such, they are likely to be used by women of reproductive age. The limited data available for Africa is from South Africa, and indicates that between 3. The most commonly used illicit substances in South Africa include methamphetamine and cannabis. Opiate use has also increased in places like Africa and Asia 17, and is likely to become more prevalent in pregnancy. Prenatal substance use can bring about several deleterious consequences for both mother and baby, as described in detail below. The concern for the impact of substances on the developing fetus can motivate some women to curb their drug and alcohol use during pregnancy. Offsetting the reduction in pregnancy-related use is the dramatic rise in substance use from 6 to 12 months postpartum 9. Thus, while the levels of abstinence in pregnancy may be high, the impact of this is diminished due to the high rates of relapse postpartum. Unfortunately, maternal relapse happens at a time of high childcare needs and when infant development is dependent on maternal bonding. It is also important to note that this was a study conducted in the United States and that the levels of abstinence may not be equivalent in other countries, especially middle- and low-income countries where women may encounter significant socioeconomic stressors, low levels of education, and limited available treatments for substance use. As evidenced by these data, substance use in pregnancy is still a critical public health concern. The purpose of this review is to provide a brief overview of the pregnancy outcomes, neonatal and long-term developmental consequences of prenatal substance use, and current available treatments for pregnant women. Adverse effects of substance use in pregnancy Heavy alcohol use in pregnancy has been associated with a range of negative birth outcomes, including increased risks of miscarriage 19, stillbirth and infant mortality 20, 21, congenital anomalies 22, low birthweight 23, reduced gestational age 24, preterm delivery 25, and small-for-gestational age 22, 26. The evidence for low to moderate alcohol use in pregnancy has either been inconclusive 28 or shown no increased risk for these adverse pregnancy outcomes. Alcohol use in pregnancy has the most well established adverse fetal health effects 30–32 and is associated with the development of fetal alcohol spectrum disorders 33–35 and adverse neurodevelopmental outcomes. In addition, prenatal drinking is associated with long-term effects, such as cognitive and behavioral challenges 37, 38, adverse

speech and language outcomes 39 , executive functioning deficits in children 40 , and psychosocial consequences in adulthood Smoking during pregnancy exerts direct adverse effects on birth outcomes, including damage to the umbilical cord structure 42 , miscarriage 43 , increased risk for ectopic pregnancy 44 , low birthweight 45 – 47 , placental abruption 45 , 46 , 48 , preterm birth 45 , 49 , and increased infant mortality 45 , 46 , Also of concern are the deleterious health effects of second-hand smoke on newborns, which include higher rates of respiratory and ear infections, sudden infant death syndrome, behavioral dysfunction and cognitive impairment Additionally, women who were smokers before pregnancy might stop breastfeeding early so that they can take up smoking again Some pregnant women view cannabis use as harmless in pregnancy 52 ; however, it has been linked with several deleterious effects, including preterm labor, low birthweight, small-for-gestational age, and admission to the neonatal intensive care unit Prenatal cannabis use has also been linked with adverse consequences for the growth of fetal and adolescent brains 52 , reduced attention and executive functioning skills, poorer academic achievement and more behavioral problems The adverse effects of marijuana are frequently observed with comorbid substance use, and are greatest in heavy users. The extent of the adverse effects of cocaine use in pregnancy has been overestimated at times. However, there have been several large and thorough studies recently, which have all identified several risk factors associated with cocaine use during pregnancy, including premature rupture of membranes, placental abruption, preterm birth, low birthweight, and small for gestational age infants 55 , There have been inconsistent reports on the long-term effects of prenatal cocaine exposure on language, motor, and cognitive development, with a few studies describing positive findings 57 , 58 and some studies reporting very little or no effects This inconsistency is probably connected to the confounding effects of the postnatal environment, including unsteady and disordered home environments, dysfunctional parenting, and heavy maternal polysubstance use 60 – Similar to cocaine use in pregnancy, methamphetamine use is linked with shorter gestational ages, lower birthweight 63 , fetal loss 64 , developmental and behavioral defects 65 , preeclampsia, gestational hypertension, and intrauterine fetal death Opioid use in pregnancy is correlated with a greater risk of low birthweight, respiratory problems, third trimester bleeding, toxemia and mortality 12 , Maternal opiate use is associated with an increased risk of neonatal abstinence syndrome NAS , whereby opiate exposure in utero triggers a postnatal withdrawal syndrome NAS results in substantial neonatal morbidity and increased healthcare utilization 12 , 67 , and consists of an array of signs and symptoms, including irritability, feeding difficulties, tremors, hypertonia, emesis, loose stools, seizures, and respiratory distress Opioid exposure in pregnancy has also been associated with postnatal growth deficiency, microcephaly, neurobehavioral problems, and sudden infant death syndrome A significant point to take into account is that the undesirable consequences of prenatal substance use are confounded by the frequency of coexisting substance use and comorbid psychiatric illness 71 , Women with substance use disorders also frequently experience inadequate prenatal care, poor nutrition, chronic medical problems, poverty, and domestic violence 73 , Furthermore, substance use in pregnancy may also result in an early dysfunctional maternal-infant relationship that can potentiate the negative effects of prenatal drug exposure 60 , Treatment of substance use in pregnancy There are only a small number of effective therapies for substance use in pregnancy, which primarily involve behavioral counseling see Table 1. Brief interventions 75 , in particular those that utilize motivational interviewing 76 , 77 , have been shown to reduce prenatal alcohol use. A recent randomized trial utilizing a telephone-based brief intervention suggests that this method may achieve similar results to the in-person intervention method of moderating prenatal drinking Some additional interventions to reduce prenatal drinking that have recently been described include screening via non-healthcare community workers 79 , counseling by midwives 80 , and multimedia and educational efforts aimed at improving awareness Description of behavioral interventions for substance use disorders. Contingency management CM Based on the principle of positive reinforcement as a means of operant conditioning to influence behavior change. The premise behind CM is to systematically use reinforcement techniques, usually monetary vouchers, to modify behavior in a positive and supportive manner. Originally used for the treatment of cocaine users, it has since been used for opioids, marijuana, cigarettes, alcohol, benzodiazepines, and other drugs. Motivational interviewing MI A patient-centered, collaborative and highly empathic counselling style for eliciting behavior

change by helping clients to explore and resolve ambivalence. It draws from the trans theoretical model of change in order to improve treatment readiness and retention. Cognitive Behavioral Therapy CBT A psychotherapeutic treatment that uses an easy-to-learn set of strategies to help patients understand the situations that lead them to undesirable thoughts, feelings, or behaviors, to then avoid those situations when possible, and to deal more effectively with such situations when they occur. The goal of these strategies is to break old patterns of responding and replace them with new ones. Open in a separate window As with alcohol, behavioral counseling is the main treatment for smoking cessation and relapse prevention in pregnant women. Unfortunately, psychotherapeutic interventions have had only moderate success 82 “ Pharmacological treatments for smoking cessation have not been evaluated with respect to their safety and efficacy in pregnant and postpartum women 82 , Randomized clinical trials with nicotine replacement therapy in pregnant women have demonstrated limited efficacy in increasing the rates of abstinence 87 “ The most successful intervention for prenatal smoking cessation is contingency management CM with financial incentives 91 “ 93 , which has also reportedly improved birth outcomes Treatments specifically aimed at prenatal cannabis use are lacking. The current recommendation for lowering the use of cannabis in pregnancy includes the screening of pregnant women to increase the early identification of cannabis use Motivational interviewing MI 95 , 96 , cognitive-behavioral therapy CBT 95 “ 99 , and CM therapies have had some success in reducing marijuana use in women, but they have not been evaluated specifically with pregnant users. Thus, novel interventions that explicitly target cannabis use are vital, particularly given the current tendency towards marijuana legalization. As with smoking, CM is the intervention that shows most potential for treating cocaine-using pregnant women A randomized trial found that CM was associated with much longer duration of cocaine abstinence, higher number of cocaine-negative urine tests, and a greater proportion of documented abstinence when compared to community reinforcement approach and twelve-step facilitation Currently, there are no evidence-based pharmacological treatments for prenatal cocaine use. Nevertheless, a recent randomized, placebo-controlled trial supports the use of oral micronized progesterone as an intervention for postpartum cocaine use The study showed that women randomized to placebo had more self-reported cocaine use compared to women receiving micronized progesterone during the 12 weeks of the trial While these are preliminary findings and will require confirmation in a larger clinical trial, they show promise for the application of progesterone in postpartum women to reduce their cocaine use. Treatments for other stimulant use, such as methamphetamine, are limited. Research into reinforcement-based therapy RBT combined with a women-focused intervention among pregnant methamphetamine users reported a reduction in methamphetamine use over time However, there were no substantial distinctions between the intervention and control conditions , not unlike another study using RBT to treat stimulant use in pregnancy RBT seems to have potential as an intervention for methamphetamine use but more research is required. Methadone maintenance is the standard care for pregnant women with opiate use disorders Conversion from illicit opioid use to opioid maintenance therapy in a medically supervised setting decreases maternal and neonatal morbidity. Methadone maintenance offers greater relapse prevention with a steady opioid dosing regimen, reduces risk-taking behavior, enhances compliance with prenatal care, and leads to better neonatal outcomes On the other hand, medication-assisted withdrawal, that is detoxification by gradually reducing the dose of an opioid substitute medication, is associated with a high opioid relapse rate and higher fetal morbidity and mortality rates Buprenorphine has recently emerged as another potential therapy for opioid use in pregnancy. A randomized controlled trial that compared methadone and buprenorphine in pregnant opioid users showed that infants whose mothers received buprenorphine needed less treatment for NAS, substantially lower doses of morphine to treat NAS symptoms, and had shorter stays in hospital, compared to the infants of women given methadone Notably, buprenorphine had lower retention rates with flexibly delivered doses and low fixed doses compared to methadone However, buprenorphine and methadone are equally effective when given as fixed medium or high doses CM has likewise been reported to be effective in treating opioid use in pregnancy, by significantly increasing abstinence and treatment attendance compared to controls Thus, CM appears to be an important addition to methadone or buprenorphine treatment in pregnant women. Breastfeeding and postpartum substance use Breastfeeding has the potential to be a useful tool for substance

use in the postpartum period. Breastfeeding is the only available intervention shown to reduce NAS severity in opioid-exposed newborns , Breastfeeding might also be protective for postpartum relapse. In addition, non-current smokers are more likely to initiate and continue breastfeeding compared to current smokers , Therefore, the promotion of breastfeeding might prevent or delay postpartum relapse. While studies evaluating the potential role of breastfeeding as an intervention for substance use postpartum are limited, the rationale for such interventions is clear. Lactation reduces the HPA response to physical stress A behavior that promotes relaxation and reduces stress would be helpful to women with substance use disorders since psychosocial stress increases cravings

Chapter 3 : Partner violence during pregnancy: prevalence, effects, screening, and management

One in six abused women reports that her partner first abused her during pregnancy, and, according to the Centers for Disease Control, at least 4 to 8 percent of pregnant women report suffering abuse during pregnancy.

Sudden infant death syndrome SIDS. Preterm birth is the most common cause of death among children under 5 years of age, and many preterm children suffer from lifelong learning disabilities, as well as visual and hearing problems 9. The trauma of experiencing a stillbirth can have long-term psychological effects on a mother and the family. Studies have noted that the maternal experience after stillbirth may be characterized by depression, post-traumatic stress disorder PTSD , maternal anxiety, and unresolved mourning Prenatal Exposure and Miscarriage The most common adverse outcome of pregnancy is a miscarriage spontaneous abortion. A number of studies have found that pregnant mothers who abuse cocaine are at risk for miscarriage due to the fact that usage in early pregnancy decreases blood flow However, in the medical community, this remains controversial. In a meta-analysis of 20 scientific papers on substance use and pregnancy, researchers found that mothers who used it along with other drugs had an increased risk of miscarriage compared to drug-free mothers. However, when comparing women who only used cocaine with drug-free mothers, the effect was no longer present 5. While the aforementioned studies examining cocaine and miscarriage show somewhat mixed results 12, the other potential risks introduced throughout pregnancy—such as those associated with placental problems—underscore an undeniable connection between maternal use and fetal endangerment. Effects on a Developing Child One study found that children who were exposed to cocaine before birth had 2. Cocaine affects the central nervous system CNS. It is small in molecular weight and can cross the placenta, directly reaching the fetus. The direct impact of the drug on a developing fetus may lead to a number of congenital abnormalities or birth defects , including Limb reduction defects a limb fails to form properly. Congenital heart diseases CHDs. Cocaine in utero may also cause neurodevelopmental problems for offspring, potentially contributing to 5, Impaired adolescent functioning poor school performance, behavior, brain structure. Impaired perceptual reasoning and procedural learning. Attention deficit hyperactivity disorder ADHD. Impaired memory and executive function. Problems with language development. Research has also found that using stimulant drugs, such as amphetamines and cocaine , is associated with increased odds of physical abuse of the child This may be due to the fact that these drugs cause significant mental disturbances These teens were also more likely to have Less control over their emotions. If the child was mistreated, for example neglected or emotionally or physically abused, they were also more likely to suffer from the problems above. Teens exposed to the drug in-utero were also more likely to engage in aggressive behaviors at school, as well as steal or use tobacco or alcohol Long-term drug abuse can greatly impact the development of a child. After a baby is born, their environment can play a major role in how they develop. If a child is raised in a stressful environment, it can decrease their chances of overcoming the effects of prenatal exposure to cocaine Getting Help for Cocaine Addiction If you are abusing cocaine during your pregnancy, it is important that you seek medical care for your addiction. Getting help for an addiction to this drug can greatly boost the health of your entire family in numerous ways and reduce the incidence of Chaotic lifestyles with rotating caregivers. Ongoing paternal drug use. There are a variety of treatment options available to help you stop using the drug and learn coping skills. Often, a parent who abuses illicit drugs like cocaine does so in order to cope with underlying stressors, such as past trauma or abuse. Treatment can help you learn skills to help cope with these triggers without the use of cocaine or other drugs. Options for addiction treatment include: This option typically requires hours a week of time spent visiting the treatment center. Treatment will consist of sessions on drug abuse education, individual and group counseling, and coping skills. Therapy provides you with the opportunity to learn about addiction so that you can better understand your addiction and ways to overcome it. In a group setting, you can learn and support others who are recovering from an addiction to cocaine. Group therapy is a common treatment approach offered in both outpatient and inpatient recovery programs. By taking the steps to get treatment, you are creating a safe and healthy environment for your child. Research shows a positive association between mothers receiving drug treatment and

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18 Percent of Pregnant Women Drink Alcohol during Early Pregnancy (Substance Abuse and Mental Health Services Administration) - PDF; Alcohol Use and Binge Drinking Among Women of Childbearing Age: United States, (Centers for Disease Control and Prevention).

Reaffirmed Committee on Health Care for Underserved Women This information should not be construed as dictating an exclusive course of treatment or procedure to be followed. The Role of the Obstetrician-Gynecologist Abstract: Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Obstetricianâ€™gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. They are encouraged to work with state legislators to retract legislation that punishes women for substance abuse during pregnancy. A disturbing trend in legal actions and policies is the criminalization of substance abuse during pregnancy when it is believed to be associated with fetal harm or adverse perinatal outcomes. Although no state specifically criminalizes drug abuse during pregnancy, prosecutors have relied on a host of established criminal laws to punish a woman for prenatal substance abuse 1. As of September 1, , fifteen states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes, and three consider it grounds for involuntary commitment to a mental health or substance abuse treatment facility 1. States vary in their requirements for the evidence of drug exposure to the fetus or newborn in order to report a case to the child welfare system. Examples of the differences include the following: Most states focus only on the abuse of some illegal drugs as cause for legal action. For instance, in Maryland, the use of drugs such as methamphetamines or marijuana may not be cause for reporting the pregnant woman to authorities 2. Some states also include evidence of alcohol use by a pregnant woman in their definitions of child neglect. Although legal action against women who abuse drugs prenatally is taken with the intent to produce healthy birth outcomes, negative results are frequently cited. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse 3â€™5. Legally mandated testing and reporting puts the therapeutic relationship between the obstetricianâ€™gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient 6, 7. In one study, women who abused drugs did not trust health care providers to protect them from the social and legal consequences of identification and avoided or emotionally disengaged from prenatal care 8. Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity 9. Seeking obstetricâ€™gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing 6. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes. Substance abuse reporting during pregnancy may dissuade women from seeking prenatal care and may unjustly single out the most vulnerable, particularly women with low incomes and women of color Although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction Pregnant women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment As of , only 19 states have drug treatment programs for pregnant women, and only nine give priority access to pregnant women 1. Obstetricianâ€™gynecologists have important opportunities for substance abuse intervention. Three of the key areas in which they can have an effect are 1 adhering to safe prescribing practices, 2 encouraging healthy behaviors by providing appropriate information and education, and 3 identifying and referring patients already abusing drugs to addiction treatment professionals Substance abuse treatment programs integrated with prenatal care have proved to be effective in reducing maternal and fetal pregnancy complications and costs The use of the legal system to address perinatal alcohol and substance abuse is inappropriate. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive

legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions. These approaches should include the development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women, especially pregnant women, and their families. Substance abuse during pregnancy. State Policies in Brief. Retrieved September 10, This report lists policies regarding prosecution for substance abuse during pregnancy and drug abuse treatment options for pregnant women for each state. It is updated monthly. Governmental responses to pregnant women who use alcohol or other drugs: Punishing pregnant drug users: Drug Alcohol Depend ; Drug addiction and pregnancy: Am J Public Health ; Drug use and limited prenatal care: Am J Obstet Gynecol ; At-risk drinking and illicit drug use: American College of Obstetricians and Gynecologists. Legal interventions during pregnancy. Court-ordered medical treatments and legal penalties for potentially harmful behavior by pregnant women. Womens Health Issues ; Prenatal care reduces the impact of illicit drug use on perinatal outcomes. Maternal decision making, ethics, and the law. The prevalence of illicit drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. N Engl J Med ; Flavin J, Paltrow LM. Punishing pregnant drug-using women: J Addict Dis ; Safe use of medication. Perinatal substance abuse intervention in obstetric clinics decreases adverse neonatal outcomes. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Requests for authorization to make photocopies should be directed to:

Chapter 5 : Pregnancy and Substance Use | Drug War Facts

In recent years, opiate abuse during pregnancy has shown a worrisome increase. Polysubstance abuse is common among women who are expecting, and this is frequently complicated by co-occurring psychiatric illnesses, pregnancy-related health concerns, and environmental stressors.

This is an Open Access article which permits unrestricted noncommercial use, provided the original work is properly cited. This article has been cited by other articles in PMC. Abstract The purpose of this review is to provide an overview of the current state of knowledge regarding the experience of intimate partner violence IPV during pregnancy. Pregnancy IPV is a significant problem worldwide, with rates varying significantly by country and maternal risk factors. Pregnancy IPV is associated with adverse newborn outcomes, including low birth weight and preterm birth. Many mechanisms for how IPV may impact birth outcomes have been proposed and include direct health, mental health, and behavioral effects, which all may interact. Screening for IPV during pregnancy is essential, yet due to time constraints and few clear recommendations for assessment, many prenatal providers do not routinely inquire about IPV, or even believe they should. More training is needed to assist health care providers in identifying and managing pregnancy IPV, with additional research needed to inform effective interventions to reduce the rates of pregnancy IPV and resultant outcomes. It is our hope that this paper will provide useful information for researchers, health care providers, and policy makers. Findings from research conducted in countries throughout the world are described including information on the prevalence of pregnancy IPV, known effects, available screening methods, and management of this important health concern. The research reviewed was limited to English language reports. Preference was given to reports of large scale quantitative studies published in peer reviewed journals. However, some government reports were used, as were a few smaller scale and qualitative studies. As a result, however, conclusions drawn throughout this paper reflect the subjective interpretation of the author and the authors of other cited published papers. While a handful of systematic reviews of the literature have been published on various subtopics covered in this paper, a large scale comprehensive systematic review is still needed in order to draw specific and completely evidence-based conclusions formulated from comparisons of level of evidence and scientific rigor across available studies. Prevalence General IPV is a significant medical, public health, and societal concern worldwide. Recent comprehensive reviews have generally concluded that while some hospital and clinic based studies noted an increased risk, national and international population-based studies have found either that pregnant women are no more likely than nonpregnant women to experience IPV, or may even be at decreased risk. These questions were not behaviorally specific. Based on findings from research like that presented above, some researchers have estimated that every year in the US, over 1 million pregnant women experience IPV. Many reports have identified an association between younger age and pregnancy IPV, with those abused up to four years younger on average. It is clear, then, that a substantial proportion of women worldwide have been victimized by an intimate partner. Whether pregnancy is a protective factor is unclear, however, expectant women across various studies and settings have reported significant levels of IPV. Rates of pregnancy IPV appear to differ across countries, although comparative conclusions are difficult due to differences in study methodologies. However, we know that many more women will report abuse when questions about psychological victimization are included. Additionally, we know that while no groups of women can be considered immune from pregnancy IPV, certain characteristics are associated with an increased likelihood of this experience, and disproportionate inclusion of higher risk women in studies will increase reported prevalence rates. In particular, younger minority women at the lower socioeconomic levels and who are unmarried are more likely than other women to experience IPV while pregnant. Effects Low birth weight and preterm delivery The experience of IPV during pregnancy is associated with numerous negative consequences, including decreased infant birth weight and increased rates of prematurity. Low birth weight LBW and preterm births are leading causes of neonatal morbidity and mortality. Premature and low birth weight infants consume disproportionate amounts of scarce health care resources, and for those babies who survive prematurity and low birth weight, adverse initial and long-term outcomes are common. Such children

commonly have cognitive deficits, motor delays including cerebral palsy, academic difficulties, language delays, and significantly increased rates of attention problems, behavioral difficulties, and psychological problems. Indeed, given such an association, it may be possible to reduce LBW and prematurity rates through interventions targeting IPV. Generalizations across studies are difficult due to different populations, assessments, methods, and data analysis. However, over a dozen recent studies have identified significant associations. For example, among over low income women, any form of IPV during pregnancy was associated with a g decrease in infant birth weight, and this link remained significant even after control for sociodemographic factors including prenatal care and stressors. Finally, a meta-analysis of eight methodologically sound and recent studies revealed a significant association between pregnancy IPV of any kind and newborn outcomes pooled odds ratio of 1. The authors of this review concluded that due to the recent findings from analyses that included control for a multitude of factors, a relationship between IPV and newborn outcomes indeed exists, but may be secondary to, or explained by, prenatal smoking, substance use, or inadequate pregnancy weight gain among other factors. Many factors may explain the association including direct physical effects, and the impact on mental health and behavioral changes. For example, abuse involving abdominal trauma can lead to premature labor, rupture of membranes, placental abruption, and ruptured uterus, all of which lead to preterm birth or even fetal demise. These behaviors, including inadequate prenatal care utilization, inadequate weight gain, and smoking, drinking, and substance use during pregnancy, have in turn been associated with negative newborn outcomes. For example, one of the primary health behavior factors associated with both IPV and prematurity and LBW is inadequate prenatal care utilization. A link between IPV and late entry into prenatal care has been described in multiple reports, 91 , , with those experiencing IPV twice as likely to begin care in the third trimester, 65 , and entering care up to 6. Poor nutritional intake and inadequate weight gain have also been associated with both pregnancy IPV and adverse newborn outcomes. Several reports detail an association between pregnancy IPV and failure to gain weight. Many studies have described an association between IPV and pregnancy smoking. National statistics for reveal that Multiple projects have described an increased risk of alcohol and substance use among pregnant battered women. Babies born to women who are subjected to IPV while pregnant have a significantly increased risk of being born preterm or LBW, which can result in immediate and long term health and developmental problems. Effects are not limited to women who experience only physical abuse or trauma, as even psychological IPV has been linked to poor pregnancy outcomes. Many maternal factors are associated with pregnancy IPV, including physical and mental health problems, and negative health behaviors. Causality has not been established, and thus the direction of these relationships is not known. However, knowledge of the maternal characteristics statistically associated with pregnancy IPV can provide useful information to clinicians attempting to identify women experiencing or risk for experiencing IPV. Again, while any woman could be a potential victim, those most likely to be experiencing pregnancy IPV are women with recurrent pregnancy infections, including STDs, women who suffer from depression or anxiety, women with inadequate prenatal care utilization, those who fail to gain adequate weight, and women who smoke, consume alcohol, or use illicit substances during pregnancy. Knowledge of these characteristics and related demographic factors described in the previous section, together with the use of validated IPV assessment tools described in the subsequent section, can aid health care providers in the identification of women most at risk for IPV.

Screening and management Many professionals and organizations have addressed IPV by recommending universal screening and promoting zero tolerance for IPV. Nearly two decades ago, the American Medical Association recommended screening all women presenting to primary care and many secondary care specialties. Studies vary widely in findings related to whether providers believe they should screen and whether they actually do screen female patients for IPV. Finally, because of these widely varying prevalence rates of acceptance and practice related to IPV screening, the CDC concluded in that the extent to which US clinicians incorporate screening for IPV into their practices is relatively unknown. Unfortunately, recent research has suggested that responses to single IPV items do not correspond to scores on longer, standardized measures. While the original CTS2 asks questions about IPV based on occurrences in the past year, the authors permit use of other referent periods, and pregnancy studies typically ask about occurrences in the 12

months before pregnancy, and separately for occurrences since the beginning of pregnancy. Even short versions contain, at a minimum, 24 items. The CDC have recently developed a compendium of brief partner violence assessment tools that are recommended for use in health care settings. Some of the more commonly used tools are described here. The five-item AAS, is a commonly used IPV screen due to ease of administration and established reliability and validity. While comprehensive for a screening tool, cut-points for determination of abuse have not been well validated. Questions are answered on a five-point scale, with a cut-off of Feder and colleagues conducted a comprehensive review of dozens of studies from across the world, many of which involved comparisons of various screening tools to gold standards such as the CTS. However, this tool does not ask about sexual abuse or ongoing violence, and thus may need to be combined with another screening tool. Thus, it appears that any of these three tools could be effectively used by prenatal care providers to screen for IPV in their patients. Management and intervention While we are beginning to learn about the best way to screen for IPV during pregnancy, much less is known about how to effectively manage this problem once it is identified. Indeed, as described above, many providers do not routinely screen for IPV because they do not know what they should do if it is discovered. This is unfortunate as studies have revealed that disclosure of abuse in a health care setting, even in the absence of a subsequent intervention, can reduce the incidence of additional violence. Most felt helping IPV victims was stressful, difficult, and risky. The study authors concluded that health care workers need additional training and support in order to effectively manage patients experiencing IPV. Several options are available to health care providers in the management of patients, and pregnant women in particular, who are being abused. The first type is interventions for the women themselves. Health care providers with training in this area may be able to provide limited counseling in the form of a brief intervention or motivational interviewing. However, lack of time and experience precludes this option in the vast majority of cases. Other more commonly employed options are referrals to safe environments, including family members or shelters, referrals to counseling or other community based resources, and the provision of resource information. Another set of intervention options is referral of the perpetrator to a batterer treatment program. The practicality of this approach is somewhat limited, however, if the provider has no contact with the abuser or the abuser is unwilling to seek help. However, along these lines, a woman who is being physically abused can be encouraged to file legal charges or seek a protective order. Unfortunately, few published studies provide data to demonstrate the effectiveness of any of the above management options. One exception is a report on a US intervention project involving six telephone calls from a nurse over an eight-week period in which safety-promoting behaviors were discussed. A handful of reports can be found on projects outside the US and Europe. One is an initial report on an IPV intervention implemented in Australia which focused on the provision of a community mentor to provide assistance, support, and advocacy. A second report is from a study in Nicaragua with an intervention focused simply on inquiring about possible IPV discussing attitudes toward it. Two recent reviews have attempted to synthesize what we know about the effectiveness of treatment options in North America and Europe for women experiencing IPV. The first was conducted by Wathen and MacMillan, published in In terms of studies on interventions for women, most involved examining the effectiveness of shelter stays, advocacy counseling, personal and vocational counseling, and enhanced prenatal counseling addressing IPV. While all studies reviewed had methodological weaknesses, some conclusions could be drawn. First, no current evidence of suitable quality exists to evaluate the effectiveness of a shelter stay to decrease the incidence of violence. While this does not mean that a shelter stay may not be useful for some abused women, further research is needed to more definitely evaluate the effectiveness of this option. However, there was fair evidence to suggest that a shelter stay combined with advocacy counseling can decrease the rate of re-abuse and improve quality of life over the next two years. The Wathen and MacMillan review also examined studies that targeted male batterers, either alone or with their partners. These interventions have been more thoroughly studied, and thus evidence about their effectiveness is more readily available. Unfortunately, most programs that work with abusers to decrease the incidence of IPV have not been shown to be effective. In contrast, there is some evidence to suggest that arrest of the perpetrator, and the use of protective orders, can be effective in some cases. However, there is also data demonstrating that in

some cases this approach can actually lead to an escalation of violence, especially when the perpetrator is unemployed or otherwise has little to lose by not complying with the legal system. Finally, initial data suggest that protection orders combined with legal advocacy and counseling may reduce the incidence of re-perpetration for many men.

Chapter 6 : Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist - ACOG

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. When a pregnant woman drinks alcohol, so does her baby. Women also should not.

Neonatal Abstinence Syndrome "Neonatal abstinence syndrome NAS is a drug withdrawal syndrome in newborns following birth. The syndrome most commonly occurs in the context of antepartum opiate use, although other drugs have also been implicated. American Medical Association, April 30, , p. Antepartum maternal opiate use also increased from 1. In , newborns with NAS were more likely than all other hospital births to have low birthweight American Medical Association, April 30, , Abstract. Low birth weight is a major factor in infant mortality in the U. Infants weighing grams or less are almost 40 times more likely to die during their first 4 weeks of life than the normal birth weight infant. The two major contributors to low birth weight are preterm birth and intrauterine growth retardation IUGR. Both contribute to inadequate fetal growth. A birth is considered preterm if it has a duration of less than 37 weeks from the last menstrual period. IUGR refers to low weight for a given duration of gestation. Princeton University, Spring Volume 1, Number 1, p.

Multiple Determinants of Poor Birth Outcomes "Recent research stresses the multiple determinants of poor birth outcomes, with important factors including maternal poverty, poor nutrition, homelessness, a history of domestic violence, and lack of prenatal care. Pace University School of Law: April 24, , pp.

Neonatal Drug Testing "Urine, hair, and meconium samples are sensitive biological markers of substance use. Urine drug screening can detect only recent substance exposure, while neonatal hair and meconium testing can document intrauterine use because meconium and hair form in the second and third trimester, respectively. Although child protection agencies sometimes request hair analyses, neither hair nor meconium is appropriate for routine clinical use because of the high costs and propensity for false positive results. April , p.

Inadequate Prenatal Care and Illicit Drug Use "Many economic, psychosocial, behavioral, biological, and health services factors have been implicated in these adverse perinatal outcomes. May , p.

Constitutional View On Prosecuting Pregnant Women "Another constitutional argument [against prosecuting pregnant women] is based on the right to privacy: Risk of Seeking Medical Care "Research and clinical experience teach that when, as here, the personal risks of seeking medical care are raised to intolerably high levels, it is more likely that prenatal care and patient candor - and not drug use - will be what is deterred, often with tragic health consequences. City of Charleston, et al.

Drug Testing of Pregnant Women "A difficult dilemma is created by State laws that require the reporting of nonmedical use of controlled substances by a pregnant woman or that require drug testing after delivery if illicit drug use is suspected. These laws can have the unintended effect of women not seeking prenatal care. Drug testing during pregnancy, or postnatally, can have severe consequences. In many States, pregnant and parenting women can be reported to child protective services, even though the courts have struck down criminal charges against women who are pregnant and use drugs. Women have the right to refuse drug testing American College of Obstetricians and Gynecologists, ; however, if drug abuse is suspected that is contributing to child abuse, reporting to child protective services is necessary. Department of Health and Human Services, , p.

This principle prohibits the selective and arbitrary application of penalties against minority groups. While other nations also have populations of poor women whose lives are highly dysfunctional or who are addicted to alcohol and other drugs, only in the United States are these women treated as criminals or civilly committed based on their conduct while pregnant. Only in the United States do prosecutors take the position that embryos and fetuses should be protected as full human beings while in utero. April 24, , p.

Prosecution for Drug Use "The Constitution does not provide an individual with the right to use drugs. Nevertheless, the Court in *Robinson* held that the Constitution prohibits the State from punishing an individual simply due to his status as a drug user. In *Robinson*, the Court gave three reasons why the California statute criminalizing drug addiction violated the Cruel and Unusual Punishment Clause: Statutes Used to Prosecute Pregnant Women "Since there were not, and still are not, any statutes on the books specifically criminalizing drug use during pregnancy, women have been prosecuted under statutes that deal

with child abuse, assault, murder, or drug dealing []. One of the newest attempts in prosecuting women is using statutes related to the delivery of drugs to a minor. However, it is much more difficult to convince a judge and jury of prosecuting on these grounds because there is no explicit language in any statute delineating that a fetus can be considered a minor, entitled to all the rights and privileges afforded thereto [.,]. April Volume 1, Issue 5, p. Ultimately, the case addresses how best to strike the sometimes competing interests between mothers and their unborn children. The petitioners won, but their victory is likely to be short lived. History "Illicit drug use by women is also not new. Less than 15 years after Chuck Yaeger shattered the sound barrier, several events combined to shatter the placental barrier" the notion that the fetus was protected and even invulnerable. The placental "barrier" suddenly became quite porous. The rubella German measles epidemic and, in particular, the tragedies caused by two drugs, thalidomide and diethylstilbestrol DES , amplified public sentiment about the need for protecting the fetus from risks from drug use. Thalidomide was approved for marketing in and was used primarily as a sedative and antidote for nausea in early pregnancy. By , evidence showed that a rare set of deformities, mostly limb malformations, were caused by the drug and 8, children had been affected [10]. DES was a synthetic hormone prescribed in the s and s to prevent miscarriage. By the late s and s, the side effects of the drug became known: Licit and illicit drugs became suspect as possible teratogens, and the activities, diet and behaviors of pregnant women have been under close scrutiny ever since [11]. Moderate Alcohol Consumption Alcohol "We found that alcohol consumption up to moderate levels had no independent effects on weight or HC [head circumference] at birth, and there was no evidence of longer-term effects at 5 years. There was an apparent effect of binge drinking on birth weight, but this was due to confounding by cigarette use. Cigarette exposure, not binge drinking, adversely affected HC and birth weight. One study that measured children at birth and then again at 6 years also found no effects associated with measures of actual alcohol consumption, although reduced HC and length were associated with a measure of indications of problem drinking [24,51]. Of particular interest is a study that investigated a group who would be considered to be at high risk of adverse outcomes since it involved disadvantaged mothers with a history of alcohol abuse [31]. Although detrimental effects on weight, length, and HC appeared to be due to alcohol consumption, they were no longer significant once covariates such as maternal smoking and race were taken into account. Fetal Alcohol Syndrome FAS , characterized by pre- and post-natal growth retardation, facial dysmorphism, and central nervous system CNS dysfunction, was recognized in as a consequence of chronic alcohol exposure during pregnancy Since then, major and minor malformations, spontaneous abortion, and decreased birth weight have been among the many reported consequences of heavy alcohol use during pregnancy. Effects of Maternal Alcohol Use "Alcohol is a potent teratogen with a range of negative outcomes to the fetus, including low birthweight, cognitive deficiencies, and fetal alcohol disorders. June, 27, Vol. Twenty years later there is scant evidence to substantiate the dire predictions of permanent and severe damage to their children due to their drug use. Fetal Cocaine Exposure and Cognitive Development "Our study found significant cognitive deficits with cocaine-exposed children twice as likely to have significant delay throughout the first 2 years of life. Because 2-year Mental Development Index scores are predictive of later cognitive outcomes, it is possible that these children will continue to have learning difficulties at school age. Further, poorer cognitive outcomes were related to higher amounts of cocaine metabolites in infant meconium as well as to maternal self-reported measures of amount and frequency of cocaine use during pregnancy, providing further support for a teratologic model. Quality of Prenatal Care Important "We conclude that comprehensive prenatal care may improve outcome in pregnancies complicated by cocaine abuse; however, the perinatal morbidity associated with cocaine abuse cannot be eliminated solely by improved prenatal care.

Chapter 7 : When Pregnancy Triggers Violence

Smoking during pregnancy exerts direct adverse effects on birth outcomes, including damage to the umbilical cord structure 42, miscarriage 43, increased risk for ectopic pregnancy 44, low birthweight 47, placental abruption 45, 46, 48, preterm birth 45, 49, and increased infant mortality 45, 46,

What is intimate partner abuse in pregnancy? Intimate partner violence, also known as domestic violence, may happen during pregnancy. The abuser uses fear to control or overpower the relationship by using intimidation, threats, or physical force. There may be a pattern of an ongoing or on and off abuse. The abuser may beg for forgiveness, promise to change, or try to make up for the wrongdoing. The abuser may also act as if the violence never happened. Intimate partner abuse is not normal or acceptable. What are the types of intimate partner abuse? This includes pushing, hitting, kicking, slapping, biting, choking or pulling hair. Physical violence may also include stalking, or being held down. Your abuser may use a knife or gun on you. Physical violence may become life-threatening. Emotional or psychological abuse: This may include verbal abuse such as name-calling and insults. The abuser may also not let you do what you want to do with family or friends. He may not let you spend any money. This is when your partner has sex with you when you do not want it. Sexual abuse may include forcing sex when you are tired or sick. Using objects, or inviting other people to have sex when you do not agree is also sexual abuse. What increases my risk of intimate partner abuse in pregnancy? You are a young woman who is single, separated, or divorced. You have low income or live in a crowded place. Your pregnancy was not planned. You have delayed seeing your healthcare provider since you became pregnant. You have a medical condition, such as high blood pressure. You use drugs and alcohol. What are the signs and symptoms of intimate partner abuse in pregnancy? Physical signs and symptoms: Bruises, cuts, scratches or burns from the abuse Unexpected vaginal bleeding Sexually transmitted infections, such HIV and herpes High blood pressure Increased alcohol and drug use Emotional signs and symptoms: Feelings of stress, anxiety, worry, or sadness Sleeping problems Thoughts of harming yourself, your fetus, or other people How is intimate partner abuse in pregnancy diagnosed? Your healthcare provider will ask you questions. Everything you say to your healthcare provider will be kept private. Tell your healthcare provider as much as possible, so that you can get the help that you need. Your healthcare provider must report the abuse to police. Your healthcare provider may need to examine you, and may ask if they can take pictures of your injuries. You may also need any of the following: Blood and urine tests: Blood and urine tests may be done to check for problems, such as an infection. Vaginal and pelvic exam: You may need to have this exam so healthcare providers can check for any injuries that may have resulted from the abuse. A sample of discharge may be collected from your genitals, and sent to a lab for tests. This test uses sound waves to show pictures of your fetus inside your uterus. Gel is put on your abdomen, and a small wand is gently moved through the gel. As this is done, pictures of your baby can be seen on a monitor. Healthcare providers can learn the age of your baby, and see how fast he is growing. The movement, heart rate, and position of your baby can also be seen. These may be done to see if any bones have been broken or are displaced. X-rays of your chest and abdomen may also be taken. How is intimate partner abuse in pregnancy treated? When you are ready, you can get help. Your healthcare provider may suggest any of the following: Intimate partner violence may cause you to feel scared, depressed, or anxious. Your healthcare provider may suggest that you see a counselor to talk about how you are feeling. Healthcare providers may give you medicine to help decrease pain, anxiety, or depression. You may also need antibiotic medicine. You may need surgery to treat injuries. Surgery may return bones to their normal position if you have a broken bone. Surgery may also be needed to correct a deformity or treat other injuries. What are the risks of intimate partner abuse? Your abusive partner may grow angrier and more violent if he learns that you are seeking help. Contact your healthcare providers and support services secretly. The abuse may increase the risk that your children will get hurt. Children who see intimate partner abuse are more likely to use drugs and have behavior problems. Your child may become angry, very sad, or want to kill himself. Intimate partner abuse can cause serious health problems for you and your fetus. You may get bruises, cuts, or serious infections. The abuse may cause your baby to be born before he is ready.

Your newborn baby may be very small and need special care after birth. You are also at higher risk for depression after your baby is born. Without treatment, intimate partner abuse may get worse during your pregnancy. The attacks may happen more often and become more severe. Your abuser may use weapons, such as knives and guns, on you and other family members. Intimate partner abuse may become life-threatening to you and your fetus. What can I do to protect myself? Create a safety plan: Prepare a bag with clothes, spare money, and important papers in case you need to leave your house quickly. Hide an extra set of house and car keys. Have a secret way to let your family or friends know you need urgent help. Plan where you can go if you need to leave. If you do not have a cell phone, ask your healthcare provider about emergency cell phones for calls only. When you are attacked, avoid rooms with one entrance such as bathrooms and stay out of the kitchen. The police can remove your abuser and make him stay away from you if that is what you choose. Think about spending one or more nights in a shelter: Ask for names and phone numbers: Get a list of phone numbers for people who can help you. People at these phone numbers can answer your questions, and tell you where to go to get help. Ask about a domestic violence advocate: This is a trained healthcare provider who will talk to you about your choices. Contact with this healthcare provider is private. This person may also help you in an emergency to make sure that you are safe from your abuser. Where can I find support and more information? National Domestic Violence Hotline.

Chapter 8 : Substance Use During Pregnancy | Guttmacher Institute

Many states have expanded their civil child-welfare requirements to include substance abuse during pregnancy as grounds for terminating parental rights in relation to child abuse and neglect. The laws that address prenatal substance abuse are as follows.

By extension, the usefulness of this information carries over to the subset of pregnant women, although there are separate statistics on the latter group as well. Per the results of the National Survey on Drug Use and Health, the following data opens a window into the prevalence of drug abuse among females versus males: In terms of initiation into drug use, based on a month survey review, Of the females who abuse drugs, compared to males, they may have unique needs based on background circumstances. As the National Institute on Drug Abuse discusses, the following are some social factors that are likely to be prevalent among females who use drugs compared to males who engage in drug use: Lower level of educational attainment i. There is no one-size-fits-all approach to treatment, and research shows that sex and gender are relevant factors. In addition to sex-specific requirements females may have, pregnancy adds another layer of needs that will need to be addressed in treatment. Pregnancy and Substance Abuse The informational site Get the Facts provides data on the rates of substance abuse among pregnant females. The most recent data available was averaged over the years and took into account different age groups as well as trimesters. The data collected reflects the following: To provide a benchmark, the research noted that In the age group, 5. When trimesters are considered, in the age group of pregnant females, the rate of current illicit drug use was lower in the third trimester compared to the first and second trimesters 2. The age of the pregnant female was found to be a factor in the rate of current illicit drug use.. In the age group, In the group, the rate was 8. In the age group, the rate dropped to 3. From a biological standpoint, drugs impact body functions of both the fetus and the mother. The harm that may result from drug abuse depends on different contributing factors, including the type of drugs present, the point in pregnancy during which the drug use commenced, and the frequency of use. Further, fetuses have their own unique biological status. A fetus is highly sensitive to drugs and cannot eliminate them with the same proficiency as the mother. As a result, drugs can reach toxic levels in the body of a fetus in addition to causing a host of other health problems. Tennessee hospitals registered cases of infants born drug-dependent from the start of through June 21 of that year. Other states have since followed suit and passed new laws or construed existing laws to apply to this context. As the Washington Post reports, the Obama Administration steadfastly supports treatment rather than criminalization in the drug abuse context. Attorney General Eric Holder has called for reduced criminal sentences for those who have been convicted of low-level drug offences that may help to stimulate entry into rehab programs. The Washington Post Different drugs can have varying types of impact on a fetus. Ready to leave addiction behind? Call now to speak to a consultant about your treatment options Back to Top Effects of Drugs on Mother and Baby During pregnancy, the placenta allows the delivery of oxygen and nutrients from the mother to the fetus through the exchange of blood. Substance abuse may harm the fetus in one or more ways: By causing complications with pregnancy, such as the separation of the placenta from the uterus or premature contractions of the uterus By interfering with the delivery of oxygen or vital nutrients through the placenta By harming the fetus directly by restricting growth or interfering with normal development By causing spontaneous miscarriage, premature delivery, or fetal death Even a single episode of drug use during pregnancy can have a negative health outcome for a fetus. Drug abuse also exposes pregnant women to the lifestyle-related risks of drug use, such as communicable diseases, domestic violence, sexual assault, and criminal prosecution. Seeking treatment and stopping drug use with proper medical advice and supervision can help at any stage in pregnancy. To provide greater detail on the possible health effects in pregnant women and their unborn babies, consider the following substances of abuse and known side effects: Alcohol Alcohol can cause a condition known as fetal alcohol syndrome FAS , characterized by abnormal facial features, slowed fetal growth, and dysfunctions of the central nervous system brain and spinal cord. Damage to the central nervous system can lead to a baby growing up to have a low IQ or a behavioral disorder, such as attention deficit hyperactivity disorder ADHD. Approximately one in every ,

newborns is born with FAS. Marijuana Research shows that percent of pregnant females use this drug. When a pregnant woman uses cocaine, the drug passes directly through the placenta to the fetus, where it has a rapid effect on the developing infant. In utero, there is a risk that the fetus will not survive. Newborns may experience withdrawal symptoms such as irritability, tremors, sleep problems, diarrhea, or seizures. Children exposed to cocaine in utero have a higher risk of learning disabilities, developmental delays, and low IQ. Heroin abuse in pregnant women can cause serious complications, including placental abruption separation of the placenta from the uterine wall, premature labor, and fetal death. If the infant is born physically dependent on this opioid, withdrawal symptoms may occur after birth. Infants with NAS can experience tremors, sweating, poor feeding, diarrhea, vomiting, and seizures. Women who abuse heroin are at risk of respiratory depression, loss of consciousness, and fatal overdose. Amphetamines Amphetamines, known commonly as speed, are available through illegal sources or may be abused in the form of certain prescription medications. Amphetamines stimulate the activities of the brain and nerves. In utero, the fetus is at an increased risk of placental separation and death. Exposure to amphetamines in utero has been linked to cleft palate and heart abnormalities. Prenatal methamphetamine exposure PME has been associated with complications with pregnancy, restricted fetal growth, and withdrawal symptoms in newborns. When used during pregnancy, hallucinogenic drugs can increase the risk of miscarriage and premature labor, and they may cause withdrawal symptoms in newborn infants. Like heroin, which belongs to the same family of opiate-based narcotics, these drugs depress the activity of the central nervous system. Some of the most popular opioids include oxycodone OxyContin, Percocet, hydrocodone Vicodin, Norco, hydromorphone Dilaudid, and codeine Tylenol with Codeine and other combination drugs. These drugs are widely prescribed to pregnant women; however, recent research published in the American Journal of Obstetrics and Gynecology shows that taking opioid analgesics during pregnancy can increase the risk of spina bifida, congenital heart defects, cleft lip and cleft palate. Sedative-hypnotics Sedative-hypnotic drugs include prescription sleep aids, tranquilizers, and anti-anxiety medications that calm the central nervous system and induce relaxation or drowsiness. This category of drugs includes benzodiazepines like lorazepam Ativan, alprazolam Xanax, and diazepam Valium, which are some of the most widely prescribed drugs in the US, as well as sleeping medications like zolpidem Ambien and barbiturates like pentobarbital Nembutal. Many of the medications in this family of drugs are habit-forming and can cause withdrawal symptoms in the newborn. Infants born to mothers addicted to sedatives show signs of withdrawal syndrome and may have developmental complications or behavioral problems later in childhood. Because many illicit drugs of abuse and prescription drugs cross the placenta easily, infants born to addicted mothers are often dependent on these substances and must go through a period of withdrawal after birth. This condition is known as neonatal abstinence syndrome NAS. As the March of Dimes explains, the main drugs involved in NAS are heroin, prescription pain relievers, benzodiazepines, and antidepressants. In addition to withdrawal symptoms, the infant may be born small and have breathing problems, fever, blotchy skin, diarrhea, feeding troubles, and seizures. The duration of NAS can range from one week to six months. Infants who are born before the week mark may experience more severe NAS symptoms. Once such a facility has been identified, the next consideration is to learn whether there is an all-female program option. Although research is limited, it appears that all-female treatment is not more effective for females than mixed-sex treatment programs. However, the availability of all-female programs are crucial because some females will only engage treatment in an all-female environment. The first step at a rehab center is to go through the intake process to ensure that the center has the appropriate services. There are numerous warnings and advisements available that can help to inform prospective mothers about the many dangers associated with tobacco, alcohol, and other drug use. Designed to be a comprehensive resource, Childbirth Connection covers many facets of the pregnancy process, including its physical, emotional, psychological, and financial dimensions. Back to Top Intensive Therapy for Substance Abuse Typically, after the medical detox process ends, those in recovery will begin intensive therapy treatment that includes both individual and group sessions. Therapy can occur in either an inpatient or outpatient program. There are different research-based therapies available, including Cognitive Behavioral Therapy, Contingency Management therapy, Motivational Interviewing, and couples and family therapy. The therapy approach taken generally depends on the treatment philosophy of the

particular rehab center. Back to Top Medication for Opioid Addiction To narrow down to the needs of pregnant females once they are in treatment, it is helpful to lay the discussion out as an inverted triangle from the most broad approaches that can be taken to treat females in general to the methods that have been shown to be effective for this discrete group. The framework of substance abuse can be viewed as having two main pillars: Medications for opioid abuse recovery include methadone, buprenorphine in trademarked drugs Suboxone and Subutex, and naltrexone. During an induction window of typically at least a week, generally in the withdrawal phase, the attending physician will determine the dosage required for the recovering client to avoid the undesirable physical and psychological side effects of withdrawal as well as to prevent the onset of drug cravings, which can trigger a relapse. After withdrawal, medication may continue to be used to help maintain abstinence. In the context of pregnant females who have been abusing an opioid, treatment medications may be used, but special care must be given to protect the health of the fetus. A discussion of treatment medications in the context of pregnant females is particularly vital as rates of opioid dependence are high. For example, one university-affiliated drug treatment program for pregnant women in North Carolina reports that 40 percent of its clients are treated for opioid dependence, mainly for abuse of prescription pain relievers. Further, the rate of NAS in infants rose over this period from 1. Approved for use in pregnancy, buprenorphine is less habit-forming than methadone and less likely to cause withdrawal symptoms in pregnant clients and newborns. A research project comparing the effectiveness of methadone and buprenorphine during pregnancy showed that buprenorphine provides the following advantages: Buprenorphine causes fewer symptoms of opiate withdrawal in newborns. Unlike methadone, buprenorphine does not have to be taken in a structured clinical setting under direct medical supervision. The required dose of buprenorphine is generally lower than methadone. Infants born to mothers who took buprenorphine required less intensive treatment after birth and shorter hospital stays. Research and clinical cases show that it is possible for pregnant females who are undergoing a supervised medical detox to be gradually tapered off the opioids during any trimester. After detox, pregnant women may also be placed on these treatment medications as a method of abstinence maintenance. Each rehab center reviews the needs of pregnant clients on a case-by-case basis. In the case of females in recovery, research shows that in addition to standard therapy treatment, ancillary services can help with treatment retention and outcomes. Supportive services that can help pregnant and non-pregnant females include: Rehab centers that create services geared toward helping pregnant females to overcome barriers to treatment are both attractive and practical. Such programming can improve treatment retention and outcomes for both mother and child. Childbirth Connection is a national advocacy group dedicated to improving the quality of life of mothers and children.

Chapter 9 : Drugs and Pregnancy - calendrierdelascience.com

A disturbing trend in legal actions and policies is the criminalization of substance abuse during pregnancy when it is believed to be associated with fetal harm or adverse perinatal outcomes.

Alcohol consumption during the early stages of pregnancy, such as before a woman knows that she is pregnant, can harm the mother and her child in a number of ways. There is no safe amount of alcohol when a woman is pregnant. Evidence-based research has found that drinking even small amounts of alcohol while pregnant can increase the risk of miscarriage, stillbirth, prematurity, or sudden infant death syndrome. American Academy of Pediatrics pulled from Amian Academy of Pediatrics website Unfortunately, many babies are born with health complications “ some life-threatening “ due to alcoholism. Some infants are required to stay in the hospital for weeks or months after their birth so medical staff can closely monitor their vitals. Others may face a range of developmental issues such as cognitive impairments and learning disabilities. Babies who were exposed to alcohol in the womb are also at risk for fetal alcohol spectrum disorders FASDs and birth defects. If you or someone you know is struggling with a drinking problem while pregnant, help is available. Our treatment specialists can put you in touch with alcohol rehab facilities that specialize in alcohol abuse during pregnancy. Contact us now to get started on your road to recovery. How Does Alcohol Affect a Baby? When a pregnant woman consumes alcohol, it quickly travels through the bloodstream, eventually making its way to the placenta and umbilical cord. Anything a mother consumes also passes down to her baby, including dangerous substances like alcohol. Prenatal exposure to alcohol, no matter the amount, can cause a wide range of health complications before and after birth. It can be weeks or even months before a woman learns they are pregnant. In the early stages of pregnancy, alcohol consumption can be extremely harmful and even lead to a miscarriage. Because of this, any woman who thinks she may be pregnant or is trying to become pregnant should not drink. Consequences of Drinking While Pregnant The ways in which alcohol can affect an unborn child varies by case, but health risks can include both short-and long-term complications. Although some dangerous effects of alcohol exposure in the womb can be quickly identified in newborns, other health complications may take years to manifest. Miscarriage or Stillbirth One of the most common factors that affect miscarriage and stillbirth rates is alcohol consumption during pregnancy. A miscarriage is when a fetus dies within the first 20 weeks of pregnancy. If a baby dies after the first 20 weeks of pregnancy, it is considered a stillbirth. Both a miscarriage and a stillbirth can cause a mother a substantial amount of pain and suffering for months to follow. In order to reduce the chance of having a miscarriage or stillbirth, a woman should abstain from drinking and receive proper prenatal care while she is pregnant. Premature Birth Alcohol use significantly increases the chances of a premature birth. A premature birth occurs when a baby is born before a mother reaches 37 weeks of pregnancy. Not only do premature births come with a high risk for serious health conditions, but they can be fatal. Even if a baby survives a premature birth, developmental delays can arise later in life. Many times, a child who is born prematurely will require additional medical care and attention during the first few years. Fetal Alcohol Spectrum Disorders FASDs When a woman drinks while pregnant, she is putting her baby at risk of developing a host of physical and behavioral problems. These conditions, known as FASDs, are incurable and can have lifelong effects. Several of the most common issues that arise with FASDs are impaired cognitive skills, inability to control emotions, trouble communicating and completing everyday tasks. Because FASDs affect the brain, children may also suffer from mental health disorders, repeat mistakes and fall victim to bad choices. Birth Defects Drinking alcohol during pregnancy is one of the main causes of birth defects. Birth defects can include heart problems, cleft lip, spina bifida, down syndrome and clubfoot. An alcohol-free lifestyle is the best way to prevent birth defects and other harmful consequences during pregnancy. Roughly 10 percent of pregnant women between the ages of 18 and 44 have admitted to drinking alcohol in the past 30 days. Women who drink on a weekly basis pre-pregnancy are up to 50 percent more likely to consume alcohol while pregnant. Approximately one in three women who consume alcohol during pregnancy binge drink. This means that they have four or more alcoholic beverages in a two-hour time period. Identifying Alcoholism During Pregnancy

Family members and friends are typically some of the first individuals to recognize a potential drinking problem. Some women may feel ashamed or helpless about their alcohol consumption while pregnant. Others may try to conceal their drinking and become resistant to asking for help. In some cases, loved ones may stage an alcohol intervention with the help of a counselor. If a woman is ready to quit drinking and seek help, treatment options may also be discussed. The common warning signs of dangerous drinking behaviors while pregnant include: Avoiding prenatal care such as doctor appointments and taking nutrients Rationalizing how small amounts of alcohol will not affect pregnancy Distancing themselves from loved ones and living in isolation Lashing out, acting aggressively and behaving recklessly Forgetting daily responsibilities and tasks at home or work In many areas, prenatal doctor appointments also involve substance abuse screenings. During these screenings, medical staff will look for any warning signs of illicit drug and alcohol use – dilated pupils, scent of alcohol on breath or skin, and shakiness. If alcohol use is suspected, a referral for treatment is often provided. Get help for alcoholism Learn more about treatment Keeping Your Baby Safe After Birth Heavy alcohol use can affect a baby even after a woman has given birth. For example, drinking and breastfeeding is a dangerous combination. However, that is not the case. In fact, it can take several hours for just one drink to be entirely eliminated from the body. A baby exposed to alcohol through breast milk has an increased risk of delaying motor skill development and other health conditions. To avoid potential complications from arising after birth, a woman should speak with a healthcare professional about caring for a newborn. Doctors and nurses will be able to provide information on what to expect during the first few weeks and months, as well as other safety tips. Alcohol Treatment for Pregnant Women There are countless alcohol treatment programs across the nation that specialize in helping pregnant women overcome a drinking problem. The sooner a woman commits to stop drinking, the greater the chance of having a trouble-free pregnancy and healthy baby. The recommended form of treatment will often vary depending on how long and how frequent the woman has been drinking. These programs allow treatment specialists to monitor both mother and baby closely during detox and other stages of the recovery process. We can provide you with information about recovery programs that specialize in treating pregnant women.