Prenatal Drug Exposure: The Impetus for Overreaction by the Legal Community or a Serious Problem Needing a Serious Solution

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Introduction

In the 1980's and 1990's, the general populace was just beginning to learn about the deleterious effects of drugs on the developing fetus. Not surprisingly, that knowledge led to a great hue and cry. At that time, as now, I was teaching in the area of children and the law. The more that I learned about prenatal drug and alcohol exposure, the more concerned I became. As a result, in 1994, I published a comprehensive article that outlined the problems associated with prenatal alcohol and drug exposure, the inadequacy of the law's response to this problem, and a proposed legislative solution to the problem.¹ The legislative solution that I proposed was a fairly radical one: making the conduct a crime that was not punishable by incarceration, but rather was punishable by probation with conditions of drug treatment and no-pregnancy. My extensive research indicated that such a solution was necessary.

Since that time, a number of articles have been written, laws have been passed, and cases have been decided, all directed at the issue of prenatal drug exposure. In addition, we have learned more about the effects of prenatal drug exposure and encountered a new nemesis: methamphetamine. Further, after a period of relative inactivity, the attempted legislative, judicial and prosecutorial responses to the problem of drug-exposed infants have increased dramatically.
As a counter, however, some commentators have suggested that the problems caused by prenatal drug exposure to crack/cocaine are not as serious as previously thought. Therefore, they contend that the community needs to “avoid a ‘rush to judgement’ about the potential developmental outcomes of children born to methamphetamine users.” Finally, various groups have organized to create a concerted opposition to any form of legislative or judicial action that is perceived to give rights to a fetus.

The purpose of this article is to re-examine the legislation that I proposed in 1994, and assess whether it continues to be a viable solution in light of the above-outlined changes that have taken place in the intervening 14 years. This article concludes that the central ideas that form the basis for the proposal are still necessary and viable. Contrary to the assertions of the above-mentioned commentators, prenatal substance abuse continues to be a serious problem. To address that problem, the best ideas need to be used from two opposing camps - the treatment-only camp and the criminal prosecution camp - to create an effective state initiative. Doing this will allow the state to protect as many children as possible, while respecting their mothers’ autonomy as much as possible. The legislation that I proposed in 1994 attempted to

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create this hybrid solution. In light of political and practical realities, however, some of the provisions in my 1994 proposal need to be modified, though the guiding principles behind that proposal should be retained.

Part I of this article will discuss the effects of prenatal drug and alcohol exposure on a child, with particular focus on the effects of crack/cocaine and methamphetamine. That section will demonstrate that the effects of such prenatal exposure are significant and warrant some type of state intervention to protect children. Part II will demonstrate that the incidence of prenatal crack/cocaine exposure remains high, while the incidence of prenatal methamphetamine exposure has risen. Thus, without effective state intervention, large numbers of children will continue to be harmed by prenatal exposure. Part III will then catalog the changes that have occurred since 1994 in the legal landscape, in the treatment world and in the community. This will be done in order to examine whether my 1994 proposed legislation is still a viable solution. It will demonstrate that community and state intervention in this area has improved, but that some modifications are necessary. Such modifications should be in line with the guiding principles behind my 1994 proposed legislation. Part IV will demonstrate that while the guiding principles behind my 1994 proposed legislation continue to be viable and necessary in response to the problem of prenatal drug and alcohol exposure, the legislative proposal itself needs to be modified. Thus, part V will outline a new proposed state-based initiative and explain the reasons for the modifications.
I. Effects of Prenatal Drug and Alcohol Exposure

As this author stated in 1994, “contrary to some myths and stereotypes in this area, there is no evidence that drug-exposed children are ‘asocial and incapable of bonding,’ ‘missing the core of what it takes to be human,’ ‘oblivious to any affection,’ or ‘likely to be sociopaths.’” The studies since 1994 have reinforced this statement. As this section will demonstrate, these current studies also reaffirm that alcohol, cocaine, and methamphetamine all cause physical and behavioral problems that are serious enough to warrant state intervention.

There are a variety of substances that can cause harm to a developing fetus. This article focuses on crack/cocaine and methamphetamine because they are currently two of the three substances of choice for addicted women. As will be shown, various


4 Although there are scientific studies that demonstrate that in utero exposure to tobacco is also detrimental to children, the effects of such exposure (and the proper response to such exposure is beyond the scope of this article. See Cynthia Kuhn, Buzzed, p.172, (Norton 2nd Ed. 2003) prenatal exposure to nicotine has been shown to retard in utero growth and to have a detrimental effect on the mental functioning of the subsequent child). There is evidence, however, that smoking during pregnancy is on the decline. Barry M. Lester, et al., Substance use during Pregnancy: Time for Policy to Catch up with Research, 1 Harm Reduction Journal 1, [7] (2004), found at at http://www.harmreductionjournal.com/content/1/1/5.

5 Treatment admissions statistics for men and women from California help to illustrate this point. In the year 2002 the residential treatment admissions were as follows: 36% for methamphetamine; 27% for alcohol; 18% for cocaine/crack; 12% for heroin/other opiates; 6% for marijuana; and 1% for other drugs. For outpatient
studies indicate that both cocaine and methamphetamine can, by themselves, have a detrimental effect on a developing fetus.

It should be noted that alcohol is the other substance of choice\(^6\) and probably causes the most devastation to a developing child.\(^7\) This is generally due to the fact that, unlike the other drugs where an addicted woman is more likely to get a hit only once or twice a day, an alcoholic will often imbibe alcohol continuously.\(^8\) Thus, the developing fetus is continually exposed, which results in a high level of harm.\(^9\) The admissions, the percentages were as follows: 33% for methamphetamine; 19% for alcohol; 11% for cocaine/crack; 17% for heroin/other opiates; 19% for marijuana; and 2% for other drugs. Mary-Lynn Brecht, Lisa Greenwell, M. Douglas Anglin, *Methamphetamine Treatment: Trends and Predictors of Retention and Completion in a Large State Treatment System* (1992-2002), 29 Journal of Substance Abuse Treatment 296, 299 (2005). Treatment statistics in California for women show only slightly different results in the year 2000 [the statistics were based upon a sample of 15,000 women]. Those admissions were as follows: 41.8% for methamphetamine; 21.4% for alcohol; 11.7% for crack/cocaine; 13.4% for heroin/other opiates; 9.6% marijuana; and 2.1% for other. Christine E. Grella, Yih-Ing Hser, Yu-Chuang Huang, *Mothers in Substance Abuse Treatment: Differences in Characteristics Based on Involvement with Child Welfare Services*, 30 Child Abuse & Neglect 55, 63 (2006).

\(^6\) *Id.*

\(^7\) See Cynthia Kuhn, et al, *Buzzed* pp. 46-47 (2\(^{nd}\) Ed. 2003) (heavy alcohol consumption during pregnancy can lead to Fetal Alcohol Syndrome, and even moderate alcohol consumption can lead to Fetal Alcohol Effect); Lester, *supra* note 7, at [7] (FAS is arguably the most common non-genetic cause of mental retardation).

\(^8\) July 4, 2008 conversation with Traci R. Rieckmann, Ph.D., Research Assistant Professor, Dept. of Public Health and Preventive Medicine, Oregon Health and Sciences University.

\(^9\) *Id.*
detrimental effects of alcohol have been well-documented in other books and articles.\textsuperscript{10} Thus, while the abuse of alcohol is covered in my proposed solution, this article focuses on the effects of prenatal exposure to cocaine and methamphetamine.

\textbf{A. Cocaine and Crack}

As will be shown, various studies indicate that cocaine exposure, in and of itself, can have a detrimental effect on a developing fetus. Whether it will in fact have an effect, and the nature of that effect, is dependent upon a number of factors including the genetic makeup of the child,\textsuperscript{11} the severity of the mother’s drug use, and the mother’s abuse of other drugs. The state should, however, intervene whenever a woman is ingesting harmful substances because we do not know whether a child’s genetic make-up will protect it from the effects of exposure, and we know that most abusers are polydrug users.\textsuperscript{12} Because the harm that results may be dependent upon the severity of

\begin{itemize}
\item \textsuperscript{10} See, Lester, \textit{supra} note , at 6 (chronicling the effects of alcohol exposure and referencing studies documenting the effects).
\item \textsuperscript{11} See G. Koren, et al., \textit{Novel Methods for Detection of Drug and Alcohol Exposure During Pregnancy: Implications for Maternal and Child Health}, 83(4) Clinical Pharmacology and Therapeutics 631 (2008) (scientists can now use hair to determine the level of prenatal drug exposure [at least during the second half of pregnancy]; in studying twins of drug-exposed mothers it has been shown that, although the hair levels of drugs for identical twins are similar, there is a large variability in exposure for non-identical twins).
\item \textsuperscript{12} DeBrauf, \textit{supra} note , at 285 (90\% of methamphetamine users in the study reported using one to five other licit and illicit drugs); Polina Friedland, \textit{Children and Mothers at Risk: a System Failing to Alleviate the Devastation of Drug Abuse}, 10 S. Cal.
the use, the nature of the state intervention should also be dependent upon the severity of the use. Thus, the spectrum can range from educational campaigns for the occasional user, to mandated drug and alcohol treatment and recovery services for the recalcitrant heavy abuser.

In terms of the harm caused, in 1994, it was quite clear that “[w]hen an addicted woman conceive[d] a child, her use of drugs and the circumstances of her being an addict ‘stack[ed] the deck’ against her developing child.” With regard to cocaine in particular, the research at the time indicated that use of the drug had a harmful effect on a developing fetus because of physical harm to the developing child, physical harm to the pregnant woman, and tendancy to lead to lack of prenatal care by the pregnant woman. As will be discussed, subsequently, in 2001, some commentators asserted that previous studies had significantly overstated the detrimental effects of cocaine. In response, more rigorous studies were conducted on the effect of prenatal exposure to cocaine. These studies demonstrate that while there is no evidence to support the existence of a “crack baby” syndrome, there is evidence of significant short and long-term detrimental effects of crack/cocaine exposure.

Interdisc. L.J. 107, 112 (2000) (average, addicted pregnant woman in treatment programs is a polydrug user).

Kosofsky, supra note , at 113 (cocaine, especially at high dosages, may place the fetus at risk of developmental harm).

Steverson, supra note .
Studies in the 1980's indicated that this harm to the developing fetus occurred because cocaine passes freely through the placenta. More recent studies have confirmed that, because of its low molecular weight, cocaine is able to cross the placental barrier with ease. Note, however, that recent evidence also indicates that the placenta may be able to at least partially block fetal exposure to cocaine, thus perhaps preventing some potential harm for some fetuses.

Once through the placental barrier, cocaine’s addictive and teratogenic characteristics can lead to withdrawal, respiratory problems, heart problems, congenital deformities, low birth weight, neurological damage, and death. In addition, many newborn cocaine-exposed infants will suffer from medical problems that, while often

15 Steverson, supra note , at 299-312.
17 Feng, Q., Postnatal Consequences of Prenatal Cocaine Exposure and Myocardial Apoptosis: Does Cocaine in Utero Imperil the Adult Heart?, 144 (7) British Journal Of Pharmacology 887 (Apr. 2005); see also Kosofsky, B., Cocaine-Induced Alterations in Neurodevelopment, Seminars in Speech and Language Vol. 19 (1998), 113.
18 See infra note .
19 Steverson, supra note , at 300-303; see also Feng, supra note , at 887 (finding that cocaine exposure was found to induce cell death (apoptosis) in cardiac cells which can cause cardiac abnormality in cocaine-exposed offspring; Kosofsky, supra note , at 113 (cocaine constricts vascular flow in the uterine environment that can cause damage to fetal tissues; in addition, cocaine decreases blood flow through the placenta, reducing oxygen and nutrients to the fetus, that may in turn be responsible for growth retardation and congenital malformations in cocaine-exposed children).
short-lived, can lead to extended stays in the hospital.\textsuperscript{20} This can generate significant expenses for the state.

During the 1980's and 1990's, however, the long-term effects of cocaine exposure were relatively unknown. It was predicted that the children were likely to have some special needs.\textsuperscript{21} Since that time, some commentators have asserted that the prediction of special needs was erroneous. Some commentators are simply refuting news reports that “the use of cocaine during pregnancy inevitably caused significant and irreparable damage to the developing fetus.”\textsuperscript{22} However, such news reports were not part of scholarly legal or medical journals and thus do not impact policy arguments made in such journals.

Other commentators go beyond the refutation of news reports and suggest that cocaine exposure by itself does not cause serious harm to a developing fetus.\textsuperscript{23} Some

\begin{itemize}
  \item \textsuperscript{20} See Steverson, \textit{supra} note , at 306-307 (outlining the medical issues).
  \item \textsuperscript{21} Steverson, \textit{supra} note , at 308.
  \item \textsuperscript{22} Lynn M. Paltrow, David S. Cohen, Corinne A. Carey, \textit{2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs}, p. 1, found at \url{http://advocatesforpregnantwomen.org}.
  \item \textsuperscript{23} Paltrow et al, \textit{supra} note , at 1 (“studies establish that the impact of cocaine on the developing fetus has been greatly exaggerated and that other factors are responsible for many of the ills previously attributed to pregnant women’s use of cocaine.”); Deborah Frank et al., \textit{Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review}, 285 (12) JAMA 1613, 1621 (2001) (“Among children up to 6 years of age, there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors”).
\end{itemize}

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contend that “the inner-city child who has had no drug exposure at all is doing no better than the child labeled a ‘crack-baby.’”\textsuperscript{24} However, as several commentators stated in a thoughtful and expansive article on the subject, “such exaggerated statements about the benign effects of cocaine. . .can have negative policy implications.”\textsuperscript{25}

The statements are exaggerated because they ignore the short-term effects of cocaine exposure on a newborn infant. The most pronounced short-term effect of prenatal exposure is drug withdrawal of the infant upon birth.\textsuperscript{26} The symptoms of such withdrawal include “high-pitched crying, sweating, trembling, irritability, poor feeding, restlessness, and upset stomach (including vomiting and diarrhea).”\textsuperscript{27} The symptoms can last from two to three weeks, up to four to six months.\textsuperscript{28} A newborn does not suffer these effects when it is simply born to a poor mother.

In addition, the statements have been refuted by subsequent studies. Studies that corrected some of the errors of the previous studies. Although these subsequent studies show that the question of whether cocaine-exposure has an impact on raw IQ is

\begin{flushleft}
\textsuperscript{24} Paltrow et al., \textit{Overview, supra note}, at 1. \\
\textsuperscript{25} Lester, \textit{supra note}, at 3. \\
\textsuperscript{26} Steverson, \textit{supra note}, at 301. \\
\textsuperscript{27} \textit{Id.} \\
\textsuperscript{28} \textit{Id.}
\end{flushleft}
currently in dispute, they have affirmed that prenatal cocaine exposure can have subtle, but serious long-term effects on the physiological, behavioral, and cognitive development of drug-exposed children. It is important to note that while these studies found that factors such as poverty or the use of alcohol and tobacco can exacerbate the effects of cocaine-exposure, they present strong evidence that cocaine, by itself, can

29 A number of studies have demonstrated that cocaine exposure does not appear to affect the raw IQ of children. See Chasnoff, L.J., Anson A, Hatcher R, Stenson H., Laukea, K, Randolph L.A., *Prenatal Exposure to cocaine and other drugs. Outcome at four to six years*. Annals of the New York Academy of Sciences, Vol. 846 (June 21, 1998), 323 (there were no significant differences on standardized tests between cocaine-exposed and nonexposed children and 4 and 6 years); see also Beeghly; Martin; et. al. *Prenatal Cocaine Exposure and Children’s Language Functioning at 6 and 9.5 Years: Moderating Effects of Child Age, Birthweight, and Gender*. Oxford Journal of Pediatric Psychology Vol 31(1) (April 20, 2005), 98-115; Hurt, H; Malmud E; Betancourt L; Braitman LE; Brodsky NL; Giannetta J. *Children with in utero cocaine exposure do not differ from control subjects on intelligence testing*. Archives Of Pediatrics & Adolescent Medicine Vol. 151(12) (Dec. 1997), 1237-41 (In study of children of low socioeconomic status backgrounds it was found that scores on standardized IQ tests did not differ significantly between exposed and nonexposed children. All scored below average.).

Other studies indicate that cocaine exposure can affect raw IQ, particularly as the child gets older. See Scott D. Azuma and Ira J. Chasnoff, *Outcomes of Children Prenatally Exposed to Cocaine and Other Drugs: A Path Analysis of Three-Year Data*, Pediatrics Vol. 92(3) (Sept. 1993), 400 (cocaine exposure had a negative effect on IQ at age 3 that was further confounded by external variables, including the home environment); Lester, *supra* note , at 10 (finding that the effects of cocaine on IQ increased over time from 1.5 in infancy to 3.5 IQ points at age 7. The authors of the study predicted that if the pattern continued, at age 11 the child would have an IQ deficit of 7.6 points.).


31 Henrietta S. Bada, et al., *Impact of Prenatal Cocaine Exposure on Child Behavior Problems through School Age*, 119, no 2. Pediatrics e348, 357 (2007) available at http://pediatrics.aapublications.org/cgi/content/full/119/2/e348 (their study demonstrated that high alcohol and tobacco use had as great an impact as prenatal cocaine exposure
cause detrimental effects. Further, given that a large percentage of cocaine and methamphetamine users use alcohol, tobacco and marijuana “more frequently and more copiously than nonusers,” the child of a cocaine or methamphetamine user is likely to suffer the additive and detrimental effects of these other substances.

One of the long-term effects that the subsequent studies found is that cocaine and other drugs affect the developing brain such that it creates a predisposition for the use and abuse of controlled substances. A second effect is an increased possibility on childhood behavior problems; see also Luis B. Curet, Drug Abuse During Pregnancy, 45(1) Clinical Obstetrics and Gynecology 73, 75 (2002) (cataloging the harmful effects of smoking on a developing fetus).

Put in cites from the studies.


See Bada, supra note , at 356 (outlining the adverse effects of tobacco); Smith 2003, supra note , at 21 (findings support the work of other investigators that nicotine has an effect on fetal growth); Frank, supra note , at 1620-1621 (disputing the detrimental effects of prenatal cocaine exposure, but acknowledging the detrimental effects of prenatal tobacco exposure).

Bennet D., Bendersky, M., Lewis, M., Preadolescent Health Risk Behavior as a Function of Prenatal Cocaine Exposure and Gender, 28(6) Journal Of Developmental And Behavioral Pediatrics 467, 472 (Dec. 2007) (In a study of 154 children, 60 of whom where prenatally exposed, 36% of cocaine-exposed males at age 10.5 had engaged in
that a child will exhibit learning, attention, or behavioral disorders during childhood.\textsuperscript{36}

For example, in a 2007 study, nine researchers recognized that reports on the effects of prenatal cocaine exposure on childhood behavior had shown conflicting results.\textsuperscript{37}

Therefore, they undertook a study to try to resolve the conflict. The researchers controlled for such confounders as polydrug use and found that high prenatal cocaine exposure “was associated with higher behavior problem scores compared with some or no cocaine use during pregnancy.”\textsuperscript{38} This effect persisted to seven years (the age at which the study stopped).\textsuperscript{39} Their findings added credence to other reported associations between prenatal cocaine exposure and childhood behavior problems.\textsuperscript{40}

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36 Singer, \textit{supra} note, at 1957 (study found significant cognitive deficits with cocaine-exposed children in first two years of life); Bennett, \textit{supra} note, at 467 (study demonstrated that cocaine exposed children exhibited inhibitory control problems such as high levels of disobedience and rapid frustration with tasks); Kosofsky, \textit{supra} note, at 111 (exposure at critical periods in brain formation can cause malformation of brain circuitry with such malformations being evidenced as altered brain growth, delayed development, or altered cognitive, behavioral, or linguistic maturation).

37 See, Bada, et al., \textit{supra} note, at e348.

38 Bada, \textit{supra} note, at 352.

39 \textit{Id.}

The researchers indicated that their findings highlighted a need for continued prevention and treatment programs directed at illegal drugs.41

In addition, a large 2002 study of children up to two years of age was done. This study acknowledged the deficits in previous studies and therefore took care to avoid the methodological problems in those studies.42 After controlling for confounding variables the study found that the rate of mental retardation in high dosage cocaine-exposed children was 4.89 times higher than that expected in the population at large.43 In addition, the percentage of high dosage cocaine-exposed children with mild or greater delays that required intervention was “almost double the rate of the high-risk noncocaine-but polydrug-exposed comparison group.”44 The study concluded that it was possible that the children in the study would continue to have learning difficulties at school age because the scores in the study were “predictive of later cognitive outcome.”45 A subsequent 2006 study confirmed that the predictions of learning difficulties at school age was accurate. It found that by age seven, children prenatally exposed to cocaine were three times more likely to meet criteria for a learning disability

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41 Id. at 357.
43 Id. at 1958.
44 Id.
45 Id.
than nonexposed children, with the children being particularly likely to have math-related difficulties.\textsuperscript{46}

\textbf{B. Methamphetamine}

Recent studies demonstrate that while more research is needed concerning the effects of prenatal methamphetamine exposure, the available evidence demonstrates that prenatal exposure to methamphetamine is at least as detrimental as cocaine and potentially more detrimental. Similar to cocaine, prenatal exposure to methamphetamine can negatively impact a child’s physical health, cognitive ability, and behavioral health. Further, as will be shown below, several factors may lead to more severe difficulties for a child who is prenatally exposed to methamphetamine than for a child who is prenatally exposed to cocaine. Those factors include the chemical make-up of methamphetamine, the unhealthy living environment of many methamphetamine users, and the characteristics shared by many methamphetamine addicted mothers.

1. \textbf{Harmful Effects of Methamphetamine on a Developing Fetus}

Because the use of methamphetamine by pregnant women in the United States is a recent phenomenon, the scientific and medical world has just begun to study the

effects of prenatal methamphetamine exposure. Thus, there is still much to learn about such effects.\textsuperscript{47} However, some research has been done regarding the effects of prenatal methamphetamine exposure. As will be explained, this research demonstrates that methamphetamine exposure can cause both physical and neurological damage to a developing fetus. Unlike some of the early cocaine studies, these studies are more reliable. This is due to the fact that the researchers, having learned from the mistakes made in the cocaine research, have worked to avoid those mistakes.

Similar to cocaine, the developing fetus is exposed to methamphetamine use by its mother because methamphetamine freely crosses the placenta.\textsuperscript{48} With cocaine, however, the placenta seems to partially block fetal exposure,\textsuperscript{49} thus potentially ameliorating the effects of such exposure. Unfortunately, the placenta does not seem to have the same ability to block fetal exposure to methamphetamine.\textsuperscript{50} Thus, the effects  


\textsuperscript{49} Koren, \textit{supra} note , at 631 (in comparing the levels of cocaine concentrations of mother and child, it was found that the placenta appears to at least partially block fetal exposure because levels of cocaine in neonatal hair are substantially lower than levels in their mothers’ hair).

\textsuperscript{50} Koren, \textit{supra} note , at 631 (similar concentrations of methamphetamine exist in maternal and neonatal hair indicating that the placenta is not able to block fetal exposure to methamphetamine).
of prenatal exposure to methamphetamine have the potential to be more devastating than those associated with cocaine exposure.

Among other difficulties, such exposure may lead to physical damage such as central nervous system defects, cardiovascular system defects, oral clefts, and defects affecting the limbs. With regard to oral clefts, although such defects have not been reported with prenatal cocaine exposure, as of 1998, five different studies had reported the existence of cleft lip or palate with maternal amphetamine use. Although the individual reports indicated only an association with methamphetamine use, such associations become “better defined by the number of reports demonstrating similar findings in different populations.” It is hypothesized that such defects are more likely to occur if methamphetamine exposure occurs when oral facial development is occurring, generally prior to seven weeks gestation. As the above studies indicate, exposure at this time can lead to defects in other organs or body parts because other

51 Mathias B. Forrester and Ruth D. Merz, *Risk of Selected Birth Defects with Prenatal Illicit Drug Use*, 70(A) Journal of Toxicology and Environmental Health 7, 16 (2007) (study is limited, but its investigation found significantly higher than expected rates for methamphetamine, cocaine and marijuana among the listed types of birth defects); Wouldes, *supra* note at 1183 (reporting that “some of the methamphetamine effects that were reported in animal studies have also been found in methamphetamine exposed human infants.” These include clefting and cardiac anomalies. The human studies to which she refers are those reported in the Mark A. Plessinger article, *infra* note.


53 Plessinger, *supra* note , at 125.
organs are also developing in the first trimester of pregnancy.

In addition to physical defects, other, earlier studies indicated that prenatal methamphetamine exposure increases the risks of preterm births, lower birth weight, decreased fetal growth, smaller head circumference, and neurologic alterations.\textsuperscript{55} Lower birth weight infants have an increased risk of mortality and infant morbidity, while small-for-gestational-age infants have an increased risk of long-term health and neurodevelopmental implications.\textsuperscript{56} Although these early studies had some limitations that impaired their reliability,\textsuperscript{57} a recent paper by three researchers indicated that the studies “do suggest that these children may be at risk developmentally due to both the direct effects of prenatal drug exposure and the caregiving environment associated with that drug use.”\textsuperscript{58}

\textsuperscript{54} Plessinger, \textit{supra} note \textsuperscript{1}, at 125.
\textsuperscript{55} Plessinger, \textit{supra} note \textsuperscript{1}, at 124 (reporting on three studies where such effects were reported).
\textsuperscript{56} Smith (2006), \textit{supra} note \textsuperscript{1}, at 1155.
\textsuperscript{57} Amelia Aria et al, \textit{Methamphetamine and Other Substance Use During Pregnancy: Preliminary Estimates from the Infant Development, Environment, and Lifestyle (IDEAL) Study}, 10(3) Maternal and Child Health Journal 293, 294 (2006) (previous studies had limitations due to small sample size, confounding with other variables, especially other drugs, and problems with detection of methamphetamine exposure status); Wouldes, \textit{supra} note \textsuperscript{1}, at 1183 (previous studies are limited in several ways).
\textsuperscript{58} Wouldes, \textit{supra} note \textsuperscript{1}, at 1183; \textit{see also}, Aria, \textit{supra} note \textsuperscript{1}, at 294 (despite limitations of earlier studies, the literature suggests that methamphetamine exposed children “might be at risk for poor child outcomes due to methamphetamine exposure, alcohol and tobacco use and factors relating to the caregiving environment”).
More recent studies, that were careful to avoid some of the methodological problems existing with the earlier studies,\(^5^9\) have found that after controlling for alcohol, tobacco and other drugs, prenatal methamphetamine exposure is associated with a higher incidence of smaller-for-gestational-age infants, preterm infants and lower birth weight infants.\(^6^0\) Significantly, a recent study found that, similar to cocaine exposure, this growth-restricting effect of methamphetamine was not ameliorated through adequate prenatal care.\(^6^1\)

2. **Exacerbating Factors**

In addition to the harm caused by methamphetamine exposure, the fetus of a methamphetamine user may suffer from additional harm due to exacerbating factors. One such factor is that a women who abuses methamphetamine is also highly likely to


\(^6^0\) Smith (2006), *supra* note , at 1153 (it should be noted that the authors also found that other factors contributed to lower birth weight, however, the authors also found that the majority of the factors (e.g., <5 prenatal visits, <$10,000 annual household income, prenatal tobacco exposure, and being without a partner) are likely to exist with a significant percentage of maternal methamphetamine users); Lynne Smith et al., *Effects of Prenatal Methamphetamine Exposure on Fetal Growth and Drug Withdrawal Symptoms in Infants Born at Term*, 24(1) Journal of Developmental and Behavioral Pediatrics 17,21 (2003) (finding an increased risk of growth restriction for infants prenatally exposed to methamphetamine).

\(^6^1\) Smith (2003), *supra* note , at 22 (findings of no effect on growth restriction from adequate prenatal care were consistent with findings by Richardson and colleagues in cocaine-exposed infants—citing, Gale A. Richardson et al., *Growth of Infants Prenatally Exposed to Cocaine/Crack: Comparison of a Prenatal Care and a No Prenatal Care Sample*, 104 Pediatrics e18 (1999).
abuse both alcohol and tobacco. As a result, the developing fetus is subjected to the harmful effects of methamphetamine, alcohol and tobacco, all three of which are harmful in and of themselves.

A second exacerbating factor is that illicit drug use is associated with having fewer prenatal visits. A third exacerbating factor is the poor home environment that an exposed child will often go to if its mother retains custody. This poor environment occurs because many methamphetamine using women are likely to have poor parenting and care-giving skills, and are extremely likely to be dependent upon methamphetamine. In fact, one study stated that “any sign of methamphetamine use during pregnancy is likely to be predictive of methamphetamine dependence;

See text supra at note .
See text supra at note .

Smith 2006, supra note , at 1152 (in the study the methamphetamine using group had fewer prenatal visits); Aria, supra note , at 298 (IDEAL study demonstrated that illicit drug use was associated with having fewer than 11 prenatal visits); Polina Friedland, Children and Mothers at Risk: a System Failing to Alleviate the Devastation of Drug Abuse, 10 S. Cal. Interdisc. L.J. 107, 117 (2000) (“substance-abusing women who carry their child to term frequently do not have access to or avail themselves of prenatal care and are often ignorant about infant care the developmental needs of children.”).

DeBrauf, supra note , at 286 (findings “suggest that methamphetamine using women are more likely to have multiple, intertwine psychosocial risks that may result in maladaptive parenting and caregiving.”).

DeBrauf, supra note , at 287 (almost 75% of women who used methamphetamine during pregnancy had a high likelihood of being substance dependent).
conversely, ‘casual use’ or even ‘abuse’ without dependence is likely to be infrequent.”67

This dependence can lead to abuse or neglect.68 In addition, the homes of many methamphetamine users put newborns at risk from the chemicals used to make methamphetamine.69

II. Number of Children Exposed

Not only is methamphetamine use by its mother problematic for a child, but there is evidence to suggest that the numbers of children exposed to methamphetamine are likely to be higher than those of children exposed to cocaine. This is due to the fact that methamphetamine is currently the most widely used drug worldwide.70 Further, data suggests that, partially due to the availability of methamphetamine, the rate of illicit drug

67 Id.


69 Smith 2008, supra note , at 27 (newborns could be at risk from the chemicals used to make methamphetamine); Davies, supra note , at 1369 (care-giving environment of methamphetamine users are often characterized by hazardous conditions).

70 Smith (2008), supra note , at 20; see Mary-Lynn Brecht, supra note , at 299 (as of 2002, for residential treatment admissions in California, 36% were for methamphetamine, 27% were for alcohol, 18% were for cocaine/crack, 12% were for heroin/other opiates, 6% were for marijuana, and 1% were for other drugs; outpatient admissions have similar numbers, 33%, 19%, 11%, 17%, 19% & 2% respectively).
use during pregnancy might be increasing.\textsuperscript{71} In addition, data shows that women comprise approximately 45% of this large population of users.\textsuperscript{72}

This high number of users by itself is likely to translate into more methamphetamine-exposed infants. Unfortunately, however, the numbers are likely to be even higher because the majority of methamphetamine users who become pregnant will not stop using methamphetamine during the pregnancy.\textsuperscript{73} This is in contrast to other women users of other drugs, where the percentage of use dropped during pregnancy.\textsuperscript{74}

III. Changes Since 1994

Not surprisingly, in addition to changes on the drug and alcohol front, a number of changes have occurred in the legal landscape since 1994. A federal statute and a large number of state statutes have been enacted. All in an attempt to combat the problem of substance abusing women and prenatally exposed infants. In addition, in part due to new legislation, the available treatment options for pregnant and parenting...
substance-abusers have expanded. Further, civil and criminal cases have been decided that have an impact on the problem.

The purpose of this section is to examine these changes in order to determine two things. One, has my 1994 proposed legislation been adopted in whole or part by any state? Second, do the changes cataloged above indicate that the 1994 proposed legislation should be changed in any way. The section will demonstrate that although no state has adopted all of the components of my 1994 proposed legislation, most of the individual components have been adopted in some form or another. The section will then discuss the positive and negative effects of such piecemeal adoption. The section will conclude that the proposed legislation does need some change, but the core elements should remain.

A. The 1994 Proposed Legislation

Before discussing the changes that have occurred, it is necessary to remember that in 1994, the states had just begun to understand and attempt to grapple with the extremely complex problem of substance abusing women and their children. At that time, there was a marked shortage of effective drug and alcohol treatment programs for women, pregnant women or women with small children. In addition, many states were responding to the problem through removal of the prenatally exposed children from their mothers’ custody or through punitive measures, i.e., prosecution followed by a period of incarceration. I, along with others, demonstrated that such an approach to the problem
was ineffective for a variety of reasons. One reason for the ineffectiveness of the
states’ approaches, was that they were reactive rather than proactive. Thus, even if the
states’ approaches worked to protect the prenatally exposed children after birth (an
assumption that I argued was incorrect), they did nothing to prevent future children from
being prenatally exposed to harmful substances. The 1994 proposed legislation was an
attempt to design a proactive solution.

This solution was to be implemented in the future because its success depended
upon the existence of effective treatment programs for pregnant and/or mothering
substance abusers, programs that did not yet exist in large numbers. Once those
programs were in place, however, if a woman chose to forgo offered and available
treatment, then the state could intervene on behalf of her current and future children.
The nature of this intervention was the subject of my 1994 proposed legislation.

This legislation had three basic components. The first component created the
crime of fetal abuse.\textsuperscript{75} This was done to give the state jurisdiction over those women

\footnotesize\textsuperscript{75} Steverson, supra note \textit{at} 333, 334 (“Any person who knowingly, or with reckless
disregard for the consequences, uses alcohol or uses controlled substances not
prescribed by a physician or abuses controlled substances prescribed by a physician,
where such use endangers the person or health of an unborn child, shall be guilty of
criminal fetal abuse. A defense to the crime is that the woman is enrolled in a drug
treatment program. \textit{See also}, James Denison, Note, \textit{The Efficacy and Constitutionality
of Criminal Punishment for Maternal Substance Abuse}, 64 S. Cal. L. Rev. 1103, 1121
(1991) (Sample statute provided that “Any person who, under circumstances or
conditions likely to produce great bodily harm or death, knowingly or with reckless
disregard for the consequences causes or permits the person or health of a child \textit{in
utero} to be endangered by substance abuse is guilty of criminal fetal abuse.”).
who have harmed their children through prenatal exposure and who have not submitted or will not voluntarily submit to treatment. However, a crucial part of the statute was that the crime not lead to incarceration. Rather, depending upon whether or not the woman was pregnant, the judge was directed to apply either the second or third component of the legislation.

Thus, the second component provided that if a woman had already given birth, then sentencing for such a crime should not, as a first resort, lead to incarceration. Rather, the woman should have a choice of incarceration or probation. If she chose probation, then it was to be conditioned upon enrollment in a drug treatment program and no-pregnancy. Finally, the third component provided that if the woman was still pregnant at the time of conviction, and was not actively participating in a drug treatment program, then the court should civilly commit her to an appropriate drug treatment program. The probation conditions and civil commitment were all designed to help the women lead a drug-free life and to prevent the birth of any additional drug-exposed children.

As can be seen, in order to be effective, all parts of the legislation need to be enacted. In addition, the state needs to provide for comprehensive treatment programs.

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76 Steverson, supra note , at 336.
77 Steverson, supra note , at 334.
78 Id.
Unfortunately, as will be shown, some states have not enacted any portion of my 1994 proposed legislation, but have instead followed the traditional route of enacting legislation that classifies prenatal drug (and sometimes alcohol) exposure as abuse and/or neglect under their child welfare laws. Others continue to attempt to punish substance abusing women through incarceration, either on drug possession charges or charges relating to their use of drugs during pregnancy. In contrast, some states have taken a more progressive approach and have put in place legislation that is similar to portions of my 1994 proposed legislation. For example, a number of states have recognized the ineffectiveness of punishing an addicted person and have adopted the idea of alternative sentencing for drug-related crimes. These states have put in place a major piece of the 1994 proposed legislation, that of diversion from incarceration to comprehensive treatment programs.

In addition, a major and beneficial change since 1994 is legislation attempting to provide access to more effective drug treatment programs for pregnant and/or mothering substance abusers, something that my 1994 proposal stressed as being vitally important to the success of any initiative. In addition to providing access, a number of states have created mechanisms that are designed to incentivize the greatest number of pregnant and mothering substance abusers to access appropriate services and treatment programs. Finally, a few states have enacted legislation allowing for the civil commitment of pregnant women, an approach that my 1994 proposed legislation advocated for egregious cases.
B. Civil Child Abuse and Neglect

The most traditional approach to the problem of prenatal drug and alcohol exposure is the use of the child welfare system to protect the exposed child either through the provision of services to the family and/or the removal of the child from the home. As of 1994, Florida, Illinois, Indiana, Massachusetts, Minnesota, Nevada, Oklahoma and Utah already had some type of abuse, neglect or reporting statute in place for prenatally exposed children.\(^79\) Since that time, at least twelve states have added a prenatal abuse/neglect type statute.\(^80\) As will be discussed below, some of the

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\(^79\) Steverson, supra note, at 329, fn 250.

\(^80\) Alaska Stat. §47.17.024 (Westlaw 2008) (health care provider obligated to report prenatal exposure to child welfare); Ariz. Rev. Stat. Ann. §8-819 (Westlaw 2008) (prenatal exposure is a factor in determining if a child is neglected); Ark. Code Ann. §9-27-303(36(B)(I) (Westlaw 2008) (defining neglect to include prenatal exposure); Colo. Rev. Stat. Ann. §19-3-102(1)(g) (Westlaw 2008) (defining a child as abused or neglected if the child has been prenatally exposed); D.C. Code §4-1321.02(a) (Westlaw 2008) (defining a neglected child to include a child that was prenatally exposed); Haw. Rev. Stat. Ann. §587-89(a)(1)-(3) (Westlaw 2008) (mandatory reporter may report prenatal exposure); Ky. Rev. Stat. Ann. §214.160 (Westlaw 2008) (allowing a physician to test a pregnant woman or a newborn infant and indicating that a positive test requires the physician to determine whether abuse or neglect has taken place, and if it has, to report such); LA Stat. Ann.-Ch.C. Art 603(14) (Westlaw 2008) (prenatal neglect, which occurs through prenatal exposure to drugs, constitutes neglect); Mich. Stat. Ann. §722.623a. (Westlaw 2008) (a mandated reporter is obligated to report to child welfare if has cause to suspect or knows that a newborn infant has any amount of alcohol or a controlled substance in its body); Mo. Ann. Stat. §191.737 (Westlaw 2008) (physician or health care provider may refer to child welfare children who may have been exposed to alcohol or drugs); West’s North Dakota Cent. Code Ann. §§50-25.1-17, 50-25.1-16 (Westlaw 2008) (if results of a test of a pregnant women or newborn are positive then physician must report the results to child welfare; all mandatory reporters must report to child welfare if know or have reasonable cause to suspect that a woman is pregnant.
states have enacted legislation such that adequate comprehensive treatment services are available for the mother if a child is found to be neglected or abused; however, a few of the states have only enacted the neglect or reporting legislation. In such a case, the state risks having a number of children placed in foster care and parental rights of the mother terminated because there are inadequate services available to assist the mother in overcoming her substance abuse problem.

C. Criminal Prosecutions

Since 1994, a number of jurisdictions have continued to attempt to prosecute women for the harm that they have caused to their child in utero. Although my 1994 proposed legislation created the crime of fetal abuse, it differed significantly from the current attempts to criminalize prenatal exposure in that it did not advocate incarceration of the women involved. As explained previously, incarceration is not beneficial to the child, the mother, or the state.\textsuperscript{81} Thus, my 1994 proposed legislation directed the court to offer the convicted woman probation as an alternative to incarceration if the woman chose this option. Because of the ineffectiveness of incarceration and the harm caused by it, unless a state is willing to mandate or strongly urge diversion or alternatives to incarceration, then it should not allow for prosecution of

\textsuperscript{81} Steverson, \textit{supra} note , at 325-329.
a woman for abusing drugs or alcohol while pregnant.

In attempting to prosecute women for prenatal exposure, the charges that have been brought since 1994 include criminal neglect,\textsuperscript{82} child abuse,\textsuperscript{83} criminal mistreatment,\textsuperscript{84} wanton endangerment,\textsuperscript{85} child endangerment,\textsuperscript{86} reckless injury,\textsuperscript{87} manslaughter,\textsuperscript{88} and homicide.\textsuperscript{89} In the majority of cases, however, if the case goes up on appeal, the conviction is overturned.\textsuperscript{90} The reasoning supporting the majority of the

\textsuperscript{82} Whitner v. State, 328 S.C. 1, 492 S.E. 2d 777 (S.C. 1997).


\textsuperscript{87} Collins v. State, 890 S.W.2d 893 (Tex. App. 1994).

\textsuperscript{88} State v. Aiwhohi, 109 Hawai‘i 115, 123 P.3d 1210 (Hi 2005).


reversals is that of statutory interpretation, although two cases were overturned on grounds of ineffective assistance of counsel. For reasons of due process, a criminal statute is to be strictly construed, and if the statute at hand does not by its words apply to an unborn child, most courts will find that no crime has been committed by the mother through her conduct during pregnancy.

In spite of the above, the possibility exists for women to be prosecuted and incarcerated for their substance abuse during pregnancy. First, there are instances when women have pled guilty or been successfully prosecuted and not appealed their conviction. In addition, at least two states have found that a woman could be charged with a crime for her conduct during pregnancy, even in the absence of a specific statute. In South Carolina, the supreme court found that a viable fetus was a person for civil and


91 Aiwohi, 123 P.3d at 1223-1224; Wade, 223 S.W.3d at 665; Hudson, 2007 WL at *2; Kilmon, 905 S.2d at 311-314; Martinez, 137 P.3d at 1196-1197; Reinstein, 894 P.2d at 735; Deborah J.Z., 596 N.W.2d at 492-493; Encoe, 885 P.2d at 598; Collins, 890 S.W.2d at 897-898.

92 McKnight, 2008 WL at *2-*7; Richards, 2005 WL at *5.

93 Id.

94 See, e.g., Adam Nossiter, In Alabama, A Crackdown on Pregnant Drug Users, (3/15/2008) available at www.nytimes.com (discussing a recent flurry of prosecutions for prenatal drug use in a small town in Alabama. Because the town is so small, the women are not contesting the prosecutions or the incarcerations).
criminal purposes, even though no explicit statutory authority existed on the point.\textsuperscript{95}

Also, the Kentucky Court of Appeals held this year that a viable fetus was a person for purposes of criminal law.\textsuperscript{96} Based on this finding, the court upheld an indictment for wanton endangerment based upon a mother’s use of cocaine during pregnancy.\textsuperscript{97} In order to support its holding, the court of appeals had to avoid the application of \textit{Commonwealth v. Welch},\textsuperscript{98} where the Kentucky supreme court vacated a criminal child abuse conviction that was based upon prenatal exposure on the basis that the statute did not cover prenatal injury.\textsuperscript{99} The court of appeals held that \textit{Welch} was not applicable because it had been effectively overruled by a Kentucky supreme court case that recognized a viable fetus as a person for purposes of bringing criminal charges against a third party.\textsuperscript{100} The \textit{Cochran} court indicated that it was illogical to allow criminal charges for injuries to a viable fetus caused by a third party and not allow criminal charges for injuries to a viable fetus caused by the mother.\textsuperscript{101} It remains to be seen

\textsuperscript{95} \textit{Whitner}, 492 S.E.2d at 779-780; \textit{see also McKnight}, 576 S.E.2d at 174 (court reiterated the holding of \textit{Whitner} in upholding a homicide by child abuse conviction; the charges were later overturned on post-conviction relief for ineffective assistance of counsel, State v. McKnight, __ S.E.2d __, 2008 Wl 2019141 (S.C. 2008)).

\textsuperscript{96} \textit{Cochran}, 2008 WL at *7.

\textsuperscript{97} \textit{Id}.

\textsuperscript{98} \textit{Commonwealth v. Welch}, 864 S.W.2d 280 (Ky. 1993).

\textsuperscript{99} \textit{Id}.


\textsuperscript{101} \textit{Id}.
whether the Kentucky supreme court will uphold *Cochran* or not, especially given that other courts have not found it illogical to distinguish between injuries caused by a third party and injuries caused by the fetus’ mother.\textsuperscript{102}

In addition to the above case law, at least two states have made changes to their statutory schemes that could allow for the prosecution of women who abuse harmful substances while pregnant.\textsuperscript{103} For example, for purposes of assaultive offenses,\textsuperscript{104} the Tennessee Code defines “another,” “individual,” “individuals” and “another person” to include a viable fetus where such terms refer to the victim of a crime.\textsuperscript{105} In addition,

\textsuperscript{102} See, e.g., Deborah J.Z., 596 NW2d at 490 (Wisconsin allows for criminal charges against a third party who causes injury to a fetus, but not against a mother who harms her fetus).

\textsuperscript{103} It has been asserted that Ariz. Stat. §13.604.01(m) can be used to allow for prosecution of substance-abusing pregnant women. Reproductive Rights 2005 Mid-year report available at [www.reproductiverights.org/st_leg_summ_midyear_05.html](http://www.reproductiverights.org/st_leg_summ_midyear_05.html). The relevant provision indicates that for purposes of punishing a defendant for committing a dangerous crime against children, the phrase “minor under twelve” includes an unborn fetus. However, the definition only applies for purposes of punishment and Arizona has not changed its child abuse statute to include an unborn fetus. (Ariz. Stat. §13-3623 defines a child for purposes of criminal child abuse as an individual who is under eighteen years of age.) In addition, other possible statutes (negligent homicide, manslaughter, 2\textsuperscript{nd} degree murder, and 1\textsuperscript{st} degree murder) all specifically exclude conduct of the mother of the unborn child. Ariz. Stat. §§13-1102, 113-1103, 13-1104, 13-1105.

\textsuperscript{104} Such offenses include assault (including reckless assault) and reckless endangerment. Tenn. Code §§39-13-101 & 39-13-103 (Westlaw 2008).

\textsuperscript{105} Tenn. Code §39-13-107(a) (Westlaw 2008).
similar terms in the criminal homicide statutes also are defined to include a viable fetus. Similar statutes in other states specifically exclude a mother from prosecution under such statutes; however, Tennessee provides no exclusion. Thus, while the definitions above do not apply to the criminal child abuse and neglect statutes, the Tennessee attorney general has opined that a mother who ingests an illegal drug that injures her viable fetus can be criminally liable for assault, aggravated assault, or reckless endangerment.

Similar to Tennessee, Oklahoma defines a human being to include an unborn child for purposes of its homicide statute. Although the statute provides for an exception for the mother of the unborn child, the exception is worded in such a way as to leave the door open for possible prosecution of a mother. Specifically, the exception

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106 The homicide offenses include first degree murder, second degree murder, voluntary manslaughter, criminally negligent homicide, or vehicular homicide.


108 See., e.g., TX Penal Code §1.07(26) defines an “individual” as a human being who is alive, including an unborn child at every stage of gestation from fertilization until birth. Although some commentators have indicated that this definition opens the door to prosecution of mothers for prenatal exposure, an examination of all of the specific statutes that could be used for such purpose demonstrates that each provides an exemption for conduct of the mother of the unborn child. TX Penal Code §§19.06 (criminal homicide); 20.01 (kidnapping–individual = born human being); 22.12 (assaultive offenses–including reckless endangerment, abandoning or endangering a child, injury to child, aggravated assault, and assault).


111 Okla. St. 21 §691 (Westlaw 2008).
provides that “under no circumstances shall the mother of the unborn child be prosecuted for causing the death of the unborn child unless the mother has committed a crime that caused the death of the unborn child.” (Emphasis added.)\textsuperscript{112} Given that use of a dangerous controlled substance is a crime in Oklahoma,\textsuperscript{113} it may be possible for the state to prosecute a woman on the grounds that she committed the crime of use of a dangerous controlled substance which caused the fetus’ death.

Although only a handful of states allow for prosecutions specifically for prenatal exposure, it is important to recognize that even in the absence of specific prosecutions, many women will be prosecuted for prostitution, property crimes, and/or drug-related crimes.\textsuperscript{114} Thus, the state does not provide legislation or court procedures for diversion or alternative sentencing, a large number of women with young children will end up in jail. Fortunately, some jurisdictions are providing for just such alternatives. For example, Missouri enacted legislation mandating the creation of a pilot project called Alt-care, to provide a comprehensive substance abuse and rehabilitation program as an

\textsuperscript{112} \textit{Id.}

\textsuperscript{113} Ok. St. T. 63-2-405 (Westlaw 2008) (use of drug paraphernalia to ingest a dangerous controlled substance is a misdemeanor).

\textsuperscript{114} \textit{See, e.g., State v. Luster, 204 Ga. App. 156, 419 S.E.2d 32 (1992) (mother who exposed child to cocaine during pregnancy was charged with possessing cocaine and delivering and distributing cocaine (to the unborn child). The second charge of delivering and distributing was dismissed, however, the first charge of possession was allowed to stand).}
alternative to incarceration for pregnant and mothering substance-abusers.\footnote{115} In
addition, California obtained funding for and began a similar program for pregnant and
mothering substance-abusers.\footnote{116} Such programs are good models for other states to
replicate.

\textbf{D. \textit{Drug Treatment Programs and Outreach}}

As previously stated, my 1994 proposed legislation indicated that the state
needed to have effective treatment programs available to pregnant and mothering
substance abusers prior to any coercive action by the state. A corollary to the existence
of effective programs is the implementation of mechanisms to reach out to the women in
need of the services. Needless to say, I was not the only one to indicate the need for
such programs and outreach. A number of commentators during that time period
pointed out the need for effective treatment programs and outreach.\footnote{117} This point has


\footnote{116} Cal. Pen. Code §1174 (creating the Pregnant and Parenting Women’s Alternative
Sentencing Program Act); see Lester, supra note , at [25] (describing California’s
program).

\footnote{117} Kathryn Jones, \textit{Prenatal Substance Abuse: Oregon’s progressive approach to
treatment and child protection can support children, women, and families}, 35 Willamette
L. Rev. 797 (Fall 1999); Julie Zitella, \textit{Protecting Our Children: A call to reform state
policies to hold pregnant drug addicts accountable}, 29 John Marshall L. Rev. 765
(Spring 1996); Victoria Swenson and Cheryl Crabbe, \textit{Pregnant Substance Abusers: A
problem that won’t go away}, 25 St. Mary’s Law Journal 623 (1994); Janna Merrick,
\textit{Maternal Substance Abuse During Pregnancy: Policy implications}

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also been reiterated in current literature.¹¹⁸

A number of states heard the commentators’ cries and enacted legislation designed to increase the availability of effective treatment programs. Some states took a fairly minimalist approach and simply indicated that treatment centers were to give priority to pregnant substance abusers and/or not discriminate against pregnant substance abusers.¹¹⁹ While helpful, such legislation does nothing to attempt to reach out to pregnant and mothering substance abusers. Further, it does not ensure the existence of treatment programs that can meet the complex needs of pregnant and mothering substance-abusers.

Some states attempted to rectify this latter problem by putting in place mechanisms for creating programs designed specifically to meet the needs of the

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¹¹⁹ See, e.g., Ga. Code Ann. §§26-5-5 & 26-5-20 (Westlaw 2008) (respectively directing the children’s welfare department to promulgate “criteria for providing priority in access to services and admissions to programs for drug dependent females,” and requiring all drug treatment programs to “implement a priority admissions policy for the treatment of drug dependent females which provides for immediate access to services for any such female applying for admission.”).
pregnant or mothering substance abuser,\textsuperscript{120} or mechanisms for coordinating services among various agencies to better meet the needs of pregnant or mothering substance abusers.\textsuperscript{121} Others attempted to address only the issue of outreach.\textsuperscript{122} At least one state, Illinois, attempted to address both problems by directing the coordination of services for pregnant and mothering substance abusers, while also putting in place

\textsuperscript{120} See, e.g., Conn. Gen. Stat. Ann. §17a-710 (Westlaw 2008) (policy to develop and implement comprehensive treatment programs for substance-abusing women and their children); Kan. Stat. Ann. §65-1,165 (Westlaw 2008) (the provision does the following: gives priority for service to a pregnant woman referred for service; directs the secretary of social and rehabilitation services to ensure that family oriented substance abuse treatment is available; and prohibits substance abuse treatment facilities that receives public funds from refusing to treat women solely because they are pregnant.); Vernon’s Ann. Missouri Stat. §191.731 (Westlaw 2008) (directing the division of alcohol and drug abuse to ensure that family-oriented substance abuse is available; mandating that a pregnant woman referred for substance abuse treatment be a “first-priority user”of available treatment; and prohibiting publicly funded treatment programs from refusing to treat pregnant women);

\textsuperscript{121} See, e.g., 71 Pa. Stat. §553 (a) (Westlaw 2008) (the Department of Health directed to find the means to provide residential drug and alcohol treatment and related services for pregnant women, mothering women, and women who have lost custody of their children, but who have a reasonable likelihood of regaining custody by participating in the treatment program.); Ind. P.L. 193-2007, Sec. 5, eff July 1, 2007, as noted in Ind. St. 12-23-14.5-1 (Westlaw 2008) (establishing the prenatal substance abuse commission “to develop and recommend a coordinated plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco.”).

\textsuperscript{122} Me. Rev. Stat. Tit. 22, §§4011-B, 4004-B (Westlaw 2008) (creates an obligation of health care provider to report suspected cases of prenatal exposure, however, such notification is to only be used by the child welfare department to investigate, assess, and refer the child or mother or both to social service agency or substance abuse prevention service); Nev. Rev. Stat. Ann. 432B.220 (Westlaw 2008) (provides that certain mandatory reporters are required to report suspected cases of prenatal drug exposure to child welfare department, but department is not to investigate if the problem can be eliminated by referral to or participation in appropriate services).
mechanisms for reaching out to the affected women. It did so however, only for pregnant substance abusers, not mothering substance abusers. Mothering substance abusers who gave birth to a drug-exposed infant were subject to Illinois’ neglect laws.

While the above legislation is a start, simply providing appropriate treatment programs, even with an outreach component, will fail to reach a large number of substance-abusing pregnant or mothering women. As was demonstrated in my 1994 article, while the preferred method of providing assistance to substance-abusing pregnant women is through voluntary, comprehensive treatment programs, a significant number of the pregnant substance-abusers will not voluntarily seek out treatment. Thus, additional legislation is needed to reach this segment of the abusing population.

Some states already have additional legislation in place that can be used to encourage reluctant women to enter treatment. The difficulty is that the most frequently adopted mechanism of encouragement consists of classifying as neglect any prenatal

123    West’s Smith-Hurd Illinois Compiled Stat. Ann. §301/35-5 (respectively provides for the coordination of services among the various agencies in order to serve addicted pregnant and, although the statute defines a prenatally exposed child as neglected, with regard to a pregnant woman, a referral to the Department of Human Services will result only in the Department preparing a case management plan and assisting the pregnant woman in obtaining counseling and treatment).


125    See Steverson, supra note at, pp. 318-323 (demonstrating that while drug treatment programs are necessary, relying upon self-referral by pregnant women is inadequate because even when such services are available a significant number of women will not seek help for their drug abuse); infra text accompanying notes.
exposure to alcohol and/or drugs. On the plus side, classifying the conduct as neglect gives child protective services some leverage in encouraging the affected women to obtain treatment. That is, the state has the ability to use the threat of removal of custody of a woman’s children to encourage the woman to participate in drug

126 In 1994 Florida, Illinois, Indiana, Massachusetts, Minnesota, Nevada, Oklahoma and Utah already had some type of abuse, neglect or reporting statute in place for prenatally exposed children. Steverson, supra note , at 329, fn 250. Since that time Alaska, Arizona, Arkansas, Colorado, District of Columbia, Hawaii, Kentucky, Louisiana, Michigan, Missouri, North Dakota, Ohio, South Dakota and Texas have added such legislation. Alaska Stat. §47.17.024 (Westlaw 2008) (health care provider obligated to report prenatal exposure to child welfare); Ariz. Rev. Stat. Ann. §8-819 (Westlaw 2008) (prenatal exposure is a factor in determining if a child is neglected); Ark. Code Ann. §9-27-303(36(B)(l) (Westlaw 2008)(defining neglect to include prenatal exposure); Colo. Rev. Stat. Ann. §19-3-102(1)(g) (Westlaw 2008) (defining a child as abused or neglected if the child has been prenatally exposed); D.C. Code §4-1321.02(a) (Westlaw 2008)(defining a neglected child to include a child that was prenatally exposed); Haw. Rev. Stat. Ann. §587-89(a)(1)-(3) (Westlaw 2008) (mandatory reporter may report prenatal exposure); Ky. Rev. Stat. Ann. §214.160 (Westlaw 2008) (allowing a physician to test a pregnant woman or a newborn infant and indicating that a positive test requires the physician to determine whether abuse or neglect has taken place, and if it has, to report such); LA Stat. Ann.-Ch.C. Art 603(14) (Westlaw 2008) (prenatal neglect, which occurs through prenatal exposure to drugs, constitutes neglect); Mich. Stat. Ann. §722.623a. (Westlaw 2008) (a mandated reporter is obligated to report to child welfare if has cause to suspect or knows that a newborn infant has any amount of alcohol or a controlled substance in its body); Mo. Ann. Stat. §191.737 (Westlaw 2008) (physician or health care provider may refer to child welfare children who may have been exposed to alcohol or drugs); West’s North Dakota Cent. Code Ann. §§50-25.1-17, 50-25.1-16 (Westlaw 2008) (if results of a test of a pregnant women or newborn are positive then physician must report the results to child welfare; all mandatory reporters must report to child welfare if know or have reasonable cause to suspect that a woman is pregnant and has used a controlled substance); Ohio-In re Blackshear, (Ohio 2000) (found that a newborn child who was prenatally exposed to a controlled substance was per se an abused child under the civil child abuse statutes); S.D. Codified Laws §26-8A-2 (Westlaw 2008) (abused or neglected child include a child prenatally exposed to alcohol or drugs); Tex. Fam. Code §261.011(Westlaw 2008) (abuse includes use of a controlled substance in a manner or to the extent that the use results in physical, mental or emotional injury to a child).
treatment. On the downside, however, none of the legislation provide that such is the only authorized use of the neglect statute. Thus, there is nothing to prevent the state from removing the affected child from its mother’s custody. In fact, statistics show that a significant number of women lose custody to the state of their drug-exposed child at birth. This is due in large part to mandatory reporting by hospital staff or by a prior child protective referral.

An example of a state with a combination of treatment and neglect is Colorado. Colorado has enacted legislation that creates a treatment program for high-risk pregnant women, with the definition of high-risk including those addicted to alcohol or drugs. At the same time, Colorado provides that a child is neglected or dependent if

127 Harris, supra note (Harris noted that the state referred the majority of women with children who are enrolled in Central City Concern’s drug treatment program. The state gave the women the option of either attending treatment or losing custody of their children), see, e.g., Andrew Reese, Evaluating Maryland’s Response to Drug-exposed Babies, SB 512 Children in Need of Assistance—Drug-Addicted Babies, 10 Psychol. Pub. Pol'y & L. 343, 347 (2004) (indicating that Md Code, Cts and Jud. Proc. §3-818 and Md. Code, Family Law, §5-706.3 together allow the state to initiate a Child in Need of Assistance and/or petition for termination of parental rights when a child is born exposed to a controlled substance and the mother refuses drug treatment or fails to complete recommended treatment).

128 See Chris DeBrauf et al., Demographic and Psychosocial Characteristics of Mothers Using Methamphetamine During Pregnancy: Preliminary Results of the Infant Development, Environment and Lifestyle Study (IDEAL), 33 Am. J. Drug Alcohol Ab. 281, 283 (2007) (by one month of age 35% of drug-exposed infants in study were no longer with their mother); Singer, supra note , at 1956 (34% of children of women in the study were in non-maternal care just after birth.).

129 Id.

it tests positive at birth for a controlled substance. Thus, as long as the state has evidence of drug exposure, it can remove the child from the mother’s custody without proving that the child is likely to suffer additional harm. Other states that have both treatment legislation and neglect or reporting legislation include Alaska, Arkansas, Arizona, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Colorado, Alaska, Arkansas, Arizona, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana.  

132 See footnote for a list of the neglect/reporting statutes.
133 Alas. Stat. §47.37.045 (Westlaw 2008) (“the department shall grant a priority to a proposed program or project . . . if the proposed program or project provides prompt substance abuse treatment for a pregnant woman”).
135 Ariz. Rev. Stat. §§ 36.141, 8-812, 46-300.04 (Westlaw 2008) (1). providing for priority to treatment services for pregnant abusers of alcohol and other drugs in allocating any new and existing undedicated monies; 2). creating a child protective services expedited substance abuse treatment fund; and 3). providing funding for perinatal substance abuse treatment and services for impoverished families.).
136 Fla. Stat. Ann. §381.0045 (Westlaw 2008) (creates a targeted outreach program for high-risk pregnant women); Fla. Stat. Ann. §411.231 (Westlaw 2008) (Children’s Early Investment Act–creation of a program for expectant mothers and children who are at risk of developmental dysfunction or delay and for their families; program is to coordinate a variety of resources for children from birth to 2 years old; program gives priority for services such as alcohol and drug abuse treatment).
137 HI Legis. 248, 2006 Reg. Sess. of 23rd Legis. (Westlaw 2008) (the legislation authorized the creation of a pilot prenatal clinic, but the creation is not effective until 2050).
In addition to the legislation outlined above, one state has combined legislation removing barriers to treatment\textsuperscript{141} with legislation allowing for civil commitment in appropriate cases.\textsuperscript{142} Further, at least two states have put in place more comprehensive legislation that attempts to apply a multi-faceted approach to the problem of substance-abusing pregnant and mothering women. Minnesota has enacted legislation that provides for the following: testing,\textsuperscript{143} reporting,\textsuperscript{144} outreach,\textsuperscript{145} a finding of

\textsuperscript{138} Ky. Rev. Stat. §222.037(1) (Westlaw 2008) “The Cabinet for Health and Family Services may establish four (4) or more pilot projects within the Commonwealth to demonstrate the effectiveness of different methods of providing community services to prevent smoking and alcohol and substance abuse by pregnant females; improving agency coordination to better identify the pregnant smoker and substance abuser and other females who have smoking and substance abuse problems; linking with community services and treatment for the chemically dependent woman, her children, and other family members; and gaining access to early intervention services for infants in need.”


\textsuperscript{140} Put in the cites for the treatment provision and the neglect provision.

\textsuperscript{141} 63 Okl. St. Ann. §1-546.5 (Westlaw 2008) (provides mechanisms for removing barriers for addicted pregnant women and authorizes the implementation of a pilot project.

\textsuperscript{142} 63 Okl. St. Ann. §1-546.5 (Westlaw 2008) (authorizing the district attorney to convene a multidisciplinary team to assist in making a determination of the appropriate disposition of a case of an abusing pregnant women where such disposition can include filing a petition for involuntary commitment for treatment).

\textsuperscript{143} Minn. Stat. Ann. §626.5562 (Westlaw 2008) (requires a physician to test a pregnant woman or a newborn if there is evidence of prenatal exposure).
neglect and civil commitment. Wisconsin has similar legislation and, in addition, has legislation that provides for the allocation of funds for special treatment and recovery programs, as well as the allocation of funds for multidisciplinary prevention and treatment teams.

**E. Federal Law**

In addition to changes in state law there have been changes in federal law since 1994. Two of the changes relate specifically to the issue of prenatal substance abuse. First, in 2003, Congress adopted the Keeping Children and Families Safe Act as an amendment to the Child Abuse Prevention and Treatment Act (CAPTA). Under the act,

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144 Minn. Stat. Ann. §626.5562 (Westlaw 2008) (If test results by a physician show drug use by pregnant woman or drug exposure of an infant then physician must report the results).

145 Minn. Stat. Ann. §§253.05, 626.5561(1)-(2) (Westlaw 2008) (when child protective agency receives a report from a mandatory reporter that a woman is pregnant and has used a controlled substance; they must immediately conduct an appropriate assessment and offer services indicated under the circs—the svces can include prenatal care and chemical dependency treatment).

146 Minn. Stat. Ann. §626.556(2) (Westlaw 2008) (definition of neglect includes prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance”).


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states who received CAPTA grants were required to improve their child protective services systems. In addition, in order to be eligible for a grant, a state must have policies and procedures in place to address the needs of prenatally exposed infants. In particular, there is a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrences of such condition in the infants. In response to this amendment some states have enacted the legislation outlined in Section B. The difficulty with the legislation, and the states’ responses, is that without additional guidance from the state, in a large number of cases the child welfare department will remove the child from the mother’s custody and require the mother to attend a treatment program. All too often, however, the mother will not start treatment or will not complete treatment and will then risk having her parental rights terminated.

The second change in federal law was the U.S. Supreme Court case of Ferguson, where restrictions were placed upon a state’s ability to test a mother for the presence of alcohol or drugs. In my 1994 article, the question of the testing of

151 See, e.g., Reese, supra note , at 347 (indicating that Md Code, Cts and Jud. Proc. §3-818 and Md. Code, Family Law, §5-706.3 together allow the state to initiate a Child in Need of Assistance and/or petition for termination of parental rights when a child is born exposed to a controlled substance and the mother refuses drug treatment or fails to complete recommended treatment).
mothers and newborns for the presence of alcohol or controlled substances was not addressed. However, the permissive scope of a hospital’s ability to test for the presence of alcohol or drugs became the subject of some controversy. The Supreme Court settled the controversy in 2001 with regard to the testing of substance abusing mothers. It found that the hospital’s method of urine testing of substance abusing mother’s without consent, probable cause or a warrant violated the mother’s Fourth Amendment rights.\textsuperscript{153} The Court reasoned that the state hospital was a government actor subject to the constraints of the Fourth Amendment.\textsuperscript{154} Further, the urine tests conducted on the mothers were searches covered by the Fourth Amendment.\textsuperscript{155} Thus, the Fourth Amendment prohibited the hospital from “nonconsensual, warrantless, suspicionless searches.”\textsuperscript{156}

\textbf{F. Probation Conditions and Civil Commitment}

The final component of my 1994 proposed legislation involved the involuntary civil commitment of pregnant women who were causing harm to their developing child through the abuse of drugs and/or alcohol and who refused to participate in voluntary drug treatment. To date, four states have enacted legislation that allow for civil

\textsuperscript{153} \textit{Id.}

\textsuperscript{154} \textit{Id. At 77.}

\textsuperscript{155} \textit{Id.}

\textsuperscript{156} \textit{Ferguson}, at 86.
commitment.\textsuperscript{157} Probably the best of these is Wisconsin’s, because it recognizes that outreach and assistance in obtaining voluntary treatment must precede any involuntary commitment.\textsuperscript{158}

IV. Broad Outline of a Proposed State-Based Initiative

As was demonstrated above, no state has enacted all of my 1994 proposed legislation, although most parts have been enacted individually in some form or another. As explained previously, my 1994 proposal was designed to be only a small part of a much larger state-based initiative.\textsuperscript{159} The review of the legislation indicates that the states continue to need guidance as to the necessary components of a state-based initiative. To start, it must be stressed that what is needed is collaboration between the health care system (including treatment programs), the state’s welfare system, and the state’s criminal justice system. Such collaboration must combine comprehensive services with coercive elements and sanctions when necessary.\textsuperscript{160} Unfortunately, some

\begin{itemize}
\item \textsuperscript{158} Wis. Stat. §§48.133, 48.193, 48.205(1m), 48.213(1)(b)2008.
\item \textsuperscript{159} Steverson, supra note , at 335 (“In implementing the proposed legislation, the state must keep in mind that the problem of prenatal drug exposure is a complex one requiring a multidimensional approach. Thus, it is imperative that the state view the legislation as part of a larger plan.”)
\item \textsuperscript{160} Steverson, supra note , at 335; see Wouldes, supra note , at 1186 (discussing the need for new collaborative efforts between the healthcare community and the criminal justice system to provide treatment as well as sanctions).
\end{itemize}
states have seen the prosecution of drug abusing pregnant women or automatic removal of drug-exposed children as a “quick fix” and have pursued such options to the exclusion of broader, non-punitive measures. Consequently, before discussing the proposed solution, this section will outline the five necessary components of any state-based initiative in this area and will explain why each of these components is necessary. Section V will then further elaborate upon how to create a mechanism for the fifth component.

The components to be discussed are as follows: (1) reasons why incarceration should almost never be used; (2) comprehensive drug and recovery programs; (3) retention of custody by the mother of her child(ren); (4) provision of effective birth control and family planning services; and (5) a mechanism for intervening, coercively if necessary, if a woman is causing serious harm to her unborn child or has caused harm to one child and is likely to cause harm to another child.

The one component that is not a part of the state-based initiative is an attempt to target all substance abusing women of child-bearing age. This is not desirable for a myriad of constitutional and policy reasons.\(^{161}\) Thus, the state-based initiative is only designed to reach women who are pregnant and abusing, or women who have given birth to a drug-exposed child and are still abusing.

The main objective of a state-based initiative should be to protect as many

\(^{161}\) Steverson, supra note , at 352-356.
children as possible from prenatal drug exposure. An ancillary objective is to protect the woman’s right to autonomy as much as possible. The woman’s right is ancillary because, unlike the developing fetus, she has some control over her actions and thus must bear some responsibility for failing to prevent the harm. It is recognized that many women are addicted or alcoholics and, as a result, most cannot simply stop using through sheer willpower. They need treatment to overcome the addiction. However, when the state provides options for overcoming the addiction and protecting a woman’s children, and the woman refuses, then her right to autonomy must give way to the child’s need for protection. This is especially true because the child has no ability to protect itself.

In order to achieve its objective, the initiative needs to address five important

\[162\] Honorable Peggy Fulton Hora, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System’s Response to Drug Abuse and Crime in America*, 74 Notre Dame L. Rev. 439, fn 113 (1999) (“[i]t is crucial for addicts . . . to realize that although they are not at fault for their disease, they are responsible for their recovery.” John Steinberg, Medical Strategy: Interventions, in *Addiction Intervention: Strategies to Motivate Treatment-Seeking Behavior* 21, 23 (Robert K. White & Deborah G. Wright eds., 1998); “addicted people are not responsible for having developed an addictive disease, but they most certainly are responsible for dealing with the illness once they know they have it.” John Wallace, Theory of 12-Step-Oriented Treatment, in *Treating Substance Abuse*, 13, 31 (Fredrick Rogers et al. eds., 1996).

\[163\] Paltrow, *Overview*, supra note , at 5.

\[164\] *Id.*

\[165\] For a more comprehensive discussion of the why addiction does not absolve a woman of responsibility for her acts see Steverson, *supra* note , at 339-340.
components. First, punitive measures that lead to incarceration generally fail to effectively address the problem of prenatal drug exposure.\textsuperscript{166} This is due to the fact that incarceration does not deter such conduct in the majority of cases and incarceration will harm, rather than protect, the unborn child.\textsuperscript{167} In addition, a perception by abusing women that any use will lead to criminal prosecution will scare women away from prenatal care, and such care is necessary to ameliorate some of the effects of alcohol or drug-exposure.\textsuperscript{168}

The second component of the initiative is comprehensive treatment and recovery services. As previously mentioned, many substance-abusing women are addicts who need assistance to overcome their addiction.\textsuperscript{169} Accordingly, this component requires the state to first create sufficient appropriate programs for all pregnant substance-

\textsuperscript{166} Stevenson, \textit{supra} note, at 324.

\textsuperscript{167} Stevenson, \textit{supra} note, at 324, see pages 326-329 for a thorough discussion of the harms posed by prosecution followed by incarceration.

\textsuperscript{168} See Marilyn L. Poland et al., \textit{Punishing Pregnant Drug Abusers: Enhancing the Flight from Care}, 31 Drug & Alcohol Dependence 199, 202 (1993)– “One hundred forty-two low income women were interviewed postpartum to determine their attitudes regarding the potential effects of a punitive law on the behavior of substance-using pregnant women. The study revealed that subjects believed a punitive law would be a significant deterrent to substance-using gravida seeking prenatal care, drug testing or drug treatment. The comments indicated that substance-using pregnant women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of their children.”

\textsuperscript{169} Paltrow, \textit{supra} note, at 5.
abusers and mothers of drug-exposed children.\textsuperscript{170} Then, the state must provide mechanisms such that the women can access the services as soon as possible.

Such services are necessary for a pregnant woman because, although a large part of the harm occurs in the first trimester,\textsuperscript{171} treatment during pregnancy can perhaps alleviate the harm of drug exposure, or at least ameliorate it.\textsuperscript{172} In addition, failing to obtain treatment will generally lead the mother to continue to abuse alcohol and/or drugs such that she loses custody of her children and, in a large percentage of cases, eventually has her parental rights terminated.\textsuperscript{173} Conversely, those parents who are able to complete comprehensive treatment and recovery programs have a high likelihood of retaining custodial and parental rights. As is demonstrated below, retaining the mother-child relationship at all times is the best outcome for the state, the child and the mother.\textsuperscript{174} Further, if a woman is able to remain alcohol or drug-free through drug

\textsuperscript{170} Other commentators have also argued for the need for comprehensive programs. See, e.g., Curet, supra note, at 77; Rommell P. Cruz, The Greatest Source of Wealth: Washington State’s Response to Prenatal Substance Abuse, 41 Gonz. L. Rev. 1, 11 (2005-2006); Lester, supra note, at [26]; Coleman, supra note, at 62.

\textsuperscript{171} Cruz, supra note, at 11; Steverson, supra note, at 301-302.

\textsuperscript{172} Cruz, supra note, at 11.

\textsuperscript{173} Grella, supra note, at 59 (noting a strong association between treatment noncompletion and “continued substance abuse and eventual loss of parental rights.” Citing Gregoire, K.A., & Schultz, D.J. 80(4), Substance-Abusing Child Welfare Parents: Treatment and Child Placement Outcomes, Child Welfare 433-452 (2001); Steverson, supra note, at 311-312 (one study estimated that one-half of addicted mothers lose custody of their children by one year of age).

\textsuperscript{174} Steverson, supra note, at 331-332.
treatment, she eliminates the prospect of exposing another child to harmful substances in utero.

All of the above benefits will occur only if the state works to ensure that women obtain treatment as soon as possible. The longer the woman goes without treatment, the more harm the developing fetus will suffer, and for a woman who has already given birth, the greater her chance of losing custody of the child because of her inability to adequately care for the child.

Obviously, in order to receive the benefits of comprehensive treatment programs such programs need to exist. As a result of the legislation in this area as well as the federal block grants given for treatment programs, the numbers of treatment centers with specialized programs and services designed for pregnant women or women with children has increased. Unfortunately, additional treatment centers are still needed.

In addition to increased numbers of programs, there have been strides in the alcohol and drug treatment community’s knowledge of what is appropriate for women in general, and pregnant women in particular. For example, in Portland, Oregon, the drug treatment community has learned that the key to eliminating alcohol or drug addiction is having an effective recovery system after treatment. Thus, while treatment is certainly

175 Cruz, supra note 11 (“medical studies show that the fetus’s susceptibility to drugs and alcohol starts early in the pregnancy and worsens as the fetus develops”).

necessary, as Richard Harris, Executive Director Emeritus of Central City Concern in Portland, Oregon, pointed out, treatment is simply the doorway to overcoming addiction.\(^\text{177}\) It is now known that, in addition to treatment, it is crucial to provide two to three years of appropriate recovery services after treatment.\(^\text{178}\)

It is important to point out that it is not generally sufficient for the state to simply have treatment centers available. Rather, the state must put in place a mechanism for the women to easily access the available options, i.e., “one stop shopping” as described in an article by Luis Curet on treatment options for pregnant addicts.\(^\text{179}\) Further, the programs must encompass more than just treatment. This article will not spend too much time on the elements of a successful treatment and recovery program because other commentators have provided exhaustive information on this topic.\(^\text{180}\) It is, however, useful to mention some of the key elements.

One such element is, of course, the provision of effective recovery services.\(^\text{181}\)

\(^{177}\) Interview with Richard Harris, Executive Director Emeritus of Central City Concern, in Portland, Oregon on June 13, 2008.

\(^{178}\) Id.

\(^{179}\) Curet, supra note , at 77.

\(^{180}\) Curet, supra note , at 76; Lester, supra note , at [26]; Cruz, supra note , at 23; Elizabeth E. Coleman, Monica K. Miller, Assessing Legal Responses to Prenatal Drug Use: Can Therapeutic Responses Produce More Positive Outcomes than Punitive Responses?, 20 Jour. Law and Health 35 (2007).

\(^{181}\) See Curet, supra note , at 77 (part of the comprehensive plan includes recovery services).
Such is necessary in order to prevent addiction relapses.\textsuperscript{182} Unless a recovering addict is able to remove herself from the circumstances and environment that led to her addiction, she is likely to relapse. In order to remove herself, she needs to be able to live away from her previous drug-using associates.\textsuperscript{183} Thus, a vital component of an effective recovery system is safe and stable housing\textsuperscript{184} In fact, Richard Harris, Executive Director Emeritus of Central City Concern, stressed the importance of housing by stating that, if the state had sufficient safe and stable housing for its recovering addicts to move into immediately after treatment, then the current treatment centers in Oregon would likely be sufficient to meet the needs of the persons needing treatment.\textsuperscript{185} This is because an effective recovery system decreases the rate of relapse, which in turn decreases the demand for treatment, thus freeing up space for others in the treatment centers. The availability of appropriate housing will also free up treatment spaces because many treatment centers will keep substance-abusing mothers and pregnant women in treatment longer than necessary because they do not want to release them until appropriate housing is available.\textsuperscript{186} If more housing is

\begin{itemize}
\item \textsuperscript{182} Harris, \textit{supra} note .
\item \textsuperscript{183} Harris, \textit{supra} note .
\item \textsuperscript{184} Harris, \textit{supra} note .
\item \textsuperscript{185} Harris, \textit{supra} note  (Contending that if Oregon had sufficient safe and stable housing for its recovering addicts then its current treatment centers would be sufficient to meet the needs of the persons requiring treatment).
\item \textsuperscript{186} \textit{See, e.g.}, Harris, \textit{supra} note  (Indicating that his program keeps addicted pregnant women and addicted mothers in treatment longer than absolutely necessary,
available, then the treatment centers can release the treated women earlier and free up space for other women.

It is important to note, however, that it is not sufficient to simply provide safe housing. Rather, the housing must be drug-free, where all inhabitants are recovering and able to support each other in their recovery.\(^{187}\) In addition, the women and their children need to be able to stay in the housing for two to three years, the length of time that it takes to fully recover after treatment.\(^{188}\)

In addition to providing appropriate housing, pregnant substance-abusers and substance abusing mothers need other services. These include, but are not limited to, case managers and mentors to help the women with education, jobs, daycare, parenting classes and the avoidance of relapses.\(^{189}\)

Finally, as will be shown in the next paragraph, the best treatment outcomes can be attained if the women are able to retain custody of their children while they go while they wait for appropriate housing to become open. This is because if they release them without appropriate housing a relapse is quite likely.).\(^{187}\) Harris, \textit{supra} note ; \textit{see also} Grella, \textit{supra} note , at 68 (“residing in neighborhoods where drug use is prevalent presents a high-risk for relapse to substance use.”).

\(^{188}\) \textit{Id.}\n
\(^{189}\) Harris, \textit{supra} note ; \textit{see} articles cited \textit{supra} note .
through drug treatment. Thus, there is a strong need for residential treatment centers like those of Central City Concern in Portland, Oregon, where the women may keep their children with them while in treatment and afterwards, in recovery housing.

The third component of the state initiative dictates that whenever feasible, the mother of a drug-exposed child should retain custody of her child. Further, if she needs residential treatment, she should have the child with her in treatment. This component is based in part upon the importance of the mother-child relationship for the state, the child and the mother. Keeping the child with its mother benefits all three parties because women in treatment have better outcomes when they retain custody of their children. In addition, the state benefits further because it saves the large amount of money that it would otherwise spend on foster care. An additional benefit for the child is that it avoids the harm that is inflicted by even short-term foster care. Finally, the mother avoids the emotional harm that loss of custody generally brings.

Retaining custody should not be a difficult component for the state to implement.

190 Grella, supra note , at 58 (indicating that “studies have shown that mothers who are able to retain their children with them while in residential drug treatment, or who retain custody of their infants while in intensive day treatment, have higher rates of treatment retention, particularly among those who are involved with child welfare (citing Chen, et al., 2004), or who are mandated to treatment (citing Nishimoto & Roberts, 2001).”); Friedland, supra note , at 125 (studies have found that women who have their children with them during residential treatment are less likely to drop out of treatment and are more successful after treatment).

191 Harris, supra note .

192 Grella, supra note , at 58; Lester, supra note , at [24].
In thinking about removal of children, it is important to remember the purpose of the child welfare laws. That purpose is to protect children from prospective harm.\textsuperscript{193} The state is authorized to practice this purpose through the doctrine of \textit{parens patriae}. Under this doctrine, the state has the power to act as the parent of a child when the parents are not or cannot perform that function. The state is in fact limited to this role by the U.S. Constitution. Constitutional precedent provides that a parent has a fundamental right to the care, custody and control of her child.\textsuperscript{194} The state can only interfere with this right when it demonstrates that removing custody from the parent is necessary to protect the child from harm.\textsuperscript{195} Thus, in order to remove a child, the child welfare system needs to demonstrate that the mother’s past harm (\textit{in utero} drug exposure) indicates that she is likely to cause future harm. If the mother is immediately diverted into a treatment and recovery program that includes medical care and parenting training, it is difficult to see how a state can contend that prospective harm is likely.

The fourth component involves the provision of appropriate birth control and family planning services for a mother once she has given birth to a drug-exposed infant. This component recognizes that the mother needs to utilize such birth control to avoid

\textsuperscript{193} \textit{Paltrow, supra} note 4, at 4.


\textsuperscript{195} \textit{Id}.
becoming pregnant while using. Such is necessary to avoid having any substance exposure for a second child. In this way, at least, the woman’s subsequent child(ren) can avoid the significant harm that occurs with drug exposure in the first trimester.\footnote{Steverson, \textit{supra note} , at 301-302 (a lot of the severe harm to the fetus occurs in the first trimester due to cocaine’s teratogenicity and its effect on the developing brain and organs).}

This need for family planning is suggested by evidence indicating that, for a variety of reasons, if a woman gives birth to one drug-exposed infant, there is a significant likelihood that she will give birth to another drug-exposed infant unless she can overcome her drug abuse.\footnote{See Singer, \textit{supra note} , at 1956 (cocaine users are likely to have more children than non-users); Steverson, \textit{supra note} , at 319, fn. 174 (due to a number of factors, addicted women “run a high risk of pregnancy”, \textit{citing} Michelle Oberman, \textit{Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs}, 43 Hastings L.J. 505, 512 (1992)).}

Further, even if she seeks drug treatment after she finds out that she is pregnant with a second child, a lot of the harm to the child may have already occurred.\footnote{See also Steverson, \textit{supra note} , at 300-303.} In fact, such birth control and family planning is an element of most of the successful treatment and recovery programs designed for pregnant and parenting women.

As a practical matter, birth control is the most effective mechanism for protecting a child from exposure while his mother is using. This stems from the fact that in the majority of cases of substance abusing pregnant women, the community will not know that she is pregnant until she starts showing. Thus, state intervention cannot occur until
the child has already been harmed by some exposure. Also, even when a pregnant woman voluntarily decides to obtain treatment, this is unlikely to happen in the first trimester. This is because, for a variety of reasons, drug-addicted women do not seek treatment until the second or third trimester.\footnote{Steverson, supra note , at 319.}

Some might argue that the immediate enrollment in drug treatment component makes birth control unnecessary because the woman will not be using alcohol or drugs. Unfortunately, however, the reality of drug addiction is that many will relapse. In fact, the drug treatment community views periodic relapses as “typical parts of the recovery process.”\footnote{Grella, supra note , at 57, citing Christine E. Grella, Yih-Ing Hser, S.C. Hsieh, Predictors of Drug Treatment Re-Entry Following Relapse to Cocaine Use in DATOS, 25(3) Journal of Substance Abuse Treatment, 145-154 (2003).} During any such period(s) of relapse or prior to the initiation of treatment, it is imperative that the woman avoid getting pregnant.

The fifth component of the initiative is the potentially coercive one. As explained earlier, in order for pregnant and parenting women to get the assistance that they need, they need to be able to access the comprehensive treatment and recovery program, and to the extent that it is not covered by the program, access appropriate birth control. Unfortunately, even when the services are available, many women will not voluntarily avail themselves of such services. This fact is demonstrated by the 2007 National Survey on Drug Use and Health, which found that in 2006, 84.2% of the 7.4 million
women who needed treatment for a substance abuse disorder neither received treatment, nor perceived a need for it.\textsuperscript{201} While it is true that for some women pregnancy and childbearing are strong motivators to seek treatment,\textsuperscript{202} many need an additional incentive to begin or, once begun, to finish treatment.\textsuperscript{203} This is especially true for women users of methamphetamine for whom pregnancy does not seem to be a strong motivator for seeking treatment.\textsuperscript{204}

As outlined above, however, these services are necessary to protect as many children as possible. Thus, for reluctant women, the state needs to encourage them to utilize the services.

In some instances the state can provide an incentive by simply removing barriers to treatment. For example, in those states where a woman is reported to the child welfare department if she seeks treatment, such reporting needs to be eliminated.

\textsuperscript{201} Substance Use Treatment among Women of Childrearing Age, the NSDUH (National Survey on Drug Use and Health) Report (Oct. 4, 2007) pg. 2, found at \url{http://www.oas.samhsa.gov}. (hereinafter the NSHUH Report).

\textsuperscript{202} Curet, \textit{supra} note, at 76.

\textsuperscript{203} Steverson, \textit{supra} note, at 319-323; Curet, \textit{supra} note, at 77 (complaint most shared by health-care professionals is feeling ineffectual because their pregnant, addicted clients “generally are difficult, are not motivated, and are difficult to engage and retain in treatment”); \textit{see also} NSDUH Report, \textit{supra} note at 3 (of the 5.5% of women who perceived the need for treatment, but did not receive it, only 34.4% did not receive it because of lack of access (inability to pay); 36.1% of the 5.5% did not receive treatment because they were not ready to stop and 28.9% of the 5.5% did not receive treatment because of the social stigma).

\textsuperscript{204} See \textit{supra} text accompanying footnote.
Further, while it makes sense to test all newborns for alcohol or drugs so that as many women who need treatment will obtain it, a positive toxicology should simply lead to an assessment by a comprehensive treatment program and services provided where indicated. The child welfare department should not become involved with a pregnant or parenting substance-abuser unless the program determines that the woman needs services and is refusing to obtain them. Even then, while the department can use the often highly effective threat of eventual removal of the woman’s children as a coercive measure, it should not remove the child unless the woman continues to balk at the services and there is a threat of imminent harm to her child.

Thus, if adequate appropriate services are in place, the state-created barriers to treatment are erased, and the child welfare laws and policies are realigned to that of minimal intervention, many women will enroll in the comprehensive treatment and recovery programs and be helped. However, as those in child welfare, law enforcement, and drug treatment know, there are a number of women who will ignore outreach programs and even civil intervention. In addition, there are non-addicts who cause *in utero* harm through their substance use. For this group of women stronger

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205 Edgar P. Nace, et al., *Socially Sanctioned Coercion Mechanisms for Addiction Treatment*, 16 The American Journal on Addiction 15, 16 (2007) (found that “addicted individuals may benefit from coercive mechanisms.” One of the reasons for this was due to the nature of addiction; it is sometimes difficult for the addicted person to initiate treatment without coercion.); Brecht, *supra* note , at 298 (for drugs in general, having a legal status within the criminal justice system and coercion both predict improved retention and completion).
incentives are needed. This is where my 1994 proposed legislation comes into play.

V. Modification of the 1994 Proposed Legislation

In light of the changes outlined in Part III, as well as some re-thinking on the issue, I believe that some aspects of my 1994 proposed legislation need to be modified. I still believe that the objective of my 1994 proposed legislation and the reasons for choosing the proposed mechanisms are valid. However, several changes dictate that the mechanisms for achieving the objective be modified. First, political realities dictate that efforts to create a specific crime of fetal abuse are likely to be stymied. Second, there is evidence that the criminal justice system, the child welfare system and the treatment programs have the capability to work together to provide an optimal result for society, mothers and children. Third, much improved treatment options are now available.

The first modification stems from the change in political realities. As indicated, the first component of my 1994 proposed legislation was to make it a crime for a pregnant woman to use illicit drugs or alcohol or to abuse licit drugs, where such use or abuse is likely to cause her to give birth to a child that has suffered identifiable harm (including stillbirths). In making it a crime, the legislation's aim was to bring as many women into custody as possible. Thus, the crime encompassed all types of potential

206 Steverson, supra note , at 333.
substance abuse.

This part of my 1994 proposed legislation is deleted and, instead, the legislature should simply change the definition of child to include an unborn child. In this way, serious cases of abuse through substance exposure can be brought before the criminal court, but all others will be handled by the other components of the state-based initiative. The change is proposed because to date, no state has been able to enact legislation that creates the specific crime of fetal abuse. Although bills have been proposed that specifically criminalize a woman’s substance abuse while pregnant, none have passed. However, at least one state legislature has been able to change its definition of child to include an unborn child, and two state courts have also done so. With such a definition in place, the child welfare department can refer to the prosecutor any woman who has refused services and is pregnant and heavily abusing alcohol or drugs, or who gave birth to a seriously harmed alcohol or drug-exposed infant and is refusing services.

The second change in the proposed legislation concerns the sentence for commission of the crime. After reviewing some fairly effective sentencing alternatives in

\footnote{Cf. Tenn. Code §39-13-107(a) (Westlaw 2008) (changing definition of individual, etc. to include an unborn child).}

\footnote{Whitner, 492 S.E.2d at 779-780 (S.C.); see also McKnight, 576 S.E.2d at 174 (S.C.) (court reiterated the holding of Whitner in upholding a homicide by child abuse conviction; the charges were later overturned on post-conviction relief for ineffective assistance of counsel, State v. McKnight, ___ S.E.2d ___, 2008 WI 2019141 (S.C. 2008)); Cochran, 2008 WL at *7 (KY).}
some of the states, California in particular, this article recommends that the proposed legislation eliminate the probation sentence. In its place, the court should be mandated to order the woman to a comprehensive drug treatment and recovery program that has been specifically designed for just such referrals. This mandated diversion can only be avoided in exceptional circumstances where it is shown that the woman would be a danger to other clients in the program. Other articles have thoroughly outlined how alternative sentencing should work, so only a brief summary is provided here.

An alternative to incarceration can work in one of two ways. First, after a woman is charged with a crime, the judge can offer the woman diversion into the program. If the woman accepts and successfully completes the program, all charges are dropped. This first method has the advantage of allowing the woman to avoid a record of conviction. If the woman rejects the diversion offer, goes to trial and is convicted, the judge can offer the program as an alternative to a prison sentence. If the woman accepts and successfully completes the program, no other sentence will be imposed. If she does not complete the program, then she will be returned to the court and the original sentence imposed.

In order to make this sentencing alternative work, the state must first fully fund


the requisite comprehensive drug treatment and recovery programs. Further, the programs should be limited to entry by pregnant or parenting women who heavily abuse alcohol or drugs. In addition, similar to California’s model, the sentencing alternative should not be limited to women charged with criminal abuse. Rather, it should apply to any woman who is a pregnant or mothering substance-abuser and is before the court for a minor or moderate crime that would ordinarily lead to incarceration. After studying the issue, the legislature should specify the type of crimes that qualify. The list should not, however, be quite as restrictive as California’s. A list that is too restrictive eliminates too many women who would benefit from the program.

In addition to the above, the program also needs to have a birth control and family planning component. The court must make it clear that compliance with this aspect of the comprehensive treatment and recovery program is also required.

**Conclusion**

In the area of prenatal substance abuse a number of changes have occurred since 1994, both beneficial and detrimental. What has not changed is that high numbers of women continue to expose their developing children to harmful substances and have added methamphetamine to the list of harmful substances. In addition, the majority of states have failed to implement a comprehensive state-based initiative to protect their children from such exposure. In 1994, to address the problem, I proposed a piece of legislation that was designed to be a part of this comprehensive state-based
initiative. In looking back at that proposal I have learned that the states need more guidance as to what components this state-based initiative should have and have I provided that guidance here. In addition, I have tempered my 1994 proposed legislation to better reflect the states' current needs and political realities. I still believe that any state-based initiative must have a coercive element. Prior to using this coercion, however, the state must put in place and exhaust non-coercive components such as comprehensive treatment programs and outreach.