Pregnant and Parenting Women with a Substance Use Disorder: Actions and Policy for Enduring Therapeutic Practice

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Executive Summary

The American Academy of Nursing (Academy) calls for an end to criminal prosecution and punitive civil actions against pregnant and parenting women based solely on their substance use or substance use disorder (SUD). The Academy supports a public health response to the needs of women and their children and families affected by SUDs that incorporates multi-disciplinary culturally- and trauma-responsive models of health care, child welfare, treatment and recovery supports and clinician practices that are in line with the accumulated scientific evidence.

Background

Since the 1970s, many law enforcement agencies, state legislatures, courts, and medical personnel in the United States have used punitive legal sanctions against pregnant women with the purported intent of protecting the fetus from maternal use of alcohol, tobacco, and other drugs (Guttmacher Foundation, 2018; Jos, Marshall & Perlmutter, 1995; *Reyes v. Superior Court*, 1977). Women of color and those who are financially disenfranchised have been disproportionately targeted for drug screening and drug related charges and as a result have experienced disparities in access to needed health and social services (Amnesty International, 2017; Kunins, Bellin, Chazott, Du & Arnsten, 2007; Roberts, 1991). The net impact of these actions on women who are using substances and on their families has been to incite fear, suppress women's disclosure of substance use, and create barriers to essential health and social services, with resulting poor outcomes (Angelotta, Weiss, Angelotta, & Friedman, 2016; Stone, 2015). After more than four decades of criminal and civil actions against women who are pregnant and parenting and their families, the accumulating evidence of inherent harm and threats to maternal and child health and to women's constitutional and civil rights is undeniable (Amnesty International, 2017; *Ferguson v. City of Charleston*, 2001; Paltrow & Flavin, 2013). Recovery-oriented public health responses are urgently needed to institutionalize evidence-driven practice, and to permanently shift the culture of punishment to one of enduring therapeutic intent in line with a health justice framework (Benfer, 2015).

Scientific evidence and cost-benefit analyses strongly support the use of therapeutic treatment interventions to ensure optimal health and social outcomes for women and their children (French, McCollister, Cacciola, Durell & Stephens, 2002; National Institute on Drug Abuse [NIDA], 2018; Substance Abuse Mental Health Services Administration [SAMHSA], 2018). Clinical protocols for healthcare practitioners and best practice model programs for state agency responses also

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provide guidance to significantly improve the health and wellness of women and their children and families, and to direct therapeutic and humanitarian public policy actions in the U.S. (Klaman et al., 2017; Maguire, 2014; SAMHSA, 2014, 2016, 2017a, 2018).

Criminal and civil sanctions

The available data sources indicate that since the 1970's, more than 1000 women in the U.S. have been prosecuted for substance use during pregnancy[1] with the majority of those cases occurring since 2005 (Amnesty International, 2017; Paltrow & Flavin, 2013). Some states and jurisdictions have created "fetal assault" laws to prosecute women with SUDs. In Alabama and Tennessee alone, several hundred women have been charged under similar statutes (Amnesty International, 2017; Paltrow & Flavin, 2013). Recent actions by state legislatures and county prosecutors have led to criminal charges, arrests, and incarceration (Code of Alabama, 2012; Tennessee Fetal Assault Law, 2014;[2] Terplan & Minkoff, 2017). There has also been a call for the public to specifically report pregnant women who are "using drugs or alcohol" so they may be identified and arrested (Office of the County Attorney, Big Horn County, Montana, 2018).

Currently, 24 states and the District of Columbia have laws enforcing the position that substance use during pregnancy constitutes child abuse under civil child welfare statutes, and three states enforce civil commitment as a means of deterrence for drug use (Guttmacher, 2018). Although model protocols for risk evaluation exist (Centers for Disease Control and Prevention [CDCP], 2015; SAMHSA, 2016; Washington State Department of Health, 2016), no requirements for in-depth clinical evaluation of parenting capacity prior to filing a report were identified in any of the child welfare statutes for the 24 states and the District of Columbia. Law enforcement, probation officers, and courts have been known to order women to discontinue medication approved by the Food and Drug Administration for treatment (Legal Action Center, 2018a, 2018b), potentially placing them at risk for relapse and/or overdose death.

The impact of substance use on women, infants, children and families

Substance use during pregnancy places women at increased risk for inadequate prenatal care, infectious diseases, obstetric complications, needle-related morbidity, overdose, and death. In surveys of women who were pregnant, 5.9% report use of illicit drugs, 8.5 % report alcohol use, and 15.9% report smoking (SAMHSA, 2012a). Among women using substances, between 55% and 90% have histories of trauma (Najavits, Weiss & Shaw, 1997) and are three times more likely to experience intimate partner violence (El Bassel, Gilbert, Wu, Go, & Hill, 2005). Additionally, these women are more likely to have a co-occurring mental illness (SAMHSA, 2014). State reviews of pregnancy-related deaths conducted in 2015-2016 cite opioid overdose as a significant contributor to maternal deaths, ranging from 11-20% of all deaths during pregnancy (Maryland Department of Health and Mental Hygiene, 2016; Metz et al., 2012; Virginia Department of Health, 2015).

Among women who gave birth between 2000 and 2009, opioid use increased from 1.19 to 5.63 per 1,000 hospital births annually (Smith & Lipari, 2017). Neonatal abstinence syndrome (NAS) has increased 300% in 28 states in the past two decades (Ko et al., 2016; Patrick, Davis, Lehmann & Cooper, 2015; Patrick et al., 2012) with one NAS-affected infant born every 25 minutes in the U.S. (Ebell, 2010). NAS appears within 48–72 hours of birth and includes central nervous system irritability, respiratory and feeding difficulties, low birth weight, and temperature instability (Hudak & Tan, 2012). A 2012 cost estimate of NAS-associated hospital charges noted an economic burden of $1.5 billion with 80% of costs financed by Medicaid programs (Patrick, et al., 2015). In addition to opioid-induced symptoms, prenatal exposure to alcohol, tobacco and other licit and illicit substances can also contribute to low and extremely low birth weight, prematurity, cognitive, neurological, and developmental problems, and fetal alcohol spectrum disorders.

Women with SUDs and their families face multiple challenges including potential loss of child custody, mother-child separation due to incarceration, homelessness, exposure to violence, limited parenting opportunities and abilities, and trauma-related mental health conditions. Early therapeutic intervention can lead to lifelong benefits for these women and their children. Access to quality healthcare plays a vital role in long-term health and social outcomes, birth spacing, prevention of preterm delivery, and low birth weight (Sonfield, 2014).

Responses and Policy Options

There is widespread agreement among public health organizations, as well as scientific evidence, that prosecution in lieu of treatment is ineffective and potentially harmful. Congress has taken legislative actions including the Comprehensive Addiction and Recovery Act of 2016 (CARA), [Public Law 114-198] and the Protecting Our Infants Act of 2015 (POIA), [Public

[1] There is no national data bank monitoring the number of prosecutions of women for substance use during pregnancy. The number of cases referenced above is derived from existing analyses of known cases in several states and is believed to be an undercount of the actual number of cases (see Amnesty International, 2017, p. 8; Paltrow & Flavin, 2013, pgs. 304–305).

[2] The Tennessee Nurses Association in collaboration with other public health organizations played a central role in the sunset of Public Chapter 820 on July 1, 2016 through legislative testimony, alerts to Tennessee nurses, and by maintaining a continued public presence in support of treatment for Tennessee women with SUDs.

Law 114-91], which emphasize the beneficial outcomes of quality treatment and recovery services during pregnancy and parenting. Government agencies including SAMHSA, and professional organizations have crafted clinical guidelines and both CARA and SAMHSA (2017b) call for plans of safe care to address patient needs, with the conspicuous absence of beneficial outcomes arising from the imposition of punitive sanctions.

Recent proliferation of therapeutic family dependency model drug courts has also demonstrated improvements in SUD treatment initiation and completion and increased rates of reunification among families at risk for child abuse and neglect where substance use is a factor (Marlowe & Carey, 2012; National Council of Juvenile and Family Court Judges, 2018; SAMHSA, 2003). Among state responses to pregnant and parenting women with SUDs, Texas funded and disseminated the Mommies Program, a fully integrated model of care that included comprehensive treatment services, medication assisted treatment (MAT), recovery support services, housing, and specialty health services (Texas Health and Human Services Commission, 2015). In May, 2014 Ohio established the M.O.M.S. (Maternal Opiate Medical Support) model program consisting of specialty prenatal care, MAT, and behavioral health services in five care sites statewide. Today, the Ohio Perinatal Quality Collaborative is building upon the M.O.M.S. model with a program titled Maternal Opiate Medical Supports Plus (MOMS+) to optimize the maternity medical home and improve outcomes for pregnant women (Ohio Perinatal Quality Collaborative, 2018).

The Academy's Position

The American Academy of Nursing (Academy) calls for an end to criminal prosecution and punitive civil actions against pregnant and parenting women based solely on their substance use or substance use disorder (SUD). The Academy supports a public health response to the needs of women and their children and families affected by SUDs that incorporates multi-disciplinary culturally- and trauma-responsive models of health care, child welfare, treatment and recovery supports and clinician practices that are in line with the accumulated scientific evidence.

Recommendations

Federal

1. Increase funding for SAMHSA State Targeted Response to the Opioid Crisis grants (Opioid STR) and Opioid STR Supplement grants that include SUD services for pregnant and parenting women and that develop community-based partnerships to ensure safe access to health services including prevention, treatment, and recovery supports for women, their children, and families.
2. SAMHSA should conduct widespread targeted dissemination of Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants (SAMHSA 2018).
3. SAMHSA should advance ongoing training and technical assistance for service design to ensure cultural competence and sensitivity in SUD treatment and recovery approaches for women and families and to eliminate disparities based on race in terms of entry to and retention in treatment and recovery supports.
4. The CDCP and state Offices of Maternal and Child Health should collect comprehensive data on maternal deaths due to opioid and other drug overdose including decedents' associated behavioral health conditions, SUD and mental health treatment history, and preventability of death. The data should be made available to the public for research and to inform prevention and SUD treatment and recovery support policy approaches.

States

1. Increase state funding to ensure accessible community-based treatment, recovery supports, and health and social services for women, their children, and families affected by substance use regardless of immigration status or ability to pay for services.
2. Pass legislation to improve integrated comprehensive SUD services that include a continuum of gender- and trauma-responsive programming comprised of prenatal care, accessible MAT, individual and group therapy, trauma recovery, case management, psychosocial support, parent skills training, family education, pediatric health care and developmental services, and transition to ongoing women's health and wellness care, preventive health services, and family planning.

Nurses

Nurses have a critical role as patient advocates to protect individual health, human and legal rights of patients (ANA, 2016). Whereas law enforcement authorities have historically used a single drug test as grounds for prosecution of pregnant and parenting women with a SUD (Amnesty International, 2017), comprehensive assessments are essential to ensure the validity and integrity of clinical findings and must be upheld and protected. Nursing leadership is needed to safeguard accurate and comprehensive assessment and practice consistent with a therapeutic health justice approach.

1. Working with their health care institutions, Chief Nursing Officers, Nurse Administrators, and Nurse

Managers in women's health settings should lead the implementation and adoption of five essential actions in their clinical sites:

a. Use of an objective protocol for clinical assessment of all women who are pregnant or of childbearing age at entry into care that includes a valid substance use screening instrument, and conduct screening of all pregnant and postpartum women for anxiety, depression, and substance use (SAMHSA, 2018).
b. Use of a standardized NAS scoring instrument for assessment and use of standardized protocols for treatment of NAS in infants (SAMHSA, 2018).
c. Conduct maternal drug testing when the indication for testing is based on objective clinically observable criteria. Obtain informed consent for drug testing and provide education on testing procedures and the meaning of drug test results (SAMHSA, 2018). Ensure that the drug testing process used by the healthcare setting employs a secure chain of sample custody and the option for confirmatory testing (SAMHSA, 2012b, 2018).
d. Promote maternal-child bonding through the use of in-hospital rooming-in (McMillan et al., 2018), breastfeeding support (American College of Obstetrics and Gynecology and The American Society of Addiction Medicine, 2017; McGlothen & Cleveland, 2018; SAMHSA, 2018), and education on infant care and growth and development (Abrahams et al., 2007).
e. Ensure that discharge planning includes a referral to accessible community-based SUD treatment and recovery supports and to parenting programs.

2. Join community-based and state coalitions addressing the welfare of children affected by prenatal SUD to promote evidence-based therapeutic family and child interventions for the health and safety of children and to maintain family cohesion.
3. Work with law enforcement, district attorneys, and judges to unite and align these stakeholders in therapeutic responses to pregnant and parenting women with SUDs and their children and families.
4. Contribute expertise to collaborate on a national nurses training project to disseminate evidence-based practices for healthcare settings on clinical management and adoption of health justice-based policy approaches in the assessment, treatment and recovery supports for pregnant and parenting women with SUDs.

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