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

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From the seemingly objective and scientific sounding statement, "the use of drugs and alcohol during pregnancy is harmful to the developing child," Frank Vandervort and Vincent Palusci recommend that every state's law should make clear that the use of any amount of alcohol or drugs by any woman at any stage of pregnancy is civil child abuse.

To make their case, they cite data that is either misleading or not relevant to the question at hand. For example, they cite a reported increase in the numbers of opioid exposed neonates. This increase is apparently intended to cause alarm and support the need for their proposed response. Exposure to opioids, however, is not the same as harm nor even a diagnosis of Neonatal Abstinence Syndrome. Moreover, it is not evidence of increased misuse or dependency on opioids by pregnant women. Exposure could be from appropriately prescribed pain management. (Are pregnant women whose agonizing pain is relieved by opioids child abusers?) Data from Tennessee and other states indicate that the majority of this increase is from the very positive news that more pregnant women are receiving the gold standard of medical care for opioid dependency: methadone and buprenorphine, both of which will produce a positive drug test in a newborn.

Our counterparts also devote substantial space to what they describe as "clear evidence" of the substantial harm of use of these substances by pregnant woman. We asked Dr. Carl Hart, a professor of psychiatry and psychology at Columbia University and the author or co-author of dozens of peer-reviewed scientific articles in the area of neuropsychopharmacology to comment on this "clear evidence" claim. He explained to us, "There are multiple inappropriate global statements asserting that prenatal substance exposure unequivocally produces harmful effects on the developing child. These conjectures either are not supported by evidence or are over-interpretations of limited data" (C. Hart, personal communication, February 14, 2019). Dr. Hart emphasized that the effects of substance use during pregnancy on children have been grossly overstated, and noted that recent research on alcohol indicates overstatement of risks from moderate prenatal alcohol exposure (McCormack et al., 2018).

Dr. Hart explained "that statistical differences" between exposed and non-exposed children reported in various studies "do not equate to clinically-relevant deficits. That is why it is paramount to determine whether scores are within the normal population range. If researchers are not cognizant of this potential pitfall, we run the risk of inappropriately labeling children as impaired as was the case during the so-called crack baby epidemic." He also noted that FMRI studies, among those Vandervort and Palusci referred to in support of their argument, "cannot

determine structural abnormalities; they only provide a measure of blood flow in brain as the participant completes an activity such as a cognitive task. The available brain-imaging techniques alone are insufficient to determine brain pathology or dysfunction" (C. Hart, personal communication, February 14, 2019; Hart, Marvin, Silver, & Smith, 2011).

Moreover, our counterparts fail to acknowledge, much less address, the social and legal consequences of treating pregnant women as a special class of persons whose legal activities—such as using alcohol, taking certain prescribed medications, or using (as opposed to possessing) certain drugs—may be treated as child abuse. And while the authors do include a paragraph about the harmful impacts of smoking tobacco on the developing fetus, they notably fail to include pregnant cigarette smokers in their list of women who should be treated as child abusers. Their unwillingness to label smoking as child abuse makes manifest that their position is less about science or child well-being than about choices shaped by conscious and unconscious beliefs regarding women, race, class, and privilege.

Insisting that women who use certain substances during pregnancy cause harm, the authors argue that their policy recommendation will reduce the use of alcohol and drugs by pregnant women and will protect children. However, for a decade or more, numerous states have done precisely what these authors call for: define pregnant women who use alcohol or drugs as child abusers. Yet there has not been a single peer reviewed study examining, much less finding, that such laws reduce substance use, protect children, or ensure their safety. Similarly, there is no peer-reviewed research to substantiate the claim that defining pregnant women as child abusers will allow CPS to ensure that any parent will receive the services they need, including appropriate drug dependency treatment (National Advocates for Pregnant Women, 2017).

There is plenty of evidence, however, that state child welfare agencies, including the New Jersey Division of Child Protection and Permanency (Pilkington, 2014; N.J. Div. of Child Prot. & Perm. v. Y.N., 2014), as well as CPS workers and family court judges believe that pregnant women parents who get the gold standard for opioid treatment—methadone and buprenorphine—should be reported and treated as child abusers.

The authors also suggest that newborns prenatally exposed to opioids are a financial drain on society. They neglect to address the fact that part of the costs attributed to these newborns are actually costs that result from hospital policies of removing such newborns from their mothers and putting those newborns in extremely expensive neonatal intensive care units. Such policies contradict peer reviewed research finding that babies do far better if allowed to remain with their mothers (rooming-in) and to breastfeed (Lacaze-Masmonteil & O'Flaherty, 2018). Such practices, though cost-saving and effective, will never become the norm as long as people stigmatize and demonize pregnant women as child abusers (Grossman et al., 2017).

We refuse to erase or demean pregnant women: What a woman who becomes pregnant does in response to her own life, health, and circumstances, is not the same as what she or anyone else does to a child once born. The greatest risk to children is not their own mothers; claiming so is a terrific distraction from the need to join together to address the social, economic, and racial disparities that are.

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