

Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness

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Supplementary Issue: Harm to Others from Substance Use and Abuse

ABSTRACT: In spite of the growing knowledge and understanding of addiction as a chronic relapsing medical condition, individuals with substance use disorders (SUD) continue to experience stigmatization. Pregnant women who use substances suffer additional stigma as their use has the potential to cause fetal harm, calling into question their maternal fitness and often leading to punitive responses. Punishing pregnant women denies the integral interconnectedness of the maternal-fetal dyad. Linking substance use with maternal unfitness is not supported by the balance of the scientific evidence regarding the actual harms associated with substance use during pregnancy. Such linkage adversely impacts maternal, child, and family health by deterring pregnant women from seeking both obstetrical care and SUD treatment. Pregnant women who use substances deserve compassion and care, not pariah-status and punishment.

KEYWORDS: pregnancy, fetal exposure, public attitudes, public policy, pregnant women, opioid use in pregnancy, substance use in pregnancy, neonatal abstinence syndrome

SUPPLEMENT: Harm to Others from Substance Use and Abuse

CITATION: Terplan et al. Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness. *Substance Abuse: Research and Treatment* 2015;9(S2) 1–4 doi: 10.4137/SART.S23328.

TYPE: Commentary

RECEIVED: June 30, 2015. **RESUBMITTED:** August 20, 2015. **ACCEPTED FOR PUBLICATION:** August 22, 2015.

ACADEMIC EDITOR: Gregory Stuart, Editor in Chief

PEER REVIEW: Four peer reviewers contributed to the peer review report. Reviewers' reports totaled 1439 words, excluding any confidential comments to the academic editor.

FUNDING: Authors disclose no funding sources.

COMPETING INTERESTS: Authors disclose no potential conflicts of interest.

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In spite of the growing knowledge and understanding of the science of addiction as a chronic relapsing medical condition, individuals with substance use disorders (SUDs) continue to experience stigmatization. Pregnant women who use substances bear additional stigmas because of the potential of prenatal substance use to cause fetal harm. This potential risk calls into question the fitness of substance-using women to be mothers, which can lead to government interventions on behalf of the fetus and, in some cases, to punitive steps against the mother.¹ Although the motivations for such actions are to protect fetal health, punishing pregnant women who use substances is counterproductive and does not align with research on the values and motivations of such women nor with the scientific evidence regarding the treatment of SUD.^{2–6} Punitive approaches for women who use alcohol and illicit drugs during pregnancy, as well as for those undergoing pharmacologic treatment with an opioid agonist (known as medication-assisted treatment [MAT]), include, but are not limited to, arrest, detention, prosecution, civil commitment, and loss of parental custody or termination of parental rights.^{1,7,8} Such approaches are not based on scientific evidence, can be

unequally applied, and fail to address the multiple structural factors contributing to untreated SUD during pregnancy. Such strategies may also have the unintended consequence of further alienating such women from seeking both obstetrical care and SUD treatment,^{3–6} thus exacerbating many problems already faced by families struggling with substance use.

Prenatal substance use first attracted widespread public attention in the United States (US) during the 1980s when preliminary research raised concern about potential negative birth outcomes among women using crack cocaine.^{9–11} This attention occurred in the context of the growing anti-abortion movement and the push for welfare reform¹² and coalesced around the symbol of the *crack baby*.^{2,13–15} Public concern focused on pregnant women as the agents responsible for propagating a predicted underclass of children whose cognitive and developmental disabilities would strain the country's economic and social welfare system for years to come.^{13,15} Although subsequent research debunked many of these exaggerated claims,^{16–18} the assumption of prenatal substance use (particularly illicit substance use) as an indicator of maternal unfitness has persisted.¹⁵



Once again, substance use by pregnant women is at the center of public scrutiny as rates of neonatal abstinence syndrome (NAS) have increased in parallel with the opioid epidemic, particularly in the US.^{19–21} Even though NAS is an expected and treatable outcome of both opioid use and its pharmacologic treatment, pregnant women are framed as perpetrators of harm to the fetus, sometimes resulting in punitive responses. For example, in 2014, Tennessee passed a legislation that criminalized substance use during pregnancy.²² In contrast to expert opinion,^{23,24} the bill's sponsor depicted pregnant women as caring little for the welfare of their future children and as disinterested in prenatal care and anything beyond the pursuit of *their next fix*.²⁵ The main federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 and last reauthorized in 2010. CAPTA now mandates that healthcare providers notify state child welfare agencies of any newborns exposed to prenatal substance use.²⁶ Although individual states have latitude in their interpretation and implementation of this provision,^{8,27} most recommend notification to child welfare agencies regarding newborns exposed to MAT for a preliminary safety evaluation, even in the absence of any maternal alcohol or illicit drug use. Such reports do not automatically result in the opening of an active child welfare case, but they can lay the groundwork for a range of outcomes of concern to mothers, including loss of parental custody or termination of parental rights, and can weaken trust in the patient–clinician relationship.^{7,8,27} Currently, 18 states define substance use during pregnancy as a form of child abuse. The American College of Obstetricians and Gynecologists has recommended that healthcare providers caring for this population advocate the retraction of punitive state actions against pregnant women with SUD.²⁷ Reducing state-level discretion in responding to this provision of CAPTA is another strategy that may help reduce punitive approaches overall.

Although the authors recognize that the use of substances by mothers of infants and older children can also pose serious individual and public health risks, this commentary focuses on prenatal substance use. The authors present three main arguments why equating substance use during pregnancy with maternal unfitness is counterproductive and harmful to maternal, child, and family health.

First, the belief that a substance-using pregnant woman is failing is to protect an innocent other, and thus, deviating from the social norms surrounding motherhood, positions the woman as an adversary of the developing fetus.^{2,13,14} This attitude assumes that substance use during pregnancy is incompatible with good mothering, and therefore constitutes maternal unfitness. This is a false dichotomy as it denies the integral interconnectedness of the maternal–fetal dyad and undermines the historical reality of women's role as advocates for the health of their pregnancy and that of their children and family. Both a pregnant woman and her developing fetus benefit when the mother is embedded in a supportive environment.

Similarly, a pregnant woman and her fetus face increased risk when the mother is in an unsupportive, unsafe, and impoverished setting. Disregarding the interconnectedness of maternal and fetal health detracts from widely shared public health objectives, including safe pregnancies and healthy women, children, and families.

Second, the paradigm of maternal unfitness and its emphasis on illicit substances is not supported by the balance of the scientific evidence regarding the relative harms of prenatal exposure to illicit versus licit substances. Over the past 50 years, a large body of evidence has accumulated on the many adverse health effects of prenatal exposure to tobacco and alcohol. Generally, there is more robust causal evidence for the negative impact of prenatal substance exposure to licit substances (eg, tobacco, alcohol) than to illicit substances (eg, cocaine, opioids, methamphetamines).^{28,29} For example, cigarette smoking is the leading preventable cause of pregnancy-related morbidity and mortality, and alcohol is the leading preventable cause of developmental and intellectual disabilities.^{30–32} This may be because of the differences in the level of rigor for studies of licit versus illicit substances, as a result of the methodological and measurement challenges in isolating the effects of prenatal exposure to illicit substances on child and maternal outcomes.²⁸ Nevertheless, despite the stronger evidence of harm from pregnant women's use of the licit substances, alcohol and tobacco, punitive policies disproportionately focus on pregnant women's use of illicit substances. Furthermore, although substance use and SUD during pregnancy are present in all racial and class groups,³³ the reporting of pregnant women to state authorities as well as prosecution and incarceration in the US has disproportionately affected the low-income women of color.^{1,13,34,35} Third, the assumption that prenatal substance use constitutes maternal unfitness adversely has impacts on maternal, child, and family health by deterring pregnant women from seeking both obstetrical care and SUD treatment.³ Pregnant women who use substances represent a group with significant unmet treatment needs,³⁶ and, for those who are able to access treatment, the quality of available treatment services for pregnant substance-using women is highly variable.^{37,38} Geographic barriers to high-quality treatment exist, with fewer than half the states having programs focused on the needs of substance-using pregnant women⁸ and with varying coverage of MAT by state Medicaid programs.³⁸ In addition, attitudinal barriers to high-quality treatment also exist. For example, despite the strong body of evidence supporting the role of MAT in the case of opioid-dependent patients, it remains a highly stigmatized treatment,³⁹ including within the substance abuse treatment community, for both pregnant and nonpregnant opioid-dependent populations, such that one may not be considered abstinent if taking MAT. These barriers contribute to the fact that despite recent increases in opioid use among women in the US,⁴⁰ only a minority of opioid-using pregnant women enrolled in substance use treatment programs actually receive the recommended pharmacologic treatment, namely, MAT.³⁶

Rather than expanding the knowledge and use of MAT and other effective evidence-based pharmacologic and behavioral treatments,^{41–43} punitive approaches have been leveraged against women who use substances during pregnancy. Proponents of such approaches suggest that the threat of jail time or reporting to state authorities may give pregnant women the motivation they need to engage in treatment and discontinue their substance use. However, appealing this may be in theory, the scientific evidence does not support the utility of this approach and, in fact, raises questions about the adverse effects that punitive approaches may have on the engagement of substance-using women in prenatal care and/or the disclosure of their substance use to health care professionals.^{2–6} Furthermore, the assumption that legal threats will motivate changes in substance use relies on a simplified and misinformed understanding of SUD as a failure of individual willpower. Although most women who use substances are able to quit or reduce their use during pregnancy,^{44,45} those with SUD, by definition, cannot, in part because of the behavioral effects of conditioned learning. Conditioning, both by the positive effects of substance use and by the negative effects of withdrawal, increases a woman's drive to use and greatly limits her ability to stop using. Therefore, continued use during pregnancy indicates the presence of a SUD and should be treated as the medical condition it is.

To be sure, prenatal substance use is a significant public health concern. Proper identification of pregnant women with a SUD is necessary in order to facilitate treatment. Such treatment not only improves pregnancy outcomes but also reduces the likelihood of the newborn and any older children being raised by a mother with an untreated SUD, which can have lasting negative effects on a range of child health and development outcomes.^{46,47}

However, equating SUD with maternal unfitness is inconsistent with how other chronic illnesses are conceptualized and managed during pregnancy, reflecting the continued perception of prenatal substance use and SUD as moral failures rather than medical conditions. Individuals with substance use face systematic stigmatization, which on an individual level impedes engagement with the health care system and on a population level prevents broader investment in treatment and other services to support recovery.^{39,48–50} Pregnant women with SUD face greater and unique challenges when they are portrayed – by healthcare professionals, the public and its policies, and even other substance users – as harming their children and being unfit mothers.

Rather than punishing pregnant women with SUD, which may exacerbate the problem and further marginalize a vulnerable population, efforts should focus on addressing the medical, behavioral, and social service needs of these women and their families. These include the need for structural changes, such as improving the availability and financing of substance use treatment, particularly MAT,³⁸ given the current opioid epidemic in the US and rising rates of NAS. In addition, there is a need for more programs focused on the treatment of pregnant women

with SUD. Integrated programs that target both behavioral and nonbehavioral health needs of pregnant women with SUD, including providing parenting classes and other child-focused services, may reduce participants' substance use and improve parenting skills.^{51–53} Johns Hopkins' Center for Addiction and Pregnancy (CAP), for example, is one such comprehensive intensive outpatient substance abuse treatment program, designed to eliminate barriers to care and improve health outcomes for substance-dependent pregnant women.⁵⁴ In addition to providing behavioral and pharmacologic treatments for SUD, CAP delivers obstetrical, psychiatric, and pediatric care on site, as well as housing, meals, and transportation services. Given the growing numbers of opioid-dependent pregnant women across the US, many more programs serving this population are needed to improve maternal, child, and family health.

Assumptions of maternal unfitness because of prenatal substance use are indeed flawed. They are not based on science and can confer unintended consequences. The way in which prenatal substance use is framed, and the language used, has implications for the types of solutions supported by the public and by policymakers. Pregnant women who use substances deserve compassion and care, not pariah status and punishment.

Author Contributions

Conceived the concepts: MT, AK-H, MSC. Wrote the first draft of the manuscript: AK-H. Contributed to the writing of the manuscript: MT, MSC. Agree with manuscript results and conclusions: MT, AK-H, MSC. Jointly developed the structure and arguments for the paper: MT, AK-H, MSC. Made critical revisions and approved final version: MT, AK-H, MSC. All authors reviewed and approved of the final manuscript.

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