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CHILD WELFARE INTERVENTIONS FOR DRUG-DEPENDENT PREGNANT WOMEN: LIMITATIONS OF A NON-PUBLIC HEALTH RESPONSE

Ellen M. Weber*

ABSTRACT & TABLE OF CONTENTS

National drug policy, medical practice and the child welfare system have not kept pace with scientific research that points to effective health interventions to address alcoholism and drug dependence among pregnant women. In its 2003 amendments to the Child Abuse Prevention and Treatment Act, Congress adopted a policy requiring physicians to report to child protective services all patients who give birth to an infant affected by illicit drug use. Drawing on epidemiological, medical and social science research, this Article critiques Congress's decision to require health professionals to engage in a surveillance role instead of a therapeutic intervention.

In seeking to craft an effective child protection strategy, this Article explores two fundamental issues that weigh against the adoption of a nationwide physician reporting requirement. The first is the child welfare system's limited capacity—as an institution that carries out both child protection and rehabilitation functions simultaneously—to help drug-dependent pregnant women change their behavior. The second is the adverse effect of coerced treatment on both a physician's ability to deliver effective prenatal care and a drug-dependent woman's willingness to access health care that will mitigate the harm associated with drug use. This Article proposes that states adopt an alternative child protection model that restores physicians to their role of healer and requires them to carry out their ethical and therapeutic obligation to diagnose this serious medical problem during prenatal care.

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I. INTRODUCTION

Alcoholism and drug dependence are serious medical conditions that are addressed all too often by institutions outside of the primary health care system, such as the child welfare system. Physicians frequently fail to diagnose alcohol and drug problems in women, notwithstanding the existence of standardized and easily administered assessments.¹ The consequences of this failure are

¹ National Center on Addiction and Substance Abuse (CASA) at Columbia University, *Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse 5* (2000), available at <http://www.casacolumbia.org/Absolutenm/articlefiles/29109.pdf> [hereinafter *Missed Opportunity*]. CASA reported that “[p]hysicians are not screening their patients carefully for substance abuse. Nearly 94 percent of them fail to accurately diagnose an alcohol problem in adults. Forty percent miss an illegal drug abuse diagnosis in teens.” *Id.* “Physicians regularly miss the diagnosis of underlying substance abuse in patients because their training has not demanded that they develop the requisite attitudes, knowledge, and clinical skills.” John N. Chappel & David C. Lewis, *Medical Education: The Acquisition of Knowledge, Attitudes and Skills*, in *SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK* 787, 787 (Joyce H. Lowinson ed., 3d ed. 1997) (quoting Thomas H. Mickle, Jr., M.D.); see also Committee on Crossing the Quality Chasm, Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions* 202 (2006), available at <http://www.nap.edu/catalog/11470.html> [hereinafter *Institute of Medicine*] (noting that less than 20% of general internal medicine physicians, obstetricians/gynecologists, family medicine physicians and psychiatrists “use any formal alcohol screening tool to screen for problems among patients who drink.”). The American Medical Association (AMA) adopted a policy in December 1997 that calls on physicians “to be alert to the presence of alcohol-related

particularly acute for pregnant women and their unborn children. Although primary care physicians often discuss alcohol, drug and tobacco use with pregnant patients,² alcohol and illicit drug use disorders by pregnant women “remain one of the most frequently missed diagnoses in perinatal medicine.”³ When health care providers fail to diagnose or help women address alcohol or drug problems during pregnancy, women risk exposing their fetuses to serious health and developmental problems.⁴ After birth, some of these women will be unable to adequately care for their children while others will inflict abuse, depending upon the severity of the alcohol or drug problem, the existence of other physical and mental health conditions, and environmental factors such as poverty.

Beginning in the 1980s, states responded to the widely-publicized use of crack cocaine among primarily poor, pregnant and parenting women by adopting punitive measures against new mothers, such as mandatory child protective service reporting. States, to a lesser degree, also pursued criminal prosecutions against pregnant women to “protect” infants exposed to drugs in utero. As a result, the child welfare system—not the health care system—is the institution

problems among women and to screen all patients for alcohol abuse and dependence.” Laura N. Blum et al., *Alcoholism and Alcohol Abuse Among Women: Report of the Council on Scientific Affairs*, 7 J. WOMEN'S HEALTH 861, 869-70 (1998). The AMA's Council on Scientific Affairs identified appropriate patient screening tools, counseling and intervention approaches for women. *Id.* at 866-69. See also ACOG Committee on Ethics, American College of Obstetricians & Gynecologists, Committee Opinion No. 294, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecological Practice*, reprinted in 103 OBSTETRICS & GYNECOLOGY 1021, 1022 (2004) [hereinafter ACOG Ethics Opinion No. 294].

² Missed Opportunity, *supra* note 1, at 6. Among the physicians who see pregnant patients in their practice, 87% reported on a national survey that they discuss tobacco use with almost all their pregnant patients, and 79% reported discussing alcohol and drug (illegal, over-the-counter, and prescription) use with almost all these patients. *Id.* OB/GYNs were far less likely, however, to administer screening and intervention procedures. CASA found that only 40% of OB/GYNs were “careful screeners,” defined as physicians who report at least three of the four following activities: (1) “almost always” asking patients about their substance use when necessary; (2) administering a health history form annually that asks about alcohol, psychoactive medications and illegal drug use and family history of substance abuse; (3) administering substance abuse screening instruments to patients; and (4) “almost always” discussing, tobacco, alcohol and drug use with pregnant patients. *Id.* at 38, 40. Only 54% of OB/GYNs reported the use of brief intervention strategies—five to ten minutes of counseling on drinking levels and associated problems—with patients who appear to have alcohol-related problems. *Id.* at 54, 90. See discussion *infra* accompanying notes 230-234 regarding efficacy of brief interventions to address maternal alcohol and drug use.

³ Ira J. Chasnoff et al., *Screening for Substance Abuse in Pregnancy: A Practical Approach for the Primary Care Physician*, 184 Am. J. Obstetrics & Gynecology 752 (2001). See also Kimberly Frost-Pineda et al., *Are Physicians and Medical Students Prepared to Educate Patients About Alcohol Consumption?*, 23(2) J. Addictive Diseases 1, 8-9 (2004) (reporting that 60% of Family Medicine specialists surveyed in Florida “failed to identify the diagnostic criteria for [Fetal Alcohol Syndrome] and were unable to correctly identify alcohol-related birth defects.”); Missed Opportunities, *supra* note 1, at 7, 41 (only 4% of OB/GYNs offered a diagnosis of alcohol abuse as one of five possible diagnoses when presented with a hypothetical case of a 38-year-old female patient with early symptoms of alcohol abuse).

⁴ See discussion *infra* accompanying notes 87-106, 108-112, and 125.

that our society has come to rely on primarily to assist families, particularly poor women of color, who struggle with alcoholism and drug dependence.⁵

In 2003, the paths of the health care and child welfare systems converged in the context of maternal drug use. Congress amended the Child Abuse Prevention and Treatment Act (CAPTA)⁶ to require health care providers who deliver or care for infants affected by illicit drug use to report such children to child protective services.⁷ Lawmakers conditioned a state's receipt of federal child abuse prevention funds on the adoption of this policy.⁸ The provision's sponsor had the laudable goal of ensuring that children receive necessary services by implementing a uniform standard of mandatory reporting.⁹ Yet, like other recent efforts by the federal government to regulate medical practice related to a

⁵ Institute of Medicine, *supra* note 1, at 224 (noting that substance-use problems are "detected (sometimes for the first time) by agencies or organizations that are not part of the traditional healthcare sector—[e.g.] . . . the welfare and justice systems."). The child welfare system began to play a more visible role in the lives of these families beginning with the crack epidemic of the mid-1980s. Referrals of prenatally drug-exposed infants to child protective services soared in many cities between 1986 and 1989. Mary Ann Lewis et al., *Two-Year Placement Outcomes of Children Removed at Birth from Drug-Using and Non-Drug-Using Mothers in Los Angeles*, 21 SOC. WORK RES. 81, 81 (1997). A Child Welfare League of America survey published in 1990 found that 88% of the 152 agencies providing family foster care services reported an increase in the number of children entering foster care who had been prenatally exposed to alcohol or other drugs. *Id.* (citing Child Welfare League of America, *Crack and Other Addictions: Old Realities and New Challenges for Child Welfare* (1990)). Currently, national and state policy-makers actively promote the establishment of linkages between the child welfare system and alcohol and drug treatment systems, but ironically have done little to link or integrate the primary health care and drug treatment systems. On the national level, the Department of Health and Human Services has studied the scope of drug problems among the child welfare population and reported on ways to improve coordination between drug treatment and child welfare services. U.S. Dep't of Health & Human Services, *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection* (1999), *available at* <http://www.ncsacw.samhsa.gov/files/BlendingPerspectives.pdf> [hereinafter *Blending Perspectives*]. It has also established the National Center on Substance Abuse and Child Welfare to improve systems and practices for families with drug use disorders who are in the child welfare system. *See* National Center on Substance Abuse and Child Welfare, <http://www.ncsacw.samhsa.gov> (last visited Jan. 29, 2007). States, such as Maryland, have enacted legislation that requires co-locating addiction specialists at child welfare offices. *See* MD. CODE ANN., FAM. LAW § 5-1202(a)(4) (West 2006). In contrast, addiction professionals operate primarily in specialty practices that are separated financially and organizationally from the general health care system. Institute of Medicine, *supra* note 1, at 203. While they may be co-located with primary care physicians in some community health centers and other medical practices that serve low-income populations, no coordinated effort exists for co-locating these health practices. *Id.* The Institute of Medicine has found that co-location of primary care and substance-use treatment services facilitates collaboration among health care providers and improves patient care. *Id.* at 218.

⁶ Pub. L. No. 93-247, 88 Stat. 4 (codified as amended at 42 U.S.C. §§ 5101-5107).

⁷ Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36, 117 Stat. 800 (codified in scattered sections of 42 U.S.C.); *see* 42 U.S.C. § 5106a(b)(2)(A)(ii) (Supp. III 2003).

⁸ *Id.*

⁹ *See* discussion *infra* accompanying notes 30 and 43-46.

patient's use of a controlled substance,¹⁰ Congress has adopted a policy that can be interpreted as pitting the health care provider against the interests of her patient rather than promoting effective health care services to pregnant women.¹¹ Rather than encouraging or requiring physicians to make prenatal diagnoses of drug or alcohol use disorders and to offer treatment to the mother,¹² CAPTA instead requires physicians to participate in a seemingly punitive child welfare reporting practice *after* a child's birth.¹³ This policy poses three separate, but related, concerns. It may compromise the trust underlying the physician-patient relationship that is essential to address drug use problems during prenatal care.¹⁴

¹⁰ The federal government, for example, strictly regulates the dispensing of methadone in connection with addiction treatment, 42 C.F.R. § 8 (2005), notwithstanding recommendations by the Institute of Medicine to ease such regulation so that patients can obtain treatment tailored to their needs, and physicians can exercise professional judgment in treating patients. INSTITUTE OF MEDICINE, FEDERAL REGULATION OF METHADONE TREATMENT 31 (Richard A. Rettig & Adam Yarmolinsky eds., 1995). The Bush Administration has also challenged state standards related to doctor-recommended marijuana use (*Gonzales v. Raich*, 545 U.S. 1 (2005)) and physician-assisted suicide (*Gonzales v. Oregon*, 126 S. Ct. 904 (2006)), as violative of the Controlled Substances Act, 21 U.S.C.A. §§ 801-904 (West 1999 & Supp. 2006).

¹¹ Many health care experts have observed that drug-using pregnant women avoid the health care system because they fear that the detection of their drug use will result in punitive actions, including the possible removal of a child from her custody. See, e.g., Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, 1 Harm Reduction J. 5 (2004), available at <http://www.harmreductionjournal.com/content/1/1/5>; Deborah L. Haller et al., *Factors Influencing Treatment Enrollment by Pregnant Substance Abusers*, 29 Am. J. Drug & Alcohol Abuse 117, 127 (2003) (noting that "coercive legal policies that are designed to protect the fetus but which pit the rights of mother and unborn child against one another can undermine trust and result in decreased contact with prenatal care."); ACOG Ethics Opinion No. 294, *supra* note 1, at 1025. A significant quantitative study and other qualitative studies have found, however, that a large proportion of drug-using pregnant women do participate in prenatal care. See discussion *infra* accompanying notes 164-167.

¹² At least one state, Virginia, requires physicians, as a routine component of prenatal care, to screen all pregnant patients for substance abuse and to counsel women with positive screens on the potential for poor birth outcomes and appropriateness of treatment. Va. Code Ann. § 54.1-2403.1 (2005); see *infra* discussion accompanying notes 285-286. Some may object to Congress's regulation of state policy in this context pursuant to its Spending Clause authority, as such legislation would likely exceed its powers under the Commerce Clause. See Lynn A. Baker, *Conditional Federal Spending After Lopez*, 95 Colum. L. Rev. 1911, 1916 (1995) (suggesting framework for limiting federal regulation of state policy by distinguishing "reimbursement spending" from "regulatory spending" legislation). An evaluation of the merits of this practice in the context of health care practices is beyond the scope of this article. See Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. Kan. L. Rev. 149 (2004) (discussing federal regulation of medical practice including the medical use of marijuana and controlled substances in physician-assisted suicide).

¹³ See discussion *infra* accompanying note 29.

¹⁴ ACOG Ethics Opinion No. 294, *supra* note 1, at 1025; see also Mark A. Hall, *Law, Medicine, and Trust*, 55 Stan. L. Rev. 463, 470 (2002) (asserting that a patient's trust in physicians and medical institutions "plays a central role in enhancing medicine's therapeutic value," as trust is necessary to form a medical relationship and activate the healing process).

It requires physician interventions long after the optimal time has passed to protect the fetus's health. And finally, it promotes the unproven theory that instituting coercive measures after the child's birth will produce a lasting ameliorative effect on the health of drug dependent women and their children by either deterring drug use during pregnancy or facilitating recovery post-partum.¹⁵

Congress's policy choice is not surprising given our Nation's current drug policy climate.¹⁶ Yet for those interested in improving the health of alcohol and drug-dependent women and their children, it is important to rigorously examine whether this policy advances the goals it seeks to achieve. Implicit in CAPTA's policy are several assumptions regarding the harm posed by illicit drug use, the child welfare system's capacity to assist drug-using mothers and their children, and the effect of mandatory state intervention on behavior change; each of these assumptions must withstand scrutiny for this policy to be fully effective. This Article tests these assumptions by examining the current scientific knowledge about both the effect of maternal alcohol and drug use on a fetus and child development, the child welfare system's capacity to address maternal drug problems and the circumstances under which drug and alcohol dependent individuals change their addictive behavior.

Part II of this Article describes the CAPTA physician-reporting provision and state legislation that implements the federal standard. Part III examines whether the federal policy is supported by scientific knowledge on the epidemiology of maternal alcohol and drug problems, the current understanding of the effect of perinatal alcohol and drug use on fetal and child development, and the child welfare system's record of serving children affected by maternal drug use. It also explores important evidence regarding a drug-using woman's willingness to access prenatal care and the ability of the prenatal care system to

¹⁵ See Institute of Medicine, *supra* note 1, at 113.

With respect to the use of coercion in treatment for substance use, research is needed to determine the effects, both positive and negative, of outpatient commitment, drug courts, the use of treatment conditions in probation and parole, and less formal mechanisms of pressure on persons with substance-use problems and illnesses. Empirical data will not resolve the debate on the legitimacy of these approaches, but to the extent that their consequences are known, such data can inform treatment interventions and policy making.

Id. The same principle applies to coercion that arises in the child welfare context where a mother is threatened with the loss of child custody. See *id.* at 97.

¹⁶ Since 1996, Congress has excluded individuals with drug addiction and alcoholism from the federal Supplemental Security Income and Supplemental Security Disability Income programs (42 U.S.C.A. § 423(d)(2)(C) (West Supp. 2006)); barred individuals with drug-related felony convictions from receiving cash assistance and food stamps under welfare reform legislation absent state waiver (21 U.S.C. § 862a (2000)); facilitated the exclusion of individuals involved in drug-related activities from public, federally assisted and Section 8 housing (42 U.S.C. § 13661(a), (c) (2000) and 42 U.S.C. § 1437d(l)(6) (West Supp. 2006)); and, prior to July 1, 2006, suspended eligibility for higher education loans, grants and work assistance to students convicted of drug-related offenses (20 U.S.C. § 1091(r)(1) (2000), amended by Pub. L. No. 109-171, Sec. 8021, 120 Stat. 4, 178 (2006)).

both prevent problems associated with prenatal alcohol and drug use and engage women in behavioral change. Part IV explores whether coercive practices that rely on postpartum child abuse reporting are compatible with the widely-accepted model for intentional behavioral change and can achieve the goal CAPTA has set for itself: to help women change their behavior to protect their children's health and well-being. The analysis in Parts III and IV concludes that the mandatory child welfare reporting practices embodied in CAPTA will likely interfere with the delivery and receipt of effective prenatal care and will not adequately safeguard children who enter the child welfare system because of their mother's drug dependence. By ignoring the lessons of science, Congress has perpetuated a flawed response to maternal drug and alcohol dependence and has squandered an opportunity to engage health professionals in more effective interventions.

Responding to the flaws in Congress's CAPTA policy, Part V proposes that states adopt an alternative model that engages physicians in health care interventions instead of surveillance. Under a health model rather than a regulatory one, physicians would respond to both alcohol and drug problems among their pregnant patients just like they address any other medical condition; i.e., with early assessment, diagnosis and, where appropriate, referral for treatment. The point of mandatory physician intervention would shift from delivery to prenatal care and the means of identification from selective toxicology testing for illicit drug use to universal screening for alcohol, drug and tobacco use. Where prenatal care interventions fail and the mother's alcohol or drug problem is identified at the child's birth, the physician's primary response would be to provide referrals for appropriate health services.¹⁷ A non-punitive, post-partum *health* intervention would complement the proposed prenatal assessment and diagnostic model. Child protective services referrals, while necessary in individual cases, would occur only where evidence exists that current alcohol or drug use places the child at risk of abuse or neglect.¹⁸

This Article considers but ultimately rejects the notion that CAPTA's mandatory physician reporting requirement could be compatible with effective prenatal care and, thus, could co-exist with the proposed alternative model as a useful back-up intervention. The coupling of punitive measures with health care delivery would likely perpetuate the stigma associated with maternal drug use, and thereby, undermine the delivery of effective prenatal care. Even if this were not the case, this Article suggests that the child welfare system, with its limited resources and child rescue emphasis, is not an institution well suited to addressing this health problem.¹⁹

¹⁷ See ACOG Ethics Opinion No. 294, *supra* note 1, at 1022.

¹⁸ *Id.* at 1027. ACOG cautioned that "[m]aternal substance abuse does not by itself guarantee child neglect or prove inadequate parenting capacity." *Id.*

¹⁹ Lester et al., *supra* note 11, at 5-7, 17-19, 39.

II. CONGRESSIONAL RESPONSE TO MATERNAL DRUG USE: CAPTA'S PHYSICIAN REPORTING PROVISION

Few socio-medical issues are more controversial than the proper response to maternal drug use during pregnancy.²⁰ Discord on how to address prenatal drug use exists at every level of decision-making: state legislative mandates,²¹ state prosecutorial and judicial decisions,²² child welfare practices;²³ and

²⁰ Some of the controversy is associated with the debate over fetal rights and abortion. For a discussion of these issues, see Lawrence J. Nelson, *Criminalization of Prenatal Substance Abuse and Drug Addiction*, in LAWRENCE J. NELSON & MARY FAITH MARSHALL, *ETHICAL AND LEGAL ANALYSES OF THREE COERCIVE POLICIES AIMED AT SUBSTANCE ABUSE BY PREGNANT WOMEN* 37 (1998) (discussing the constitutional and general legal status of prenatal humans); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451 (2000) (discussing the physician's role in creating maternal/fetal conflict in the area of maternal drug use); Lynn M. Paltrow, *Pregnant Drug Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999 (1999) (discussing how recognition of fetal rights against maternal drug use threatens a woman's right to abortion).

²¹ For a summary of state legislation addressing maternal drug use, see LYNN PALTROW ET AL., *YEAR 2000 OVERVIEW: GOVERNMENTAL RESPONSES TO PREGNANT WOMEN WHO USE ALCOHOL OR OTHER DRUGS* (2000), available at http://advocatesforpregnantwomen.org/articles/gov_response_review.pdf; Jean Reith Schroedel & Pamela Fiber, *Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women*, 1 YALE J. HEALTH POL'Y L. & ETHICS 217 (2001).

²² Much has been written on the prosecution of women for drug use during pregnancy and particularly the State of South Carolina's application of its criminal child abuse statute to prosecute drug use during pregnancy. See, e.g., Kary Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278 (1990); Paltrow, *supra* note 20, *passim* (discussing *Whitner v. State*, 328 S.C. 1 (1997), *cert. denied*, 523 U.S. 1145 (1998)); Loren Siegel, *The Pregnancy Police Fight the War on Drugs*, in *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE* 249 (Craig Reinerman & Harry G. Levine eds., 1997).

²³ Steven J. Ondersma et al., *Child Protective Services' Response to Prenatal Drug Exposure: Results from a Nationwide Survey*, 25 CHILD ABUSE & NEGLECT 657, 661 (2001). Survey data from 199 county-level child welfare staff across all states revealed extreme variations in filing abuse or neglect petitions and removing custody. *Id.* Among the 90% of respondents who received referrals of infants with prenatal drug exposure, roughly one-quarter reported never responding by filing an abuse or neglect charge; one-quarter reported filing abuse or neglect charges in approximately half of all referrals; and one-quarter reported doing so in 75% of the cases. *Id.* Among those receiving referrals, 13% reported never removing a cocaine-exposed infant from the mother; 17% reported removing the infant in half of the cases; and 29% reported doing so in more than 75% of the cases. *Id.* Despite this variation, nearly 70% of the respondents viewed their practices as appropriate in most cases. *Id.* See also NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY (CASA), *NO SAFE HAVEN: CHILDREN OF SUBSTANCE-ABUSING PARENTS* 40 (1999), available at http://www.casacolumbia.org/pdshopprov/files/No_Safe_Haven_1_11_99.pdf [hereinafter *NO SAFE HAVEN*] (survey of child welfare professionals revealed that slightly more than half believed that evidence of substance abuse during pregnancy should trigger immediate removal of the infant; roughly one-third thought it should not; and slightly less than 10% did not know).

physician practices.²⁴ At the time Congress adopted the CAPTA provision in 2003, states already had adopted a wide range of identification, intervention, rehabilitation and child protection policies and practices to address maternal drug use. Twelve states required health care professionals to report to child welfare officials those infants who exhibited symptoms of alcohol or other drug exposure.²⁵ Twelve states and the District of Columbia defined child abuse or neglect as including an infant's exposure to alcohol or other drugs.²⁶ Other states enforced similar measures through administrative policies.²⁷

Amidst this patchwork of state activity, Congress stepped in, establishing a national standard for child protection interventions. The following section describes the federal standard, potential justifications for Congress's policy, and the State response to the federal mandate.

A. The Federal Standard

In 2003, Congress amended CAPTA to regulate physician response to prenatal drug use via state abuse and neglect reporting practices.²⁸ CAPTA established a uniform reporting rule mandating all states to require health care providers involved in the delivery and care of infants to notify child protective services of "infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure"²⁹ (hereinafter "reporting provision"). CAPTA conditions a state's receipt of federal child abuse funds on the enforcement of the reporting provision. Under the law, states must also develop a "plan of safe care" for infants affected by

²⁴ See discussion *infra* accompanying notes 69-70.

²⁵ NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION, PARENTAL DRUG USE AS CHILD ABUSE: FULL-TEXT EXCERPTS OF STATE LAWS 1 (2004) available at http://childwelfare.gov/systemwide/laws_policies/statutes/drugexposedall.pdf. The states that implement this standard through statute are: Arizona, California, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Oklahoma, and Utah. *Id.* (see *id.* at 3-15 for citations). Wisconsin and Arkansas have subsequently added similar requirements for health care professionals. See WIS. STAT. ANN. § 146.0255(2) (West Supp. 2006); ARK. CODE ANN. § 12-12-507(b) (Supp. 2005).

²⁶ NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION, *supra* note 25, at 1. The states that implement this standard through statute are: Florida, Illinois, Indiana, Iowa, Massachusetts, Minnesota, North Dakota, South Carolina, South Dakota, Texas, Virginia and Wisconsin. *Id.* Arkansas has subsequently amended its child abuse or neglect statute to include newborn drug exposure. ARK. CODE ANN. §§ 12-12-503(12)(B), 9-27-303(36)(B) (Supp. 2005).

²⁷ Wendy Chavkin et al., *National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women*, 88 AM. J. PUB. HEALTH 117, 118 tbl.1 (1998).

²⁸ Keeping Families and Children Safe Act of 2003, Pub. L. No. 108-36, sec. 114, § 106(b), 117 Stat. 800, 809. While physicians are mandated to report suspected abuse and neglect under all state reporting laws, as of 2003 when CAPTA was enacted, slightly less than a majority of states had statutes that specifically required the reporting of maternal drug use at the time of delivery, absent evidence of abuse or neglect or substantial risk of harm. See *supra* notes 25-26.

²⁹ 42 U.S.C. § 5106a(b)(2)(A)(ii) (Supp. III 2003).

maternal drug use.³⁰ The law extends the mandatory reporting requirement to infants affected by illegal drug use, excluding from this requirement cases involving fetal alcohol effect or fetal alcohol syndrome.³¹

Neither the statute nor the legislative history defines what Congress meant by the term “drug-affected,”³² an imprecise term that has no basis in medical criteria.³³ Thus, states are left to devise both the means³⁴ and the criteria³⁵ by

³⁰ 42 U.S.C. § 5106a(b)(2)(A)(iii) (Supp. III 2003). The statute does not identify the types of services that would be provided in connection with the plan of safe care. Under the House-passed version of the bill, the plan of care would have evaluated whether the mother required health services, including mental health services, social services, parenting services, and substance abuse prevention and treatment counseling. H.R. 14, 108th Cong. § 114(b)(1)(B)(ii) (2003). It also would have evaluated whether the infant should be referred to the statewide early intervention program funded under part C of the Individuals with Disabilities Education Act, 20 U.S.C.A. § 1418 (West Supp. 2005), for services. *Id.* The House provision was dropped in the conference committee. H.R. REP. NO. 108-150, at 36 (2003) (Conf. Rep.) (“The conference agreement follows the Senate Bill . . .”). Congress adopted the Senate-passed version of the bill. 149 CONG. REC. S2191, 2193 (daily ed. Feb. 11, 2003) (Sec. 114(b)(1)(B)(ii) of the bill, codified at 42 U.S.C. § 5106a(b)(2)(A)(ii)).

³¹ *See* 42 U.S.C.A. § 5106a(b)(2)(A)(ii) (West 2003). Congress rejected the House-passed version of the bill, H.R. 14, which would have required notification of infants “born and identified with fetal alcohol effects [and] fetal alcohol syndrome” as well as medical conditions resulting from prenatal drug exposure. H.R. 14, 108th Cong. § 114(b)(1)(B)(ii) (2003). The Senate-passed version of the bill, S. 342, did not require CPS notification of prenatal alcohol exposure “because of limited ability to detect and diagnose it at birth.” S. REP. NO. 108-12, at 16 (2003). The committee noted its “concern about the effects of alcohol on infants and possible later diagnosis of fetal alcohol syndrome” and indicated that this omission should not “signal that States should no longer investigate cases involving prenatal exposure to alcohol.” *Id.* at 16-17. The House standard was dropped in the House-Senate conference committee negotiations. H.R. REP. NO. 108-150, at 36 (2003) (Conf. Rep.). The Senate’s rationale for omitting identification of prenatal alcohol exposure rings hollow based on the well-documented medical indications of fetal alcohol syndrome as compared to the medical conditions that have been linked to other drug use alone. *See* discussion *infra* accompanying notes 87-98.

³² The “drug-affected” standard was taken from the Senate bill. 149 CONG. REC. S4035 (daily ed. March 19, 2003). The Senate committee report provides very limited guidance on the circumstances that would trigger a CPS report, noting that the “committee believes that any child who is experiencing symptoms or showing signs of addiction to or withdrawal from drugs” should be provided medical care and referred to CPS. S. REP. NO. 108-12, at 16 (2003). This suggests that something more than a positive toxicological test result from the mother or infant is required for a report. The House-passed version of the bill, in contrast, would have required a CPS report when the infant presented specific, diagnosable medical conditions: “neonatal intoxication or withdrawal syndrome or neonatal physical or neurological harm resulting from prenatal drug exposure.” H.R. REP. NO. 108-150, at 36 (2003) (Conf. Rep.). This standard would have focused resources on infants who were at substantially greater risk of harm and whose mothers were more likely to have untreated drug dependence. *See* discussion *infra* accompanying note 43.

³³ Thus, of the six states that have enacted laws to conform to CAPTA, four (Maine, Arkansas, Colorado and Louisiana), require reporting of infants based on “exposure” to illegal drugs, and two (Hawaii and Nevada), incorporate the “drug-affected and withdrawal” standard. *See infra* discussion accompanying notes 56-67.

which health care providers will identify infants who will be reported to child protective services (CPS). They must also devise policies that will avoid the racial and socio-economic bias that has been documented in hospital-based testing and reporting programs.³⁶

³⁴ Toxicology tests using urine or infant meconium samples and the patient's self-report of drug use are the two most common means of identification. Barry M. Lester et al., *The Maternal Lifestyle Study: Drug Use by Meconium Toxicology and Maternal Self-Report*, 107 PEDIATRICS 309 (2001). The rate of identification will vary depending upon the toxicology test selected. A urine test identifies drug use within 24-48 hours of birth, while a meconium test can detect drug use occurring throughout the second half of pregnancy. *Id.* Error rates of up to 25% exist without confirmation testing. *See id.* at 315.

³⁵ Standards adopted by several jurisdictions demonstrate the lack of consensus on appropriate medical criteria for screening mothers and infants at delivery. For example, a protocol that is implemented in all hospitals in Bernalillo County, New Mexico identifies dramatically different standards than the protocol recommended for hospitals throughout Arizona. The New Mexico protocol lists four criteria for conducting a urine drug test on the mother at delivery: history of substance abuse in current pregnancy; preterm labor; placental abruption; and behavior consistent with acute intoxication. ANDY HIS ET AL., GUIDELINES FOR OBTAINING MATERNAL AND NEONATAL UDM: ALBUQUERQUE, NEW MEXICO 1 (2004), available at http://aia.berkeley.edu/media/pdf/nm_sen_guidelines.doc. The Arizona policy identifies the following ten criteria for testing women: history of previous or current substance use by mother or others living in the home or history of delivery of substance exposed newborn; non-compliance with prenatal care; unexplained poor weight gain during pregnancy; medical non-compliance; medical symptoms of withdrawal; signs of substance use or abuse; medical history of Hepatitis B or C, HIV infection or two or more sexually transmitted diseases; placental abruption or unexplained vaginal bleeding; cardiovascular accident; and pre-term labor in combination with other factors. SUBSTANCE-EXPOSED NEWBORN COMMITTEE, GOVERNOR'S ACTION PLAN ON CHILD PROTECTIVE SERVICES REFORM, GUIDELINES FOR IDENTIFYING SUBSTANCE-EXPOSED NEWBORNS 5 (2005), available at <http://www.governor.state.az.us/cps/documents/SenGuidelines.pdf>. The criteria for newborn testing are similarly discordant. *Compare* HIS ET AL., *supra*, at 1; and SUBSTANCE-EXPOSED NEWBORN COMMITTEE, *supra*, at 6.

³⁶ *See* James R. MacMahon, *Perinatal Substance Abuse: The Impact of Reporting Infants to Child Protective Services*, 100 PEDIATRICS 7 (1997), available at <http://pediatrics.aappublications.org/cgi/reprint/100/5/e1.pdf> (reporting significant disparity between the testing of patients of private physicians versus those treated by hospital staff at Stanford University Hospital, notwithstanding uniform hospital criteria); Marilyn Birchfield et al., *Perinatal Screening for Illicit Drugs: Policies in Hospitals in a Large Metropolitan Area*, 15 J. PERINATOLOGY 208, 209, tbl.2, and 212 (1993) (reporting that, among forty-nine of fifty eligible hospitals in Cook County, Illinois, 70% relied on hospital worker suspicion of drug use which permitted racial and socio-economic bias to influence testing); and Ira J. Chasnoff et al., *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1204 (1990) (African-American women were almost ten times more likely than white women to be reported to child protective services, even though the rate of drug use among the two groups was essentially the same). Data from other medical contexts also suggest that physicians rate African-American patients as more likely to abuse drugs and alcohol than white patients. *See* Michelle Van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 820 (2000). Biased reporting may exacerbate the child welfare system's high level of state intervention in and disruption of African-American families. *See, e.g.*, Dorothy E. Roberts, *Is There Justice in Children's Rights?: The Critique of Federal Family*

Although CAPTA clearly establishes a nationwide CPS reporting requirement related to prenatal drug use, Congress made clear that the provision does not preempt state abuse and neglect standards.³⁷ Congress also did not set a national standard guiding the prosecution of women who use drugs prenatally.³⁸ The law explicitly provides that “notification shall not be construed to . . . establish a definition under Federal law of what constitutes child abuse . . . or require prosecution for any illegal action.”³⁹ Both the House and Senate committees explained that the reporting requirement was not intended to require, or interfere with, the state prosecution of women for their use of drugs during pregnancy.⁴⁰ Raising the specter of prosecution in connection with the physician-reporting practice, even if only to preserve the status quo of state practice, signals the federal government’s endorsement of punitive measures that will not only complicate but also undermine the relationship between a pregnant woman and her physician.⁴¹

The physician-reporting requirement was championed by former Pennsylvania Congressman James Greenwood, a former child protective services worker. He believed his proposal would address a critical gap in the *prevention* of child abuse: the failure to identify and intervene early in the lives of children with alcoholic or drug-addicted mothers.⁴² He envisioned the role of health care personnel as facilitating direct interventions in the lives of children who “either suffer from fetal alcohol syndrome or . . . the systemic presence of a drug or . . .

Preservation Policy, 2 U. PA. J. CONST. L. 112, 125-26, 140 (1999) (documenting the disproportionate rate of African-American children placed in foster care and asserting that excessive disruption of African-American families devalues their autonomy and relationships and harms the entire community’s ability to fight institutional discrimination).

³⁷ 42 U.S.C. § 5106a(b)(2)(A)(ii)(I) (Supp. III 2003).

³⁸ 42 U.S.C. § 5106a(b)(2)(A)(ii)(II) (Supp. III 2003). See PALTROW ET AL., *supra* note 21, at 8-9 (discussing criminal prosecution theories).

³⁹ 42 U.S.C. § 5106a(b)(2)(A)(ii)(I - II) (Supp. III 2003).

⁴⁰ H.R. REP. NO. 108-26, at 29 (2003). The House Committee on Education and the Workforce explained that the “amendment does not preempt a state’s law regarding what constitutes child abuse or requires [sic] prosecution. . . . [S]tates that choose to prosecute women who have given birth to infants addicted to drugs or alcohol may continue to do so.” *Id.* Similarly, the Senate Committee on Health, Education, Labor and Pensions emphasized that its intent is not “to preempt State law regarding what constitutes child abuse or requirements for prosecution” S. REP. NO. 108-12, at 17 (2003).

⁴¹ SHEIGLA MURPHY & MARSHA ROSENBAUM, *PREGNANT WOMEN ON DRUGS: COMBATING STEREOTYPES AND STIGMA* 88-96 (1999) (describing problematic relationship with prenatal care providers based on concerns that disclosure of drug use would affect child custody); Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 *DRUG & ALCOHOL DEPENDENCE* 199, 201-02 (1992) (reporting view that law threatening incarceration for drug use during pregnancy would drive women underground and discourage women from seeking medical care).

⁴² 149 CONG. REC. H1511 (daily ed. Apr. 23, 2002) (statement of Rep. James Greenwood regarding H.R. 3839, Keeping Children and Families Safe Act of 2002). This provision was reintroduced and enacted in 2003.

[who are] in withdrawal from the drug.”⁴³ According to Representative Greenwood,

We do not want to necessarily deem the mothers as having abused the child by virtue of their abuse of the substance. We want to provide intervention . . . [W]e need to talk with the parents of this child and find out how they intend to overcome their own personal issues so that they can be prepared to nurture this vulnerable child.⁴⁴

The goal of the provision, according to the House committee report, was “to identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child.”⁴⁵ Indeed, the House-passed bill explicitly identified those services as including mental health and substance abuse treatment for the mother, social services and early child development services.⁴⁶

Congress did not adopt Congressman Greenwood’s vision. The reporting provision, as enacted, focuses exclusively on infants “affected by illicit drug use” and does not require assistance for children who are harmed by a mother’s alcohol dependence.⁴⁷ It also does not ensure that CPS will intervene in only those cases where the child’s health condition suggests that a risk of abuse or neglect exists.⁴⁸ Instead, the “drug-affected” standard encompasses a child who has been exposed to maternal drug use but presents no symptoms of such exposure or is at risk of abuse or neglect. Moreover, the “safe care” plan requirement contains none of the “teeth” that were included in the House-passed bill,⁴⁹ providing no assurance that CPS will identify or provide necessary health, education or social services; the key to preventing abuse and neglect.

While Congressman Greenwood’s vision falls far short of the *child abuse prevention* measures this Article asserts are needed, Congress’s solution sacrifices the ability to target scarce resources⁵⁰ to the families in greatest need of addiction treatment and other services. In fairness, Congress may have chosen to

⁴³ 149 CONG. REC. H5433 (daily ed. June 17, 2003) (statement of Rep. James Greenwood during floor debate over the conference report on S. 342).

⁴⁴ *Id.*

⁴⁵ H.R. REP. NO. 108-26, at 29 (2003).

⁴⁶ *See supra* note 30.

⁴⁷ *See supra* note 31.

⁴⁸ *See supra* note 32 and discussion *infra* accompanying notes 64-67 of state standards adopted to implement CAPTA.

⁴⁹ *See supra* note 30.

⁵⁰ The National Survey of Substance Abuse Treatment Services (N-SSATS) found that, in 2003, only 14% of substance abuse facilities offered specialized programs for pregnant or postpartum women, with no expansion since 1997. SAMHSA OFFICE OF APPLIED STUDIES, U.S. DEP’T OF HEALTH & HUMAN SERVICES, WOMEN IN SUBSTANCE ABUSE TREATMENT: RESULTS FROM THE ALCOHOL AND DRUG SERVICES STUDY (ADSS) 32 (Thomas M. Brady & Olivia S. Ashley eds., 2005), available at <http://www.drugabusestatistics.samhsa.gov/womenTX/womenTX.pdf>. Approximately 8% of the facilities offered child care services. *Id.* Thirty-five percent (35%) of substance abuse facilities offered special programs for women. *Id.*

cast a wider net to identify all women whose illicit drug use immediately prior to delivery would suggest an inability to control their drug use, thereby requiring some form of coercion to alter dangerous behavior. Reserving a punitive sanction until the post-partum period would respect both the autonomy and reproductive rights of women. It would not only avoid state interference with the physician-patient relationship during prenatal care, but also reflect the fact that most pregnant women attempt to alter their alcohol and drug use to ensure the best birth outcome without punitive external pressure.⁵¹ This scheme would also be consistent with most state child abuse and neglect laws, which limit state intervention to address alcohol and drug exposure in children, not fetuses.⁵²

The efficacy of Congress's choice depends upon whether three assumptions are borne out by the data: that illicit drug use poses sufficient harm to a child's health and development to merit a harsh sanction;⁵³ that a punitive post-partum intervention will not interfere with effective prenatal care; and that the child welfare system is capable of both protecting vulnerable children affected by maternal drug use and providing necessary services to preserve family unity and facilitate a woman's recovery.⁵⁴ Congress's policy loses much of its appeal if the mandatory physician reporting requirement negatively affects the delivery and receipt of prenatal care, diminishes a woman's ability to achieve long-term behavior change or fails to protect children exposed to maternal drug use. The data discussed in Parts III and IV suggest that this is likely to be the case.

⁵¹ See discussion *infra* accompanying notes 146-150.

⁵² Among the states that have explicit statutory standards in this area, see *supra* notes 25 and 26 and *infra* note 62, only North Dakota and Wisconsin authorize child welfare interventions for prenatal harm to a fetus. N.D. CENT. CODE § 50-25.1-16(1), (4) (Supp. 2005) (prenatal exposure to controlled substances) and N.D. CENT. CODE § 50-25.1-18(3), (5) (Supp. 2005) (prenatal exposure to alcohol abuse); and WIS. STAT. ANN. § 48.02(1)(am) (West 2003). In addition, the South Carolina Supreme Court has interpreted its criminal neglect statute to apply to a viable fetus who has been exposed to illicit drugs in utero. *Whitner v. State*, 328 S.C. 1 (1997), *cert. denied*, 523 U.S. 1145 (1998).

⁵³ Congress need not tackle all aspects of maternal drug use at one time and, in this case, could have made the judgment that other interests are served by first addressing use that is illegal, even if relatively less harmful to the child's health. See discussion *infra* accompanying notes 76-119, 125, 128-29. The question becomes, however, whether Congress's intervention is commensurate with the harm posed by illicit drug use.

⁵⁴ Some scholars would assert that the child welfare system need only protect vulnerable children affected by maternal drug use to justify the policy Congress has adopted. See ELIZABETH BARTHOLET, *NOBODY'S CHILDREN: ABUSE AND NEGLECT, FOSTER DRIFT, AND THE ADOPTION ALTERNATIVE* 216-17 and 226-27 (1999) (discussed *infra* at notes 179, 189, and 191). The evidence suggests, however, that the child welfare system is not capable of accomplishing even that. See discussion *infra* accompanying notes 175-82.

B. State Implementation of CAPTA's Reporting Provision

It is too early to evaluate the effect of CAPTA's reporting requirement, as states have only begun to comply with the standards set by federal law.⁵⁵ Since CAPTA's enactment, Hawaii,⁵⁶ Arkansas,⁵⁷ Louisiana,⁵⁸ Colorado,⁵⁹ Maine⁶⁰ and Nevada⁶¹ have passed legislation related to prenatal drug use.⁶² In three of those states, legislators expanded the state's definition of abuse and neglect to include maternal drug use, while the three others track the CAPTA provision closely.⁶³

⁵⁵ STEVE CHRISTIAN, NATIONAL CONFERENCE OF STATE LEGISLATURES, SUBSTANCE-EXPOSED NEWBORNS: NEW FEDERAL LAW RAISES SOME OLD ISSUES 2 (2004) (observing that "[b]ecause the health care system is independent of the child welfare system, implementation of the new CAPTA notification provision will likely require the enactment of legislation in many, if not most, states.").

⁵⁶ S. 2165, 2004 Leg., 22nd Sess. (Haw. 2004).

⁵⁷ S. 114, 2005 Leg., 85th Sess. (Ark. 2005).

⁵⁸ S. 243, 2005 Leg., Reg. Sess. (La. 2005) and H.B. 215, 2006 Leg., Reg. Sess. (La. 2006) (effective Aug. 15, 2006).

⁵⁹ H.R. 05-1141, 65th Gen. Assem., 1st Reg. Sess. (Colo. 2005).

⁶⁰ H.R. 1420B, 121st. Leg., 2d Spec. Sess. (Me. 2004).

⁶¹ S.B. 296, 2005 Leg., 73d Sess. (Nev. 2005).

⁶² In addition, North Dakota enacted a toxicology testing and reporting requirement in March 2003 in the midst of the two-year debate on CAPTA. The law requires physicians to conduct toxicology tests of pregnant women and women at delivery when obstetrical complications indicate possible use of a controlled substance. N.D. CENT. CODE § 50-25.1-17(1) (Supp. 2005). It also requires toxicological testing of infants at birth when a medical assessment of the infant or mother indicates prenatal use of a controlled substance. N.D. CENT. CODE § 50-25.1-17(2) (Supp. 2005). Physicians must report all positive test results as neglect to the department of human services. N.D. CENT. CODE § 50-25.1-17(1), (2) (Supp. 2005). Physicians are also required to report pregnant women who use controlled substances or abuse alcohol during pregnancy unless the woman voluntarily enters treatment at a licensed program and complies with treatment recommendations. Failure to enter, complete or comply with treatment must be reported to the department of human services. N.D. CENT. CODE § 50-25.1-16(1), (4) (Supp. 2005) (prenatal exposure to controlled substances) and N.D. CENT. CODE § 50-25.1-18(3), (5) (Supp. 2005) (prenatal exposure to alcohol abuse).

⁶³ Hawaii requires its department of human services to implement statewide reporting and safe care plan policies in compliance with federal standards and to develop triage procedures that ensure referrals to voluntary preventive services for families where no risk of imminent harm exists. HAW. REV. STAT. ANN. § 587-89(a)(1)-(3) (LEXIS 2005). The law explicitly provides that notification "shall not be construed to require criminal prosecution for any illegal action," (HAW. REV. STAT. ANN. § 587-89(a)(1) (LEXIS 2005)), but does not prohibit the prosecution of women for prenatal drug use. See *State v. Aiwahi*, 123 P.3d 1210 (Haw. 2005) (reversing manslaughter conviction of mother who used methamphetamines during pregnancy and whose infant son died several days after birth; definition of "person" in manslaughter statute does not include "fetus"). Maine requires health care providers to notify the state's department of health and human services of all infants who have been exposed to illegal substances or suffer from withdrawal symptoms related to both legal and illegal drugs. ME. REV. STAT. ANN. tit. 22 § 4011-B (Supp. 2005). The department is required to investigate all reports to determine whether the infant has been affected by prenatal drug exposure and is abused or neglected (ME. REV. STAT. ANN. tit. 22 § 4004-B (Supp. 2005)) and to create a plan of safe care in collaboration with the mother and infant's health care provider. *Id.* Maine's provision, like Hawaii's, makes clear that notification does not require prosecution for any

State legislation in Louisiana, Arkansas and Colorado suggests a trend to enforce the federal mandate by explicitly equating prenatal drug use with abuse and neglect.⁶⁴ Louisiana has amended its definition of “neglect” to include prenatal neglect, defined as a mother’s unlawful use of a controlled substance during pregnancy that results in the presence of the drug in the infant’s body or withdrawal symptoms.⁶⁵ Arkansas’s provision amends its definition of “neglect” to include illegal drug use during pregnancy that results in a drug being present in a newborn’s bodily fluids or the newborn being born with a health problem resulting from illegal drug use.⁶⁶ Finally, Colorado has amended its definition of both “abuse” and “neglect” to include a child who tests positive at birth for either a Schedule I or II controlled substance, absent evidence of the mother’s lawful use of the drug.⁶⁷

Achieving uniform compliance by health practitioners remains a real issue even after states adopt conforming standards.⁶⁸ One study that examined the attitudes of obstetricians, pediatricians and family practitioners about mandatory reporting of prenatal alcohol and drug use suggests physician ambivalence about mandatory identification and reporting requirements.⁶⁹ Roughly half (52%) the

illegal action. ME. REV. STAT. ANN. tit. 22 § 4011-B(1)(B) (Supp. 2005). Nevada requires health care providers to report an infant who has been affected by prenatal illegal substance use or has withdrawal symptoms resulting from prenatal drug exposure to the state’s child welfare agency. NEV. REV. STAT. ANN. § 432B.220(3) (LEXIS 2006). Nevada’s provision also makes clear that notification does not require prosecution for any illegal action. *Id.*

⁶⁴ Maine’s statute, for example, accurately reflects the federal standard that notification to CPS of an infant affected by illicit drug use does not establish a definition of abuse or neglect. ME. REV. STAT. ANN. tit. 22 § 4011-B(1)(A) (Supp. 2005).

⁶⁵ H.B. 215, 2006 Leg., Reg. Sess. (La. 2006) (effective Aug. 15, 2006).

⁶⁶ ARK. CODE ANN. § 12-12-503(12)(B)(i)(a), (b) (Supp. 2005).

⁶⁷ COLO. REV. STAT. ANN. § 19-1-103(1)(a)(VII) (West Supp. 2005) (definition of “abuse” or “child abuse or neglect”) and § 19-3-102(1)(g) (West Supp. 2005) (definition of “neglected or dependent child”). Schedule I and II controlled substances are those drugs listed in the Controlled Substances Act, 21 U.S.C. § 812(b)(1) and (2), that have a high potential for abuse and have either no accepted medical use in treatment or, notwithstanding an accepted medical use, may lead to dependence. *Id.*

⁶⁸ The views of medical organizations on this issue are not part of the legislative history. Indeed, there is no discussion about the physician reporting provision in the public witness testimony on the Keeping Children and Families Safe Act. *See Implementation of the Adoption and Safe Families Act of 1997, Hearing Before the Subcomm. on Human Resources of the H. Comm. on Ways & Means, 108th Cong. (2003), available at http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.52&filename=90545.pdf&directory=/disk2/wais/data/108_ho use hearings.*

⁶⁹ Ernest L. Abel & Michael Kruger, *Physician Attitudes Concerning Legal Coercion of Pregnant Alcohol and Drug Users*, 186 AM. J. OBSTETRICS & GYNECOLOGY 768 (2001) (anonymous questionnaire sent to all obstetricians, pediatricians and family practitioners in the Michigan Medical Association list, with a 50% to 52% response rate for each specialty. *Id.* at 769-70). RAND’s 1995 nationwide survey of physician reporting practices found that the physician’s concern about a disruption in care was an important reason for not acting on a suspicion of prenatal drug exposure. SUZANNE L. WENZEL ET AL., *PRENATAL COCAINE EXPOSURE: SCIENTIFIC CONSIDERATIONS AND POLICY IMPLICATIONS* 11, 12 (2001), *available at <http://www.rand.org/publications/MR/MR1347>* (reporting results of G.L. Zellman et al., *Influencing Physician Response to Prenatal Substance Exposure Through State Legislation and*

physicians favored enactment of a statute that would define illicit drug use and alcohol abuse during pregnancy as “child abuse” for the purpose of removing that child from the mother’s custody.⁷⁰

Even this level of physician support for mandatory reporting alarms the Ethics Committee of the American College of Obstetricians and Gynecologists (ACOG), the national organization of women’s health care physicians.⁷¹ ACOG opposes legally mandated testing and reporting, explaining that such practices “endanger the relationship of trust between physician and patient, place the obstetrician in an adversarial relationship with the patient, and possibly conflict with the therapeutic obligation.”⁷² Ethical and therapeutic obligations, according to ACOG, require physicians to implement an evidence-based protocol of universal screening questions to identify alcohol and drug use, brief interventions,⁷³ and referral for treatment.⁷⁴ Any effort to link these recommended strategies with punitive measures may discourage a woman from seeking medical care to avoid the risk of being reported and will, according to ACOG, “actually increase the risks to the woman and the fetus rather than reduce the consequences of substance abuse.”⁷⁵

ACOG’s implicit rebuke of the CAPTA standard on ethical and therapeutic principles is supported by a significant body of medical and social science research available to Congress in 2003 that explores the scope and health

Work-place Policies, 92 ADDICTION 1123 (1997)). See also SUBSTANCE-EXPOSED NEWBORN COMMITTEE, *supra* note 35, at 8 (describing physician’s ethical dilemma in conducting drug tests; detection of drug use may hold the benefit of treatment but also trigger mandatory reporting which may result in custodial litigation, disruptions in the mother and infant relationship and entry into the child welfare system where limited resources may result in suboptimal outcomes for both mother and infant).

⁷⁰ Abel & Kruger, *supra* note 69, at 770.

⁷¹ ACOG Ethics Opinion No. 294, *supra* note 1, at 1025 (citing Abel’s survey results, the Committee stated that support for a statute permitting removal of child custody based on a mother’s alcohol or drug use “is particularly troubling because these physicians did not state that there needed to be evidence of physical or emotional neglect . . . for children to be so removed.”).

⁷² *Id.*

⁷³ A brief intervention would involve the physician providing advice on the risks associated with alcohol or drug use and motivating a patient to change her behavior without assigning self-blame. KRISTEN LAWTON BARRY, U.S. DEP’T OF HEALTH & HUMAN SERVS., TREATMENT IMPROVEMENT PROTOCOL SERIES NO. 34, BRIEF INTERVENTIONS AND BRIEF THERAPIES FOR SUBSTANCE ABUSE 1, 3 (1999), available at <http://ncadi.samhsa.gov/govpubs/BKD341/default.aspx>. “Brief interventions for alcohol problems . . . have ranged from relatively unstructured counseling and feedback to more formal structured therapy . . .” depending upon the setting in which they occur (hospital, primary health care office, mental health clinic or treatment program). *Id.* at 3, 5.

⁷⁴ ACOG Ethics Opinion No. 294, *supra* note 1, at 1022. The American Academy of Pediatrics has also recommended universal screening about past and present alcohol, nicotine and other drugs at the first prenatal visit, counseling about the implications of drug use and referral for treatment if a drug problem is suspected. AM. ACAD. OF PEDIATRICS AND AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 85 (5th ed. 2002) [hereinafter GUIDELINES FOR PERINATAL CARE].

⁷⁵ ACOG Ethics Opinion No. 294, *supra* note 1, at 1025. See discussion *infra* accompanying note 168.

consequences of maternal alcohol and drug use and proposes effective health interventions prior to the birth of the child. This research, discussed below, casts doubt on the efficacy of the CAPTA standard.

III. HOSPITAL-BASED REPORTING STANDARDS: DOES THE LAW REFLECT SCIENCE?

CAPTA is an appropriate policy if two basic assumptions hold up. The first is that illicit drug use during pregnancy poses a significant risk to an infant's health and development, requiring state intervention. The second is that a child welfare intervention protects the drug-exposed child from health risks that occur in utero or post-partum and aids the mother's recovery from drug dependence or provides necessary supportive services to the child and parent. To test these assumptions, the following Part begins with an examination of the epidemiology of drug, alcohol and tobacco use among pregnant women and the known effects of such substance use. It then evaluates whether the timing and nature of the intervention will promote or inhibit the health care system's ability to reduce harm associated with prenatal alcohol and drug use. Finally, it examines the capacity of the child welfare system to address the needs of these families.

A. The Real Problem: The Scientific Facts on the Prevalence and Effect of Maternal Alcohol and Drug Use

1. Epidemiology of Alcohol and Drug Use During Pregnancy

CAPTA's focus on infants affected by illicit drugs and disregard of maternal alcohol use and dependence ignores the fact that alcohol is *the* drug that science has shown to be both the most widely-abused and that, along with tobacco, has demonstrated teratogenic effect for infants and children.⁷⁶ According to the Department of Health and Human Services' National Survey on Drug Use and Health (NSDUH),⁷⁷ 4.3% of pregnant women ages fifteen to forty-four years, report using an illicit drug; 9.8% report drinking alcohol; and 18% report tobacco use.⁷⁸ Approximately 4% of pregnant women report binge alcohol

⁷⁶ See discussion *infra* accompanying notes 87-106.

⁷⁷ SAMHSA OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE NSDUH REPORT: SUBSTANCE USE DURING PREGNANCY: 2002 AND 2003 UPDATE 3 (2005), available at <http://www.oas.samhsa.gov/2k5/pregnancy/pregnancy.htm> [hereinafter NSDUH: 2002 AND 2003 UPDATE].

⁷⁸ *Id.* at 2. The NSDUH distinguishes "use" from "abuse or dependence," which are medical diagnoses based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), "including symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home during the past year." SAMHSA OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE NSDUH REPORT: SUBSTANCE ABUSE AND DEPENDENCE AMONG WOMEN at 1-2 (2005), available at <http://www.oas.samhsa.gov/2k5/women/women.htm> [hereinafter NSDUH SUBSTANCE ABUSE]. While estimates of substance abuse and dependence among pregnant women are not available from

use and less than 1% report heavy alcohol use; such drinking patterns appear to have the most significant consequences for the health and development of a fetus.⁷⁹

The rate of alcohol use, compared to illicit drug use among pregnant women, may be substantially greater, according to studies that estimate the prevalence of drug use through toxicological tests in combination with self-reporting.⁸⁰ The Maternal Lifestyle Study, the largest prospective study of cocaine and opiate use among pregnant women with varied racial, ethnic and socio-economic backgrounds,⁸¹ found that 10% of infants were exposed to cocaine and/or opiates during pregnancy,⁸² with a majority of those infants (8.3%) exposed to cocaine alone.⁸³ Among pregnant women who did not use

the NSDUH, the 2003 NSDUH estimates that 5.2 million women (4.7%), age eighteen and older, abused or were dependent on alcohol, and 2 million (1.8%) women abused or were dependent on an illicit drug. *Id.* at 2.

⁷⁹ NSDUH: 2002 AND 2003 UPDATE, *supra* note 77, at 2. See discussion *infra* accompanying notes 87-98 for the effects of binge and heavy alcohol use. According to the NSDUH, the rate of drug, alcohol and tobacco use by pregnant women varies across racial and ethnic groups. Eight percent (8%) of black women, 4.4% of white women and 3% of Hispanic women report use of illicit drugs during pregnancy, and 25% of white women, 9.3% of black women and 6.8% of Hispanic women report tobacco use. *Id.* at 2. According to the 2002 NSDUH, approximately 3% of white, black and Hispanic women report binge drinking during pregnancy. SAMHSA OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE NSDUH REPORT: PREGNANCY AND SUBSTANCE USE 2 Fig.2 (2004), available at <http://www.oas.samhsa.gov/2k3/pregnancy/pregnancy.htm>. The rate of alcohol or drug abuse or dependence among women eighteen years of age or older reveals a different pattern across racial and ethnic groups: 6.3% of white women, 4.5% of black women and 4.4% of Hispanic women abused or were dependent on alcohol or illicit drugs. NSDUH SUBSTANCE ABUSE, *supra* note 78, at 2. For a discussion of the implications of these racial patterns, see *supra* note 36 and accompanying text.

⁸⁰ Societal disapproval, fear of negative consequences related to child protective services involvement, and inaccurate recall affect the accuracy of prevalence estimates based on self-reports alone. Lester et al., *supra* note 11, at 5.

⁸¹ Charles R. Bauer et al., *The Maternal Lifestyle Study: Drug Exposure During Pregnancy and Short-Term Maternal Outcomes*, 186 AM. J. OBSTETRICS & GYNECOLOGY 487 (2002). Women were recruited for participation in the study between May 1993 and May 1995 during their hospital stay shortly after delivery. *Id.* at 489. The racial composition of the study participants was 49.6% black, 35% white, and 15.4% Hispanic, and nearly two-thirds of the participants were Medicaid recipients. *Id.* at 491 tbl.III.

⁸² *Id.* at 493. Of the 11,811 mother-infant dyads who agreed to participate in the study, 1185 infants were identified as exposed to cocaine and/or opiates. *Id.*

⁸³ *Id.* at 493 tbl.IV. The Maternal Lifestyle Study, like the NSDUH, also found disparate rates of illicit drug use across racial groups. Black women comprised almost 50% of the Maternal Lifestyle Study sample, but 76% of the women who used cocaine or opiates. *Id.* at 491 & tbl.III. Other studies have also found cocaine use to be "especially concentrated among poor women of color." Lester et al., *supra* note 11, at 4. Chasnoff found that, although rates of drug use were equal among black women and white women in Pinellas County, black women were more likely to use cocaine. Chasnoff et al., *supra* note 36, at 1204 tbl.2.

cocaine or opiates, 30% reported drinking alcohol and nearly 20% reported smoking.⁸⁴

Although the CAPTA standard will certainly identify women who have both alcohol and drug problems, it will miss a substantial number of women whose alcohol use could affect fetal health and development. Indeed, the number of alcohol users in the Maternal Lifestyle Study—30% of those who did not use cocaine or opiates—far exceeds the number of women who used these illicit drugs. CAPTA's singular focus on women who use illicit drugs is more questionable when examined in light of scientific findings on the effect of alcohol, tobacco, and illicit drugs on fetal and child development.

2. Effect of Alcohol, Tobacco, and Illicit Drugs on Child Development

As demonstrated by CAPTA and most state abuse and neglect statutes, “[i]llicit drugs are the most often targeted drugs in the fight against maternal substance abuse, because they are perceived to produce the most harmful side effects in both the mothers and the children.”⁸⁵ Yet, science leaves much room for debate on the effect of illicit drug use during pregnancy,⁸⁶ while painting a clear picture of the deleterious short and long term effects of heavy and moderate alcohol use and tobacco exposure during pregnancy.

⁸⁴ Bauer et al., *supra* note 81, at 493. One must be cautious when comparing the current NSDUH data with the Maternal Lifestyle Study data, which reports drug use patterns from four jurisdictions nine to ten years prior to this most recent NSDUH survey. According to a more contemporaneous 1994 National Institute on Drug Abuse report, 5.5% of infants were born prenatally exposed to illicit drugs. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 37.

⁸⁵ Lester et al., *supra* note 11, at 7. Other explanations exist for targeting illicit drug use. Certainly the legal status of alcohol and tobacco influences policymakers. Political and economic interests routinely undermine regulation of alcohol and tobacco even where harm has been demonstrated. See BARTHOLET, *supra* note 54, at 228. Institutionalized racism may also contribute to the targeting of illicit drug use during pregnancy. While drug use and dependence is more prevalent among white women than black women, drug use during pregnancy (especially cocaine use) is more prevalent among black women. See *supra* note 83. David Musto has described how, in the early 1900s, cocaine use among blacks in the South offered a rationale for their repression. Southern whites feared that cocaine use by African-Americans would trigger violence against white society, even though both African-Americans and whites in the North and South used cocaine for medicinal and non-medicinal purposes and no evidence existed that cocaine use caused a crime wave among the former. DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTICS CONTROL 6, 8-10, 295 (3d ed. 1999). See Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1436-40 (1991) (asserting that current governmental efforts to control the reproductive decisions of African-American women who are drug dependent are a legacy of slavery).

⁸⁶ Lester et al., *supra* note 11, at 7.

a. Effect of Alcohol Use During Pregnancy

Children exposed to heavy or moderate alcohol use in utero typically suffer from physical, intellectual and behavioral impairments.⁸⁷ The most severe condition stemming from very heavy drinking during pregnancy is Fetal Alcohol Syndrome (FAS).⁸⁸ Children with FAS have distinctive abnormal facial features and experience retarded growth before and after birth.⁸⁹ These children also have significant cognitive problems: many are mentally retarded, with an IQ below seventy, while others perform in the low-average to average range on IQ tests.⁹⁰ Research comparing children with FAS to those with similar IQs who were not exposed to alcohol in utero found that children with FAS lacked specific mathematical skills and displayed attention deficit symptoms, including the inability to coordinate, plan and execute appropriate responses. The children with FAS also had poorer socio-emotional development than would be expected based on their IQs.⁹¹ Their socialization deficits include “poor interpersonal skills and an inability to conform to social conventions.”⁹² Research also indicates that behavior problems during childhood do not improve as the individual reaches adulthood.⁹³

Children exposed to moderate prenatal alcohol use⁹⁴ may also present more subtle, yet measurable, neurobehavioral deficits that fall under the diagnosis of “alcohol-related neurodevelopmental disorder” or ARND.⁹⁵ Although such children do not generally have lower IQ scores, they nonetheless are impaired in their arithmetic, socio-emotional, and attention capabilities,⁹⁶ particularly in their ability to retrieve information from memory.⁹⁷ Research also suggests that neurodevelopmental impairments in infants with ARND are “dose-related” insofar as women who binge drink (drinking five or more drinks per occasion) rather than drink frequently but in smaller volumes (less than two drinks per occasion) expose their infants to greater functional impairments.⁹⁸

⁸⁷ Joseph L. Jacobson & Sandra Jacobson, *Drinking Moderately and Pregnancy: Effects on Child Development*, 23 ALCOHOL RES. & HEALTH 25, 26 (1999) [hereinafter *Moderate Drinking*]; WILLIAMS OBSTETRICS 210 (F. Gary Cunningham et al. eds., 22d ed. 2005).

⁸⁸ Joseph L. Jacobson & Sandra Jacobson, *Effects of Prenatal Alcohol Exposure on Child Development*, 26 ALCOHOL RES. & HEALTH 282 (2002) [hereinafter *Prenatal Alcohol Exposure*].

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Jacobson & Jacobson, *Moderate Drinking*, *supra* note 87, at 27.

⁹³ Jacobson & Jacobson, *Prenatal Alcohol Exposure*, *supra* note 88, at 285.

⁹⁴ Moderate alcohol use is defined as 7-14 drinks per week. Jacobson & Jacobson, *Moderate Drinking*, *supra* note 87, at 25 n.1.

⁹⁵ Jacobson & Jacobson, *Prenatal Alcohol Exposure*, *supra* note 88, at 282.

⁹⁶ *Id.*

⁹⁷ Jacobson & Jacobson, *Moderate Drinking*, *supra* note 87, at 26.

⁹⁸ *Id.* at 29. Research also suggests that prenatal alcohol and tobacco exposure may affect the development of the brain and predict adolescent alcohol and tobacco use more than family history of alcohol problems or smoking exposure. Lester et al., *supra* note 11, at 9.

b. Effect of Tobacco Use During Pregnancy

Tobacco use during pregnancy, like heavy alcohol use, has known teratogenic effects on the fetus and potential long-term consequences for child development.⁹⁹ Smoking is responsible for 20-30% of infants born with low-birth weight;¹⁰⁰ nicotine affects the fetus' nervous system and brain development independent of low birth weight.¹⁰¹ Prenatal nicotine exposure has been linked to sudden infant death syndrome, short and longer term behavioral problems and cognitive impairment, including effects on IQ.¹⁰²

Identification of tobacco-related consequences is important because of the high incidence of smoking among pregnant women who use illicit drugs¹⁰³ and because the mechanism by which nicotine affects the fetus is similar to that of cocaine.¹⁰⁴ Thus, untangling the effects of tobacco versus cocaine on an infant is difficult.¹⁰⁵ Dr. Deborah Frank's seminal review of the literature regarding the effects of in utero cocaine use on early child development concluded that "[m]any findings once thought to be specific effects 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."¹⁰⁶

c. Effects of Cocaine, Opiate and Marijuana Use During Pregnancy

Controlled studies of the effect of cocaine exposure in utero soundly discredit early scientific reports that portrayed these infants as "irreparably doomed and damaged."¹⁰⁷ In contrast to FAS, the Maternal Lifestyle Study found no evidence of a "clinically significant disorder or disease process"¹⁰⁸ related to cocaine exposure for one-month old infants.¹⁰⁹ Indeed, all

⁹⁹ WILLIAMS OBSTETRICS, *supra* note 87, at 354.

¹⁰⁰ Lester et al., *supra* note 11, at 6.

¹⁰¹ *Id.*

¹⁰² *Id.*; see also Deborah Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 J. AM. MED. ASS'N 1613, 1620-21 (2001).

¹⁰³ Bauer et al., *supra* note 81, at 491 & tbl.IV.

¹⁰⁴ Frank et al., *supra* note 102, at 1620-21.

¹⁰⁵ *Id.* at 1624.

¹⁰⁶ *Id.*

¹⁰⁷ Lester et al., *supra* note 11, at 7; Frank et al., *supra* note 102, at 1621-24. The early studies suffered from a number of methodological problems, including "using anecdotal data, failing to use control groups, inadequately controlling for other variables that could cause the same adverse effects, and identifying users and non-users with unreliable methods." Barry M. Lester et al., *Keeping Mothers and Their Infants Together: Barriers and Solutions*, 22 N.Y.U. REV. L. & SOC. CHANGE 425, 428 (1997) (citations omitted).

¹⁰⁸ Barry M. Lester et al., *The Maternal Lifestyle Study: Effects of Substance Exposure During Pregnancy on Neurodevelopmental Outcome in 1-Month-Old Infants*, 110 PEDIATRICS 1182, 1190 (2002) [hereinafter *Neurodevelopmental Outcome*].

¹⁰⁹ *Id.*

neurobehavioral effects that were identified in the study, such as poor self-regulation, were deemed “subtle,” meaning small.¹¹⁰ The study did identify “reliable but small differences attributable to drugs,”¹¹¹ but explained that these differences did not necessarily amount to deficits.¹¹² In other words, the commonly-held perception of cocaine-exposed infants as “blighted”¹¹³ is not based on fact.¹¹⁴

The Maternal Lifestyle Study research team has cautioned, however, that these children may have “neurobehavioral vulnerability that may be exacerbated by the care-giving environment,”¹¹⁵ which for many drug-exposed children is not optimal.¹¹⁶ Pregnant drug-dependent women who participate in drug treatment programs often have significant histories of emotional, physical and sexual abuse, mental health problems, and frequently live with others who have an alcohol or drug problem.¹¹⁷ Cocaine exposure is also found more frequently among children of poor women,¹¹⁸ which means that they face additional developmental risks associated with poverty, such as “low birth-weight,

¹¹⁰ *Id.*

¹¹¹ *Id.* As Lester explained, the Maternal Lifestyle Study “did find increased medical problems, however, the prevalence rates were low, raising issues as to the clinical significance of the findings.” Lester et al., *supra* note 11, at 10. The study found that the exposed infants were on average one week younger in gestational age, lower weight, and smaller in length and head circumference. They did not present gastrointestinal, genital-urinary and cardiac system abnormalities, as reported in other studies, but, when compared to non-cocaine/opiate exposed children, did present more central nervous system, respiratory and autonomic system “findings.” Charles R. Bauer et al., Abstract, *Maternal Lifestyle Study (MLS): The Effects of Substance Exposure During Pregnancy and Acute Infant Outcomes*, 39 PEDIATRIC RES. 257A (1996). The research team concluded that prenatal drug exposure had more impact on social rather than medical outcomes, citing data that demonstrated that drug-exposed infants were more frequently referred by hospitals to child protective services and identified as boarder babies. *Id.*

¹¹² Lester et al., *Neurodevelopmental Outcome*, *supra* note 108, at 1190.

¹¹³ Frank et al., *supra* note 102, at 1613.

¹¹⁴ Wendy Chavkin, *Cocaine and Pregnancy—Time to Look at the Evidence*, 285 J. AM. MED. ASS’N 1626, 1627 (2001). Researchers caution that prenatal cocaine use also may have latent effects that either cannot be evaluated or are not observable at infancy or early childhood, but could result in problematic behavior and cognitive problems as children age. Lester et al., *supra* note 11, at 8-9; *see also* Frank et al., *supra* note 102, at 1621.

¹¹⁵ Lester et al., *Neurodevelopmental Outcome*, *supra* note 108, at 1190. The postnatal caregiving environment includes factors such as socio-demographics, caregiving context and style, and caregiver characteristics. Lester et al., *supra* note 11, at 9.

¹¹⁶ Penelope L. Maza et al., *Maternal Lifestyles Study (MLS): Caretaking Environment and Stability of Substance-Exposed Infants at One Month Corrected Age*, 846 ANNALS N.Y. ACAD. SCI. 358, 359 (1998). The Maternal Lifestyle Study found higher levels of welfare dependence and unemployment and lower levels of education among mothers with drug-exposed infants as compared to mothers whose infants were not drug-exposed. *Id.* at 359-60 & tbl.2.

¹¹⁷ Wendy B. Kissin et al., *Characterizing Pregnant Drug-Dependent Women in Treatment and Their Children*, 21 J. SUBSTANCE ABUSE TREATMENT 27, 29-30 (2001); Lester et al., *supra* note 11, at 9 (citing research).

¹¹⁸ *See supra* note 83.

prematurity, malnutrition, anemia, pre- and post-natal lead poisoning, and congenital infections.”¹¹⁹

Longitudinal research suggests, however, that the caregiving environment, not cocaine exposure itself, is associated with developmental deficits that some children present at a young age.¹²⁰ The Maternal Lifestyle Study concluded that neither prenatal cocaine nor opiate exposure was associated with a child’s deficits in mental, psychomotor and behavioral development in children at ages one through three after controlling for low birth weight and environmental risks.¹²¹ The study found that at three years of age “infants who were exposed to illicit drugs did not show unique deficits with respect to their peers, [but] all infants in the sample were at risk of poor developmental outcomes.”¹²² All of the toddlers, regardless of whether they had been exposed to cocaine or not “had mean mental scores . . . 15 points below the standardized [Mental Development Index] mean of 100,”¹²³ placing them all in the delayed range.¹²⁴

The short and long-term effects of opiates and marijuana are also not clear cut based on existing research. Opiates, unlike cocaine, can create fetal dependence and will in some cases result in withdrawal symptoms that may interfere with bonding between the mother and infant.¹²⁵ Research indicates that the “quality of the postnatal environment” appears to be a more important determinant of developmental outcome than maternal opiate use, much like the studies of cocaine suggest.¹²⁶ The Maternal Lifestyle Study found that, by age

¹¹⁹ Barry Zuckerman & Deborah A. Frank, “Crack Kids:” *Not Broken*, 89 PEDIATRICS 337, 338 (1992) (citing a study by Chasnoff that found that, while cocaine-exposed infants who received comprehensive clinical interventions “do as well on global developmental scores as their social class-matched peers, both groups function below the national norms, reflecting the double jeopardy afflicting children living in poverty.”).

¹²⁰ Frank et al., *supra* note 102, at 1621.

¹²¹ Daniel S. Messinger et al., *The Maternal Lifestyle Study: Cognitive, Motor, and Behavioral Outcomes of Cocaine-Exposed and Opiate-Exposed Infants Through Three Years of Age*, 113 PEDIATRICS 1677, 1683 (2004). This study compared cocaine and/or opiate exposed infants (658 infants) with non-drug-exposed infants (730 infants) of the same gestational age, sex and race. *Id.* at 1678.

¹²² *Id.* at 1683. The study concluded that while cocaine use was associated with low birth weight, disruptions in maternal care, low socio-economic status and low maternal vocabulary scores, “[t]hese factors, rather than cocaine exposure, were associated with large deficits in mental development.” *Id.*

¹²³ *Id.*

¹²⁴ *Id.* at 1682.

¹²⁵ Lee N. Robins & James L. Mills, *Effects of In Utero Exposure to Street Drugs*, 83 (12 supplement) AM. J. PUB. HEALTH 8, 16-18, 27 (1993).

¹²⁶ Zuckerman & Frank, *supra* note 119, at 338. See Robins & Mills, *supra* note 125. Robins and Mills’ 1991 literature review regarding the long-term consequences of in utero drug exposure among children ages two to four compared with children of similar socioeconomic status, found: (1) drug-exposed children showed considerable catch-up in growth, resulting in “small or no long-term differences between drug-exposed children and control children;” (2) IQ and neurological development is not seriously affected, “although some mild disadvantage may be present;” and (3) “most of the differences [in social behaviors] observed at birth seem to disappear over time.” *Id.* at

three, low infant birth weight, low maternal vocabulary scores and low home environment scores, rather than opiate exposure, “were associated with substantial deficits in psychomotor performance and behavioral difficulties.”¹²⁷ Research related to marijuana exposure is also inconclusive. While some studies have identified growth retardation among infants exposed to marijuana in utero,¹²⁸ others find no “growth or neurobehavioral deficits in relation to prenatal marijuana use.”¹²⁹

The salience of the child’s postnatal environment interacting with the potential biological effects of drug use¹³⁰ on a child’s long-term development highlights the need for comprehensive medical, social, and educational services to help families prevent poor outcomes. Yet, to the extent factors independent of illicit drug use compromise child development, one must question whether CAPTA’s mandatory intervention by the child welfare system is the appropriate way to link families with these services. Certainly, the child welfare system must demonstrate its capacity to provide necessary services to justify such a harsh penalty. These issues are explored below.

B. CAPTA’s Failure to Apply the Science

The scientific research available at the time Congress enacted the physician-reporting provision suggests three fundamental flaws with this policy: its imposition of a harsh sanction that is not commensurate to the harm caused or the risks posed to children by illicit drug use relative to the harms caused by alcohol and tobacco exposure; its inability to prevent harm that may occur during pregnancy and its potential for discouraging effective prenatal care; and its reliance on the child welfare system which is ill-equipped to address the long-term developmental needs of children affected by maternal drug and alcohol use.

1. Intervention Mismatched with Harm to Child

If Congress adopted CAPTA to help children who have been harmed by maternal drug use, the science demonstrates that it should not have focused exclusively on illicit drug use, which results in fewer clinical symptoms than

18-19. The authors cautioned that the research left substantial gaps in knowledge on this issue. *Id.* at 20.

¹²⁷ Messinger et al., *supra* note 121, at 1683.

¹²⁸ Steven J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 CHILD MALTREATMENT 93, 96 (2000) (citing B. Zuckerman & E.R. Brown, *Maternal Substance Use and Infant Development*, in HANDBOOK OF INFANT MENTAL HEALTH 143-158 (Charles H. Zeanah ed., 1993)).

¹²⁹ Sandra W. Jacobson et al., *Validity of Maternal Report of Prenatal Alcohol, Cocaine, and Smoking in Relation to Neurobehavioral Outcome*, 109 PEDIATRICS 815, 823 (2002).

¹³⁰ Lester et al., *supra* note 11, at 9; Zuckerman & Frank, *supra* note 119, at 337 (explaining that “[t]he prenatal effects of drugs on the central nervous system may create biological vulnerability” for developmental dysfunction that may be “compensated partially or completely by the brain itself and/or by competent caretaking”). But poor caretaking and family instability may render the child more vulnerable to developmental problems. *Id.*

fetal alcohol or tobacco exposure.¹³¹ The legal nature of alcohol and tobacco, while an important distinction in a criminal context, has little relevance to the child welfare system's interest in addressing parental behavior that impairs a parent's ability to adequately care for her child. While it is not appropriate to "widen the net" where the intervention is ineffective or harmful to the family,¹³² it would be far more effective to apply to the illicit drug use context the health intervention that Congress has adopted for addressing serious prenatal alcohol use. Indeed, in 2000, Congress enacted public health legislation to address the needs of children affected by FAS¹³³ and adopted a comprehensive service delivery scheme for individuals diagnosed with FAS and their families.¹³⁴

Little justification exists for imposing punitive interventions based on illicit drug exposure if it presents no greater (and perhaps less) harm than alcohol or tobacco exposure¹³⁵ and does not appear to account for developmental problems that are presented by children living in poverty.¹³⁶ Brenda Smith and Mark Testa posit that a justification for opening a child protective services case would exist, even without evidence of harm directly related to in utero drug exposure, if "children in families with identified prenatal substance use face greater subsequent maltreatment risks than children with other types of allegations."¹³⁷

¹³¹ See discussion *supra* accompanying notes 87-106. As previously noted, *supra* note 31, the House-passed CAPTA provision would have required interventions for infant medical conditions resulting from maternal alcohol use disorders.

¹³² See discussion *infra* accompanying notes 178-185.

¹³³ Children's Health Act of 2000, Pub. L. No. 106-310, sec. 3110, §§ 519C and 519D, 114 Stat. 1101, 1183-86 (codified at 42 U.S.C. §§ 290bb-25c and 290bb-25d).

¹³⁴ 42 U.S.C. § 290bb-25c (2000). The legislation also called for the establishment of centers of excellence to study innovative techniques to prevent alcohol use by women of child-bearing age. 42 U.S.C.A. § 290bb-25d (2000). Since 1994, Congress has also funded efforts to provide comprehensive residential substance abuse treatment services for pregnant and postpartum women and their children (see 42 U.S.C. § 290bb-1 (2000)), but, as reflected in CAPTA, it has opted not to limit its intervention to this public health approach. The limited availability of specialized women's services (see *supra* note 50), certainly contributes to the lack of diagnosis of this problem. Telephone Interview with Dr. Wendy Chavkin, Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, in New York (July 7, 2006) (noting that public health principles discourage screening for any condition for which treatment does not exist).

¹³⁵ Peter D. Jacobson et al., *Reciprocal Obligations: Managing Policy Responses to Prenatal Substance Exposure*, 81 MILBANK Q. 475, 478-79 (2003) (recognizing that legal substances may cause more harm than illicit substances, "future policies should be based on the expected harm to the fetus, not on the type of substance"); Lester et al, *supra* note 11, at 11 (observing that, "if 'harm' to the fetus is no worse for cocaine than it is for legal substances such as tobacco and alcohol, should the same criminal and treatment policies apply for use of all these substances?").

¹³⁶ See discussion *supra* accompanying notes 107-129.

¹³⁷ Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 CHILD ABUSE & NEGLECT 97, 99 (2002); see also Ondersma et al., *supra* note 128, at 99 ("Those advocating for court involvement with drug-exposed infants must show that this response is based on clear evidence of unique environmental risk associated with illicit drug use in the home . . . and not on damage due to exposure alone.")

Their research, however, revealed no such effect.¹³⁸ Indeed, any justification must be balanced against the deterrent effect that such interventions have on women obtaining the optimal level of prenatal care, which, as discussed below, has the greatest likelihood of improving birth outcome and preventing state intervention.¹³⁹ By focusing on illicit drugs alone, CAPTA perpetuates the stigma and stereotypes that have “demonized some drugs and drug users”¹⁴⁰ and their children. While some may argue that increased stigma will deter women from using drugs during pregnancy,¹⁴¹ there is strong reason to believe that stigma has a negative effect on health care delivery. According to the Institute of Medicine, stigma reinforces an unwillingness among some health care providers to help women address their drug problems during prenatal care by prompting non-therapeutic attitudes among clinicians.¹⁴² From the patient’s perspective, most drug-using pregnant women do not need external state pressure to modify, if not cease, their unhealthy behavior to improve the health of their unborn

¹³⁸ Smith & Testa, *supra* note 137, at 110. Smith and Testa found that, among families entering the Cook County child welfare system based on a drug-exposed infant allegation, the rate of subsequent maltreatment allegations among mothers with a drug-exposed infant did not differ from those who entered the system based on other types of maltreatment allegations, absent a subsequent birth that also involved infant drug exposure. *Id.* at 106. The authors concluded that, “among open child welfare cases, a [substance-exposed infant] allegation may predict subsequent prenatal drug use, but it does not predict other types of maltreatment allegations.” *Id.* at 110.

¹³⁹ Chasnoff has observed that because physicians have a very low rate of interaction with families regarding substance abuse problems, legal alternatives are all that is left. Ira J. Chasnoff, *Silent Violence: Is Prevention A Moral Obligation?*, 102 PEDIATRICS 145, 146 (1998). See discussion *infra* accompanying notes 155-162.

¹⁴⁰ Frank et al., *supra* note 102, at 1621.

¹⁴¹ Some scholars posit that the level of stigma associated with social welfare programs will affect an individual’s personal behavior. Douglas Besharov has asserted, for example, that the destigmatization of welfare participation resulted in the swelling of welfare rolls between 1963 and 1973. Douglas J. Besharov & Peter Germanis, *Welfare Reform—Four Years Later, The Public Interest*, 17, 18 (Summer 2000). Robert Rector suggests that strong official disapproval of out-of-wedlock childbearing slowed the rate of out-of-wedlock births during the 1990’s. *Hearing to Review Outcomes of 1996 Welfare Reforms: Hearing Before the Comm. on Ways and Means*, 109th Cong. (2006), (Statement of Robert Rector) available at <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=488>. Whatever the merits of these arguments in the social welfare context, current theories of behavioral change in the addiction context reveal that increasing stigma does not have a therapeutic effect, particularly for women. See discussion *infra* accompanying notes 210, 214-218; and AMY PRICE & CASSANDRA SIMMEL, PARTNERS’ INFLUENCE ON WOMEN’S ADDICTION AND RECOVERY: THE CONNECTION BETWEEN SUBSTANCE ABUSE, TRAUMA, AND INTIMATE RELATIONSHIPS 7 (2002), available at <http://aia.berkeley.edu/media/pdf/partners.pdf> 7 (noting that women are more likely than men to feel guilt and shame related to drug use based on their “increased likelihood of involvement with child welfare authorities and on their self-hatred for their perceived failure as caregivers” and society’s “expectations about the image of the ideal mother”).

¹⁴² INSTITUTE OF MEDICINE, *supra* note 1, at 74 (stigma and stereotypes threaten the receipt of patient-centered care by “encouraging pessimistic and non-therapeutic attitudes and behaviors among clinicians, making them less likely to foster and support patients’ self-management efforts . . .”).

child.¹⁴³ But they do appear, however, to curtail participation in prenatal care based on a physician's negative attitude and threats to child custody.¹⁴⁴

2. Intervention: Too Late to Prevent Harm

The CAPTA provision is designed to prevent child maltreatment by intervening at the earliest point in an infant's life. Based on the science, a postpartum intervention is theoretically useful in assessing and potentially influencing the environment in which a child is raised.¹⁴⁵ Yet the science also suggests this solution is nothing short of "too little too late." Both the *timing* and the *nature* of the CAPTA intervention create distinct, but related, concerns.

The timing of the intervention is critical because women, including those with well-established drug histories, tend to decrease their drug and alcohol use during pregnancy but appear to return to higher levels of use postpartum.¹⁴⁶ Pregnant drug-dependent women adopt a range of "harm reduction"¹⁴⁷ practices in an effort to improve their health and protect their developing fetus.¹⁴⁸ Women in one study "[t]ypically . . . decreased drug consumption or switched to drugs

¹⁴³ See discussion *infra* accompanying notes 147-50.

¹⁴⁴ See discussion *infra* accompanying notes 168-70.

¹⁴⁵ See discussion *supra* accompanying notes 115-24.

¹⁴⁶ See, e.g., Lester et al., *Neurodevelopmental Outcome*, *supra* note 108, at 1185 (reporting that among 353 women who admitted using cocaine, the percentage that used cocaine daily decreased from 17% in the first trimester to 7% in the third; the percentage that used cocaine three or more days per week decreased from 15.9% in the first trimester to 9.2% in the third trimester). Sandra W. Jacobson et al., *supra* note 129, at 820-21 (reporting that a sample of 354 women participating in an inner-city hospital's prenatal clinic reduced alcohol use during pregnancy but reported higher levels of alcohol use at thirteen months postpartum); Kissin et al., *supra* note 117, at 33 (reporting that among a sample of 240 opiate and/or cocaine-dependent pregnant women who entered a comprehensive treatment program, women reduced alcohol and other illicit drug use prior to entering treatment, despite reporting a significant lifetime history of use, but "[c]linical impression indicates that many of the women relapse soon after giving birth."). The NSDUH data suggest this same fluctuating pattern of decreased drug and alcohol use during pregnancy with an increase in use post-partum. Whereas 10.6% of non-pregnant women report using illicit drugs, 4.3% of pregnant women and 8.5% of recent mothers who gave birth during the prior year did so. NSDUH: 2002 AND 2003 UPDATE, *supra* note 77, at 3. Patterns of binge drinking reveal that 24% of non-pregnant women engage in binge drinking compared with 4.1% of pregnant women and 15% of recent mothers. *Id.*

¹⁴⁷ "Harm reduction" is a public health approach to drug addiction that provides drug users with "information and assistance that can help them reduce drug consumption and minimize the risks associated with their continuing drug use." MURPHY & ROSENBAUM, *supra* note 41, at 100.

¹⁴⁸ See, e.g., MURPHY & ROSENBAUM, *supra* note 41, at 99 (study of 120 pregnant or postpartum women who used heroin, cocaine or methamphetamines during pregnancy and had, at some point, tried various drug treatment modalities); Martha A. Jessup et al., *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003) (a study of thirty-six pregnant women or recent mothers participating in residential treatment programs).

they believed were less dangerous . . .”¹⁴⁹ “[A]ll . . . believed that prenatal care was one of the most important means to improve fetal health.”¹⁵⁰ Thus, a delay in intervention misses a unique window of opportunity to provide health care that could lead to long-term behavioral change.¹⁵¹ As discussed in Part IV, appropriate brief interventions and comprehensive drug treatment can help women convert their reductions in alcohol and drug use during pregnancy into more permanent behavior after birth.¹⁵² But behavioral change is less likely to occur once the mother enters the child welfare system.¹⁵³

Moving up the time of intervention is of value, however, only to the extent the *nature* of the intervention involves health services, not child welfare surveillance.¹⁵⁴ Prenatal care, as opposed to child welfare interventions, can, in fact, *prevent* FAS and ARND¹⁵⁵ and the health problems caused by tobacco and illegal drug use.¹⁵⁶ Prenatal care also vastly improves the health of women—even those continuing to use drugs and alcohol during pregnancy—and their infants.¹⁵⁷ The National Institute of Child Health and Human Development concluded in the early 1990s that “[t]he only scientific information now available concerning the prevention of adverse drug effects during pregnancy is . . . the repeated observation that more prenatal care is associated with fewer difficulties . . .”¹⁵⁸ Prenatal care, if comprehensive and non-judgmental,¹⁵⁹ improves

¹⁴⁹ MURPHY & ROSENBAUM, *supra* note 41, at 74. Study participants who used crack, for example, would switch to marijuana or took time off from smoking crack. *Id.* at 83-84.

¹⁵⁰ *Id.* at 88.

¹⁵¹ See *infra* discussion accompanying notes 225-29.

¹⁵² See *infra* discussion accompanying notes 225-34.

¹⁵³ See *infra* discussion accompanying notes 235-39.

¹⁵⁴ Professor Elizabeth Bartholet has proposed a system that would combine prenatal health interventions with child welfare surveillance. Under her proposal, a universal, mandatory home visitation program would send health care workers into the homes of pregnant women to provide support and advice on pregnancy and parenting issues and identify and assist pregnant women in obtaining treatment for alcohol and drug problems. BARTHOLET, *supra* note 54, at 222. These health aids would also have a surveillance role, “alerting CPS and other appropriate authorities to substance abuse problems during pregnancy and early childhood and to help monitor compliance with any treatment requirements imposed by courts in conjunction with CPS intervention.” *Id.* Professor Bartholet acknowledges, but dismisses, the problems inherent in a model that combines support and surveillance functions and, as a mandatory program, “collide[s] head on with our tradition of family privacy and family autonomy.” *Id.* at 170.

¹⁵⁵ Lester et al., *supra* note 11, at 6; see also March of Dimes, Drinking Alcohol During Pregnancy (Quick Reference: Fact Sheets) (Aug. 2002), available at http://www.marchofdimes.com/professionals/681_1170.asp?link=alcohol.

¹⁵⁶ Lester et al., *supra* note 11, at 6; see also March of Dimes, Smoking During Pregnancy (Quick Reference: Fact Sheets) (Nov. 2004), available at http://www.marchofdimes.com/professionals/14332_1171.asp (noting that if all pregnant women stopped smoking, there would be an estimated 11% reduction in stillbirths and a 5% reduction in newborn deaths).

¹⁵⁷ Bauer et al., *supra* note 81, at 492-95.

¹⁵⁸ Robins & Mills, *supra* note 125, at 26.

outcomes because women receive treatment for infections and high blood pressure associated with drug use that might also harm the fetus. Caregivers can also connect women with social services, including nutritional assistance, and often persuade women to reduce or stop using drugs.¹⁶⁰ Research has demonstrated that medical complications commonly associated with cocaine use during pregnancy, like low birth weight, abruptio placentae, or preterm labor and delivery, are significantly reduced if a woman discontinues cocaine use by the third trimester.¹⁶¹ Beneficial results from prenatal care for women diagnosed with alcohol, marijuana, methamphetamine and prescription drug problems have also been documented in Kaiser Permanente's managed care clinical setting.¹⁶²

¹⁵⁹ Murphy and Rosenbaum suggest that the "most powerful harm-reduction strategy may be tolerant and compassionate care by practitioners with an understanding of drug users and their related life-style issues and the leeway to provide information and interventions appropriate to each patient's needs." MURPHY & ROSENBAUM, *supra* note 41, at 93.

¹⁶⁰ *Id.* at 16.

¹⁶¹ Chasnoff et al., *supra* note 3, at 757. Similarly, if alcohol use is detected early in pregnancy and a woman, including one who is chronically alcoholic, becomes alcohol free by the third trimester, the rate of fetal alcohol syndrome is significantly reduced. *Id.* See also Dace S. Svikis et al., *Cost-Effectiveness of Treatment for Drug-Abusing Pregnant Women*, 45 DRUG & ALCOHOL DEPENDENCE 105 (1997) (in a study that compared drug-dependent pregnant women who entered a comprehensive women's treatment program at a mean gestational age of 26.5 weeks and drug-dependent pregnant women who did not receive treatment, birth outcomes were dramatically improved among the treatment cohort. Infants from the treatment group had a gestational age of three weeks longer, a higher mean birth weight, and lower incidence of low birth weight. *Id.* at 108. These infants required neonatal intensive care unit (NICU) care at half the rate of the comparison group and, when admitted to the NICU, required care for significantly fewer days. *Id.* at 108-09 & tbl.3). See also Claire Brindis et al., *Options for Recovery: Promoting Perinatal Drug and Alcohol Recovery*, *Child Health and Family Stability*, 27 J. DRUG ISSUES 607, 617 (1997) (among 761 women who participated in comprehensive women's programs in seven California sites, women who entered treatment in the first or second trimester of pregnancy were more likely to deliver children who tested negative for drugs at birth than women who entered in third trimester or after delivery—77% negative tests versus 52% negative tests, respectively). Data from a national cross-site evaluation of federally-funded, gender-specific residential treatment programs for pregnant and postpartum women also found that among women who were in treatment for one to four months prior to giving birth, 4.7% had pre-term deliveries and 4.3% had babies with low birth weight; birth outcomes that were far better than the national population average in 1997 of 11.5% pre-term and 7.6% low birth weight infants. H. Westley Clark, *Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children: Treatment and Policy Implications*, 80 CHILD WELFARE 179, 188 (2001). An even smaller proportion of women had pre-term and low birth weight deliveries if they entered treatment more than four months prior to delivery. *Id.*

¹⁶² Mary Anne Armstrong et al., *Perinatal Substance Abuse Intervention in Obstetric Clinics Decreases Adverse Neonatal Outcomes*, 23 J. PERINATOLOGY 3, 5 tbl.1 (2003). The Kaiser Permanente Medical Care Program's Early Start program, an obstetric clinic-based perinatal substance abuse intervention program, found that the infants of women who received treatment had similar rates of low birth weight, preterm delivery, and need for assisted ventilation as women who were not diagnosed with a drug or alcohol problem and significantly lower rates in these areas than the newborns of women who needed but received no treatment. *Id.* at 7 tbl.3.

Congress' decision to intervene at the time of delivery may have been based on the conventional view that drug using women either avoid prenatal care or fail to disclose their drug use to their physicians.¹⁶³ Again, the research tells a different story. The Maternal Lifestyle Study found a remarkably high level of participation in prenatal care among women who used cocaine or opiates.¹⁶⁴ Over 77% of the drug-exposed women reported having one or more prenatal visits with a doctor or nurse, with the median number being seven visits.¹⁶⁵ The Kaiser Permanente study also found that pregnant women who were diagnosed and provided outpatient counseling for their drug or alcohol problem received a significantly higher median amount of prenatal care than both women who were identified with this condition, but received no treatment, and those who had no drug or alcohol problem at all.¹⁶⁶ Other studies of drug-dependent women who participated in treatment programs during pregnancy reveal not only a desire to participate in prenatal care but also a higher than expected level of participation.¹⁶⁷

It is the threat of child welfare interventions that may have the most detrimental effect on a woman's decision to access prenatal care delivery. Women who avoid or limit participation in prenatal care may do so because of negative experiences with health care providers who stigmatize and humiliate them for both using drugs and accessing health care "too late" in their pregnancy or because they fear disclosure of drug use to them would jeopardize custody of current children or the newborn.¹⁶⁸ Additional empirical research is clearly

¹⁶³ WILLIAMS OBSTETRICS, *supra* note 87, at 210 ("Often the mother who uses drugs does not seek prenatal care, and even if she does, she may not admit to the use of such substances.").

¹⁶⁴ This occurred even though mandatory child protective service reporting requirements were in place in two of the four study sites. Bauer et al., *supra* note 81, at 489.

¹⁶⁵ *Id.* at 492. Cocaine users participated in prenatal care far less than opiate users: 76% of cocaine-only users versus 94% of opiate-only users. *Id.* at 493. Ninety-seven percent (97%) of the non-exposed women reported participating in prenatal care with the median number of visits being eleven. *Id.* at 492. The research team concluded that this "higher-than-expected use of preventative services . . . and the increased frequency of medical monitoring, may have improved [the] health status of both mother and infant and may account, in part, for the overall low prevalence of serious complications observed." *Id.* at 495.

¹⁶⁶ Armstrong et al., *supra* note 162, at 5 tbl.1.

¹⁶⁷ Jessup's study of women in drug treatment also reported that, while the primary emotional state of the women was one of "fear and worry about loss of infant custody, arrest, prosecution and incarceration" if their drug use was revealed to health care workers, virtually all sought prenatal care to help themselves and their unborn child, and over 60% did so without being mandated. Jessup et al., *supra* note 148, at 291-92. Murphy and Rosenbaum found that over half the women in their study participated in prenatal care, albeit receiving less care than they would have liked. MURPHY & ROSENBAUM, *supra* note 41, at 89, 93.

¹⁶⁸ MURPHY & ROSENBAUM, *supra* note 41, at 88-99. An evaluation of five federally-funded demonstration projects that were implemented in the mid-1990s to link low-income pregnant substance abusers with prenatal care and substance abuse care found that, in some settings, doctors expressed a high level of anger and frustration with these patients. "Once physicians identified a pregnant substance-abusing woman, the relationship could quickly become strained. There especially was anger when a woman relapsed." Embry M. Howell & Ira J. Chasnoff, *Perinatal*

needed to evaluate how the stigma associated with a post-partum child welfare sanction affects both physician attitudes¹⁶⁹ and their patients' responses during the critical prenatal care period. Existing evidence, however, calls into question whether CAPTA's standard will effectively prevent abuse and neglect.¹⁷⁰ That determination will rest, in part, on the capacity of the child welfare system to protect children after birth and provide adequate services to families with alcohol and drug problems.

3. Inability of Child Welfare System to Address Real Needs

A third and fundamental assumption underlying the CAPTA standard is that the child welfare system is capable of intervening with appropriate services to aid the mother and her infant. If a child welfare referral can address what research suggests will influence the child's long-term development much more than the prenatal exposure to illicit drugs—the availability of early and consistent interventions to strengthen the care-giving environment, address potential cognitive and behavioral problems, and enhance resiliency—then the policy is certainly warranted.¹⁷¹ Unfortunately, the child welfare system has a dismal record of providing appropriate services to children who have been placed in kinship care or foster care and fails to provide adequate family preservation services to improve the home environment, which is often affected by poverty.

Data on the outcome of CPS referrals for infants exposed to prenatal drug use is extremely limited, but the profile that emerges does not support Congress' reliance on this institution to safeguard children. The Maternal Lifestyle Study found, for example, that 42% of the drug-exposed infants were reported to child protective services at birth, with reporting rates varying dramatically based on state reporting requirements.¹⁷² Eighteen percent of the infants were placed in out-of-home custody at birth and, by one-month of age, only 13% of these children had been reunited with their mother.¹⁷³ Of the other children, 41% were in non-relative foster care, 32% were in kinship care and 14% were in some other living arrangement.¹⁷⁴ A study that examined the custody status of infants who were born drug-exposed and referred to the Los Angeles County department of social services found that two-thirds of these cases remained open two years after the referral compared to slightly more than one-half of the cases that did not

Substance Abuse Treatment: Findings from Focus Groups with Clients and Providers, 17 J. SUBSTANCE ABUSE TREATMENT 139, 145 (1999). Jessup also observed that “threatening statements [from health care providers about custody outcomes resulting from positive drug tests] served to increase women’s ambivalence and fear about participating in care.” Jessup et al., *supra* note 148, at 293.

¹⁶⁹ See discussion *supra* accompanying notes 140-42.

¹⁷⁰ ACOG Ethics Opinion No. 294, *supra* note 1, at 1022-23.

¹⁷¹ See *supra* discussion accompanying notes 120-24, 126.

¹⁷² Maza et al., *supra* note 116, at 359.

¹⁷³ *Id.* It is unclear whether these families remained under CPS supervision.

¹⁷⁴ *Id.* at 359, tbl.1.

involve drug exposure.¹⁷⁵ African-American mothers of drug-exposed children were far more likely than white women to have their children remain in child welfare custody (72% versus 52%) two years out.¹⁷⁶ In general, children from families with substance abuse problems fare much worse than other children in the child welfare system: they are much more likely to be placed in foster care than served in the home; they spend longer periods of time in foster care; and they are less likely to leave foster care within a year.¹⁷⁷

Infants in out-of-home placements not only experience the harm associated with separation from their mothers¹⁷⁸ but also receive inadequate services.¹⁷⁹ Children who are placed in kinship care do not generally receive enhanced services.¹⁸⁰ Placement in a non-relative foster care setting, which in some situations is no better and often worse than the home environment,¹⁸¹ is likely to expose a child to multiple placements with inadequate support.¹⁸² Although child welfare agencies are required by federal law to provide family preservation services,¹⁸³ these services are inadequately funded, are of short duration, and are not responsive to the multiple needs of individuals with alcohol and drug

¹⁷⁵ Lewis et al., *supra* note 5, at 81 (study of 1035 drug-exposed infants compared with 203 non-drug-exposed infants who were referred during the period July 1989 to March 1991).

¹⁷⁶ *Id.* at 85.

¹⁷⁷ U.S. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 52. See also CASA, NO SAFE HAVEN, *supra* note 23, at 37 (citing study that found that 62.5% of children of parents with drug problems were in foster care four years after entry compared to 46.6% of children whose parents did not have a drug problem).

¹⁷⁸ CASA, NO SAFE HAVEN, *supra* note 23, at 22.

¹⁷⁹ Even proponents of increased CPS involvement, such as Professor Bartholet, acknowledge the failure of the child welfare system to provide adequate and effective services. BARTHOLET, *supra* note 54, at 102. The value in CPS interventions with drug and alcohol dependent children, according to Professor Bartholet, is that children cannot wait for parents to address their drug dependence and should be freed-up for adoption as early in their lives as possible. *Id.* at 216-17, 226-27.

¹⁸⁰ Deborah A. Frank et al., *Level of Prenatal Cocaine Exposure & Scores on the Bayley Scales of Infant Development: Modifying Effects of Caregiver, Early Intervention, and Birth Weight*, 110 PEDIATRICS 1143, 1150 (2002) (describing developmental differences that appear in children up to age twenty-four months who have been raised in different settings); Lester et al., *supra* note 11, at 18; and DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 24-25 (2002). Professor Roberts reports that "[b]lack children in kinship care receive fewer services than do children in nonrelative foster care Caseworkers have less contact with relatives and the children in their care and are less likely to offer them services." *Id.* at 24. Most alarming for infants who have been exposed to drug and alcohol use is that children in kinship care receive inferior health care. *Id.* at 25.

¹⁸¹ Kurt Mundorff, *Children as Chattel: Invoking the Thirteenth Amendment to Reform Child Welfare*, 1 CARDOZO PUB. L. POL'Y & ETHICS J. 131, 149-50 (2003) (citing research regarding the harm associated with living in foster care, including higher rates of sexual and physical abuse and death than the general population, and the lasting legacy of foster care placement resulting in poorer outcomes in education and employment and access to healthcare).

¹⁸² See Lester et al., *supra* note 11, at 18.

¹⁸³ 42 U.S.C. § 629a-629e (2000 & Supp. III 2003); 42 U.S.C. § 671(a)(15)(B) (2000).

problems who frequently live in poverty.¹⁸⁴ The chronic lack of drug treatment remains a significant barrier to family reunification, according to child welfare agencies across the country.¹⁸⁵

Thus, Congress's justification for requiring referrals to CPS—to prevent future harm and ensure a child's healthy development—is not supported in practice. While a CPS referral will be necessary to protect the health and safety of some children, it will not effectively link many to health care and intensive child development services that will be essential for their development. Moreover, as discussed in Part IV, a drug-dependent mother's ability to achieve sobriety while under the supervision of the child welfare system is quite difficult. The child welfare system's focus on child rescue and expedited permanency planning dictated by the Adoption and Safe Families Act and its reliance on coerced treatment do not create the non-judgmental environment that is necessary for intentional behavioral change to occur.

IV. COERCION AND BEHAVIOR CHANGE AMONG PREGNANT AND POSTPARTUM WOMEN

If CAPTA's requirement fails the tests of science and services, will the physician reporting requirement serve some other important purpose? The most commonly asserted justification for mandating CPS intervention is that women who use drugs during pregnancy need external legal coercion¹⁸⁶ to change their

¹⁸⁴ Roberts, *supra* note 180, at 135-38.

¹⁸⁵ CORNELIA M. ASHBY, U.S. GENERAL ACCOUNTING OFFICE, FOSTER CARE: STATES FOCUSING ON FINDING PERMANENT HOMES FOR CHILDREN, BUT LONG-STANDING BARRIERS REMAIN 21, n.36 (2003), available at <http://www.gao.gov/new.items/d03626t.pdf> (noting that in a 2002 survey, thirty-three out of forty-six states reported that adequate treatment services did not exist for parents whose children were in foster care, and twenty-six reported that the lack of treatment "represented either a moderate, great, or very great hindrance to finding permanent homes for children"). A federal government study of the provision of treatment services to parents with substance abuse problems who had open child welfare cases in 1994 found that approximately half the parents received treatment services; 23% were offered, but not provided, treatment; and 23% were not offered treatment. U.S. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 53.

¹⁸⁶ The term "coercion" refers to an individual's "loss of control over decisions [she] would like to make for [herself] through threats, pressure, persuasion, manipulation, or deception on the part of another." Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1145 (1997). William Miller and Stephen Rollnick state that "[a] sense of coercion arises when a person is pressured to change behavior because it is discrepant with *someone else's* goals or values." WILLIAM R. MILLER & STEPHEN ROLLNICK, MOTIVATIONAL INTERVIEWING: PREPARING PEOPLE FOR CHANGE 39 (2d ed. 2002). Among the numerous sources of external coercion are non-legal mandates, including psychological, financial, social, familial, and medical considerations, as well as legal mandates. Douglas B. Marlowe et al., *Assessment of Coercive and Noncoercive Pressures to Enter Drug Abuse Treatment*, 42 DRUG & ALCOHOL DEPENDENCE 77, 81 (1996). Marlowe's research suggests that "legal pressures may exert substantially less influence over drug treatment entry than do informal, extra-legal influences . . ." *Id.*

behavior¹⁸⁷ and to provide a safe care-giving environment.¹⁸⁸ Avoidance of or inadequate prenatal care by some women—albeit a response to the threat some perceive from a physician reporting requirement—and continued drug use is deemed evidence that a woman will not “voluntarily” enter or remain in treatment long enough to address her addiction and, as a result, will be unfit for unsupervised parenting.¹⁸⁹ CPS involvement and the threat of the loss of custody is a significant “consequence” that commentators believe will motivate behavior change, especially in young women who have not previously experienced adverse consequences from their drug or alcohol use.¹⁹⁰ Thus, coercion is imposed to aid treatment and protect children.¹⁹¹

Proponents of coercion rely on research and clinical experience that suggest that few individuals enter treatment without some type of external pressure, whether legal or extra-legal.¹⁹² They also cite to studies primarily in the criminal justice context that find that criminal offenders who are “coerced” into treatment¹⁹³ remain in treatment longer¹⁹⁴ than individuals who enter

¹⁸⁷ Representative Greenwood expressed this sentiment in noting that CPS’s role is to “find out how [parents] intend to overcome their own personal issues so that they can be prepared to nurture this vulnerable child.” 149 CONG. REC. H1511 (daily ed. Apr. 23, 2002) (statement of Rep. Greenwood). See *supra* discussion accompanying note 44.

¹⁸⁸ BARTHOLET, *supra* note 54, at 227. See also INSTITUTE OF MEDICINE, *supra* note 1, at 94 (“coercion [is] intended to compensate for poor decision making, compulsive behavior, or a risk of danger to oneself or others.”).

¹⁸⁹ SALLY L. SATEL, DRUG TREATMENT: THE CASE FOR COERCION 42 (1999). Dr. Satel, a proponent of coerced treatment, explains that “[t]he reasonable assumption has been that a pregnant woman who cannot bring herself to stop abusing drugs or alcohol—either directly, or through self-imposed ‘cold turkey’ withdrawal, or through treatment—is either so profoundly physiologically addicted that she is not competent to protect her unborn child or, if not physiologically addicted, so irresponsible as to be unfit for unsupervised parenthood.” *Id.* See also BARTHOLET, *supra* note 54, at 231. Professor Bartholet asserts that “increasing treatment opportunities, without an interventionist program would [not] provide the protection children need. . . . Most [parents with alcohol and drug problems] don’t pursue treatment when it is available . . . [a]nd most who do pursue treatment initially eventually drop out.” *Id.*

¹⁹⁰ See discussion *infra* accompanying note 192.

¹⁹¹ Professor Bartholet maintains that few individuals with substance abuse problems can function well enough to meet the “special needs of drug-exposed infants.” BARTHOLET, *supra* note 54, at 227.

¹⁹² Douglas L. Polcin & Constance Weisner, *Factors Associated with Coercion in Entering Treatment for Alcohol Problems*, 54 DRUG & ALCOHOL DEPENDENCE 63 (1999); and David Farabee et al., *The Effectiveness of Coerced Treatment for Drug-Abuse Offenders*, FED. PROBATION, June 1998, at 3, available at <http://www.uscourts.gov/fedprob/1998june.pdf>.

¹⁹³ Researchers warn that the term “coerced treatment” has been used inconsistently in criminal justice research and encompasses a wide range of options from simply “being involved” in the criminal justice system, to being “referred” to treatment by probation, to being given the “choice” of treatment or jail by a judge, or to being “mandated” to treatment as a condition of probation. Farabee et al., *supra* note 192, at 3. In addition, the individual whose behavior is being influenced may perceive legal or other pressure to enter treatment as “non-coercive” and, thus, respond to the intervention as one who participates voluntarily. *Id.* at 6. See also Winick, *supra* note 186, at 1146

“voluntarily,” and have comparable treatment outcomes.¹⁹⁵ At the same time, two decades of research on the process by which individuals change addictive behavior¹⁹⁶ and the essential role of internal motivation¹⁹⁷ in that process

(describing the perception of coercion among patients with mental illness who are involuntarily committed to psychiatric hospitals).

¹⁹⁴ Treatment retention is critical because treatment success has been linked consistently to the length of time one remains in treatment. NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE 16 (1999), available at <http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf>. Participation in outpatient or residential treatment for less than ninety days has been found to be of limited or no effectiveness, and, for individuals in methadone treatment, a minimum of twelve months of treatment is required. *Id.* Indeed, research demonstrates that, “like other chronic illnesses, the effects of drug dependence treatment are optimized when patients remain in continuing care and monitoring,” such as long-term methadone maintenance programs and continued participating in AA or other support groups. A. Thomas McLellan et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 J. AM. MED. ASS'N 1689, 1694 (2000). Length of stay in treatment is also predictive of abstinence among women (including pregnant and postpartum women) six months after completing long-term residential treatment programs. Three different national-level studies found that 71% of women who stayed in treatment for more than six months were abstinent six months after completing treatment. Lower levels of abstinence were found among women with shorter lengths of stay: 30% to 50% of women who remained in treatment from one to three months were abstinent, and 40% to 60% who remained in treatment from four to six months were abstinent. CALIBER ASSOC., RWC/PPW CROSS-SITE EVALUATION: FACTORS AFFECTING POST-TREATMENT ABSTINENCE 2 (2001), available at <http://womenandchildren.treatment.org/media/factsheets/doc/factsheet15.doc>.

¹⁹⁵ SATEL, *supra* note 189, at 2-3; and NAT'L INST. ON DRUG ABUSE, *supra* note 194, at 19. These findings are not uniformly established by the research. Farabee's review of eleven studies of coerced treatment for criminal offenders in different treatment modalities concludes that five found a positive relationship between criminal justice referral and treatment outcomes, four reported no difference and two reported a negative relationship. Farabee et al. *supra* note 192, at 5. See also Robert H. Nishimoto & Amelia C. Roberts, *Coercion and Drug Treatment for Postpartum Women*, 27 AM. J. DRUG & ALCOHOL ABUSE 161, 163 (2001) (summarizing the studies that find mixed results in treatment retention and program completion); INST. OF MED., *supra* note 1, at 98 (noting that a review of longitudinal studies concluded “that compulsory treatment (legal, formal, informal, and mixed), generally achieved better treatment retention, but no reduction in substance use or criminal behavior.”).

¹⁹⁶ Dr. James Prochaska and Dr. Carlo DiClemente have developed the Transtheoretical Model of intentional behavior change. CARLO C. DICLEMENTE, ADDICTION AND CHANGE: HOW ADDICTIONS DEVELOP AND ADDICTED PEOPLE RECOVER, at viii (2003) The model, commonly identified as the “stages of change,” has evolved from more than twenty years of research that began with an examination of how smokers overcome their addiction to nicotine. *Id.* at 22-23. The model has been applied to alcohol and drug addictions and has become an accepted paradigm for understanding the “common pathway involved whenever an individual moves through an intentional change process.” *Id.* at 23. The Substance Abuse and Mental Health Services Administration (SAMHSA) has relied on the “stages of change” model in its Treatment Improvement Protocols, best practice guidelines for the treatment of alcoholism and drug dependence. See, e.g., WILLIAM R. MILLER, U.S. DEP'T OF HEALTH & HUMAN SERVS., ENHANCING MOTIVATION FOR CHANGE IN SUBSTANCE ABUSE TREATMENT, at xvi and 15-19 (1999); BARRY, *supra* note 73, at 14-15.

demonstrates the limitations of “coercion” in achieving long-term successful outcomes. As one study observed, the role of coercion is “to influence entry into treatment,” but “stable recovery cannot be maintained by external (legal) pressures only; motivation and commitment must come from internal pressure.”¹⁹⁸ A brief exploration of the complex concept of behavior change suggests that CAPTA’s reliance on legal coercion through postpartum CPS reporting misses the opportunity to build on a woman’s motivation to change her behavior during pregnancy and may fail as a “surveillance” mechanism postpartum to help women achieve stable recovery.

A. The Transtheoretical Model of Intentional Behavior Change

Intentional behavioral change, according to Dr. James Prochaska and Dr. Carlo DiClemente, follows a predictable progression through five stages: precontemplation, contemplation, preparation, action and maintenance.¹⁹⁹ An individual moves from having no interest in changing addictive behavior (precontemplation) to recognizing the problem (contemplation) to taking steps to change that behavior (preparation and action).²⁰⁰ Individuals with alcohol or drug problems must, on their own or with the assistance of counselors, medical professionals, or peers, undertake specific cognitive tasks that will move them from one stage to the next to achieve behavioral change.²⁰¹ The movement through the various stages is more cyclical and halting than linear, with individuals getting stuck, often for long periods, at particular points and moving back to previous stages.²⁰² External interventions can help individuals move

¹⁹⁷ D. Dwayne Simpson & George W. Joe, *Motivation as a Predictor of Early Dropout from Drug Abuse Treatment*, 30 PSYCHOTHERAPY 357, 357-58 (1993) (setting out research on the role of motivation in treatment); Quansheng Shen et al., *Client’s Perceived Need for Treatment and Its Impact on Outcome*, 21 SUBSTANCE ABUSE 179, 179-80 (2000); MILLER & ROLLNICK, *supra* note 186, at 18-19, 22-24.

¹⁹⁸ Farabee et al., *supra* note 192, at 7 (quoting Carl G. Leukefeld & Frank M. Tims, *Compulsory Treatment: A Review of Findings*, in NAT’L INST. ON DRUG ABUSE, COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE 236, 243 (C.G. Leukefeld & F. M. Tims eds., 1988)). Proponents of coerced treatment acknowledge that, without the patient’s internal commitment to changing their behavior, coercion alone will not do the job. SATEL, *supra* note 189, at 8-9.

¹⁹⁹ DICLEMENTE, *supra* note 196, at 26-30. According to DiClemente, one progresses through these same stages in *acquiring* an addiction. *Id.* at 44-57. It is important to note that the transtheoretical model of intentional behavior change is one among many models that describe how individuals change their behavior. See MILLER & ROLLNICK, *supra* note 186, at 25-26 (comparing behavioral change approaches that rely on extrinsic means to reinforce one kind of behavior and discourage another with an internal motivation approach that recognizes that change occurs only if it is in the person’s inherent interest). The transtheoretical model is useful here because it has been applied widely to address addictive behavior and it sets out general principles that are consistent with a patient-centered system of care, in which the individual, even if pressured through external means to enter treatment initially, controls her recovery process. See DICLEMENTE, *supra* note 196 at 26.

²⁰⁰ DICLEMENTE, *supra* note 196, at 26-29.

²⁰¹ *Id.* at 23-24.

²⁰² *Id.* at 30.

through the stages, but they must be geared to the individual's place on the continuum—stage status—to avoid treatment resistance or noncompliance.²⁰³

Research indicates that the “stages of change” model applies to women who have chronic drug addictions accompanied by physical and mental health problems, and domestic violence concerns and is “useful in predicting the clients who actually enter drug treatment.”²⁰⁴ A brief (and simplified) examination of the discrete stages and the value of coercion in this process is needed to evaluate whether postpartum CPS reporting will promote or inhibit the behavior change that pregnant and postpartum women with addictions must undertake.

Individuals in the first stage, precontemplation, are satisfied with or unwilling to change their behavior and are not considering changing it in the foreseeable future.²⁰⁵ The essential task for one to move from precontemplation to contemplation is to become aware of and concerned about the harmful pattern of behavior and the possibility of changing the behavior.²⁰⁶ External legal or other coercion, such as loss of custody, can heighten awareness of the consequences of one's addictive behavior and is, therefore, embraced by many policy makers and others to motivate persons who seem resistant to change.²⁰⁷ But adverse consequences are not, according to DiClemente, “the magic that

²⁰³ BARRY, *supra* note 73, at 14. DiClemente provides the example of court-mandated referrals for treatment which impose an action-oriented task without evaluating whether the offender is in fact ready to change his behavior. “Because all that really can be mandated is the offender's presence at a mandatory number of sessions or events, mandating treatment often produces attendance at treatment sessions but not always effective, intentional change.” DICLEMENTE, *supra* note 196, at 246.

²⁰⁴ Vivian B. Brown et al., *Women's Steps of Change and Entry Into Drug Abuse Treatment: A Multidimensional Stages of Change Model*, 18 J. SUBSTANCE ABUSE TREATMENT 231, 237 (2000). A study of 451 women regarding their readiness to seek help for physical violence, high risk sexual behavior, drug use and emotional problems concluded that women with multiple needs may be ready to change some, but not other, behaviors, and they enter treatment modalities that most appropriately address their most immediate needs. *Id.* at 238.

²⁰⁵ DICLEMENTE, *supra* note 196, at 26.

²⁰⁶ *Id.* at 26-27 & tbl. 2.2.

²⁰⁷ *Id.* at 121. DiClemente explains that consequences can provide “instructive moments and promote consideration of change,” but they do not teach everyone. *Id.* at 122-23. “Often multiple consequences simply reinforce a sense of hopelessness and helplessness to change. In some cases, severe consequences actually contribute to increasing the engagement in the addictive behavior in an effort to relieve the stress or in an indirect and suicidal attempt to stop the pain.” *Id.* Murphy and Rosenbaum's study provides evidence that a mother's loss of child custody at her child's birth can lead to drug use and repeat pregnancies. The universal response of women who lost custody of their infant “was to go on an extended drug-using binge to dim their memories and drown their sorrows . . . These women lost not only their children but yet another opportunity to inhabit a positive and productive social role . . . [G]etting pregnant again and again while trying each time to become a ‘good’ mother became one available lifeline.” MURPHY & ROSENBAUM, *supra* note 41, at 128-29. See also Valerie Raskin, *Maternal Bereavement in the Perinatal Substance Abuser*, 9 J. SUBSTANCE ABUSE TREATMENT 149, 152 (1992) (suggesting that maternal bereavement over involuntary loss of child custody because of drug use could result in repeated pregnancies to cope with loss).

necessarily or automatically motivates consideration of change or moves the precontemplator forward in the process of change.”²⁰⁸ Instead, the individual’s internal processes are the key to change: the individual must see the problem, perceive the risks, experience the consequences and see the potential for change.²⁰⁹ This awareness is more likely to occur, according to the research on motivation for behavioral change, if one is approached with “empathy, understanding and objective feedback” that provides an opportunity to recognize the problems that result from addictive behavior.²¹⁰

In the second stage, contemplation, the individual examines her current behavior and the potential for change. The task at this stage is to evaluate the pros and cons of the current behavior and the potential new behavior and weigh the merits of each. The individual will struggle with ambivalence over abandoning one behavior that has served an important purpose in her life and adopting a new behavior.²¹¹ When the “decisional balance” tips in favor of change, the individual has moved from contemplation to preparation.²¹² As with the precontemplation stage, external confrontation does not generally produce successful long-term change unless the “external motivation influences the internal motivation and the processes of consciousness raising and self-reevaluation.”²¹³

²⁰⁸ DICLEMENTE, *supra* note 196, at 122. Miller and Rollnick confirm that change is not motivated by “just mak[ing] people feel bad enough.” MILLER & ROLLNICK, *supra* note 186, at 11. “Humiliation, shame, guilt and angst are not the primary engines of change. Ironically, such experiences can even immobilize the person, rendering change more remote.” *Id.* at 12.

²⁰⁹ DICLEMENTE, *supra* note 196, at 125. Miller and Rollnick have similarly concluded that “constructive behavior change seems to arise when the person connects it with something of intrinsic value, something important, something cherished. Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued.” MILLER & ROLLNICK, *supra* note 186, at 12.

²¹⁰ DICLEMENTE, *supra* note 196, at 123-25. This approach parallels Miller and Rollnick’s motivational interviewing model (Carlo C. DiClemente & Mary Marden Velasquez, *Motivational Interviewing and the Stages of Change*, in MILLER & ROLLNICK, *supra* note 186, at 201, 202-03), which is defined as “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” MILLER & ROLLNICK, *supra* note 186, at 25. Motivational interviewing has prompted the development of brief interventions that can be used effectively at each stage of the process to motivate particular behavioral changes. BARRY, *supra* note 73, at 14. As discussed in Part I, ACOG has advised obstetricians to use brief interventions to address alcohol and drug problems among their patients. *See supra* discussion accompanying notes 71-75.

²¹¹ DICLEMENTE, *supra* note 196, at 142-45. Brown provides an example of the important role drug use plays for a woman whose partner uses drugs and is physically abusive. A woman who is battered has an immediate need to stop the battering and, thus, believes her drug use is keeping her “safer” because her partner wants her to use drugs with him. Brown et al., *supra* note 204, at 238.

²¹² DICLEMENTE, *supra* note 196, at 28.

²¹³ *Id.* at 147.

The preparation stage involves making a commitment to invest the time and energy to change the behavior and to develop a plan of action.²¹⁴ A key element in the preparation stage is the individual's assessment of her ability to accomplish the desired change—self-efficacy.²¹⁵ The evaluation shifts from the question in contemplation of “should I or shouldn't I” to an evaluation of one's ability to carry out the change—“can I or can't I.”²¹⁶ People have little incentive to act unless they believe that they can “produce desired events through their actions.”²¹⁷ Coercion, by its very nature, undermines an individual's autonomy and can create a disempowering atmosphere that dashes one's internal confidence in her capacity “to cope with obstacles and to succeed in change.”²¹⁸

The implementation of the plan represents the action stage. The individual's tasks in this stage involve stopping the old behavior, adopting a new behavior pattern and sustaining the new behavior in the face of challenges over a three to six month period.²¹⁹ Once the new behavior pattern “is established in the routine of the individual,” and becomes integrated into her lifestyle, she moves into the maintenance stage.²²⁰ At this point in the change process, the individual must sustain the change over time and when confronted with situations that may be associated formerly with drug use, and must also avoid temporary resumption of drug use (a slip or lapse) and relapse to the old behavior.²²¹ According to DiClemente, “the new behavior becomes fully maintained only when there is little or no energy or effort needed to continue it”²²² At this point, the new behavior becomes the “status quo” and the individual returns to the precontemplation stage, having “little or no desire or intention to change.”²²³

B. Application of Behavioral Change Model to CAPTA Requirement

1. Behavior Change During Pregnancy

The research set out in Part III certainly suggests that most pregnant drug-dependent women are acutely aware of the problems that alcohol and drug use can pose to their unborn child, have developed a plan—albeit incomplete—to take action, and have begun to modify their drug use in connection with or

²¹⁴ *Id.* at 28.

²¹⁵ *Id.* at 165, 166 tbl.8.3; MILLER & ROLLNICK, *supra* note 186, at 40–41 (noting that self-efficacy is a key element in motivation for change. If an individual “perceives no hope or possibility for change, . . . no effort will be made . . .”).

²¹⁶ DVD: Motivational Interviewing Professional Training (Univ. of N.M. Dep't of Psychology 1998) (on file with author).

²¹⁷ INSTITUTE OF MEDICINE, *supra* note 1, at 75.

²¹⁸ MILLER & ROLLNICK, *supra* note 186, at 41; *see also id.* at 12 (noting that motivation for change arises in an “empowering atmosphere”).

²¹⁹ DICLEMENTE, *supra* note 196, at 29.

²²⁰ *Id.*

²²¹ *Id.* at 27 tbl.2.2.

²²² *Id.* at 29.

²²³ *Id.* at 29.

independent of formal treatment.²²⁴ Thus, a public policy that encourages non-judgmental intervention during pregnancy and is directed at the particular woman's stage status would help her move forward with the change process that she has already commenced.²²⁵ Assistance can be directed at helping a woman develop a plan that will be effective for her unique situation and, if necessary, determine the sequence for addressing the multiple environmental, family, and health problems confronting many drug-dependent pregnant women.²²⁶ If a woman is ready to enter treatment, assistance in locating appropriate treatment, including residential treatment,²²⁷ and addressing potential barriers to participation (child care, housing or transportation) is essential to minimize interference with the change process.²²⁸ According to DiClemente, adequate public funding for the range of treatment services that persons need would "most seriously impact individuals in the Preparation and Action stages of change."²²⁹

For pregnant women who may not be contemplating behavioral change, brief interventions²³⁰ and motivational interviewing during routine obstetric care have been found to be effective in helping women reduce their alcohol consumption during pregnancy and postpartum.²³¹ One study of drug-dependent

²²⁴ See discussion *supra* accompanying notes 146-150. See also Bridget L. Perry et al., *Assessing Maternal Perceptions of Harmful Effects of Drug Use During Pregnancy*, 22 J. ADDICTIVE DISEASES 1, 2, 6-7 (2003) (citing research that level of knowledge about harmful effects of alcohol and tobacco use during pregnancy is an important factor in behavior change and concluding that refusal to enter treatment for illicit drug use during pregnancy may be related to a lack of awareness about potential adverse consequences of drug use for baby).

²²⁵ Grace Chang et al., *A Brief Intervention for Prenatal Alcohol Use: An In-Depth Look*, 18 J. SUBSTANCE ABUSE TREATMENT 365 (2000).

²²⁶ DiCLEMENTE, *supra* note 196, at 157, 163.

²²⁷ See Brown et al., *supra* note 204, at 236, 237-38 (explaining that women who are in abusive relationships were more likely to enter residential treatment, which removed them from the dangerous environment).

²²⁸ DiCLEMENTE, *supra* note 196, at 248. See Deborah L. Haller et al., *Perinatal Substance Abusers: Factors Influencing Treatment Retention*, 14 J. SUBSTANCE ABUSE TREATMENT 513, 517-18 (1997) (in a study of sixty-five pregnant and postpartum poly-drug abusing women, provision of housing in connection with an intensive outpatient program was a critical factor in retention of pregnant women in treatment).

²²⁹ DiCLEMENTE, *supra* note 196, at 248.

²³⁰ For a description of a brief intervention in connection with prenatal care, see Chang et al., *supra* note 225, at 366.

²³¹ Chang et al., *Brief Intervention for Prenatal Alcohol Use: A Randomized Trial*, 105 OBSTETRICS & GYNECOLOGY 991, 996 (2005) (in a study of 304 pregnant women, brief intervention was more effective in reducing frequency of alcohol use than diagnostic interview alone and was more effective among women who were drinking more often at time of intervention); Chang et al., *supra* note 225, at 367-68 (brief intervention that focused on identifying drinking goals during pregnancy and alternatives to drinking resulted in reduction or abstinence among women who set a goal of abstinence); Nancy Sheehy Handmaker & Paula Wilbourne, *Motivational Interventions in Prenatal Clinics*, 25 ALCOHOL RES. & HEALTH 219, 220-21 (2001), available at <http://pubs.niaaa.nih.gov/publications/arh25-3/219-229.pdf> (reporting findings of study on brief intervention that found that intervention in first pregnancy with booster session in subsequent

pregnant women with significant psychosocial needs similarly found improvement as a result of motivational interviewing, but also identified the need to provide intensive services, including drug treatment, to be most effective.²³² The addition of case management services in conjunction with motivational interviewing enhanced retention in a four-session brief intervention and helped address this population's overwhelming need for other critical services.²³³ These studies provide the foundation for ACOG's conclusion that an obstetrician's therapeutic and ethical obligations require screening pregnant women for alcohol and drug problems, conducting brief interventions for those with problems and making referrals for treatment as necessary.²³⁴

pregnancy resulted in no increased use in subsequent pregnancy, and findings of motivational interviewing study designed to resolve ambivalence about reducing drinking that resulted in significant reductions in alcohol use at follow-up).

²³² Hendrée E. Jones et al., *What If They Do Not Want Treatment?: Lessons Learned from Intervention Studies of Non-Treatment-Seeking, Drug-Using Pregnant Women*, 13 AM. J. ON ADDICTIONS 342, 353-55 (2004) (in study of cocaine and opiate dependent women who received motivational intervention and behavioral incentives, participation in motivational intervention reduced drug use, but reduction was not sustained over time and drop-out rate prior to completion of four sessions was high). Brief interventions have been found to be effective in reducing drug use among intravenous drug users who sought HIV testing but not drug treatment. See McLellan et al., *supra* note 194, at 1692.

²³³ Jones et al., *supra* note 232, at 353-55. The different level of effectiveness of brief interventions among alcohol and drug using women may be associated with differences in socio-economic status, education and family support as well as the severity of the drug or alcohol problem. The demographic profile of women who are most likely to drink during pregnancy is white, well-educated, married, of higher income and/or a smoker. Chang et al., *supra* note 225, at 368. The women in Jones's study, like many with chronic cocaine and opiate problems, had less than a high school education and were generally single and unemployed. Jones et al., *supra* note 232, at 346 tbl.1. DiClemente explains that individuals who have greater personal and financial resources "may be better able to plan and have more support for their efforts to change." DiCLEMENTE, *supra* note 196, at 161. Chang's research also found that "the effects of the brief intervention were significantly enhanced when a support partner . . . also participate[d] in the brief intervention. Chang et al., *supra* note 231, at 996. In addition, the pregnant women who have been studied primarily in brief intervention research use alcohol heavily or have high risk drinking patterns that can pose a risk to the fetus, but have not been diagnosed as having a current alcohol abuse or dependence problem. See Chang et al., *supra* note 225, at 366.

²³⁴ See *supra* discussion accompanying notes 73-74. The feasibility of training physicians or other health care professionals in these skills has been documented in a study that compared intervention techniques of physicians who viewed a videotape on motivational interviewing and those who viewed a documentary on the effects of fetal alcohol syndrome. The physicians who viewed the motivational interviewing tape, while not proficient in the technique, were able to direct a subsequent consult more effectively toward a decision to change while the other physicians adopted a more confrontational style after viewing the FAS documentary. Handmaker & Wilbourne, *supra* note 231, at 228.

2. Behavior Change in Connection with CPS Involvement

a. Threat of Custody Loss and Motivation to Change Behavior

Relying on CPS involvement as the primary motivator for change after the child's birth is inherently problematic given what is known about the process for changing addictive behavior. First, if a commitment to change a drug use pattern has not occurred during pregnancy, women tend to resume higher levels of alcohol, drug and tobacco use postpartum.²³⁵ This can reflect the failure to develop a firm commitment to change²³⁶ or to have a sufficient period of time to integrate the new behavior pattern into one's life. Whatever the reason, a return to pre-pregnancy use patterns signals the woman's cycling back to precontemplation or contemplation.²³⁷ At this stage, a CPS requirement that the woman enter and successfully complete treatment at the risk of losing custody of her newborn may be hard to satisfy; the mandate requires action that the woman may deem either unnecessary or not sufficiently beneficial.²³⁸

Where continued drug use results in the removal of the infant from the mother's custody, the mother's motivation to change may be further undermined by the despair of losing custody. A sense of helplessness about change is one of the emotional responses that characterize those in precontemplation and which

²³⁵ See *supra* discussion accompanying note 231. DiClemente supports his claim that extrinsic motivation often fails to create "successful, free-standing, sustained change" by pointing to the ability of pregnant women to abstain from smoking for several months only to resume shortly after the child's birth. DICLEMENTE, *supra* note 196, at 246.

²³⁶ DICLEMENTE, *supra* note 196, at 146.

²³⁷ *Id.* at 183. Relapse is recognized as "an integral part of the basic change process" and provides "critical learning events" that can make the next change effort more successful. *Id.* at 184-85. Relapse is a phenomenon common among individuals who have other chronic illnesses, including asthma, diabetes and hypertension, and studies demonstrate that the rate of relapse for these conditions is comparable to that for persons with alcohol and drug problems. McLellan et al., *supra* note 194, at 1693. The societal and medical response to individuals who relapse to drug or alcohol use differs dramatically, however, from the response to relapse in these other chronic conditions. For the former, relapse is viewed as failure of treatment and, for those involved in the child welfare context, may be the basis for denial of custody and permanent termination of rights. See U.S. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 84. In the latter, relapse is viewed as evidence of the effectiveness of treatment and the need to medically monitor the patient. McLellan et al., *supra* note 194, at 1694. While one cannot ignore the affect of relapse to drug use on a parent's care taking abilities, a fair understanding of this process should lead to a more effective response that could minimize the duration of the relapse and adverse consequences for the mother and child. U.S. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 83.

²³⁸ Brown's study of readiness to enter treatment confirmed that "clients in the precontemplation and contemplation stages were less likely to enter treatment," and those "in the preparation and action stages were more likely to enter treatment." Brown et al., *supra* note 204, at 237.

neutralizes momentum for thinking about change.²³⁹ While children should never be placed in an unsafe home environment, a policy (backed by sufficient services) that promotes entry into a treatment program where the mother's interaction with her child may be monitored or the provision of intensive home supervision may be more effective in helping the woman address her addiction while maintaining family unification.

Research demonstrates the value of keeping mothers and infants together. One of the few studies to examine the effect of coercion on treatment retention and discharge status among postpartum drug-dependent women found that the loss of "custody of the infant" was the single indicator of coercion that was significantly related to treatment retention and discharge status.²⁴⁰ The study found that women who retained custody of their infant and participated in a gender-specific day treatment program remained in treatment longer than women who participated in this level of care but had lost custody.²⁴¹ In addition, 60% of women who had custody of their infant successfully completed the day treatment program compared with 32% of the women who did not retain custody.²⁴² Stated differently, pressure from the criminal justice or child welfare system to enter treatment *standing alone*, which existed for one-half of the women in the study,²⁴³ was not associated with treatment retention or completion, and loss of custody was negatively associated with these important outcomes.²⁴⁴ A national evaluation of federally-funded residential treatment services for pregnant and postpartum women also found that postpartum women who had their infants living with them had the highest completion rates (48%) and the longest average stays in treatment (192 days), while women who did not have custody had the lowest completion rates (17%) and shortest lengths of stay in treatment (76 days).²⁴⁵ The director of the federal agency that funded this effort concluded

²³⁹ DICLEMENTE, *supra* note 196, at 116, 118. Individuals who are overwhelmed by all their problems may be resigned to living with their addiction. Movement will not occur without "an infusion of hope and a vision of the possibility of change." *Id.* at 118-19.

²⁴⁰ Nishimoto & Roberts, *supra* note 195, at 168-69. The other indicators of coercion included whether the woman was on probation or parole, currently awaiting trial, was prompted to attend treatment by the criminal justice system (the dependency court and child welfare system), and perceived severity of legal problems. *Id.* at 164.

²⁴¹ *Id.* at 168. The study found few statistically significant differences in psychosocial characteristics between the women who retained custody and those who did not that might explain the differences in treatment retention. *Id.* at 170. The women in day treatment who did not have custody of their children "had greater drug severity, more legal problems, and poorer self-esteem." *Id.* at 172.

²⁴² *Id.* at 170.

²⁴³ *Id.* at 169 tbl.2.

²⁴⁴ The study authors noted that "[e]xternal coercion alone may be insufficient, but as found in this study, the provision of infant custody during the treatment process may be a mediator between successful attachment and retention in treatment. *Id.* at 175.

²⁴⁵ Clark, *supra* note 161, at 180, 189 (summarizing results for 1847 women who participated in twenty-four of the thirty-five comprehensive, gender-specific, culturally appropriate residential treatment programs for women and children who received five-year grants during the period 1993 through 1995). This study, which examined treatment retention among postpartum women alone,

from these results that “many of the mothers who were separated from their young children were unable to concentrate fully on their own recovery and left treatment prematurely.”²⁴⁶

b. Behavior Change in Context of Child Protective Services’ Mission and Structure

It is also debatable whether the CPS context is conducive to the consciousness raising and decision-making process that must precede entry into, and successful completion of, treatment. The institutional mismatch derives, in part, from the skills²⁴⁷ and resources the caseworker can offer to the parent to accomplish this task.²⁴⁸ A study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that “child welfare workers . . . lack training . . . to understand the nature of substance abuse” (including relapse), to assess its severity, or to develop strategies to encourage individuals to seek treatment.²⁴⁹ While child welfare workers surveyed by CASA overwhelmingly cited the parent’s lack of motivation as the primary barrier to getting her into appropriate drug treatment, CASA observed that “few child welfare agencies have a strategy for motivating parents other than to make regaining custody of the child dependent on the parent completing treatment.”²⁵⁰

did not report other variables that might also explain higher levels of successful completion and longer lengths of stay among women who had custody of their infants.

²⁴⁶ *Id.*

²⁴⁷ Lisa D’Aunno and Gay Chisum have proposed that the stages of change model be applied in the child welfare context and have identified the actions child welfare workers should take to help parents move through the initial stages of problem recognition and entry into treatment. Lisa D’Aunno & Gay Chisum, *Parental Substance Abuse and Permanency Decision Making: Measuring Progress in Substance Abuse Recovery*, CHILD. LEGAL RTS. J., 52, 56-58 (1998). While the child welfare system would benefit from workers who incorporate change theory in their approach, I question the system’s institutional capacity and mission to do so and, therefore, suggest that the health care system is far better situated to initiate and carry out this therapeutic process. Indeed, an initiative by the Department of Health and Human Services of Sacramento County, California, to train caseworkers to use substance abuse diagnostic tools and motivational interviewing skills to engage parents in treatment met with worker resistance, particularly among veteran case workers who had the most extensive social work training. The response was attributed to workers being entrenched in the habits of their daily routine. CASA, NO SAFE HAVEN, *supra* note 23, at 45-46. This entrenchment also speaks to the fact that the child welfare system views the child as the focus of its activity and whose safety is of paramount concern. U.S. DEP’T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 70.

²⁴⁸ See discussion *supra* accompanying notes 183-85.

²⁴⁹ CASA, NO SAFE HAVEN, *supra* note 23, at 32, 36. The Department of Health and Human Services came to the same conclusion based on several studies. U.S. DEP’T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 90. See also INST. OF MED., *supra* note 1, at 278 (reporting that most schools of social work fail to provide students with a basic knowledge of alcohol and drug issues, as the national education policy-making body does not mandate substance-use content in social work curricula).

²⁵⁰ CASA, NO SAFE HAVEN, *supra* note 23, at 36. Ondersma has also observed that child protection workers lack training to work with persons with addictions and, thus, respond with extremes of

As discussed above, the removal of a child and mandate to complete drug treatment, even if it is available and appropriate,²⁵¹ are not likely to motivate lasting behavioral change if a woman is not prepared to change her behavior.²⁵² Other interventions are needed to help her develop a commitment and plan for change. Yet, the “crisis” environment in which many child welfare agencies operate, with large caseloads and attention being given to only the most pressing situations,²⁵³ has resulted in a system that devotes more resources to investigation and foster care than services.²⁵⁴ The system simply is not equipped to provide the necessary individualized intervention for drug-dependent women.²⁵⁵

More fundamentally, the structure of the child welfare system, which carries out child “rescue” and rehabilitative functions simultaneously²⁵⁶ and under a constrained timetable, renders sustained recovery more difficult. The Institute of Medicine has captured the implications of the system’s conflicting roles for patient care: “[r]esidual stigma, discrimination, and the multiple types of coercion that sometimes bring individuals with . . . substance use illnesses into treatment have substantial implications for their ability to receive care that is respectful of and responsive to their individual preferences, needs and values . . .

“either mistrustful confrontation or accommodating sympathy,” neither of which apply the lessons of motivational interviewing. Ondersma et al., *supra* note 128, at 105.

²⁵¹ CASA concluded that to the extent treatment is provided, it “is determined almost exclusively by what is available at the moment.” CASA, NO SAFE HAVEN, *supra* note 23, at 32. The Department of Health and Human Services reached the same conclusion, noting that child welfare is further hampered because it does not have the authority to access or pay for treatment services. U.S. DEP’T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 75.

²⁵² See *supra* notes 238-39.

²⁵³ U.S. DEP’T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES, *supra* note 5, at 75.

²⁵⁴ CASA, NO SAFE HAVEN, *supra* note 23, at 34; ROBERTS, *supra* note 180, at 135-36, 142-44.

²⁵⁵ CASA, NO SAFE HAVEN, *supra* note 23, at 34.

²⁵⁶ ROBERTS, *supra* note 180, at 274. Professor Roberts criticizes the child welfare system for having a “dysfunctional structure, pursuing the conflicting tasks of both providing services to help families and investigating families for the purpose of removing children from their homes.” *Id.* She advocates for a system that “offers voluntary services, without threat or stigma, to the vast majority of its clients, shifting its philosophical orientation and resources away from foster care toward prevention and family preservation.” *Id.* at 275. A critique of systems that carry out both coercive and rehabilitative functions is that rehabilitative efforts are debased and are used to justify punitive actions. Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1243 (1998). Leroy Pelton has explained in his evaluation of our nation’s child protection system that “[w]hen it is placed under the cover of benevolent intervention, a coercive system can take on a life of its own and expand independently of need.” ROBERTS, *supra* note 180, at 274 (quoting Leroy H. Pelton, Commentary, FUTURE OF CHILDREN, Spring 1998, at 126, 128). Professor Richard Boldt provides a similar critique of drug treatment courts, which have the dual goal of providing drug treatment, on the one hand, and punishing and deterring criminal behavior on the other. Boldt, at 1244-45. In addition, Professor Boldt cautions that the decision to “locate significant treatment resources within the criminal justice system” reduces the ability to engage policymakers and the public in an examination of alternative and more effective institutional responses to addiction. *Id.* at 1304-05. The same can be said about reliance on the child welfare system to address maternal drug dependence. CAPTA promotes a singular response to drug dependent women and makes public health and preventative measures less likely.

.²⁵⁷ Perhaps no single group experiences greater stigma than drug-dependent women who bear children and lose them to the child welfare system. Stigma alone “lead[s] down a pathway . . . to diminished health outcomes.”²⁵⁸ It undermines a woman’s self-esteem which in turn diminishes her sense of self-efficacy to manage her illness over time and achieve recovery.²⁵⁹ Not surprisingly, one study found that pregnant women who were involved with child protective services were more likely to be mandated into drug treatment and, on average, remain in treatment longer than those who were not involved with CPS, but were much more likely to receive an unsatisfactory treatment discharge rating than women not involved with CPS.²⁶⁰ The study’s authors suggested that “being pregnant and a known substance user can place the CPS mother under more intense scrutiny, which in turn could be perceived as added pressure, making treatment and recovery more difficult.”²⁶¹

Moreover, the child welfare system’s lack of transparency regarding the conditions that will initiate and terminate coerced treatment can affect recovery.²⁶² Child welfare workers are unable to assess under most circumstances whether a home environment is safe.²⁶³ This fact, compounded by

²⁵⁷ INST. OF MED., *supra* note 1, at 71.

²⁵⁸ *Id.* at 74.

²⁵⁹ *Id.* at 74-77.

²⁶⁰ Melinda M. Hohman et al., *A Comparison of Pregnant Women Presenting for Alcohol and Other Drug Treatment by CPS Status*, 27 CHILD ABUSE & NEGLECT 303, 313 (2003).

²⁶¹ *Id.*

²⁶² *Id.* at 111-12 (noting that transparency in the policies that result in coerced treatment as well as information about “how one ‘gets off’ coercion” could “help minimize the risk that coerced treatment will be used for other than therapeutic purposes or for protection of the public, as well as help establish a normative database to guide decision making in this area”).

²⁶³ Dr. Richard Gelles described the dismal capacity of child welfare workers to assess level of risk at congressional hearings on the reauthorization of CAPTA. *CAPTA: Successes and Failures at Preventing Child Abuse & Neglect: Hearing Before the Subcomm. on Select Educ. of the H. Comm. on Educ. & the Workforce*, 107th Cong. 61, 68-69 (2001) (statement of Richard J. Gelles, Ph.D.), available [at](http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.88&filename=80038.pdf&directory=/diskc/wais/data/107_ho_use_hearings) http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.88&filename=80038.pdf&directory=/diskc/wais/data/107_ho_use_hearings. He explained that child protective services workers are not trained professionally to assess risk and family needs. *Id.* at 68. In addition, risk assessment tools are not reliable and valid measures of risk and can be subverted by the workers “arriving at a subjective sense of risk and then completing the form to attain the desired risk score.” *Id.* at 69. Kurt Mundorff confirms these fundamental deficiencies based on his experience as a child protective worker in New York City. He notes that protocols for assessing whether a child can be left in the parent’s custody are checklists that are generally filled out after the caseworker returns to the office and are not taken very seriously. Kurt Mundorff, *Opening Remarks: Advocating for Change*, 3 CARDOZO PUB. L. POL’Y & ETHICS J. 353, 356 (2005). Mundorff concludes that, for the vast majority of cases, “[t]he belief that we can reliably identify kids who should be taken into state care is a myth.” *Id.* at 357. “Whether a child is removed depends not so much on the type or degree of maltreatment, but on the particular caseworker, supervisor, or manager assigned to the case, and on the amount of media attention child fatalities have received.” Mundorff, *supra* note 181, at 154-55. See also ROBERTS,

a child welfare worker's lack of knowledge about drug and alcohol dependence, will more likely result in formal court oversight to enforce treatment compliance and placement decisions that err on the side of removal, given a worker's fear of a custody decision that goes bad.²⁶⁴ A mother must then comply with multiple counseling, education, visitation, and employment training or work requirements under heightened CPS and court scrutiny to regain custody and exit the child welfare system.²⁶⁵ Any number of missteps can be used to justify the continuation of out-of-home placement, but a mother's lapse to drug use or failure to attend counseling sessions, even for legitimate reasons, will be deemed evidence of her inability to provide a safe home.²⁶⁶ At the same time, a woman's compliance with treatment and other CPS requirements does not always guarantee reunification and a path out of the child welfare system.²⁶⁷ Some treatment providers who work with pregnant and parenting women to satisfy case

supra note 180, at 54 (citing Duncan Lindsay's conclusion that "the child welfare system is unable to tell which children should be removed and which should be left at home").

²⁶⁴ CASA, NO SAFE HAVEN, *supra* note 23, at 33.

²⁶⁵ Professor Roberts describes the "outlandish" nature of the reunification plans for some parents with drug problems, including multiple courses in parenting and repetitious drug treatment even when completion had been documented. ROBERTS, *supra* note 180, at 67, 81-82. "Compliance overshadows the child's needs or parents' ability to care for the child . . . The issue is no longer whether the child may be safely returned home, but whether the mother has attended every parenting class, made every urine drop, participated in every therapy session, shown up for every scheduled visitation, arrived at every appointment on time, and always maintained a contrite and cooperative disposition." *Id.* at 80. Courts then sever parental ties based on a parent's failure to fulfill a requirement on a caseworker's checklist. *Id.* at 81; and Paul Chill, *Burden of Proof Begone: The Pernicious Effect of Emergency Removal in Child Protective Proceedings*, 41 FAM. CT. REV. 457, 460-61 (2003) (describing the tendency of courts to exhibit the same defensive decision-making as child protective services workers and, thus, continue out-of-home placements even if not appropriate initially).

²⁶⁶ CASA, NO SAFE HAVEN, *supra* note 23, at 19, 38-39. For an example of how one court in the context of a guardianship decision evaluated a mother's use of drugs after a year of abstinence and her failure to fulfill treatment requirements, see *In re Caya B.*, 834 A.2d 997, 1004-06 (Md. Ct. Spec. App. 2003) (upholding lower court's refusal to return custody and guardianship to mother based on evidence that she had tested positive for marijuana use on one occasion, had failed to obtain an Alcoholics Anonymous sponsor, could not provide proof of attendance at AA meetings, and had missed thirteen of twenty-six therapy sessions over a several month period. This evidence was sufficient for the court to conclude that the mother had failed to satisfy her burden of demonstrating that "there is no likelihood of further abuse or neglect," even though the mother was providing adequate care to a younger child and had had successful extended visitation with her daughter). See Richard C. Boldt, *Evaluating Histories of Substance Abuse Cases Involving the Termination of Parental Rights*, 3 J. HEALTH CARE L. & POL'Y 135 (1999) (courts terminate parental rights based on a parent's failure to comply with treatment requirements or maintain sobriety without assessing whether the drug treatment services that have been offered are appropriate to address the individual's disease and a woman's unique psycho-social needs).

²⁶⁷ Interview with Dr. Hendrée Jones, Associate Professor, Johns Hopkins School of Medicine, and Research Director, Center for Addiction and Pregnancy, in Baltimore, Md. (July 13, 2004) (noting that particular caseworkers in the Baltimore Department of Social Services will refuse uniformly to reunite mothers and their children notwithstanding treatment completion and ability to care for an infant while others will permit reunification in situations that do not appear to be safe).

plans have observed that reunification decisions are guided more by the individual case worker's predilection than evidence of safety.²⁶⁸ This leaves mothers demoralized and uncertain as to what can be done to regain custody and exit the system.²⁶⁹ Many simply give up after having developed a very tenuous relationship with their child during the course of the out-of-home placement.²⁷⁰

c. Federal Family Reunification Deadlines and Behavior Change

The strict timetable for family reunification and termination of parental rights established under the Adoption and Safe Families Act of 1997 (ASFA)²⁷¹ also may unwittingly undermine a sustained change process. A system that requires a permanency planning hearing for a child within twelve months of entering foster care²⁷² and the filing of a petition to terminate parental rights for an infant who has been in foster care for fifteen months²⁷³ offers little forgiveness for a recovery process that can take significantly longer and often involves a lapse to drug use or relapse.²⁷⁴ Women who attempt to change their behavior on

²⁶⁸ *Id.*

²⁶⁹ *Id.*

²⁷⁰ See Chill, *supra* note 265, at 462.

²⁷¹ Pub. L. No. 105-89, 111 Stat. 2115 (codified in scattered sections of 42 U.S.C.). The enactment of ASFA marked a dramatic departure from standards enacted in the 1980s that required states to make reasonable efforts to preserve families prior to removing children from their parents on either a temporary or permanent basis. BARTHOLET, *supra* note 54, at 23. ASFA eliminates the family preservation requirement in certain cases of egregious parental conduct, permitting immediate petitions for termination of parental rights, (42 U.S.C. § 675(5)(E) (2000)) and sets "strict time deadlines to limit the period children can be held in foster care for family reunification efforts before they are moved on to adoptive or other permanent homes." BARTHOLET, *supra* note 54, at 24. ASFA also permits child welfare agencies to provide services to facilitate family reunification while concurrently making efforts to place a child for adoption or with a legal guardian. *Id.* at 190 (quoting from 42 U.S.C. § 671(a) (2000)). See Note, *Unified Family Courts and the Child Protection Dilemma*, 116 HARV. L. REV. 2099, 2115-16 (2003) (describing ASFA provisions and philosophy that "places the child's interest in finding any safe and permanent home on par with—if not above—the child's interest in returning to his or her family and community"); and Chill, *supra* note 265, at 463 (noting that "[u]nder ASFA, parental rights can now be terminated, or at least gravely threatened, on the basis of the mere passage of time").

²⁷² 42 U.S.C. § 675(5)(C) (2000), amended by Pub. L. No. 109-239, § 12, 120 Stat. 508, 514 (effective Oct. 1, 2006).

²⁷³ 42 U.S.C. § 675(5)(E) (2000).

²⁷⁴ Nancy Young of the National Center on Substance Abuse and Child Welfare and others have observed that poor, drug-dependent women who are involved in the child welfare system must contend with "four clocks:" the ASFA timetable; TANF work requirement and five-year life-time benefit limitation; child developmental process; and the addiction recovery process. NANCY K. YOUNG ET AL., RESPONDING TO ALCOHOL AND OTHER DRUG PROBLEMS IN CHILD WELFARE: WEAVING TOGETHER PRACTICE AND POLICY 20-21 (1998), available at <http://www.cffutures.org/docs/SGPresentoCADPAACIntro.pdf>. These "clocks" are wildly out of sync and place competing and often irreconcilable work, child-rearing and treatment requirements on drug-dependent women. U.S. DEP'T OF HEALTH & HUMAN SERVS., BLENDING PERSPECTIVES,

a truncated timetable under the threat of permanent custody loss may be more likely to suppress addictive behavior than change it.²⁷⁵ This could account, in part, for the pattern among some women to give birth to subsequent children who are drug-exposed²⁷⁶ and to have a child removed shortly after the family has been reunited.²⁷⁷

CAPTA's reliance on the child welfare system's use of coercive measures to motivate rehabilitation among drug-dependent women will likely have a negative effect on both the physicians involved in administering the scheme and the women who are expected to change their behavior. As the Institute of Medicine has observed, the continued reliance on coercive measures to compel entry into drug treatment imposes unique obligations on health care providers and policy makers to "combat the effects of stigma on patient-centered care."²⁷⁸ Nowhere is this more important than in the context of maternal drug dependence, as stigma creates a significant barrier to drug-dependent pregnant women obtaining appropriate levels of prenatal care.²⁷⁹ Policies governing the use of coercion must, among other things,

reduce the risk of its use in situations in which it is not needed by making transparent the policies and practices used to assess decision-making capacity and dangerousness; preserve as much patient decision making as possible whenever coercion is used . . . and minimize the risks associated with coerced treatment.²⁸⁰

The following proposal offers a health model to address maternal drug use that will minimize reliance on coercion, as recommended by the Institute of Medicine.²⁸¹ It also seeks to sever the link between the health care and child welfare systems and propose measures to ensure greater transparency regarding the type of maternal alcohol and drug use behavior that poses a real risk to the health of a newborn.

supra note 5, at 72. The ASFA timetable, alone, requires child welfare agencies to simultaneously provide family reunification services and plan for permanent placements outside the mother's custody. YOUNG ET AL., *supra*, at 44. Roberts describes cases in which courts have refused to extend the deadline for permanency decisions based on a mother's lapse to drug use, notwithstanding solid evidence of treatment progress. ROBERTS, *supra* note 180, at 156-57.

²⁷⁵ DICLEMENTE, *supra* note 196, at 247 (explaining that "[p]unishments work best when they are immediate and linked to the target behavior, but they tend to suppress rather than eliminate behaviors").

²⁷⁶ Smith & Testa, *supra* note 137, at 106.

²⁷⁷ CASA, NO SAFE HAVEN, *supra* note 23, at 38-40.

²⁷⁸ INST. OF MED., *supra* note 1, at 99.

²⁷⁹ See discussion *supra* accompanying notes 142 and 168.

²⁸⁰ INST. OF MED., *supra* note 1, at 110.

²⁸¹ *Id.* at 115 (noting that coercive treatment "should be avoided whenever possible").

V. AN ALTERNATIVE STATE RESPONSE TO THE CAPTA PHYSICIAN REPORTING REQUIREMENT

CAPTA's postpartum, CPS-centered intervention and reliance on coerced treatment does not constitute an effective policy for preventing the harm associated with prenatal drug use. The science points to a different set of solutions. As Professor Martin Guggenheim has observed, by "conceiv[ing] of child welfare as a public health problem rather than solely focusing on child abuse, we could develop policies that address directly and proactively the conditions that adversely affect the health and welfare of poor children in the United States."²⁸² In enacting the CAPTA physician-reporting requirement, Congress failed to implement a public health policy capable of reducing the number of children who enter the child welfare system due to their mother's untreated drug or alcohol dependence. States ought not adopt a policy that tracks the inadequate federal model. Instead they should heed the lessons of science and enforce basic standards of physician care so that women have a meaningful opportunity to change their behavior during pregnancy, ensure the best possible birth outcome, and avoid state interventions that make recovery and family preservation more difficult.

The following offers an alternative state framework that would address critical gaps in identifying alcohol and drug problems during a woman's pregnancy and restore physicians to their role of health provider in this context. Although the proposed prenatal intervention model cannot be expected to eliminate the need for child protection referrals, research demonstrates that prenatal interventions, coupled with gender-specific treatment, would have a positive effect on the mother's and infant's health, thereby reducing the need for state intervention. Such interventions would also reduce reliance on coercive treatment. Health care delivery would remain the physician's primary focus even when mandatory child welfare reporting obligations arise, as they and other hospital staff would be required to refer mothers and their infants to appropriate community-based treatment and health services as part of their discharge planning.

A. Mandatory Screening of Alcohol and Drug Problems During Prenatal Care and Referral for Care

The disappointing track record of obstetricians and other primary care physicians in failing to follow professional practice guidelines for screening²⁸³

²⁸² Martin Guggenheim, *Issues Surrounding Initial Intervention*, 3 CARDOZO PUB. L. POL'Y & ETHICS J. 359, 363 (2005).

²⁸³ Screening protocols, as recommended by the American College of Obstetricians and Gynecologists, consist of questions that are asked of all patients to identify alcohol and drug use. ACOG Ethics Opinion No. 294, *supra* note 1, at 1022. Unlike urine and blood testing that identifies very recent drug use, screening protocols help uncover patterns of alcohol and drug use and create opportunities to discuss the effect of such use on the patient's health. *Id.* at 1023.

and referring pregnant women to appropriate drug treatment, and the lax enforcement of these ethical and therapeutic obligations, calls for formal state regulation and oversight.²⁸⁴ Following a model enacted by the Virginia legislature,²⁸⁵ states should require all practitioners in the course of prenatal care to implement a medical protocol to screen all pregnant women for alcohol, tobacco and other drug use disorders and either conduct or make referrals for more extensive diagnosis and evaluation where medically indicated.²⁸⁶ States may choose to require a particular screening tool for the screening of pregnant women in order to ensure uniformity and efficacy²⁸⁷ and may require screening to be repeated periodically during the pregnancy²⁸⁸ and postpartum. State standards should also require practitioners to discuss the results of the assessment and evaluation with each patient, and provide information about the effect of alcohol, tobacco, and drug use on the woman's health, possible adverse birth outcomes, and available treatment resources for the patient and her partner if he or she is also drug dependent, regardless of the screening results.²⁸⁹

This approach avoids CAPTA's flaws as it is guided by scientific evidence regarding the scope and consequences of prenatal drug use. Ascertaining a patient's use of alcohol, tobacco and other drugs enables a physician to focus on *all* prenatal drug use behavior that poses a risk to the fetus. Early diagnosis during pregnancy, coupled with appropriate education and referral, offers women the best opportunity to change their behavior and prevent harm to their unborn child. In addition, the implementation of uniform screening protocols for all patients will address several shortcomings inherent in selective toxicology testing for illicit drug use. First, racial and socio-economic bias, which has characterized hospital-based toxicology testing and CPS reporting for drug use,²⁹⁰ will be less likely to seep into office-based gynecological care if the standard of care requires physicians to ask uniform questions of all pregnant patients. As physicians acquire a more realistic understanding of the prevalence of alcohol and drug use among their patients, low-income, African-American women will

²⁸⁴ Resistance to a mandated standard of care is to be expected from the medical community. The adoption of a statutory standard would raise important policy questions about medical malpractice exposure, capacity of overburdened obstetric practices to provide additional care, and the limitations of a static standard of care as medical knowledge advances. An evaluation of these issues and identification of potential positive incentives to encourage a change in medical practice will be addressed in a future article. The author's present goal is to set out the appropriate standard for prenatal and post-partum interventions.

²⁸⁵ VA. CODE ANN. § 54.1-2403.1 (2005).

²⁸⁶ VA. CODE ANN. § 54.1-2403.1(A) (2005).

²⁸⁷ See VIRGINIA LEGAL REQUIREMENTS & HEALTH CARE PRACTICE IMPLICATIONS: A GUIDE FOR HOSPITALS & HEALTH CARE PROVIDERS—PERINATAL SUBSTANCE USE 2-3 (2003), available at http://www.dss.virginia.gov/pub/pdf/perinatal_substance_abuse.pdf; WASH. STATE DEP'T OF HEALTH, SUBSTANCE ABUSE DURING PREGNANCY: GUIDELINES FOR SCREENING 6 (rev. ed. 2002), available at http://aia.berkeley.edu/media/pdf/wa_sen_screening_guidelines.pdf.

²⁸⁸ WASH. STATE DEP'T OF HEALTH, *supra* note 287, at 7.

²⁸⁹ VA. CODE ANN. § 54.1-2403.1(D) (2005).

²⁹⁰ See *supra* note 36.

be subject to less targeted scrutiny. And women who do not fit the conventional “profile” of an alcohol or drug dependent woman will be more readily identified and offered medical assistance if a problem exists. Second, a standardized medical procedure will help physicians become more skilled and comfortable in broaching drug use by their patients, increasing the likelihood that interventions will actually occur at a time when a woman is most likely to be committed to changing her behavior to ensure the best birth outcome for her child.

In addition to requiring uniform screening protocols, state regulation should also contain clear guidance on the use and disclosure of the woman’s assessment and evaluation. Explicit confidentiality protections are an effective antidote to concerns—whether accurate or not—that a physician will report a woman’s prenatal drug use to child protective services. Confidentiality standards contained in the Virginia statute are a sound starting point. They authorize the disclosure of screening results only to those individuals the patient designates in a written consent form, health care providers for purposes of consultation or treatment, and third-party payers to the extent necessary for reimbursement.²⁹¹ These confidentiality standards, which reinforce the notion that screening information is intended for therapeutic purposes and require the patient’s consent to disclose screening information to child protective services, promote trust in the physician. Confidentiality safeguards, along with the law’s explicit prohibition against a court admitting this information in any criminal proceeding,²⁹² will encourage women to disclose stigmatizing information about their alcohol and drug use to promote treatment. This contrasts with CAPTA’s mandatory CPS reporting standard that, indeed, perpetuates stigma through state investigations. Providing a description of the state’s abuse and neglect reporting requirements would also educate women about the possible implications of continued alcohol or drug use on child custody and permit them to make more informed health care decisions, consistent with patient-centered care.

States should also consider using their licensure and public health authority to require wide-scale dissemination of the universal screening and confidentiality standards. This would serve a number of purposes. Punitive responses to maternal drug use have created distrust of health care providers among women who need prenatal care the most. To the extent practices are changing, it is important to get a more inviting “word on the street.” Second, physicians would be informed that a single standard of care applies to all women, thereby minimizing subjectivity and potential bias in screening.²⁹³ Finally, dissemination would enable women to enforce their rights and report violations to state licensing boards, professional grievance bodies or public health authorities.

The goal of promulgating mandatory universal screening and confidentiality standards is to provide the necessary incentive for physicians to develop the skills or staff capacity to effectively screen and respond to patients who have drug problems. This, in turn, fills the health care delivery gap that

²⁹¹ VA. CODE ANN. § 54.1-2403.1(B), (D) (2005).

²⁹² VA. CODE ANN. § 54.1-2403.1(C) (2005).

²⁹³ See WASH. STATE DEP’T OF HEALTH, *supra* note 287, at 7.

CAPTA's standard exacerbates by limiting the physician's role to that of investigator, not healer. Over time, as universal screening becomes the standard of care, pregnant women with drug use disorders would gain trust in the health care process, access prenatal services more consistently, and be more likely to disclose alcohol or drug problems early enough in their pregnancy to seek necessary care. Depending upon the availability of appropriate treatment services, many would be able to avoid state intervention or, at a minimum, be engaged in services that preserve family unity even when state oversight is necessary to protect against neglect.

B. Hospital-Based Identification and Referral of Newborns in Need of Services

A health care model should also guide hospital-based interventions for women and newborns at the time of delivery, in contrast to CAPTA's reliance on medical personnel for primarily identification and reporting purposes. The primary goal of identification should be to identify alcohol and drug use problems that affect the health of the mother or infant and to link women with necessary drug treatment and infants with services to aid development. Drug testing, to the extent a hospital chooses to conduct such tests, should be used as *one* tool, along with clinical observation and medical history information, to diagnose a woman or infant's condition.²⁹⁴ To accomplish this, states should develop uniform drug testing standards based on medical criteria that reflect current scientific knowledge and require physicians to document the applicable criteria in the medical record when ordering a drug test. State standards should explicitly provide for an informed consent process that authorizes the woman to provide consent both for herself and her infant, and require the disclosure of the medical reasons for testing and the consequences of a positive result, including the standards for CPS referral. This approach addresses CAPTA's failure to ensure the implementation of uniform identification criteria.²⁹⁵

The standard should also identify actions that will be taken if the woman refuses to provide consent for a drug test. One proposed protocol developed by a Maryland task force charged with crafting a response to maternal drug use disorders²⁹⁶ would, in circumstances where consent is denied, require a referral to the hospital social worker, public health nurse, or available treatment resources, in addition to CPS if statutory standards are met based on other available information.²⁹⁷ This standard has the advantage of ensuring that an

²⁹⁴ See *id.* at 13-14 (describing appropriate use and limitations of drug testing, including inability to identify chronicity and amount of drug use, to rule out drug use occurring in recent past or early in pregnancy, to identify alcohol use, or to identify users who delay care or alter samples to evade detection).

²⁹⁵ See discussion *infra* accompanying notes 35 and 36.

²⁹⁶ Panel to Examine Drug-Affected Children: A Preliminary Plan for Action, (June 26, 1991) Guidelines for Hospital Identification, Reporting and Management of Prenatal Drug Exposure, App. VIII, at 85-86.

²⁹⁷ *Id.*

appropriate child safety investigation is performed without violating a woman's right to control her health care decisions.

A separate set of criteria should define the circumstances that constitute grounds for reporting a "drug-affected" newborn to CPS, for any state that elects to implement CAPTA's standard. The medical conditions that were identified in the House-passed CAPTA legislation—neonatal intoxication or withdrawal syndrome or neonatal physical or neurological harm resulting from prenatal drug or alcohol exposure—provide one set of criteria that would improve upon CAPTA's standardless scheme.²⁹⁸

In addition, while some state abuse and neglect laws require reporting based on drug exposure alone, compliance with CAPTA provides an opportunity to re-examine the value of such standards. A public health model would be guided by scientific research that has shown that maternal drug use and infant drug exposure do not necessarily result in an adverse medical effect and would follow practice protocols that have concluded that prenatal drug and alcohol use alone does not constitute neglect.²⁹⁹ Maryland's task force recommended a protocol that, while not crafted specifically with a "drug-affected" newborn standard in mind, proposes a comprehensive assessment to determine whether an abuse or neglect report is appropriate.³⁰⁰ It would take into consideration the woman's drug and alcohol history, previous treatment attempts, motivation for recovery, the family's history of addiction and support system, and the extent of negative consequences from alcohol or drug use.³⁰¹

Regardless of whether a CPS referral is made, states should require hospitals to initiate community-based service delivery to women and infants as a part of discharge planning, instead of relying on the child welfare system to carry out this role.³⁰² The delivery of appropriate rehabilitative services to children and their families is of secondary importance, both fiscally and philosophically, to the investigation and foster care placement functions of the current child welfare system.³⁰³ CAPTA's standard fails to address this reality in its safe care plan requirement³⁰⁴ and, more problematically, ignores the inherent incompatibility of a single institution carrying out rehabilitation and investigation functions simultaneously.³⁰⁵ This proposal would separate these two functions placing the responsibility for health care in an institution that has healing as its core mission.

²⁹⁸ See *supra* note 32.

²⁹⁹ See ACOG Ethics Opinion No. 294, *supra* note 1; HIS ET AL., *supra* note 35, at 3.

³⁰⁰ Guidelines for Hospital Identification, Reporting and Management of Prenatal Drug Exposure, App. VIII of 1991 Panel Report, *supra* note 296, at 86-87.

³⁰¹ *Id.*

³⁰² *Id.* at 88-89 (including identification of a case manager who will coordinate services for infant, evaluate home environment for safety, assist with parenting skills, and link mother with drug treatment if necessary); and HIS ET AL., *supra* note 35, at 2 (discharge plan developed by health team in collaboration with family will address significant social and medical conditions of the mother and her baby).

³⁰³ See *supra* discussion accompanying notes 178-85 and 253-54.

³⁰⁴ See *supra* discussion accompanying note 30.

³⁰⁵ See *supra* discussion accompanying notes 256-59.

A useful model can be found in Virginia's hospital licensure standards. The standards require all licensed hospitals to implement a discharge planning process for "identified, substance-abusing, postpartum women and their infants" that provides appropriate referrals to treatment services, comprehensive early intervention services for infants and toddlers, pursuant to the Individuals with Disabilities Education Act, and family-oriented prevention services.³⁰⁶ The law requires hospitals to include, to the greatest extent possible, the father of the infant and other family members who will participate in follow-up care. Finally, the law requires the hospital to contact a designated community services board that is required to appoint a discharge plan manager to implement the plan.³⁰⁷ The discharge planning process applies regardless of whether the woman is referred to CPS³⁰⁸ and is likely to enhance the woman's ability to obtain necessary services.

The model outlined here offers a starkly different policy for addressing maternal alcohol and drug problems. It has the advantage of ensuring that physicians intervene with measures that are more likely to help pregnant drug and alcohol dependent women address behavior that may harm their unborn child. The model does not discount the child welfare system's role in protecting children who are at risk of abuse or neglect. It does recognize, however, that mandatory child welfare interventions for families affected by illicit drug use are not compatible with either the delivery or receipt of effective health care or the preservation of families. A health care model, freed from the stigma associated with child protective services interventions, can do far more to prevent the harm children may suffer as a result of maternal alcohol and drug dependence use.

VI. CONCLUSION

No single institution can adequately respond to the health and social consequences of maternal alcohol and drug dependence. This Article argues that federal and state policymakers place too much stock in the child welfare system's ability to solve the problems inherent in maternal and alcohol dependence. Initiatives to address this health problem have neglected the far more appropriate venue for intervention: the primary health care system. As a result, our policies have allowed some physicians to ignore their obligations to diagnose and refer women to treatment at a point in the pregnancy at which those services would be most beneficial to both the woman and her child. The model proposed here refocuses institutional responsibility to doctors treating pregnant women consistent with the lessons of medical and social science research.

³⁰⁶ VA. CODE ANN. § 32.1-127(B)(6) (2005).

³⁰⁷ *Id.*

³⁰⁸ VA. CODE ANN. § 63.2-1509B (2005) (requires physicians and other designated health care professionals to report "suspected abuse or neglect" based on a positive toxicology screen for any drug not prescribed to the mother; a finding that an infant is born drug dependent on a non-prescribed drug and presents withdrawal symptoms; a diagnosis of an illness attributable to in utero drug exposure; and fetal alcohol syndrome).

Some may question the wisdom of relying on a health care system that has demonstrated far too little interest in grappling with this health condition. There is no question that health care professionals require better education and training to acquire the skills and develop the attitudes to effectively diagnose alcohol and drug problems.³⁰⁹ Significantly more funding for gender-specific treatment services is needed to ensure physicians have referral resources for those who need treatment, particularly women with chronic alcohol and drug dependence who live in poverty. Addressing these workforce development and resource issues, which exist regardless of the institution that addresses maternal drug dependence, will certainly improve the ability and willingness of physicians to carry out their therapeutic and ethical obligations. At the same time, the science is too compelling to permit physicians to shirk their responsibilities to address maternal drug dependence or to establish additional barriers to prenatal care that adversely affect the woman and her fetus.

Most pregnant drug-dependent women want and seek medical care to ensure the best birth outcome possible. The medical profession can do much by meeting them halfway and providing essential diagnostic and therapeutic care. Absent federal leadership, state policy makers and public health officials who are serious about reducing the harm caused by maternal alcohol and drug use must ensure that obtaining prenatal care is no longer a risky endeavor for drug-dependent women.

³⁰⁹ INST. OF MED., *supra* note 1, at 274-82.

