Drugs and Alcohol in Pregnancy and the Affected Children

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Over the past three decades, the use of alcohol and illicit drugs during pregnancy has become a major public health concern. A number of studies have found poor pregnancy outcomes among women who used alcohol or illegal drugs during pregnancy (1–5), and effects on their newborns also have been documented (6–9). Recent publications have begun to track the long-term impact of prenatal alcohol or illicit drug exposure on the development and behavior of the exposed child (10–16).

In addition to public health problems, child welfare systems across the nation have found that substance use in the family has become a leading reason for children to be referred into out-of-home placement. In some states, up to 80% of children in custody are there because of substance abuse problems in the family (17,18). On a daily basis, courts are being called on to make decisions in the best interest of a child whose birth parents are unable or unwilling to address their substance abuse problems. This chapter examines the policy and practice issues related to identification of pregnant women at risk for alcohol and drug use and discusses what is known about the impacts of prenatal exposure to maternal substance abuse on a child’s long-term physical and mental health and on behavioral and learning outcomes.

Early Identification of Pregnant Women at Risk for Substance Abuse

The harm done by substance abuse in pregnancy was documented by Aristotle, who noted the damage alcohol can cause in the unborn child. Etchings from the 1700s depicting the scourge of the gin epidemic in England portray children with facial features characteristic of fetal alcohol syndrome. However, despite this early recognition of the problems alcohol consumption during pregnancy can cause, little progress has been made in reducing the rate of alcohol or other drug use by pregnant women. In fact, physicians rarely ask a pregnant woman about her alcohol use, and fetal alcohol
syndrome remains the most common cause of diagnosable mental retardation in the United States as well as one of the leading causes of behavioral problems in children (14).

Despite professed public and professional concern over the consequences of prenatal alcohol and drug exposure, the American College of Obstetricians and Gynecologists documented the low priority that obstetricians place on advising their patients about alcohol use during pregnancy (19). Although 97% of obstetricians declared that they asked their patients about alcohol use, 80% confirmed that they advise their patients that “a little alcohol” does not pose a threat to the pregnancy or the developing fetus. In addition, 4% of the obstetricians surveyed stated that eight drinks or more per week was a safe level of alcohol consumption for pregnant women. This of course is in direct contrast to a recent study that documented that any alcohol use in pregnancy places the child at more than three times increased risk for delinquent behavior (20).

Although the lack of an appreciation for alcohol’s toxicity stands at the heart of the problem, legal, social, and attitudinal barriers often come together to restrain open communication between physician and patient. Most pregnant women state that they simply will not talk to primary care providers about their alcohol or drug use, the most common reason given being the fear of prosecution or loss of their baby to the child protection system (21).

There is good reason for this fear. When screening for alcohol or drug use is implemented in clinical practice, it often focuses on targeted populations rather than on the general population. Providers often state that they can tell who is an alcoholic or drug user by looking at the person. A 1990 study of substance use in pregnancy in Pinellas County, Florida (22), revealed that although the overall use of licit and illicit substances was approximately 15% in African-American women and in white women within the population, African-American women were 10 times more likely to have a urine toxicology performed or to have intensive evaluation for substance use than were white women. This study demonstrated that physicians’ selection of pregnant women for toxicology testing was influenced by race and social class.

On a more positive note, recent work has focused on universal screening of pregnant women for the risk of alcohol or drug use. However, it is important that screening take place in the context of a much larger integrated system of screening, assessment, referral, and treatment. If there is no capability to educate the pregnant woman about the dangers of substance use, if there is no ability to link a pregnant woman who is drinking or using drugs to a treatment program, or if there is no treatment available, identifying the at-risk woman usually results in more punitive policies that disrupt families and drive women out of prenatal care, further complicating medical risk for the pregnancy and the baby.

A successful approach to community-based screening and early intervention can be found in data developed through the use of the 4Ps Plus© Screen for Substance Use in Pregnancy in prenatal care sites in eight California