How Should We Respond to Pregnancy and Substance Use?

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The question raised in this point-counterpoint is whether substance use in pregnancy should be treated as child abuse and, if not, what should be the appropriate public response? Consider some of the embedded questions raised here. Is our society better off legislating as if fertilized eggs, embryos, and fetuses inside a woman's body are equivalent to children born and outside of her body? How much control over women should a just society allow? And, is there a medical, scientific basis for the assumption underlying this exchange—that use of any of the criminalized drugs causes unique or exceptional risks of harm? These are vital antecedent questions to the one formally proposed in this point-counterpoint exchange.

There is not enough space here to address all of these important questions. It is clear though that from the perspective of personified eggs, embryos, and fetuses, every pregnancy creates extremely well-documented risks of harm. Approximately 15-20% of all pregnancies (unrelated to use of controlled substances) end in miscarriage or stillbirth (Office on Women's Health, 2019). In other words, by becoming pregnant a woman puts her unborn child at risk of harm, including death. Indeed, everything she does or doesn't do, everything she breathes, eats, and drinks can, arguably, pose a risk of harm. As a result, the question posed for this point-counterpoint creates the illusion of focus on only one action—drug use—but provides the basis for making every woman, from the moment she has a fertilized egg inside of her, subject to state scrutiny as a potential child abuser for all of her actions and choices.

So, the short, simple answer to the question posed here should be "no," purely in terms of gender equality, and the avoidance of oppressing women. But we realize many readers will reject this perspective, insisting that treating a woman's drug use during pregnancy as child abuse is perfectly fair, even gender neutral. So, we will address two other questions that presume the legitimacy of this exchange.

The first is whether a pregnant woman's use of substances deserves attention by public health officials and healthcare providers. The second is, if it does, how it should be addressed. We have little doubt that both pregnancy and the use of substances are subjects worthy of attention by public health officials. Treating pregnancy and drug use as child abuse, however, is a serious mistake, because it drives pregnant women underground to avoid being reported, discourages honest communications if they remain above ground, and turns control of healthcare decisions over to people without training in health care, including caseworkers and judges with the power to regulate pregnant women's lives as a condition of keeping or regaining custody of their children.

Treating pregnancy and drug use as child abuse also radically expands the role of child welfare authorities and sets a dangerous precedent for interpreting pregnant women's lives and health as proper subjects of control through state child welfare systems. Instead, public resources should be devoted to addressing poverty, which has repeatedly been shown

to pose greater risks to infants than exposure to any criminalized drugs or controlled substances. Drug use should not be confused with drug dependency problems any more than alcoholism should be confused with drinking alcohol. Public health policy should encourage and provide the resources that pregnant women with dependency problems need to secure appropriate treatment, including such medications as methadone and buprenorphine. The best way to ensure this is not to treat drug use during pregnancy as child abuse.

Consider a different matter: Should doctors report families to child welfare officials when they learn that children are living in homes with exposed asbestos and lead paint in the apartment walls, are residing near mercury emitting coal facilities or drinking lead contaminated water in Flint, Michigan or Newark, New Jersey? There is no doubt that children exposed to these substances are at risk of significant health harms that are well established as contributing to or causing asthma, cancer, and reduced brain functioning. Nonetheless, it begs the question: Should doctors who are aware that children are living in conditions exposing them to these hazards notify child welfare officials?

The answer, of course, is "no." And that's because we have collectively agreed that not everything that might be hazardous to children's health or well-being ought to the fall within the ambit of child welfare. We comfortably leave many things that constitute significant dangers to which children are exposed to the category of public health. The claim that drug use is different because it requires an affirmative act taken by the pregnant woman ignores the volition involved when people decide where to live and with whom they will live. And for people whose drug use has actually become problematic, the question is not about choice to use but rather how it, along with anything else in their lives, actually affects their parenting ability. The critical point we mean to make is that not all public health problems impacting children should be (or in fact are) committed to the child welfare system.

We suggest that one of the worst choices public health officials could make would be to require that a woman's pregnancy and use of certain drugs become the focus of the child welfare system (American College of Obstetricians and Gynecologists, 2014). In our experience, the child welfare system too commonly lacks the skill, resources, and commitment to serve the well-being of the families with which it interacts. Too often, children are needlessly removed from their parents' custody, an extremely counterproductive response for a system putatively committed to preserving families, which in some cases may involve actually helping a parent address a substance dependency problem that is affecting their parenting ability.

Moreover, once a child enters the foster care system, child welfare officials possess an extremely dangerous power which, in the past generation, has been unleashed at an unprecedented level—the termination of parental rights. Today, more than at any other time in United States history, labeling pregnancy and drug use as child abuse runs the risk of leading to the permanent destruction of the family. In an ever-growing number of states, any evidence of use is defined as abuse. In Texas and Kentucky, for example, parents are fast tracked to parental termination (Tex. Fam. Code Ann. § 161.001(R); Ky. Rev. Stat. Ann. § 625.090(1)(a)(3)). In Alabama, a report to child welfare based on pregnancy and evidence of drug use is the same as a report to the police with arrest and incarceration likely along with the certainty of family separation (Ala. Code § 26-14-3(a); Martin, 2015). In South Carolina, Oklahoma, and West Virginia, mothers are often arrested for crimes in relationship to their pregnancies and subjected to family separation through child welfare interventions (*Whitner v. State*, 1997; *State v. McKnight*, 2003; Okla. Stat. Ann. tit. 10A, § 1-1-105; *In re A.L.C.M.*, 2017). For some women, their parental rights will be permanently terminated, because the prison sentence exceeds the time period parents are required to be able to take custody of their children under the 1997 Adoption and Safe Families Act.

So, to cut to the chase, only those willing to risk that pregnant women who use drugs will be forbidden from ever having custody of their children should endorse treating pregnancy and drug use as child abuse. The rest of us should not. We should refuse to count pregnant people in relationship to the fertilized eggs, embryos, or fetuses still inside of them as "child

abusers." This not only ensures that women do not lose their civil rights upon becoming pregnant, it also frees public health officials from a straight-jacketed child welfare system that too rarely improves the lives of the families it serves.

Moreover, we should have a public health system in the United States that accords expert professionals the widest degree of discretion to make informed decisions about the patients they serve. Nothing is more threatening to that vision than the universal mandatory reporting requirements in the United States. In every state, mandated reporters are supposed to contact child welfare officials whenever they have reason to believe that a child has been or at risk of being "maltreated" by his or her parent. In this arrangement, all professionals are low level deputies of the child welfare system (and in a number of other states, of the criminal law system) assigned a nondiscretionary task: identify children who have been exposed prenatally to any amount of select substances, and report them as abused or neglected to other professionals authorized to address the matter. Child welfare laws should not impede a health professional's capacity to exercise discretion to treat each patient individually.

We should explore this question from still another angle. If healthcare professionals are persuaded that they should involve child welfare authorities whenever they become aware that a woman has become pregnant and is using selected substances, then what about the science establishing the teratogenic effect for infants and children of alcohol and the extensive, evidence-based research identifying multiple and serious risks of tobacco use during pregnancy? The use of illicit drugs is not different in terms of the risk of harm to fetuses and newborns; indeed, the myth of the "crack baby" has been exposed by the scientific community as racism disguised as medical information (The New York Times Editorial Board, 2018b). Moreover, none of the claims of unique harm from any of the criminalized substances has ever been supported by actual evidence-based medical research. Indeed, the risks, both in terms of types of harm and in terms of number of children exposed, are significantly smaller as compared with tobacco or alcohol use. A false campaign focused on the impact of cocaine use on fetuses led to a public health panic focused almost exclusively on Black women that has never quite abated. This set the precedent for punitive child welfare interventions for all pregnant women, including increasing numbers of low-income, rural, white women who use methamphetamine or opioids (Martin, 2015; The New York Times Editorial Board, 2018b).

None of these matters should be the subject of child welfare, if for no other reason than that it results in pregnant women avoiding treatment, including prenatal care, discourages women from giving birth in approved medical facilities, and encourages some women to have unwanted abortions rather than face loss of custody if they continue to term (Frank, Augustyn, Knight, Pell, & Zuckerman, 2001; Gomez, 1997; Morgan & Zimmer, 1997; Boyd, 1999; Terplan & Wright, 2011). It also too often results in misinformed judges placing women's lives at risk by forbidding them from obtaining methadone or buprenorphine treatment—the gold standard of care for opioid dependency problems.

Ultimately, our focus should be on how to assure people who would benefit from health-related interventions that their efforts will be rewarded with access to that care on a confidential basis. Relying on the child welfare system does the opposite. It also exacerbates class- and race-based inequality of response leading to the ever-growing disproportionate negative impact on poor women and, especially, poor women of color.

Finally, we should understand that this inquiry is neither neutral nor science-based. Our public health system has long accepted that pregnant women and their future children face many risks to their health—some of them related to addictions to alcohol and nicotine. For more than a generation, drinking alcohol during pregnancy has been on the radar of public health professionals as behavior that has a potential for negative impacts on fetuses and newborn children. Smoking is responsible for as many as 30% of infants born with low birth weight. Nicotine affects fetuses' nervous systems and brain development. Yet the most our public health systems have been willing to do about this is to alert the public of the possible risks

associated with ingesting alcohol or tobacco during pregnancy. We've never seriously considered making it a gender specific crime for pregnant women alone to engage in this disfavored behavior.

We cannot engage in the question of this point-counterpoint without asking why we have deliberately chosen to limit our response to these known hazards. For some problems, American society has engaged in a public education program, believing that informing the public is a sufficient response. But for pregnancy and substance use, some propose a very different response. Why the difference? We believe it is cultural, class- and race-infused, conforms to entrenched presumptions and prejudices about drug use, and provides a very convenient distraction from real threats to child and family well-being such as lack of access to health care, housing, and jobs for an increasing number of Americans. Treating drug use in pregnancy as child abuse is a bad idea that disserves the needs of the community, of parents, and of children.

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