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Consensus Guidelines and State Policies: The Gap Between Principle and Practice at the Intersection of Substance Use and Pregnancy

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Abstract

The opioid crisis has had a substantial effect on women who are pregnant and parenting, focusing both public health and policymaker attention on opioids and on other substance use in pregnancy and postpartum. There is overwhelming consensus on the principle of a non-punitive approach towards substance use in pregnancy. Experts universally endorse supportive policies, which reduce barriers to care, and oppose punitive policies, which can increase the fear of legal penalties, discouraging women from seeking prenatal care and addiction treatment during pregnancy. We review the change over time in state-level policy environments around substance use in pregnancy and contrast the policy response with the principles and guidance from professional societies and federal agencies. Between 2000 and 2015, more states adopted punitive policies than supportive policies, in direct contrast with guidance from professional societies and federal agencies. The increase in punitive policies over the past two decades suggests that the gap between principles and practice is widening. Furthermore, the increase in punitive policies is occurring in the context of significant structural barriers to comprehensive health care across the woman's entire life course, a growing awareness of racial and ethnic inequities in maternal morbidity and mortality, and increasing restrictions at the state level on abortion access. Women with substance use disorder (SUD) need comprehensive, coordinated, evidence-based, trauma-informed, family-centered care. This care should be delivered in a compassionate and non-punitive environment, and clinicians, policymakers, and public health officials all have a role to play in achieving this goal.

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Condensation: Between 2000 and 2015, more states adopted punitive policies than supportive policies related to substance use in pregnancy, in direct contrast with expert guidance.

Keywords

opioid use disorder; pregnancy; policy; substance misuse; substance use

The opioid crisis and substance use in pregnancy

The opioid crisis has had a substantial effect on women who are pregnant and parenting, focusing both public health and policymaker attention on opioids and on other substance use in pregnancy and postpartum. The number of pregnant women with an opioid use disorder diagnosis at delivery quadrupled from 1999 to 2014,[1] and the incidence of neonatal opioid withdrawal syndrome (NOWS) increased nearly seven-fold from 2000 to 2014.[2,3] Alcohol use remains common, with 1 of 9 pregnant women endorsing past 30 day use, one third of whom reported binge drinking.[4] Cannabis use is increasing, with daily or near-daily cannabis use in pregnancy increasing from <1% in 2002 to nearly 3.5% in 2017.[5] Stimulant use, specifically methamphetamine, doubled in pregnancy from 2008 to 2015.[6] These trends have contributed to an increase in drug-related deaths among women in general[7] and during pregnancy and postpartum in particular, with overdose among the leading causes of maternal death in the US today.[8] Furthermore, the child welfare system response to substance use in pregnancy is straining already-limited resources. From 2011 to 2017, the number of infants entering the U.S. foster care system grew by almost 10,000, and at least half of infant placements are associated with parental substance use.[9]

Below, we review the change over time in state-level policy environments around substance use in pregnancy and contrast the policy response with the principles and guidance from professional societies and federal agencies. As SUDs, particularly involving opioids, increasingly affects pregnant women and their families, it is important to better understand how state policy environments with respect to substance use in pregnancy have evolved and the nature of policies being enacted by states.

Professional society and federal agency guidance

Professional societies and federal agencies universally endorse supportive policies and oppose punitive policies. Statements from the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the American Nurses Association, and several others (Table 1) all warn that policies penalizing pregnant women and imposing negative consequences for disclosing substance use to health care providers increase the fear of legal penalties and discourage women from seeking prenatal care and addiction treatment during pregnancy[10–12]. Guidance documents and professional society committee opinions further suggest that punitive policies may lead to disengagement from care[13] and poor pregnancy outcomes, although few studies have examined this issue[14,15].

Expert consensus is grounded in the view of substance misuse in pregnancy as a medical condition requiring integrated care for both the pregnancy and the SUD[10,12,16] and the recognition that supportive policies reduce barriers to care. For example, punitive policies

enacted, in part, to reduce neonatal opioid withdrawal syndrome (NOWS), have the opposite effect. Infants born in states that implemented policies that punish pregnant women for substance use had higher rates of NOWS than those born in states without such policies.[17]

How have policymakers sought to address substance use in pregnancy?

The change in state policy environments with respect to substance use in pregnancy from 2000 to 2015 are detailed in the maps in Figure 1. Six types of relevant policies[18] were examined: those that (1) define substance use in pregnancy as child abuse or neglect, criminalize it, or consider it grounds for civil commitment, (2) mandate testing of infants with suspected prenatal substance exposure or pregnant women with suspected substance use; (3) require reporting of suspected prenatal substance use to officials at local health and human services departments; (4) create or fund targeted programs for pregnant and postpartum women with SUDs; (5) prioritize pregnant women's access to SUD treatment programs; and (6) prohibit discrimination against pregnant women in publicly funded SUD treatment programs. Consistent with prior work[17] and others' approach,[19,20] policies imposing legal consequences for substance use or requiring health professionals to test for or report suspected substance use to authorities (policies 1–3) were considered punitive. Policies reducing barriers for pregnant women with SUD or those that expand treatment (policies 4–6) were considered supportive. If a state enacted a policy with both punitive and supportive components, it was considered to have a mixed policy environment. Enactment dates were obtained from the Guttmacher Institute[18] and supplemented with information from the National Conference of State Legislatures, ProPublica, and published studies retrieved through a targeted literature review.[21–23] In addition, state statutes were reviewed to capture language illustrative of policy categories. Box 1 shows an example punitive policy enacted in North Dakota in 2003 and Box 2 contains a supportive policy enacted in Kentucky in 2015.

Figure 1 shows substantial state policy activity in this area, with more states adopting punitive policies than supportive policies. This increase, from 18 states with at least one punitive policy in 2000 to 33 states in 2015, was primarily driven by states adopting policies considering substance use in pregnancy to be child abuse, grounds for civil commitment, or a criminal act, as well as policies requiring healthcare professionals to report suspected prenatal drug use. By 2015, states with only punitive policies increased from six to eight, while states with only supportive policies declined from 17 to 8. States with both types of policies (i.e., a mixed policy environment) doubled from 12 in 2000 to 25 by 2015, and only 10 states had no policies specific to substance use in pregnancy in 2015, down from 16 in 2000. While encouraging that 28 states had supportive policies in 2000, only 4 additional states adopted supportive policies in the subsequent 15 years.

A concerning gap between principles and practice

The maps in Figure 1 are consistent with a pattern described in 1998[24] of more states enacting punitive policies than policies expanding treatment for women with SUD and echo the punitive approaches taken towards women with crack cocaine use in the 1980s and 1990s.[25] These policies disproportionately affected Black women and women living in

poverty,[26] and continue to do so today.[27] While the government's current approach to substance use in the general population is "remarkably less punitive" than its approach a few decades ago, it has recently been observed that "…pregnancy may represent an exception to the overall national willingness to treat the opioid epidemic as an issue of public health and not of law enforcement."[26] In addition, as one journalist put it, "There's a growing consensus in the U.S. that drug addiction is a public health issue, and sufferers need treatment, not prison time. But good luck if you are pregnant."[28] Despite overwhelming consensus on the principle of a non-punitive approach towards substance use in pregnancy (Table 1), the increase in punitive policies over the past two decades suggests that the gap between principles and practice is widening.

What is needed is a holistic, public health-and prevention-oriented approach to substance use in pregnancy, consistent with the statements in Table 1. Imagine for a moment that pregnant women with diabetes, or epilepsy, or major depressive disorder, all of which are chronic medical conditions that confer some level of risk to the fetus, faced criminal charges and imprisonment if convicted of harming their infants. These examples illustrate just how differently many in the public and medical community view addiction.

Addiction is a chronic medical condition, but pregnancy is a temporary period in the life course of a woman dealing with the recurring and remitting illness of addiction. Yet, too often, policies, health systems, and health services are designed to engage individuals in treatment only during pregnancy which is insufficient. Instead, women with SUD should be engaged throughout their life course.

Recommendations for public health and policy at the intersection of substance use disorder and pregnancy

Women with SUD need comprehensive, coordinated, evidence-based, trauma-informed, family-centered care not only during the 40 or so weeks of pregnancy but in the preconception, postpartum, and inter-conception periods—as well as throughout the life course for those not able to or not choosing to have children. This care should be delivered in a compassionate and non-punitive environment, and clinicians, policymakers, and public health officials all have a role to play in achieving this goal.

There are encouraging examples of sound policy at both the federal and state levels.[29] For example, recent federal legislation (e.g., the Comprehensive Addiction and Recovery Act of 2016 and the SUPPORT for Patients and Communities Act of 2018) takes a much-needed public health approach to this issue, building on prior efforts to address gaps in the continuum of care for women who are pregnant and postpartum and strengthening Plans of Safe Care for infants with prenatal substance exposure. There has been a slow but noticeable shift in federal policy language towards less stigmatizing terminology and "people-first" language, such as an "individual in recovery" as opposed to a "drug addict," and replacing "NAS baby" with "infant experiencing withdrawal." Certain states are taking a dyadic approach to the challenge of mothers and infants affected by opioids. Medicaid policy levers have also shown promise. In Virginia, the Addiction and Recovery Treatment Services program,[30] launched in 2017 to increase access to services for Medicaid members with

SUDs, increased residential treatment capacity and removed the 16-bed reimbursement limit, which was a barrier to children and mothers remaining together during the mother's treatment. ARTS successfully increased the percentage of pregnant women with SUDs receiving treatment from 2% to 18% a year after implementation. Further research is needed to examine factors that may influence state-level variation in both the implementation and impact of different policy responses to substance use among pregnant women, but these are promising models.

It is also encouraging that both federal and state policymakers are testing innovative ways to expand SUD treatment for women who are pregnant and parenting, including through telehealth and through telementoring and remote capacity building, based on the Project ECHO model.[31] Importantly, public health and health systems are collaborating to address the often-overlooked "fourth trimester,[32–34]" the vulnerable early postpartum period in which a lot of the support and services a pregnant woman was eligible for rapidly fall away. Finally, the recommendation by multiple professional societies to extend postpartum Medicaid coverage to one year postpartum is garnering much-needed attention from policymakers.[35]

In conclusion, effectively addressing SUD, including opioid misuse, among pregnant women is a pressing public health issue, given both the dramatic increase in NOWS[2] as well as the deleterious effects of untreated maternal opioid use disorder on both mothers and young children.[10] Policymakers are aware of this issue, given the rapid pace of enacting policies addressing substance use in pregnant women. However, the greater increase in punitive compared to supportive policies is a concern. Better understanding how policies related to prenatal substance use affect maternal and child outcomes is essential as decisionmakers seek to best support pregnant women with SUDs.

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Box 1.

Example of a punitive statute, North Dakota, (2003)

"If a physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy, the physician shall administer, without the consent of the child's parents or guardian, to the newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance."

Box 2.

Example of a supportive statute, Kentucky (2015)

"Substance abuse treatment or recovery service providers that receive state funding shall give pregnant women priority in accessing services and shall not refuse access to services solely due to pregnancy as long as the provider's services are appropriate for pregnant women."

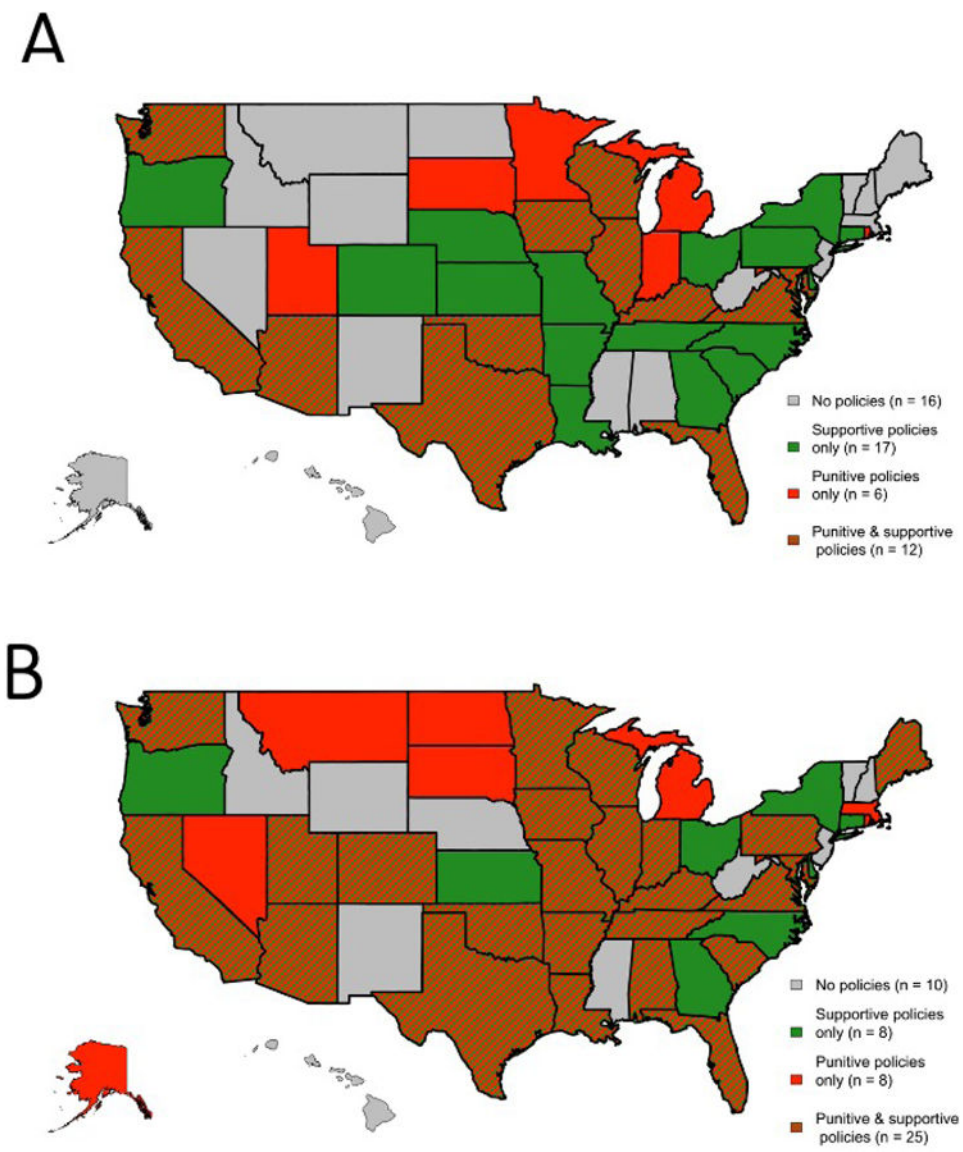

Figure 1.

Overview of policy combinations in 2000 (panel A) and 2015 (panel B)

Panel A. States with no policies related to substance use in pregnancy, supportive policies only, punitive policies only, and both types of policies in 2000.

Panel B. States with no policies related to substance use in pregnancy, supportive policies only, punitive policies only, and both types of policies in 2015.

Table 1.

Key Points from Selected Position Statements, Policy Statements, Panel Reports, and Guidance Documents Related to Substance Use in Pregnancy

Organization	Key Points
American Academy of Family Physicians (AAFP)[36]	• "The AAFP opposes imprisonment or other criminal sanctions of pregnant women solely for substance use during pregnancy, but encourages facilitated access to an established drug and alcohol rehabilitation program for such women."
American Academy of Pediatrics (AAP)[12]	• "Several state governments responded to this increase by prosecuting and incarcerating pregnant women with substance use disorders; however, this approach has no proven benefits for maternal or infant health and may lead to avoidance of prenatal care and a decreased willingness to engage in substance use disorder treatment programs. A public health response, rather than a punitive approach to the opioid epidemic and substance use during pregnancy, is critical..."
American College of Obstetricians and Gynecologists (ACOG) and the American Society of Addiction Medicine (ASAM)[37]	• "… a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families." • " it is important to advocate for this often-marginalized group of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized." • "In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions."
American Nurses Association (ANA)[38]	• "The American Nurses Association (ANA) recognizes substance use disorders as treatable conditions and commits to primary prevention and treatment for pregnant and breast-feeding women. This includes treatment for pregnant women who misuse substances as well as appropriate therapy for exposed infants. ANA opposes laws that may result in punitive legal actions and result in incarceration of pregnant women because of substance use disorder. Within the confines of state law, ANA directs registered nurses who work with pregnant and breast-feeding women to seek providers that offer appropriate rehabilitative therapy, rather than law enforcement or the judicial system, to obtain help for women and infants."
Centers for Disease Control and Prevention (CDC)[39]	• "Public health measures to prevent and treat opioid dependence before and during pregnancy are essential to reducing the incidence of NAS and its related health care burden." • "Stigma, provider bias, and legal consequences pose additional barriers to screening and subsequent identification of women in need of treatment." • "…legal ramifications for maternal substance use vary by state. Eighteen states classify maternal substance use as child abuse and three states consider it grounds for involuntary hospitalization…The impacts of these varied state legislations on prenatal care attendance, disclosure of substance use, and treatment seeking or receipt are unclear."
Office of Women's Health (OWH)[40]	• "Involvement with the child welfare system plays a critical role in a woman's decision to seek care, because admitting to a substance use disorder may lead to involvement with the criminal justice system and potential loss of custody. The 2011 National Drug Control Strategy has acknowledged the importance of women not having to choose between seeking treatment and caring for their children." • "The health of the mother is vital to the health of the baby, and health care policies and treatment interventions should treat them as one unit."
Substance Abuse and Mental Health Services Administration (SAMHSA)[41]	• "Gender-responsive treatment involves a safe and non-punitive atmosphere, where staff hold a hopeful and positive attitude toward women and show investment in learning about women's experiences, treatment needs, and appropriate interventions." • "…women who have substance use disorders often fear prosecution and incarceration if they seek treatment during pregnancy." • "…once treatment is initiated, issues surrounding pregnancy, child care, parenting, and custody need be addressed in a nonthreatening but constructive manner—showing support and guidance in promoting and nourishing a healthy parent–child relationship."[42]
Surgeon General's Report: Spotlight on Opioids[43]	• Federal, state, local and tribal governments should…"implement criminal justice reforms to transition to a less punitive and more health-focused approach."
World Health Organization (WHO)[44]	• "Interventions should be provided to pregnant and breastfeeding women in ways that prevent stigmatization, discrimination, criminalization, and marginalization of women seeking treatment to benefit themselves and their infants. Prevention and treatment should promote and facilitate family, community and social support as well as social inclusion by fostering strong links with available childcare, economic supports, education, housing, and relevant services."