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Invited Commentary | Pediatrics

It's Time to Support, Rather Than Punish, Pregnant Women With Substance Use Disorder

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Increasing prevalence of opioid use disorder (OUD) among pregnant women in recent years has led state policy makers and health care professionals alike to focus on reducing rates of neonatal abstinence syndrome (NAS) and associated complications experienced by families. Policy makers in some states have responded by adopting punitive laws that criminalize substance use during pregnancy, considering it grounds for civil commitment or presuming child abuse or neglect. However, as the recent analysis of state policy and NAS rates in the study by Faherty et al[1] suggested, punitive approaches are counterproductive and instead are associated with higher rates of NAS. Faherty et al[1] hypothesized that pregnant women were less likely to engage with the health care system and pursue interventions, such as substance use disorder treatment, owing to these punitive polices, leaving the substance use untreated and NAS a more likely outcome. We applaud the authors' conclusion that states should pursue policies that instead focus on primary prevention strategies.

However, framing the discussion about perinatal opioid use using NAS reduction as a primary outcome is problematic. From the maternal-fetal perspective, decreasing substance exposure is an important goal; polysubstance exposure is associated with overall increased risk for the mother, fetus, and neonate, including greater severity, longer duration, and increased need for pharmacologic treatment of NAS.[2] Maternal OUD treatment improves all of these outcomes. However, maternal OUD treatment also causes NAS, making the presence of NAS diagnosis a nonspecific measure, as it does not differentiate exposure to nonprescribed drugs vs maternal OUD treatment. Symptoms of NAS may also be exacerbated by other maternal medications (eg, SSRIs) that were appropriately prescribed for cooccurring mental health disorders, such as depression, anxiety, and posttraumatic stress disorder. The finding in the study by Faherty et al[1] that NAS rates were higher in counties with better access to maternal substance use treatment programs illustrates this point.

Faherty et al[1] reported no apparent association between rates of NAS and the enactment of policies that require reporting of prenatal substance use to child protection services (CPS), suggesting that "reporting policies are more likely to result in conversations between clinicians and pregnant women that result in decreased opioid use or greater engagement in treatment for opioid-related complications, actions that may decrease rates of NAS." We are not convinced. Qualitative studies on this topic have suggested that women who fear losing custody of their children may not see much distinction between policies defining maternal substance use as child abuse and those which require reporting substance use to CPS based on prenatal substance exposure alone. For example, a study by Stone[3] reported that 73% of the women interviewed were afraid of their drug use being detected specifically due to fear of losing custody or legal consequences. A study by Roberts and Pies[4] also found that "most women [using substances] avoided prenatal care or attempted to stop using drugs before attending prenatal care because of fear of CPS." Therefore, women in need of treatment for OUD who live in states with either reporting or punitive policies may be more likely to try to avoid detection, engage less in prenatal care or treatment, and continue nonprescribed substance use, including other substances (eg, benzodiazepines) shown to increase NAS severity.

We suspect that the lack of change in NAS rates associated with policies requiring reporting to CPS was the result of an atmosphere of stigma about substance use by pregnant women that existed

before and after enactment. In this context, laws that require reporting merely codify an approach already in place, and the preenactment and postenactment difference may seem insignificant from a pregnant woman's perspective. As Terplan and colleagues[5] pointed out in 2015, most state policies are based on a foundational perception of women who use drugs as unfit to parent their children, whether or not punitive laws are in place. In fact, arrests and forced interventions against pregnant women who use substances have occurred in all regions of the United States during the past 30 years.[6] This narrative of the unfitness for parenting and criminality of women who use substances is pervasive, and the findings of Faherty et al[1] should be interpreted in this context.

It is important to emphasize that laws that criminalize prenatal substance use also run counter to the intent of federal child abuse prevention legislation, which is intended to support the needs of infants and families. The Child Abuse Prevention and Treatment Act (CAPTA) was amended by the Comprehensive Addiction and Recovery Act (CARA)[7] in 2016 to ensure that states adopt policies and procedures that address the health and substance use treatment needs of infants who have been exposed to substances prenatally and their families, including through the development of plans of safe care and ensuring appropriate referrals to services and supports. The CAPTA and CARA legislation includes data collection and state notification requirements when infants are born affected by substance exposure; however, the law specifically states that notification of CPS shall not be construed to establish a definition under federal law of what constitutes child abuse or neglect or require prosecution for any illegal action.

States are given flexibility in the adoption of required policies and procedures to support the needs of infants and families. States that use this flexibility to adopt punitive measures are misconstruing the intent of federal child abuse prevention legislation. We believe states should strive to achieve CAPTA and CARA compliance processes that encourage women to seek substance use disorder treatment and engage in prenatal care using social and ecological models of care and use data collection and compliance monitoring tools through collaborative public health surveillance approaches to achieve better outcomes for infants and families.

We agree with the interpretation of Faherty et al[1] that state policies criminalizing prenatal exposure are likely to result in fewer women seeking care and treatment and ultimately jeopardize the health and well-being of the mother, infant, and family. There is a great deal of work ahead to replace current written (and unwritten) policies that force pregnant women into hiding with policies that instead incentivize and facilitate access to treatment for substance use disorders. State policies should reflect current medical knowledge that OUD and other substance use disorders are chronic, life-threatening conditions for which evidence-based treatments are available and beneficial.

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