

# SUBSTANCE ABUSE AMONG PREGNANT WOMEN

## ISSUE:

The problem of drug abuse among pregnant women continues to be a national health issue. It is estimated that 4% of all live births in the US (160,000) occur in women who abuse illicit or prescription drugs such as opioid pain relievers (Oxycontin, Vicodin), barbiturates (Seconal, Nembutol), benzodiazepines (Xanax, Ativan), and stimulants (Dexedrine, Ritalin) during pregnancy (“National Survey on,” 2006; “Selected prescription drugs,” 2005). In addition to abusing illicit and prescription drugs, approximately 32% of pregnant women also use alcohol and tobacco (Wenzel et al., 2001).

Circumstances contributing to female drug addiction include physical abuse, sexual abuse, and mental illness. In fact, it has been reported that 70% of women who abuse drugs reported physical and/or sexual abuse before the age of 17, and more than one-third suffer from mental health problems (Lester et al., 2004; Liebschutz et al., 2002; Snyder, 2000). Other factors associated with drug abuse include ethnicity, gender, genetics, peer pressure, and socioeconomic status (InfoFacts, 2011).

Drug abuse is not strictly a social problem. It is a chronic disease that impacts the brain, which makes stopping more than a matter of will power (“InfoFacts,” 2011; Leshner, 1997). Because drug addiction is characterized by a syndrome of behaviors, changing these behaviors requires comprehensive treatment. This comprehensive treatment must address emotional, physical, and sexual abuse, contraception, family, and parenting; as well as complement the primary and prenatal health care required for recovery (“Substance abuse treatment,” 1997; Lester et al., 2004; Messinger & Lester, 2005).

## BACKGROUND:

Many communities have chosen to criminalize and prosecute women who use substances, including alcohol, during pregnancy. Many states twist or bend criminal statutes to prosecute women who use drugs during pregnancy to punish them with jail sentences. Many other states consider use of substances during pregnancy indicative of child abuse and neglect, which results in the loss of custody of the baby at birth. These consequences reinforce women’s reluctance to access prenatal care and other services (Tillett & Osborne, 2001).

Data suggest that punishment is not the answer to perinatal substance abuse. Incarceration or the threat of incarceration is not effective in reducing drug or alcohol abuse in pregnant women (Poland et al., 1993; Chavkin, 1990; Schempf & Strobino 2009). Using the criminal justice system is a misguided attempt to protect the fetus, undermines maternal and fetal wellbeing, and discourages the development of programs that address the needs of these women and their children (Flavin & Paltrow, 2010). As reported by the Child State Welfare Laws

Position Paper

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and Procedures, Office of Former Inspector General Richard P. Kusserow (1990, p. 12), prosecution does not stop pregnant women from abusing drugs. Rather, fear of prosecution can cause women to abort their pregnancies, push them underground, and discourage them from seeking treatment for their addiction. In addition to fear of prosecution, women who worry that their children will be taken away at birth if they admit to substance abuse are less likely to seek essential prenatal and medical care. Moreover, the threat of criminal punishment fosters fear and mistrust between healthcare providers and patients, imperiling the health of women and their children (Lester et al., 2004).

### **STRATEGY:**

NPA opposes punitive measures that deter women from seeking appropriate care during the course of their pregnancies.

Additionally, NPA encourages the screening and referral of all pregnant women for substance use, including alcohol, tobacco, and prescription drugs, during the course of their pregnancy. NPA supports fully funded, comprehensive drug treatment programs for pregnant women rather than criminal or civil punishment.

### **POLICY:**

NPA supports comprehensive drug treatment programs for pregnant women that are family-centered and work to keep mothers and children together whenever possible. The most successful treatment models will include access to quality prenatal and primary medical care, child development services, crisis intervention, drug counseling, family planning, family support services, life skills training, mental health services, parent training, pharmacological services, relapse strategies, self-help groups, stress management, and vocational training (Lester et al., 2004).

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