The New Moral Panic Over Drug-Dependent Babies

As with the hyped-up crack-baby crisis, fears about neonatal abstinence syndrome appear to be overblown. But that won't stop states from punishing pregnant women.

By Amelia Thomson-DeVeaux

Last month, the Tennessee legislature passed a bill that would allow state authorities to file criminal assault charges against women who use illegal drugs during pregnancy.

Shelby County Attorney General Amy Weirich **described** the measure as a "velvet hammer" designed to force recalcitrant women into substance abuse programs. Wielding a classic think-of-the-children argument, lawmakers pointed to a tenfold surge in babies born with neonatal abstinence syndrome (NAS), where infants temporarily exhibit some of the symptoms of drug withdrawal. "These babies are born addicted and their lives are totally destroyed," **said Tennessee Rep. Terri Lynn Weaver, a Republican**, when she introduced the bill in February.

Contemporary anxieties over NAS echo the widespread moral panic over "crack babies" that unfolded in the late 1980s and early 1990s. Hospital staff and social workers in cities like Philadelphia and Washington, D.C., discovered, to their alarm, that many of the poor, predominantly black women who gave birth in their maternity wards were addicted to crack cocaine.

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The idea that Tennessee might be poised to lock up women for using drugs during pregnancy was alarming enough to make national headlines. Doctors and civil liberties advocates wrote to the governor, Bill Haslam, urging him to veto the bill. The *New York Times* editorial board weighed in, **calling the measure "meanspirited and counterproductive."** (He signed it last week anyway.)

But the Tennessee law is just one extreme manifestation of a larger—and subtler—trend, which threatens to separate countless mothers from their children. In states with high levels of opiate abuse, growing anxiety over NAS is also spawning a surge of laws that could result in civil penalties for women who use drugs or participate in drug treatment programs during pregnancy.

Prescription drug abuse is on the rise across the country, especially among women. **A study released last summer by the CDC** found that emergency room visits related to narcotic pain relievers like OxyContin more than doubled among women between 2004 and 2010. Pregnant women are by no means immune to this trend; according to a recent analysis, nearly 23 percent of pregnant Medicaid recipients filled a prescription for an opioid pain reliever in 2007, a 5 percent increase since 2000.

The growing incidence of NAS in newborns is likely connected to this wave of prescription drug use, says Mark Hudak, a neonatologist **who wrote guidelines on neonatal drug withdrawal** for the American Academy of Pediatrics. Babies with NAS exhibit a range of symptoms, from seizures to diarrhea to difficulty feeding. Often, hospitals will send infants who test positive for opiates straight to the neonatal intensive care unit. The babies stay in the neonatal ICU for anywhere between a week and two months, as

doctors slowly wean them off the drug they were exposed to in utero.

During the crack crisis, troubling tales began to circulate in the media of "crack babies" born with small heads, irritability, and poor muscle tone. The children, experts and politicians predicted, would suffer from mental retardation. They would never be able to hold down a job or have a meaningful relationship. Many of the babies born to low-income women who admitted to cocaine use were sent into the foster system. A few women were even arrested and prosecuted. "Crack baby" became synonymous with bad mothering.

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Two decades later, the myth of the "crack baby" **has been repeatedly debunked.** Longitudinal studies that followed crack-exposed infants through their childhood and adolescence found that in terms of their IQ and school readiness, cocaine-exposed children were no different than their peers. But none of the children in the study performed especially well on these tests. The researchers concluded that the confounding factor wasn't whether their mother had used drugs during pregnancy; what held the children back was poverty.

Today's trepidation about NAS carries a similar tenor. While it's hardly a favorable circumstance for entering the world, there's no evidence that NAS has long-term consequences for infants. Moreover, some doctors say there's a tendency toward overtreatment for NAS, which can be mitigated by breastfeeding and close contact with the mother.

Politicians lament the babies "born addicted," although Hudak notes that this terminology is incorrect; infants with NAS are drug *dependent*, and their symptoms are predictable and treatable. Implicit in laws like Tennessee's is the assumption that the responsibility for babies born with NAS can be traced directly to the mother.

"It's all about the framing," says Susan Boyd, a professor of law and drug policy at the University of Victoria. "Here's this vulnerable fetus or baby who's being threatened by the mother's selfish actions. If we think about it that way, we don't need to figure out why the women are using drugs in the first place, and helping them get treatment, because it's their fault."

Ignoring the advice of medical professionals, states are roaring ahead with policies that penalize women for using drugs during pregnancy, rather than seeking treatment for both mother and child. Already, seventeen states treat drug exposure at delivery as a form of civil child abuse.

This year, Ohio and Indiana required hospitals to report NAS diagnoses to the Department of Health. Three other states—Florida, Kentucky, and Tennessee—have similar laws on the books. Although Ohio's law specifically forbids hospital staff from turning over information about pregnant mothers' drug use to criminal authorities, there's nothing to prevent doctors and nurses from involving child welfare agencies, especially if they suspect that the mother may have been using illegal drugs, or abusing prescription pills. In some hospitals with reporting requirements, staff members call state social workers to investigate whenever there's an NAS diagnosis.

"Once a child welfare agency intervenes, it can be very difficult to get them out of your life," says Kylee Sunderlin, the Soros Justice Fellow at National Advocates for Pregnant Women, a nonprofit law firm with a focus on reproductive issues. "In worst-case scenarios, it can lead to termination of parental rights."

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Even women who enter substance abuse treatment programs during pregnancy can find themselves faced with civil penalties. Julie Jones (not her real name), a woman living in rural southern Ohio, began taking opiate painkillers without a prescription in February 2011, after her 20-year-old sister died in a traffic accident. "They made me forget about everything," she says. "That made me more functional, for a while." More than a year later, she was dependent on the painkillers and spent most of her time among other drug users; she had even experimented with heroin. Then Julie discovered she was pregnant. "That was when I realized I needed help."

Her best shot for a healthy pregnancy, Julie's doctor told her, was to enter into a substance abuse program immediately. If she quit cold turkey, she'd risk a miscarriage. Julie began making the two-hour drive to Cincinnati once a week, for counseling and doses of buprenorphine, an opiate drug that staves off withdrawal symptoms. By the time she gave birth to her son, Elliott, in July 2013, she had been clean for more than six months.

But while she was still in the hospital, days after Elliott was born, a social worker came into Julie's room and told her that Elliott had tested positive for opiates—because of Julie's buprenorphine treatment. Hospital staff transferred him to the neonatal intensive care nursery, where he stayed for nearly two weeks for addiction treatment. They also filed a report with Child Protective Services.

This reaction is not unexpected in southern Ohio, where diagnoses of neonatal abstinence syndrome have increased fivefold over the past five years. In September 2013, hospitals throughout the Cincinnati area—including the

hospital where Julie gave birth—**began to implement universal drug testing of mothers in labor.**

Although women have the right to refuse these tests, parental consent isn't required to perform drug screens on newborns like Elliott. After an infant is diagnosed with neonatal abstinence syndrome, Child Protective Services gets involved as a matter of course. "The intention isn't bad," Julie says. "The people at the hospital just want to make sure the baby is going home to a safe place."

"He said, 'Hurry up, get home right now,'" she remembers. "'They're taking you to court.'"

At first, the social workers from Child Protective Services assured Julie and Tom, her husband (also not his real name), that their case would be simple. They would sign up for counseling, Julie would continue her substance abuse treatment, and the state would close its investigation. But in October 2013, three months after Elliott was born, Julie was driving home from the grocery store when Tom called in a panic. "He said, 'Hurry up, get home right now,'" she remembers. "'They're taking you to court.'"

Within the week, Julie and Tom found themselves in a courtroom, facing charges of civil child abuse and neglect. The problem, the social workers said, was that the buprenorphine Julie took to treat her drug dependence was an opiate, a substance no different from OxyContin or heroin.

Robert Newman, a doctor who specializes in addiction treatment, says there's a widespread misperception that drug replacement therapies are the functional equals of powerful prescription opiates or illegal drugs like heroin. In addiction treatment programs, patients like Julie take controlled doses of

medication under a physician's care.
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prevent withdrawal but don't include a
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Now Julie is pregnant again and still taking buprenorphine. She's less worried about a second tangle with Child Protective Services after transferring to a program at a different hospital with a specific emphasis on treating high-risk pregnancies like hers. But programs like these are unusual.

Henrietta Bada, a neonatologist and professor of pediatrics at the University of Kentucky, says that in her state, where diagnoses of neonatal abstinence syndrome rose more than 300 percent between 2000 and 2009, the number of treatment programs can't meet the demand. "We need more residential treatment programs where women can take their babies or intensive outpatient programs with daycare," she says. "But it's expensive, and where's the funding?"

Money is often part of the calculus behind state laws designed to check NAS. A frequently cited study published in 2012 reported that, on average, the cost for treating an infant with NAS was more than $50,000. Because the mothers of children with NAS are often low-income, most of the bill goes to Medicaid.

One way to cut costs, says Michael Musci, chief medical officer of ProgenyHealth, a neonatal care management company, is to create outpatient programs for infants suffering from NAS. The goal is for babies to live at home with their families while they're weaned off the drugs, speeding their recovery and avoiding the expense of weeks in the neonatal ICU.

It's hard to find supporters in the medical community for a law like Tennessee's, which threatens drug dependent women with jail time if they get

pregnant. The incentives are misaligned, say advocates and medical professionals; women who fear retribution will be even less likely to seek prenatal care.

Strangely enough, it was only last year that Tennessee legislators passed the Safe Harbor Act, a law that protects drug dependent women from having their parental rights terminated if they enter treatment. "It seemed like last year, legislators were starting to realize that people can struggle with addiction and still be good parents," says Allison Glass, an organizer with Healthy and Free Tennessee, a coalition of organizations that focuses on sexual health and reproductive rights. "The important thing is to keep families together, to the extent we can. This new law is a huge step backward."

If the Tennessee laws represent two extremes, the laws that require hospitals to report cases of NAS are more mixed. On the one hand, more data can show states where opiate abuse is concentrated, so they can expand treatment facilities by geographic need.

"Marginalized women, low-income women and women of color, are being over-tested," says Farah Diaz-Tello, an attorney for National Advocates for Pregnant Women. "That means that women of color are vastly overrepresented in arrests and punitive child welfare interventions."

But these laws also give wide discretion to hospital staff and social workers, which leaves room for discrimination. "Marginalized women, low-income women and women of color, are being over-tested," says Farah Diaz-Tello, an attorney for National Advocates for Pregnant Women. "That means that women of color are vastly overrepresented in arrests and punitive child welfare interventions."

Whether other states will try to follow in Tennessee's footsteps remains to be seen. The national flap over what reproductive justice advocates call "criminalizing pregnancy" may convince other politicians to take a subtler

tack. Nevertheless, anxiety over NAS seems likely to continue to spiral, fed by the nagging belief that women should be punished for failing to properly care for their fetuses.

Like the "crack baby epidemic," this narrative puts mothers in opposition to their children, rather than seeing them both as vulnerable people, in need of care. "The fetus is part of the mother," Susan Boyd says. "What's good for her is good for her baby. I think sometimes we forget that."
