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Commentary

Pregnant Women Who Use Substances and the Need for Systemic Change

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Abstract

The rising rates of substance use among pregnant and postpartum women in the United States represent a growing social welfare crisis, with serious implications for maternal health, infant outcomes, and an already strained child welfare system. In 2022 alone, over 45,000 children were referred to child welfare agencies for prenatal substance exposure, and 7.5 million children were involved in child protective referrals overall. Among the concerns is the dramatic increase in Neonatal Abstinence Syndrome (NAS), a condition affecting infants exposed to drugs in utero, particularly opioids. Yet, despite increased awareness and data, the systemic response to substance use during pregnancy remains largely punitive, rather than supportive.

This editorial explores how Substance Use Disorder (SUD)—particularly involving opioids and stimulants—intersects with child welfare and legal systems in ways that disproportionately penalize and stigmatize pregnant women, especially those who are low-income or from racial and ethnic minority backgrounds. These women face heightened surveillance, limited access to treatment, and significant legal risks including incarceration and loss of child custody. The absence of standardized screening protocols and treatment access further complicates their ability to seek help without fear of reprisal.

Existing child welfare policies, rooted in the Child Abuse Prevention and Treatment Act (CAPTA), often conflict with evolving understandings of addiction and harm reduction. While criminal justice reforms have begun to acknowledge the need for alternatives to incarceration, similar progress is lacking in the child welfare arena. This editorial argues for a shift in perspective: rather than treating SUD in pregnancy as a moral failing or criminal issue, it should be approached as a public health and human rights concern. The Reproductive Justice Framework offers a pathway forward, emphasizing the structural and intersectional barriers faced by pregnant women with SUD and advocating for systems-level change that prioritizes care, equity, and dignity.

Keywords: Child welfare; Pregnancy; Substance use

The increase in substance use among women who are pregnant is a social welfare problem that impacts the pregnant women who are struggling, their children, and an overburdened foster care system [1,2]. For the purposes of this paper, the topic is limited to pregnant women and postpartum mothers. This is not intended to discount the experiences of people of other genders who also experience pregnancy and parenthood. In 2022, approximately 4.25 million referrals regarding 7.5 million children were made to the child welfare system across the United States [3]. Of these, 49.5% were screened in for services, meaning a report of potential child maltreatment was made and was forwarded to Child Protective Services (CPS) for investigation. Of those investigated, 74.3% were indicated for neglect, and 10.2% were indicated for other maltreatment, including exposure to parent's drug/alcohol use. There were 45,756 children referred to child welfare agencies for prenatal substance exposure from 50 states in 2022 [3]. A study published in 2021 demonstrated a national increase of 82% from 2010 to 2017 of babies born with neonatal abstinence syndrome [4]. Neonatal Abstinence Syndrome (NAS) is a specific diagnosis assigned to infants who experience withdrawal symptoms after birth due to drugs they were exposed to in utero. It is most frequently applied to infants exposed to opioids, but it can include other drug exposure as well [5]. According to the Adoption and Foster Care Analysis and Reporting System (AFCARS) data published by the National Center on Substance Abuse and Child Welfare (NCSACW), parental alcohol or drug abuse as an identified condition of removal of children and placement in out-of-home care has increased from 2000 to 2019. Data from 2000 show a prevalence rate of 18.5%. This increased to 38.9% in 2019, a cumulative increase of 20.4% [6].

Substance Use Disorder (SUD) is measured by the DSM-V on a continuum from mild to severe [7]. Each specific substance is addressed as a separate use disorder, for which a minimum of two to three symptoms from a list of 11 must be present in order to meet diagnostic criteria. These patterns of symptoms are caused by the use of a substance that an individual continues using despite its negative effects, e.g., using more than intended or for longer than one intended, needing more of the substance to get the desired effect (tolerance), and giving up important or desirable social and recreational activities due to substance use [7]. This summary will focus primarily on illicit substances with high abuse potential, i.e., opioids and stimulants. Opioids are defined as a class of drugs that includes synthetic opioids such as fentanyl, the illegal drug heroin, and prescription opioids such as oxycodone, codeine, and morphine [8]. They are used medically to relieve pain and in many people can create a feeling of euphoria [8]. Stimulants are defined as a class of drugs including illicit drugs such as methamphetamine, cocaine, or crack as well as prescription

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drugs such as methylphenidate and diet aids [9]. Stimulants increase the speed of the body's systems and can create feelings of increased alertness, high energy and activity levels, and euphoria [9]. For women who are pregnant, any identified use of substances, regardless of whether it meets criteria for a disorder, is subject to scrutiny and potential consequences from medical systems, child welfare systems, and penal systems [10,11]. In addition, there are no specific guidelines for screening in pregnancy, making it difficult to ascertain the true scope of this issue [10]. According to the National Drug Control Strategy, the rate of substance use among women, particularly those with children, has increased steadily since 2000, and some states report that their increase in child neglect reports is directly related to an increase in substance use in their regions [12].

Child welfare policy is defined by the Federal Child Abuse Prevention and Treatment Act (CAPTA) as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation', or 'an act or failure to act which presents an imminent risk of serious harm" [12]. According to a report by the National Institute on Drug Abuse from 2023, having an SUD during pregnancy is not child abuse or neglect in and of itself. However, pregnant women living in states with punitive policies for SUD in pregnancy have a lower likelihood of accessing and receiving treatment and higher rates of incarceration and loss of custody [8,13-15]. A report from the Virginia Journal of Social Policy & the Law from 2016 discusses the stark disconnect between the child welfare system and the drug policy reform movement. While initiatives to decrease mass incarceration from the racially driven 'war on drugs' and Harm Reduction policies are being implemented and showing positive outcomes, the child welfare system response to drug using pregnant women remains disproportionately punitive [16].

The overwhelming stigmatization and potential legal consequences that accompany using substances during pregnancy present many women with significant systemic oppression. Pregnant women living with SUD, especially women of color and women in lower socio-economic brackets, are subject to increased surveillance by both medical systems and child protection services systems. They live with increased risk of arrest, prosecution, conviction and removal of their children from their custody [16-18]. Pregnant women with SUD are marginalized, as are minority women. The intersectionality of these two identities presents issues regarding access to treatment and systemic stigmatization that are multiplicative in nature. Pregnant women should be prioritized for accessing treatment, but in fact the opposite is true [13,19]. The increased stress caused by systems that are designed to maintain safety for everyone creates additional pressures that are frightening and painful to navigate. Arrest and prosecution, along with the threat of losing custody of one's child, does not improve maternal and fetal health. Rather, fear of detection and punishment presents a significant barrier to care for pregnant women with SUD [17].

In addition to having to navigate typical physical and emotional complications around pregnancy, pregnant women with SUD also suffer from legal, social, and moral repercussions that often accompany substance use. As pregnant women with SUD make efforts to stop or reduce their use and get healthy, they are often confronted by barriers not experienced by the general population, specifically the threat of being reported and having their existing children removed along with the threat of having their unborn child removed at birth [20]. This creates an additional burden of managing this trauma while also navigating postpartum changes [17]. There are also practical realities that confront pregnant women that do not apply to the general population, such as the inability to detoxify from substances in a medical detoxification facility. Detoxification is contraindicated due to association with high maternal relapse rates [21]. Women who are pregnant and addicted to opioids are instead directed to get on Medication Assisted Treatment (MAT) programs [22]. This is the standard of care for pregnant women with an opioid use disorder. However, a study in 2020 showed that pregnant women are 17% less likely to be accepted by MAT providers when compared to non-pregnant women [13]. This limitation presents another barrier for pregnant women, further reducing their treatment options [23].

Pregnant women with SUD are struggling, vulnerable and disadvantaged. Penalizing them further presents issues for both their well-being as well as that of their unborn children. Most literature written thus far addresses pregnant women with SUD as an individual problem or a criminal justice issue. In order to create meaningful change for this population in addition to better outcomes for their children, there needs to be a theoretical framework applied to this social problem that organizes the issues on a systemic as well as an individual level. The Reproductive Justice Framework fills this gap by addressing the underlying power differentials between the multiple systems at play and the individual experiences of women engaging with those systems.

Declaration of Interest Statement

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