To Protect and Provide for Children, Prenatal Substance Use Must be Considered Abuse

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The use of drugs and alcohol during pregnancy is harmful to the developing child. When children are born having been exposed to these substances, children's protective services should uniformly substantiate child maltreatment in order to ensure that the child's parent(s) and the child receive the treatment and services necessary to address the child's immediate safety, protect the government's compelling interest in the child's welfare, and ensure the best long-term outcome for the child.

Approximately 4 million babies are born annually in the United States. For decades, public health professionals, medical providers, and advocates for children have expressed concern about children exposed in utero to alcohol, tobacco, and illicit drugs. Because of the complexity of the problem, policy makers have struggled with the proper response.

In addition to ongoing concerns about alcohol and tobacco exposure, a major current focus is the increased exposure to opioids in the midst of the ongoing epidemic. For example, a statewide task force in Massachusetts in 2016 found that the number of neonates with opioid exposure increased from 2.6 per 1000 hospital births in 2004 to 14.7 per 1000 in 2013, an increase of more than 500% (Franca, Mustafa, & McManus, 2016). Between March 1, 2014 and March 31, 2015, the state's Department of Children and Families (DCF) responded to 2265 cases of children born exposed to opioids (Ho & Rovzar, 2017).

These drug exposed newborns and their families require a tremendous amount of public and private resources. The Massachusetts task force found they account for some 10,000 hours per month of DCF employee time, as well as approximately $169 million taxpayer dollars annually (Franca, Mustafa, & McManus, 2016; Ho & Rovzar, 2017). The cost of providing medical care to these babies drives up the cost of health insurance. The costs of ongoing intervention and education dwarf medical costs, and lifetime costs and lost productivity are even higher.

Concern about the impact of prenatal exposure is not new, although the most immediate focus has changed over time. In different eras, concern about substance use by pregnant women has included alcohol (since the early 1900s), marijuana (1930s), cocaine (1980s–1990s), methamphetamine (early 2000s), and opioids (later 2000s). In recent years, research suggests there has again been an upsurge in methamphetamine use.

Impacts of Use

Each substance (e.g., alcohol, cocaine) has both short- and long-term deleterious effects on the child's development. The precise impact of prenatal exposure varies depending on a host of factors such as the mother's general health, nutrition, level of prenatal medical care, timing of use, and the existence of other stressors in the mother's life (e.g., domestic violence) during the pregnancy. A particularly important factor is polysubstance use.

The harms of alcohol to the developing fetus are difficult to overstate. For instance, prenatal exposure

to alcohol is a leading cause of intellectual disability in the United States (Williams & Smith, 2015). Thus, the American Academy of Pediatrics takes the position that no amount of alcohol use during pregnancy is safe (Williams & Smith, 2015). The impacts on the child impose tremendous consequences on the communities in which these children live. Recent research suggests that prenatal alcohol exposure often goes unrecognized or is misdiagnosed (Chasnoff, Wells, & King, 2015).

Smoking tobacco has numerous harmful impacts on the developing fetus. Among these are increased risk of miscarriage, low birth weight, and increased risk of perinatal death. Prenatal exposure to tobacco smoke negatively impacts both cognitive and behavioral functioning, as well as motor and sensory functions.

Children born exposed to marijuana experience sleep disturbances through the first three years of life, increased impulsivity, decreased attention, and lowered IQ. By age 10, these children exhibit increased levels of juvenile delinquency, which continues into adolescence. Prenatal exposure seems particularly to impact the brain's executive functioning (Ross, Graham, Money, & Stanwood, 2015; Day, Leach, & Goldschmidt, 2011; Irner, 2012).

Research finds a correlation between prenatal exposure to cocaine and premature birth, low birth weight, smaller than average head circumference, and generalized growth retardation. As they grow, these children may experience poor self-regulation, increased excitability, and poorer language skills than their non-exposed peers. They may also have difficulty attaching to a primary caregiver. Later in childhood, these children exhibit increased aggression and elevated levels of delinquent behavior. FMRI studies have shown structural abnormalities in their brains (Ross et al., 2015; Shankaran et al., 2007).

Prenatal methamphetamine exposure is associated with premature birth, low birth weight, growth restrictions during gestation, cardiac and cranial anomalies, brain development deficits (e.g., visual-motor integration, verbal-spatial memory, and attention), and small brain size (Ross et al., 2015).

As noted, opioid use has increased dramatically in recent years. Their use during pregnancy is associated with lowered birth weight, small head circumference, smaller brain volume, increased cognitive and motor skills impairment, hyperactivity, and increased difficulties with attention. These children may experience structural brain deficits that are "debilitating and long-lasting" (Ross et al., 2015, p. 68). Infants with opioid exposure can be born opioid dependent and may go through a withdrawal syndrome, which, if untreated, can be life threatening. Today, when healthcare professionals treat opioid addiction, they typically do so with medications that themselves can have harmful side effects, but which have benefits that outweigh these risks. For example, heroin addiction may be treated with methadone. But methadone use during pregnancy may result in a newborn who experiences withdrawal symptoms with a number of the same or similar impacts as heroin use. The rationale for this form of treatment is that both withdrawal and relapse present even greater risks to the developing child.

The medical evidence is clear. Prenatal exposure to alcohol and illicit drugs has long-term, possibly permanent, negative impacts on a child. In addition, the postnatal environment plays a critical role in mitigating or exacerbating these impacts.

Policy Question

Given the harm of prenatal exposure, the question becomes one of public policy. What policies should governments implement to reduce the use of alcohol and drugs by pregnant women? What policies will protect the welfare of prenatally exposed children and provide them the best chance for a positive long-term outcome? What policies best protect the government's paramount interest in child safety and its compelling interest in child well-being? How do we balance the needs of pregnant women with the harm to their children? Whose rights should prevail?

Legal Structure

The law presumes that a parent is fit to raise his or her child without the interference of state authorities. A fit parent has a constitutional right to the care, custody, and control of his or her child, to make choices about parenting. Those choices, however, are not beyond

the authority of government agents. Courts have held for nearly a century that the government has a compelling interest in the welfare of children, which provides the state broad authority to protect children. Every state has exercised that prerogative in the child protection context by establishing a system to identify and respond to child maltreatment. For their part, children have conflicting interests. A child has both a constitutional right to be cared for by his or her parent and a statutory right to benefit from state protection.

The presumption that a parent is fit to raise a child is rebutted by evidence that a parent's actions are harmful to a child, or when the parent fails to provide the child those things necessary to a healthy upbringing (e.g., basic necessities, medical care). This is the basis for child protection laws.

A basic definition of child abuse is the non-accidental infliction of a physical injury upon a child. This definition does not require that a parent intend to harm to the child. According to the Children's Bureau, which administers the federal government's child protection laws, child abuse may include "any action that results in a physical impairment of a child" (Children's Bureau, 2016, p. 2). Yet in most states, using drugs or alcohol while pregnant is not considered child abuse. It should be.

Imagine this scenario: a mother injects her newborn baby with heroin, and that injection results in impairment of the child's functioning. That act would almost certainly be considered child abuse in every state in the country. But if that same mother injects herself with heroin before giving birth, with the same impact on the baby, that is typically not considered child abuse.

Given the overwhelming evidence that prenatal use of alcohol and drugs is harmful to the child, our contention is that state child welfare agencies should call this what it is: child abuse. Doing so allows the state to effectuate its compelling interest in the welfare of the child, and provides the authority to ensure that the mother and/or father receive the necessary addiction treatment. A finding of abuse provides the best opportunity for the child's needs—both medical and non-medical—to be monitored and addressed, and, in some cases, may be the only way for the family to obtain needed services.

Government should take a number of actions to prevent and respond to this form of child abuse. First, it is imperative that pregnant women who are using alcohol, tobacco, or illicit drugs be supported in obtaining treatment. Yet there is a dearth of treatment available. This is particularly true of treatment of the quality and duration necessary to make a meaningful impact on the problem. As a purely financial matter, the government would save tremendous amounts of money in the long-term by providing more money for drug treatment and prevention of drug exposed infants. For example, a baby born experiencing neonatal abstinence syndrome—withdrawal from opioids—will cost about $45,000 more to care for in the immediate post-birth period than a child that is born unexposed (Patrick et al., 2012). Multiply that by many thousands and add to it the long-term costs of addressing the needs outlined above, and the case for the provision of treatment is clear.

A purely voluntary system presents complications. Research and clinical experience demonstrate that pregnant users will often withhold information about their use from healthcare providers and may lie when directly asked (Lester, Andrezzi, & Appiah, 2004; Lester et al., 2001). Thus, identifying the pregnant user may be difficult.

States have experimented with more aggressive responses when a pregnant user is identified. Neither is optimal and each presents other problems. A small number of states allow civil commitment of a pregnant woman for drug treatment if she refuses to enter treatment voluntarily, just as a court may commit a person for mental health treatment. These laws have not been effective because there is a lack of adequate treatment facilities and a lack of funding to support the ordered treatment. Another option is criminal prosecution, which several states allow. The purpose of criminal prosecution is to punish criminal wrongdoing. Such a prosecution may be used to force a woman to seek treatment, but that is not always the case. Prosecution does nothing to protect or provide for the child's needs. No evidence suggests that these laws have led to less drug use during pregnancy or to

fewer drug-exposed babies being born.

Neither of these approaches is optimal. None alone, or in any combination, is likely to solve the problem. To complicate the picture, any—or all—may discourage pregnant women from seeking out prenatal medical care, an outcome that could exacerbate the harm to children. It is therefore imperative to approach this issue as one of child maltreatment, using case investigation and determination for service provision and support, rather than penalty and criminalization.

Unfortunate at it is, children are going to continue to be born having been prenatally exposed to these substances. The federal government, through the Child Abuse Prevention and Treatment Act, now encourages states to enact mandatory reporting laws that cover exposed newborns, but explicitly leaves the definition of child abuse to individual states. Therefore, every state's law and agency policy should make clear that alcohol or drug use during pregnancy is child abuse. Doing so provides the best chance that that child's mother will receive necessary treatment, that the child's needs will be addressed, and that the government's compelling interest in the child's well-being will be protected.

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References

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Chasnoff, I.J., Wells, A.M., & King, L. (2015). Misdiagnosis and missed diagnosis in foster and adopted children with prenatal alcohol exposure. *Pediatrics*, *135*, 264–270.

Children's Bureau. (2016). *Definitions of child abuse and neglect*. Retrieved from https://www.childwelfare.gov/pubPDFs/define.pdf

Day, N. L., Leach, S.L., & Goldschmidt, L. (2011). The effects of prenatal marijuana exposure on delinquent behaviors are mediated by measures of neurocognitive functioning. *Neurotoxicology and Teratology*, 33(1), 129–136.

Franca, U.L., Mustafa, S., & McManus, M.L. (2016). The growing burden of neonatal opiate exposure on children and family services in Massachusetts. *Child Maltreatment*, *21*(1), 80–84.

Ho, J.A., & Rovzar, A.O. (2017). Preventing neonatal abstinence syndrome witin the opioid epidemic: A uniform facilitative policy. *Harvard Journal of Legislation*, 54, 301–333.

Irner, T.B. (2012). Substance exposure in utero and developmental consequences in adolescence: A systematic review. *Child Neuropsychology*, *18*(6), 521–549.

Lester, B.M., ElSholy, M., Wright, L.L., Smeriglio, V.L., Verter, J., Bauwe, C.R., Walls, H.C., Huestis, M.A., Finnegan, L.P., & Maza, P.L. (2001). The maternal lifestyle study: Drug use by meconium toxicology and maternal self-report. *Pediatrics*, *107*(2), 309–317.

Lester, B.M., Andrezzi, L., & Appiah, L. (2004). Substance use during pregnancy: Time for policy to catch up with research. *Harm Reduction Journal*, *9*(5), 1–44.

Patrick, S.W., Schumacher, R.E., Benneyworth, B.D., Krans, E.E., McAllister, J.M., & Davis, M.M. (2012). Neonatal abstinence syndrome and associated health care expenditures United States, 2000-2009. *Journal of the American Medical Association*, E1–E7.

Ross, E.J., Graham, D.L., Money, K.M., & Stanwood, G.D. (2015). Developmental consequences of fetal exposure to drugs: What we know and what we still must learn. *Neuropsychopharmacology Reviews, 40*(1), 61–87.

Shankaran, S., Lester, B.M., Das, A., Bauer, C.R., Bada, H.S., Lagasse L., & Higgins, R. (2007). Impact of maternal substance use during pregnancy on childhood outcomes. *Neuropsychopharmacology Reviews*, *40*(1), 61–87.

Williams, J.F., & Smith, V.C. (Committee on Substance Abuse). (2015), Fetal alcohol spectrum disorders. *Pediatrics*, *136*(5), e1395–e1406.