2010

Forum
Proceedings

The Bronx Health Link and
National Advocates for Pregnant Women

Drug Use, Pregnancy, and Parenting

Abstract: The goal of the forum was to provide participants with the opportunity to meet and learn from experts to address what happens to children who remain in the care of mothers who used drugs during pregnancy and/or continue to be involved with drug use.

About the Forum Sponsors

The Bronx Health Link, Inc. is a clearinghouse of health information for the community and the members of the health and human service delivery system of the Bronx. In this capacity, we inform, educate and empower the community and others through our educational workshops, community resource centers and through electronic mediums such as the website and the e-newsletter. We conduct community-based research and house the Bronx Community Research Review Board. To give voice to the needs and concerns of the community, we participate on numerous workgroups, advisory boards and task forces. This work and our mission is dedicated to the principle that The Bronx Health Link works with many community partners to improve the overall health of Bronx women, children and families.

National Advocates for Pregnant Women (NAPW) is a non-profit organization that works to secure the human and civil rights, health and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable – women of low income, women of color, and women who use drugs. NAPW combines legal advocacy, local and national organizing, and public education to ensure that women do not lose their constitutional and human rights as a result of pregnancy; that addiction and other health and welfare problems they face during pregnancy are addressed as health issues, not as crimes; that families are not needlessly separated, based on medical misinformation; and that pregnant and parenting women have access to a full range of reproductive health services, as well as non-punitive drug treatment services.

The contact info for NAPW is:
National Advocates for Pregnant Women
15 West 36th Street
New York, NY 10018-7910
212-255-9252
info@advocatesforpregnantwomen.org
www.advocatesforpregnantwomen.org

The contact info for TBHL is:
The Bronx Health Link
851 Grand Concourse, Suite 914
Bronx, New York 10451
718-590-2648
www.bronxhealthlink.org

Copies of this report can be obtained by calling the Bronx Health Link at (718) 590-8512 or by emailing bob@bronxhealthlink.org.

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About The Bronx Health Link, Inc.

The Bronx Health Link, Inc. (TBHL)), is a unique collaboration created in 1998. The vision was to build an organization that addresses community concerns by creating linkages between the different providers, organizations, coalitions and stakeholders that serve Bronx communities. The goal of TBHL is to create a platform for the involvement of residents and other stakeholders in public health planning, programming and decision-making, TBHL currently works with over 150 community organizations and providers. While TBHL serves the entire borough, the focus is on low income neighborhoods with the highest risk poor health outcomes, many located in the 16th Congressional District, the poorest Congressional District in the entire United States.

The Bronx Health Link, Inc. is an organization that serves as a clearinghouse for the members of the health and human service delivery system of the Bronx. In this capacity, we reach over 1000 members and agencies that actively participate in an electronic mailing list and numerous workgroups, advisory boards and task forces. We work extensively with the community and health care providers with the aim of improving birth outcomes, prenatal care and the reproductive health of women in the Bronx.

The Bronx Health Link, Inc.

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Purpose of the Forum

This forum, held on June 3, 2010 at Lehman College in the Bronx and attended by 50 people, was designed to provide participants with the opportunity to meet and learn from experts to address what happens to children who remain in the care of mothers who used drugs during pregnancy and/or continue to be involved with drug use. The program featured researchers and health practitioners in this field, as well as a parent with direct experience, who helped participants distinguish myth from fact, evidence-based information from media hype and provided meaningful tools for improved advocacy, representation, care and treatment. The event was particularly aimed at reaching Bronx care providers and community residents with some of the information that had been presented at two earlier forums in Manhattan by National Advocates for Pregnant Women.

The objectives of the Bronx forum were for participants to gain knowledge in the following areas:

- Research on the effects of prenatal exposure to drugs
- Research on the comparative effects of keeping and separating children from family members who use drugs
- Research on drug use and human behavior including decision-making
- Drug treatment and other interventions that do and don't work
- What the law says about drug use, pregnancy and parenting and the role of scientific evidence and research in implementing the law.

Forum Program:
Drug Use, Pregnancy, and Parenting:
What the Research and Experts Have to Say

10:00 – 10:15	Welcome and introductory remarks Joann Casado, JD - The Bronx Health Link
10:15 – 10:35	Overview Lynn Paltrow, JD - National Advocates for Pregnant Women
10:35 – 11:00	Treating the Opioid Dependent Pregnant Woman (and Her Baby!) Robert Newman, MD, MPH - Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center
11:00 – 11:10	Break
11:15 – 11:30	Video
11:30 – 11:50	Pregnancy, Parenting, and Drugs Sharon Stancliff, MD - Harm Reduction Coalition
11:50 – 12:20	Parent Advocacy and the Child Welfare System Sabra Jackson, Child Welfare Organizing Project
12:20 – 12:45	Discussion
12:45 – 1:00	Wrap-up

Overview Presentation, by Lynn Paltrow, Executive Director, National Advocates for Pregnant Women

Ms. Paltrow opened the proceedings by explaining that the conference represents the intersection of several issues – health, pregnant women, child welfare policy and law. She said that when it comes to the issue of pregnancy and drug use, many people who deal with pregnant women in the fields of social work, law, and health care don't have access to experts on these issues. They have not heard from the researchers doing the studies in this area. As a result, they rely for their understandings on the mass media – especially, newspapers, magazines, and TV. So National Advocates for Pregnant Women decided to make opportunities such as this available to practitioners in the field to meet those experts.

She began by noting that, given the quantity of coverage of this issue, drug use during pregnancy might seem to be the biggest threat to women's and infants' health. National surveys, however, have found that no more than 1 to 5% of pregnant women use *any* illegal drug, the vast majority of whom use marijuana. Different communities show different quantities, but the national figures are consistent. Such factors as obesity, cigarette smoking, alcohol use, use of prescription drugs, violence against women, and inadequate prenatal care, among others, all affect far more women. So why does drug use get so much more attention?

The evidence shows that, for example, cigarette smoking is a greater risk of spontaneous abortion and a greater risk to the pregnant woman than use of cocaine. According to the Institute of Medicine, the risk factors for low birth weight (one of the greatest predictors of infant mortality) are numerous and include such things as membership in certain demographic groups and various pre-existing medical conditions before pregnancy. Only one of more than two dozen such factors is drug and alcohol use.

To show the imbalances in media coverage of these issues, Ms. Paltrow pointed to the coverage of a woman who took a fertility drug and gave birth to seven babies, one of whom was stillborn and another of whom had serious disabilities. She took the drug knowing that there was a risk. But, Ms. Paltrow explained, because it was a fertility drug, not only was she not criticized in the media (nor should she have been) for putting her babies at risk by taking this drug, she was lauded with cover stories in such magazines as *Good Housekeeping*. She was not called a murderer; she was not reported to the Child Welfare authorities for making bad decisions, and her kids were not called "fertility-drug babies" – they were called "miracle babies." So, Ms. Paltrow asked, why are some families more or less sympathetic?

In 1990, *Time* magazine ran a typical cover story about "crack kids," subtitled, "Their mothers use drugs and now their children suffer." There was also a headline about the kids as "innocent victims." This fed the narrative of defining some people (mainly women of color) as "guilty." This coverage was directed mainly to white middle-class readers. On another page, an older child was pictured with a darker skin color in a menacing way, implying that these kids will threaten your kids.

Another example cited by Ms. Paltrow was a 1990 *New York Times* article, "Born on Crack and Coping with Kindergarten," about inner-city school-children with behavioral problems allegedly due to their mother's crack use. In that article, the writer quoted a teacher who acknowledged, "I can't say for sure it's crack, but I can say that in all my years of teaching I've never seen so many functioning at low levels." Yet the article went on to make just such a case. Eventually, however, the article revealed that researchers "after extensive interviews [found] the problems in many cases were traced not to drug exposure but to some other traumatic event, death in the family, homelessness, or abuse, for example."

The context for all these health-damaged infants was the massive set of cuts to social programs instituted during the Reagan era administration in the 1980s. This further reduced the already meager services available to help families. In addition, most of these children had experienced violence. Stories about kids and drug exposure, past and present, rarely quote actual experts - that is, people who have spent years researching the issue. Rather, they typically focus on a pregnant woman who has been arrested or reported, so those quoted might be a sheriff, pediatrician, or Bronx schoolteacher – but not a researcher who has studied the matter. Just because one has an M.D. doesn't mean one is an expert in the relevant field. The one researcher whom the *Time Magazine* writer eventually did quote, deep deep down in the story, said, "We don't think there's any such thing as 'crack children' – these are poverty children, and it's way too early to say that cocaine causes any particular set of harms to the infant."

In response to this alarm raised by the media in the early '90s, some individual prosecutors in several states started treating drug use in pregnancy as a matter of criminal child abuse. There were several cases in which women who suffered coincidental stillbirths were prosecuted for manslaughter or even homicide. At that time, drug treatment programs typically refused to take pregnant women. In one case, a pregnant woman went to every treatment center in her area, but was told there was a waiting list everywhere.

National Advocates for Pregnant Women's involvement with leading national researchers came in large part because pediatricians who *were* experts in this field came to the organization out of frustration. In one case several years ago in New Jersey, four children who had been adopted by their foster parents had almost starved to death. There was apparently some psychosis in the family, which led them to nearly starve to death those four of their many adopted children. But when friends, neighbors and others confronted the family about why those boys looked so thin, the parents deflected concern by saying, "These are crack babies – that's why they're sick." So they used the label to make people's brains go dead and stop people from investigating the real causes of their malnutrition. So, Ms. Paltrow said, there is real harm in adopting labels that not only lack scientific basis, but also stigmatize in ways that hurt both mothers and children.

More recently, there has been wider circulation for the view questioning the evidence to support the risks of certain drugs taken during pregnancy. For example, a 2007 article in

the *Oklahoman* reported, "Deepening research shows babies who are exposed to cocaine or methamphetamine in the womb fare similarly to other babies as they age." In 2008 a unanimous South Carolina Supreme Court overturned the arrest of a woman for cocaine use that allegedly caused her to suffer a stillbirth, citing "...recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor."

Ms. Paltrow said that there is still some skewed media coverage. Recently, a *TIME* magazine article referred to a woman who "gave birth to drug-addicted twins." Leading experts and researchers are clear that children exposed prenatally to such drugs as cocaine and methamphetamine do not experience addiction or withdrawal at birth. A recent *Washington Post* story was headlined, "Once written off, 'crack babies' have grown into success stories," and subheadlined, "Many Crack Babies Successful; Damage Reports Exaggerated." This was an important story, Ms. Paltrow noted, that challenged many of the dismal and damning assumptions about the effects of prenatal exposure to cocaine. But it also demonstrated continuing problems with coverage of the issue. For example, now that the story was about how kids actually turn out fine much of the time, it focused on a white family. And while the story did eventually rely on real scientific researchers and experts, it falsely suggested that real "experts" once said the opposite. The story said that the "experts" were wrong in claiming in the late '80s that crack babies would never have normal intellectual development. But the earlier "experts" whom they cite were not real experts: Neither Boston University President John Silber nor *Washington Post* columnist Charles Krauthammer has training in this field.

Addressing again the question of who are the experts vs. who gets to speak as if they are an expert, recently Bryan Cranston, a TV actor who plays a meth dealer – and who has no medical expertise in this area – made all sorts of claims on the *Daily Show* about what methamphetamine does to users and the host, Jon Stewart, did not question or challenge him in any way.

The stigmatizing labeling also persists. MSNBC republished the *Washington Post* story mentioned above but changed the headline to "'Crack Babies' Defy Mother's Curse – Despite dire predictions, most are now thriving adults." So the story about how pregnant women's use of cocaine is not devastating is transformed, once again, by the new title into a condemnation of pregnant women – portraying them as people who "curse" their children. In contrast, a story the same week in the *New York Times* about fetal alcohol syndrome in Russia labeled the problem "Vodka's Curse," not the mother's curse. When the drug - here, alcohol - is primarily associated with white people, it's the drug's curse. But if the drug is predominantly associated with people of color, it's the person's curse.

Another, older example of media mischaracterization is a story from the *New York Times* describing NYC drug treatment programs for pregnant and parenting women as "a casualty of the deficit" – referring to Mayor Giuliani's cut to the program's funding in the 1990s. But this type of programs had been demonstrated to be extremely effective and actually cost-saving, so Ms. Paltrow said that it was really "a casualty of politics."

Drug Use in Pregnancy Under New York State Law

Ms. Paltrow explained that many care providers who work with mothers and babies have been told that New York State law treats a positive toxicology for illegal drugs in a pregnant woman as evidence of child neglect. Further, they have been instructed that as mandated reporters, they must report it. But that's not what the law says. The New York Family Court Act has these definitions:

> "Neglected " -- a child is . . ..impaired or is in imminent danger of becoming impaired as a result of the failure of his parent . . . to exercise a minimum degree of care. . . ***by misusing*** a drug or drugs.; or by misusing alcoholic beverages to the extent that he loses self-control of his actions; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has ***repeatedly misused*** a drug or drugs or alcoholic beverages to the extent that he ***loses self-control of his actions*** shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in paragraph (i) of this subdivision.

Thus, New York State law says that a case worker has to report a child as neglected or abused *only* if the mother has "misused" a drug – not just "used" any amount of a drug. Nowhere in the law does it say that a single positive drug test is sufficient grounds for reporting. Ms. Paltrow explained that the claim that one toxicology test result mandates reporting for neglect lacks foundation in law.

Guidance for what this all means comes from another provision of the law explaining:

> "(a) In any hearing under this article (iii), proof that a person repeatedly misuses a drug or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing in the user thereof a substantial state of
>
> - stupor,
> - unconsciousness,
> - intoxication,
> - hallucination,
> - disorientation,
> - incompetence,
> - substantial impairment of judgment,
> - substantial manifestation of irrationality,
>
> shall be prima facie evidence that a child of or who is the legal responsibility of such person is a neglected child except that such drug or alcoholic beverage misuse

> shall not be prima facie evidence of neglect when such person is voluntarily and regularly participating in a recognized rehabilitative program."
> §1046(a)(iii).

On the ultimate question of neglect, the New York State Court of Appeals held in 1995 that a positive toxicology result could not provide the sole basis for a neglect determination. It further determined that one of two conditions must be established to make a finding of child neglect in a case in which there is evidence of illegal drug use by a pregnant woman:

1) actual physical, emotional or mental impairment of the child, or
2) imminent danger of such impairment.

But instead what is often done is that evidence of the parent's drug use is treated as child endangerment. Ms. Paltrow noted that the New York State statute governing child neglect requires evidence that the parent "repeatedly misuses" a drug or alcoholic beverage to the degree that it puts the user in a state of "stupor, unconsciousness, intoxication, hallucination, disorientation, incompetence, substantial impairment of judgment, or substantial manifestation of irrationality."

However, despite the law and the Court of Appeals ruling, it is New York State administrative policy that case workers are required to report positive tox results in pregnant women. But, she noted, "You are absolutely protected by state law that says you have to determine the presence of these factors." Ms. Paltrow advised case workers, "These are the guides you should use. If you see a pregnant woman whom you really think can't parent, then yes, you should report. But if you don't have any such indication, then you should think before you make that call. And if you report only because you're being pressured to (or really any time you report), you should be sure to tell the whole story, to give the state agency a complete picture of the person and your assessment of risk. You can say, 'This is a caring parent, but she happened to test positive.' If you find someone whose drug use is out of control, you can immediately refer them to treatment – then you don't have to report them. Parents in treatment are not considered neglectful."

Furthermore, there is no law in New York State that mandates drug testing of any pregnant woman, new mother, or newborn. A federal panel of experts was assembled and asked to recommend when care providers should drug-test pregnant women, and they concluded that they couldn't recommend any particular set of tests or times to give them. Ms. Paltrow argued that if a woman's drug use really could jeopardize the delivery, if it really gave those doctors useful medical information, then there would be medical testing that's not simply targeted to poor women and women of color. The federal panel also recommended that if routine testing is done, it should be based on informed consent and follow federal regulations for workplace drug testing – which set a certain threshold for a positive finding, require a confirmatory test, and afford an opportunity to challenge the finding. But Ms. Paltrow said, "We know from our work with hospitals that there's no cutoff [level below which a finding is not considered positive], and currently, because hospitals do not follow those federal regulations, a patient in a hospital has fewer rights than a worker as far

as drug testing."

Ms. Paltrow then discussed the gender bias in punitive policies on parental drug use. She noted that former President Bush had an alcohol and possibly a cocaine problem while raising children, but no one said, "We'll report you to child welfare." She added, "If the E.R. doesn't test fathers and report them to child welfare authorities if they are positive when they come to E.R., then you have to question your assumptions about fathers and mothers. If you can really predict parenting ability by whether they use drugs, then we have a lot to do – can you tell from a urine test whether I'm a good parent?" She noted that 72 million people have smoked marijuana, and many are parents. "If you can tell from that use about their parenting ability, we ought to do a lot more testing and reporting."

Ms. Paltrow explained that the child welfare literature is full of claims that drug use is a predictor for child abuse. But she notes that those claims are not based on studies looking at parents who used drugs versus those who didn't. Rather, they are derived from surveys which don't indicate whether drug use can make one a bad parent. She stated that when one looks at the research, the evidence is weak for a relationship between drug use and child abuse. An American Bar Association report found that many parents suffer from drug or alcohol dependence, yet remain fit to parent. The Center for the Future of Children recommended in 1991: "An identified drug-exposed infant should be reported to child protective services only if factors in addition to prenatal drug exposure show that the infant is at risk for abuse or neglect."

Presentation by Robert Newman, MD, MPH
Director of the Baron Edmond de Rothschild Chemical Dependency Institute
of Beth Israel Medical Center
Treating the Opioid-Dependent Pregnant Woman (and Her Baby!)

Dr. Newman opened by emphasizing, "What we are talking about is treating the mother and the child. If you treat one well, you treat the other well." Similarly, he said, "If you have an attitude of punishing one, you're punishing the other as well." A host of problems are associated with heroin use in pregnancy. Treating an opiate-dependent pregnant woman can help decrease the negative effects on the baby.

One of the most effective methods is methadone treatment. Medical authorities from the National Institute on Drug Abuse to the World Health Organization have found that this treatment is highly effective for opiate dependency. For example, the WHO wrote in 2008: "…substitution therapies such as methadone remain the most promising method of reducing drug dependence."

Furthermore, there is no evidence that methadone treatment is unsafe for the fetus. A pamphlet on addiction treatment during pregnancy published by SAMSA (the federal Substance Abuse and Mental Health Services Administration) states that methadone is an effective treatment for heroin addiction and is good for the mother and the baby. A 1975 study of 313 births found that pregnant women on methadone had the same rates of prenatal care as the overall population, lower rates of low birth weight than did heroin-using women, and an infant mortality rate no higher than the general NYC rate.

A study from the U.K. looked at babies with neonatal withdrawal from opiates and found that those put on the regular postpartum floor as opposed to the NICU had less need for treatment. Dr. Newman titled his slide "Neonatal withdrawal: it ain't just pharamacology" and attributed the results to "the difference between positive and negative expectations."

In terms of availability of methadone treatment, the FDA has requires that "pregnancy demands priority admission," i.e., that pregnant women must be placed ahead of others on any waiting list. He cited a recent report from Alaska finding that some pregnant women may have gotten pregnant on purpose in order to receive treatment.

Dr. Newman discussed the widespread stereotype among doctors, healthcare workers, and police that methadone treatment is "just substituting one drug for another." He said this is due to a fundamental misunderstanding of the nature of addiction and treatment. He explained that once the body has developed tolerance for an opiate, the state of dependence does not actually serve the purpose of producing a particular effect, but rather of avoiding the pain of withdrawal symptoms. Once you become tolerant of one narcotic, you are tolerant of all of them. So the best treatment is one that can maintain the patient in a state that avoids either euphoria or withdrawal – methadone does that.

Dr. Newman commented, "We don't know how to cure addiction, but we do know how to

treat it." Abstinence from drugs can be relatively easy to achieve in the short term, but maintenance over the long term is the challenge.

He explained that for many decades now, medical authorities have considered addiction to heroin a chronic illness, not a moral vice or weakness. The National Institute on Drug Abuse stated in 2009, "Drug addiction is a brain disease that can be treated." In recent years, it has been widely agreed by medical authorities that, as a 2000 *JAMA* article expressed, "Drug dependence should be insured, treated and evaluated like other chronic illnesses."

Yet many people continue to ignore the evidence and demand that those who are addicted "cure" themselves. For example, a recent editorial in a Nashua, TN newspaper called for an ordinance banning "drug replacement therapy facilities" but not other types of addiction treatment facilities. In Wisconsin, a state regulator of methadone clinics was quoted as saying, "Patients have to start working on why they became addicted … The state is considering limits on how long people can be in treatment." Dr. Newman emphasized that saying there is "no cure" for heroin addiction is realism, not nihilism. It is no different from any chronic illness, such as diabetes, coronary artery disease, or alcoholism, about which it is agreed that there is no cure, but there are viable treatments. He criticized the common requirement that a patient has to first "fail" another form of drug treatment before being eligible for methadone maintenance.

Dr. Newman then spoke about the "relevant analogy" of nicotine addiction – "We don't look upon smoking as an evil." New York State offers smokers free patches that administer a drug to aid in kicking the habit. The message is "You've got a problem – here's help." No one says, "You're substituting one drug for another." He described his own difficult (but ultimately successful) struggle to conquer his 45-year tobacco addiction. He questioned why so many people can accept measures to help people quit smoking, but not a similar approach to heroin addiction – methadone treatment.

Dr. Newman emphasized that methadone maintenance is consistent with fundamental principles of pharmacology known to all clinicians. The goal – reached by methadone – is to create a physiological level of the drug which is between the dependence level (at which the person suffers symptoms from abstinence) and the tolerance level (at which the person feels the euphoric effect). As both of those levels escalate, the methadone dosage also increases until it reaches a plateau at which it has the maximum beneficial effect of stabilizing the person.

Dr. Newman cited one of several recent examples of punishing a mother with drug use issues in order to "protect the child." In Illinois, a pregnant woman taking methadone was prosecuted for trying to submit friend's urine for a drug screen that had been mandated as part of her probation for heroin possession 3 years earlier. She faces a felony charge with a possible 3-year sentence, and the potential long-term separation from her child. Dr. Newman labeled this "seeking to rationalize the irrational."

Dr. Newman recommended that care providers accept opiate dependency as a chronic, treatable medical condition; recognize there's no dichotomy between interests of mother and child; encourage—but not impose—treatment; remove all possible disincentives; and respect choice of treatment as a decision to be reached by jointly by physician and patient. "Any type of treatment that the patient is willing to accept should be encouraged," he urged.

Dr. Newman concluded by criticizing the fallacy of "protecting" the child by punishing the mother for drug use. He said, "This can lead to the separation of the mother from her child for years. It takes gall to say that this is for the benefit of the child."

In response to a question about breastfeeding while on methadone, Dr. Newman said that methadone has been shown not to be harmful to the infant receiving breast milk. He said breastfeeding has many benefits, not least the "unduplicated bonding experience," and urged that new mothers on methadone be strongly encouraged to do it.

When asked how many patients on methadone eventually discontinue it, he said it depends on the pressure to detox experienced by the patient. But he noted that relapse is the rule, not the exception, with *all* treatment modalities.

Prenatal Drug Exposure: What the Science Tells Us
Video of Presentation by Deborah Frank, MD
Professor of Pediatrics at the Boston Unversity School of Medicine

Dr. Sharon Stancliff of the Harm Reduction Coalition then introduced an online video (available at http://www.vimeo.com/3916613) of a presentation by Dr. Deborah Frank on the scientific facts about prenatal exposure to drugs.

Dr. Frank first asked people to imagine a "mystery drug" that increases the risk of stillbirth, birth defects, infant mortality, and developmental harm. She asked if people would adopt such a baby, and what should be done to the mother -- arrest her, remove her children? She revealed that the drug in question is tobacco, which is actively marketed to women -- and thus many pregnant women use this drug. Yet, she noted, nobody says, "Oh my God, there's a tobacco baby in my class." So her first point was that drugs have social meaning. She then defined addiction as "compulsive behavior that continues in spite of adverse consequences" and by that definition argued that newborns cannot be addicts. As to "agonizing withdrawal," she said this does not occur for babies whose mothers used cocaine or methamphetamines. The drugs that do cause children to have a withdrawal syndrome that can be quite serious but treatable are: any opiate (of which only heroin is illegal), benzodiazepines (such as Valium) and barbiturates. Drug exposures in pregnant woman that have been associated with subtle changes in neonatal behavior include tobacco, marijuana, alcohol, cocaine, amphetamines, and SSRIs. Drugs most associated with birth defects: alcohol, lithium, Retin-A, anti-epileptic drugs, but all are legal. She noted that not all illegal substances are more toxic than legal substances, whether the legal substance is recreational or prescribed.

Dr. Frank then asked where the misinformation comes about the alleged risk of birth defects for prenatal use of certain illegal drugs. She answered that it comes from the misuse of human behavioral teratology - the study of the effects of intrauterine toxic exposure on cognitive and behavioral development. This field does have several appropriate uses, including advancing knowledge of teratogens (substances that can cause birth defects, such as lead) and targeting interventions. But some "not so good" uses of this knowledge, she said, are "to try to get society to fund children's services by creating panic about 'drug babies'; to justify social inequality in medical care and opportunity, particularly for impoverished women of color; and to justify disenfranchising groups of children as impervious to intervention."

She noted that there is such a thing as paternal mutagenesis (though it's not as strong as the maternal type) -- but nobody talks about it. So the real question, she posited, is not whether a drug is good or bad, but under what conditions do different patterns of exposure produce measurable impairments, at what age, and in what populations? Also, what is the severity of the impairment? Just because one can measure it doesn't mean the child is doomed.

She cited important questions to ask when reading the scientific literature -- if the article doesn't pass muster, she contended, one should not take it seriously:

- How was the exposure identified?
- Was the study prospective (following patients before pregnancy and going forward) or retrospective (looking back, which tends to vastly overestimate the problem)?
- Is there a comparison group? If one compares kids to national norms, they look awful, but if one compares them to their neighbors who are also poor, iron-deficient, and/or witnesses to violence, they will all look awful. In her research, the exposed babies don't look much different from the unexposed.
- Was there masked assessment? If those doing the assessment know what the exposure is, it may unconsciously influence the results.
- Was there consideration of other exposures? People very rarely use only one substance, so it's important to separate the effects of one from the other.

She cited the harm to society of stereotypical news coverage of this issue. Buying into a stigma jeopardizes children, she argued, because if women think they will be prosecuted or have their kids removed, they will be afraid to get prenatal care, which means they will have less healthy babies. Studies have shown that co-locating substance abuse treatment with prenatal care results in babies doing better and is highly cost-effective.

But first, a pregnant woman has to acknowledge that she is using and not be too frightened to get care. Dr. Frank cited a study in which teachers were told that certain students were late bloomers, others were fast learners - all with no basis - and a year later the so-called "fast learners" had gained 10 IQ points. Also, if every time a baby throws up or has a tantrum one says, "it's the cocaine," instead of "this is typical of two-year-olds," the different response can damage the child. One study involved two sets of students observing a baby who was not actually exposed to any substance - the group that was told the child was a 'crack baby' gave more negative ratings for intelligence, alertness, affection, and other criteria.

Research has found that risk factors such as exposure to violence as a victim or witness, death or incarceration of a parent, iron deficiency, lead poisoning, or psychiatric distress by the caregiver can put children at risk for poor outcomes. Conversely, social protective factors such as more privileged and educated caregivers, caregiver recovery from substance use, case management; nurse home visiting, early intervention, preschool enrichment such as Headstart, and close supervision by caregivers of teenager, can all predict better outcomes.

Dr. Frank urged providers to be cautious about generalizing from groups of children to an individual child - research is based on aggregates, so some may have lots of trouble, others may have none. She noted, "We're treating the child before us, not statistical constructs." She advised, "If a child with prenatal exposure has a problem, neither overinterpret nor dismiss." There are common pathways to harm from a variety of exposures, so it can be difficult to distinguish them. She concluded, "Like all families at medical and social risk, children exposed to any intrauterine drug (including cocaine, tobacco or alcohol) and their families benefit from comprehensive evaluation and care." She added, "Bad science leads to bad public policy."

Pregnancy, Parenting and Drugs
Presentation by Sharon Stancliff, MD,
Medical Director, Harm Reduction Coalition

Dr. Stancliff began by saying, "I have had a lot of stereotypes in my life challenged by drug addicts." She said that for 13 years her patients have all been current and former drug users, and they have talked extensively about their families and children—and in many cases, the children have led normal, achievement-filled lives even though their mothers used drugs during pregnancy and/or the children's early years.

Pregnant women using drugs face many barriers to obtaining prenatal care and drug treatment. Some fear they're more likely to be judged more harshly than are men. Fear of losing custody is a huge barrier. Another is time constraints to manage everything, and yet another is that some partners don't want the woman to give up her drug use and psychiatric disorders. There can also be psychiatric disorders that complicate matters. In some areas (not so much in NYC), there can be a lack of drug treatment facilities willing to accept pregnant women.

People take drugs to feel good – when they first take them, they usually do feel alert and have more sexual interest. Eventually, they see a range of negative effects. Dr. Stancliff then reviewed the research on several drugs used in pregnancy.

Cocaine - The primary associations that have been found for cocaine in pregnancy are spontaneous abortion (miscarriage), premature labor, babies who are small for their gestational age, and babies with smaller head circumference. However, low birth weight and prematurity have also been found to be associated especially with poverty, and also with poor nutrition, late prenatal care, low education, high stress (from crime and/or discrimination) and cigarette smoking. Dr. Stancliff said that the so-called "crack baby" phenomenon never materialized in terms of long-term effects. The majority of follow-up studies have found either no effects or only subtle behavioral changes. In one study that followed such children for ten years, they looked like their peers in the same neighborhood. As to effects on parenting, some studies have found cocaine use to be a marker for potential child abuse. But one well-controlled long-term study comparing children with maternal cocaine exposure to those without exposure found that when controlling for other factors, tobacco use was a better marker for substantiated child maltreatment reports. However, cocaine use was more likely to be the cause for children being removed from the home.

There are no good pharmaceutical treatments for cocaine dependence – so it's not, according to Dr. Stancliff, that the patient fails treatment, but that the treatment fails the patient. Psychosocial measures can help somewhat, and some people can quit without treatment, but relapse often occurs. For many people it's a lifelong struggle. Researchers are looking at low-level stimulant maintenance as a possible treatment; this is being used experimentally in Britain.

Methamphetamines - There is almost no data about use of this drug in pregnancy, so Dr. Stancliff urged great caution in reading media accounts about this. She noted that this drug has not been seen much with pregnant women in NYC. The small studies thus far show an increased correlation with low birth weight, small size for gestational age, and inadequate maternal weight gain, but there are yet to be any long-term studies.

Alcohol - Signs of abuse include frequent trauma, liver disorders, elevated liver enzymes, missing work, and sexual dysfunction. (Alcohol disappears quickly from the urine, so that is not a viable test.) Fetal alcohol syndrome is generally associated with high doses of alcohol (8-10 drinks a day), although it can occur with smaller doses, and usually is occurs in poverty situations. It can lead to babies who have low birth weight, neurological problems and facial abnormalities.

Marijuana – This is very commonly used to heighten senses, to relax, and to stimulate appetite and reduce nausea from medicines. Clues to possible use by the woman include red eyes and giddiness. One apparent correlation is that it can lead to early cavities in young children. Research on use in pregnancy has been inconclusive. A couple of studies suggest there might be some increased arousal in babies during their first month, and perhaps a small decrease in birth weight. But only one study of pregnant women involved women who didn't smoke cigarettes as well, and it actually showed slightly better results in babies whose mothers used marijuana.

Tobacco – Studies have found that 10-15% of women smoke during their pregnancies. One estimate is that tobacco use is responsible for 15% of preterm births, 15-30% of low birth weight infants, and 15-25% of placental abruptions. Tobacco may also have long-term effects on child behavior.

In additional comments about opiates, Dr. Stancliff said that the chief problem with heroin use during pregnancy is the withdrawal from heroin – it creates a roller-coaster effect on the pregnancy, and can lead to earlier contractions and lower birth weight. Bupenorphine is a treatment used to treat opiate addiction, but it is not approved for use in pregnancy (unlike methadone).

Dr. Stancliff also discussed harm reduction, the approach to helping drug users that recognizes that for some people will continue to use drugs, but that measures can be taken to reduce the harm of drugs, such as safer injection and avoidance of overdose. Harm reduction is also about changing policies that stigmatize drug users and make it harder for them to get help. She noted that harm reduction and drug treatment are not opposites and indeed are quite compatible.

Dr. Stancliff summarized by saying that use of several substances – not just illegal drugs, but also alcohol, tobacco, and prescription drugs – has been associated with various degrees of poor birth outcomes. At the same time, while substance use may be a marker for poor parenting, that problem has a range of causes. She closed by recommending, "Don't substitute the urine test for observing the behavior and talking with the family – learning what is going on with the baby in reality."

Parent Advocacy and the Child Welfare System
Sabra Jackson
Coordinator, Parent Advocate Network,
Child Welfare Organizing Project

Ms. Jackson began by telling the story of her journey with drug use, childbearing, and the child welfare system. Shortly after the birth of her second child (a son), at a time when she was being abused by her domestic partner, she had a positive toxicology test for cocaine, which led the child welfare authorities to remove both the newborn and her 7-year-old daughter. (One issue she noted that comes up with some women in her current work is the impact of domestic violence on false and malicious reporting to child welfare.) She noted that no one took into account her experience and expertise developed over a 20-year period as a social worker, nor the fact that she had been a good mother to her older child. Both of her children (her older daughter and her newborn son) were removed from her custody. Her daughter was severely abused by her foster family, and her toddler son was neglected. Finally, Ms. Jackson completed a full course of drug treatment, as well as parenting classes, and after strong advocacy, she eventually got her children returned.

She learned about the Child Welfare Organizing Project (CWOP) and became involved in their education and advocacy on behalf of other parents who have been targeted by the child welfare system. Ms. Jackson was trained in CWOP's six-month curriculum about how to navigate the child welfare system and advocate for themselves, and now she trains others in peer advocacy using that curriculum. Today, Ms. Jackson is the coordinator for CWOP's city-wide Parent Advocate Network, a professional network that supports and reinforces the role of parent advocates with the Administration for Children's Services. CWOP also runs weekly support groups for parents involved with the child welfare system and works with legal services organizations and other child advocacy agencies to help these parents.

Summary of Forum Evaluation Responses

A total of 44 attendees returned evaluation forms, a response rate of 88%. Evaluations of the presentations were highly positive – the majority (51-64%) gave overall "excellent" ratings, with lesser numbers (31-44%) deeming them "good," and only none giving "poor" ratings except for 5% of those assessing Dr. Newman. For the overall program ratings – which included audience ability to ask questions, usefulness of information, clarity of information, and forum quality – 59-74% gave "excellent" ratings, 19-34% "good," and only 5-7% "satisfactory" and 2% "poor."

The overall positive assessment of the forum can be seen in the many highly favorable comments: Among them were "great overview," "very useful and informative," and "very helpful." One person wrote, "I love the idea of the conference, which [is] sharing the update information and the knowledge for the first and second parts, and sharing the individual real-life stories." Another wrote, "More forums should be conducted on this subject." There were also a couple of comments critical of two of the presentations.

Among participants' suggestions for future events on this topic were: allocating more time and covering more aspects; making PowerPoints more interactive; and involving faith-based organizations in the educational work.

The full quantitative and qualitative data are presented on the following two pages.

Comments and Suggestions

Comments:

- Thank you, a very useful and informative program.
- I think this kind of education is crucial to changing policy.
- It was my second time to attend the Bronx Health Link conference. I love the idea of the conference, which [is] sharing the update information and the knowledge for the first and second parts, and sharing the individual real-life stories. More opportunity.
- Great Forum… Very, very informative!
- The entire presentation was very helpful. Enjoyed it! It was mind provoking.
- Good presenters, interesting, nice food spread, great location.
- Overall, forum was useful for future application and information to participants of programs.
- Very informative topic. More forums should be conducted on this subject.
- Very good training.
- Great overview of this issue.
- Great workshop and topic.
- Mrs. Jackson's personal story - little unorganized - TMI on children - we didn't need so much pictures and proof of children's well being.
- One negative was the viewing of a video (during Dr. Stancliff's session) that repeated the info we learned during Ms. Paltrow's presentation.

Listed as "most useful":

- Bringing the experts.
- Facts/comparisons to other countries about methadone maintenance.
- Drug treatment improvement.
- Very useful info on addiction as well as pregnancy and drug use.
- All information shared is most useful. Inspiring being in a workshop where everyone understands the benefits in treating the pregnant female and child.

Suggestions:

- PowerPoint presentations can be more interactive and informative to support presenter's lecture.
- Longer training and topic on drug addicted mother's why they aren't mandated to drug program, and why are they able to continue to have several children although knowingly on drugs.
- Wish we had more time, i.e., 10am – 4pm.
- Wish we had more time.
- How to talk with the clients in the office which I serve.
- Hope you will consider faith-based organizations. They need to benefit from this.
- Good for the faith community to get this info.

Forum Evaluation Data

Overview Presentation Lynn Paltrow	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Presenter's knowledge of the subject		7%	32%	61%
2. Clarity of the information presented		11%	37%	51%
3. Overall presentation quality		10%	32%	58%

Treating the Opioid-Dependent Pregnant Woman *(and Her Baby!)* *Dr. Robert Newman*	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Presenter's knowledge of the subject	2 %	2%	20%	77%
2. Clarity of the information presented	5%		30%	65%
3. Overall presentation quality	5%		31%	64%

Pregnancy Parenting, and Drugs *Dr. Sharon Stancliff*	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Presenter's knowledge of the subject		3%	33%	65%
2. Clarity of the information presented		2%	39%	59%
3. Overall presentation quality		5%	44%	51%

Parent Advocacy and the Child Welfare System *Sabra Jackson*	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Presenter's knowledge of the subject		9%	23%	69%
2. Clarity of the information presented		9%	33%	58%
3. Overall presentation quality		9%	31%	59%

Overall Program Quality	**Poor**	**Satisfactory**	**Good**	**Excellent**
1. Audience ability to ask questions		7%	34%	59%
2. Usefulness of information	2%	5%	19%	74%
3. Clarity of information presented	2%	5%	33%	60%
4. Overall forum quality	2%	5%	32%	61%

Biographies of Presenters

Lynn M. Paltrow, J.D., is the Founder and Executive Director of National Advocates for Pregnant Women. Ms. Paltrow has served as a Senior Staff Attorney at the ACLU's Reproductive Freedom Project, Director of Special Litigation at the Center for Reproductive Law and Policy, and Vice President for Public Affairs for Planned Parenthood of New York City. Her honors include the Arthur Garfield Hays Civil Liberties Fellowship, the Georgetown Women's Law and Public Policy Fellowship, the Justice Gerald Le Dain Award for Achievement in the Field of Law and the 2008 National Women's Health Network's Barbara Seaman Award for Activism in Women's Health. Women's E-news selected Ms. Paltrow as one of 21 Leaders for the 21st Century in 2005. Ms. Paltrow has participated in numerous presentations of her work, including conferences, panel presentations, classroom lectures and media interviews.

Robert G. Newman, M.D., M.P.H. was, until January 2001, President and CEO of Continuum Health Partners, Inc., a $2.2 billion hospital network in New York City. Prior to the creation of Continuum in 1997 he was CEO of the Beth Israel Health Care System for 20 years. He is now President Emeritus of Continuum and Director of The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center. For the past 35 years Dr. Newman has played a major role in planning and directing some of the largest addiction treatment programs in the world - including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the mid-'70s treated over 33,000 patients annually. Dr. Newman graduated with honors from the University of Rochester (NY) School of Medicine and Dentistry, and has a Master's Degree in Public Health from the University of California, Berkeley. He is Professor of Epidemiology and Population Health and Professor of Psychiatry and Behavioral Sciences at the Albert Einstein College of Medicine in New York. Dr. Newman is the recipient of numerous awards including the David E. Rogers Award of the Association of American Medical Colleges for major contributions to improving the health and health care of the American people. He is a member of the Advisory Committee of Adjuncts of the Drugs & the Law Committee of The Association of the Bar of the City of New York, and the Advisory Committees of the Open Society Institute's Public Health Programs and its Global Health Advisory Group, the International Harm Reduction Development Program and the Law and Health Initiative. Dr. Newman serves on the editorial boards of several addiction-related professional journals, and the author of numerous peer reviewed articles and book chapters. Dr. Newman has presented his work, research and experience on numerous occasions both in the conference setting, as well as in the classroom setting.

Deborah Frank, M.D., is a Professor of Pediatrics at Boston University School of Medicine, where she has taught since 1981. She is also the Founder and Director of the Grow Clinic at Boston Medical Center, and Principal Investigator of the Children's Sentinel Nutrition Assessment Program ("C-SNAP"). C-SNAP's goal is to monitor the impact of policy changes on nutrition, growth and development of low-income children, ages 0-3 years. She also conducts research funded by the National Institute on Drug Abuse and has given testimony to the United States and Massachusetts House and Senate. Dr.

Frank has also served on numerous committees and advisory boards and has received many awards recognizing her dedication and advocacy for children in need. Dr. Frank received her M.D. from Harvard Medical School.

Dr. Frank has written numerous peer-reviewed and published scientific articles and papers including, Deborah A. Frank et al., Maternal Cocaine Use: Impact on Child Health and Development, 40 *Advances in Pediatrics* 65 (1993). She is also the author of the seminal meta-analysis published by The Journal of the American Medical Association ("JAMA"). This comprehensive, systematic, and authoritative analysis of the medical research assessing the relationship between maternal cocaine use during pregnancy and adverse developmental consequences for the fetus and child concluded that: "[T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific findings of in utero cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment."

Sharon Stancliff, M.D., is a physician with 20 years experience in public health and a focus on issues of drug use, harm reduction, and HIV, including provision of primary care, drug treatment, HIV care, and syringe exchange. Currently Dr. Stancliff is the Medical Director of the Harm Reduction Coalition (HRC), where she serves as the director of HRC's Skills and Knowledge on Overdose Prevention (SKOOP) program, which provides services both directly in New York City and through education and capacity building nationally and internationally. In addition to a small buprenorphine practice, she consults for Harlem East Life Plan, which offers methadone maintenance. Dr. Stancliff is also a consultant on drug-related programs in Zanzibar for ICAP-Columbia, in Ukraine for Pangaea Foundation, and for the AIDS Institute, New York State Department of Health. Previously, Dr. Stancliff was medical director at a methadone maintenance program and at community health care center. Dr. Stancliff earned her MD from the School of Medicine, University of California at Davis, did her Family Practice residency at the University of Arizona, and completed the AIDS Institute-sponsored Nicolas Rango HIV Clinical Scholars Program at Beth Israel Medical Center in New York City. She is board certified in Family Medicine, a Fellow of the American Academy of Family Practice, and certified by the American Board of Addiction Medicine. She has broad experience in teaching clinicians and has published and presented extensively.

Sabra Jackson is currently the coordinator for the city-wide Parent Advocate Network, a professional network within New York City designed to cultivate and formalize the role of the Parent Advocates in the child welfare system. This network was created through collaboration between The Child Welfare Organizing Project (CWOP) and the Parent Advocate Initiative. Ms. Jackson also has the distinction of being the only Parent Advocate on the New York State Child Welfare Court Improvement Project in Albany. Ms. Jackson is a graduate of CWOP's 2005 East Harlem Parent Leadership Curriculum. She has worked with Voices of Women, a self-help advocacy organization for survivors of domestic violence, with the Administration for Children's Services (ACS) Parent Advisory

Work Group, and was formerly a member of the ACS City-Wide Headstart Policy Council. Ms. Jackson has an understanding of child welfare policy and practice as both a client and a service provider. She is the proud single mother of two children: Sabra Inez (12 yrs.) and Peyton Ulysses (5 yrs.). She has prior experience participating in events and conferences where she speaks about her life experience, as well as her ongoing advocacy work.

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