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TO: New Jersey Acute Care Hospitals pursuant to N.J.A.C. 8:43G and Birth Centers pursuant to N.J.A.C. 8:43A

FROM: Iris Jones LPC, LCADC, Assistant Commissioner
Family Health Services

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Division of Certificate of Need and Licensing

DATE: January 22nd, 2026

SUBJECT: Recommendations for hospital management and support for pregnant and postpartum individuals with substance use.

The Department of Health is issuing this guidance memorandum to assist New Jersey acute care hospitals and birth centers to develop effective policies and procedures that address the significant public health issue of substance use disorders (SUD) during pregnancy. This memo emphasizes that universal screening is an important tool to achieve health equity. Moreover, facilities are reminded that a positive screen test for substances is not in itself evidence of child abuse under New Jersey law, and that follow up biologic testing should only be undertaken with a patient's informed consent.

Understanding Perinatal Substance Use:

Substance use and substance use disorders (SUD) in pregnancy are common and present a significant public health issue in the United States.[1,2] Identification of substance use in pregnancy provides an opportunity for engagement and evidence-based treatment intervention, which can improve outcomes for both mother/birthing individual and baby. Persistent stigma, which involves blaming individuals for their substance use, increases barriers, preventing those with SUD from accessing treatment or the appropriate supports necessary for their health and safety. Studies show that women who identified as pregnant with SUD were 17% less likely to be accepted for opioid use disorder (OUD) treatment appointments by outpatient buprenorphine providers compared to identical non-pregnant women.[3] Evidence-based treatments for OUD, like buprenorphine and methadone, improve pregnancy outcomes and reduce the risk of relapse and death for pregnant women and birthing individuals.[4]

Health care systems can support pregnant people with SUD by providing evidence-based treatment, including medications for addiction treatment (MAT), medications for opioid use disorder (MOUD), and increasing screening, brief intervention and referral to treatment (SBIRT). Treating substance use in pregnancy requires addressing the use and misuse of all substances, including those that are classified as legal. Recognition that criminalizing SUD in pregnancy does not result in improved outcomes and is harmful to both mother and baby[5] is an essential step in eliminating stigma and increasing access to effective treatments.

Universal Screening & Health Equity:

The American College of Obstetricians and Gynecologists (ACOG) recommends screening all pregnant women for substance use with a validated questionnaire for the purpose of intervention and referral.[8] Hospitals and birthing centers should create substance screening and testing policies that are both clinically and ethically sound. Testing for the purpose of gathering evidence of criminal conduct requires informing patients of their constitutional rights to protection from unreasonable search and seizure, also known as informed consent.[9] Informed consent should include information on any potential adverse consequences, to include the possibility of referrals to child protective agencies.

In *Ferguson v. City of Charleston*, the United States Supreme Court established patient consent is required when performing urine drug testing. Any biologic testing should only be undertaken with the patient's informed consent. The Provider should have clear objectives, after weighing benefits and potential harms, for obtaining such information and should document consent in the patient's record.

Screening for substance use is part of comprehensive obstetric care and, when possible, completed at the first prenatal visit. Routine screening should be done with consent and utilizing validated screening tools (i.e., 4Ps, NIDA Quick Screen). Screening and identification of SUD in pregnancy can result in improved outcomes in pregnancy and during the post-partum period. Screening should be conducted universally, as screening based on clinician suspicion is vulnerable to conscious and unconscious bias and results in the disproportionate testing of minorities, immigrants, or those of lower socioeconomic status. Black patients are more likely to receive urine drug testing at delivery than their non-Hispanic White counterparts though Black individuals were not more likely to have a positive test result compared to non-Hispanic White individuals and other racial groups.[10,11]

Hospitals and birthing centers must ensure that their screening and testing policies comply with the New Jersey Law Against Discrimination (LAD), which prohibits places of public accommodation, including hospitals and birthing centers, from discriminating based on LAD-protected characteristics such as sex, pregnancy, disability, race, and others (N.J. Stat. § 10:5-12(f)(1).

The LAD prohibits both disparate treatment discrimination and disparate impact discrimination. Disparate treatment discrimination arises when a policy or practice treats members of a protected class differently from others. Disparate impact discrimination occurs when a facially neutral policy or practice disproportionately harms members of a protected class, unless the policy is necessary to achieve a substantial, legitimate, nondiscriminatory interest. Even then, the policy may still violate the LAD if a less discriminatory alternative exists that would achieve the same interest.

Historically, screening based solely on clinician suspicion has resulted in disproportionately higher testing rates for Black pregnant women, implicating LAD-protected characteristics such as race, color, creed, national origin, or ancestry.[10,11] In such cases, a hospital or birthing center must be prepared to demonstrate that its policy is genuinely effective in achieving its stated goal—for example, encouraging pregnant patients to engage in treatment. Similarly, a policy of universal testing may also violate the LAD if it is applied only to pregnant patients and not to other similarly situated populations.

Universal testing of biological specimens is not currently recommended by any major medical association.[9] Biological testing should be conducted if there are clinical indications and with the patient's informed consent. Any positive results should have reflex confirmational testing and results should be shared with the patient prior to any other disclosures. Patients should be counseled on SUD and informed that SUD in pregnancy is treatable, and treatment can result in improved outcomes for both mom and baby. Referrals to treatment should accompany all positive testing for substance use or diagnoses of substance use disorders.

Universal screening and standardized policies combat bias and racial disparities in testing and reporting to child welfare.

Child Welfare & Mandated Reporting:

Mandated reporting criteria for abuse and neglect is outlined in New Jersey Legislative Statue (N.J. Stat. § 9:6-1). SUD in pregnancy is not, by itself, child abuse or neglect.[7] Substance use in pregnancy alone is insufficient to establish abuse and neglect and is, therefore, not a part of mandatory reporting.[6,7]

New Jersey Administrative Code (N.J.A.C.). 8:43G-2-13 requires hospitals to establish polices that govern child welfare reporting. N.J.A.C. 8:43G-28.7 requires birth centers policies and procedures. These policies should include a discussion of how the facility shall report substance- affected infants. The hospital policies and procedures should address how they will report as required by N.J.A.C. 3A:26-1.2.

When reporting a substance-affected infant, patients should be informed of and offered to participate in reporting to child welfare. Patients who experience substance use during pregnancy may elect to engage with community-based organizations or other treatment providers, prior to the birth of their baby and create a prenatal Family Care

Plan (FCP), formerly known as a Plan of Safe Care (POSC).[15] Providers should support parents in creating and implementing Family Care Plans, which will assist patients in accessing comprehensive treatment that supports improved outcomes for both mom and baby.

Breastfeeding:

It's essential for every mother to be well-informed about the benefits of breastfeeding, allowing them to make decisions about feeding that best suit them and their baby. While breastfeeding offers numerous health benefits for both the mother and the infant, it's equally important to respect each mother's choice, as many factors—physical, emotional, or situational—can influence decisions. Supporting mothers in their decision, whether they choose to breastfeed or not, and ensuring they have access to accurate information and resources is key to promoting, both, their well-being and the health of their children.

Patients who are planning to breastfeed should review medication, supplements, and substances they are taking with their treating Provider and/or Lactation Consultant. Providers should provide education about the risks/benefits of breastfeeding while on any medications that could pose health risks to patients and/or their newborns. Appropriate supports including breast pumps should be offered to all patients, regardless of their ability to provide breast milk during their hospital admission. If breastfeeding must be delayed and/or interrupted, patients should be counseled on what medications or substances to avoid and when it is safe to begin or resume breastfeeding.

The Academy of Breastfeeding Medicine (ABM), the American Academy of Pediatrics (AAP), and the American College of Obstetricians and Gynecologists (ACOG) all recommend breastfeeding for women who are stable on medications for addiction treatment (MAT) in the absence of other contraindications.[8,12]

If contraindications are present, the Provider should have a non-judgmental conversation with the patient about what, if anything, they can do to begin breastfeeding and how to maintain their breastmilk supply until such time that they are able to breastfeed. Patients with positive toxicology results that would preclude the use of breastmilk should have follow-up toxicology testing options offered, as well as support for pumping. Patients who are stable on their MAT should never be encouraged to discontinue MAT in order to breastfeed.

Definitions:

Substance Use: Refers to the use of selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects.[13]

Substance Use Disorder (SUD): A cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment, such as impaired control and risky use.[14]
Substance dependence: A physical dependence of a substance resulting in a withdrawal syndrome in the pregnant person and/or infant in the absence of that substance.
Neonatal Abstinence Syndrome (NAS): A spectrum of clinical manifestations seen in neonates due to withdrawal secondary to intrauterine drug exposure.
Neonatal Opioid Withdrawal Syndrome (NOWS): A subcategory of NAS that includes a spectrum of clinical manifestations seen in neonates due to withdrawal secondary to intrauterine opioid exposure.

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