EXPECTANT MOTHERS AND SUBSTANCE ABUSE: INTERVENTION AND TREATMENT CHALLENGES FOR STATE GOVERNMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

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THURSDAY, JULY 23, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY,
INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:52 p.m., in room 2154, Rayburn House Office Building, Hon. Mark Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder and Barrett.

Staff present: Robert B. Charles, staff director and chief counsel; Margaret Hemenway, professional staff member; Amy Davenport, clerk; and Michael Yeager, minority counsel.

Mr. SOUDER. This hearing before the Subcommittee on National Security, International Affairs, and Criminal Justice will come to order.

Thank you all for coming and we're going to see how much we can get in before the next vote because I know we're running behind and I apologize for that.

Drug abuse and drug-related crime affects our Nation, our communities, and our children. Prenatal drug abuse is a health problem of national dimensions and one that cuts across geographic, socio-economic, and cultural lines. Research indicates that as many as 11 percent of deliveries are affected by substance abuse. I agree with President Clinton's director of the National Institute Against Drug Abuse that maternal drug use during pregnancy is a form of child abuse.

The link between substance abuse and child abuse is growing and we cannot look the other way. As history too often teaches us, all it takes for ill to prevail is for good people to do nothing. Early intervention and treatment must be a goal since a baby born to a drug-addicted mother is a situation ripe for future child abuse and the costs to society of that abuse are high, morally and economically.

In Illinois a decade ago, a mother was charged with involuntary manslaughter after a 2-day-old baby died of severe oxygen deprivation attributed to cocaine. This case, in which the charges were dropped, served as an impetus for Illinois' Infant Neglect and Controlled Substances Act of 1989. This act made it a felony to, "inflict

or create a substantial risk of physical injury to a newborn infant by means of illegal drug use by the mother during pregnancy."

Similarly, the U.S. Supreme Court, on May 26, allowed the State of South Carolina to uphold its law making it illegal to refuse or neglect to provide the proper care and attention that endangers or is likely to endanger a child's life. The High Court ruled, "It strains belief for Lightner," the South Carolina plaintiff, "to argue that using crack cocaine during pregnancy is encompassed within the constitutionality recognized right to privacy."

More recently, Wisconsin's cocaine mom law was signed by the Governor on June 16 and has been widely described as designed for treatment-resistant cases. It contains no criminal penalties, no mandatory reporting requirements, and no provisions for terminating parental rights. Still, it almost certainly will save lives and more fully protect children.

There's an agreement that the objective of protecting unborn children from the consequences of parental addiction is laudable. But there remain open questions, one of which is the best role the Federal Government can play in protecting America's at-risk children. But we hope, with our expert witnesses, particularly those with firsthand or clinical experience, we hope they can explain to us today what the nature of the problem is, its prevalence, and what methods they believe work best in trying to deal with addicts who become pregnant. I particularly look forward to hearing from the Haymarket House, which is in the chairman's home State of Illinois, which is helping prevent drug addicts through the highly regarded faith-based treatment program.

Now I'd like to recognize a good friend, the ranking minority member, Congressman Barrett, for his opening statement.

Mr. BARRETT. Thank you, Mr. Chairman, and thank you for holding this very important hearing. Welcome to all of our witnesses today. I'd like to give a special welcome to my former assembly and senate colleagues: State senator Joanne Huelsman from Wisconsin; Mr. William Domina, who is the corporation counsel from the Corporation Counsel's Office in Waukesha County; and Francine Feinberg, who is the executive director of Meta House, which is located in the district that I represent.

This hearing will focus on two approaches to the problem of substance abuse by expectant mothers. One approach, enacted by the Wisconsin Legislature, gives juvenile court judges the power to order expectant mothers into drug treatment, including confined inpatient care. Another approach in South Carolina, recently upheld by the Supreme Court of South Carolina in *Whitner* v. *State*, involves the use of the criminal law against child abuse to prosecute expectant mothers who refuse drug treatment offered by the State.

There are areas of deep disagreement on this issue, both in Wisconsin and, from what I understand, in South Carolina. But let's begin with some common ground: the problem. We all agree that substance abuse by expectant mothers hurts their unborn children and must be stopped. We've got to do everything we can to keep pregnant women healthy and off dangerous substances. That's the goal.

Now let's turn to the solution. We are looking at measures in Wisconsin and South Carolina that certainly, at least on first

blush, have tremendous appeal. Both have the potential to deter substance abusers who refuse treatment and, by their own irresponsibility, place their unborn children at risk. But opponents argue that both have the potential to do more harm than good, to do more grievous injury to unborn children, and their substance abusing mothers.

Unfortunately, we don't have conclusive data on the effect of these measures in Wisconsin and South Carolina. But we are hearing from health care and substance abuse professionals that pregnant women who use drugs are afraid to come into the system for prenatal care and drug treatment. Why? Because many in the substance abusing population are already wary of the system and now they believe that they risk arrest or losing custody of their children.

This is an unintended consequence for sure, but one that may drive more pregnant women away from drug treatment than it will attract. The impact will fall most heavily on the unborn children, not only because they will continue to be exposed to harmful substances, but because they will be denied the benefits of basic medical care that their mothers might otherwise obtain. Just one example: For those expectant mothers with HIV, unborn children could be denied medication that has been demonstrated effective in preventing transmission of the disease.

For this and other related reasons, the leading associations of health care professionals oppose punitive approaches to this problem. These include the American Medical Association, American Nurses Association, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine.

For those of us in Congress, this is an unusual problem, because I think that everybody who is appearing before us today really cares about this issue. This is not one where there are a lot of deep ideological differences. We all want to make sure that we can help these women and help the children. And that's very important. I can tell you that it's very important for the district that I represent, because cocaine use is a serious problem in the district that I represent and we have seen a sharp increase in the number of women who have entered hospitals who have a cocaine problem.

So this is an issue that hits home in all parts of this country. But, like physicians, the first duty of all politicians ought to be do no harm. If it is the child that we are to protect—and that is the undisputed goal—we must help and encourage expectant mothers into treatment. It's not simple and it's expensive. But I suspect it's the best way to get the results that we all want. Finally, I think we have to recognize that this problem is also a problem of resource allocation. There are many places in this country where these programs are simply underfunded or not funded at all. And, as we debate this, if we are going to be serious about dealing with the problems of women who use cocaine during pregnancy, we have to make sure that the resources are there, not only in a punitive measure, but also in a treatment measure, so that we do not have to go to the judicial system at any resort.

Thank you, Mr. Chairman. I look forward to hearing the testimony of our witnesses today.

Mr. SOUDER. Thank you very much. At this time, I'd like to introduce our first panel. First off, I want to welcome our distinguished colleague and fellow classmate of mine, Congressman Tom Latham of Iowa. Congressman Latham has introduced a bill, H.R. 4204, the Drug Dealer Liability Act, which is intended to provide a civil remedy for damage to persons in a community injured as the result of illegal drug use. He also serves as an active member of the Speaker's Task Force For A Drug Free America.

Mr. Charles Condon is the attorney general of the State of South Carolina. Ms. Catherine Christophillis is the director of drug prosecution for the State of South Carolina. Senator Joanne Huelsman is the State senator from the State of Wisconsin. Mr. William Domina is the senior assistant corporation counsel for Waukesha County.

It is a rule of our committee that we swear in all our witnesses, so would you please stand and raise your right hands.

[Witnesses sworn.]

Mr. SOUDER. Members of Congress are the only people in Washington who don't have to swear to tell the truth. [Laughter.]

Actually it's in our——

Mr. BARRETT. They figure it won't do any good.

Mr. SOUDER. Actually, it's in our oath, so we're already covered by that.

Mr. Latham, will you begin.

STATEMENTS OF HON. TOM LATHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA; CHARLES CONDON, ATTORNEY GENERAL, STATE OF SOUTH CAROLINA; CATHERINE CHRISTOPHILLIS, DIRECTOR OF DRUG PROSECUTION, STATE OF SOUTH CAROLINA; JOANNE HUELSMAN, STATE SENATOR, STATE OF WISCONSIN; AND WILLIAM DOMINA, OFFICE OF CORPORATION COUNSEL, WAUKESHA COUNTY

Mr. LATHAM. Thank you very much. Mr. Chairman, I thank you for giving me the opportunity to testify here today at this very important hearing on drug abuse among expectant mothers. As a member of the Speaker's Task Force For A Drug Free America, I commend you for providing a platform to address the tragedy of the birth of children addicted to narcotics.

Unfortunately, as others will testify today, this is a growing trend across the Nation. For years, the Midwest States thought themselves immune from the drug problems on America's coasts and in the big cities. However, this is no longer the case. In fact, there is a drug problem growing faster in America's heartland.

Mr. Barrett's district, Milwaukee, WI, is a perfect example. A University of Wisconsin Medical School study found that perinatal substance abuse, evident in 2 percent of the births in 1983, had jumped to 11 percent by 1990. Today in Milwaukee that rate is upwards of 15 percent and hospitals with stricter drug attention procedures have reported rates almost twice that.

So it is likely that this problem is more widespread than we think. My home State of Iowa is experiencing an influx of methamphetamine from Mexico and regional clandestine laboratories.

We have yet to see the full effects of the drug abuse on children of their addicts.

Initially meth, or crank, was used primarily by males. However, it is now making inroads with women as well. In fact, last week, two women were arrested in Boone County, in my district, on meth charges stemming from a lab, a meth lab, and a bust at that lab. One of the women was also charged with child endangerment and three children had to be placed in the care of the Iowa Department of Human Services. Unfortunately, since meth is as addictive as crack cocaine and the stimulation, or "high," is sustained much longer, there may be a greater opportunity for in utero damage to the fetus of a meth-abusing mother.

This is creating additional problems and challenges for law enforcement and human service providers in the Midwest. Drug babies are clearly the most innocent and vulnerable of those affected by illegal drug use and are often the most physically and mentally damaged due to the existence of the illegal drug market in a community. For many of these babies, the only hope is extensive medical and psychological treatment, physical therapy, and special education. All of these potential remedies are expensive.

These babies, through their legal guardians and through court-appointed guardians should be able to recover damages from those in the community who have entered and participated in the marketing of the types of illegal drugs that have caused their injuries. To address this problem, I recently introduced H.R. 4204, the Drug Dealer Liability Act, which is modeled after similar legislation enacted in 11 States, including the chairman's home State of Indiana. This legislation is intended to provide a civil remedy for damages to persons in the community injured as the result of illegal drug use. These persons include parents, employers, insurers, health care and drug treatment providers, as well as drug babies. H.R. 4204 would enable them to recover damages from those persons in the community who have joined the illegal drug market.

A further purpose of the Drug Liability Act is to shift, to the extent possible, the cost of the damage caused by the existence of the illegal drug market in a community to those who illegally profit from that market. It is my hope that the prospect of substantial monetary loss made possible by the Drug Dealer Liability Act would also act as a deterrent to entering the narcotics market. In addition, the bill would establish an incentive for users to identify and seek payment for their own drug treatment from those dealers who have sold drugs to the user in the past.

While this legislation is not meant to be a silver bullet, it is another tool to combat and deter drug abuse and trafficking. Today, in 39 States, it is not clear under established law that families who lose a child to drugs or a drug baby needing treatment or special education can compel dealers in a community to pay for the injuries they cause. This is true even though, in most States, a producer of a product that injures a consumer can be liable for injuries resulting from the use of that product. The Drug Dealer Liability Act fills the gap to make drug dealers liable under civil law for the injuries of the families of drug users.

The first lawsuit brought under a Drug Dealer Liability Law resulted in a judgment of $1 million in favor of a Michigan drug baby

and more than $7 million to the city of Detroit's expenses for providing drug treatment to the city's prison inmates. In addition, this bill could fill a possible gap in asset forfeitures by law enforcement resulting from the decision handed down by the U.S. Supreme Court last month that may rule total forfeiture of a defendant's assets as an excessive fine under the eighth amendment's excessive fines clause.

I look forward to working with you, Mr. Chairman, my colleagues on the Speaker's Drug Task Force, to enact a Drug Dealer Liability Act and give the victims of drug abuse, in particular, drug babies, an opportunity to hold the dealers of this poison accountable under criminal and civil law. Again, Mr. Chairman, I want to thank you and the ranking member, Mr. Barrett, for providing me with this opportunity.

[The prepared statement of Hon. Tom Latham follows:]

Testimony of Representative Tom Latham (IA-5th) Before the House Subcommittee on National Security, International Affairs, and Criminal Justice

July 23, 1998

Mr. Chairman, thank you for giving me an opportunity to testify here at this very important hearing on drug babies.

As a member of the Speaker's Task Force for a Drug-Free America, I commend you for providing a platform to address the tragedy of the birth of children addicted to narcotics. Unfortunately, as has been noted by others testifying today, this is a growing trend across the nation. For years, the Midwest states thought themselves immune from the drug problems on America's coasts and in the big cities. However, this is no longer the case.

In fact, nowhere is the drug problem growing faster than in America's heartland. Milwaukee, Wisconsin, in Mr. Barrett's district, is a perfect example. A University of Wisconsin Medical School study found that perinatal substance abuse, evident in 2 percent of births in 1983, had jumped to 11 percent by 1990. Today in Milwaukee, that rate is upwards of 15 percent and hospitals with stricter drug detection procedures have reported rates almost twice that. So, it is likely that this problem is more widespread than we think.

My home state of Iowa is experiencing an influx of methamphetamine from Mexico and regional clandestine laboratories, and we have yet to see the full effects of the drug on children of addicts. Initially, "meth" or "crank" use was predominantly by males, however, it is now making inroads with women as well. In fact, last week, two women were arrested in Boone County in my district on meth charges stemming from a clandestine meth laboratory bust. One of the women was also charged with child endangerment and three children had to be placed in the care of the Iowa Department of Human Services.

Unfortunately, since meth is as addictive as crack cocaine and the stimulation or "high" is sustained much longer, there may be a greater opportunity for *in utero* damage to the fetus of a meth-abusing mother. This is creating additional problems and challenges for law enforcement and human service providers in the Midwest.

Drug babies are clearly the most innocent and vulnerable of those affected by illegal drug use, and are often the most physically and mentally damaged due to the existence of an illegal drug market in a community. For many of these babies, the only hope is extensive medical and psychological treatment, physical therapy, and special education.

All of these potential remedies are expensive. These babies, through their legal guardians and through court appointed guardians *ad litem*, should be able to recover damages from those in the community who have entered and participated in the marketing of the types of illegal drugs that have caused their injuries.

To address this problem I recently introduced HR 4204, the Drug Dealer Liability Act, which is modeled after similar legislation enacted in eleven states, including the Chairman's home state of Illinois. This legislation is intended to provide a civil remedy for damages to persons in a community injured as a result of illegal drug use. These persons include parents, employers, insurers, health care and drug treatment providers, as well as drug babies. HR 4204 would enable them to recover damages from those persons in the community who have joined the illegal drug market. A further purpose of the Drug Dealer Liability Act is to shift, to the extent possible, the cost of the damage caused by the existence of the illegal drug market in a community to those who illegally profit from that market.

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education can compel dealers in their community to pay for the injuries they cause. This is true even though in most states a producer of a product that injures a consumer can be liable for injuries resulting from the use of that product. The Drug Dealer Liability Act fills the gap to make drug dealers liable – under civil law principles – for the injuries to the families of drug users.

The first lawsuit brought under a Drug Dealer Liability law resulted in a judgement of $1 million in favor of a Michigan drug baby and more than $7 million to the City of Detroit's expenses for providing drug treatment to the city's prison inmates. In addition, this bill could fill a possible gap in asset forfeitures by law enforcement resulting from the decision handed down by the U.S. Supreme Court last month that may rule total forfeiture of a defendant's assets as an excessive fine under the Eighth Amendment's excessive fines clause.

I look forward to working with you Mr. Chairman and my colleagues on the Speaker's Task Force to enact the Drug Dealer Liability Act and give the victims of drug abuse, particularly drug babies, an opportunity to hold the dealers of this poison accountable under criminal *and* civil law.

Again, Mr. Chairman, I want to thank you and the ranking Member, Mr. Barrett, for providing me this opportunity.

Mr. SOUDER. Thank you very much. We're looking forward to working with you on your legislation.

Mr. Condon.

Mr. CONDON. Thank you, Mr. Chairman. I'm Charlie Condon, attorney general in South Carolina and I, too, am grateful for the opportunity to be here today on behalf of the citizens of South Carolina, both born and unborn.

As you may know, the U.S. Supreme Court recently let stand our State supreme court's ruling that a viable fetus is a fellow South Carolinian and, therefore, entitled to protection under the law. These court decisions have enabled us to proceed with a policy that is successfully bringing drug users who are pregnant into treatment centers and reducing the number of babies born with a dangerous and even fatal addiction.

Our approach is not only highly effective, but infinitely humane. It considers the welfare of both the mother and unborn child. It recognizes the complexity of drug addiction, its medical as well as its legal aspects. It treats addicts as patients, rather than as criminal, while recognizing that the abuse of such substances as crack cocaine and heroin is a serious violation of the law, particularly when such behavior affects an innocent, unborn child. It allows health care experts to control the destiny of cooperative women while law enforcement officials wait in the wings, prepared to act only in worst-case scenarios.

Now, a member of my staff headed the task force responsible for developing the policy currently used to deal with pregnant drug addicts. That task force included representatives from the State social service agencies. The procedures the members developed reflected a diversity of viewpoints and concerns, but the final report revealed a unanimity of purpose.

The highest priority of all involved was to spare babies the unimaginable suffering they experience when they come into the world as drug addicts. Some don't survive the trauma. Others are horribly impaired for the rest of their lives. Most experience extreme pain during their first days.

The task force's second priority was to rehabilitate mothers, enabling them to care for their own children and to lead healthy, productive lives. Fortunately, those two priorities were perfectly consistent with each other and the procedures the task force established have been implemented throughout the State of South Carolina.

Now, following my remarks, some of those who developed this and who administer it will tell you exactly how it works and just how well it succeeds. However, I want to warn you that what you'll hear from them will bear little resemblance to descriptions of the procedures given in recent weeks by the media. I'm sure that never happens to people on this committee.

For example, Bob Herbert of the New York Times attacked the program as, "irrational and extreme." He suggested we recently sent one woman to prison merely because she "smoked cocaine when she was pregnant in 1991." We did this, he said, after she "overcame her drug habit, obtained employment, and has successfully been raising three children."

In fact, we don't put pregnant addicts in jail. The woman in question was sent to prison years later, only after she violated her probation by attempting to knife a known drug dealer in a domestic dispute. The Department of Social Services reported she had repeatedly flunked her drug tests while in treatment and was unable to hold down a job.

However, this story, even this story, has a happy ending. This woman did indeed kick her drug habit and obtain a legitimate job, but only—but only—after she faced the prospect of serving time. Indeed, she's the best example I know of why we need to threaten the hardest cases with jail if they don't give up drug use following delivery. In several instances, that threat has worked, and only that threat.

Finally, for the first time in my experience as a public prosecutor, I believe we're making progress in solving this problem. We've learned how to mix compassion with tough love, providing pregnant addicts with positive encouragement to do what's right, while reminding them that we intend to enforce the law if they continue to do what's wrong. I want to thank you for the opportunity to share this information to you.

And I do feel I would be remiss if I couldn't also testify in light of the concern of the ranking member about the official positions of the different medical groups. If you read those positions, what they address—and here's what they say, "The opinions listed by medical organizations actually state that criminalization of any illicit substance, whether used by pregnant women or not, does not work as well as treatment in reducing substance abuse." They don't address the type of program that we have where you force them in through prosecutions into drug treatment.

Additionally, there will be a witness later on named Mary Faith Marshall from my home town of Charleston at the Medical University of South Carolina. I've seen her testimony. I've been there, done that, and I've got the t-shirt. Here's the t-shirt. She makes allegations of racial bias; political opportunism; unconstitutional—illegal, the program that we've developed.

Please let the record reflect that there was a civil trial in Charleston where I was sued for millions of dollars personally, along with the police chief, who happens to be African-American, along with officials of MUSC. That witness testified at that trial and the jury and judge—judge appointed by President Carter—reached conclusions in which all these claims were dismissed.

If I could briefly quote from the order; won't take but a second. "The evidence shows that white cocaine users were treated the same as black cocaine users. If a patient had cocaine in her system, then she was given a choice of treatment or jail. No disparity exists in that form of treatment." The judge also writes, "The court concludes that the policy was necessary to help cocaine dependent mothers and their babies." The court concludes: "And actually achieve that goal, as evidenced by the fact that a substantial majority of plaintiffs stopped abusing cocaine." The judge found the policy worked, obviously along with the jury.

Finally, if I could leave the testimony at this. The approach that this witness, who came to the MUSC years after this program was developed, is to legalize drugs during pregnancy. And I ask you, on behalf of the children of South Carolina, not to do that. Thank you, Mr. Chairman.

[The prepared statement of Mr. Condon follows:]

STATEMENT

by Charles Molony Condon

Attorney General of South Carolina

I'm grateful for the opportunity to speak before this committee in behalf of the citizens of South Carolina -- both born and unborn. As you may know, the U.S. Supreme Court recently let stand our State Supreme Court's ruling that a viable fetus is a fellow South Carolinian and therefore entitled to protection under the law. These court decisions have enabled us to proceed with a policy that is successfully bringing pregnant drug users into treatment centers and reducing the number of babies born with a dangerous and even fatal addiction.

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Following my remarks, some of those who developed this policy and who administer it will tell you exactly how it works and just how well it succeeds. However, I warn you that what you'll hear from them will bear little resemblance to descriptions of the procedures given in recent weeks by the media.

For example, Bob Herbert of the New York Times attacked the program as "irrational and extreme." He suggested we recently sent one woman to prison merely because she "smoked cocaine when she was pregnant in 1991." We did this, he said, after she "overcame her drug habit, obtained employment and has successfully been raising three children."

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Finally, for the first time in my experience as a public prosecutor, I believe we're making progress in solving this problem. We've learned how to mix compassion with tough love -- providing pregnant addicts with positive encouragement to do what's right, while reminding them that we intend to enforce the law if they continue to do what's wrong. Thank you for the opportunity to share this good news with you today.

Mr. SOUDER. I wanted to ask, for the record, I assume the New York Times ran a front-page apology with your picture and everything for their story?

Mr. CONDON. Even better than that; we actually had a good response, written letter to the editor, and faxed it to them. I believe it might have been the second or third day. They said it was too late. Didn't respond quickly enough.

Mr. SOUDER. Thank you for your testimony. I'm going to go where the other Members did—went to go to vote.

Mr. CONDON. I understand. Thank you.

Mr. SOUDER. So we're in recess. And we'll pick up the testimony afterwards.

[Recess.]

Mr. SOUDER [presiding]. This hearing is now called back to order. I apologize for the long delay. We wound up with five different votes.

I also wanted to ask unanimous consent to insert into the record the letter to the editor that Mr. Condon had referred to. And also any other materials that the witnesses want to provide as additional supplements now and in this panel and the next panel.

Hearing no objection, so ordered.

One of the things that we do through this hearing process is build an official public record and that way, if you here, people in the second panel—if people in the second panel want to put additional information in, it makes for a good record.

Ms. Christophillis, would you go ahead with your testimony.

Ms. CHRISTOPHILLIS. I'm Catherine Christophillis, the drug prosecutor from the State of South Carolina. As Attorney General Condon has demonstrated, our program has often been misrepresented. To clear up any misunderstandings, allow me to review the current policy.

In the first place, if someone reports drug use by a pregnant woman after 24 weeks of gestation, the information is not handed over to a law enforcement agency, either local or State. An investigation is initiated by South Carolina Department of Social Services. Thus, at the onset, the woman is treated as a patient, rather than a criminal.

DSS is directed to obtain all relevant information about the viable fetus, the mother, and other household members. Again, the State's clear purpose is to understand the family situation, rather than to gather evidence for a prosecution. DSS may call on a response team, which is a multidisciplinary team of people, to participate in the investigation. When the facts are gathered, the response team is empowered to recommend a treatment plan.

If the Department's investigation indicates abuse or neglect, according to the protocol, "The Department of Social Services shall take all steps necessary to ensure the health and welfare of the fetus and to effectuate treatment for the mother and other household members." It's important to note that, while the welfare of the fetus is placed first, perhaps because the unborn child is the family member least able to take care of itself, the mother's health is also of immediate concern. So is the well-being of other family members.

Under current policy, the Department of Social Services is the lead agency in the case, even when an investigation reveals that

the law has been broken. If the mother refuses to cooperate, does a law enforcement agency move in? No. The current policy reads: "Should the mother refuse to voluntarily cooperate with the treatment plans, Department of Social Services shall petition the family court," which is the Court of Equity in South Carolina, "for authority to intervene."

In such a case, the likely intervention would be involuntary commitment of the mother to a drug treatment program. As the protocol states: "The intervention of the Department of Social Services should include a requirement that the mother and other household members complete a treatment program certified by the Department of Alcohol and Other Drug Abuse Services, if appropriate." Up until this point, nothing has been said about prosecution of a mother by law enforcement agencies. After the child is born, DSS continues to monitor the case.

Only at this stage does the protocol talk about legal aspects. First, the policy requires medical professionals to report abuse to the County Department of Social Services. By the way, this is the same policy in force for cases of abuse among children who are already born. However, it's important to understand that the threat of incarceration following the birth of the child gives the pregnant addict the strongest possible incentive to remain in a drug rehabilitation program.

It's ironic that Melissa Crawley, whose case has been cited as an example of the program's inhumanity, is the best example I know of its success. After giving birth to two cocaine babies, testing positive on virtually every drug test subsequent to her initial arrest, and breaking probation by knifing a known drug dealer, she successfully kicked the habit only when told that she faced a jail sentence because of her repeated offenses.

This program works because it is humane, caring when appropriate, and, when necessary, double tough. In order to underscore that point, we've submitted some written evidence and also have asked some professionals from South Carolina in the second panel to give you the benefit of their experience.

[The information referred to follows:]

Statistics Relevant to Drug-Exposed Births

South Carolina 1990

Total S.C. births 1990.....58,461

Cost per severely drug-exposed (non-alcohol) birth.....present value dollars (1993)

Estimated measurably exposed drug births per year.....8,769
Estimated drug exposed births w/ impact to age 5, per year.....239
Est. drug exposed births w/ impact beyond age 5, per year.....48
Excess hospitalization costs at delivery (100%).....$3,600
Other excess medical costs in 1st year of life (100%).....$16,790
Costs per early intervention age 0 – 5 (100%).....$27,846
Costs for special education (non-resid) age 5 – 18 (20%).....$9,784
Costs sheltered workshop 42 years (10%).....$1,640
Costs residential care (MR, ED, etc) 55 years (10%).....$8,726
Excess medical costs age 2 – 60 (100%).....$662
Productivity losses (lost wages) 48.5 years ($20).....$31,537
Total lifetime economic losses per impacted drug birth.....$100,585

Note: Many of these facts and figures are underestimated due to the fact that the diagnosis is so often retroactive in later years (symptoms may not manifest at birth)

Statistics Relevant to Alcohol-Exposed Births
South Carolina 1990

Total S.C. births 1990.....58,461

Cost per severely alcohol exposed birth	present value dollars (1993)
Admitted alcohol exposed births per year	28,061
Estimated alcohol exposed births w/ measurable impact (FAE)	1,310
Estimated Fetal Alcohol Syndrome births per year (FAS)	164
Excess hospital costs at delivery (100%)	$3,600
Other excess medical costs, 1st year of life (100%)	$16,790
Cost for 14 years non-residential special education (44%)	$21,524
Costs of sheltered workshop 42 years (44%)	$7,213
Costs of residential care (MR, ED, etc) (56%)	$46,101
Excess medical costs, ages 2 – 60 (100%)	$662
Productivity losses (lost wages) 48.5 years (100%)	$157,685
Total lifetime economic losses per FAS birth	$253,575
Total lifetime costs per FAE birth	$84,525
Total average life costs per FAS or FAE birth	$105,656

Note: FAS refers to Fetal Alcohol Syndrome
FAE refers to Fetal Alcohol Effects, which can be just as devastating as FAS, but lacks one or more of the symptoms of the full Syndrome

Note: Many of these facts and figures are underestimated, due to the fact that the diagnosis is often retroactive in later years (may be difficult to diagnose at time of actual birth, and access to later diagnostic services may be limited)

Ms. CHRISTOPHILLIS. I also would like to ask to be introduced for the record a statement from Dr. Lee Beasley, who is a woman OB/GYN who runs a clinic in Pickens, SC, who, and I quote, says that approximately 70 reports have been made to DSS after our protocol was implemented by them, regarding drug use and pregnant women after 24 weeks of gestation. All of the women have successfully participated in or completed therapy. During this time period, there has not been an increase in the number of women delivering no prenatal care at the hospital. This fact would imply that women are not avoiding prenatal care for fear of urine drug screening.

I'm also asking, for the record, the introduction of our most recent protocol, which was written by a multidisciplinary team of people, including our medical association, district attorneys, law enforcement, hospital associations, public defenders, legal service personnel, as well as our treatment people. This protocol sets up a layer of intervention that is beneficial for the child and the mother. Treatment is all of our goal and I ask you all to not forget the cries of these children who so desperately need your help.

Thank you.

[The prepared statement of Ms. Christophillis follows:]

STATEMENT

by Catherine Christophillis

Assistant Deputy Attorney General of South Carolina

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If the Department's investigation indicates abuse or neglect, according to the protocol, "[the] Department of Social Services shall take all steps necessary to ensure the health and welfare of the fetus and to effectuate treatment for the mother and other household members."

It's important to note that, while the welfare of the fetus is placed first (perhaps because the unborn child is the family member least able to take care of itself), the mother's health is also of immediate concern. So is the well-being of other family members.

Under current policy, the Department of Social Services is the lead agency in the case even when an investigation reveals that the law has been broken.

If the mother refuses to cooperate, does a law enforcement agency move in? No. The current policy reads: "Should the mother refuse to voluntarily cooperate with the treatment plans, Department of Social Services shall petition the family court for authority to intervene."

In such a case, the likely intervention would be involuntary commitment of the mother to a drug treatment program. As the protocol states: "The intervention of Department of Social Services should include a requirement that the mother and other household members complete a treatment program certified by the Department of Alcohol and Other Drug Abuse Services, if appropriate."

Up until this point, nothing has been said about the prosecution of a mother by law enforcement agencies. After the child is born, DSS continues to monitor the case.

Only at this stage does the protocol talk about the legal aspects. First, the policy requires medical professionals to report abuse to the County Department of Social Services. (By the way, this is the same policy in force for cases of abuse among children who are already born.)

However, it's important to understand that the threat of incarceration following the birth of the child gives a pregnant addict the strongest possible incentive to remain in a drug rehabilitation program. It's ironic that Malissa Crawley, whose case has been cited as an example of the program's inhumanity, is the best example I know of its success. After giving birth to two cocaine babies, testing positive on virtually every drug test subsequent to her initial arrest, and breaking probation by knifing a known drug dealer, she successfully kicked the habit only when told that she faced a jail sentence because of her repeated offenses.

This program works because it is humane, caring when appropriate -- and, when necessary, double tough. In order to underscore that point, we've submitted written evidence and also asked a professional in the field to give you the benefit of her experience.

Thank you.

Mr. SOUDER. Thank you very much.

Senator Huelsman.

Ms. HUELSMAN. Thank you. Thank you very much, Mr. Chairman, Mr. Barrett, for the opportunity to tell you a little bit about why we passed 1997 Wisconsin Act 292, which has been commonly known as Wisconsin's cocaine mom law.

First of all, I need to comment on the fact that this bill was introduced to address a specific problem: How does society provide treatment for women who are pregnant, who have every intention of carrying their pregnancy to term, who repeatedly refuse to seek treatment, and, if it is offered, refuse to accept it? That is the problem that we sought to address in the bill that we passed.

We've talked here today about the fact that untreated and chronic abuse of alcohol and drugs during pregnancy is a devastating public health problem. We know that severe alcohol or drug abuse by pregnant women during any part of the pregnancy can cripple a child for life. However, unlike other disorders, the damage caused by alcohol and other drugs is 100 percent preventable.

Untreated alcohol and drug abuse during pregnancy is of particular concern to the State of Wisconsin. We have—I don't think I've heard anyone say—comment here today about the problems with Fetal Alcohol Syndrome, that Fetal Alcohol Syndrome alone is the leading known cause of mental retardation in America, surpasses both Down's Syndrome and spina bifida in frequency.

When we look at the cost to the State of Wisconsin, according to the Wisconsin Department of Health and Human Services, each year approximately 70 to 80 children are born in Wisconsin with Fetal Alcohol Syndrome, another 150 to 200 with Fetal Alcohol Effect. And the Department estimates the cost of these births to be approximately $90 million each year.

When we've looked at how to address this chronic, severe, and untreated alcohol and drug abuse during pregnancy, the legal and medical opinions run across a broad spectrum. At one end are those who are completely opposed to the bill, to the law that we passed. They say we should just do nothing. At the other end are those who say, well, wait until the child is born and use the criminal statutes. That doesn't do any good for the unborn child.

We believe that the bill that we passed stands squarely between these two extremes. It's a moderate and balanced solution to a complex and vexing problem. The bill was supported in the Wisconsin Legislature by a diverse coalition of legislators: pro-life and pro-choice legislators, Democrats, and Republicans. We chose to take a remedial, as opposed to a punitive, approach. And part of the reason, as I commented, if you go with just a criminal approach, very often you can't do anything until the baby has already been born and it's too late then for the baby.

So, we chose to amend our existing Children's Code, looking at a two-fold intent. First of all, to prevent serious harm to the unborn child and the child when born and second to provide care and treatment for addicted, expectant mothers who, for whatever reason, have refused to seek or to accept treatment.

We approached the issue as a child protection issue. We've talked here today about the fact that we're really talking about child abuse. I've spent a fair amount of time in the legislature working

on prevention of child abuse and on domestic abuse issues. We don't excuse the behavior of people who abuse their children. We don't excuse the behavior of people who abuse their spouses, even when that abuse is related to alcohol or drug addiction. Rather than excusing it, we require them to get treatment.

So, I'd like to just comment on some of the major objections that we heard as we were discussing this bill in the legislature. The most came from—one of them was from people who said, look, your bill is scaring our clients. And then they gave us some specific examples: It'll keep pregnant women away from treatment because they will lose their children. Nowhere—nowhere—does this bill say that this can cause you to lose your children. From a practical standpoint, people who don't get their addiction taken care of are more likely at some point in time to lose their children.

The bill does allow courts to order treatment. To order treatment-resistant women to enter into AODA treatment, but not behind locked doors. It doesn't authorize incarceration. It was claimed that it will scare women away from treatment professionals. We're talking about women who are refusing to accept or to seek treatment right now. I'm not sure how you can scare someone away from treatment that they're refusing to look for in the first place. Some people have said that the answer is to increase government spending on treatment, but, again, that isn't going to be responsive to the problem of the women who are not willing to seek treatment.

As we look at women who are unable on their own to seek the help that they need, there needs to be some governmental intervention on behalf of the unborn child. The passage of this bill in the State of Wisconsin offered a unique and perhaps unprecedented opportunity for people who are pro-life and pro-choice to find common ground and unite on an issue to improve the health of the kids of our State. Thank you.

[The prepared statement of Senator Huelsman follows:]

Joanne B. Huelsman
WISCONSIN STATE SENATOR

TESTIMONY OF WISCONSIN STATE SENATOR JOANNE B. HUELSMAN

Before the House Government Reform and Oversight Committee's

Subcommittee on National Security, International Affairs and Criminal Justice

Subject: Wisconsin's "Cocaine Mom" law

July 23, 1998

I would like to thank Chairman Hastert and all committee members for this opportunity to tell you about 1997 Wisconsin Act 292, which has been commonly referred to as Wisconsin's "cocaine mom" law. The law took effect July 1, 1998.

I authored and introduced Act 292 to address a specific problem: how does society provide treatment for women who are pregnant, who have every intention of bringing their pregnancy to term, and who repeatedly refuse to seek treatment for severe and chronic alcohol or drug abuse, or who even refuse such treatment when it is offered to them?

That is the problem we sought to address. We believe Act 292 offers some valuable, if admittedly partial, solutions. We do not pretend that it is a panacea.

Untreated and chronic abuse of alcohol and drugs during pregnancy is a devastating public health problem. The effects of this problem are felt most profoundly by the thousands of disabled children born every year to alcohol- and drug-addicted women.

Severe alcohol and drug abuse by pregnant women – during any part of the pregnancy – can cripple a child for life.

Fetal Alcohol Syndrome alone is the leading known cause of mental retardation in America. Fetal Alcohol Syndrome surpasses both Down's syndrome and spina bifida in frequency. According to the Centers for Disease Control, the percentage of babies born in America with Fetal Alcohol Syndrome has increased six-fold since 1979.

Unlike other disorders, however, the damage caused by alcohol and other drugs is 100% preventable.

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WAUKESHA: 235 W. Broadway, Suite 210, Waukesha WI 53186-4832 • 414-521-5010 or 414-521-5165
Internet Address: http://badger.state.wi.us/agencies/wilis/senate/sen11/sen11.html • E-mail: Sen.Huelsman@legis.state.wi.us
Toll-free Legislative Hotline: 1-800-362-WISC (9472)

Abuse of drugs other than alcohol can also have a devastating effect on unborn children. No one will dispute that the illegal consumption of drugs during pregnancy poses a substantial health risk to the unborn child.

Untreated alcohol and drug abuse during pregnancy is of particular concern to the state of Wisconsin. According to the Wisconsin Department of Health and Family Services, each year approximately 70-80 children are born in Wisconsin with Fetal Alcohol Syndrome. Another 150-200 are born with the less-severe Fetal Alcohol Effect. The DHFS estimates the resulting societal costs of these births to be approximately $90 million each year.

The Wisconsin Department of Health and Family Services does not have any reliable figures on alcohol consumption during pregnancy in Wisconsin, due to under-reporting by women who continue to drink during pregnancy.

But a telling statistic comes from a recent Centers for Disease Control study that showed Wisconsin does have the single highest reported rate in the nation of drinking by women of child-bearing age. The same CDC study also showed that the nationwide rate of drinking by pregnant women is increasing, not decreasing.

Legal and medical opinions about how we should address chronic, severe and untreated alcohol and drug abuse during pregnancy run across a broad spectrum.

At one end of the spectrum are those who are completely opposed to Act 292. Some in this camp even believe that our response to the specific problem we have identified should be this: Do Nothing.

At the other end of the spectrum are those who wish to punish pregnant women who severely abuse drugs and alcohol through incarceration and the use of the criminal code.

Wisconsin Act 292 stands squarely between these two extremes. It is a moderate and balanced solution to a complex and vexing problem. The bill was sponsored by a diverse coalition of legislators, pro-life and pro-choice, Republicans and Democrats.

We chose to take a remedial – as opposed to a punitive – approach. We did so in part because the criminal code cannot come into play until the baby is born and the damage has already been done.

That's why we chose to amend our existing Children's Code, a civil body of law used to protect children at risk of serious abuse or neglect. We believe the social services system is better prepared than the criminal justice system to help the unborn children of addicted mothers.

The intent of Act 292 is two-fold. First, it is intended to prevent serious physical harm to unborn children – and to the children when born – caused by severe, chronic and untreated alcohol or drug abuse by the expectant mother. Second, it is intended to provide care and treatment to addicted, expectant mothers who, for whatever reason, have refused to seek or accept treatment.

We approached this issue as a child protection issue. I have spent a great deal of my legislative career working on issues related to both child abuse and domestic abuse.

The issue we are talking about here is child abuse. That is the reality. That is the end result. All the hand-wringing and excuse-making in the world will not change that reality.

We do not excuse the behavior of people who abuse their children or who abuse their spouses, even when that abuse is intimately and causally related – as it often is – to alcohol or drug addiction. Rather than excusing or justifying their behavior, we usually require them to get treatment.

Prior to passage of Act 292, the only way Wisconsin law could deal with pregnant women who engaged in chronic and severe alcohol or drug abuse was as criminals in the criminal justice system. We felt that approach was inadequate.

In contrast, Wisconsin Act 292 allows a humane and remedial – as opposed to punitive – approach to such cases. Act 292 provides treatment, not incarceration.

Now, I want to tell you about a few of the major objections that were raised by the political opponents of this bill.

The most disingenuous objections came from groups that told people certain things about Act 292 that simply are not true, then came back to us and said, "Your bill is scaring our clients."

Let me give you three specific examples of the type of histrionic scare-mongering that we encountered. In each case, the statements made about Act 292 are simply not true. In each case, these groundless fears were fostered and spread by the very people who then used them as a reason to oppose the bill.

The statement was made to me repeatedly, "This bill will scare pregnant women away from treatment because they will lose their children." Nowhere does Act 292 say that treatment under this bill can be used as the grounds for termination of parental rights.

The claim was also made – repeatedly by some – that Act 292 authorizes the incarceration of pregnant women who abuse alcohol or drugs. This also is simply not true.

Here is what Act 292 does do: the law allows courts to order treatment-resistant pregnant women to enter into AODA treatment – including inpatient treatment – but never behind locked doors.

Here is what Act 292 does not do: it does not authorize the incarceration of pregnant, drug-abusing women. As a matter of fact, nowhere in the law is any authority for any type of secure detention created.

Finally, it was repeatedly claimed that Act 292 will scare pregnant, addicted women away from treatment professionals because they will fear being reported.

The focus of Act 292 is addicted, expectant mothers who are refusing to seek or accept treatment. I don't know how you can scare someone away from treatment that they are refusing in the first place.

Now, I know that there will be questions as to why Act 292 does not address any and all threats to pregnancy. Tobacco, for example, or even poor nutritional habits.

The simple answer is that we did not pretend to have a universal solution to every single substance-related or health-related threat to pregnancy. The fact that we are trying to solve this one problem does not obligate us to invent a solution to every problem. We are simply trying to solve one major public health problem.

Some who are opposed to Act 292 say that the answer to the problem we have identified is simply increased government spending on treatment.

But this proposed solution is not responsive to the specific problem we are responding to.

Regardless of the merits of increased spending on treatment for women who want it, the problem we seek to address is <u>not</u> those pregnant women who voluntarily seek treatment and who accept it when available.

Rather, the problem we seek to address is pregnant women with addictions, women who refuse to seek treatment and who <u>even refuse it when it is offered to them</u> – women who are unable on their own to seek the help they need.

Passage of Act 292 offered a unique and perhaps unprecedented opportunity for people who are pro-life and people who are pro-choice to find common ground and unite on an issue that will improve the health of the children of our state.

Mr. SOUDER. Thank you very much.

Mr. Domina.

Mr. DOMINA. Thank you very much. I'm Bill Domina, senior assistant corporation counsel for Waukesha County. I'm going to speak away from my written text.

I think that my words are only as good as you know me. So you need to know that, in addition to being a lawyer, I'm also an elected official for my local school board and when I ran the local editorial indicated that, he's a lawyer and a liberal, but vote for him anyway. In my area of the State, that's not a compliment. You also need to know that I'm active in the American Cancer Society, sit on the Midwest board of directors, and have been very active in the tobacco litigation in our State. In short, I'm a child advocate, not just from a law enforcement perspective, but from an educational perspective and from a health care perspective.

This is not an issue of us versus them. One of the discomforts I have in the presentations that you'll hear today is that it has that feel that it's either law enforcement versus the medical community or pro-life versus pro-choice or whatever simplistic division that people want to apply. I think there's a great deal of common ground. We can agree that treatment works the best and that court is a lousy place to mandate sobriety.

But many times, we have situations that arise where the best course and the best options are simply not available. In the case of drug addiction, my experience is that you will have cases where, because of the limitations of the individual or because of the nature of the addiction itself, it causes people not to realize or to acknowledge that they have a problem, that the traditional menu of services that are offered will not be taken up or availed of.

We have to answer the question, then—and we did in my State—what do you do when you have a pregnant woman who's using cocaine who's 36 weeks of gestation and who's going to have the baby, who does not want to avail herself of those options that are out there that are very good and that would help her? When we have children that are born in our society, we don't hold them up for public policy purposes, for abuse. What I mean by that is if, for example, you have a child who's being beaten and somebody thinks, Geez, you know, parents are more likely to get help with their anger control problems if we don't require that the State intervene in that abuse. We don't wait. We intervene. We hold the child up. We protect the child and we serve the best interests of that child.

My case is very fact specific and it resulted in a great deal of debate in our State and I think an important debate in our legislature. I give Senator Huelsman the credit for having the guts to bring this issue and raise—and anger many with the discussion.

The thing that this law provides, therefore, is a tool for prosecutors that are seeking to protect children and to intervene before injury. The law very simply provides that a court may issue orders upon a showing that an expectant mother habitually lacks self control. And what that phraseology is intended to provide is a high bar of admission. In other words, it isn't just lousy decisionmaking that gets you into court.

I'm a parent of two small children and I'll tell you that I make lousy choices for them sometimes. And I would regret and be offended by the State's interest in intervening in my right to make lousy choices and to learn from those choices as a parent, at times, and to grow as a parent. That's not what this bill is intended to do.

So, contrary to the verbiage that you may hear that women that chose to drink casually during pregnancy—although I think it is a lousy choice—is not a subject of jurisdiction under this bill. Or women that choose to smoke during the course of pregnancy are not the subject for this bill. Rather, women that habitually lack self control with respect to drugs and alcohol are the subject.

The orders can regulate the mother's conduct. It can place her or the child in a least-restrictive setting, again, a constitutional monitor that provides protection that people are not held in controlled circumstances. And those settings can include the home of a friend or a relative or may include a hospital. Notice I said hospital, not prison.

This bill very clearly does not provide for incarceration. It does not provide for criminal penalty. Its purpose is one of remedial intervention. It's a front-end bill and if you review what cases are being upheld across this country, many of them involve the criminal prosecution of women. I think it is abhorrent to wait for children to be injured for the criminal justice system to flex its interest in a situation.

It also provides for the appointment of counsel and for the right to a jury trial. Very fundamental issues. I want to thank the committee for inviting me today to present my information. I hope it is helpful. And I hope it serves as an opportunity to continue this very important debate. Thank you.

[The prepared statement of Mr. Domina follows:]

TESTIMONY OF
WILLIAM J. DOMINA, SENIOR ASSISTANT CORPORATION COUNSEL FOR WAUKESHA COUNTY, WISCONSIN.

Before the House Government Reform and Oversight Committee's
Subcommittee on National Security, International Affairs and Criminal Justice

July 23, 1998

It is my pleasure and honor to present testimony to the committee. I would first thank Chairman Hastert and all committee members for this opportunity.

Wisconsin's "Cocaine Mom" law took effect on July 1, 1998. It represents an attempt to proactively and remedially intervene in an extreme set of cases where a mother has chosen to carry a child to term and also chooses to uses illegal drugs or alcohol in an habitual manner.

Although Wisconsin's law attempts to deal with the problem of severe alcohol and drug abuse by pregnant women, its genesis lay in one case involving a woman named Angela M.W.. At the time that Waukesha County became involved with this issue, Angela M.W. was twenty-four years old. Angela, the mother of two older children who were placed with her mother, was a crack cocaine addict. The Waukesha County Department of Health and Human Services received a referral from Angela's obstetrician, Dr. Matthew Meyer of Waukesha. Dr. Meyer, reporting under Wisconsin's mandatory child abuse reporting law, indicated that Angela continued to abuse cocaine despite his best efforts and the offering of a traditional menu of services for drug addicted pregnant women. At the time of the report, Angela was at thirty-six weeks gestation and Dr. Meyer reported that he believed that Angela was committing child abuse on her unborn child. Dr. Meyer presented urine screens to verify Angela's usage of crack.

Under a former version of Wisconsin juvenile law, Waukesha County preceded to petition the Waukesha County juvenile court, the Honorable Kathryn Foster, presiding. The petition, filed in the same as all child abuse petitions, asked the court to detain the 36-week old viable fetus. The premise for the petition was the position that the viable fetus was a "child" within the meaning of the Wisconsin Childrens' Code. The juvenile court agreed and issued an order detaining the unborn child in a hospital. Subsequently, Angela chose to seek inpatient treatment in a drug treatment facility. The juvenile court continued the detention of the fetus in the drug treatment facility.

The juvenile court's detention order was affirmed by the Wisconsin Court of Appeals in an opinion authored by the Honorable Neal P. Nettesheim. Judge Nettesheim indicated that the detention was a natural "consequence of [the mother's] choice" to carry the child to term and to place the child at risk of serious physical injury through the use of cocaine. The Court of Appeals also held that the Wisconsin's child abuse law applied to a viable fetus in the same way that other remedial civil statutes have been interpreted to apply to viable fetuses. See Angela M.W. v. Kruzicki, 197 Wis.2d 532, 541 N.W.2d 482 (Ct. App. 1995).

Following the Court of Appeals' decision, Angela gave birth to a baby boy, who appeared healthy and did not suffer from the withdrawal symptoms frequently exhibited by cocaine children. This child was placed in foster care and was the subject of a termination of parental rights proceeding by Waukesha County.

On a 4-3 vote the Wisconsin Supreme Court reversed the Wisconsin Court of Appeals. The Supreme Court applied a narrow construction of Wisconsin's child abuse statute and held that because the Wisconsin legislature never used the word "fetus" when defining a "child" in this remedial law, that the Court would not infer such coverage. The Supreme Court reversed the detention order. See Angela M.W. v. Kruzicki, 209 Wis. 2d 112, 561 N.W.2d 729 (1997).

It was with this backdrop that the Wisconsin legislature with the support of Senator Joanne Huelsman and Representative Bonnie Ladwig took up the charge, resulting in the passage of the "Cocaine Mom" law.

The Wisconsin law uniquely attempts to allow the public the right to intervene in an extreme case where a pregnant mother is habitually using illegal drugs or chronically abusing alcohol. Like Angela's case, it is premised on the concept that children who mother's choose to bring into this society deserve to start life healthy and drug free. This law differs from the direction of most states who choose to use the local criminal codes to prosecute women who use drugs or chronically abuse alcohol during pregnancy. Wisconsin's approach recognizes that the protection of children is of paramount consideration and that waiting until a child is damaged to criminally prosecute women misses such consideration.

Specifically, the Wisconsin law provides:

> **1. A judge may intervene where a pregnant woman habitually lacks self-control in the use of drugs or alcohol to a severe degree which places her unborn child at severe risk of physical injury; and,**
>
> **2. For voluntary services; and,**
>
> **3. Orders to be entered by the Court regulating the conduct of the mother, which may include taking the mother into custody with placement in the least**

restrictive environment such as the home of a friend or relative, a hospital, a Community Based Residential Facility, a drug treatment facility or a mental health facility; and,

4. For the appointment of advocate counsel for the mother; and,

5. For the option a jury trial.

Despite the best efforts of opponents to mischaracterize the effects of the Wisconsin law, this law does not put pregnant women in jail or allow the state to intervene in all poor choices made by pregnant women. The law does not authorize the institution of the pregnancy police who will circulate through Wisconsin rousting women who may make poor nutritional or hygiene choices during pregnancy.

Most importantly, the law promotes the position of those who will be born in our society and gives them the right to be born healthy and drug free.

Critics of the Wisconsin model argue that women will believe that they will be incarcerated and held in prison despite the fact that the express language of the law states to the contrary. Such critics also decry the Wisconsin model as some sinister attempt to infringe on the rights of women and to encroach on the rights of women recognized in the seminal case of Roe v. Wade, 410 U.S. 113 (1973) as confirmed in the case of Planned Parenthood v. Casey, 505 U.S. 833 (1992). The reality is that such critics are themselves the creators of the very perceptions that some women may have. By continually mischaracterizing the direction and effect of the Wisconsin law, these extremists spread the very fear that they then criticize the law as providing. This is a clear attempt to set up a straw man issue and knock it down despite the express language contained in the Wisconsin model. This attempt is contemptuous.

Moreover, the critics need to look no further than the cases of Roe and Casey to understand that the Wisconsin model is well grounded in established precedent. Both the Roe court and the Casey court discussed the compelling state interest in insuring that the to-be-born-life was protected. In short, neither Roe nor Casey stood for the proposition that if a mother chooses to carry the child to term that she had unfettered discretion regarding the product delivered into our society. Pregnancy does not provide an "open season" of those children who will become members of our society. In many respects, the Wisconsin model use the precedents of Roe and Casey to provide the legal foundation for the law, and, thereby, solidifies such precedents in legal history.

Many of the critics of the Wisconsin model promote themselves as the protector of individual freedoms. What is missed here, however, is that frequently the law must balance the rights of individuals to insure that all are provided such freedoms. In Angela' case and in too many cases in Wisconsin and across the nation, the right of the individual to be born healthy and free from the effects of drugs and alcohol is ignored. The Wisconsin model seeks to establish the balance between individuals, both born and unborn.

Wisconsin's discussion of the thorny issues surrounding such interventions represents and thawing of the freeze in the discussion created by the vitriolic debate engaged in by the pro-life and pro-choice movement. Essentially, there has been little or no debate in this country over the past 25 years exploring the concept of choice and what consequences may occur for conduct which may impair the health and life of a newborn child. This vacuum is surprising given the great cost that impaired children have on our social services, educational and criminal justice systems.

Although the goals of the Wisconsin law are laudable and may even assist women to maintain custody of their children and not have their parental rights terminated, the law is not a panacea to the problem of drug or alcohol use during pregnancy. It is, however, one tool that a prosecutor may use to protect a child when an extreme set of facts supporting intervention is presented.

Mr. BARRETT. Very briefly, if I may, Mr. Chairman. As you can tell from the bells, there's another vote. For those of you from Wisconsin, this shows we're working for you day and night. [Laughter.]

But I apologize and I'm going to run off and vote. And Mr. Souder, I think, is going to continue. And then I'll try to get back as soon as I can. Mr. Chairman.

Mr. SOUDER. I'll go ahead with my round of questioning. First, let me ask of Senator Huelsman or Mr. Domina, the treatment program—who pays for the treatment?

Mr. DOMINA. Under the bill, it would be directed by the court. Typically, the county of jurisdiction would be responsible for the treatment provided under a court order, as it would under any normal order in a situation where a child is born. So, if the family is ordered to seek psychiatric services or drug and alcohol services, typically that is the responsibility of the county.

Mr. SOUDER. In the legislature, did you appropriate additional funds or how many cases, at this point, have you had Statewide? Do you have any idea?

Ms. HUELSMAN. There haven't been any cases since the bill was passed. The bill just became effective recently and there haven't been any cases. There was no funding appropriated in the bill. One of the reasons is that—I might compare it to some other things that we have passed and if you included funding the bill would probably not pass. So you pass the bill and address the funding in the next session of the legislature. No funding was actually appropriated in this bill.

Mr. SOUDER. We've never done that here. [Laughter.]

In fact, we just give it to the States and then——

Mr. Condon, in South Carolina, my understanding of both—it's Ms.——

Ms. CHRISTOPHILLIS. Christophillis.

Mr. SOUDER. Christophillis, is that right?

Ms. CHRISTOPHILLIS. Yes. Thank you.

Mr. SOUDER. In both your testimony, my understanding was their was treatment required as the first resort as well?

Ms. CHRISTOPHILLIS. Yes. That's correct.

Mr. SOUDER. And who pays for it in South Carolina?

Ms. CHRISTOPHILLIS. It's really a combination of different funding sources. Some of it comes from our State. We have in South Carolina our State treatment organization that funds different projects as well as each county is set up with their own local board and AODA treatment, so they receive funding. Also, we receive funding in some ways from the Federal Government and Medicaid payment and different other grants.

As well as an important factor that I think is the private factor. A lot of our local initiatives are a partnership between private and public sectors. Because the private industry has a definite stake in getting women and children off of welfare and off of addiction so they can become productive citizens and the State won't be a parent.

So, it's very much a combination. But we've been very successful. We've been involved in this area since 1989 in South Carolina. And, as of the most recent statistics from January to June of this year, 108 reports were made to our Department of Social Services

and 82 of those went into voluntary treatment without any court action whatsoever. So I think it's definitely working.

Mr. SOUDER. How many people have gone through your program? Do you have any idea?

Ms. CHRISTOPHILLIS. No. We've recently collected statistics. When the Whitner case was passed in 1996, it gave us our first opportunity in, really, last year, to do a thoughtful, Statewide study. We've had different counties that have been more involved than other counties. So we have some history in certain counties, but nothing specific statewide. But I can tell you from Greenville and Charleston and some of the other States, I know of hundreds of women that have successfully completed these programs.

Mr. SOUDER. You had a dramatic story in your testimony. Mr. Condon, also referred to, lovingly, the New York Times coverage. When you say you've had hundreds of people successfully treated, how many of those did you have respond to the first order as opposed to the second? And do you have other stories in the second?

Ms. CHRISTOPHILLIS. Well, I think that also Paula Keller, who's here in the second panel, who runs our long-term, inpatient drug facility can tell that these women were not knocking on the door. They weren't lining up saying, Here I am for treatment today. That just—it wasn't happening. The same thing at our medical university in Charleston. So we tried that and it didn't work.

So, the layers of intervention that we set up are least intrusive as possible with our family court. We had a statewide family court system that has the Court of Equity and it's not a criminal court. And that's where the bulk of these cases end up going to. I think it's pretty similar to what Wisconsin recently passed. We've had that for a long time and it gives us the ability to protect children, as well as treat the mothers.

Mr. SOUDER. My understanding is in the Atlanta Constitution they ran a poll that showed that more women favored the criminal penalties than men. Does that surprise you? How do people react in both your States?

Mr. CONDON. It doesn't surprise me at all. As the other witness talked about, this gets support across-the-board from all different groups because I think people realize that we have a responsibility, as a society, to these innocent children. And if someone could come up with a better mousetrap, a better solution, let me know about it. We find this works. That you have some intervention, whether it's civil penalties or using probate court or Department of Social Services on up to the criminal; that's what the protocol calls for. And I think what they've done in Wisconsin is marvelous.

But the point is to do something. And, sadly, in most jurisdictions in this country, nothing is done.

Mr. DOMINA. My experience and my concern is that, if there isn't sort of a recognition of the common sense middle ground that is promoted in both States, that there begins to take on a desire of the population to do something more. And there's a greater encroachment on individual rights and freedoms to the point that I think is unacceptable. And so, when my case was struck down which resulted in the legislation, there were many community members that came up to me and said, Well I think you should go and mandate sterilization of women that keep producing these

drug-addicted children. And I find that to be, gosh, a little bit more invasive than what we did.

But that type of flavor of community reaction is there if there isn't some attempt to intervene and deal with the situation in a common sense way.

Mr. SOUDER. Thank you. I have to go make sure I get my vote in. The hearing stands in recess.

[Recess.]

Mr. BARRETT [presiding]. The hearing will reconvene. Congressman Souder is voting. He will be back shortly. I'm staging a little coup here, though. [Laughter.]

Again, I apologize. We're trying to make it—it's too late to be as painless as possible for you, so we're just trying to make sure we can at least give you a chance to get out of here. I don't know if we've lost Mr. Condon? Have we lost our South Carolina delegation here? Maybe we'll just wait a moment for them.

Ms. HUELSMAN. They were waiting for another bell to ring.

Mr. BARRETT. Well, let me start. And, again, welcome to both of you. I feel sort of cozy here; I could be back in Wisconsin with this. But I'm curious as to the opposition in the State of Wisconsin. Obviously, we've got some providers who have raised some concerns. Do you find that—and, Senator Huelsman, I'll direct this to you—do you find that most of the opposition comes along the line of: You're going to discourage women from coming into the system at all?

Ms. HUELSMAN. There were two primary concerns that I would say that I heard from people. One is that you're going to scare women away. That they won't come in. And the other is: We need more money.

On the scaring women away concern, I'm concerned about some of the misinformation that women somehow got. Now maybe women get that because of the situation that they're in. But when I referred to the misinformation about the fact that some women think that that means that their kids are going to be taken away from them or some women who think they're going to be put in jail—neither one of which is true.

So somehow we have to make sure that all of those who are providing treatment help get the word out to people that this isn't going to mean that we're going to take the kids away. This just may mean that you're more likely to be able to keep your kids. This isn't going to mean that you're going to be put in jail. We have to get that factual information out to the women who are, as I understand it—and I think other people would agree with that—are kind of afraid of the system anyway.

But, again, we're looking at women—as we developed the bill, we were looking at women who, right now, just plain refuse to accept treatment. So to say that you're going to scare them away, they're not coming now.

Mr. BARRETT. And who is the reporting—is there a reporting requirement?

Ms. HUELSMAN. No. There is no reporting requirement. And I think that is where one of the problems came in. When the bill was originally drafted it was drafted as all the rest of our child abuse statutes to put in a reporting requirement. And so that scared peo-

ple in the first place. And we heard people come and testify to the fact that if we left the reporting requirement in there, people would not continue with their, for example, their AODA treatment because if they're going to be truthful to the person who's providing counseling, that person would be required to report them.

So we removed all reporting requirements. There are no reporting requirements. But there is nothing to say that a person can't report.

Mr. BARRETT. Maybe I'm stating the wrong question then. Is there a trigger mechanism that a hospital professional—if an emergency room nurse or physician sees a woman that he or she believes has used cocaine, is that physician or nurse required to report that?

Ms. HUELSMAN. No, they are not required to report.

Mr. BARRETT. OK. And what's the standard upon which they should act? Is there legal guidance given to them?

Ms. HUELSMAN. No.

Mr. BARRETT. Mr. Domina, is that it?

Mr. DOMINA. Domina. Kind of like the pizza.

Mr. BARRETT. OK.

Mr. DOMINA. The legal standard is really when they believe in a subjective way that there is abuse or neglect that's occurring, they can report. But they're not required to report. If they do provide that in a good faith way, they're given civil immunity under the statute, but they are not required to come forth and, as a mandated matter, provide that report. That was taken out of the legislation during the amendment process.

Mr. BARRETT. And how about under the South Carolina law?

Ms. CHRISTOPHILLIS. Yes. Ours is a bit different because what we were working on is our existing child abuse and neglect statutes which had been around for about 20 years in South Carolina. What happened in South Carolina is we had our supreme court decision, the Whitner case, expanded the definition of a child to the period of viability only. And, therefore, you couple that case law with the existing statutes of child abuse and neglect and that leads to our protocol.

We do have a mandatory reporting statute. But I went to the medical association in South Carolina and their Maternal, Infant and Children's Group and they wrote, which is part of our protocol, the Maternal Drug Screening Protocol and the Newborn Drug Screening Protocol, which triggers the test of when to actually order a drug screen. They are based on objective criteria with the best interests and loyalty to their patients. All of this language is in the protocol and it was written by doctors.

Mr. BARRETT. And who does it apply to? In other words, the same question is: Does it apply to health care professionals?

Ms. CHRISTOPHILLIS. Yes.

Mr. BARRETT. Does it apply to employers?

Ms. CHRISTOPHILLIS. Yes. Well, it—no, not necessarily. We have a specific statute that deals with mandatory persons to report. And it's mainly health care, day care workers, people—professionals that are around children, work with children, law enforcement, nurses, et cetera. Other people, like employers, that would be—

they would fall in a "may" category. But they are not mandatory reporters.

But we have a specific statute that spells out, in our protocol, exactly who is mandated to report. And that's been around for—like I said—for at least 20 years.

Mr. BARRETT. Does the South Carolina protocol apply to all hospitals or just public hospitals?

Ms. CHRISTOPHILLIS. Yes. All hospitals. In fact, in the protocol that the medical association wrote, "The criteria herein are intended to be applied in all clinical settings, both inpatient and outpatient and clinic and private physicians' offices." And part of my job is to train all of those people in the medical field, as well as other agencies that deal with this issue. And I have been—we have 95 hospitals in South Carolina and I'm making my way through all of them, county by county and training these physicians and nurses and risk managers who deal with this issue. And we've been very successful.

Mr. BARRETT. Mr. Chairman, if I could have another minute or two? One of the concerns that was raised with me with respect to South Carolina was a racial impact, that more African-American women were being prosecuted under this statute than white women. Could you address that issue please? Or maybe, the attorney general, if you'd like——

Mr. CONDON. I would reference, first off, what I testified to earlier in terms of a court decision. That's one thing, I guess, nice about being sued, you do get a result. And the ACLU heavily funded the case. It was a priority with their Center For Reproductive Rights. They funded it heavily; hired private lawyers and cost was no object. Of course, they offered—they wanted us to settle for nuisance value and—against the chief of police. I was sued, several other officials were sued personally. We wanted—you want a court decision, let's get a court decision.

And the decision is extremely strong in terms of these allegations of racial animus. There is no evidence of that. The court found it. The Federal judge found it. The jury found it. So, you know, when you hear these things, I would hope you would keep in mind, we've had an orderly procedure that went for weeks and weeks and weeks in which all these issues were raised and addressed and clearly decided.

Having said that, when you look at some raw numbers—I have never checked the raw numbers in terms of racial composition—but it would surprise me—if your main concern is crack cocaine in terms of damage to children—it would surprise me, based upon sociological data, that most wouldn't be African-American. It simply is a sociological fact. Every study has seen this.

You'll often hear people quote this study out of Pinellas County, FL. I actually went down there and looked at what they were doing. They're doing exactly what we're doing, forced treatment. And Dr. Ira Chasnoff, in his first sentence in his article, always says, "Statistics show that drug use among all groups are roughly the same." Well, that's a very disingenuous statement, because when you get his raw data—which I have gotten—his data shows exactly what we've found, is that for some reason, I don't know why, that crack cocaine is very popular among African-Americans.

Mr. BARRETT. Have there been prosecutions for powder cocaine?

Ms. CHRISTOPHILLIS. Yes, yes. But mainly, you know, when we—prosecution—that term is really misleading. Because this is—we're really talking about intervention. I mean, people really—it's almost like you have to break into the jailhouse under this protocol. It so rarely happens in the less than 1 percent of the cases.

Mr. BARRETT. Again, if you can give me a split. How many cases have involved crack cocaine? How many have involved powder cocaine?

Ms. CHRISTOPHILLIS. I don't think—we never distinguish the difference. We never—I mean, it's—cocaine, heroin, LSD, PCP, and their derivatives, and amphetamines.

One thing I'd like to say about the protocol, that these doctors wrote objective criteria, not subjective criteria. They're neurological, gastrointestinal, and automatic, specific, objective criteria that happens maternally or newborn to trigger a screen. That's extremely important I think.

Mr. BARRETT. I think my time is——

Mr. SOUDER [presiding]. I wanted to say for the record, too, that Charleston Police Chief Greenberg has been alluded to several times. He's an African-American police chief there. He couldn't be here to testify today because of a funeral of a good friend. But he has said that, "The program's opponents don't care about the race issue, they're just using this as tactics. I was glad that somebody was finally doing something to help kids in the black community. This is giving kids a chance who otherwise would not have had anything close to an equal playing field. At least at the point of birth, that child ought to be given the best opportunity for a full and productive life."

I think that there are legitimate questions of how we, as a society, have distinguished between powder and crack cocaine. I think that's a great argument for upping the penalties on powder, not for lowering the penalties on crack. And, initially, those penalties were changed at the request of many in the minority community. But it is something that we should make sure that there is fairness there and I think we pretty much understand that we need to do that. But it shouldn't be a back-door way to lower the accountability for crack users.

A common argument—and I understood both from South Carolina and Wisconsin that this wasn't true—but a common argument against intervention is whether the sanctions would discourage people from moving into treatment, which should be shown in several different ways. Either you'd see a rise in abortion. You'd see a lowering in treatment waiting lists. Have you seen any evidence in either State that the imposition, the establishment of these two laws have discouraged people from seeking treatment or shunning prenatal services: not going to WIC, not going to Head Start, not going to a licensed child care facility where people might report them?

Ms. CHRISTOPHILLIS. We have seen none and I think we have a little bit more history. Wisconsin just passed their law. Because, particularly in my county that I'm from—I've been personally involved with this issue since 1989—it's just the opposite.

I mean—and I bring again Dr. Beasley—and I know that will—that's part of your record. I mean, she runs an online health clinic. She's a doctor and she called me up herself, on her own, just to let me know how well this was going. And, in fact, it's just the opposite. I mean, when, once the word is out there on the street that this is amnesty, this is treatment oriented, this is a reprieve, they are coming in. They want to get help. These women do want to get help. But they are addicts. And you've got to understand the nature of an addict before you know, really, anything about this.

And that is just—it's worked because they see that people care about them. They want them to change. They want them to change their behavior. In fact, I just wrote a grant to the Department of Justice to pilot six counties in South Carolina for drug courts in family court, which is a therapeutic court of intervention, and we feel like if we can intervene in our family court—again, our Court of Equity, which is a non-criminal court—with DSS on abuse and neglect and provide a therapeutic court setting there—we hope we'll get that grant—that that's even more beneficial to the families of South Carolina.

Mr. CONDON. One thing, too, if I could maybe—I know it's confusing. You keep hearing about Charleston, SC. The reason you do is—I guess it's a happenstance. My wife happens to be a doctor, but I get a call from health care officials at MUSC in 19—I guess—89 after having heard about a crack cocaine epidemic at a prosecutors' meeting in Seattle and I thought it would never happen in Charleston. And so they called me and asked for a solution to a problem.

Their neonatal unit was full. They had no more spaces for babies because they found that this horrible drug called crack cocaine was damaging all these babies and they'd been trying a pure education model and treatment model for about 6 months or 8 months and no one went. They had one person go to treatment for free.

So I was called and we developed protocols to address that specific problem. Now, being attorney general with the court decisions very clear as to where we are, in a way it's good in terms of addressing the broader issues, Charleston's ancient history. It's gone. You're going to hear some testimony, but it's gone. We're talking about a statewide protocol for every illegal drug that damages babies in South Carolina with this protocol developed through a task force formed by our legislature with input from health care professionals.

A lot of work has gone into this. We have a full-time director; cooperation all 46 counties, virtually; so that the situation—I'm very anxious to have some time go by to really invite people to look at this, because I think we're going to have a stunning success model here.

Mr. SOUDER. In Wisconsin, what is the reporting technique? How do you find who is placed in this program? I mean, is it the same as what they described in South Carolina? And, if it is, as far as who's identified to come in, have you seen any sign—even though you're at the early stages—that people then might not go into those programs for fear somebody might turn them in?

Ms. HUELSMAN. I have been told by someone that's going to be testifying on the next panel that she has seen some of that. Again, I think one of the problems is that the law is so new in the State

of Wisconsin that people don't know what's included in it. But I spoke to a group of women at a residential treatment facility in Waukesha. After I was finished talking to them, they had no problem with it, but they had misconceptions before I came in as to what was included in the law. So I think it's going to take us some time to get some accurate information out to women.

Mr. SOUDER. Are the courts the primary way that people come into this program? And, if so, how do they come into the court system? What are the primary ways?

Mr. DOMINA. They come in as any other child abuse report would come in. Family; friends; law enforcement; physicians, even, although they're not required to report, can provide reports. And that information then would be used to assess whether or not you can prove that the individual is habitually lacking self control—that's the standard under our law—in a court. And, if you can, then the court can issue certain orders regulating conduct and placing a parent in a least-restrictive setting from a home up to a hospital.

Mr. SOUDER. If I understood what Senator Huelsman's point was, that, in fact, some of the groups who don't like the law may in fact be scaring people away from prenatal services when, in fact, if those people in those services knew that they weren't going to jail, they were going into treatment, they might, rather, be thankful about the program. Is that, in effect, what you just said? Because you said, "based on misinformation, people thought—" and there might be some declining of people going in, but once they learned what it is, at least the people you talked to didn't have the same resistance.

Ms. HUELSMAN. That is correct. And some of the misinformation is, again, because of some changes that were made in the law and so people who had information about the initial draft that was then changed, but didn't get the information about the changes, may be left with a concern in their mind.

Mr. SOUDER. And, for the record, both of you are talking about programs that have treatment, not just programs that incarcerate, which is a distinction that you made in the testimony, but it's an important distinction.

Ms. HUELSMAN. That's correct.

Mr. SOUDER. Do you have any additional questions?

Mr. BARRETT. I'm going to read a portion of written testimony that Ms. Feinberg has submitted. And I'd like your reaction. And it goes along the same thing that we've talked about, but I've got a question after I read it. This is on page 3 of what appears to be her submitted statement.

"They," meaning the women at Meta House, "indicated that, because of this law, they would be reluctant to seek prenatal care and treatment for their alcohol and drug problems. One woman stated, 'A lot of babies are going to be born at home.' The other women nodded their head in agreement. Wisconsin's attempt to capture the few pregnant women who refuse treatment is scaring away those pregnant women who want and need prenatal care and alcohol and drug treatment."

My belief is that everybody who is involved in this debate is acting in good intentions and that there's nobody with any hidden motives at all on this. And then I think everybody who is making an

argument on both sides of this is very sincere about this. So I take people at the face value on this issue.

And my first question, Mr. Domina—I keep thinking Mr. Pizza Hut after what you said before. [Laughter.]

But I know that's not right. How many women are refusing treatment? How big a problem do you see, then?

Mr. DOMINA. I'm a lawyer. I deal with individual cases and, in some respects, that's what we had in Waukesha. We had a case involving a woman——

Mr. BARRETT. A horrible case.

Mr. DOMINA. A horrible case. But one that really cried out for some sort of issue to be addressed. And I don't go out and measure in my profession, women that don't show up at treatment facilities or do show up at treatment facilities. I really can't provide you with that information today.

Now, with that said, knowing that I'm limiting my answer because of my lack of experience in the area, I also think you cannot accept, as a broad brush statement, a response that's contained in a statement of one individual. You don't know how the issue was presented. You don't know what factual predicate was part of that presentation. You don't know whether or not there was a wink and a nod in terms of you're going to be going to jail. They say you're going to the hospital, but we really know it's jail. And without that information and without statistical evidence, you really don't have the ability to gauge whether that premise is really factually accurate.

But really, in Wisconsin, we're kind of scratching the surface on this. And we cannot present you, I don't believe, a case that that premise is accurate or not accurate. I can tell you that I do know, from my experience, that many women deny that they have a problem because they're addicted to cocaine or addicted to alcohol. That that, in my experience in the court system—and I'm not a treatment professional—is part of the progression of the illness. And, given that denial, it doesn't seem to me to be a logical leap that you would have individuals that, because they don't think they have a problem, that they don't need treatment.

And the only issue I have with that is when they invite injury onto children that are going to be part of our society.

Mr. BARRETT. What about South Carolina?

Ms. CHRISTOPHILLIS. I think, again, we've had almost 10 years of experience in at least some of our counties, particularly Greenville and Charleston where both Attorney General Condon and I are from. Paula Keller is here and Shirley Brown from both of those counties and they can answer very specifically, I think, these questions.

My experience has been on the ground with this issue is it hasn't happened. It's not there.

Mr. BARRETT. What hasn't happened?

Ms. CHRISTOPHILLIS. There's no babies being born on the streets of Greenville. There's been no women not coming in for prenatal care because of our policy. It's—all of those things that were criticized in the very beginning almost 10 years ago, our evidence has found that it's just not true. And, actually, they are coming in for treatment and the vast, vast majority of them are successfully

being treated with at least a minimal intervention, just with a plan, with DAODA—our treatment people are DAODAs—and DSS (Department of Social Services), and then maybe even going to family court. And that just is borne out by our recent statistics, which I made part of the record.

Mr. BARRETT. But how widespread is the problem of women who refuse treatment?

Ms. CHRISTOPHILLIS. Who refuse treat—it's widespread. It depends on when you say—at what point they refuse. They weren't voluntary coming in without some kind of intervention, OK? And intervention—our first step in intervention is through our family court, through our Department of Social Services, which is similar to Wisconsin.

So it wasn't—so it's that intervention. It's a referral to DSS and then a referral to treatment, without going to court. And 82 out of 107 from the 6 months of 1998 did exactly that: go to treatment once they were referred to DSS.

Mr. BARRETT. And were the other 25 prosecuted?

Ms. CHRISTOPHILLIS. No. Only—well, 33 went to family court, which is another arm of intervention, but not a criminal prosecution.

Mr. BARRETT. How many criminal prosecutions?

Ms. CHRISTOPHILLIS. Six.

Mr. BARRETT. In the 10 year——

Ms. CHRISTOPHILLIS [continuing]. All met our protocol in that it was a second or third crack baby. There was a criminal history and a lack of—a very lack of—non-compliance. We know addicts are going to slip up. We know that. But these were women who, you know, year after year after year of working with, continued to not comply with the plan.

Mr. BARRETT. At what point in your process is a woman afforded counsel?

Ms. CHRISTOPHILLIS. Counsel? She is offered that in the very beginning. Of course, if she ends up going to family court, she's appointed——

Mr. BARRETT. OK, so she's entitled to counsel——

Ms. CHRISTOPHILLIS. Yes, she's entitled. And that's in the protocol as well. One of the most important things, I think, about our protocol is that it is a team approach from the very beginning by a response team or a review team. And these are people made up—they're treatment people; they're DHAC; they're medical people. It's not just, you know, the prosecutor; it's making those decisions.

Mr. BARRETT. OK. In Wisconsin, I think you said, Senator Huelsman, that the woman is given counsel at the initial entrance into the system. Is that correct? When is she entitled to counsel, under Wisconsin law?

Mr. DOMINA. When a petition is filed. Mr. Barrett, Wisconsin does have experience with a mandatory reporting law under a child abuse statute, similar to South Carolina, that would have been the direction if we had had a successful Supreme Court experience. The same arguments that you're inquiring about concerning response of people that won't go to seek physicians were made when that law was passed in our State. And our experience has been that that has not been an intervening factor, to a large degree, with respect

to individuals. Doctors do report child abuse with children that are born and it has not invaded the ability of people to seek physician treatment.

Mr. BARRETT. Thank you. And one other quick question for South Carolina. If the woman completes the treatment, the baby is born, is there still a referral? I couldn't tell from your testimony.

Ms. CHRISTOPHILLIS. If she was reported during the period of liability?

Mr. BARRETT. I'm trying to find your testimony here. But if you can look at your testimony. It's unclear to me what happens after the baby is born.

Ms. CHRISTOPHILLIS. If there's been no intervention—all right, let's say that the baby was born in a hospital and, under our protocol, meets the criteria to order a drug screen for a newborn. Then, if it is positive, then it's reported to DSS, and DSS has to investigate it and either indicate or unfound that case. And then they would take that to family court for an order for treatment.

But if the woman was identified during the period of viability in the third trimester and sought treatment and was successful, like a majority of cases in Dr. Beasley's clinic, then they never go to court. They're just monitored for a period of time to complete the treatment and that's—then the case is closed.

Mr. BARRETT. Thank you, Mr. Chairman. Thank you.

Mr. SOUDER. I wanted to do one followup. Mr. Domina referred a second ago and said, In child abuse cases, similar complaints or concerns were raised. And I wondered if that was true in South Carolina too. In other words, if a drug abusing mother has a 3-year-old and they whack them upside of the head or they insert drugs into their system, do people say, We shouldn't intervene there because they might not go into—they might avoid the system. They might not use Head Start. They might not use prenatal care or other types of things. Or is there a double standard?

Ms. CHRISTOPHILLIS. There's a double standard. No, that's not true.

Mr. SOUDER. I thank you all very much for your testimony and for your patience as we've gone through all the votes. You're now excused. [Laughter.]

If the second panel could come forth. I'm going to go ahead and introduce the second panel as you come forth. And I want to thank you, in particular, for sitting here for hours and hours as we've both gone through the first panel and had all the votes.

The first witness in the second panel will be Ms. Shirley Brown. She's outcome manager with the Medical University of South Carolina. The second witness is Ms. Paula Keller, is director of Serenity Place. The third witness is Ms. Betty Foley, associate director of the Haymarket Center. The fourth witness is Dr. Francine Feinberg. She's with the Meta House and Our Home Foundation. The fifth witness is Dr. Mary Faith Marshall. She's with the program in bioethics at the Medical University of South Carolina.

Now that you're all comfortably seated, would you please stand and, as you heard earlier, we swear in all our witnesses.

[Witnesses sworn.]

Mr. SOUDER. Ms. Brown, if you could go ahead with your testimony.

STATEMENTS OF SHIRLEY BROWN, RN, MN, OUTCOME MANAGER, MEDICAL UNIVERSITY OF SOUTH CAROLINA; PAULA KELLER, DIRECTOR, SERENITY PLACE; BETTY FOLEY, ASSOCIATE DIRECTOR, HAYMARKET CENTER; FRANCINE FEINBERG, PSY.D., META HOUSE, OUR HOME FOUNDATION; AND MARY FAITH MARSHALL, PH.D., PROGRAM IN BIOETHICS, MEDICAL UNIVERSITY OF SOUTH CAROLINA

Ms. BROWN. Thank you, Mr. Chairman, and Members of Congress. I want to thank you for inviting me to testify at this hearing regarding substance abuse during pregnancy.

Harmful effects of cocaine on pregnancy and the infant have been documented in the medical literature since the early to middle 1980's. General health problems for these women include malnutrition, anemia, hepatitis, AIDS, and other sexually transmitted diseases.

Cocaine abuse increases the risk of spontaneous abortion; preterm labor and delivery; intrauterine fetal growth retardation; intrauterine fetal death; and abruptio placentae, which is the premature separation of the placenta from the uterus that can result in fetal death. In 1987, a multi-regression analysis reported in the Journal of Pediatrics showed that only illicit drug use had independent adverse effects on age at birth and birth weight. Smoking, alcohol, economic status, and prenatal care were not significant factors.

Neonatal problems resulting from maternal cocaine usage are somewhat less defined. The neonate may be irritable, difficult to console, and a poor feeder. Many studies have documented disordered neurobehavioral development. Based on literature, substance abuse also places a child at greater risk for abuse and neglect. In Charleston, a toddler died from ingesting a bag of his mother's cocaine. The autopsy revealed no food in the child's stomach.

In October 1988, an increasing evidence of perinatal outcome parameters suggesting maternal cocaine abuse was recognized at the Medical University Hospital. Urine drug screens were ordered because of the poor perinatal outcomes of abruptio placentae or intrauterine fetal death, although occasional tests were done to investigate premature labor or previously known drug or alcohol abuse. In the spring of 1989, a protocol was adopted requiring urine drug screens for clinical indicators suggesting cocaine abuse.

In the first 12 months in which urine drug screens were obtained, 119 patients tested positive for cocaine. These patients were more likely to have inadequate prenatal care and pre-term delivery; 25 percent of these patients received no prenatal care prior to delivery or spontaneous abortion. According to the Kessner index, 30 percent of the remaining 89 patients had inadequate care. The rate of no prenatal care or inadequate care in the general obstetrical population at the Medical University was 23.1 percent in 1989. Pre-term labor occurred in 17.4 percent of the patients, whereas the premature delivery rate in the general obstetrical population was only 11.1 percent.

Except for 15, all of the patients with positive urine drug screens delivered at a time proximate to the urine collection. Each of these 15 patients returned to the Medical University Hospital in pre-

term labor and once again tested positive for cocaine. All patients with positive urine drug screens were counseled about the harmful effects of cocaine abuse to themselves and their unborn child or their infant. None of these patients accepted appointments for substance abuse evaluation and treatment. In each case, a referral was made to the Department of Social Services Child Protective Division after delivery.

Faced with the apparent increase in cocaine abuse and the unsuccessful results of education alone, in October 1989, the Medical University adopted a protocol of management. Chief Greenberg of the Charleston Police Department and then Solicitor Charles Condon of the Ninth Judicial Circuit cooperated in this effort.

Several patients testing positive for cocaine pre-protocol returned with subsequent pregnancies in 1989 and in 1990, once again testing positive for cocaine. One of these patients had delivered a very premature infant in 1988 and had abruptio placentae, resulting in a fetal death in 1990. After implementing our protocol, some women completed drug abuse treatment with positive results. Unfortunately, some people were arrested, but our ultimate goal was fetal protection.

Critics of the program point out that the threat of legal problems may drive obstetric patients from health care. When the protocol first started, we evaluated the delivery rates at the Medical University Hospital as well as out of hospital births for the tri-county area. The delivery rates remained relatively constant. According to data provided by the South Carolina Office of Vital Records and Public Health Statistics, there was no increase in out of hospital births.

Thank you so much.

Mr. SOUDER. Thank you for your testimony.

Ms. Keller.

Ms. KELLER. I have worked for the Greenville County Commission on Alcohol and Drug Abuse since 1982. I currently manage a residential treatment program for pregnant women and their children, but I began specializing in services for this population in 1988.

In the 5-plus years that I operated the out-patient program, a total of three women showed up for help on a voluntary basis. One dropped out after the first session and two of them dropped out after the third. The program was filled with women for whom successful completion of treatment was a stipulation of some form of legal involvement: probation, parole, pre-trial intervention; Family Court involvement; or imminent threat of removal of children from the home by the Department of Social Services.

Addicts simply did not show up voluntarily for treatment. That didn't have anything to do with the morals, values, or beliefs of the women, their levels of education or income. It had nothing to do with whether or not they loved their babies. It is simply the nature of addiction.

People who say, If she loved me, she would quit drinking do not understand the nature of addiction. People who say, If she would put God in her life or if she cared about her baby, she would quit using do not understand the nature of addiction. At the core of every addiction is an internal voice that tells the addict whatever

it has to say in order to cover up the painful truth and perpetuate the addiction: I don't need any help; I can quit any time I want. I'll quit tomorrow. She's the one with the problem; she uses twice as much as I do. I may drink a case of beer at night, but I've never missed a day of work.

This is the voice of denial. To us, it may sound like excuses, but to the addict, it is a survival mechanism which may be all she has to hang on to make it through the day. Love does not break through denial. Maternal instinct does not break through denial. Religious beliefs, imminent loss of home or job, or financial ruin do not break through denial. Sixteen years of experience in this field tells me that there is only one voice that speaks louder than the voice of denial—the law.

The fact is, addicts need a carrot and a stick to help them get to treatment. In our system in South Carolina, the carrot is the amnesty-based treatment oriented approach, designed to give pregnant women several chances to access treatment services. Failure to do so results in increased legal pressure at each level, which may, eventually, result in the use of the stick, a court hearing which will mandate treatment. At that point, continued failure to complete a program constitutes contempt of court and may result in jail time.

One of the things I hear most often from the general public is, pregnant women don't need to go to jail; they need help. I agree 100 percent, but I must ask these questions in return. Where are all these women who are supposedly begging for help, and why are voluntary women's programs closing down and struggling to remain open, when in Greenville, where the legal protocol has been in existence since 1989, our women's programs are filled to capacity with long waiting lists?

I love my job, and I love the women that I work with. I would like nothing better than to see them come voluntarily through our doors, seeking help as soon as they find out they're pregnant. But, that's not the way addiction works.

Another thing that I frequently hear from the public is, women will avoid prenatal care, and give birth outside of hospitals, and we will be finding babies in dumpsters. Again, I must ask the question, where are they? Since the advent of the legal protocol in Greenville, a metropolitan area of about 360,000 and the second largest city in the State, I have not heard of a single baby in a dumpster. Three of the four primary sources of referrals to my program are the prenatal clinic and the neonatal nursery at the hospital, and the county health department, evidence that women are continuing to access these health care services, as always.

In preparing for this trip, Ms. Christophillis asked me to bring statistics. I did that, and you will find them attached to your copies. Statistics are not my area of expertise. I don't know what to do when I'm faced with 25 percent of this, or 68,000 of those. But when I'm faced with an addict across the desk from me, I know exactly what to do. And this is the approach I have chosen to use in my words to you, from my heart as a mother and from my experience in the field.

As proud as I am of both of those things, I really wish it could have been Amanda and her baby Amber, or Jackie and her babies

Whitney and Ray Ray, or Dawn and her baby Crystal, or Leila and Scottie, or any of dozens of others, because then you could have seen for yourselves the results of the law in South Carolina, a State which says we will not allow this to happen to our children. Each of those women would have said the same thing to you. I carry their message for them in the terminology which they use. "If it wasn't for the law, I'd still be out there."

I thank you for your consideration of their message.

[The prepared statement of Ms. Keller follows:]

July 23, 1998

Committee on Reform and Oversight

Subject: Expectant Mothers and Substance Abuse

Prepared Statement: Paula Keller

Director of Serenity Place, a long-term residential addictions treatment facility for pregnant and post partum women and their children. Serenity Place is a program of the Greenville County Commission on Alcohol and Drug Abuse, Greenville, South Carolina.

National Board of Certified Counselors

Licensed Professional Counselor/Supervisor

National Master Addictions Counselor

South Carolina Master Addictions Counselor

Licensed Master Social Worker

Licensed Administrator of a Long Term Health Care Facility

I have worked for the Greenville County Commission on Alcohol and Drug Abuse since 1982. I currently manage a residential treatment program for pregnant women and their children, but I began specializing in services for this population on an out-patient basis in 1988. In the 5+ years that I operated the out-patient program, a total of 3 women showed up for help on a voluntary basis. One dropped out after the first session, and 2 of them dropped out after the 3rd session. The program was filled with women for whom successful completion of treatment was a stipulation of some form of legal involvement: probation; parole; pre-trial intervention; Family Court involvement; or imminent threat of removal of children from the home by the Department of Social Services.

Addicts simply did not show up voluntarily for treatment.

That did not have anything to do with the morals, values, or beliefs of the women, their levels of education or income. It had nothing to do with whether or not they loved their babies. It is simply the nature of addiction.

People who say, "If she loved me she would quit drinking" do not understand the nature of addiction. People who say, "If she would put God in her life", or "If she cared about her baby she would quit using" don't understand the nature of addiction.

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At the core of every addiction is an internal voice that tells the addict whatever it has to say in order to cover up the painful truth and perpetuate the addiction.

"I don't need any help. I can quit any time I want"
"I'll quit tomorrow"
"She's the one with the problem; she uses twice as much as I do"
"I may drink a case of beer at night, but I've never missed a day of work"

This is the voice of denial. To us, it may sound like excuses. But to the addict, it is a survival mechanism which may be all she has to hang onto to make it through the day.

Love does not break through denial. Maternal instinct does not break through denial. Religious beliefs, imminent loss of home or job, or financial ruin do not break through denial.

16 years of experience in this field tell me that there is only one voice which speaks louder than the voice of denial – the law.

The fact is, addicts need a carrot and a stick to help them get to treatment. In our system in South Carolina, the carrot is the amnesty-based, treatment-oriented approach designed to give pregnant women several chances to access treatment services. Failure to do so results in increased legal pressure

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at each level, which may, eventually, result in use of the stick; a court hearing which will mandate treatment. At that point, continued failure to complete a program constitutes contempt of court and may result in jail time.

One of the things I hear most often from the general public is, "Pregnant women don't need to go to jail. They need help"

I agree, 100%. But I must ask these questions in return; *Then where are all these women who are supposedly begging for help?* And *Why are voluntary women's programs closing down or struggling to remain open, when in Greenville, where the legal protocol has been in existence since 1989, our women's programs are filled to capacity, with long waiting lists?*

I love my job, and I love the women that I work with. I would like nothing better than to see them come voluntarily through our doors seeking help as soon as they find out they are pregnant. But that is not the way addiction works.

Another thing that I frequently hear from the public is, "Women will avoid prenatal care, will give birth outside of hospitals, and we will be finding babies in dumpsters".

Again, I must ask the question, *Where are they?* Since the advent of the legal protocol in Greenville, a metropolitan area of about 360,000, and the

second largest city in the state, I have not heard of a single baby in a dumpster.

3 of the 4 primary sources of referrals to my program are the prenatal clinic and the neonatal nursery at the hospital, and the county Health Department, evidence that women are continuing to access these healthcare services as always.

In preparing for this trip, Ms. Christophillis asked me to bring statistics. I did that, and you will find them attached to your copies. Statistics are not my area of expertise. I don't know what to do when faced with 25% of this, or 68,000 of those.

But when I am faced with an addict across the desk from me, I know exactly what to do, and that is the approach I have chosen to use in my words to you; from my heart as a mother, and from my experience in the field. As proud as I am of both of those things, I really wish it could have been Amanda and her baby Amber, or Jackie and her babies Whitney and Ray-Ray standing here in front of you today. Or Dawn and her baby Crystal, or Lila and Scottie, or any of dozens of others. Because then you could have seen for yourselves the results of the law in South Carolina, a state which says, "We **will not** allow this to happen to our children".

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Each of those women would have said the same thing to you. I carry their message for them, in the terminology which they use: "If it wasn't for the law, I'd still be *out there*".

Thank you for your consideration of their message.

Mr. SOUDER. Thank you for your testimony.

Ms. Foley.

Ms. FOLEY. Thank you, Mr. Chairman, for granting Haymarket Center the opportunity to be present before your subcommittee today. I ask that my written testimony be entered into the record. I serve as Associate Director at Haymarket Center.

As you heard from our president, Ray Soucek, in yesterday's hearing, Haymarket is the largest provider of substance abuse treatment services in Chicago, and the third largest in the State of Illinois. Founded in 1975 by Monsignor Ignatius McDermott, we have grown in the past 23 years to serve an average of 13,000 clients annually. Many of the services have been cited by the Center for Substance Abuse Treatment as models for replication, and have been presented throughout the United States and the world.

Throughout our 23 years, we have developed several unique, gender-specific programs to address the needs of the especially high risk substance abusers. Our population of highest risk are the pregnant addicts, who have had a particularly difficult time receiving treatment. Today, pregnant, postpartum, and parenting women comprise over 50 percent of our client base.

Older treatment models were originally designed for males. They accepted pregnant women only in the early stages of pregnancy, did not include child care services, and were reluctant to serve this high risk population. Haymarket's willingness to serve as a pioneer in offering services to this population resulted in the successful birth of over 500 healthy and drug free babies, and opened the door for other treatment providers to follow suit.

Significant research has already been done on the treatment effectiveness for this population. I would like to enter a sample of this research for the record.

Unfortunately, drug abusing pregnant women are perceived to exist only in lower economic, minority, and urban areas, while the more affluent, suburban, middle or upper middle income areas, where drug abuse is often equally as prevalent, are considered relatively problem free. The effects of alcohol abuse and resultant fetal alcohol syndrome and fetal alcohol effects in newborns born in suburbia remain sorely unaddressed. Fetal alcohol syndrome also is present, but under less scrutiny, than illicit drug use in the inner city.

In January 1990, Haymarket responded to a newly enacted Illinois law that allowed the Illinois Department of Children and Family Services to seize any baby testing drug positive at birth. By providing residential treatment services for pregnant women in our maternal addiction center, MAC, we accepted women at any time during pregnancy, and allowed them to remain until childbirth. Haymarket chose to capitalize on what appeared to be the major motivational force to change a drug addicted mother's lifestyle to produce a healthy baby that would not be taken away at birth. Our MAC program has successfully treated over 500 women who have remained in treatment to deliver just under 500 drug free babies. The slightly lesser number is accounted for with our several sets of twins and one set of triplets.

We consider these positive birth outcomes to have saved many taxpayer dollars and kept many families together. We knew from

the onset that just helping an addicted pregnant mother to achieve abstinence and a healthy baby was not enough. In 1991, Haymarket established postpartum programs to allow mothers to continue in treatment following birth. These programs, which allow babies in residence with their mothers, integrate parenting with recovery. They assist mothers to gain tools for self-sufficiency and to reenter society as productive citizens and healthy parents.

Other program and supportive services have been integrated into our continuum of care in order to holistically meet the clients' needs. They include child care, transportation, 24-hour prenatal care and medical monitoring, domestic abuse services, nutrition assessment, recreational therapy, parental stress programs, and linkages to other medical, dental, and psychiatric needs.

Our outpatient programs, specializing in aftercare, provide clients with an opportunity to complete the transition from chemical dependency treatment to a productive lifestyle.

The continuum provides clients with a comprehensive and integrated range of treatment programs, which are gender-specific and culturally sensitive. Clients are encouraged to address their issues, including all negative and criminogenic behavior, as they progress along this continuum of care, and are afforded the opportunity to infuse faith and spirituality in their recovery. By working through these levels of care and transition, our clients gain identity, empowerment, confidence, and self esteem.

Mr. Chairman, studies have shown that great cost savings can be associated with investing dollars into treatment programs, especially those for pregnant, postpartum, and parenting women. Our treatment outcomes continue to show positive findings. However, as the number of women we treat and our positive birth outcomes continue to grow, so does our demand for treatment.

In addition to the savings connected to treating the mother, there are significant savings to be realized by delivering drug free infants. The expense of intensive hospital care for each drug affected newborn in need of medical services ranges from $20,000 to $40,000 per month. The average total cost of care from birth to age 18 for each drug exposed child is minimally $750,000, according to the GAO.

The Haymarket programs, at a cost of about one-tenth of hospital care, are less than $3,000 per month per client, and significantly more cost effective.

Mr. Chairman, and members of this subcommittee, we believe that the drug abuse treatment community is doing an exceptional job to serve these clients. The biomedical factors of the disease of addiction have been documented extensively in NYTA research. The disease of addiction does not discriminate on the basis of race, creed, ethnic origin, age, sex, or socioeconomic background. It is imperative that we work to assist those who are most vulnerable to the dangers of addiction, mainly addicted mothers and their babies.

As Congress determines the direction of Federal emphasis on drug control policy, I urge you to recognize the value of treatment for pregnant and postpartum women and their children, as a worthy and cost effective investment of Federal, State, and local resources.

I would like to enter into the record three research documents I have with me today, with regard to the value of treatment for this population. Thank you for the opportunity to testify, and I will be happy to answer any questions.

[The prepared statement of Ms. Foley follows:]

Thank you, Chairman Hastert, for granting Haymarket Center the opportunity to be represented before your Subcommittee today.

I serve as Associate Director of Haymarket Center. As you heard from our President Ray Soucek during yesterday's hearing, Haymarket is the largest provider of substance abuse treatment services in Chicago, and the third largest in the State of Illinois. Founded in 1975 by Monsignor Ignatius McDermott, we have grown in the past twenty-three years to serve an average of 13,000 clients annually.

Though Haymarket is a non-sectarian, non-denominational, not-for-profit organization, we consider our treatment approach to be *faith-based* since we believe that spirituality plays a role in recovery. Spirituality in our programs is focused on our efforts to reunite and reconnect recovering addicts with aspects of their lives from which they have been separated.

Throughout our twenty-three years, we have developed several unique gender-specific programs to address the needs of especially high-risk substance abusers. The high-risk population of particular concern to Haymarket in recent years has been pregnant and postpartum women and their children. Historically, pregnant addicts have had a particularly difficult time receiving treatment. Models which were originally designed for males would accept women only in the early stages of the program, not include child care services, and were reluctant to treat high-risk pregnant women. Haymarket's willingness to serve as a pioneer in offering services to this population has resulted in the successful birth of over 500 drug-free babies, and has opened the door for other treatment providers to follow-suit. Still, additional research and evaluation of treatment effectiveness for this population is needed.

In addition, drug abusing pregnant women are perceived to exist only in lower income minority urban areas – while more affluent suburban middle-upper income areas, where drug abuse is equally as prevalent, are considered relatively problem-free. The effects of alcohol abuse and resultant fetal alcohol syndrome in newborns in suburbia as well as in the inner-city remains sorely under-addressed.

In January 1990, Haymarket responded to a new Illinois law that allowed the Illinois Department of Children and Family Services to seize any baby testing drug-positive at birth. To meet the new treatment demands resulting from this law, Haymarket began to provide full treatment services for pregnant women, during any trimester, and established a permanent "Maternal Addiction Center," abbreviated (MAC). Haymarket's strategy has been to capitalize on what appears to be a major motivational force to change a drug addicted mother's lifestyle and produce a healthy baby that will not be taken away at birth. The MAC has successfully treated over 500 women who have delivered drug-free babies -- keeping families together, and saving many taxpayer dollars.

We also recognized that just helping an addicted pregnant mother to achieve abstinence was not enough. In 1991, in order to serve those women in a more supportive and holistic manner, Haymarket established postpartum programs to allow mothers to remain in treatment with their newborns. These programs integrate parenting with recovery, and assist mothers to gain tools for self sufficiency so they might re-enter society as productive citizens and healthy parents.

Haymarket's other residential and outpatient programs offer specialized services similar to those of our pre-natal and postpartum units. Many of our services have been cited by the Center for

Substance Abuse Treatment as models for replication, and have been presented throughout the United States and the world.

To further our commitment to this parenting population, we opened Sangamon House in early 1992. Sangamon House is a recovery home for women with children and is located in the Haymarket Center complex. It offers structured living in a safe environment for women who have completed treatment and are working toward re-entry into society. It also provides on-site daycare so that mothers may gain employment, further education, or vocational training services.

Other supportive services have been developed in order to address the specific needs of addicted pregnant and postpartum women and their children. These have been integrated into our programs in order to holistically meet the clients' needs. They include child care, transportation, 24-hour medical monitoring, extensive counseling, domestic abuse services, nutrition, recreational therapy, parental stress programs and linkages to other medical, dental and psychiatric needs. In addition, our outpatient programs, specializing in aftercare, provide clients with an opportunity to make the complete transition from chemical dependency to a productive livelihood. By working through these levels of service, our clients seek to gain identity, confidence and self esteem.

Despite our successes with pregnant addicts during the past seven years, we acknowledge a need to continue to refine what we refer to as a "continuum of care" for our clients. As you heard from Mr. Soucek, this "continuum" is the integration of drug abuse prevention, drug abuse treatment, health services, day care, parent training, vocational education, job placement and screening for domestic violence and gambling addiction for *every* Haymarket client. The continuum provides clients with a comprehensive and integrated range of treatment programs

which are gender specific and culturally sensitive. Clients are encouraged to address their issues as they progress along the continuum of care, and are offered the opportunity to infuse faith and spirituality into their recovery.

Mr. Chairman, studies have shown that great cost savings can be associated with investing dollars into treatment programs for pregnant and postpartum women and their children. Our treatment outcomes continue to show positive findings. However, as the number women we treat and our positive birth outcomes continue to grow, so does our waiting list for treatment. In addition to the savings connected to treating the mother, there are significant savings to be realized by delivering drug-free infants. The expense of intensive hospital care for each drug-exposed newborn ranges from $20,000 to $40,000 per month. The average total cost of care from birth to age 18 for each drug exposed child is $750,000 according to the General Accounting Office. The cost effectiveness of the prenatal program at Haymarket Center is easily demonstrated – the cost is less than $100 a day per client.

We at Haymarket believe that the drug abuse treatment community is doing exceptional work to serve clients. Utilizing federal resources, the community can continue to improve its services. However, to improve local and state-level services, federal policy related to prevention and treatment must become more coherent and better coordinated. This will enable the treatment community to further develop and refine the "continuum of care," and provide better, more comprehensive services to vulnerable populations.

Mr. Chairman and Members of the Subcommittee, substance abuse disorders do not discriminate on the basis of race, creed, ethnic origin, age, sex or socioeconomic background. It is imperative that we work to assist those who are *most* vulnerable to the dangers of addiction, namely

addicted mothers and their babies. As Congress determines the direction of federal emphasis on drug control policy, I urge you to recognize the value of treatment for pregnant and postpartum women and their children as a worthy and cost-effective investment of federal, state and local resources.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

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Perinatal morbidity and mortality in substance using families: effects and intervention strategies

L. P. FINNEGAN

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ABSTRACT

The epidemic of drug abuse has overwhelmed men, women and children and caused incalculable damage to an honoured structure in human civilization - the family. Moreover, during the past decade, increasing numbers of pregnant drug-dependent women have been presenting themselves to medical facilities, some to receive ongoing prenatal care, but others only to deliver their babies without the benefit of any medical services. The present chapter reviews the current literature, as well as the experiences of the author, with regard to the sociomedical characteristics of pregnant, drug-dependent women. The effects of substances of abuse on pregnancy, the foetus and the newborn with respect to morbidity and mortality are presented. Recommendations for management of both the pregnant drug-dependent women and her child, on the basis of clinical research, are also outlined. Although overall medical advances have escalated during the past three decades, there is still much to learn with regard to the effects of drugs of abuse upon families. Moreover, methods of prevention and treatment still need considerable study. By re-evaluating the areas of strength and weakness in the body of available knowledge, future research will be able to enhance the ability to help those unfortunate families that are effected by substance abuse.

Social and medical characteristics of pregnant substance-dependent women that influence the intrauterine milieu

The use of psychoactive substances has led to an ongoing and increasing number of individuals suffering from the chronic, relapsing

disease of addiction. It affects all sectors of the world population and it is widely recognized that millions of individuals use illicit drugs regularly. Many millions more are addicted to nicotine, alcohol or both. Large numbers of people die every day as a result of nicotine's role in heart disease, lung disease and cancer. The effects of alcoholism have wreaked incalculable damage across generations throughout societies. The epidemic of drug abuse has overwhelmed men, women and children and caused incalculable damage to an honoured structure in human civilization - the family. Moreover, during the past decade, increasing numbers of pregnant drug-dependent women have been presenting themselves to medical facilities, some to receive ongoing prenatal care, but others only to deliver their babies without the benefit of any medical services prenatally.

The present chapter reviews the current literature, as well as the experiences of the author, with regard to the sociomedical characteristics of pregnant, drug-dependent women. In addition, the effects of substances of abuse on pregnancy, the foetus and the newborn with respect to morbidity and mortality are presented. Recommendations for management of both the pregnant drug-dependent woman and her child, on the basis of clinical research, are also outlined.

Because of the high incidence of polysubstance use, it is essential to remember the inherent difficulties involved in ascribing any individual perinatal effect to one specific substance. However, because of space limitations, the present chapter can only deal with opiates (primarily heroin and methadone) and the stimulant cocaine. It must be realized that use of the latter agents is frequently augmented by excessive use of the licit drugs alcohol and nicotine, both of which have been found to have a profound effect on pregnant women and their offspring.

As a result of pre-existing conditions and ongoing active drug use, the narcotic-dependent woman frequently suffers from chronic anxiety and depression. Social problems such as poverty, hopelessness, involvement in an abusive relationship and alcoholism may overwhelm coping mechanisms. She usually lacks confidence and hope for the future, and has extreme difficulty with interpersonal, especially heterosexual, relationships. Over 80 per cent of addicted women were raised in households marked by parental chemical abuse, 67 per cent of those women had been sexually assaulted, 60 per cent had been physically assaulted, and almost 100 per cent of the women wished that they were someone else as they were growing up [1]. In addition to those problems, the treatment and possible resolution of the superimposed addiction is complicated and requires understanding and patience. Addiction is a chronic, progressive, relapsing disease, and a smooth and rapid recovery cannot be expected. It should not be surprising, therefore, that the lifestyle of the pregnant addict has a profound influence upon her psychological, social and physiological well-being and that of her child and the family relationships.

It is well known that medical complications compromise many drug-involved pregnancies. The most frequently encountered complications of injecting drug users are listed in table 1. The human immunodeficiency virus (HIV) has been linked increasingly with drug use. The practices of sharing contaminated needles to inject heroin or cocaine, engaging in prostitution to buy drugs, or conducting the direct sex-for-drugs transaction associated with "crack" smoking have all contributed to this serious international health crisis. Currently, the spread of HIV disease is linked less to homosexual than to heterosexual transmission. Although the exact risk of an infected mother's passing the disease to her offspring is not precisely known, it is estimated that approximately 25 to 30 per cent of infants exposed in this fashion will actually contract the acquired immunodeficiency syndrome (AIDS). AIDS prevention counselling forms an essential part of services that must be offered to pregnant substance-abusing women or women involved in close relationships with addicted men. In addition, recent studies have shown that the use of zidovudine in pregnant HIV-positive women can reduce perinatal transmission from 25 per cent to 8 per cent.

The drug-dependent pregnant woman may also develop anaemia as a result of iron and folic acid deficiency. Nutritional deficiencies associated with drug addiction are due largely to the lack of proper food intake because of inhibition of the central mechanism that controls appetite and hunger. Furthermore, toxic responses to narcotics may contribute to malnutrition by interfering with the absorption or utilization of ingested nutrients. Absorption abnormalities are common among drug addicts because of the high incidence of lesions of the intestine, liver and pancreas; malnutrition is often related to the presence of liver disease. Sometimes, in the chronic drug addict, peripheral neuritis due to thiamine depletion is seen, although a deficiency of vitamin B6, pantothenic acid or nicotinic acid may produce identical signs. Hypoglycaemia, vitamin B6 deficiency, thiamine depletion or magnesium deficiency may cause seizures in both alcoholics and drug addicts. Hepatitis, a frequent complication of abuse of injectable drugs, is nutritionally depleting because it causes a loss of protein, vitamins, minerals and trace elements. Intensive dietary therapy is desirable in drug and alcohol addiction, and parenteral therapy may be necessary to correct fluid, mineral and vitamin deficits in acutely ill patients [2].

Cocaine is known to cause many medical complications in adult users. These complications may include acute myocardial infarction, cardiac arrhythmias, rupture of the ascending aorta, cerebrovascular accidents, hyperpyrexia, seizures and infections, as well as a range of psychiatric disorders such as dysphoric agitation [3]. Table 2 elaborates upon the medical complications.

Table 1. Medical complications of intravenous drug users

Type and description		
INFECTIONS	CARDIOVASCULAR	GASTROINTESTINAL
Bacterial endocarditis	Arrhythmia	Constipation
Pneumonia	Mycotic aneurysm	Diarrhoea
Cellulitis	Thrombophlebitis	
Cutaneous abscesses		MISCELLANEOUS
Osteomyelitis	PULMONARY	Anaemia
Septic arthritis	Pulmonary oedema	Overdose
Sexually transmitted diseases	Pneumothorax	Allergic reaction
Tuberculosis	Pneumomediastinum	Pyrogenic reaction
Tetanus		Trauma
HIV infection	NEUROMUSCULAR	Needle embolus
HTLV-I/HTLV-II infection	Stroke	Amenorrhoea
Hepatitis A, B, C and D viruses	Brain abscess	Hormonal abnormalities
	Epidural or subdural abscess	Thrombocytopaenia
IMMUNOLOGICAL	Anoxic encephalopathy	Needle embolus
Generalized lymphadenopathy	Peripheral neuropathy	
Elevated serum immunoglobulins	Horner's syndrome	
False-positive serologic tests	Mitosis	
Lymphocytosis	HEPATIC	
Increased lymphocyte subset cell numbers	Acute and chronic hepatitis	
Reduced responsiveness of lymphocytes to mitogens	Cirrhosis	
Reduced natural killer cell activity	RENAL	
	Glomerulonephritis	
	Renal failure	

Source: Adapted from J. Lowinson, J. Ruiz and R. Millman, eds., *Substance Abuse: A Comprehensive Textbook* (Baltimore, Maryland, Williams and Wilkins, 1992), pp. 657-674.

In addition to the vast numbers of medical complications that pregnant substance-using women are predisposed to, a number of obstetrical complications are seen. Table 3 outlines the most common disorders. Because of the lack of prenatal care, many women are more apt to develop pre-eclampsia or eclampsia. Addicted women should also be closely observed for postpartum haemorrhage.

Table 2. Medical complications seen in cocaine abusers

Type and description	
CARDIOVASCULAR	MISCELLANEOUS
Myocardial infection	Acute hepatic necrosis
Arrhythmia	Hyperpyrexia
Aortic rupture	Loss of sense of smell
Hypertension	Perforated nasal septum
Cardiomyopathy	Loss of eyebrows, eyelashes
PULMONARY	Sexual dysfunction
Decreased diffusing capacity	Motor vehicle accidents
Pneumomediastinum	Trauma
Pulmonary oedema	Sudden death
NEUROLOGIC	Endocarditis
Stroke	HIV infection
Subarachnoid haemorrhage	PSYCHIATRIC
Seizures	Psychosis
Fungal meningitis	Depression
Headache	Personality changes
GASTROINTESTINAL	Delusions of paranoia
Intestinal ischaemia	
Colitis	

Source: Adapted from J. Lowinson, J. Ruiz and R. Millman, eds., *Substance Abuse: A Comprehensive Textbook* (Baltimore, Maryland, Williams and Wilkins, 1992), pp. 657-674.

Table 3. Obstetrical complications associated with substance abuse

Type and description
Foetal wastage resulting in
Spontaneous abortion
Intrauterine death
Amnionitis
Chorioamnionitis
Gestational diabetes
Premature rupture of membranes and septicaemia
Placental disorders
Abruption
Infarction
Insufficiency
Foetal growth retardation
Premature labour with or without breech presentation

In addition to the many potential medical and obstetrical problems, the lifestyle of the addict is also detrimental to herself, her family, and to society. To meet the high cost of maintaining a drug habit, the pregnant drug-dependent woman must often indulge in robbery, forgery, the sale of drugs and prostitution. Because most of her day is consumed by the two activities of either obtaining drugs or using drugs, she spends most of her time unable to function in the usual activities of daily living. The opiate addict will have intermittent periods of normal alertness and well-being, but for most of the day she will either be "high" or "sick". The "high", or euphoric state, will keep her sedated or tranquillized, absorbed in herself, and incapable of fulfilling responsibilities. The "sick" stage, or the state during which she is going through abstinence, generally is characterized by craving for narcotics accompanied by malaise, nausea, lachrymation, perspiration, tremors, vomiting, diarrhoea and cramps. As a result of such a lifestyle and because she may fear calling attention to her drug habit, the pregnant addict often does not seek prenatal care. There may be no experiences of prenatal care, either in a hospital setting or in the office of a private physician. The woman may be unmarried and have venereal disease. Tattoos or self-scarring of the forearm to disguise needle marks may be evident. Due to the diminished pain perception when smoking while "high", burns of the fingertips and cigarette burns of the clothes may be found. The use of poorly cleaned needles or shared needles predisposes the women to serum hepatitis, and jaundiced skin or sclera may be evident.

Examination of her personal history may reveal several other aspects of the pregnant heroin addict's life. She may have several other children who are currently not living with her but with a relative, or who have been placed in care. Drug-dependent women frequently are intelligent, although in a Philadelphia survey the average level of high school achievement was the eleventh grade [1]. Housing situations frequently are chaotic, and plans for the impending birth of the child often have not been considered.

Therefore, when assessing the impact of addiction on the pregnant woman, one must put into perspective the milieu within which she must survive. The cycle of addiction not only includes illicit and licit drug use, but also medical and obstetrical complications, family dysfunction, psychiatric disorders, physical and sexual abuse, social issues, legal problems and educational deficits, followed by employment failure and economic loss. Figure I further elaborates on the tragic problems that drug-affected families encounter.

In the United States, alcohol and illicit drug use is frequently associated with tragic fatalities, drownings, suicides, assaults, rape, manslaughter charges and murders. The above stressors have tremendous impact on family integrity.

Figure I. Drug-affected families

Source: National Training Center, Foundation for Children with AIDS, Boston, Massachusetts, United States of America.

Impact of maternal substance abuse on foetal welfare

Because of the obvious lack of quality control seen in street drugs, the pregnant woman frequently may experience repeated episodes of withdrawal and overdose. Maternal narcotic withdrawal has been associated with the occurrence of stillbirth [4]. Severe withdrawal is associated with increased muscular activity, thereby increasing the metabolic rate and oxygen consumption in the pregnant woman. During maternal withdrawal, foetal activity also increases, and the oxygen needs of the foetus can be assumed to increase. The oxygen reserve in the intervillous space of the placenta may not be able to supply the extra oxygen needed by the foetus. During labour, contractions further compromise the blood flow through the uterus. If labour coincides with abstinence symptoms in the mother, the increased oxygen needs of the withdrawing foetus coincide with a period of variable uterine blood flow, leading to foetal hypoxia and possibly foetal death. As the foetus grows older, its metabolic rate and oxygen consumption increase; therefore, a pregnant woman undergoing severe abstinence symptoms during the latter part of pregnancy could be less likely to supply the withdrawing foetus with the oxygen it needs than would an addict in the first trimester of pregnancy [4]. Many other effects upon the foetus exposed to narcotics include: acute infection, intrauterine growth retardation and congenital anomalies. A more extensive description of these effects is found in reviews by Finnegan and Kandall [5].

Various parameters to assess foetal welfare have been studied in the drug-abusing pregnant woman, including: content of amniotic fluid, prostaglandins, corticosteroid production, oestriol excretion, heat-stable alkaline phosphatase enzyme levels, liver function studies, serum immunoglobulin M levels and lecithin/sphingomyelin ratios in amniotic fluid. In comparing the content of amniotic fluid prostaglandins with that of normal, diabetic and drug-abuse-associated human pregnancies, Singh and Zuspan [6] did not find any significant differences; however, variable effects have been reported concerning the other parameters [5].

The low molecular weight and high solubility of cocaine in both water and lipids allows this drug to cross the placenta easily and enter foetal compartments. This transplacental passage is enhanced with intravenous or freebase use of cocaine. In addition, the relatively low pH of foetal blood (cocaine is a weakbase) and the low foetal level of plasma esterases, which usually metabolize this drug, may lead to accumulation of cocaine in the foetus. Furthermore, the "binge" pattern commonly associated with cocaine use may lead to even higher levels of cocaine in the foetus. Transfer of cocaine appears to be greater in the first and third trimesters of pregnancy. Because cocaine has such potent vasoconstrictive properties, the constriction of uterine, placental and umbilical vessels may retard somewhat the transfer of cocaine from mother to foetus. A

deleterious effect of this vasoconstriction, however, is a concomitant foetal deprivation of essential gas and nutrient exchange resulting in foetal hypoxia [7]. In addition to an acute hypoxic insult, cocaine use of long duration may produce a chronic decrease in transplacental nutrient and oxygen flow, leading to intrauterine growth retardation. Although the relationship of cocaine use to congenital malformations is still controversial, a decrease in foetal blood supply during critical periods of morphogenesis and growth may result in organ malformations [8-13].

Studies in sheep have also shown that maternal cocaine administration results in a dose-dependent catecholamine-mediated increase in maternal blood pressure and a decrease in uterine blood flow, with a significant reduction in uterine blood flow for at least 15 minutes [14, 15]. The course of labour may also be affected by maternal cocaine use. Intravenous administration of a local aesthetic such as cocaine may cause a direct increase in uterine muscle tone. "Crack" also appears to directly increase uterine contractility and may thus precipitate the onset of premature labour. Higher rates of early pregnancy losses and third-trimester placental abruptions appear to be major complications of maternal cocaine use. Several investigators have reported increased stillbirth rates among cocaine-using women [11,16,17,18]. It is currently postulated that increased levels of catecholamines, increased blood pressure and increased body temperature all may play aetiologic roles in early foetal loss and later *abruptio placentae*. Wang and Schnoll [19] have suggested that cocaine-induced down-regulation of placental beta-adrenergic receptor sites may be linked with release of endogenous opiate peptides.

With regard to the teratogenic potential of cocaine in humans, there are conflicting results in the literature. Animal studies have helped to provide some answers regarding the effects of cocaine by controlling many of the confounding variables found in the human literature. The animal studies, like the human literature, has produced evidence of growth retardation, placental abruption, cerebral infarctions, increased prenatal and postnatal mortality, limb/digit reductions and eye anomalies. But like the human literature, the teratogenic risk seems low in animal models, and seems to require high doses and individual susceptibility [20].

The potential teratogenic effects of cocaine have been extensively reviewed, and a meta-analysis has been published by Lutiger and others [21]. Koren proposes a hypothesis regarding maternal-foetal toxicology of cocaine [22]. It is based on his analysis of published data and experimental laboratory evidence. Cocaine is used by pregnant women in two distinct modes. The social cocaine users consume cocaine as part of a mixed socio-economic class, maintain reasonable medical care, and tend to discontinue cocaine use once pregnancy is detected. There is no evidence that this mode of exposure increases the reproductive risk of such pregnancies in terms of either perinatal complications, dysmorphology or neurobehavioural development [23]. Addicted women

use cocaine throughout pregnancy and, in addition to cocaine, they have clustering of other reproductive risk factors, some of which include cigarette smoking, alcohol consumption, tendency to belong to low socio-economic classes, shorter education, poor prenatal and medical care, use of other drugs of abuse, young age, single parenthood and sexually transmitted diseases. Analysis of all available studies conducted with this population suggests that cocaine is not a major human teratogen, and that most children are likely to be normal both morphologically and neuro-developmentally. However, it has been hypothesized that there is a subgroup of foetuses susceptible to the adverse effects of cocaine because of the following: variability in maternal pharmacokinetics of cocaine; variability in placental transfer of cocaine; variability in placental-vascular response to cocaine; and foetal pharmacodynamic variability.

Infant morbidity

Because of the extremely high risk environment from which the pregnant drug-dependent woman comes, her infant is predisposed to a host of neonatal problems. In heroin-dependent women, a significant part of the medical complications seen in their neonates is due to low birth weight and prematurity. Therefore, such conditions as asphyxia neonatorum, intracranial haemorrhage, hyaline membrane disease, intrauterine growth retardation, hypoglycaemia, hypocalcaemia, septicaemia and hyperbilirubinaemia may be commonly seen in opiate-exposed, low-birth-weight babies. Because infants born to women who receive methadone maintenance are more apt to have higher birth weights and a decreased incidence of premature birth, medical complications generally reflect:

(*a*) The amount of prenatal care that the mother has received;

(*b*) Whether she has suffered any particular obstetrical or medical complications, including toxaemia of pregnancy, hypertension or infection;

(*c*) Most importantly, multiple drug use that may produce an unstable intrauterine milieu complicated by withdrawal and overdose.

The last-mentioned situation is extremely hazardous, since it predisposes the neonate to meconium staining and subsequent aspiration pneumonia, which may cause significant morbidity and increased mortality [24].

Although many reports expound on the detrimental effects of cocaine on infant morbidity, many have not been substantiated by repeated studies. Assessments of the organic impact of cocaine on human pregnancy have not always considered confounding drug-use-associated

variables such as poverty, hopelessness, inadequate prenatal and postnatal care, deficient nutrition, varying types of cocaine use, multiple drug use, sexually transmitted diseases and the possible presence of toxic adulterants that are mixed with or used to process cocaine.

Consistent findings include the impact of maternal morbidity upon the neonate (i.e. infections), impaired growth, smaller head circumference and prematurity. Inconsistent findings include the occurrence of congenital abnormalities and abnormal neurobehaviour. Transient findings include electroencephalographic abnormalities [25] and tortuous iris vasculature in the eye grounds [26]. Additional reports concerning infant morbidity related to cocaine are elaborated elsewhere [27-33].

Narcotic abstinence contributes considerably to neonatal morbidity. However, not all infants born to drug-dependent mothers show withdrawal symptomatology. Several investigators have reported that between 60 and 90 per cent of infants show symptoms [34-36]. Because the biochemical and physiologic processes governing withdrawal are still poorly understood, and because of polydrug abuse, erratic drug-taking, and vague and inaccurate maternal histories, it is not surprising to find varying descriptions and experiences in reports from different centres.

Neonatal narcotic abstinence syndrome is described as a generalized disorder characterized by signs and symptoms of hyperirritability of the central nervous system, gastrointestinal dysfunction, respiratory distress and vague autonomic symptoms that include yawning, sneezing, mottling and fever [37-39]. These infants initially develop mild high-frequency, low-amplitude tremors that progress in severity. A high-pitched cry, increased muscle tone, irritability, increased deep tendon reflexes and an exaggerated Moro reflex are all characteristic of this syndrome. The rooting reflex is increased and sucking of fists or thumbs is common, yet when feedings are administered the infants have extreme difficulty and regurgitate frequently. The feeding difficulty occurs because of an uncoordinated and ineffectual sucking reflex. The infants may develop loose stools and therefore are susceptible to dehydration and electrolyte imbalance. Time of onset of symptoms is variable. Once the infant is delivered, serum and tissue levels of the drugs used by the mother begin to fall. The newborn infant continues to metabolize and excrete the drug, and withdrawal or abstinence signs occur when critically low tissue levels have been reached.

Because of the variation in time of onset and in degree of severity, a spectrum of abstinence patterns may be observed. Withdrawal may be mild and transient, delayed in onset or characterized by a stepwise increase in severity. It may be intermittently present, or have a biphasic course that includes acute neonatal withdrawal followed by improvement and then an exacerbation of acute withdrawal [40].

More severe withdrawal seems to occur in infants whose mothers have taken large amounts of drugs for a long time. Usually, the closer to

delivery a mother takes a narcotic, the greater the delay in the onset of withdrawal and the more severe the symptoms in her baby. As noted, the maturity of the infant's own metabolic and excretory mechanisms plays an important role after delivery. Because of the variable severity of the withdrawal, the duration of symptoms may be anywhere from six days to eight weeks. Although the infants are discharged from the hospital after drug therapy is stopped, their symptoms or irritability may persist for more than three to four months [41].

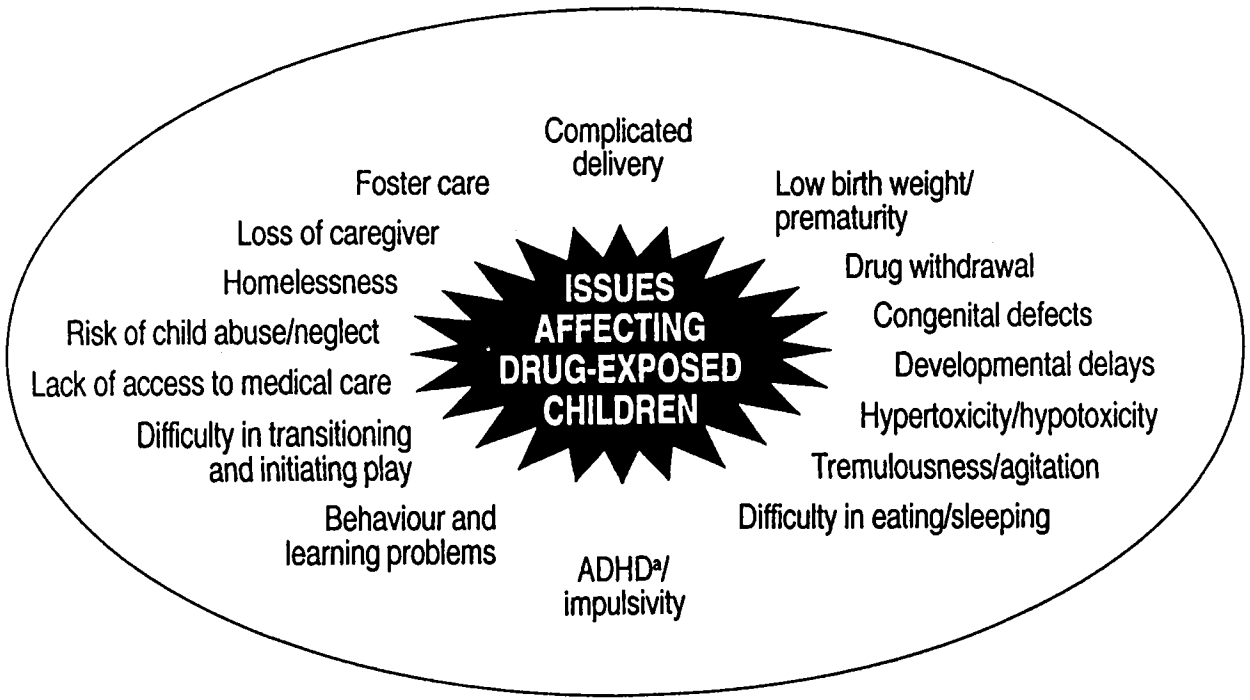
The final impact of prenatal drug exposure has many ramifications when the pharmacologic agents are complemented by the severity of the various above-mentioned maternal complications and the environment into which the infant is born. Without comprehensive services to mother, infant and family, some or many of the problems illustrated in figure II may occur.

Infant mortality

Among the major causes of infant mortality in drug-exposed infants are low birth weight, prematurity, birth defects, sudden infant death syndrome (SIDS), or cot-death, and child abuse. Given the increase in obstetrical and medical complications, the lack of prenatal care, and the increase in low-birth-weight infants, it is not surprising to find that the mortality rate in infants born to drug-dependent women is markedly increased. With the advent of newer techniques for the care of sick newborn infants, however, mortality rates in the 1980s decreased markedly. It has been shown that mortality can be reduced if prenatal care and comprehensive substance abuse services are provided for pregnant substance-abusing women [42].

SIDS is defined as the sudden and unexpected death of an infant between one week and one year of age, whose death remains unexplained after a complete autopsy examination, full history and death site investigation. Compared with an incidence of approximately 1.5 per 1,000 live births in the general population, a number of studies have found increased rates of SIDS in opiate-exposed infants [43-48]. It is critical to remember that other high-risk factors for SIDS such as low socio-economic status, low birth weight, young maternal age, black ethnic background and maternal smoking are all overrepresented in the drug-using group. The most extensive study has been done by Kandall and others [49], who studied SIDS rates in 1.21 million births in New York City from 1979 to 1989. Maternal opiate use increased the risk of SIDS about sixfold; after control for high-risk variables, the risk of SIDS was still three to four times that of the general population. An extensive review of maternal drug use and subsequent SIDS has been published recently by Kandall and Gaines [50].

Figure II. Drug-exposed children



a/ ADHD = Attention deficit hyperactivity disorder.

Source: National Training Center, Foundation for Children with AIDS, Boston, Massachusetts, United States of America.

Previous maternal and paternal physical and sexual abuse as children, the lack of being parented themselves, the continued use of psychoactive agents, the concomitant occurrence of physical and medical illness with irritability and lack of responsiveness by the baby, all create the potential for abuse by drug-using mothers of the drug-exposed infant. Since child abuse is a preventable phenomenon, professionals in the field of substance abuse and paediatrics must be aware of its potential occurrence and provide appropriate assessments of the family and psychological support systems to protect the infant at risk.

Behaviour of drug-exposed infants in the neonatal period

Neurobehavioural adaptation in neonates born to narcotic-dependent mothers has been studied by several investigators [51-54]. The Brazelton Neonatal Assessment Scale has been used extensively for evaluating newborn behaviour. This instrument assesses habituation to stimuli such as the light and bell, responsivity to animate and inanimate stimuli (face, voice, bell, rattle), state (sleep, alertness, crying) and the requirements of state change (irritability, consolability), and neurologic and motor development. Soule and others [53] found that methadone-exposed babies were restless, tended to be in a neurologically irritable condition, cried more often and were state-labile. The infants were also more tremulous and hypertonic, and manifested less motor maturity than did the control group. In addition, although quite available and responsive auditorially, the methadone-exposed subjects responded poorly to visual stimuli. These babies seemed to be uncomfortable when opening their eyes and attempting to focus (pupil size was within normal limits).

Strauss and others [54] also studied the behaviour of narcotic-exposed newborns and non-drug-exposed controls in the first two days of life using the Brazelton Scale. In addition to the classic signs of narcotic abstinence, the narcotic-exposed infants were less able to be maintained in an alert state and to orient to auditory and visual stimuli, signs that were most pronounced at 48 hours of age. Drug-exposed infants were as capable of self-quieting and responding to soothing intervention as normal neonates, although they were substantially more irritable. These findings have substantial implications for caregivers' perceptions of infants, and thus may have long-term impact on the development of infant-caregiver interaction patterns. These implications have been further developed by Kaltenbach, Graziani and Finnegan [55], who found that infants born to methadone-maintained women showed deficiencies in their attention and social responsiveness during the first few days of life; these abnormalities persisted during the infants' course of abstinence and treatment. Fitzgerald and others [56] found that the interaction of drug-dependent mothers and their infants showed abnormalities on

measures of social engagement. This dyadic interaction was explained by less maternal affection and attachment as well as by infant behaviour impeding social involvement. Many of the interactive abnormalities normalized by four months of age, but the need for parenting training is obvious.

Studies reporting effects of cocaine on behaviour are variable, and perhaps reflect a dose-response effect as speculated by Hutchings [57]. There appears to be no observable effect at low doses on neonatal behaviour [58]. Higher doses may be associated with symptoms of hyperarousal (i.e. tremulousness, irritability) during the early neonatal period [59-62]. It has been suggested that these symptoms are more likely the result of persistent, pharmacologically active levels of cocaine in the newborn central nervous system, and do not represent a cocaine withdrawal syndrome. Studies using the Brazelton Neurobehavioral Scale in cocaine-exposed infants are very inconsistent [59, 62-65]. It can be concluded that even though behavioural effects of prenatal cocaine exposure are biologically plausible by direct or indirect mechanisms, currently available research is limited by methodological weaknesses, and no independent effects are credibly established [62].

From the foregoing, it may be seen that the physical and behavioural response of the drug-exposed infant can have a destabilizing effect on the family. Stresses encountered in dealing with a difficult, irritable, non-responsive, poor-feeding, non-sleeping baby cannot only have an effect upon parent-child attachment, but also an adverse effect on the parents' relationship. Figure III shows how the sense of security of the infant can be disrupted with the potential for an adverse behavioural outcome if maternal lifestyle is influenced by addiction. With the above postnatal maternal-infant dyadic interactions, appropriate assessments and interventions must be provided for both mother and child.

Interventions to improve stability and perinatal outcomes

Appropriate interventions for the substance-abusing family have been researched and utilized by many throughout the world [66-69]. The essentials are the combination of traditional substance abuse counselling with primary health care, mental health services and prevention, assessment and treatment of HIV disease. Table 4 lists the schema of services that have been recommended [67]. Medications for addictive diseases have been used, and more are expected to become readily available as a result of ongoing research. Methadone for opiate dependence has been highly researched and its efficacy substantiated. However, for opiate-addicted patients in general and for pregnant women in particular, there are many prejudices concerning the use of this safe and efficacious medication. Most of those attitudes stem from a lack of knowledge concerning

Figure III. Impact of substance abuse on infants

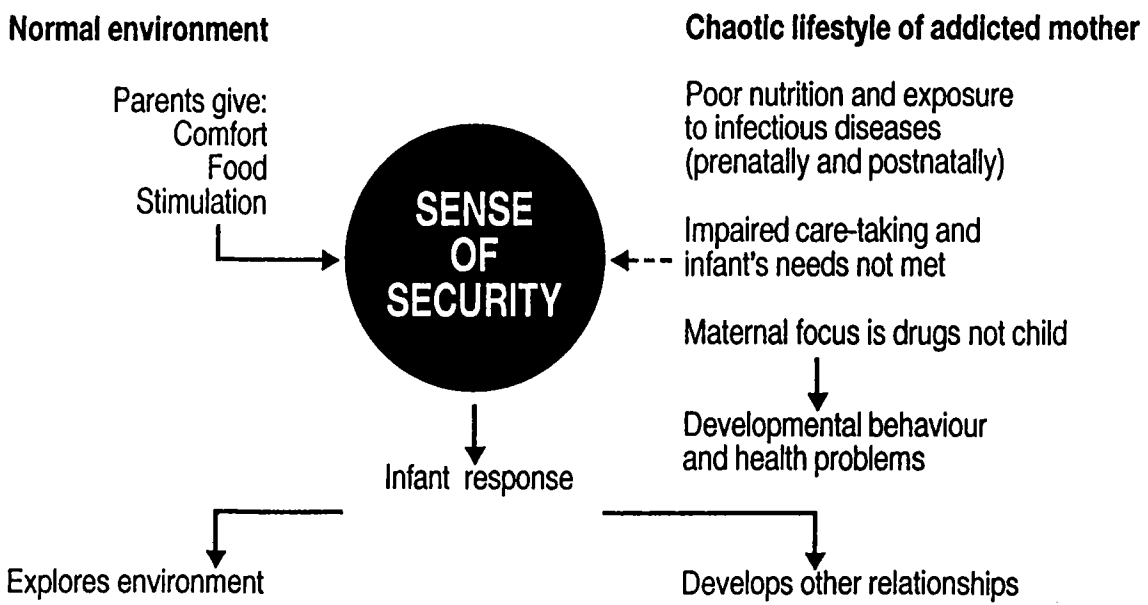


Table 4. Schema of services for drug-abusing families

Type and description

OUTREACH	MEDICAL	PSYCHOLOGICAL/BEHAVIOURAL	DEMOGRAPHIC/SOCIOCULTURAL
Community liaison	For potential infections	Life-skills management	Survival management
indigenous workers	assess complications of drug abuse and HIV infection: tuberculosis, hepatitis, CMV	defining and accessing problems associated with addiction	housing
mobile van	assess various organ systems: hepatic, renal, cardiovascular, pulmonary, GI, CNS	attitudes, beliefs, knowledge and expectation modification	clothing
distribution of prevention and educational information	assess for STDs	problem-solving	food
work with community organizations, churches, recreational centres etc.	assess immunologic status	coping mechanisms	financial and budgetary
Immediate access to treatment	Pharmacological	relapse prevention	Sociological consideration
provide transportation	methadone maintenance	social skills competence	gender
coordinate intake	psychotropic medication	Psychological	race
medical	antibiotics for bacterial infections	psychiatric assessment and treatment	social class
drug-abuse treatment	HIV drug treatment		economics
psychiatric evaluation			culture

PRENATAL	MOTHER-INFANT RELATIONSHIPS	EARLY CHILDHOOD INTERVENTION
Prenatal examination	Assess caregiver infant dyad	Intervene in unresponsive and dysfunctional maternal behaviours
HIV counselling/testing	Intervention strategies to meet individual mother-infant needs	Encourage optimal social, emotional and cognitive development of children born to drug-dependent mothers
Nutritional counselling	Facilitate caregivers' needs in relation to environmental realities	Promote parenting skills
Antenatal testing		Provide child care

Note: STD = sexually transmitted disease; GI = gastrointestinal; CMV = cytomegalovirus; CNS = central nervous system.

the pharmacology and the appropriate prescribing instructions for methadone. Specifics concerning treatment of opiate dependent pregnant women have been described elsewhere [5, 69].

Research has shown that a significant number of women who have enrolled in comprehensive treatment services during pregnancy can be rehabilitated, and that maternal and infant morbidity can be reduced. When maternal medical and obstetrical complications are treated, a similar outcome has been seen in drug-dependent mothers as in drug-free mothers of the same socio-economic and ethnic class. Moreover, the incidence of low-birth-weight infants can be reduced from nearly 50 per cent to less than 20 per cent, which is a significant reduction in terms of neonatal morbidity, mortality and medical costs.

Addiction must be recognized as a chronic, relapsing disease. Because each addicted woman is different from all others, treatment plans should be individualized. Comprehensive services must include high-risk prenatal care, and clinics must be staffed by obstetricians specifically trained in the field of addiction and high-risk pregnancy. Additional treatment modalities should include individual, group and family therapy.

For maximum recovery rates, dedicated clinicians who realize the need to coordinate such services for addicted women are needed. Since the medical needs of these women are so overwhelming, a perinatologist, in conjunction with a neonatologist and psychiatrist, should lead the team of professionals necessary to encompass, in addition to the physiological and psychological effects of substance abuse, the tremendous sociological issues that exist. Women will not recover if their co-morbidity issues are not identified and treated.

The families of drug-addicted women have higher levels of conflict and physical violence and lower levels of cohesion. Treatment must therefore respond to each of the medical and social variables that complicate addiction issues and recovery. The women have problems associated with support issues, food, access to housing and day care, all of which are clearly overwhelming to the recovering female addict. Relapse is imminent when daily survival is at risk.

AIDS prevention, counselling and testing, as well as educational services in the form of prenatal and parenting classes, must be available. Services should be aimed at eliminating drug use, developing personal resources, improving family and interpersonal relationships, reducing and eliminating socially destructive behaviour and facilitating maximum obtainable adaptation for new parents within their environment.

In spite of the definition of specific intervention strategies for the substance-abusing woman and her family, as well as those used for similarly troubled individuals, the required services have not been available, understood or adequately supported. Negative attitudes exist about maternal drug abuse. Many professionals who could provide appropriate services refuse to do so, and others lack adequate training in

the identification of substance-abusing individuals and the effects of drug abuse on pregnancy and the family. As a result of the lack of provision of such services for drug-abusing families, the escalation of the numbers of individuals and families affected has been dramatic. With intergenerational transmission of the disease of addiction, perinatal transfer of HIV and other infectious diseases, as well as perinatal complications, families are being devastated throughout the world.

Drug abuse is not a new phenomenon. It has existed for centuries, and in the last three decades it has reached epidemic proportions. While overall medical progress has been great during this time, there has been a failure to give appropriate attention to resources for research, treatment and education concerning the effects of drug abuse and potential intervention strategies. The result has been the devastation of families suffering from drug abuse and the associated adverse effects on society. The devastation has reached uncontrollable heights, and many children and their families are suffering today because of the unwillingness of society to act with urgency in the past. There must be an end to the physical, psychological and sociological disabilities that have resulted from the neglect of issues confronted by families affected by substance abuse. In 1994, the International Year of the Family, the people of all nations must stand united to avoid the further destruction of the fibre that holds society together - the family.

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Pregnancy, Drugs, and the Perils of Prosecution

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In the war on drugs an offensive has been launched against pregnant women who use drugs. Over the past four years, prosecuting attorneys have been indicting women who use drugs while pregnant. In South Carolina alone, eighteen women who allegedly took drugs during pregnancy were indicted last summer for criminal neglect of a child or distribution of drugs to a minor.[1] In the only successful prosecution so far, Jennifer Johnson was convicted in Florida for delivering illegal drugs to a minor via the umbilical cord in the moment after her child was born and before the cord was clamped.[2] No one seriously maintains that the transitory "delivery" was the conduct on trial. Rather, the crime was the mother's use of illegal drugs during pregnancy. But the indictment contorted the statute's prohibition against drug "delivery" to characterize as criminal the kind of conduct that could not have been considered within its scope by the enacting legislature.

No new law had been passed making it a special criminal offense to use drugs during pregnancy. Rather, the prosecutions have been based on obviously strained interpretations of existing law, such as child endangerment or delivery of drugs to a minor. Since both drug use and criminal laws prohibiting sale, distribution, or possession of drugs have been with us for decades, why should prosecuting attorneys be searching the statute books today for creative ways to prosecute pregnant women who use drugs? The answer may lie in a peculiar confluence of changing attitudes towards pregnancy and drug use. Public attitudes are pro-natalist in the broad sense of supporting efforts to overcome infertility and to have children.[3] Advances in medical technology have produced new methods for detecting and sometimes correcting fetal abnormalities,[4] which enables us to think of fetuses as "patients" separately from their mothers. Public health studies have found that pregnant women can have a positive impact on the outcome of their pregnancies through prenatal care, improved nutrition, and the avoidance of teratogenic or toxic substances like alcohol and drugs. This had led to a close scrutiny of the behavior of pregnant women. Finally, the war on illegal drugs announced by the Reagan Administration has spurred intense publicity about the dangers of drug use and has tended to legitimize virtually any action to suppress drugs.[5] Indeed, the civil liberties of individuals are often seen as a hindrance to winning the "war." Media reports of increases in the number of infants born with traces of drugs in their systems have linked the horrors of drugs with our concern for healthy babies.

The influence of changing knowledge and values has led us to see the mother as responsible for many ills that befall her newborn. If she did not receive prenatal care, ate poorly, drank too much, or took drugs, she is assumed to be the cause of any injury to the baby—she is a bad mother. It is easy to feel outrage at behavior that seems avoidable and that risks injury to a newborn. So it is understandable that many have argued for controlling women to protect a fetus.[6] Few would argue that a pregnant woman has no moral responsibility to her developing fetus. However, violation of this moral responsibility not to harm is being transformed into a punishable crime.

Prosecuting women for prenatal drug use offers immediate and visible action against an identifiable "wrong-

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doer." It is always a news story. Unable to make significant inroads against drug traffickers, prosecutors can appear to take a strong stand against illegal drugs and for protecting children. The alternatives—intercepting the drug supply, finding effective treatment for drug dependency, and providing drug treatment programs—are tedious, expensive, and rarely newsworthy.

No one really disagrees that drug use, among other things, risks jeopardizing fetal health, and that, ideally, such drug use should be eliminated. The question is who should be responsible for, and who will be effective in, taking steps to protect fetal health—the public health community or the criminal justice system?

This article examines the assumptions that underlie current prosecutions of pregnant women who use drugs. It argues that the professed goals of such prosecutions cannot be achieved through the criminal law. The offense that pregnant women are thought to commit cannot be defined in terms of any intelligible duty enforceable by the criminal law. Prosecuting pregnant women for drug use is unlikely to alter the spread of drugs or the health prospects of children. Instead, it is likely to threaten the rights of women as autonomous individuals and, ultimately, the future of their children.

The Goal of Prosecution

Most prosecutors argue that their actions are not intended to punish women. For example, one prosecutor was reported to say, "We are not really interested in convicting women and sending them to jail. We're just interested in getting them to stop using drugs before they do something horrible to their babies."[7] If the goal is to stop drug use, there is no need to resort to rationalizations about protecting the fetus in order to prosecute. In virtually all states, the manufacture, delivery, or possession of controlled substances (illicit drugs) is already a criminal offense.[8] This applies to everyone, not just pregnant women. Women are not immune from prosecution for these crimes merely because they are pregnant. Few pregnant women, however, are involved in drug trafficking. At most they might be guilty of illegal drug possession. Yet because they are not ordinarily discovered until their children are born and drug metabolites are found in the newborn's system, there is not likely to be proof sufficient to permit a conviction for the offense of possession. Thus, as a practical matter, pregnant women are not likely to be successfully prosecuted for drug possession.

Drug use, by itself, is not ordinarily a criminal offense,[9] largely because of the difficulty of proof and because offenders can ordinarily be charged with possession. Moreover, if drug use results in harm to another person, such as an assault, the undesirable behavior is ordinarily proscribed by another criminal statute, such as that making assault a criminal offense. In such cases, however, the prosecution is limited to the crime of assault, independent of drug use. Thus, drug use that results in harm to a fetus cannot be prosecuted unless either drug use alone or harm to the fetus by itself is an independent crime. If neither is punishable as a crime, their co-existence should not constitute a crime. If drug use alone is not a criminal offense, then what is being punished is the status of being pregnant.[10] This makes pregnancy a necessary element of a remarkable new criminal offense: pregnancy by a drug-dependent person, or drug use by a pregnant woman.[11]

There are instances in which two lawful activities constitute an offense when combined. Driving while intoxicated is the most obvious example. Yet this offense does not automatically justify criminalizing the combination of pregnancy and drug use. It is not the act of drinking that offends but the condition of intoxication that precludes the driver from safely managing a vehicle. After all, motor vehicles are inherently dangerous objects. It is for this reason that driving itself is regulated. Driving is not permitted without a license, obtainable only upon demonstration of at least a minimal level of competence and skill. Pregnancy, in contrast, is not deemed a privilege for which licensure is required.[12] Pregnancy is a condition, not an activity, and while it poses some risks to the pregnant women, it is not inherently dangerous to

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others. Prosecutions for drug use during pregnancy appear to enforce an implied license, one that stipulates the conduct required of those granted the privilege of pregnancy. Yet pregnancy is unlike driving in more fundamental ways. Pregnancy is symbolic of the continuation of the human race. For individuals, it is, ideally, a time of joy, of preparing for an expanded family. It involves nurturing and growth. To convert it into a symbol of woman as threat is likely to profoundly affect the way society views women in general and to transform pregnant women from nurturers into suspects.

The justifications for wanting to stop pregnant women from taking drugs have to do with preventing harm to the fetus and insuring the birth of a health baby. This raises several questions. What is the harm to be prevented? What acts or omissions cause the harm? What kind of duty can a pregnant woman have to prevent the harm? Can the duty be enforced and the harm prevented by prosecuting pregnant women under the criminal law?

Duty

Criminal prosecutions of women's conduct during pregnancy assume that women have a special duty to the fetus.[13] But precisely what is this duty? And what qualifies as a violation of the duty? General discussions of the subject appear to assume that women have a legal duty not to *harm* the fetus. (In this article, we discuss only duties arising in existing *law*, not moral obligations that may exist in the absence of any legal duty.

One of the truisms of criminal law is that it exists to prevent harm. What is the harm to be prevented in the case of pregnant women who use drugs? The most extreme case of harm would be the death of the fetus. Criminal law governing killing a fetus is already in place. In most states, homicide can be committed against the fetus, but only if it dies after live birth.[14] A few states have made feticide a crime if someone other than the mother intentionally kills the fetus. Convictions have been sustained in cases of brutal attacks upon the woman, often by men who specifically intended to kill the fetus.

The duty to prevent risk to the fetus amounts to imposing on a pregnant woman a state-defined standard of care for her own body.

Unintentional or negligent killing of a fetus by one unaware of the pregnancy, however, is not even manslaughter in most states.[15] There are good reasons why the criminal law has treated feticide differently from homicide. The harm ordinarily sought to be prevented is that directed against the pregnant women herself. Ascribing legal personhood to fetuses for purposes of applying homicide laws would unnecessarily subject most stillbirths to criminal investigation. It could also create two independent rights-holders within the body of one pregnant woman—the woman and the fetus—with controversial implications for both criminal and civil law that society has not yet agreed on and is not likely soon to accept.

Even so, one might argue that a woman has a duty not to cause the death of her fetus.[16] If the duty is to guarantee the fetus's survival to live birth, then no harm occurs when the baby is born alive. It should be evident that there is no general duty to guarantee survival to birth. However, women have been prosecuted when their babies have been born alive. So death is not the harm—or at least not the only harm—being targeted.

In the absence of fetal death or stillbirth, the harm might be any physical or developmental damage that the living child suffers. If so the duty is to guarantee the child optimal or at least normal mental and physical health. Or it might be the seemingly lesser duty of preventing avoidable injury. But this is not a duty imposed generally on pregnant women. And with good reason. First, before the state can accuse one of a criminal offense, it must define the crime in an understandable way. How would we define the degree of health or well-being that a woman should have a duty to produce? How would we define the degree of health or well-being that a woman should not adversely affect?

Second, there is the problem of determining the cause of any harm. The physical and mental status of a child is affected by a multitude of actors, some genetic, some gestational, some perinatal, some environmental in the

postnatal period, many unknown.[17] Many of these lie outside a woman's control, such as her genetic contribution to the child or her exposure to rubella or toxic air pollutants. How is the state or anyone else to know whether and when a crime has been committed? Must every birth with an Apgar score of less than 10 be investigated? There is no general duty to produce a perfect or even a healthy or "normal" child. Thus, this cannot be the duty that pregnant women are said to violate. Moreover, any general duty to perform or refrain from specific acts that harm the fetus in some clearly identifiable way would be derivative of a more general duty not to harm the fetus.[18]

Interestingly, few prosecutions of drug-using women have demonstrated that a drug actually caused harm to a newborn. The offense that is prosecuted is not the materialization of harm at birth. It is the conduct that exposes the child to risk. This conduct takes place during pregnancy, not after birth.[19] This suggests that it is not enough to avoid harm. The duty implied is really a duty to prevent any *risk* of harm. Since the fetus is integrally connected to the pregnant woman, preventing risks of harm to the fetus requires caring for the woman's body or at least preventing harm to her. Thus, the woman's duty to the fetus is necessarily a duty to protect her own body, for she cannot take proper care of the fetus unless she cares properly for her own body. This duty to prevent risk to the fetus amounts to imposing on a pregnant woman a state-defined standard of care for her own body, or conduct toward herself. It is noteworthy that while the state justifies its prosecutions on the basis of its interest in protecting the fetus, it does not undertake any duty to ensure the necessary care for the woman's body. Instead, it imposes that duty on the pregnant woman.

The *Johnson Controls* case[20] now before the United States Supreme Court will decide whether a company can impose controls on women employees to protect a future fetus—excluding those without proof of sterility from higher-paying jobs that expose them to lead. If criminal prosecutions are acceptable, it would follow that not only *may* employers impose such controls, they *must* do so, and women must abide by them.

Causation

The evidence that drug use harms the fetus is suggestive but problematic as a basis for criminal offense. The harmful effects of heroin and alcohol when taken frequently in very large quantities are well known. Yet a surprising number of children of substance abusers escape damage. For example, the Public Health Services has estimated that 86 percent of women drink at least once during pregnancy, with 20 to 35 percent drinking regularly.[21] Most of their children are born quite healthy. Alcohol appears to be teratogenic only if used on a few specific days of gestation.[22] Different substances have different effects on the fetus at different times during pregnancy. For example, significant damage to organs generally occurs early in pregnancy; birth weight problems happen later; there is still uncertainty about when brain damage can occur. Given the difficulties in estimating gestation in general, how are we to know whether a particular substance caused a particular harm in one infant?

The evidence with respect to cocaine use is still being accumulated. Women who use cocaine have newborns with low birth weight (5.5 pounds or less), reduced head circumference, some congenital malformations, and an increased risk of premature birth and of *abruptio placentae* resulting in stillbirth.[23] However, cocaine's precise contribution to these and other risks remains uncertain and under study. The effect of occasional as opposed to regular heavy use is unclear. Studies indicate that the health of women who used cocaine during pregnancy is often impaired by other factors, such as poor nutrition and the use of alcohol, cigarettes, marijuana, and other drugs.[24] Some researchers studied only poor minority women, who typically have poorer prenatal health than the general population. Poverty, poor nutrition, lack of prenatal care, and even stress adversely affect fetal development.[25] One of the most important determinants of low birth weight (itself a major risk factor for infant mortality) is inadequate prenatal care.[26] Thus, drug use may not be the primary determinant of poor birth outcomes. Stopping drug use during pregnancy will not guarantee a healthy baby. Continued drug use does not always cause damage. Moreover, the long-term effects of drug use are still under study. The degree to which children who are born prematurely, or with low birth weight or small head size, are actually prejudiced in their development remains to be seen.[27] Care-

taking and their environment contribute significantly to their developmental functioning.

Women who use drugs typically are beset with problems in addition to substance abuse—from lack of housing and income to family difficulties—that contribute to poor birth outcomes. Yet, when a bad outcome occurs, it is easier to blame it on a drug the women took during pregnancy than to recognize the constellation of possible causes. As a practical matter, it seems almost impossible to satisfy the standard of proof of causation in a criminal prosecution, given the complexity of fetal development and the multiplicity of factors that affect it. While drug use is certainly a risk factor, focusing on drugs draws attention away from the much more global problem of inadequate prenatal care.

Sources of Harm

If harm is what is to be prevented, then the source of the harm should not matter. Anything that causes serious harm should be the subject of prosecution. Women who fail to get adequate prenatal care or proper nourishment should be prosecuted. This approach was used in California when Pamela Rae Stewart's baby died six weeks after birth. She was prosecuted not just for taking amphetamines but also for disregarding her physician's advice to refrain from sex with her husband and to get to the hospital at the first sign of bleeding.[28] The court dismissed the criminal action on the grounds that the child support statute under which it was brought was not intended to apply to refusals to follow physician's orders.[29] Amending the statute to prohibit pregnant women from having sex with their husbands might protect some fetuses from harm but would be seen by most people as an outrageous violation of liberty.

A recent study compared the neurological development of children born prematurely whose heart rates were monitored electronically before and during delivery with children (also born prematurely) whose heart rates were checked periodically by auscultation or "listening" through the pregnant woman's abdomen.[30] Children who were monitored with state-of-the-art electronic fetal monitors had cerebral palsy 2.9 times as often as children monitored by ordinary auscultation. After adjustment for other risks factors, the risk of cerebral palsy was 3.8 higher for the electronically monitored children than the other group. Does this mean that the use of electronic fetal monitors is or should be a criminal offense? Such a law would merely require women and physicians to avoid using something that creates a risk of fetal harm.

Variations in medical practice should make us wary of relying on current medical standards as ideal pregnancy care. Over the decades, women have been alternately praised and chastised for gaining more than ten pounds during pregnancy. Attitudes toward giving birth outside the hospital have varied from acceptance as normal to rejection as dangerous or crazy. A former president of a state chapter of the American College of Obstetrics and Gynecology reportedly said that people who have home births are "kooks, the lunatic fringe, people who have emotional problems they're acting out."[31] Physicians in Alaska even requested the attorney general to charge a physician with murder after a baby died following a home birth he attended.[32] Such incidents are reminders of the fallibility of medical opinion and how quick some are to equate unfashionable conduct with crime.

There is little doubt that drug use during pregnancy presents a risk of harm to the fetus. But it is hardly the only risk. How are we to distinguish the harm from drug use from harm arising from poor nourishment during infancy and childhood, from poor parenting practices such as emotional detachment, excessive discipline, or lack of supervision? What kind of duty will prevent such similar harms? Should we require a license to have children, as some have suggested,[33] obtainable upon proof of adequate parenting capabilities? How will we define these? Can they be predicted before one has a child?

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The duty pregnant women who use drugs are assumed to have cannot, in fact, be explained in terms of the harm to the fetus or child or even risk of harm. Harm can be caused by more than just drug use. Thus, the duty cannot be justified by the desire to prevent the harm

itself. It must be justified, if at all, by the need to proscribe specific drug use that causes harm that does not result from other sources. The only distinction between cases of possible harm to a child from drug use and cases of harm arising from alcohol, tobacco, malnutrition, lack of prenatal care, and physical trauma is the assumed source of the harm—the drugs. The duty that is really imposed here is the duty not to use drugs, a duty that may already exist regardless of pregnancy. If the real concern is to avoid fetal harm, there is no principled way to distinguish between harm caused by drugs and harm caused by these other avoidable factors, and, therefore, no principled way to limit prosecutions to drug using pregnant women.

But, it might be argued, the harm from drug use can be singled out because drug use is already illegal in some states or could be made unlawful. Certainly drug use could be prosecuted as an offense. But its illegality does not distinguish it from other risks of harm to a fetus. Anyone—male or female—could be prosecuted for illegal drug use. Prosecuting *only* pregnant women for drug use requires a justification beyond illegality based on harm to the fetus that other risk factors do not create.

Duty to Whom?

The idea of a duty raises the additional question of to whom the duty is owed. If the law is criminal, then the duty is owed to the state. This transforms any normal desire to avoid harm to the fetus into an obligation to the government.

Parents do have obligations to their children. Analogizing to child abuse and neglect laws, some commentators have argued that pregnant women should have an enforceable duty not to take drugs that risk harm to the fetus.[34] This notion of "fetal abuse" however, treats the fetus better than a child. The harm to children prohibited by civil child abuse laws is both greater in degree and easier to identify than the more general risk of harm to a fetus. While drug use may expose a fetus to *risk*, harm occurs only in a proportion of cases. The fetus is also at risk from other factors. Child abuse intervention ordinarily occurs only when a child has suffered real injury. Only in the most extreme cases of intentional, long-lasting injury are parents charged with a crime. Even then, the crime is not a special offense of child abuse but ordinary homicide or assault.

Child abuse laws are most active—and most successful—in the civil sphere. They create a system of social services intended to enable the family to provide adequate care for a child. This is a social service model; the intervention is directed at the family unit, parents and child together. If the parents refuse to cooperate, the state may take custody of the child, but this is not automatic and is ordinarily viewed as a last resort. Children who are abused can be removed from parental custody because they are physically separate persons.[35] "Fetal abuse," however, cannot be stopped without physically intervening on the mother, or at the least, seriously restricting her liberty. As long as the two are physiologically united, such an intervention subordinates the woman to the fetus. The concept of fetal abuse can be justified only by granting to the fetus rights of an independent live-born person and denying such rights to the woman. Pregnant women would be treated as chattel, as inert "fetal containers."[36] Even temporary denial of the rights of personhood to women is incompatible with the fundamental principles of individual autonomy and equal respect for persons that form the core of our law.[37] If there is a duty to the fetus, it cannot be bootstrapped into a fetal abuse hypothesis.[38]

Intent

Attaching criminal liability to drug use raises the issue of criminal intent—whether, in taking drugs, the woman could be said to have intended the harm in question. Criminal intent is sometimes attributed to reckless conduct, in which the risk of harm is consciously disregarded, even though the actor has no reason or desire to cause harm. What is often thought to provide an explanation or reason for the action—the motive—is generally considered to be irrelevant. Were motive relevant, the absence of any purpose to harm would render many reckless actions nonculpable.

Motive and intention are not always easily distin-

guished in fact.[40] Indeed, culpability of drug-using pregnant women seems predicated on the motives attributed to them rather than on their intention, as construed in the traditional sense just described. If intent were all that were at issue, then *any* act that produced harm to a fetus could be declared a criminal offense. The source of the harm should not matter. And if intent includes reckless behavior, then any thoughtless behavior that causes harm to the fetus would entail the requisite *mens rea*.[41] A pregnant woman who intentionally walked on an icy sidewalk might be said to have acted criminally if a fall causes injury or death to the fetus. Indeed, if the goal is to prevent any *risk* of fetal harm, then the crime is committed once the woman sets foot on the ice, even if no injury results. Similarly, a pregnant woman who has sex with her husband could be guilty of endangering her fetus. In fact, when such an event results in injury, it is considered a tragedy and not a crime. This suggests that it is not the behavior alone that determines liability. Rather, it is society's perception of the behavior as desirable or undesirable that controls. From the fetus's perspective, walking on ice and taking drugs may have the same unwanted consequences. The only explanation for making the latter a crime is that we think drug use is bad.

The focus on pregnant women who use illegal drugs is best explained by societal disapproval of mothers who need or want to get high, an attitude that "betrays a profound suspicion of pregnant women."[42] It is as though we believe that women are taking a drug for the purpose of harming the fetus. Yet it is doubtful that any woman has taken any drug for the express purpose of harming her fetus. However the initial use of a drug might be characterized, its continued use by addicts is rarely, if ever, truly voluntary. Drug addiction tends to obliterate rational, autonomous decision making about drug use. Drugs become a necessity for dependent users, even when they would much prefer to escape their addiction. In virtually all instances, a user specifically does *not* want to harm her fetus. Yet she cannot resist the drive to use the drug. Thus, it is not plausible to attribute to drug-using women a motive of causing harm to the fetus. The only intent the women form is to take the drug. But this is the traditional definition of intent merely to do the act, which is not sufficient to define *this* crime.

Criminalizing Drug Use Is Counterproductive

Even if one could plausibly argue that pregnant women have a duty to have healthy children, and that they intend by drug use to injure a child, and even if the causal link between drug use and harm to the fetus could be proved beyond a reasonable doubt, use of the criminal law to protect fetuses from their drug-using mothers should still be opposed because it will be counterproductive.

One of the goals of prosecuting women who use drugs seems to be to create an incentive for pregnant women to stop using drugs, as by entering a drug treatment program. But treatment is rarely available to pregnant women.[43] Dr. Chavkin's survey showed that about 54 percent of New York City's drug treatment programs excluded pregnant women.[44] Moreover, 67 percent refused to admit pregnant women whose source of payment was Medicaid. Eighty-seven percent excluded pregnant Medicaid patients who used crack.[45] In Massachusetts, there are only thirty state-funded residential beds for pregnant women in drug treatment programs.[46] Ten of these are in a new program that opened only last year; fifteen are in the women's correctional facility.

In part, the scarcity of treatment for pregnant women reflects a history of ignoring drug treatment for women.[47] Even now, little is known about how to eliminate drug dependence among women. The absence of child care has made it impossible for many women to enter or remain in treatment. Also, few programs deal with the problems of domestic violence or husbands or partners who introduce women to drugs, so that women return to circumstances that foster drug use.

In addition, there continues to be considerable uncertainty about *how* to treat drug-dependent women. Medical opinion has both recommended and cautioned against methadone detoxification during pregnancy over the years.[48] There is little successful experience in treating dependency on cocaine and crack, the drugs that appear to be increasingly used by women. A handful of residential programs that provide comprehensive medical services and job training, and help women learn how to care for their children have had some success.[49] But these are labor intensive and expensive.

The general absence of drug treatment programs for pregnant women means that there is little likelihood that

women who want to get off drugs will be able to.[50] In these circumstances, there is little justification for making the pregnant woman's drug use a crime. The woman would be punished for society's more general failure to provide treatment. Some prosecutors have claimed that they prosecuted women in order to get them into treatment, and indeed, have recommended sentencing them to a treatment program instead of prison.[51] This type of sentence assumes an obligation on the part of drug users to join a treatment program, an obligation they cannot meet because of the woefully inadequate treatment facilities available. The irony of requiring a criminal conviction in order to gain access to treatment is apparent. Prosecutions cannot be justified as long as there are insufficient treatment programs to meet the needs of pregnant women.

Punishment is the only goal served by defining drug use by pregnant women as a crime.

Finally, criminalizing drug use during pregnancy is likely to be counterproductive in protecting the fetus. There is reason to believe that women will avoid prenatal delivery care if detection of their drug use could lead to their arrest or loss of child custody. Several states currently require that health care providers report to the state women or their newborns who are drug dependent or exhibit drug withdrawal symptoms. The state may act to take custody of the newborn and may notify the district attorney to initiate criminal charges.

Newborns are rarely protected by such a system. If women avoid prenatal care for fear of losing their babies or going to jail, the child's birth weight and development are likely to be prejudiced. Removing the child from the mother after birth compounds the injury. There are already too few foster homes available without adding more children to the system. Many of these children languish as boarder babies in hospitals waiting for placement.[52] The emotional deprivation that is necessarily typical of institutional care may harm these children more than living at home with their mothers. The paucity of resources devoted to caring for children belies the assertion that the purpose of separating mother and child is to protect the child. William Bennett, the Bush Administration's "drug czar," has recommended removing children from every woman who uses drugs. But prenatal drug use, by itself, does not predict postnatal abuse or neglect. If the mother demonstrates conduct sufficient to constitute child abuse or neglect after birth, existing law is more than adequate to take the child into custody for its own protection.

It seems clear that punishment is the only goal that is served by defining drug use by pregnant women as a crime. No one can seriously maintain that prosecution serves the traditional goal of deterrence. Existing prohibitions and increased penalties have not stopped the distribution or use of drugs. In the absence of adequate treatment programs, "rehabilitation" cannot be provided. Rehabilitation is generally conceived as appropriate for recalcitrant offenders who have refused to comply with the law. Creating a new crime for the sole purpose of getting pregnant women into treatment stands the goal of rehabilitation on its head. Jennifer Johnson was unable to get into a drug treatment facility when she became pregnant. After she was convicted, she was sentenced, in part, to a treatment program. This is not rehabilitation. It is using the criminal law to gain access to social services. Why should a pregnant woman have to be convicted of a crime in order to enter a social program that is, in theory, open to anyone? While some prosecutors may think of themselves as heroes because their conviction forced a treatment program to accept a woman (no longer pregnant), in reality the government is giving its stamp of approval to a barrier that keeps pregnant women out of treatment programs.

If neither deterrence nor rehabilitation is served by prosecuting pregnant women, only punishment remains. Pregnant women who use drugs need help, not punishment. But all that prosection can accomplish is conviction and punishment.

Conclusion

Prosecutions of drug-using pregnant women are based on an illusion, and a dangerous one at that. They foster the illusion that society is protecting its future generations. In reality, such prosecutions substitute punishment for protection. By treating women as threats to their own progeny, society rejects the only source of fetal

sustenance. It separates mother and child at the time the child most needs a mother, and relegates the child to the woefully inadequate system of institutional or foster care.

Criminal prosecutions assume that women have a special duty to the fetus that men do not have. But when they are examined closely, that duty cannot be found. Any duty not to harm the fetus would cover a wide range of concededly lawful behavior. The more expansive duty to avoid any risk to the fetus would prohibit an even larger sphere of ordinary conduct. A pregnant woman might be assured of satisfying such a duty only by having an abortion.

Singling out pregnant women highlights the fact that they are being punished not for any act harming the fetus but because they are pregnant and use drugs. Making pregnancy one of the elements of a crime is disturbing. It affects the way we think about pregnancy, making all pregnant women suspect. Moreover, punishment cannot remotely be believed to deter either drug use or pregnancy.

Imposing a legal duty on pregnant women to protect the fetus—especially one enforceable by criminal law—requires stripping women of their status as rights-bearing persons. It is dangerous because it would create a precedent for controlling pregnancy and women in general. Any rationale that justifies prosecuting pregnant women for risking harm to a fetus may be used to justify controlling all behavior of pregnant women. If the goal is to protect the fetus, then there would be no impediment to controlling the behavior of all women of childbearing age.[53]

Finally, criminalizing certain conduct by pregnant women is likely to be counterproductive, deterring women not from drug use but from prenatal care and other services that have a realistic probability of improving the health of their children.

The effects of drug use are tragic for women, children, and society. Injecting the criminal law can only deepen the tragedy. The answer lies not in punishing women but in helping them to emerge from their own misery. It is an expensive and lengthy process requiring better education about pregnancy care, expansion of prenatal care facilities, research into addiction treatment, and the creation of treatment facilities. It won't get headlines, but it can work. Drug use during pregnancy is a *real* problem. It is a public health problem that can only be compounded by treating it as a crime.

NOTES

1 *Pregnant and Newly Delivered Women Jailed on Drug Charges*, 2 REPRODUCTIVE RIGHTS UPDATE, Feb. 2, 1990, at 6.

2 Johnson v. State, No. 89-1765 (Fla. Dist. Ct. App., 5th Dist., 1989). Johnson was convicted and sentenced to 15 years on probation, and required to abstain from drug and alcohol use if pregnant and to comply with prenatal care recommendations.

3 Robertson draws upon this general feeling to support a right to procreate. *See* Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333 (1982).

4 S. ELIAS & G.J. ANNAS, REPRODUCTIVE GENETICS AND THE LAW (1987).

5 Glantz, *A Nation of Suspects: Drug Testing and the Fourth Amendment*, 79 AM. J. PUBLIC HEALTH 1427 (1989).

6 Criminal prosecutions are not the only forms of control being advocated. Physicians and hospitals, among others, have endorsed requiring women to undergo caesarean section delivery in lieu of vaginal birth when physicians believe the fetus might be in distress. *See* Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192-96 (1987). Others suggest requiring pregnant women to comply with their physicians' recommendations for prenatal care, including limitations on exercise and marital sex. Some heads of Maternal-Fetal Medicine Departments would detain women who fail to abide by their physicians' "orders." *Id. See generally*, Field, *Controlling the Women to Protect the Fetus*, 17 LAW, MED. & HEALTH CARE 114 (1989); Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 75 CALIF. L. REV. 1951 (1987). The increasing availability of prenatal diagnosis and screening for genetic abnormalities suggests requiring women to undergo testing and surgery, if not abortion, to correct fetal problems. On the scope of genetic screening, *see generally*, S. ELIAS & G.J. ANNAS, *supra* note 4; Annas, *Who's Afraid of the Human Genome?* 19 HASTINGS CENTER REP. 19 (1989). One need not even wait until pregnancy to avoid such problems. Commercial industry has excluded women of childbearing capacity from jobs that could expose them to teratogens. *See, e.g.*, Wright v. Olin Corp., 697 F. 2d 1172 (4th Cir. 1982); International Union v. Johnson Controls Inc., 886 F.2d 871 (7th Cir. 1989), cert. granted, __ U.S. __ (1990). *See generally*, Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219-73 (1986). Yet making undesirable behavior a criminal offense, putting a new mother in prison, or depriving her of custody of her child, goes beyond controlling women's behavior or excluding them from certain jobs or activities.

7 Lewin, *Drug Use in Pregnancy: New Issues for the Courts*, N. Y. Times, Feb. 5, 1990, at A14.

8 Unif. Cont. Subst. Act §401, 9 U.L.A. 91 (1988) makes it unlawful for any person to manufacture, deliver, or possess with intent to manufacture or deliver, a controlled substance (the trafficking crimes), or knowingly or intentionally to possess a controlled substance. Distribution to persons under age eighteen is also an offense. The Act has been adopted by forty-eight states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

9 Mere use—as opposed to possession or trafficking—is not included as an offense in the Uniform Act. However, a few states, such as California, have made drug use a crime. *See, e.g.*, In re Orosco, 82 Cal. App. 3d 924, 147 Cal. Rptr. 463 (1978). However, use refers to a present state of being under the influence of a controlled substance, not use in the past. *See* People v. Spann, 1987 Cal. App. 3d 400, 232 Cal. Rptr. 31 (1986).

10 Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 995, 1007 n. 79 (1988).

11 Criminalizing pregnancy by a drug-dependent person creates a crime dependent on status, the status of being pregnant and the status of drug dependency. Since Robinson v. California, 370 U.S. 660 (1962), criminalization of drug addiction has been recognized as impermissible punishment of status in violation of the eighth amendment. There does not appear to be any basis for squaring the criminalization of pregnancy with the teachings of *Robinson*.

12 For an argument that parents *should* be licensed before having children, *see* McIntire, *Parenthood Training or Mandatory Birth Control: Take Your Choice*, PSYCHOLOGY TODAY, Oct. 1973, at 34. McIntire's argument, however, applies evenhandedly to both men and women. Licensure of pregnancy would burden only women.

13 Alternatively, they may assume that the fetus is entitled to legal status as a person. However, ascribing personhood to the fetus is a much harder case to make than imposing a duty to the fetus regardless of whether it is considered a person with all the rights and privileges granted to those already born. This discussion focuses on the nature of the duty rather than the legal status of the fetus because it is the duty, if any, that is the critical element of the crime.

14 Kahn, *Of Woman's First Disobedience: Forsaking a Duty of Care to Her Fetus—Is This a Mother's Crime?*, 53 BROOKLYN L. REV. 807, 818-20 (1987).

15 *But see* Commonwealth v. Cass, 392 Mass. 799, 467 N.E.2d 1324 (1984) (holding that a fetus was a "person" for purposes of vehicular homicide statute).

16 Any duty not to cause the death of the fetus is obviously complicated by lawful abortion and would require some principle to distinguish lawful abortion from lawful killing. This can be and has been accomplished when the person doing the killing is a third party, such as a felon who assaults the mother and causes the death of the fetus. But defining the duty on the part of the pregnant women requires more.

17 S. ELIAS & G.J. ANNAS, *supra* note 4.

18 It thus depends for its justification on the justification for any duty to the fetus. In addition, it requires an empirical basis for claiming that specific acts or omissions harm the fetus in particular, avoidable ways.

19 *See* Reyes v. Superior Ct, 75 Cal. App. 3d 214, 217, 141 Cal. Rptr. 912 (1977).

20 International Union v. Johnson Controls Inc., 886 F.2d 871 (7th Cir 1989), cert. granted _ U.S. _ (1990).

21 Rosenthal, *When a Pregnant Woman Drinks*, N. Y. Times, Feb. 4, 1990, §6 (Magazine), at 30, 49, 61.

22 S. ELIAS & G.J. ANNAS, *supra* note 4.

23 Chasnoff, *Perinatal Effects of Cocaine*, CONTEMPORARY OB/GYN 164 (1987); Zuckerman, Frank, Hingson, Amaro, Levenson, Kane, Parker, Vinci, Aboagye, Fried, Cabral, Timperi & Bauchner, *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, 320 NEW ENG. J. MED. 762 (1989) (hereinafter cited as *Effects*); Petitti & Coleman, *Cocaine and the Risk of Low Birth Weight*, 80 AM. J. PUBLIC HEALTH 25 (1990).

24 Frank, Zuckerman, Amaro, Aboagye, Bauchner, Cabral, Fried, Hingson, Kane, Levenson, Parker, Reece & Vinci, *Cocaine Use During Pregnancy: Prevalence and Correlates*, 82 PEDIATRICS 888 (1988); *Effects*, *supra* note 23.

25 Binsacca, Ellis, Martin & Petitti, *Factors Associated with Low Birthweight in an Inner City Population: The Role of Financial Problems*, 77 AM. J. PUBLIC HEALTH 505 (1987); Leveno, Cunningham, Roarke, Nelson & Williams, *Prenatal Care and the Low Birth Weight Infant*, 66 OBST. & GYN 599 (1985); Miller, *Infant Mortality in the U.S.*, 253 SCI. AM. 31 (1985).

26 U.S. GENERAL ACCOUNTING OFFICE, PRENATAL CARE: MEDICAID RECIPIENTS AND UNINSURED WOMEN OBTAIN INSUFFICIENT CARE, Sept., 1987, at 13, 31.

27 *Drug Babies: An Ethical Quagmire for Doctors*, MEDICAL WORLD NEWS, Feb. 12, 1990, at 39, 43, 45.

28 Stewart had placenta previa which separated from the uterus causing hemorrhaging and severe damage to the fetus. Her husband was not prosecuted for having sex with his wife or failing to take her to the hospital.

29 People v. Stewart, No. M598097, slip op. (San Diego Co. Ct., Feb. 23, 1987). In Reyes v. Superior Court, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977), Margaret Reyes was charged with felony child endangerment for using heroin and failing to seek prenatal care, against the advice of a public health nurse. She gave birth to twins who were addicted to heroin and suffered withdrawal. The prosecution was prohibited because the court found that the statute did not apply to unborn children and was not intended to apply to prenatal conduct. Similarly, in Baby X v. Misiano, 373 Mass. 265, 266, 366 N.E. 2d 755 (1977), the father's duty of support under the Massachusetts child support statute was held to extend only to a child, and not to an unborn fetus.

30 Shy, Luthy, Bennett, Whitfield, Larson, van Belle, Hughes,

Wilson & Stencher, *Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants*, 322 New Eng. J. Med. 533 (1990).

31 Harvey, *Homebirths*, Boston Globe, Oct. 16, 1977 (Magazine), at 18, quoted in Annas, *Legal Aspects of Home Birth*, in S.E. Sagov, R.I. Feinbloom, P. Spindel, A. Brodsky, Home Birth: A Practitioner's Guide to Birth Outside the Hospital 51-63, 54 (1984).

32 *Id.* at 56.

33 *See, e.g.*, McIntire, *supra* note 12.

34 Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?* 23 Duquesne L. Rev. 1 (1984); Robertson, *Legal Issues in Fetal Therapy*, 9 Seminars in Perinatology 136 (1985).

35 A few states deem a medical diagnosis of drug addiction or fetal alcohol syndrome in a newborn to be prima facie evidence of neglect for purposes of determining whether parents are fit to retain custody of the child after birth. Ill. Rev. Stat. ch. 37, § 704-6(c) (d); Utah Code Ann. § 78-36.5; In re Smith, 128 Misc.2d 976, 492 N.Y.S.2d 331 (Fam. Ct. 1985); In re Baby X, 97 Mich. App. 111, 293 N.W.2d 736. (1980). Still, the determination focuses on whether the parents will be able to care for the child after it is born. The termination of custody or parental rights remains a civil proceeding consistent with the purposes of child abuse laws. It does not entail criminal prosecution for acts committed before birth.

36 Annas, *Women as Fetal Containers*, 16 Hastings Center Rep. 13 (1986). *See generally*, Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 Yale L. J. 599 (1986).

37 Criminal laws prohibiting drug use only by pregnant women would single out pregnant women for punishment solely on the basis of their sex and reproductive capacity. It is the drug use, not the harm to the fetus, that is the conduct being proscribed. Sex is not a sufficient justification for making it a crime for pregnant women, but not men, to take drugs. The argument that this is permissible because only women can harm the fetus by drug use only underscores the discriminatory nature of the purported law. Men can cause harm to a fetus by using drugs or alcohol that affect the sperm and ultimately the delivered child, or by physically injuring a pregnant woman, for example. On the effects of drug and alcohol use by males on reproduction, *see generally*, Soyka & Joffe, *Male Mediated Drug Effect on Offspring*, Drug and Chemical Risks To The Fetus and Newborn (1980); and Abel & Lee, *Paternal Alcohol Exposure Affects Offspring Behavior but not Body or Organ Weights in Mice*, 12 Alcoholism Clinical & Experimental Research (May/June 1988). Environmental exposure to lead and other hazards can cause genetic damage prior to conception. *See, e.g.*, Occupational Safety & Health Administration, *Final Standard for Occupational Exposure to Lead*, 43 Fed. Reg. 52959 (1978); United Nations Scientific Committee on the Effects of Atomic Radiation, Sources and Effects of Ionizing Radiation (1977). What men cannot do, of course, is transmit drug metabolites to a fetus via the placenta. Allocating duties and punishments on the basis of sex is fundamentally at odds with the concept of equal protection. The United States Supreme Court has not recognized this degree of equal protection for pregnant women. *See* General Electric v. Gilbert, 429 U.S. 125 (1976), Geduldig v. Aiello, 417 U.S. 484 (1984). The Pregnancy Discrimination Act of 1978, 42 U.S.C. sec. 2000E (k), was enacted to protect pregnant women from the kind of workplace discrimination that the Court found the Constitution did not forbid. Still, the Court has not addressed the question whether the equal protection clause allows pregnant women to be burdened with criminal punishments to which men are not subject.

38 If a breach of this "duty" is punishable in criminal law, it should be remediable by a civil action for damages brought by the infant. In Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980), the Court recognized an infant's cause of action for wrongful life where a laboratory was alleged to have incorrectly notified the parents that they were not carriers of the gene for Tay-Sachs disease. The court also suggested that had the parents been warned, and then "made a conscious choice to proceed with a pregnancy, with full knowledge that a seriously impaired infant would be born ... we see no sound public policy which should protect those parents from being answerable for the pain, suffering and misery which they have wrought upon their offspring." 106 Cal. App. 3d at 829. Thus, the court indicated its willingness to recognize a cause of action by an infant against its parents where the parents knew that the infant would suffer serious injury and failed to prevent it. In a much criticized decision, Grodin v. Grodin, 102 Mich. App. 396, 301 N.W. 2d 869 (1980), a Michigan court permitted a cause of action in negligence for the mother's use, during pregnancy, of tetracycline, which discolored the child's teeth.

39. "Hardly any part of penal law is more definitely settled than that motive is irrelevant." J. Hall, General Principles Of Criminal Law 88 (2d ed. 1960), quoted in Husak, *Motive and Criminal Liability*, 8 Crim. Just. Ethics, 3, (Winter/Spring 1989). Husak criticizes this statement as an inaccurate description of the definition of many offenses. More importantly, he argues that motive cannot be divorced from intention on defensible principles in a significant proportion of cases and is thus a relevant factor in determining criminal liability, as well as punishment.

40 Husak, *supra* note 39.

41 We ignore here the possibility of defenses such as necessity or self-defense that might excuse otherwise reckless behavior.

42 Annas, *Protecting the Liberty of Pregnant Patients*, 316 New Eng. J. Med. 1213 (1987).

43 Treatment is generally scarce in the United States. A National Institute on Drug Abuse official said that only 338,365 public and private drug treatment slots were available in 1987 (the most recent figures) for an estimated 4 million addicts. Malcolm, *In Making Drug Strategy, No Accord on Treatment*, N. Y. Times, Nov. 19, 1989, § 1, at 1. The majority of these serve men only. *See, e.g., Help is Hard to Find for Addict Mothers*, L. A. Times, Dec. 12, 1986, at J1.

44 Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 Am. J. Public Health 483 (1990).

Law and Medicine

Helene M. Cole, MD, *Section Editor*

Mandatory Treatment for Drug Use During Pregnancy

Wendy Chavkin, MD, MPH

THE CRACK epidemic is unique among American drug waves because of the high level of involvement of young women.[1] In response to this, there have been attempts to impose criminal sanctions on pregnant women who use drugs or alcohol. To date, there have been 50 efforts to prosecute women for using drugs or alcohol while pregnant, with two convictions, and at least seven states have legislation pending that would alter child protective laws to encompass drug use during pregnancy under the rubric of fetal abuse.[2-4] Fueled by hotly contested political controversies, such as the legal status of the fetus and the criminalization of addiction, the debate has generally polarized between therapy or sanction.

See also pp 1521 and 1567.

Some have proposed mandatory treatment for pregnant women as a compromise. This article examines other experiences with mandatory treatment to assess whether such treatment has proven efficacious, whether these other experiences appear relevant to compulsory treatment of substance abuse during pregnancy, and whether mandatory treatment during pregnancy is consistent with American values and should be recommended as social policy. This discussion will focus on the pregnant addict who has not committed a criminal act and has not come to the attention of criminal justice or psychiatric or other authorities for reasons other than the combined conditions of pregnancy and addiction.

The US experience with mandatory treatment of chemical dependency comprises three general groupings or models: (1) mandatory treatment in the law enforcement context; (2) civil commitment; and (3) treatment mandated as a precondition for obtaining a privilege. Clearly, attempts to determine the efficacy of any of these approaches must refer to some alternative approach. Does mandatory treatment work better than voluntary treatment, no treatment, incarceration, detention, or loss of privilege? Which outcome parameters will be used to measure success: duration in treatment, participation in therapy, indication of a decline in rearrest rates after treatment, or proof of long-term abstinence from drug or alcohol use?

Failure to define clearly both the outcome parameters and the comparison groups, compounded by problems of measurement and follow-up, limit the usefulness of many of the evaluations to be described. Nevertheless, these are the only data available from which to attempt inferences about efficacy and thus to empirically make a basis for policy.

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MANDATORY TREATMENT

Law Enforcement

Mandatory treatment in this context refers to providing treatment as an alternative to trial or incarceration for those arrested or convicted of crimes and found to be drug users. Failure to remain in treatment renders one liable to criminal prosecution and penalty.

The United States has had several significant experiences with mandatory treatment: the US Public Health Service hospitals in Fort Worth, Tex, and Lexington, Ky, instituted compulsory treatment programs in the 1930s for addicts convicted of federal crimes. These programs were followed in the early 1960s by the California Civil Addict Program; in 1966 by the Federal Narcotic Addict Rehabilitation Act and by New York's Narcotic Addiction Control Commission; and in 1972 by the Federal Treatment Alternatives to Street Crime.[4]

Efforts to evaluate these programs have been plagued by shortcomings in defining program content, target population, and outcome; by difficulties regarding follow-up; by variations in program quality; and by other basic structural and methodological problems. Studies of these programs have compared addicts mandated to treatment with those who voluntarily participated, rather than with those incarcerated without treatment, and the studies have generally looked solely at male subjects.

Evaluation of the US Public Health Service experience reported inconsistent results as to whether addicts legally compelled to treatment reduced drug use more than voluntary participants.[5] While Anglin[6] concluded that the California Civil Addict Program was effective in reducing drug use and criminal activity, Barry[7] claimed that the program site

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was essentially a prison and that treatment was not systematically available.

In contrast to the California program, the New York experience generally has been deemed a failure, with overreliance on criminal justice facilities and personnel, a shortage of experienced clinicians, large caseloads, high abscondence rates, and spurious evaluation efforts.[6,9] Analysts of the Federal Treatment Alternatives to Street Crime program, which refers "criminal justice clients" to community-based treatment, concluded that compulsory treatment was positively associated with longer stays in treatment programs (6 to 7 weeks). However, compared with voluntary treatment, compulsory treatment was not associated with less criminal activity.[10-12] The Drug Abuse Reporting Program failed to reveal improved outcomes after treatment among those "legally compelled to participate" in treatment compared with male opiate addicts participating voluntarily.[13]

DeLeon[14] reviewed the experience of therapeutic communities (ie, structured treatment environments with emphasis on group process and usually include former addicts on staff) and concluded that legal compulsion was a consistent predictor of retention in treatment, which in turn was the best predictor of a successful outcome. However, one multisite study that reported on female addicts who entered drug treatment under legal pressure indicated that they were less likely to remain in treatment than women who entered voluntarily.[15]

Civil Commitment

Civil commitment refers to mandatory treatment for those persons diagnosed as addicted and considered to be incapable of self-care or to be potentially threatening to the public's safety because of their addiction, but who have not been accused or convicted of any crime. All states and civil commitment statutes require due process protection and include stringent limits on the period permitted for civil commitment.[16] Theoretically, this model is distinguishable from the law enforcement model previously described.

However, when dealing with addiction, it is virtually impossible to disentangle the civil from the criminal.[17] For example, both the California and New York programs grouped together civilly and criminally committed addicts, ostensibly for treatment but often in settings that more closely resembled prisons.[18] In Massachusetts, civilly committed female addicts were sent to prison until public outcry forced the creation of treatment programs. Yet now that the need for treatment far exceeds the capacity, many women in Massachusetts who have been civilly committed for treatment are again ending up in the Framingham, Mass, prison.[19] Because of this conceptual and operational conflation, there have not been separate efforts to evaluate civil commitment for reducing drug use.

Precondition for Obtaining Privilege

Many localities impose mandatory treatment as a precondition for maintaining a driver's license after being convicted of driving under the influence of alcohol. The term *treatment* in this context, however, subsumes a wide variety of interventions, from brief didactic sessions on the perils of drunk driving to short-term inpatient detoxification, but it generally excludes long-term intensive treatment for alcoholism. Some studies have demonstrated a reduction in rearrests for driving while intoxicated or improvements in knowledge about the dangers of driving while drunk; others report no such benefits. Long-term reduction in alcohol consumption has not been evaluated as an outcome parameter.[20-23]

Employee assistance programs generally are designed to offer counseling to employees whose work performance is impaired by alcohol, drug, or psychological problems. The parameter that is usually discussed is improved work performance rather than outcomes directly relating to alcohol or drug abuse, but the literature is descriptive rather than evaluative.[24-26]

Chemically dependent parents deemed neglectful or abusive are often mandated to receive treatment as a precondition for maintaining or regaining custody of their children. The limited literature on the efficacy of this approach suggests that those parents mandated to treatment fare about the same as those who participate voluntarily.[27,28]

OTHER CONCERNS

In addition to such basic questions as whether treatment as an alternative to incarceration has ever been well implemented and whether it has proven efficacious in reducing addiction and/or preventing further criminal activity, critics have raised a number of other concerns. These also apply to the civil commitment and precondition to privilege models.

Inequity

A basic criminal justice principle is that the nature and duration of incarceration must relate to the purpose of confinement. This principle, however, has become muddled because of confusion over the purpose of confinement for addicts in the criminal justice system. For example, ambivalence as to whether the primary goal of the New York Narcotic Addiction Control Commission was protection of society *from* the addict or therapy *for* the addict resulted in basing the length of mandatory treatment on the severity of the criminal charge rather than on therapeutic considerations.[6,9]

If, on the other hand, the purpose of mandatory treatment is the conventional criminal justice goal of punishment, then Newman[29,30] has argued that it is inequitable to punish people differently who have been convicted of the same offense solely because one is an addict and one is not.

Inadequate Quality and Availability of Treatment in General and in Alternative Programs in Particular

The scarcity of drug treatment openings compared with the need for them has received much attention in this era of the acquired immunodeficiency syndrome.[31] This scarcity has been magnified for pregnant women who have been categorically excluded from most drug treatment programs.[31] Further, the National Institute on Drug Abuse documented a decade ago that most drug treatment programs failed to effectively include women by not offering services women specifically need, such as prenatal care.[32] The current need for drug treatment services for pregnant women and mothers far outweighs their availability.

In 1967, the Presidential Commission on Law Enforcement and the Administration of Justice stated that mandatorily imposed treatment must be substantive and distinguishable from imprisonment.[17] As a prerequisite to civil commitment for drug and alcohol dependency, 14 states require evidence that appropriate treatment is available, and five require that the treatment is beneficial. Many authorities in charge of child

protection mandate treatment for chemically dependent parents without first being sure that drug treatment services are available, nor do they ensure that these services can accommodate parents with child-care needs.[39]

Since analysts of the mandatory treatment experience in the United States describe the uneven quality of services that have been proffered under that rubric, some have questioned the constitutionality of compelling persons to partake in treatment of limited availability and questionable quality.[34]

Role Confusion

Critics of the New York Narcotic Addiction Control Commission have described the conflicts that criminal justice personnel undergo developing therapeutic relationships with their clients while also functioning as law enforcement agents toward them.[4] Is the therapist's primary responsibility to the patient, as is traditional in medicine, or is it to a third party (eg, employer, law enforcement, or child protective system)? This question is central since a therapeutic alliance between provider and patient is considered essential for therapeutic success.[35-37]

Another issue is whether to maintain the confidentiality that generally privileges a physician-patient relationship. Pompi and Resnick[37] describe how dependence on client referral from the criminal justice system may not only compromise the therapeutic integrity of the program but may also bias evaluation because program personnel may fear that reporting unsuccessful treatment outcomes might lead to fewer referrals and loss of revenue.

Blurring of roles has also occurred between professions, eg, when judges or probation officers make diagnoses, prescribe therapeutic regimens, or evaluate progress of treatment.[10-12] These many levels of confusion were reflected in the 1989 sentencing of Jennifer Johnson (for transfer of cocaine to a minor via the umbilical cord), which specified that she is to comply with a prenatal care regimen to be determined by her probation officer if she becomes pregnant within the 14-year probationary period.[38,39]

This role confusion applies to other clinicians as well, including obstetricians and midwives. This past decade has witnessed a host of initiatives to decrease infant mortality by attracting low-income, high-risk pregnant women into prenatal care. If they perceive providers of prenatal care as agents of the state, such women may avoid prenatal care.[40,41] The ambiguous position of the clinician reflects the central tension of whether the goal of mandatory treatment is improved status of the individual patient, protection of society, or punishment.

RELEVANCE OF THESE MODELS TO PREGNANCY

Mandatory treatment in the criminal justice context is intended to provide an alternative to trials and/or incarceration for those who have transgressed criminal laws. In 1962, the supreme court decided that the status of addiction per se did not render one liable to criminal prosecution.[42] Others have argued that adding the status of addiction to the status of pregnancy to construct a new criminal offense would violate the Eighth Amendment of the Constitution, as well as the due process protection of the 14th Amendment.[43,44] Justification for constructing such a criminal offense would require defining maternal addiction as conduct toward an "other," thus confronting the controversy over the status of the fetus and that of the pregnant woman.

Since the grounds for civil commitment are generally "danger to self or others," in order to justify commitment on the basis of pregnancy, it would be necessary either to determine danger to *self* or to describe the fetus as *other* (raising the issue of fetal status once again). Such concern about danger to self or others has not led to the imposition of drug treatment for (nonpregnant) intravenous drug users, even in the face of the drug-associated high risk of contracting and transmitting the human immunodeficiency virus. Nor is other medical treatment (eg, hypertension control) coercively provided to those at high risk of death from untreated disease.[45,46] Indeed, both the American College of Obstetrics and Gynecology and the American Medical Association have recently adopted positions opposing court-ordered medical treatment or penalty in response to behavior by a pregnant woman deemed to jeopardize fetal welfare.[47,48]

OPPOSITION TO MANDATORY TREATMENT

Opponents of compulsory treatment have voiced three categories of concern: (1) mandatory treatment of pregnant women will exacerbate discrimination against women and against poor minority women especially; (2) mandatory treatment will probably be clinically ineffective and may sabotage more promising approaches; and (3) there is no clear purpose to mandatory treatment of pregnant women.

The controversy over whether a pregnant woman and her fetus should be viewed separately, with discrete and even competing interests, has been made manifest in the imposition of blood transfusions and cesarean sections that have been performed on pregnant women against their will.[49] Both the American College of Obstetricians and Gynecologists and the American Medical Association have rejected this route because of respect for the pregnant woman's rights of privacy, autonomy, and bodily integrity, and because of a concern about adverse consequences for the physician-patient relationship.[48,50]

Critics posit that the potential impact of policies claiming to protect fetal welfare will be to significantly limit women's opportunities in many arenas, even limiting their status as full citizens. According to Mariner et al,[51] mandating pregnant women to treatment in the name of fetal interests elevates the asserted fetal claim above the established rights of the woman.

Moreover, these critics assert that these policies have been applied in a discriminatory fashion. A 1986 study of court-ordered cesarean sections revealed that 81% of the women were of a minority ethnic group, 24% did not speak English as their primary language, and 100% were clinic patients.[52] Approximately two thirds of prosecuted pregnant drug users surveyed in 1990 were from a minority group and all were poor.[53] In Florida, positive urine toxicology tests from pregnant black women were reported to health authorities at approximately 10 times the rate as those from white women.[54] A Minnesota judge declared that the creation of a special penalty for crack use was discriminatory because crack was used disproportionately by poor minority residents of inner cities (*New York Times*. January 11, 1991:B4).

Proponents of mandatory treatment often justify their position by citing the evidence that many addicted people seek treatment because of an external precipitating event related

to their drug use, eg, abandonment by a spouse, eviction, loss of child custody, arrest, or loss of job. In interviews of 150 drug-using mothers in New York City, almost two thirds said that they sought treatment after "bottoming out."[35] Advocates for compulsory treatment have therefore argued that addicts often seek treatment when the consequences of drug use become too unpleasant "to be worth it," and, thus, that external coercion often underlies initiation of treatment.

There is a subtle but crucial difference in where the locus for treatment initiation lies in these two models. Although external consequences may have motivated the addict to seek treatment in the bottoming out version, the motivation is nevertheless internalized. In the case of mandatory treatment, it is imposed. This not only differentiates between the two politically and morally, it also carries different prognoses for success. Passive resistance and active sabotage of compulsory treatment was described in the US Public Health Service experience[4] and again by Schottenfeld.[36]

Pregnancy has been described as a "window of opportunity" for treating addiction. Three quarters of the interviewed women reported concern for their child as a major motive for initiating treatment, and 80% reported concern as the motive for decreasing or stopping drug use during pregnancy. This suggests that pregnancy can indeed be a time when women may be motivated to tackle their addiction. Moreover, penalizing approaches that underscore guilt and shame may be counterproductive and deter women from use of such services, as 42% said that guilt and shame over their drug use was their principal reason for avoiding prenatal care.[35]

What then might be the purpose of mandatory treatment during pregnancy if it is not to punish a crime, protect self or others, or to obtain a privilege? An obvious goal would be to safeguard the fetus from exposure to toxic drugs. While this is clearly a significant aim, with medical, public health, and social dimensions, mandatory treatment does not appear likely to achieve it. For example, the duration of treatment in both the civil commitment and criminal justice experiences has often been for periods far shorter than the 40 weeks of term pregnancy. Barry[7] has questioned the efficacy of trying to protect fetal well-being by sending those who do not comply with treatment to prison, where drugs are readily available but prenatal care is not.[7]

Many women are not aware that they are pregnant until late in the first, or even until the second, trimester. This is more likely to be true for those who are subjected to hunger, infections, stress, and drugs, since these can lead to irregular menstrual cycles. Thus, to effectively safeguard fetuses from exposure to illicit drugs, treatment would have to be imposed on all addicted fertile women. This would present enormous practical problems since the current system cannot even meet the needs of those seeking treatment. Moreover, it would raise issues of gender discrimination similar to those posed by corporate policies excluding fertile women from the "toxic workplace," as exemplified by the Johnson Controls Inc case recently decided on by the Supreme Court.[46]

Restricting concern about consequences of parental drug use on offspring solely to fetal exposure during pregnancy ignores other routes and timing of exposure that may adversely affect future children. Preconceptional exposure of either parent to drugs might result in genetic or functional changes in sperm or ovum. Paternal exposure to drugs might be transmitted via the semen through intercourse with a pregnant woman.[47] There is, therefore, limited biologic plausibility to restricting compulsory treatment to pregnancy alone. Nor is there biologic plausibility to restricting concern for fetal welfare to in utero exposure to illicit drugs. Two licit drugs, cigarettes and alcohol, are among the more potent known fetotoxic agents.[48,49]

Might the purpose of mandatory treatment of a pregnant woman be to improve her level of parental functioning? Providing her with treatment and support while she raises her child might achieve that goal, while mandating treatment during pregnancy and discharging her post partum, especially with the relapse-provoking stresses of new motherhood, seems unlikely to attain it.[36] Such an approach also implicitly negates the role of the father. It not only assumes parental responsibility to be solely maternal, it also ignores the potential male contribution to female drug use. Many women report initiation into drug use by male sex partners, as well as sabotage of their efforts to abstain from drugs by their drug-using partners.[50] If the goal of mandatory treatment during pregnancy is to improve parental functioning, then its achievement requires including fathers and extending treatment beyond birth.

Of course, if mandatory treatment of a pregnant woman is for her own sake, there is no need to restrict it to pregnancy. The inconsistencies described herein underscore lack of clarity as to the fundamental purpose of compulsory treatment for pregnant women.

POLICY RECOMMENDATIONS AND COMMENTS

Both National Institute on Drug Abuse and World Health Organization researchers[1,4] have reached certain conclusions after reviewing the international experience with mandatory treatment, including the following:

1. Compulsory Treatment Cannot Overcome Deficits in Services.—Mandatory treatment in the face of insufficient treatment opportunities is likely to result in detention rather than rehabilitation and to exacerbate the shortages for other addicted people voluntarily seeking treatment. This dilemma is even more pronounced for pregnant women since their categorical exclusion renders access to treatment even more problematic for them than for addicted persons in general and because the limited treatment available is rarely appropriate to their needs.

2. Many Modalities of Treatment, Including 'After Care,' Should Be Available Because of the Chronic Relapsing Nature of Addiction.—Coordination between the health, social service, and drug treatment networks is essential if the pregnant woman is to be well served.

3. Once Treatment Is Available for Which There Is Evidence of Effectiveness, Then Widespread Outreach Efforts Need to Be Made to Induce People to Enter Treatment Voluntarily.—Outreach to pregnant women would have to overcome the fear of prosecution or loss of child custody and the feelings of guilt and shame that currently deter many pregnant addicts from seeking prenatal care or drug treatment.

4. One Can Compel Attendance But Not Meaningful Participation.—Psychological treatment requires the active participation of the patient in order for it to be effective.

5. If Compulsory Treatment Is to Take Place, There Should Be a Guarantee of Substantive and Procedural Rights, the Involuntary Period Should Be Limited and Subject to Review, and Evaluative Measures of the Effica-

cy of Such Mandatory Programs Should Be Conducted.— Legal justification for compulsory treatment because of pregnancy would have to resolve questions of sex discrimination, and outcome parameters for evaluation of efficacy need to be specified in terms of reduced drug use, reproductive outcome, or parental function.

CONCLUSIONS

There is a lack of rigorous research data to substantiate the effectiveness of compulsory treatment in general. Since neither outcomes nor comparison groups have been clearly specified, we lack a firm database from which to judge efficacy. There are some data suggesting that mandatory treatment may be associated with increased duration of treatment, but these have not been compared with alternative strategies to prolong treatment.

The evaluative efforts outlined have dealt almost exclusively with male subjects. Data from the National Institute on Drug Abuse document that treatment programs often fail to address the specific needs of female addicts, suggesting that it is incorrect to extrapolate to women from the experience of men in treatment. Pregnancy adds another dimension of specific need, presumably further limiting the relevance of studies with male subjects.

Data have repeatedly indicated that concern for children often motivates addicted women to seek drug treatment and that lack of services for children precludes women's ongoing participation.[32,35] There are also descriptive profiles of female addicts demonstrating a high prevalence of sexual and physical abuse histories.[36] The retention rate in treatment programs that are designed to respond to either of these needs has not been contrasted with retention associated with mandatory treatment, and we lack evidence to compare the efficacy of these different approaches. Since imposing mandatory treatment involves depriving the person of liberty, it should require demonstration of superior efficacy compared with less intrusive measures.

The general failure to define outcome parameters by which to assess mandatory treatment is even more obvious in the case of pregnancy because of the conceptual fuzziness characterizing the whole venture. Mandatory treatment specifically aimed at pregnant women does not correspond with any of the legal models invoked to justify its other applications.

Efficacy is only one measure to be considered when formulating policy; protection of constitutional rights and furtherance of public health and other social goals are critical yardsticks as well. Experience suggests that establishing policy to compel pregnant women into treatment may exacerbate current social inequities affecting women in general and poor minority women in particular. The lack of coherent theoretical or data-driven reasons to support mandatory treatment for pregnant women underscores why some suspect that its application may be discriminatory.

There are alternative strategies for decreasing fetal and maternal exposure to toxic drugs and for bolstering families. These include enhancing drug treatment services to better meet the needs of pregnant and parenting women and ensuring that such services are readily available and appear welcoming and useful to potential clients. Indeed, in the current context of the scarcity and poor quality of drug treatment programs for women/mothers, a debate over mandatory treatment is symbolic at best and is meaningless in practical terms. If pregnancy is indeed a window of opportunity for treating addiction, let us avail ourselves of it by first making high-quality voluntary treatment services for women widespread and visible. At this time, the children of drug-using mothers may be most effectively served by the development of available, efficacious, and welcoming services for women and families.

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45 *Id. See, also,* Atters, *Women and Crack: Equal Addiction, Unequal Care,* Boston Globe, Nov. 1, 1989, at 1, 4.

46 Malaspina, *Clean Living: An Innovative Residential Program Helps Pregnant Women with Drug Problems Take Control of Their Lives.* Boston Globe, Nov. 5, 1989 (Magazine), at 20.

47 Chavkin, *supra* note 44.

48 *Id.*

49 Malaspina, *supra* note 46.

50 About 375,000 infants are born to drug-using mothers each year in the United States, according to a 1988 study by the National Association for Perinatal Addiction Research and Education. *Id.* at 20. That exceeds the total number of treatment slots for all addicts—male and female—in the country.

51 A prison sentence would make clear that the prosecution was intended to punish, not to help, the woman because drugs are easy to get in most prisons.

52 Forty percent of the more than 300 hospitals boarder babies awaiting placement daily in New York City were there because of maternal drug use. C. Driver, W. Chavkin & G. Higginson, Survey of Infants Awaiting Placement in Voluntary Hospitals 1986-87 (New York City Dept. of Health, New York, NY 1987).

53 Field, *supra* note 6; Johnsen, *supra* note 36.

When Becoming Pregnant Is a Crime

LYNN M. PALTROW

[A]s healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race.[1]

In 1907, the state's concern for "vigorous offspring" combined with paternalistic views of women led the Supreme Court in *Muller v. Oregon,* to uphold protective labor legislation which discriminated against women and excluded them from the work force. Today, "vigorous offspring" have once again become the "object of public interest" but now criminal prosecutions are being used to ensure "healthy mothers."

Although such prosecutions were once relatively rare, an increasing number of women are being arrested for pregnancy-related behavior deemed potentially harmful to the fetus. Women who allegedly threaten "the strength and vigor of the race" face not just unemployment[2] but also criminal prosecution under unprecedented interpretations of child abuse and drug trafficking statutes. The first widely publicized criminal prosecutions of pregnant women occurred in the mid-nineteen-eighties; today there are at least thirty-five cases around the country, and the trend is growing.[3] According to an article in *U.S.A. Today,* "experts expect hundreds more cases."[4]

Prosecutors in two South Carolina cities, Greenville and Charleston, have been particularly zealous in bringing these cases. In both places, individuals at local public hospitals joined with state officials to establish a procedure for prosecuting pregnant women who tested positive for the presence of illicit substances. In Charleston, women who come into the public hospital for prenatal care or delivery are selectively tested for drugs; those who test positive have their names turned over to the police. The police then go to the hospital. The women, who are still recovering from the delivery, are handcuffed and taken to jail and stay there until they can make bail. At least one woman arrived at the jail still bleeding from the delivery; she was told to sit on a towel.[5]

Like the South Carolina prosecutions, most of the cases in other states have involved allegations of illegal drug use during pregnancy. However, none of the women have been arrested for the crime of illegal drug use or possession. Instead, they are being arrested for a

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new and independent crime: becoming pregnant while addicted to drugs. These women are being prosecuted for crimes which carry significantly greater penalties than mere possession or use: the biological event of conception transforms the woman from drug user into a drug trafficker or child abuser. Because these prosecutions penalize a woman for her decision to continue a pregnancy, they violate constitutional privacy guarantees that protect the right to decide "whether to bear or begat a child."[6]

Prosecutors argue that the purpose of these arrests is to get women to stop using drugs, not to end their pregnancies. But as Representative George Miller concluded after Congressional research and hearings on the subject, "[w]omen who seek help for drug addiction during pregnancy cannot get it."[7] For example, in a survey of drug abuse treatment programs in New York City, Dr. Wendy Chavkin found that 54 percent of the city's drug programs will not accept any pregnant women; 67 percent denied treatment to pregnant addicts on Medicaid;

For a woman accused of prenatal child abuse, the only option may be an abortion.

87 percent denied treatment to pregnant women on Medicaid specifically addicted to crack.[8] Dr Chavkin further reported that "[l]ess than half of those programs that did accept pregnant women made arrangements for prenatal care and only two provided child care, despite research by the National Institute for Drug Abuse demonstrating that lack of child care effectively precludes the participation of women in drug treatment."[9]

The lack of appropriate drug treatment programs for women is a nationwide problem. Ann O'Reilly, Director of Family and Children's Services for the San Francisco Department of Social Services stated, "If these mothers were walking away from treatment, I might feel differently, but they are not walking away from treatment—they're walking away from waiting lists."[10]

Moreover, ending an addiction without help is virtually impossible. According to Martha Nencioli, a clinical nurse who counsels pregnant women seeking drug treatment, "very few women can stop on their own."[11] As one formerly addicted woman testified in recent congressional hearings:

> I can tell you that drug addicts are human beings who have the same hopes and dreams that you do. Drug-addicted mothers love their children just like any other mother. I love my children. But it is just not easy to stop using drugs. It has taken a long time and a lot of treatment for me to reach this point in my recovery. Recovering from any kind of addiction is a long-term process, fraught with relapse. It takes a tremendous support system.[12]

A woman unable to get help for her addiction or who is in the middle of the "long-term process" of overcoming an addiction problem may be held criminally liable simply for becoming pregnant and continuing it to term. In *State of Florida v. Johnson*,[13] Jennifer Johnson was convicted of delivery of an illegal substance to a minor. The prosecutor argued that cocaine was delivered to the infant through the umbilical cord during the moments after birth but before the cord was cut. In his closing argument, however, the prosecutor made clear that Johnson's real crime was not delivery of drugs but the delivery of her child: "When she delivered that baby, she broke the law in the State." The court agreed with this formulation of the "crime," noting that Jennifer Johnson "made a choice to become pregnant and to allow those pregnancies to come to term."[14]

For a woman accused of prenatal child abuse, the only option to avoid prosecution or imprisonment may be an abortion. In Washington, D.C., a woman mysteriously "miscarried" days before a hearing which had been scheduled by a judge who had threatened to put her in jail because he believed she was using drugs while pregnant.[15] But many poor women cannot afford an abortion,[16] whether it is coerced by threats of imprisonment or conscientiously and freely chosen as an ethical act.[17] Yet all of the recent prosecutions of pregnant women have been brought against poor women, several of them battered, more than half of them women of color.[18]

Treating pregnancy as a conflict between maternal and fetal rights leads inevitably down a slippery slope. Prosecutions of pregnant women cannot rationally be limited to illegal conduct because many legal behaviors cause damage to developing babies. Women who are diabetic or obese, women with cancer or epilepsy who need drugs that could harm the fetus, and women who are too poor to eat adequately or to get prenatal care could all be characterized as fetal abusers. Pregnant women engage in all sorts of behaviors that could expose their fetuses to harm, including flying to Europe[19] and cleaning their cat's litter box.[20] As the Supreme Court of Illinois observed:

If a legally cognizable duty on the part of mothers were recognized, then a judicially defined standard of conduct would have to be met. It must be asked, by what judicially defined standard would a mother have her every act or omission while pregnant subjected to State scrutiny? By what objective standard could a jury be guided in determining whether a pregnant woman did all that was necessary in order not to breach a legal duty to not interfere with her fetus' separate and independent right to be born whole? In what way would prejudicial and stereotypical beliefs about the reproductive abilities of women be kept from interfering with a jury's determination of whether a particular woman was negligent at any point during her pregnancy?[21]

Because no woman can provide the perfect womb, criminal prosecutions come dangerously close to turning pregnancy itself into a crime.

But aren't some behaviors, like illegal drug use, so clearly harmful that they can be singled out? Replacing assumptions with facts makes it clear that neither drugs nor any other substance can be considered in isolation. The extent of harm from a particular drug depends on the quantity, timing, and form of the drugs used, the health of the woman using them, and her access to prenatal health care. According to a 1985 Orlando, Florida report on prenatal care, "[i]n the end, it is safer for the baby to be born to a drug-abusing, anemic or diabetic mother who visits the doctor throughout her pregnancy than to be born to a normal woman who does not."[22]

In *In re J. Jeffrey*,[23] a probate court judge removed a child from its mother for neglect several months after its birth based on her alleged use of "illegal drugs." The petition alleged that during the last few weeks of her pregnancy, the woman had taken four non-prescription

Line-drawing at illegal drug use will not protect pregnant women from unjustified state intrusion.

valium to relieve the pain from injuries she had sustained in an automobile accident; the infant was born intoxicated but not addicted. The woman had no history of drug addiction, and the later drug screens to which she agreed were negative. In addition, she had no history of neglect or even of previous contact with protective services for her two other children. Nevertheless, it took over a year for the woman to get her baby back. Although this was a family court action for neglect, not a criminal proceeding, it illustrates that line-drawing at illegal drug use will not protect pregnant women and their children from unjustified and counter-productive state intrusion.

In fact, these prosecutions are not limited to pregnant women who engage in illegal behavior. In Laramie, Wyoming, Diane Pfannenstiel, a pregnant woman, was arrested for child abuse when she admitted to the police that she had been drinking alcohol. Pfannestiel had appeared at a police station in order to file a claim

It is clear that legislatures never intended to create a duty of care owed by pregnant women to the fetus.

against her husband for battering her; she was concerned that his continued abuse would endanger her pregnancy.[24] And in 1985, Pamela Rae Stewart was charged with "failing to follow her doctor's advice" to stay off her feet, to refrain from sexual intercourse, refrain from taking street drugs, and seek immediate medical attention if she experienced difficulties with the pregnancy.[25] The only illegal act alleged was the use of "street drugs," based on the presence in her blood of a substance that could have come from an over-the-counter antihistamine. The prosecutors later admitted that her non-criminal behaviors were the basis for the prosecution because drugs had little if anything to do with the baby's injuries.[26] These prosecutions threaten to open the door to wholesale invasions of women's rights to bodily integrity, self-determination, and privacy.

These prosecutions also violate basic principles of due process of law. Prosecutors justify cases premised on a woman's drug use during pregnancy with the claim that any person who uses illegal drugs commits a crime. Yet, in none of these cases has the state been required to prove that the woman has actually committed the underlying crime of drug possession. Moreover, it is abundantly clear that the legislatures never intended the statutes on which these prosecutions have been based to create a duty of care owed by pregnant women to the fetus, enforceable through the criminal law. Women have been arrested under criminal child support statutes and for child abuse, child neglect, manslaughter, and delivery of illegal substances to minors. All of these

statutes were created to provide state protection to born persons from post-birth actions. Thus, at a minimum these women's due process rights have been violated because there was simply no notice that these laws would apply to them.

These cases also raise serious questions about prosecutorial ethics. The American Bar Association Standards for Criminal Justice states that "the duty of the prosecutor is to seek justice, not merely to convict."[27]

A law which interferes with a fundamental privacy right must withstand searching judicial examination.

The provision concerning noncriminal disposition of cases also states that "prosecutors should be familiar with the resources of social agencies. . . ."[28] But when prosecutors know or should know that drug abuse treatment for women is unavailable and that the statutes they are using were not enacted to punish addicted women for becoming pregnant, how are the interests of justice being served? Statements like one made by the Muskegon County, Michigan attorney that the "main concern is to send a message to drug abusers that they should seek treatment before the criminal justice system has to become involved"[29] seems self-serving at best when treatment is unavailable in the first place.

But even if statutes were passed with the express intent of criminalizing pregnant women's behaviors, such laws in all likelihood would fall as unconstitutional. A law which interferes with a fundamental privacy right must withstand searching judicial examination. For the law to survive, the state must establish that it has a compelling interest and must demonstrate that the law is narrowly tailored and furthers the asserted interest.[30]

In most of these cases the asserted state interest is in the fetus. However, the Supreme Court has held that at no stage of development is a fetus a "person" with rights separate from the woman.[31] Neither legally nor biologically are fetuses independent parties with rights enforceable against the woman. As the Illinois Supreme Court observed:

> It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus. As opposed to the third-party defendant, it is the mother's every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant woman's fault: it is a fact of life.[32]

These prosecutions seek to create what the Illinois Supreme Court has called the "legal fiction" that the fetus "is a separate legal person with rights hostile . . . to the woman."[33]

But whether the asserted state interest is in fetal rights or in the health and well-being of women and children, the state would be unable to prove that such a statute would improve either maternal or fetal health through the least intrusive means. If prosecutions actually frightened women into going cold turkey (and they don't), abrupt withdrawal from certain drugs, such as heroin, could cause fetal death. Putting women in prisons, where drugs may still be available,[34] and where there is neither drug abuse treatment nor prenatal health care, will not further any legitimate health interest.[35] And even if prosecutors could prove that the outcome of a few pregnancies was improved as a result of threatening or imprisoning pregnant women, it would not justify the imposition on women's freedom that results from treating them like incubators.

In reality, prosecutions and convictions deter pregnant women from getting what little health care is available. As Senator Herb Kohl stated at Congressional hearings on perinatal substance abuse, "[m]others—afraid of criminal prosecution—fail to seek the very prenatal care that could help their babies and them."[36] In San Diego, after Pamela Rae Stewart was prosecuted, health care workers reported that patients became distrustful, believing that they would be turned in. Some potential patients refused to come in for treatment.[37] According to Ricardo Quiroga, who is helping to set up an alcohol recovery house for Hispanic women with children in Massachusetts, women "don't want to seek help for fear they will lose their children."[38] The State of Minnesota recently enacted a law which, among other things, requires hospital officials to report to the local welfare agency pregnant women who have or are believed to

Neither legally nor biologically are fetuses independent parties with rights enforceable against the woman.

have used a controlled substance during pregnancy. The National Association on Perinatal Drug Addiction and Research (NAPARE) has already observed that women are being deterred from seeking prenatal care because of this statute.[39]

Those women who do seek care are often too frightened to speak openly to their doctors about their problems. In Florida, for example, after "[u]niformed officers wearing guns entered Bayfront Medical Center . . . to investigate new mothers suspected of cocaine abuse," doctors reported that they could no longer "depend on the mothers to tell them the truth about their drug use . . . because the word ha[d] gotten around that the police will have to be notified."[40]

Rather than promoting any legitimate state interest, much less a compelling one, these prosecutions are undermining public health, a fact reflected by the increasingly outspoken opposition of public health organizations to these prosecutions. For example, fourteen public health and public interest groups, including the American Public Health Association, the American Society of Law & Medicine, the National Association of Alcoholism and Drug Abuse Counselors, the American Society of Addiction Medicine, and the National Association for Perinatal Addiction Research (NAPARE), recently sought to file *amicus* briefs in opposition to the conviction of Jennifer Johnson. These groups share the assessment of the Committee on Ethics of the American College of Obstetricians and Gynecologists, whose 1987 opinion stated that "inappropriate reliance on judicial authority may lead to undesirable societal consequences, such as the criminalization of noncompliance with medical recommendations."[41] This statement was intended as a basis for opposing "legal actions against women because they are pregnant and engage in behavior possibly detrimental to the fetus."[42]

Prosecutions of pregnant women may also violate the fourteenth amendment's guarantee of equal protection. While the state can and should enforce against pregnant women criminal laws that apply to the general population, any governmental action that singles out women for special penalties solely because they become pregnant discriminates on the basis of gender.[43] These prosecutions may also raise race discrimination claims or, at the very least, issues of selective prosecution because so many of them are directed against poor women of color. A recent study conducted by NAPARE in Pinellas County, Florida, found that, although the rate of drug use by Black women and white women was the same, Black women were reported for their drug use ten times more often than white women.[44]

It is understandable that prosecutors and others are upset or angry that babies are being born with disabilities that in some cases could have been prevented. What is less understandable is why that anger is so easily and exclusively directed against the mothers. While no one views those who run drug abuse programs that turn away pregnant women or those who consistently underfund them as fetal abusers, many are willing to condemn outright pregnant women as selfish people intent on hurting their developing babies.[45]

But pregnant women who are drinking excessively, abusing drugs, smoking, or eating inadequately are first and foremost hurting themselves. In our rush to blame women for their failure to take care of others we are missing the point that they have never been encouraged to "selfishly" care for themselves. One reason predominately male or coed drug treatment programs do not work for women may be that the women "assume caretaker or partner roles and neglect their own recovery."[46] For example, while a woman was at New Day, one of the country's only residential drug abuse programs run by and for women, the father of her child called to tell her that he had been arrested for possession of cocaine. She explained, "I'm the one who always bailed him out," but "[t]his time, she told him, she had to take care of *herself*."[47]

The last thing we should do is turn pregnant women and mothers into criminals.

Phyllis Savage, the Family Center Director at Odyssey House, New York City's only drug treatment program where mothers and small children can live together, explained that the lives of the twenty-one women in the program "have never been anything but hellish." "[A]ll they know is rage and anger and abuse. . . This is the first place that many of our women have been where they can't get hit."[48] Research has shown that 80 to 90 percent of female drug addicts and alcoholics have been victims of rape or incest.[49]

If what we really want to do is help women and children, the last thing we should do is turn pregnant women and mothers into criminals. As Dr. Ira Chasnoff, an expert on perinatal addiction has stated: "[T]he public must be assured of *non-punitive*, comprehensive care which will meet the needs of the pregnant woman

who is a substance abuser."[50] Real solutions would include making available reproductive health services, including abortion, sex and parenting education, and prenatal and other health care.[51] Non-discrimination policies must be adopted and enforced in existing drug treatment programs and more funds, including the money which is presently being used to arrest women and place their children in foster care, must be made available for drug treatment and education. And, finally, prosecutors and lawmakers must stop pretending that the criminal prosecution of pregnant women is a quick fix for the problems of drug addiction when we have known for years that drug abuse, like most other causes of infant mortality and morbidity, requires long-term solutions involving significant societal commitments to rehabilitation, treatment, and education.[52]

NOTES

The author would like to thank Hilary Fox and Louise Melling for their excellent editorial assistance.

1 Muller v. Oregon, 208 U.S. 412, 421 (1907).

2 International Union v. Johnson Controls, 886 F.2d 871 (7th Cir. 1989). In this case, the Seventh Circuit *en banc* upheld a "fetal protection" policy which prohibits hiring of any women with childbearing capacity into those jobs in which lead levels are defined as excessive. The policy applies to "all women except those whose inability to bear children is medically documented," even those who do not plan or want to have children. As the dissenters pointed out, as many as "20 million industrial jobs could be closed to women, for many substances in addition to lead pose fetal risks." 886 F.2d at 920 (Easterbrook, J. dissenting).

3 An updated list of cases can be obtained from the American Civil Liberties Union's Reproductive Freedom Project, 132 W. 43rd Street, New York, New York 10036.

4 *It's the Tip of Iceberg in Protecting Infants*, U.S.A. Today, Aug. 25, 1989.

5 Ellen Goetz & Hilary Fox, *ACLU Reproductive Freedom Project Initial Report: Poor and Pregnant? Don't Go to South Carolina* (February 1, 1990).

6 Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

7 *Born Hooked: Confronting the Impact of Perinatal Substance Abuse: Hearing Before the Select Committee on Children, Youth and Families*, 101st Cong., 1st Sess. 2 (April 27, 19890) (opening statement of Congressman George Miller, Chairman, Select Committee on Children, Youth and Families).

8 Chavkin, *Help, Don't Jail, Addicted Mothers*, N. Y. Times, July 18, 1989, at A21.

9 *Id.*

10 LaCroix, *Birth of a Bad Idea: Jailing Mothers for Drug Use*, The Nation, May 1, 1989.

11 Malaspina, *Clean Living*, Globe Magazine, Nov. 5, 1989, at 20.

12 *Missing Links: Coordinating Federal Drug Policy for Women, Infants and Children: Hearing before Senate Comm. on Governmental Affairs*, 101st Cong., 1st Sess. 1 (1989) (testimony of Elaine Wilcox) [hereinafter cited as *Missing Links*].

13 State of Florida v. Johnson, No. E89-890-CFA, (Fla. Cir. Ct. July 13, 1989), appeal docketed, No. 89-1765 (Fla. Dist. Ct. App. Aug. 31, 1989).

14 *Id.*

15 Letter from Sam W. Burgan, Esq., to Lynn Paltrow (Jan. 22, 1990) (on file with the ACLU Reproductive Freedom Project.)

16 Contraceptive services are not readily available to poor women in this country. Smits, *Women, Health and Development: An American Perspective*, 104 Annals of Intern. Med. 2, 3 (1986). Moreover, there is no federal funding for abortion and most states do not provide it either. Gold & Guardado, *Public Funding of Family Planning, Sterilization and Abortion Services, 1987*, 20 Family Planning Perspectives, 228, 233 (1988).

17 Some women who choose to have an abortion do so because they feel they cannot responsibly continue their pregnancies while suffering from an addiction or other health problem. As one woman explained:

> In February, 1982, I had an abortion. . . .
>
> I was 38 years old, married with two children. We were and are still a typical suburban family—as far as the outside world can see. But life was not ordinary for us in 1982. I was (I am) chemically addicted to the drug alcohol. Beginning in October, 1981 I made my first feeble attempts at recovery from alcoholism . . . . I wandered in and out of AA meetings . . . .
>
> In the midst of this rollercoaster ride of addiction—in February, 1982, I realized I could be pregnant . . . . I was frantic, frightened, drained physically, emotionally, spiritually from my alcoholism. I could not manage my *own* life. The prospect of a baby was overwhelming . . . . I chose to have an abortion . . . .
>
> I continued efforts toward recovery, and with the help of support of AA, I have not had a drink since April 13, 1982.

Excerpt from Brief for the *Amici Curiae* Women Who Have Had Abortions and Friends of *Amici Curiae* in Support of Appellees at L-216 by Sarah E. Burns, NOW Legal Defense and Education Fund. Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989) (No. 88-605).

18 Coakley, *Suspect Is Said to Be Battered, Frightened*, Boston

Globe, Aug.. 23, 1989, at 22. Bonavoglia, *The Ordeal of Pamela Rae Stewart*, Ms., Aug. 1987, at 92, 95. Levendosky, *Turning Women into 2-Legged Petri Dishes*, Sunday Star Tribune, January 21, 1990, at A8.

19 Wald, *Radiation Exposure is Termed a Big Risk for Airplance Crews* , N.Y.Times, Feb. 14, 1990, at 1A. Because of concern about the effect of radiation from the sun and the stars on airline crews and passengers, Dr. Gineran, a researcher, advised: "If I were a woman in the critical period of pregnancy for retardation, I would tend to avoid flights to Europe." *Id.*

20 Pregnant women who come into contact with cat feces or raw meat can be exposed to toxoplasmosis. This parasitic disease can cause serious damage to the developing baby often resulting in abortion, prematurity, or death. A.. GUTTMACHER, PREGNANCY, BIRTH AND FAMILY PLANNING 188-89 (I. H. Kaiser rev. and updated ed. 1984).

21 Stallman v. Youngquist, 531 N.E.2d 355, 360 (Ill. 1988).

22 *Taxpayers Pay for Lack of Prenatal Treatment*, St. Petersburg Times, Nov. 3, 1986, at 7B.

23 No. 99851 (Mich. Ct. App. filed Apr. 9, 1987).

24 *State of Wyoming v. Pfannenstiel*, No. 1-90-8CR (Laramie County Ct. complaint filed Jan. 5, 1990); Levendosky, *supra* note 18.

25 M. Konon, *Data Access to Fetus Case Put on Hold*, San Diego Tribune, Oct. 24, 1986, at B1, B12.

26 Schacter, *Help Is Hard to Find for Addict Mothers*, L. A. Times, December 12, 1986, § 2, at 2.

27 Standard 3-1.1(c).

28 Standard 3-3.8.

29 Jacquelyn Boyle, *ACLU to Defend Mom on Charge of Delivering Crack-Addict Baby*, Det. Free Press, Oct. 28, 1989.

30 *See, e.g.*, Akron v. Akron Center for Reproductive Health Servs., 462 U.S. 416, 427, 430-31 (1983).

31 *Roe v. Wade*, 410 U.S. 113, 162 (1973).

32 Stallman v. Youngquist, 531 N.E.2d 355, 360 (Ill. 1988).

33 *Id.*

34 Malcolm, *Explosive Drug Use Creating New Underworld in Prisons*, N. Y. Times, Dec. 30, 1989, at 1.

35 According to Ellen Barry, Director of San Francisco's Legal Services for Prisoners with Children, "incarceration of a pregnant woman is a potential death sentence to her unborn child." Cited in McNulty, *Pregnancy Police: the Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. OF LAW & SOC. CHANGE, 277, 308 n.209. *See also* Barry, *Quality of Prenatal Care for Incarcerated Women Challenged*, 6 YOUTH L. NEWS , Nov.-Dec. 1985, at 1, 2-3 .

36 *Missing Links, supra* note 12, at 5 (opening statement of Senator Herb Kohl).

37 Affidavit, Cathy Hauer, People v. Stewart, No. M508197 (Municipal Court, County of San Diego, Feb. 26, 1987).

38 *Supra* note 8, at 20.

39 Affidavit of Ira J. Chasnoff, M.D., submitted in support of Defendant's Motion to Dismiss Indictment, People v. Hardy, No. 87-2931-F7 (Mich. Dist. Ct. Dec. 5, 1989).

40 *Angry Doctors Cut Drug Tests After Police Interview Moms*, St. Petersburg Times, May 13, 1989, at 1B.

41 A.C.O.G. Committee on Ethics, *Committee Opinion: Patient Choice: Maternal Fetal Conflict*, Number 55, October 1987.

42 Correspondence from Elaine Locke, Associate Director, The American College of Obstetricians and Gynecologists, to Kary Moss and Lynn Paltrow, December 4, 1989.

43 Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After* Webster, 138 U. PA. L. REV. 179, 203-04 (1989).

44 Holly, *Study: Race Affects Drug-abuse Testing*, Miami Herald, Sept. 19, 1989, at 2B; *Black Cocaine Mothers Likely to Be Turned In*,The Orlando Sentinel, Nov. 21, 1989.

45 The ACLU Women's Rights Project, however, has recently filed a lawsuit on behalf of women turned away from drug abuse treatment programs in New York. Elaine W. v. North General, No. ___ (N.Y. Sup. Ct. filed Nov. 23, 1989).

46 Malaspina, *supra* note 11; Leff, *Treating Drug Addiction with the Woman in Mind*, The Washington Post, March 5, 1990, at E1.

47 *Id.* (emphasis added).

48 *Id.*

49 Leff, *supra* note 46.

50 *Missing Links, supra* note 12, at 5 (testimony of Ira Chasnoff).

51 "National estimates show that one out of every five women of childbearing age has no maternity care coverage, either through government programs or private health insurance." W. LAZARUS & K.WEST, BACK TO BASICS: IMPROVING THE HEALTH OF CALIFORNIA'S NEXT GENERATION 23-24 (Southern California Child Health Network, 1987).

52 *Experts Find New Hope on Treating Crack Addicts*, N. Y. Times, Aug. 24, 1989, at 1. The infant mortality rate in the United States is the worst among the eighteen industralized nations. The National Commission to Prevent Infant Mortality called for "universal access" to early maternity and pediatric care for all mothers and infants. Associated Press, *U.S. Panel Urges Universal Access to Prenatal Care*, Boston Globe, August 16, 1989.

Mr. SOUDER. Thank you very much for your testimony. Chairman Hastert is coordinating our health bill, which we're going to have to vote on tomorrow morning, so he's busy trying to keep the coalition together. But I know he visited your facility and was very impressed.

Dr. Feinberg.

Dr. FEINBERG. Good afternoon, Mr. Chairman, Congressman Barrett. Thank you for inviting me to testify today. My name is Dr. Francine Feinberg, and I am the executive director of Meta House in Milwaukee, WI. Meta House is a community-based residential program that treats alcohol and drug problems for pregnant, postpartum women, and women with their children.

Prenatal alcohol and drug use is a serious public health problem, and we are all in agreement that something should be done to treat it. Meta House and many other treatment centers for pregnant women and women with children throughout the Nation recognized this problem many years ago. And now we have an enormous amount of experience addressing it.

I'm here to tell you that we are succeeding, but I'm also here to tell you that based on both the research and my 15 years of experience, the primary reason many pregnant women with alcohol and drug abuse problems do not seek prenatal care or treatment for their addiction is fear of being turned into the authorities and ultimately losing their children. The approaches of Wisconsin and South Carolina confirm these fears.

Meta House has already seen a dramatic drop in the number of pregnant women seeking treatment. Recently, two pregnant women left treatment because we were unable to convince them that we would not turn them over to the authorities. In an attempt to help a few women and their children, these approaches will adversely impact many others who would have sought help, but now will hide in fear.

It is possible to get expectant mothers into treatment and have positive birth outcomes. At Meta House we strive to achieve two goals. We help mothers deliver healthy drug free babies, and to provide these children with a mother who can then give them the physical and emotional support necessary to help them mature into healthy adults.

Meta House has consistently achieved both these goals. During a 4 year period, 50 babies were born while their mothers were in treatment at Meta House—all were born drug free. Within a 2-year period, 205 children who had been in foster care were returned to their mothers either during treatment or very soon thereafter. An evaluation of Meta House by an objective outside organization concluded that 85.5 percent of the women at Meta House no longer use cocaine 2 years after treatment. In addition to that, over 81 percent of the Meta House clients were either gainfully employed or successfully engaged in Wisconsin's Welfare to Work Program.

Meta House successes are typical of women's treatment services across the country. According to the 1996 data from the Center for Substance Abuse Treatment's Pregnant, Postpartum Women and Infants Program, over 86 percent of their children were living with their mothers, and over 67 percent of the women were not using drugs or alcohol.

Pregnancy provides a window of opportunity for women with alcohol and drug problems. Every day at Meta House we get phone calls from women who are pleading for help. They literally say they are afraid they are going to hurt their babies with their drug use, and they want treatment. But now when they call, they ask if we're going to turn them in. This is not a simple issue.

Pregnant and parenting women who use drugs often have very complex histories. Over 95 percent of the women in treatment at Meta House of a history of being brutally abused—sexually and by other types of violence. Over 65 percent of the women also have a mental health diagnosis in addition to their alcoholism and drug dependence. And poverty often exacerbates the stress and illness that many of these women and their families face.

The treatment offered at Meta House helps to reduce and alleviate many of these problems. The women stay at Meta House from 9 to 18 months, and participate in an expanded after care program. During the residential stays, women to learn to identify what feelings are behind their addiction and then how to cope with these feelings. They learn about health care, nutrition, parenting, and all the other basic living skills. They also can resume their education and find employment in housing. In addition to that, Meta House also provides all the services that are necessary for the children to help them recover from the effects of substance abuse, and also to prevent these children from using drugs in the future.

The data certainly demonstrates that appropriate treatment does work for the child and the family, as well as for the mother. I would encourage this subcommittee to support treatment. This can be done by supporting the increases allocated by the House Appropriations Committee to public alcohol and drug treatment and prevention funding. In Milwaukee County, funding has already been stopped on many occasions. We are already capped at 44 people for only 3 months of treatment.

Health and substance abuse professionals agree that providing alcohol and drug treatment to pregnant and women with children is the most effective way to reduce the negative impact of substance abuse on children, their mothers, and their family. However, policies that are punitive in nature, such as Wisconsin's and South Carolina's are not only ineffective in addressing substance abuse, they actually may increase the likelihood of negative birth outcomes for children of addicted mothers.

Exemplary public policy focuses it's impact on the good that it does for the majority of the people affected. Meta House and other programs of it's kind have demonstrated their confidence to produce long term changes in women's ability to raise their children and to live drug free, law abiding lives.

For these reasons, we need legislation that will help women feel safe so they will access their prenatal care and enter treatment. We must increase the appropriate treatment opportunities for pregnant women and women with children. It is imperative and the most sensible public policy to support.

Thank you for providing me with the opportunity to testify, and I too would be happy to answer questions.

[The prepared statement of Dr. Feinberg follows:]

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Testimony of

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of

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Before the

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Subcommittee on National Security, International Affairs and Criminal Justice

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Introduction

Good morning Chairman Hastert, members of the Subcommittee and Congressman Barrett, my Congressman. Thank you for inviting me to testify today. My name is Dr. Francine Feinberg, and I am the Executive Director of Meta House in Milwaukee, Wisconsin. Meta House is a community-based, residential alcohol and drug treatment program for pregnant and postpartum women and women with their children.

Prenatal alcohol and drug use is a serious public health problem. We are all in agreement that something should be done to treat it. Meta House and many other treatment centers for pregnant women and women with children throughout the nation recognized this problem many years ago and now have an enormous amount of experience addressing it. And I am here to tell you that we are succeeding. The current approaches in Wisconsin and South Carolina, while perhaps well intended, will have a devastating impact on the birth outcomes of expectant women with alcohol and drug problems. Based on both the research and my 15 years of experience, the primary reason pregnant women with alcohol and drug problems do not seek prenatal care or treatment for their addiction is fear of being turned into the authorities and ultimately losing their children. The approaches of Wisconsin and South Carolina confirm their fears. Meta House already has seen a dramatic drop in the number of pregnant women seeking treatment. Recently two pregnant women left treatment because we could not convince them that we would not turn them over to authorities. In an attempt to help a few women and their children, these punitive approaches will adversely impact many others who will now hide in fear.

It is possible to get expectant mothers into treatment and have positive birth outcomes.

Alcohol and Drug Treatment for Pregnant Women and Women with Children Works

At Meta House we strive to achieve two goals: 1) to help mothers deliver healthy, drug-free babies and 2) to provide these children with a mother who can give the physical and emotional support necessary to help them mature into healthy adults. Meta House consistently achieves both these goals. Let me share some of our successes:

- During a four-year period, **50** babies have been born while their mothers have been in treatment at Meta House - all were born drug-free.
- Within a two-year period, **205** children who had been in foster care were returned to their mothers either during treatment or soon thereafter.
- An evaluation of Meta House by an objective, outside organization concluded that over **85.5%** of women no longer used cocaine two years after treatment.
- After treatment, **81.6%** of Meta House's clients were either gainfully employed or engaged in Wisconsin's welfare-to-work program.

Meta House's successes are typical of women's treatment services across the country. According to 1996 data for the Center for Substance Abuse Treatment's (CSAT) Pregnant and Postpartum Women and Infants programs, after treatment:

- **86.5%** of children were living with their mothers
- **67.4%** of women were not using drugs or alcohol
- **90.3%** of women were not involved with the criminal justice system
- Employment of women increased by **820%**

Treatment at Meta House

Pregnancy provides a window of opportunity for women with alcohol and drug problems. Every day at Meta House we get phone calls from women who are pleading for help. They literally say that they are afraid that they are going to hurt their babies without treatment. When women find out that they are pregnant they want their babies to be healthy. Now they ask if we are going to turn them in.

Pregnant and parenting women who use drugs have complex histories. Over 95% of the women in treatment at Meta House have a history of being brutally abused sexually and by other types of violence. Over 65% of the women also have a mental health diagnosis in addition to their alcoholism and drug dependence. Poverty exacerbates the stress and illness that many of these women and their families face.

The treatment offered at Meta House helps to reduce and alleviate many of the problems that these women face. Women stay at Meta House from 9 to 18 months and participate in an extended aftercare program for support. During residential stays at Meta House, women learn to identify what feelings are behind their addiction and how to cope with these feelings. Women learn about health care, nutrition, and parenting. They also resume their educations and find employment and housing. Meta House also provides children with services that help them recover from the effects of substance abuse and help to prevent these children from using drugs in the future.

The data discussed above demonstrates that treatment works for the child and family as well as for the mother.

The Negative Effects of Punitive Approaches

Health and substance abuse professionals agree that providing alcohol and drug treatment to pregnant women and women with children is the most effective way to reduce the negative impact of substance abuse on children, their mothers and their families. The experience of Meta

House and similar programs demonstrates that the cooperation of the woman is a key component to her successful recovery. Policies that are punitive in nature, such as Wisconsin's and South Carolina's, do not effectively address substance abuse and actually increase the likelihood of negative birth outcomes for children of addicted mothers.

As I stated, research indicates that the number one barrier to treatment for women is fear of losing their children. I have discussed the Wisconsin law with the women at Meta House and they view it as an attempt to punish them. They indicated that because of this law they would be reluctant to seek prenatal care and treatment for their alcohol and drug problems. One woman stated, "A lot of babies are gonna be born at home." The other women nodded their heads in agreement. Wisconsin's attempt to capture the few pregnant women who refuse treatment is scaring away those pregnant women who want and need prenatal care and alcohol and drug treatment.

South Carolina

The South Carolina Supreme Court's decision in *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997), *cert denied* 118 S. Ct. 1857 (May 26, 1998) imposed an impossible dilemma on physicians and treatment providers and, like the Wisconsin law, created an obstacle rather than an incentive for women to seek treatment and prenatal care.

The court in *Whitner* declared that a viable fetus is a "child" within the meaning of the state's criminal child abuse and neglect code. See id. at 780. In doing so, the court imposed upon physicians and health care providers a duty to divulge to state authorities, for possible prosecution, the identities and medical information of pregnant women who engage in conduct or activities that may "adversely affect" the health and welfare of the fetus. See S.C. Code § 20-7-510. Included in such activity is the use of illegal substances. See S.C. Code § 20-7-736. Physicians and providers who fail to disclose such information now face criminal sanctions including fines and possible imprisonment. See S.C. Code § 20-7-560. The *Whitner* decision creates an impossible dilemma for physicians and providers: either risk jail by upholding the confidentiality that is an essential part of medical care and is critical for effective treatment, or disclose patients' identities in compliance with the state requirements, a result which not only violates a patient's confidentiality, but also endangers her health and the health of her fetus.

As a result of the *Whitner* decision, many pregnant women now fear seeking the substance abuse treatment and prenatal care which is so vitally important to their health. A woman who fears that confiding in her treatment counselor or physician could lead to arrest and imprisonment will avoid providing important information to the very people who can help her most. The *Whitner* decision compromises the ethical practice of medicine, causes irreparable harm to patients, and severely impairs the provision of vital health and social services.

Another result of the *Whitner* decision is that women do not know what behavior will subject them to criminal charges. The statutory interpretation endorsed by the *Whitner* court is vague. It

is unclear what conduct is punishable under the statute: only illegal drug abuse? Or is alcohol abuse also punishable? Is other activity which may endanger the health of the fetus, such as smoking, illegal? As Justice Moore said in his dissenting opinion,". . . the impact of [the majority's] decision is to render a pregnant women potentially criminally liable for myriad acts which the legislature has not seen fit to criminalize." Whitner, 492 S.E.2d at 788 (Moore, J., dissenting).

Wisconsin

The Wisconsin legislature recently passed and enacted Assembly Bill 463 which amends Wisconsin's child protection laws to make them applicable to pregnant women. See A. 93-463, 1st Legis. Sess. (Wisc. 1997). The new law states that a fetus is a "child" and is thereby protected by Wisconsin law. See id. The law further provides that a court may order a pregnant women to receive alcohol and drug treatment. If the woman refuses to enter treatment, and there is a showing that there is a "substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered" by the woman's addiction, then the court may order that the state take the woman into physical custody. See id. A law enforcement officer can take a woman into custody if he/she believes that there is a risk that the fetus will be in danger unless the woman is taken into custody. A woman may be held in the home of an adult relative or friend, a residential facility, hospital, physician's office, or public treatment facility. See id.

Punitive measures ignore the root causes of addiction for so many women - sexual abuse and battering - during which women are victimized. Punitive approaches such as these make women victims again. This undermines all we have learned in treating women about how important it is to enable them to take control of their lives rather than punishing them. So, like in the *Whitner* decision, the Wisconsin law will create obstacles, rather than incentives, to getting treatment. Fearing being forced into custody, and perhaps separated from her children, a pregnant woman will likely avoid the alcohol and drug treatment and prenatal care that she needs.

In addition, the law has the potential of placing the woman in grave physical danger and exposing her to continued drug use. By allowing a pregnant woman to be held in the home of an adult relative or friend, the law has the potential to force a woman to stay in the household of a batterer or to remain in a residence where drugs are being bought, sold, or used. Keeping a pregnant woman in a physician's office or a hospital for 72 hours similarly accomplishes little and is a misuse of resources.

Futhermore, the law gives police officers dangerously wide discretion in determining whether to take a pregnant woman into custody. Law enforcement officers are not health professionals trained to recognize and treat addiction. Leaving the decision whether to take a pregnant woman into custody to an untrained police officer opens the door to widespread abuse and errors in judgment that could result in devastating effects on the health and well-being of the woman and fetus and serious constitutional violations.

Access to Treatment Is Limited

Although treatment for these women is successful, there are few resources to support it. Access to treatment at Meta House is limited. Instead of being able to offer immediate treatment and help to any woman who calls, I am forced to place woman after woman on the waiting list because Meta House is always full. Approximately 100 families, women and their children, are waiting to enter the program. Each time there is an article in the media that brings public attention to a woman who is drinking or using drugs and has harmed her baby, I look for the name of that woman on our waiting list. On more than one occasion that women tried to get help for her addiction from Meta House and I had to tell her that she had to wait.

Nationally and locally in Wisconsin, access to alcohol and drug treatment does not meet the current need for services. Nationally, only 50% of the individuals who need treatment receive it. Waiting lists for alcohol and drug treatment are six months long in some regions. Wisconsin's public treatment system budget has been cut in half. Health Maintenance Organizations (HMOs) in Wisconsin, which are tasked with providing alcohol and drug treatment for public assistance clients, are providing few treatment services. The HMO study conducted by the Wisconsin Bureau of Health Care Financing indicates that the penetration rate for alcohol and drug treatment in southeastern Wisconsin is approximately 3%. Some HMO's are providing no treatment services.

Conclusion

Exemplary public policy focuses its impact on the good that it does for the majority of people affected. Meta House and other programs of its kind have demonstrated their ability to produce long-term changes in women's ability to raise their children and to live drug-free, law-abiding lives. For these reasons, women need to feel safe so they will access pre-natal care and enter treatment. Increasing treatment opportunities for pregnant women and women with children is imperative and the most sensible public policy to support.

Thank you for providing me with the opportunity to testify today. I would be happy to answer any questions.

Mr. SOUDER. Thank you very much for your testimony.

Dr. Marshall.

Ms. MARSHALL. Thank you very much, Mr. Chairman and Mr. Barrett, for the opportunity to testify today. I feel like I've already been introduced to you earlier today, but I would like to tell you just a little bit about myself. Before I became a bio-ethicist, I was a critical care nurse for 12 years, and I began my practice in critical care in the newborn intensive care unit. And after 12 years in adult and pediatric critical care, I went to graduate school in bioethics and religious studies, and since then have been a practicing bio-ethicist.

I'm also a principal investigator under the Robert Wood Johnson Substance Abuse Policy Research Foundation, and am engaged in a project analyzing the legal and ethical issues involved in coercive approaches to perinatal substance abuse, and that includes criminalization, involuntary civil commitment, and removal of child custody.

So that my remarks to you today will be based, I hope, on well founded research and not on anecdote, horror stories, or outdated clinical studies.

As you know, the problem of perinatal substance abuse is a complex problem. It doesn't lend itself to easy solutions. I think one of the most important questions that we should examine here today are what are the goals of public health policy and any sort of law enforcement intervention, whether they are to foster healthy pregnancies with healthy outcomes, or whether they are to engage in deterrent and punishment, which certainly are legitimate law enforcement goals but may not be legitimate public health goals within the context of perinatal substance abuse.

We know that criminalization of perinatal substance abuse has no demonstrated effect on improving child health or on deterrence of substance abuse by pregnant women. On the contrary, as you've heard it may have a detrimental effect as it has been shown that substance abusing pregnant women forego early prenatal care and substance abuse treatment for fear of losing their children or for being arrested. The net effect is less prenatal care, and less substance abuse treatment. And other untoward effects might include increased rates of abortions, increased perinatal HIV transmission.

Distancing pregnant women from prenatal care and substance abuse treatment is doubly tragic, in that pregnancies that involve substance abuse are by definition high risk pregnancies, thus requiring good prenatal care, and because substance abuse treatment during pregnancy has been shown to be effective in reducing the risk of drug exposure before birth and in improving a woman's parenting skills after birth.

The drugs that are the most frequently used during pregnancy and that have been definitely shown time and again to cause the most harm to pregnancy outcomes are alcohol, which is used by 18.8 percent of pregnant women, and tobacco, which is used by 20.4 percent of pregnant women.

As you've heard today, fetal alcohol syndrome is the leading cause of mental retardation in the United States. Marijuana, cocaine, and cigarettes are used more frequently by women who are unmarried, unemployed, have less than 16 years of education, and

rely on public assistance for their health care. Alcohol, on the other hand, is primarily used by women who are employed, have 16 years or more of education, and have private health care insurance.

The criminalization of perinatal substance abuse creates untenable legal and ethical obligations for health care providers and other statutory mandatory reporters. It undermines faith and trust in the health care system and respect for the judicial system.

And I would ask you to consider the encounter between a health care clinician and a pregnant woman who comes in for prenatal care and asks whether, under the criminalization paradigm, a physician should "Miranda-ize" his patient before he takes a patient history. And also ask you to consider the notion of failing therapy—that such a notion is a frightening thing, and that noncompliance with medical treatment should merit prosecution.

And I'd also like to state for the record that all of the professional associations—and I want to point that inclusive among those were the South Carolina Medical Association and the South Carolina Nurses' Association—filed amicus briefs in both the Wittner and the Ferguson case, the medical university case, for the plaintiffs; that neither the State Medical nor the State Nursing Association are proponents of criminalization of perinatal substance abuse.

The criminalization approach has been tainted with discriminatory application along racial and socioeconomic lines; poor black women are arrested most often; arbitrary selection along racial and socioeconomic lines; only certain drugs, such as crack cocaine, are targeted; and political opportunism.

The vast majority of prosecutions in South Carolina and other States have been against black women. Of the 41 women arrested under the Medical University of South Carolina's interagency policy, 40 were black and the sole white woman had a black boyfriend, as was noted in her medical record. Of 109 women charged with criminal child abuse for perinatal substance abuse by the Greenville, SC solicitor, 101 were crack cocaine addicts and 86 of them were black. Since 1985, more than 240 women in 35 States have been criminally prosecuted for using illegal drugs or alcohol during pregnancy, and between 70 and 80 percent of these women are minorities.

The criminal sanctions are opposed against women who use illegal drugs much more frequently than those who use legal drugs, even though we know that legal drugs cause more net problems and are used more frequently. Black women, according to the Pinellas County study that was referred to earlier, are 10 times more likely to be repeated for positive drug screens while pregnant than white women. These effects of racial discrimination are invidious.

We live today in the health care system with a legacy of the Tuskeegee experiments, which is occasional conspiracy theories about the HIV virus, effects organ donations by black persons, and decisions regarding end of life care by black persons, due to mistrust of the medical establishment. It has been well demonstrated in the medical literature that substance abusing pregnant women mistrust the system as result of negative encounters with social services and criminal justice agencies.

Because of this, unanimously, professional health care and child welfare organizations are unanimous in their formal position statements against the criminalization of perinatal substance abuse. These organizations include the American Medical Association, American Nurses' Association, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, the American Public Health Association, and the National Association of Public Child Welfare Administrators.

In their guiding principles they state that, "substance abuse or the addiction of the parent to alcohol or drugs, in itself, does not constitute abuse or neglect of a child. Addiction is not a crime." And that, "the assumption that the many causes of substance abuse can be remedied through law enforcement is an error." And, "if a jurisdiction elects to mandate drug testing of pregnant women and newborns, such testing should be universal, conducted on all pregnant women in all medical facilities, not targeted to specific populations, and should be used only to identify families in need of treatment, and to make referrals. Positive test results should not be used for punitive action."

So that rather than focusing on punishment and ineffective deterrent strategies, policy approaches to perinatal substance abuse should focus on the well being of children and pregnant women. Also, the integrity of the family should assure that the harm to be prevented to children, to clearly exceed the harm of a pregnant woman's loss of liberty, as well as harms to her other dependents. It assures that the intervention is expected to be successful in terms of tangible benefits to the health of the child and the mother. It should involve the least restrictive means possible, and it should substantially benefit society and not lead to substantial social harm.

I'd like to point out that a study at the Medical University of South Carolina by Tribble, et al., showed that while equivalent portions of black and white populations were drug positive during the course of the interagency policy, black mothers were more likely to use cocaine than white mothers. Their data also suggested that the cocaine screening policy was associated with a decrease in the utilization of prenatal care by women who screen positive.

The Southern Regional Project on Infant Mortality showed that the most frequently reported perceived or experienced barriers to substance abuse treatment for pregnant women include fear that their children will be taken away, shame about being alcoholic or a drug addict, depression which causes inaction, and denial that they have an addiction problem.

Real concern for unborn children and substance abusing pregnant women, real consideration for healthy pregnancies with healthy outcomes, does not involve political rhetoric or grandstanding, but involves the following approach on the part of politicians.

Mr. SOUDER. Dr. Marshall, I need to interrupt you. We've let you go almost twice the amount——

Ms. MARSHALL. Oh, sorry.

Mr. SOUDER. We'll insert your full statement into the record. We're going to go over and vote and we'll be back well before 6, so you can get to your plane; get questions done.

Ms. MARSHALL. All right. Thank you very much.

[The prepared statement of Ms. Marshall follows:]

Expectant Mothers and Substance Abuse
Subcommittee on National Security, International Affairs, and Criminal Justice
Mary Faith Marshall, Ph.D.

Arguments Against Criminalization of Perinatal Substance Abuse

1. **Criminalization of perinatal substance abuse has no demonstrated effect on improving child health or deterrence of substance abuse by pregnant women. On the contrary, it may have a detrimental effect**, as it has been shown that substance abusing pregnant women may forgo early prenatal care or substance abuse treatment for fear of losing their children or of being arrested.[1] The net effect is less prenatal care, and less substance abuse treatment. Other untoward effects may include increased rates of abortions, and increased perinatal HIV transmission (transmission from pregnant woman to fetus). Distancing pregnant women from prenatal care and substance abuse treatment is doubly tragic in that pregnancies involving substance abuse are, by definition, high risk (thus requiring good prenatal care), and because substance abuse treatment during pregnancy has been shown to be effective in reducing the risk of drug exposure before birth and in improving the woman's parenting skills after birth.[2]

2. **The drugs that are used the most frequently during pregnancy, and that have been definitively shown to cause the most harm, are alcohol (used by 18.8% of pregnant women) and tobacco (used 20.4% of pregnant women)**. Fetal Alcohol Syndrome is the leading cause of mental retardation in the United States. Marijuana, cocaine and cigarettes are used more frequently by women who are unmarried, unemployed, have less than sixteen years of education, and rely on public assistance for health care. Alcohol is primarily used by women who are employed, have sixteen years or more of education, and have private health insurance.[3]

3. **Criminalization of perinatal substance abuse creates untenable legal and ethical obligations for health care providers and other statutory mandatory reporters, undermines faith and trust in the health care system, and respect for the judicial system.**

4. **The criminalization approach has been tainted with discriminatory application along racial and socioeconomic lines (poor Black women are arrested most often), arbitrary selection along racial and socioeconomic lines (only certain drugs, such as crack cocaine, are targeted), and political opportunism.** The vast majority of prosecutions in South Carolina and other states have been against Black women. **Of the 41 women arrested under the Medical University of South Carolina's Interagency Policy, 40 were Black,** and the sole white woman had a black boyfriend (as was noted in her medical record). **Of 109 women charged with criminal child abuse for perinatal substance abuse by the Greenville, South Carolina solicitor, 101 were crack cocaine addicts, and 86 of them were Black.**[4] Since 1985, more than 240 women in 35 states have been criminally prosecuted for using illegal drugs or alcohol during pregnancy. **Between 70% and 80% of these women are minorities.**[5] Criminal sanctions are imposed against women who use illegal drugs much more frequently than those who use legal drugs. Certain illegal drugs, such as crack cocaine, heroin, and marijuana, are often specifically targeted for screening programs while illegal drugs such as powdered cocaine, crank (methamphetamine) or non-physician-ordered psychotherapeutics are largely ignored. Pregnant women who use targeted drugs, such as crack cocaine, are much more likely to be reported and arrested than pregnant women who use non-targeted drugs, such as powdered cocaine, narcotic analgesics, and psychotherapeutic agents. A landmark study in Pinellas County, Florida, in which women presenting for obstetrical care at public health clinics and private physician's offices were

anonymously tested for drug use, found that **Black women were ten times more likely to be reported for positive drug screens while pregnant than white women.**[6]

5. **The effects of racial discrimination on Blacks and other minority groups are invidious and long lasting, and undermine public health.** This is evidenced by the ongoing legacy of the Tuskegee experiments, which has occasioned conspiracy theories about the HIV virus, which effects organ donation (lower among Blacks) and decisions regarding end-of-life care (Blacks request more aggressive therapy at the end of life) due to mistrust of the medical establishment. Several studies have shown that substance-abusing pregnant women mistrust "the system" as a result of negative encounters with social service and criminal justice agencies.[7]

Because criminalization of perinatal substance abuse is counter to the best interests of unborn children and pregnant women, and is inappropriate to the caregiver's role, **professional health care and child welfare organizations are unanimous in their formal position statements against the criminalization of perinatal substance abuse**. These organizations include:

* The American Medical Association[8]
* The American Nurses Association[9]
* The American Academy of Pediatrics[10]
* The American College of Obstetricians and Gynecologists[11]
* The American Public Health Association[12]
* The American Society of Addiction Medicine[13]
* The National Association of Public Child Welfare Administrators[14], whose Guiding Principles for Working with Substance-Abusing Families and Drug-Exposed children state that:

"In responding to complaints in which parental substance abuse is a factor it is essential that CPS agencies recognize that **substance abuse or the addiction of the parent to alcohol and drugs in itself does not constitute abuse or neglect of the child**...The response of the Administration and Congress to the nation's drug crisis equally divides spending between enforcement and treatment. Nevertheless, discussion of this problem has focused overwhelmingly on enforcement, in spite of the fact that **addiction is not a crime**. This creates the assumption

that the many causes of substance abuse can be remedied through law enforcement. This scenario is evident in states that have passed or are considering legislation requiring the selective testing of pregnant women for illicit drug use, with results used for punitive action. This places physicians and Child Protective Services workers in the role of law enforcement officials... If a jurisdiction elects to mandate drug testing of pregnant women and newborns, such testing must be universal (i.e. testing would be conducted on all pregnant women at all medical facilities and not targeted at specific populations.) **Test results should be used only to identify families in need of treatment and make referrals. Positive test results should not be used for punitive action."**

Rather than focusing on punishment and ineffective deterrence strategies, policy approaches to perinatal substance abuse should:

1. Focus on the well being of children and pregnant women and the integrity of the family;
2. Assure that the harm to be prevented to the child-to-be clearly exceeds the harm of the pregnant woman's loss of liberty as well as harms to her other dependents;
3. Assure that the intervention is expected to be successful in terms of tangible benefits to the health of the child mother. Symbolic success, such as sending a message is not sufficient;
4. Involve the least restrictive means available;
5. Substantially benefit society and not lead to substantial social harm.

Background of the Problem

The State of South Carolina has been more active than any other state in criminalizing substance abuse by pregnant women. In Charleston, the Medical University of South Carolina developed an extensive collaboration with local police and the prosecutor's office. Under the Medical University policy, information regarding pregnant women who tested positive for illegal drugs in the hospital's obstetrics clinic was turned over to the police and the prosecutor. The policy did not apply to private patients or to patients at any other health care facility in the Charleston area. For women who tested positive, freedom from arrest and prosecution was conditioned on compliance with mandatory prenatal and substance abuse treatment. Forty-one women were arrested under the policy, (all but one of whom were Black). Ten of the women

brought charges against the Medical University, the police department, and the prosecutor. Notwithstanding unanimous opposition to such collaborations by professional organizations, (listed above), many of which filed amicus briefs for the plaintiffs, citing long standing clinical norms such as privacy and confidentiality, informed consent, and the right to refuse treatment, a federal jury dismissed all charges against the hospital, the police, and the prosecutor.

On July 15, 1996 (in *State of S.C. v. Whitner*) the South Carolina Supreme Court established that a viable fetus can be considered a person under the child abuse and neglect statute. Thus, a pregnant woman may be held criminally liable for any action during her pregnancy that would "endanger the life, health or comfort" of her fetus. The High Court explicitly noted that the statute applies to acts that are either legal or illegal. In June, 1988, the United States Supreme Court refused, without comment, to hear the Whitner appeal. Since that date, two S.C. women whose newborns tested positive for marijuana and cocaine respectively have been charged with unlawful conduct to a child.

Racial and Socioeconomic Discrimination

A prevalence study conducted by the South Carolina governor's office found a high incidence of barbiturate, marijuana and opiate use among pregnant white women.[15] Data from the Medical University of South Carolina's data bank on newborn prenatal screening showed an equal distribution of drug use among white and Black patients. A study by Tribble et al at the Medical University of South Carolina showed that " while equivalent proportions of black and white populations were drug positive (2.52% blacks, 2.54% whites), black mothers were more likely to use cocaine than white mothers (1.25% blacks, 0.28% whites)." Their data also suggested that the cocaine screening policy was associated with a decrease in the utilization of

prenatal care by women who screened drug positive.[16] Nevertheless, the vast majority of prosecutions in South Carolina and other states have been against Black women. Of the 41 women arrested under the Medical University of South Carolina's Interagency Policy, 40 were black, and the sole white woman had a black boyfriend (as was noted in her medical record). Of 109 women charged with criminal child abuse for perinatal substance abuse by the Greenville, S.C. solicitor, 101 were crack cocaine addicts, and 86 of them were Black.[17]

These data clearly show racial and socioeconomic bias in South Carolina and throughout the United States in the application of criminal sanctions for perinatal substance abuse. These data mirror national statistics on the overall disproportionate impact of the criminal justice system on the poor and on racial minorities. There are currently more than one million inmates incarcerated in prisons in the United States. Since 1980 the number of inmates in the U.S. has doubled, and the number of female inmates has tripled (the rate of growth for female inmates has exceeded that for males each year since 1981[18]). Most of these arrests have been for non-violent, drug-related offenses.[19] Most of those arrested, convicted and imprisoned jailed are poor minorities.

A recent Department of Justice survey investigating the characteristics of women inmates reveals that:

> Women in United States jails are usually in their late twenties, close to half of them have never married, and about half have completed high school. Most are unemployed, use illegal drugs, are black or are Spanish-speaking, have children under eighteen, and have previously been convicted at least once.[20]

Separation from their children is a common occurrence among women inmates. Approximately two-thirds of female (adult and adolescent) inmates have children under eighteen.[21] These females are most often single parents whose children were living with them prior

to their incarceration.[22]

Not surprisingly, this profile mirrors that of women arrested for perinatal substance abuse. Since 1985, more than 240 women in 35 states have been criminally prosecuted for using illegal drugs or alcohol during pregnancy. Between 70% and 80% of these women are minorities.[23] Many factors influence this discriminatory approach. Poor women (a category that is inherently disproportionately Black) are at greater risk for drug detection because of their necessarily close relationship with social service and other government agencies. Greater scrutiny by government officials results in disproportionately higher rates of drug screening and reporting.[24] Lack of prenatal care, frequently a trigger for pre- or postnatal drug screening, correlates directly with race and income, as Black women are twice as likely to receive late or no prenatal care than white women because of poverty and other logistical barriers.

A landmark study in Pinellas County, Florida, in which women presenting for obstetrical care at public health clinics and private physician's offices were anonymously tested for drug use, found that **Black women were ten times more likely to be reported for positive drug screens while pregnant than white women**.[25] This finding is especially disturbing given the results from the same study that drug use prevalence was similar across racial and socioeconomic groups (drug use among white women was actually slightly higher [15.4%] than for Black women [14.1%] -- a finding consistent with the national trend in illegal drug use). Studies in other states have revealed similar evidence of racial bias in perinatal drug screening and reporting despite similar prevalence rates of substance abuse across racial lines.[26] Consistent with these data, a recent GAO report found that infants of non-Medicaid patients in private hospitals were screened less often than infants in public hospitals.[27]

Racial and socioeconomic discrimination in the obstetrical realm go beyond perinatal substance abuse. Historically, most coercive approaches to obstetrical care have involved poor minorities. Such coercion includes the vast majority of court-ordered obstetrical interventions, including forced cesarean section. A survey published in the *New England Journal of Medicine* in 1987 showed that of the eighteen cases in which court orders allowed coercive obstetrical interventions (out of twenty-one cases petitioned), eighty-one percent of the pregnant patients were minorities.[28] Socioeconomic status was played an even greater role, as each of the women was either receiving public assistance or was being treated at a public hospital.

Arbitrary Selection Among Illegal Drug Users

Further evidence of racial and socioeconomic bias in the application of criminal statutes to perinatal behavior is seen in arbitrary selection of certain types of drugs for reporting or criminal prosecution. Criminal sanctions are imposed against women who use illegal drugs much more frequently than those who use legal drugs. Certain illegal drugs, such as crack cocaine, heroin, and marijuana, are often specifically targeted for screening programs while illegal drugs such as powdered cocaine, crank (methamphetamine) or non-physician-ordered psychotherapeutics are largely ignored. Pregnant women who use targeted drugs, such as crack cocaine, are much more likely to be reported and arrested than pregnant women who use non-targeted drugs, such as powdered cocaine, narcotic analgesics, and psychotherapeutic agents.

Prevalence studies demonstrate clear racial and socioeconomic dividing lines among use of various substances. Data from the 1992 NIDA report, National Pregnancy & Health Survey: Drug Use Among Women Delivering Livebirths provide national estimates of the prevalence and patterns of use of illicit drugs, cigarettes, and alcohol before, during, and after pregnancy. These

findings estimate that 5.5 percent of women use an illegal drug sometime during their pregnancies. The most frequently used illegal drug is marijuana (2.9 percent of pregnant women). Psychotherapeutic drugs without physician orders comprise the second largest category of illegal drug use (1.5 percent), while cocaine is used by 1.1 percent of pregnant women. Use of drugs such as hashish, methamphetamine, heroin, methadone, inhalants and hallucinogens is much less frequent.

Much higher percentages of pregnant women use legal drugs during pregnancy than illegal drugs. Cigarettes are the most frequently used substances, (20.4 percent), with alcohol following closely behind (18.8 percent). Usage patterns of these drugs tend to be distributed along socioeconomic lines, with a higher incidence of alcohol use in the highest income group, and a higher incidence of cigarette use in the lower income group. Alcohol is the only commonly abused substance certain to cause congenital anomalies in some infants[29], and Fetal Alcohol Syndrome is the leading cause of mental retardation in the United States.[30] Sociodemographic variables also account for significant differences in usage rates between legal and illegal drugs. Marijuana, cocaine and cigarettes are used more frequently by women who are unmarried, unemployed, have less than sixteen years of education, and rely on public assistance for health care. Alcohol, on the other hand, is primarily used by women who are employed, have sixteen years or more of education, and have private health insurance.[31] Methamphetamine is used primarily by white women (as opposed to black women, or men in general), and some hospitals -- especially those in the west and midwest -- are seeing larger percentages of newborns testing positive for methamphetamine than for crack cocaine.[32] Cocaine use divides along racial lines, with powdered cocaine preferred by white women, and crack cocaine preferred by Black women. This reflects the

earlier income-related demographic, as crack cocaine use is generally associated with poverty, homelessness, and inner-city Black communities.[33]

Clearly, pregnant women who use marijuana and non-ordered prescription drugs comprise the largest category of illicit perinatal substance abusers. Women who fall into this demographic, however, are not the ones most affected by criminal interventions. Women who use crack cocaine, heroin and other "serious drugs of abuse" are screened and arrested much more frequently. A prevalence study conducted by the South Carolina governor's office found a high incidence of barbiturate, marijuana and opiate use among pregnant white women.[34] Data from the Medical University of South Carolina's data bank on newborn prenatal screening showed an equal distribution of drug use among white and Black patients: A study by Tribble et al at the Medical University of South Carolina showed that " while equivalent proportions of black and white populations were drug positive (2.52% blacks, 2.54% whites), black mothers were more likely to use cocaine than white mothers (1.25% blacks, 0.28% whites). Their data also suggested that the cocaine screening policy was associated with a decrease in the utilization of prenatal care by women who screened drug positive.[35] The vast majority of prosecutions in South Carolina and other states have been against Black women. Of the 41 women arrested under the Medical University of South Carolina's Interagency Policy, 40 were black, and the sole white woman had a black boyfriend (as was noted in her medical record). Of 109 women charged with criminal child abuse for perinatal substance abuse by the Greenville, S.C. solicitor, 101 were crack cocaine addicts, and 86 of them were Black.[36]

The Legacy of Racial and Socioeconomic Bias

The effects of racial discrimination on Blacks and other minority groups are invidious and

long lasting. This is evidenced by the ongoing legacy of the Tuskegee experiments, which has occasioned conspiracy theories about the HIV virus, which effects organ donation (lower among Blacks) and decisions regarding end-of-life care (Blacks request more aggressive therapy at the end of life) due to mistrust of the medical establishment.

The discriminatory application towards racial minorities of criminal sanctions against perinatal substance abuse fosters deep and abiding mistrust of important social institutions. Policies such as the Interagency Policy in Charleston South Carolina, in which 40 of 41 women arrested for perinatal substance abuse were Black, or in Greenville, S.C. in which 86 of 109 women charged with child abuse as a result of perinatal substance use were Black, or biased screening and reporting programs such as the one in Pinellas County, Florida undermine the foundation of the law and trust in the health care system. Several studies have shown that substance-abusing pregnant women mistrust "the system" as a result of negative encounters with social service and criminal justice agencies.[37] This fear and distrust transfers to the clinical encounter, where women may experience violations of privacy and confidentiality, and where they may encounter physicians and nurses who are racially biased or judgmental and who readily report perinatal substance abuse to state authorities. This distrust has a chilling effect: substance abusing pregnant women may forgo early prenatal care or substance abuse treatment for fear of losing their children or of being arrested.[38] The Southern Regional Project on Infant Mortality showed that the most frequently reported perceived or experienced barriers to substance abuse treatment for pregnant women included:

1. Fear that their children will be taken away;
2. Shame about being an alcoholic or drug addict;
3. Depression which caused inaction; and

4. Denial that they had an addiction problem.[39]

Distancing pregnant women from both prenatal care and substance abuse treatment is doubly tragic in that pregnancies involving substance abuse are, by definition, high risk, and because substance abuse treatment during pregnancy has shown to be effective in reducing the risk of drug exposure before birth and in improving the woman's parenting skills after birth.[40]

The Injustice of Political Influence on Prosecution

Substance abusing pregnant women, especially women who are poor and black, are at particular risk for serving as political scapegoats. Demonized by the politically ambitious and sensationalized by journalists, the pregnant substance abuser easily becomes a symbol of larger social ills. Jos. Perlumutter and Marshall expand on this theme in their analysis of the Charleston Interagency Policy:

> The political basis of the policy is not solely due to the gender, race, and social class of the targeted population. Ingesting illegal drugs while pregnant is a potent symbol of selfishness and irresponsibility. Compromising the health of one's yet-to-be-born child to satisfy physical desires is anathema to the common expectation that mothers should protect their children. Harming an innocent and defenseless child-to-be is perceived as beyond the pale. It represents not merely a lapse of judgement, but also a serious moral failing: behavior that is both unnatural and illegal. This perspective helps explain why crack babies become a powerful symbol, an occasion for reaffirming a commitment to basic human values in a disturbed public order.[41]

The symbol of the "anti-mother" is easily exploited by political opportunists who trade on symbol, myth, and public fear in order to further their own political agendas. Such practices are evident in South Carolina, where both the local Charleston prosecutor (now state attorney general) and the local chief of police have publicly acknowledged the political hegemony that

undergirded the Interagency Policy, and the effects of the subsequent federal lawsuit:

> "There's no controversy here. Only California types and ACLU types are bothered by this, and no one cares about those types here. They have no power here."
> Reuben Greenberg, Chief of Police, Charleston, S.C.[42]

> "There's not enough political will to move after pregnant women who use alcohol or cigarettes. There is, though, a political basis for this interagency program. Leaders can take a position against crack. Our legal system reflects our cultural mores. That's our system. That's the real world. The left-wing ACLU doesn't represent the American people. The left-wing ACLU doesn't represent the people of South Carolina. Tell Lynn Paltrow of the Center for Reproductive Law and Policy thanks for suing me. Running in South Carolina for attorney general, the best thing you can have happen to you is to be sued by the ACLU."
> Charles Condon, former Solicitor for Charleston County, current South Carolina Attorney General.[43]

Perinatal substance abuse has national political currency as well. Thus, this excerpt from an article entitled, "Clinton's Cocaine Babies: Why Won't the Clinton Administration Let Us Save Our Children?" published by Attorney General Condon in *Policy Review*:

> Tragically, the cocaine-baby program, which was clearly saving lives, was effectively shut down by the Clinton administration. Under the president's direction, a swarm of federal officials came to Charleston making unfounded allegations of discrimination and accusing the hospital of violating the "privacy rights" of the addicted mothers...Now, once again, the babies cry out in agony. And once again, hospital staff with no legal recourse must watch pregnant women knowingly cause neurological damage to their unborn children. MUSC nurse Shirley Brown expressed the frustration eloquently: 'You just have to sit around with your hands tied and watch them destroy a baby.' If this is what President Clinton has in mind when he calls for a return to community and individual responsibility, then this administration faces a profound moral crisis.[44]

Such rhetoric seems inconsistent with any genuine concern for the well being of prenatal humans or of pregnant women with substance abuse problems. As professor John Juergens of the

University of Mississippi stated in reaction to this article:

"Mr. Condon claims that the South Carolina policy was very successful and states that there was no evidence that the program scared women away from prenatal care. However, these claims are based on a bizarre and methodologically flawed analysis of hospital admissions described in the original research article. Many experienced and competent individuals have reviewed the South Carolina Policy and the research article Mr. Condon and his colleagues published in an attempt to validate its success.

Contrary to Mr. Condon's assertions, there has been uniform agreement among those who have reviewed the South Carolina Program that the authors did indeed engage in research as defined in 45 CFR 102 (d). However, the data and subsequent interpretations presented in the original article that appeared in the *Journal of the South Carolina Medical Association* (Vol. 86, No. 10: October 1990: 527-531) are completely without merit or foundation. I submitted this research article to several other experienced investigators in the field of health services research as well as to a class of doctoral students in research methodology, all of whom independently rejected the research as having any validity whatsoever."[45]

Real concern for unborn children and substance abusing pregnant women, real consideration for healthy pregnancies with healthy outcomes would involve the following approach on the part of politicians, prosecutors and others involved in developing social policy responses to perinatal substance abuse. Such policies would:

1. Take into account the formal position statements of professional child welfare and clinical associations, all of which condemn criminalization as morally inappropriate for clinicians and of **no proven benefit for infant health**:
2. Allow for a broader conceptualization of the problem than that of fetal versus maternal rights; and
3. Include legal, as well as illegal substances under the policy umbrella, with treatment, healthy pregnancies, and healthy families -- not punishment -- as goals.

Because the criminalization approach to perinatal substance abuse is so tainted with discriminatory application, arbitrary selection, and political opportunism, it should be ethically rejected. A further reason for its rejection is that it creates impermissible legal obligations for physicians, nurses, and other statutory mandatory reporters.

Clinical Medical Ethics

Criminalization of perinatal substance abuse has generated moral dilemmas for many health care clinicians and mandatory reporters. Most public health organizations and medical organizations, such as the American Medical Association,[46] the American Nurses Association,[47] the American Academy of Pediatrics,[48] the American College of Obstetricians and Gynecologists,[49] the American Public Health Association, [50] the American Society of Addiction Medicine,[51] the National Association of Public Child Welfare Administrators[52] have all formally rejected the imposition of criminal sanctions as (1) inappropriate to the care giver's role, and (2) counter to the best interests of the prenatal human and the pregnant woman. *Whitner v. State*, and the statewide policy it has engendered, place many of the South Carolina's mandatory reporters in what they consider an ethically untenable position. This is a clear example of the political will conflicting with clinical norms.

Rather than focusing on punishment and ineffective deterrence strategies, policy approaches to perinatal substance abuse should:

1. Focus on the well being of children and pregnant women and the integrity of the family;
2. Assure that the harm to be prevented to the child-to-be clearly exceeds the harm of the pregnant woman's loss of liberty as well as harms to her other dependents;
3. Assure that the intervention is expected to be successful in terms of tangible benefits to the health of the child mother; symbolic success, such as sending a message is not sufficient;
4. Involve the least restrictive means available;
5. Substantially benefit society and not lead to substantial social harm.

Endnotes

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EMAIL

August 5, 1998

Joseph C. Good, Esquire
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Dear Joe:

At your request, we have been asked respond to the prepared remarks given by Ms. Mary Faith Marshall to the U.S. Senate Subcommittee on Thursday, July 23,1998.

At the outset, it should be noted that Ms. Marshall has no personal knowledge of the Interagency policy and was not employed by MUSC at the time of it's implementation. After commencing her employment with MUSC and learning of the policy, rather than speaking to the principals involved at MUSC, Dr. Marshall contacted the future plaintiff attorneys at the Center for Reproductive Law and Policy.

Her lack of first hand knowledge is evident in her prepared remarks, where Ms. Marshall misrepresented the Medical University Policy. The Medical University Policy was applied throughout the Medical University and its clinics, to both private and Medicaid patients. Local police accepted references from other local hospitals but did not force them to adopt any formal policies, like the Medical University. Ms. Marshall's knowledge of the Policy is completely second-hand as she was not with the Medical University at the time it was developed and implemented, she was not with any of the pre-natal care clinics that implemented the Policy.

Further, the statistics reported by Ms. Marshall on the arrests made pursuant to the Interagency Policy are inaccurate. Ms Marshall testified that forty arrests had been made under the policy, all but one being black women not 41 arrests one of which was white as reported by Ms. Marshall. Under the Interagency Policy there were 30 arrests, two of which were white women. Arguably one, Theresa Joseph, was of mixed race. She reported her race to be white in the medical record although the arrest record lists her as "mixed?" (See attached records as Exhibit A). Further, Ms. Marshall alleges the medical record of the one white woman arrested noted the race of her boyfriend. This begs the question of how Ms. Marshall obtained this confidential information. This information was released to the plaintiff's attorneys under a confidentiality Order by Judge Houck and should not have been available to Ms. Marshall for review without violation of that Order (attached hereto as Exhibit B).

In the prepared statement, Ms. Marshall makes reference to a "study by Tribble et al at the Medical University" for the proposition that the policy discouraged women from seeking prenatal care. The abstract was written by a then neonatology fellow, Dr. Linda Tribble, along with Dr. Thomas C. Hulsey, Dr. David Annibale and Shirley B. Brown, RN., M.N. The abstract was a reflection of a preliminary report of a work in progress. Subsequently, due to a concern over potential misinterpretation of the abstract, the authors issued the attached letter on May 17, 1994. The letter states that the authors continued to investigate the issue, however, concluded that confounding factors, such as a change in the Medicaid reimbursement program for obstetrical patients, which was designed to facilitate low income women into private OB offices, may have accounted for the data. To have pursued publication of such data would not have been scientifically valid, and therefore the authors felt no conclusion could be supported by the data reported.

Ms. Marshall also makes reference to the South Carolina Medical Journal article documenting the success of the Interagency Policy as an unauthorized research study. This was not a research study and was never intended to be. This was merely a report of what appeared to be a successful program in the Charleston experience.

Ms. Marshall references amicus curae briefs filed by professional organizations which were purportedly ignored by the judge and jury who rendered a verdict on behalf of MUSC. There were no amicus curie briefs submitted to the jury for consideration. In fact, other than affidavits filed at the Preliminary Injunction stage, no amicus briefs were filed until after the judge's ruling and the jury's verdict.

Ms. Marshall also contends that medical organizations are unanimously opposed to criminalization of perinatal substance abuse. The opinions issued by medical organizations actually state that criminalization of any illicit substance, whether used by pregnant women or not, does not work as well as treatment in reducing substance abuse. They fail to address programs, like the one in Charleston, that use the threat of prosecution to push women into treatment. It has long been recognized by substance abuse professionals that some form of coercion, whether it be from family, employers, or the police, is necessary to push most substance abusers into treatment. An outright ban on all criminalization would take the police and perhaps any government entity out of this equation.

Ms. Marshall further alleges that criminalization of perinatal substance abuse has no demonstrated effect on improving child health and may have a detrimental effect. The experience of the Charleston program contradicts this statement. Without the threat of criminal prosecution not a single substance abusing mother voluntarily sought treatment over a six month period. After the introduction of threatened prosecution, many women did seek treatment.

Ms. Marshall also alleges that the drugs that are used with the most frequency during pregnancy, and that have been definitively shown to cause the most harm, are alcohol and tobacco. However, a 1987 multivariate analysis study isolated cocaine as the sole factor causing dire problems with pregnancy, independent of other criteria such as nutritional status, anemia, socioeconomic status, or alcohol use. Moreover, unlike alcohol, tobacco or other drugs of abuse, cocaine's very direct and sudden effects are uniquely harmful to the pregnancy. A single dose of cocaine can kill the mother, the fetus or both.

Nationwide, as many as 375,000 infants are born to drug abusing mothers each year. CDF Reports, Drug Abuse's Most Innocent Victims: Babies, at 5 (May 1989). In South Carolina, an estimated fifteen thousand (15,000) babies are born each year who have been exposed to illegal drugs *in utero*. The social and economic costs of this epidemic are staggering. Babies exposed to crack-cocaine are 3.6 times more likely to have a birth weight under the tenth percentile, significant depression of interactive behavior, and poor organizational responses to environmental stimuli. R. Cherukuri, H. Minkoff, J. Feldman, A. Parekh, L. Glass, A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy, 72 Obstet. Gynecol. (No. 2) at 149-150 (August 1988). In many hospitals a majority of neo-natal intensive care unit patients are children of cocaine-abusing mothers. M. Dombrowski, R. Sokol, Cocaine and Abruption, Contemporary OB/GYN, at 13 (April 1990).

In the late 1980's, Dr. Ira Chasnoff conservatively estimated that the cost to care for cocaine-exposed infants could exceed three billion dollars annually in the next decade. Caring for these infants costs the State of South Carolina an estimated three hundred sixty million dollars ($360,000,000.00). The delivery of the baby, however, is merely the beginning. The excess medical costs associated with affected drug-exposed infants can exceed fifty thousand dollars ($50,000.00) per infant in the first year of life alone. South Carolina Department of Health and Environmental Control Issue Paper, Substance Abuse in Pregnancy, at 2 (January 1993). The lifetime economic cost associated with the severe effects of drug exposure can exceed one million dollars ($1,000,000.00) per infant. Id.

Cocaine and crack-cocaine use are targeted because of the enormous dangers posed by the drug to the fetus, not due to any racial discrimination. It should be remembered that, in order to prove child abuse resulting from maternal behavior, a prosecutor would ultimately have to show that the behavior did in fact harm the child. Cocaine and crack-cocaine have been targeted because this link is not difficult to prove.

In conclusion, it is important to note that of the ten causes of action brought by the ten(10) patients who sued the Medical University, its Board of Directors, the City of Charleston, the Charleston County Solicitor's Office and several individuals over the Policy, eight of them were summarily dismissed by the District Court judge, and a jury found in favor of the Medical University on the remaining two. Specifically, the jury found that racial animus did not motivate the Medical University in implementing the Policy, and the District Court Judge found that the Policy did not have a discriminatory impact and was, therefore, not in violation of Title VI of the Civil Rights Act.

Further, the South Carolina Supreme Court has found that charging women with child abuse for the perinatal use of illegal substances is constitutional and appropriate under South Carolina law. The United States Supreme Court denied certiorari in that case. The majority of state courts that have chosen not to follow this course did so on the grounds of statutory interpretation, not constitutionality, and many state legislatures are considering changing the law to expressly criminalize this behavior.

In short, Ms. Marshall's statement mirrors the case presented by ten plaintiffs seeking money damage for taking cocaine while pregnant. The federal judge and jury who considered the constitutional claims presented unanimously rejected them and ruled in favor of the Defendants.

If we can be of further assistance to you, please do not hesitate to contact us.

Kind personal regards,

Yours truly,

Barbara Wynne Showers

BWS/mdh
cc: The Honorable Charles Molony Condon
James B. Edwards, President, MUSC

NAME	DOB	RACE	COMPLAINT NUMBER	CHARGE	DATE OF ARREST
THERESA JOSEPH		MIXED?			

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May 17, 1994

RE: Analysis of a hospital cocaine testing policy: its association with prenatal utilization patterns. (Tribble et al.)

To whom it may concern:

We would like to attach this document to the above mentioned abstract as a delineation of our attempts to follow-up the information presented in the abstract.

The investigation presented in the above abstract was aimed at determining whether a hospital drug testing policy had an association with prenatal care patterns at the Medical University of SC. The information presented was a preliminary report of work in progress. It was presented both to share our work as well as to elicit discussion which might aid our investigation. Findings presented in the abstract must be interpreted with caution, as they are preliminary data, not conclusions.

Following presentation, we have continued to investigate this issue. However, attempts to further define causative associations between the drug testing policy and patterns of prenatal care have been difficult. Indeed, we have recently reached the conclusion that the question cannot be answered from the data we have available. This conclusion is based on several attempts at re-structuring the question to avoid the need to address information which was not collected, re-defining sub-populations to reduce confounding variables (many of which cannot be addressed with available information), etc. Our conclusion is that there are significant obstacles which prevent us from reaching a satisfactory answer to our original question, and that statistical and epidemiological procedures cannot overcome those obstacles. Alterations in prenatal care utilization were observed. However, several explanations for observed effects exist including many that are clearly unrelated to the drug testing policy (i.e. Medicaid program changes designed to facilitate entry of low income women into private OB practices, etc.). Our attempts at

eliminating alternative explanations were unsuccessful.

The problems encountered which force that conclusion are, to a large degree, related to the fact that the policy was instituted as a clinical tool, not a research protocol. As such, there were no mechanisms built into it that would allow policy evaluation. Indeed, as the policy developed, it actually changed, with testing being directed toward larger populations as clinical thoughts changed. Time periods when testing criteria were formal and constant were sometimes short, while in other time periods, testing criteria were less rigid. Legal responses also varied. Additionally, information regarding the rate of drug positivity among non-tested women are unavailable, a key requirement in making definitive conclusions.

For these reasons, we have re-directed our efforts. We now feel that the data concerning the original question is incomplete and cannot support any definitive conclusion. We also feel that to pursue publication of such data would not be scientifically valid. We are currently, therefore, planning to use this policy as an example of the need for evaluation methodology in clinical policy. We hope to use the issues raised by our efforts in interpreting the effects of this policy as an example in that regard.

In reviewing the attached abstract and presentation, we think it is important to recognize that the information was preliminary, presented to further discussion and interpretation, rather than conclusive. We conclude that the data cannot be definitively interpreted.

David J. Annibale, M.D.

Thomas C. Hulsey, M.S.P.H., Sc.D.

Shirley B. Brown R.N., M.N.

Linda G. Tribble, M.D.

Mr. SOUDER. Thank you. The hearing stands in recess.

[Recess.]

Mr. SOUDER. The hearing is back in session.

Dr. Feinberg, I wanted to followup on a comment that I made at the end of the first panel. I would presume, based on your testimony that you also don't favor reporting for—for example, a child sexual abuse, or other things, when the children are a little older—because it might discourage people from entering into programs?

Dr. FEINBERG. No, there's been no evidence that that has occurred.

Mr. SOUDER. There's no scientific evidence that you have that this occurred either.

Dr. FEINBERG. That I know of. I'm not a researcher.

Mr. SOUDER. But why would you have an inconsistent position that it would discourage people in this case, but not in the other?

Dr. FEINBERG. Because there is evidence that that is what is occurring.

Mr. SOUDER. What evidence?

Dr. FEINBERG. I'm sorry?

Mr. SOUDER. What evidence? You said you talked to the people at the Meta House, and how many people are there?

Dr. FEINBERG. At any given time, we have the potential to have 68 beds filled. Now some of those are with children, though I certainly wasn't talking to the children. And I've talked about this bill and presented it to them. And I might add, I think I presented it very fairly because they did have some mis-notions about it that I tried to clear up for them. I think I was very fair in the way that I presented it, and I've done this over a period of time. This has been cooking and brewing in our State for a rather long time. So I've had an opportunity to talk to many, many people.

Mr. SOUDER. But you're aware that Ms. Keller, which has a lot more experience in South Carolina, directly contradicted your testimony that there was——

Dr. FEINBERG. I would like to see her research.

Mr. SOUDER. I mean, you didn't cite any research either. You just told your case, as in she told her cases.

Dr. FEINBERG. Well, first of all, there's two things going on here. One is, I can only tell you anecdotally what my experience has been at Meta House, and that's my personal experience. However, there is research and I think that Dr. Marshall quoted some research. I have read some research that indicates that indeed there is a flight from care, and that that does produce worse birth outcomes.

Mr. SOUDER. In fact, in October 1997, you testified that, "as a matter of fact, many women we treat in our program are there because they've been given the choice between Meta House or losing their children."

Dr. FEINBERG. That's correct. I'm not talking about—if you're talking about coercion, that's not something that I am necessarily opposed to. Almost every woman who comes into Meta House is being coerced in one way or another. It's the nature of the addiction and the consequences of behavior. One of the reasons that many people come into Meta House is because they're being given that choice, but they are being given a choice.

Mr. SOUDER. So if somebody was beating their child or giving their child drugs, if the child was 5 years old, you wouldn't favor them being coerced into treatment either? In other words, are you making a distinction only for pregnant moms and not for any other drug abusing mother, because you don't have a philosophically consistent position?

Dr. FEINBERG. Yes, I am making that distinction, because there's no evidence that reporting child abuse has this detrimental affect. There is evidence that reporting a pregnant woman while she—reporting a woman who's using drugs while she's pregnant—does enhance the flight from care.

Mr. SOUDER. Is that your position as well, Dr. Marshall, that you believe there's a double standard between those—for example, Dr. Feinberg correctly pointed out that most people who have abuse problems have a history of either having had, she mentioned, child abuse in their families, of spousal abuse, or drug abuse in their families. And therefore, we have to be careful how we handle these different people. That's also true among child abusers. It's true in all forms of this. And if we have that as a standard in our society, that we can have an intervention process. Because the person has been abused previously, why are you cutting it just at this point?

Ms. MARSHALL. Well, I guess I think you're making a dis-analogy, or I see it as a dis-analogy. I think that when we're talking about pregnant women who are substance abusers, we're talking about substance abusers. And the nature of the intervention should be treatment. And the two interventions that we've talked about today are prenatal care and substance abuse therapy. I don't think that that is directly analogous with the intervention that society condones for beating a child. The intervention there would not be substance abuse treatment.

Mr. SOUDER. When a pregnant mother ingests alcohol—when I was staff director of the Children and Family Committee on the Republican side in the House, we held three hearings on fetal alcohol syndrome. When the mother drinks alcohol, it actually has a greater intense affect on the child in the womb because of the proportion of body weight. Similar with methamphetamine and similar with cocaine. The impact is greater on the child before it's born than it actually would be at 1 year old, if the parent started giving drugs to them.

Now, why are you making this distinction suddenly that a parent—a prenatal care rather than the immediate postnatal care in the first year—what if they gave drugs to ingest into those kids at the same rate that it was being ingested before birth. You would have a distinction that you could prosecute one in the first year, but you couldn't the year before they were born?

Ms. MARSHALL. Yes, I think that that's really not a fair analogy at all. I think you're characterizing this as two different things. The context in which I look at perinatal substance abuse is this. The women are substance abusers who happen to become pregnant. They are not pregnant women who suddenly decided to abuse a substance. They're substance abusers first.

Mr. SOUDER. So they're substance abusers with a 1-year old child.

Ms. MARSHALL. The analogy is not the same as saying I think I will give my 5 year old a hit of crack cocaine.

Mr. SOUDER. No, let's say the child's now 6 months, 3 months old, 1 month old, 1 week old—once the baby is born, it's now a substance abuser who has a baby 1 month from delivery and a substance abuser 1 month after it's delivered. Is your only distinction that now you can see the baby, because there's no differential.

Ms. MARSHALL. No, that's not my distinction at all. A substance abuser who happens to become pregnant is not—the point of her taking substances is not to deliver them to her child. The point of her taking substances is because she's addicted to them. That's very different than if I had a child sitting next to me, and I handed him or her a cigarette, or drink of alcohol, or something else. The intent is not the same. So I don't think that's a fair analogy.

Mr. SOUDER. I simply do not understand your point, because the impact on the child is exactly the same. What you're saying is if a mother doesn't understand in the last month before birth that it's a child, she doesn't have the same understanding that it's a child ingesting the cocaine or the alcohol, as it would 1 month after birth.

Ms. MARSHALL. Mr. Chairman, I think you're putting words in my mouth. I mean, we may not—I think that we're not agreeing on perhaps the intentionality of the act. Again, I construe these problems as substance abusers, whether they're alcoholics, whether they are addicted to cigarettes——

Mr. SOUDER. What about child neglect? In other words, we can also report people for child neglect, which doesn't involve intentionality. For example, if a parent leaves drugs laying around, leaves feces in their house, and didn't intend to harm the child, but in fact harms the child through neglect, we report them.

Ms. MARSHALL. That's true.

Mr. SOUDER. Why wouldn't that be the same in this case? If you're saying intentionality——

Ms. MARSHALL. Because it's impossible for a pregnant woman to abuse a substance and not have it affect her fetus. That's the biological reality. I'm sure if there were some way where she could abuse substances and not have them affect her fetus, she would do so.

Mr. SOUDER. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. I just want to say at the outset as I did for the last panel, that I think that everybody here is speaking from their heart. I don't see any double standards. I don't see philosophical inconsistencies. I think every one of you people here today has the same goal, and that is to reduce the trauma on a child—or unborn child—whose mother is using cocaine. And I frankly don't see any need to say well this is inconsistent or that's inconsistent.

I want to do what's the most effective thing. And I think it's important that we keep the discussion at that level, because I know Ms. Feinberg from Milwaukee, I've been to the Meta House several times. I think that you are a woman who has dedicated your life to helping women who have substance abuse problems. I don't see any sinister motive. I don't think that you're a closet supporter of drug use, or anything like that. I think you want what works.

And I think that's what Ms. Keller wants. Ms. Keller has a similar program in South Carolina, and you want what works. And I think we can have a good discussion about what works and how we get there.

I was struck, Ms. Keller, by your comment about the voluntary programs. And I think you made reference that your program has great demand, but voluntary programs are lagging. Were you referring to South Carolina, or were you referring Nationwide?

Ms. KELLER. I was referring to South Carolina.

Mr. BARRETT. Ms. Foley, in Illinois, can you tell me whether programs such as the one Ms. Keller has, or Ms. Feinberg, or yours—the voluntary nature—is there great demand, shrinking demand, what's the situation in Illinois?

Ms. FOLEY. When we first opened the program in 1990, we were concerned that the demand might not be there. That was not true. We filled very rapidly. We remained full very rapidly. What has had the greatest impact on our prenatal program, as well as other programs—but particularly the prenatal program—has been the onset of managed care. We find for the first time in the better part of a decade, we do have empty beds. Managed care—if it is a court ordered treatment, managed care is denying payment. Their response very frequently is that you would have to do it anyway, whether or not we paid. If they do permit—if managed care does permit treatment, they are looking at maybe 2, 3, 7 days maximum. Our history shows that this is not—these women who have been abusing drugs throughout multiple pregnancies, did not happen into this overnight. We're not going to help them to change their lifestyle to become productive citizens overnight. So, this has been a tremendous concern.

Mr. BARRETT. But, again, on a demand—the demand though is still there, from what you're saying. I don't mean to put words in your mouth.

Ms. FOLEY. Yes.

Mr. BARRETT. But the problem is managed care more than lack of demand.

Ms. FOLEY. That's correct. The demand is still there.

Mr. BARRETT. And Ms. Feinberg, I think I know from Milwaukee, but I want to hear your view. Is there demand in Milwaukee for the voluntary programs?

Dr. FEINBERG. We always have people waiting—voluntarily waiting—to come into the program. If we ever have an empty bed, it's the same situation. Not necessarily managed care, because we don't have managed care contracts for Meta House. But if there's an empty bed, it's because I don't have the funding for it. It does not mean that the woman isn't out there waiting. We can't keep up with the demand.

Mr. BARRETT. Ms. Keller, what impact does managed care have?

Ms. KELLER. I didn't hear the question.

Mr. BARRETT. What impact does managed care have in your community, do you know?

Ms. KELLER. Well, it has certainly shortened our stays.

Mr. BARRETT. Has it had a positive or negative impact on treatment?

Ms. KELLER. On treatment, positive.

Mr. BARRETT. You'll get better treatment with shorter stays?

Ms. KELLER. Well, we've kind of compacted things—we've moved more toward a level of care model. In other words, Serenity Place as a residential facility used to be able—we had the luxury of keeping a woman long enough to turn out a finished product. Whereas now, with managed care, we're turning out a woman who is capable of functioning at a lesser level of treatment.

Mr. BARRETT. OK. Are you moving to that with all your patients, or just your managed care patients?

Ms. KELLER. Well, I only operate a managed care program. That's the only frame of reference I have to answer you. But I would like to point out that I think the term voluntary when you're talking about addicts is a very broad concept. I have a very large voluntary waiting list now too.

Mr. BARRETT. I was referring to your comment in your testimony where you said voluntary programs seem to be lagging.

Ms. KELLER. I was referring to prior to the law.

Mr. BARRETT. I don't mean to put words into your mouth.

Ms. KELLER. Prior to the law in South Carolina. Women just didn't turn up for treatment.

Mr. BARRETT. I mean, the reason I ask that is that based on the Illinois experience and the Wisconsin experience, it does not seem to be that there is a lack of demand for voluntary programs. Now there might be—and maybe I'll ask that Ms. Foley and Ms. Feinberg—under voluntary programs, do you have less compliance?

Ms. FOLEY. Can you clarify that—less compliance as far as treatment completion, or compliance as far as response to court recommendations?

Mr. BARRETT. Let's say treatment completion.

Ms. FOLEY. Primary treatment, the treatment compliance rate for the direct mandated length of stay is higher for that which is ordered directly by the court. When you get into the after care continued care, portion, you will find that they pretty much level off.

Mr. BARRETT. OK. And Ms. Feinberg, is that the same that you see?

Dr. FEINBERG. Basically, it is the same. I think though that the question has more to do with what we've learned more recently about women's treatment. Substance abuse treatment kind of went the way as many other medical treatments, and that is that is what normed and developed for white middle class men. And indeed, women didn't stay in treatment, and treatment did not work for these women.

Within the last 10 years or so, we've learned a lot about this, and with learning about this and providing treatment that's appropriate for women, the compliance rate is way up, completion rate is way up, and the successful completion for the women after many, many years is way up.

So, I think sometimes we're comparing apples and oranges, which is another thing that worries me a little bit about the bills, because I know that there are many women who come to our program that they have failed other treatments an average of four times. And when I ask them about their treatment, it was very clear to me that they didn't fail treatment, the treatment failed them. It was an inappropriate treatment for them because it was

based on an old model that may work for someone else, but it did not work for them.

When applied appropriately, you get very good outcomes and you get very good completion rates.

Mr. BARRETT. OK. Mr. Chairman.

Mr. SOUDER. I wanted to follow up first with Ms. Brown. In your experience, what are the financial costs of caring for children who are born drug impaired? Have you worked with these kids? Have you seen some of the impact?

Ms. BROWN. Yes, we've had various expenses related to these infants. We did a random sample of our bills back in early 1991, 1992, and the average hospital bill was averaging $24,000. This came about the time the South Carolina State study came out, where it was showing that approximately 15,000 babies were born in the State of South Carolina, or 1 out of 4 tested positive at birth for alcohol or illegal drugs. If you multiply that figure out, it's astronomical. Of course, the State does not fully understand or does not know the exact number. Some of the figures that we've seen is through the general accounting agency and they say about $1 million per child.

But in 1992, we had one infant who was transferred to our neonatal intensive care unit. After 1 year, the child's initial hospital bill was over $600,000. It had a subsequent surgery, that child's bill ended up very quickly in about a year of $731,000. While this baby was in intensive care, this mother also delivered another baby, also testing positive for cocaine, and that infant remained in the hospital for 4 months, with a hospital bill of $167,000.

So they range. Our normal newborn babies' bills should run around $500 for the delivery, and we have some of our term babies' bills who have been as much as $90,000.

Mr. SOUDER. You work with the South Carolina program. You heard the earlier statistics that certainly implied that there was a strong racial bias. Do you believe there is a racial bias in South Carolina, and could you explain a little bit, from your perspective, what you think has happened. Or do you believe, in fact, blacks have been targeted?

Ms. BROWN. I do not think that blacks were targeted. I, along with Charles Condon and Chief Greenberg, were one of the ones sued for $3 million in this civil lawsuit personally and in my professional capacity at the Medical University; and the jury found that there was no basis. And also, Judge Houck in his ruling said the policy did not have a discriminatory impact and was therefore not in violation of title VI of the Civil Rights Act.

The State Prevalence Study, when it was done in 1991, indicated that cocaine was more prevalent in the African-American. What contributes to that, I cannot say. I would like to clarify one thing for the record, though. When Dr. Marshall quoted the Tribble article, I happen to be one of the people co-authoring that. And unless she has seen an article that I did not agree to be out, it did not show that our program was causing women not to seek prenatal care. That was one of our concerns. We looked at the South Carolina DHEC statistics, not at our statistics, to see if there were out-of-hospital births, babies born in trash cans, babies born, you know,

et cetera. It was not happening when we started our program, and it is not happening now.

Mr. SOUDER. Could I ask both you and Ms. Keller, being from South Carolina, I agree with one concern. I believe the data has been distorted and we have had multiple hearings on this racial issue, and we have had multiple of the major researchers in who question some of the basic research, and we have heard them debate in front of us.

But there is sometimes, in my opinion, an unintended consequence because of the nature of what drugs we pick for putting into these programs. Would you, in fact, be supportive of, rather than focusing just on crack cocaine, also making sure that powdered cocaine, methamphetamines, heroin, other drugs that endanger the young children, would also be included in this.

Would you encourage prosecutors or courts or whatever means necessary to get people into treatment? Because, as we have heard, an implication here has been on incarceration. But it is not; the focus is treatment. But do you oppose other drugs being involved in that, other than crack?

Ms. BROWN. Our urine drug screens back in 1988 forward, we screen for all drugs. We do not distinguish between crack cocaine or powdered cocaine. And in the current State policy on the screening, it does not. I think the reason that everyone says cocaine, is that seems to be the prevalent drug that we are seeing right now.

We are fortunate in that we have not had any cases of ice detected. We are beginning to see an increase in heroin, and heroin will be treated as cocaine in the State of South Carolina.

Mr. SOUDER. Methamphetamines, as well.

Ms. BROWN. Any illegal drug will be treated under the current State policy. Everyone is screened. It is not the public hospital or the private hospital. This is a policy that is statewide. All positions that deliver care have received the guidelines that the South Carolina Medical Association helped in the development of.

I am on the Medical Council Subcommittee on Substance Abuse and Pregnancy. We have reviewed this policy. It is statewide.

Mr. SOUDER. Dr. Marshall, do you have any comments on this?

Ms. MARSHALL. I guess my general comment is this. Crack cocaine is a sexy issue. I will go back to my original statements and maintain that people who have genuine interest in healthy pregnancies and healthy outcomes should focus on the primary problem. And the primary problem is not the illegal drugs. The primary problems, the things that cause the most damage to the most babies and the most born children are legal drugs. They are alcohol, tobacco, and they are misapplied use of legal drugs.

So I guess sort of the challenge or the question that I would pose from a health policy perspective is why the attention on drugs that are illegal per se, when the goal is healthy pregnancies and healthy outcomes of pregnancies? And if that truly is the case, then the focus should be on the substances, whether legal or illegal. The legality of the drug is not the issue. The outcome of its use should be the issue.

Mr. SOUDER. I agree with that, and that is why I favor stronger efforts on fetal alcohol syndrome and also the education efforts. Although we haven't yet proven the clear damage to the fetus in the

case of tobacco, I believe that may be another place where the tobacco companies have withheld evidence and therefore, why we shouldn't grant them legal liability exclusions.

Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. Ms. Brown, maybe you can help me on this, or Ms. Keller, maybe you can help me on it, or maybe Dr. Marshall can help me.

In terms of the South Carolina experience, what have you seen in terms of a trend or women delivering babies in hospitals showing cocaine in the mother's system, has it been an increase, the same, a decrease since this program began?

Ms. BROWN. We've not really seen an increase in the use; we actually saw a decline in the use. In talking with some of the substance abuse experts at the Medical University of South Carolina, when we saw some of the numbers initially dropping down, that was one of the questions. They said that the recreational user can stop for short periods of time.

I think what everyone needs to realize is that when a person uses cocaine and we test for this cocaine, they have to have used it within 24 to 48 hours for this test to show that they are positive. So we are probably missing people, and we will always miss people until there are better methods of testing.

Mr. BARRETT. And the use in society in South Carolina in the same period, the last 10 years, of crack cocaine, has it remained constant, gone down or increased?

Ms. KELLER. In my experience, it has increased.

Mr. BARRETT. The reason I ask that question, or those two questions together, is I think there are two possible answers or two possible explanations to that.

If you have, say, a 15 percent increase in crack cocaine use in the general population over a 10-year period—and I am just taking that number out of the air—but the percentage of women delivering babies and showing cocaine in their system remains constant, that means one of two things.

To me, it means, one, women are suddenly deciding not to use cocaine during pregnancy; or they are not delivering their babies in the hospital. And I don't know which it is, but I know in Wisconsin, in Milwaukee, at least, we have seen a sharp increase in the number of women who are giving birth who do have cocaine in their system.

And I don't know what the answer is. I don't know if that means that your experience has been very successful or else it means that women are turning away.

Ms. BROWN. You need to realize in that first year when we had 109 women test positive, a number of those women have subsequently come back and had babies that tested positive again. From 1988 to 1999, it was purely voluntary to go into treatment. Now, there are a lot of steps in place to get them in treatment, so I would have to say even though it is going up, that we are helping women get off of drugs so their subsequent pregnancies, their children, hopefully, will be born drug free.

Mr. BARRETT. Dr. Marshall, using those two different possibilities, again, if there is a 15 percent increase in the general population using crack cocaine, but the graph is flat for mothers deliv-

ering babies and showing cocaine in their system, again, I only see two explanations. Either, one, the women don't come to the hospital; or two, the cocaine use has in fact dropped among pregnant women.

What has your study shown, or what do you believe are the reasons?

Ms. MARSHALL. Well, the hard data that we do have from the prevalence study and from data at the Medical University of South Carolina have shown that substance abuse, as we know, it mirrors the national data, that it crosses all racial and socioeconomic barriers. But we do know that there are influences that ethnicity, race does factor into the sorts of substances that are used.

So I think part of the picture is you find what you look for, and as was stated earlier, if you had a situation where there was screening of every pregnant woman, whether it were anonymous screening or not, then we would have some knowledge of true incidence of substance abuse.

But when you use certain criteria that are partly objective and partly subjective to say, well, I am going to test you and not you, then I guess I would maintain it is hard to make any empirical claims about incidence and use. And we don't have those sorts of data in South Carolina. They don't have them from the original interagency policy and really don't have them now. So it would be hard, I think, within the context of pregnant women, to make any claims.

Mr. BARRETT. So there have been no studies done in South Carolina measuring the——

Ms. MARSHALL. Well, the data that we have are women who have been tested for various reasons. And that is because a clinician has chosen to test a woman for a reason that he or she has been determined, late prenatal care, no prenatal care, abruption, prior history of substance abuse.

Mr. BARRETT. There is no testing at birth as to whether there is cocaine in the system.

Ms. MARSHALL. There is no automatic testing.

Mr. BARRETT. Thank you. I have no further questions, Mr. Chairman.

Mr. SOUDER. I want to just make a few closing comments. One is that this is probably somewhere near our 30th or 35th hearing on the drug issue for this subcommittee since the Republicans have taken over Congress, so it is in the last 4 years. And we have heard a lot of data.

I represent Ft. Wayne, IN, which is generally considered for the last number of years, has had the greatest crack problem vis-a-vis its size—it came down initially from Detroit, MI—and so I have been focused when I was a staffer, as well as a member, particularly on the crack problem. By saying I am concerned about all drugs, as we watch methamphetamines come, as we watch alcohol and tobacco, the uniqueness to crack that we all know who are in the field is that it particularly hits young people, and particularly it has hit the urban centers.

The reason crack was focused on in Congress was actually through Congressman Rangel, who said we have a big problem that's burst out in the urban centers. And in Ft. Wayne, that has

happened as well and it becomes fatal fast. These kids are either stealing or they are high at the time and it endangers basically inside their own community. It doesn't really spread outside.

So it is not a malicious focus on crack that we developed this way, but as a matter of societal equity. I think we need to make sure that we aren't accidentally doing things, but in fact it was to try to get control of a problem among youngsters who might go on to more serious drugs for a long term problem, which would be heroin or cocaine. We have also seen LSD pop back in.

The other thing I want to say, particularly to Ms. Keller and Ms. Foley and Dr. Feinberg—and please don't take my questioning earlier which is in the form of critically trying to examine a point you made, because I want to reiterate what Congressman Barrett said. And that is you three, in particular, are right on the front lines, with very few people congratulating you. Every day is frustrating. These people come in and their stories are difficult, and you deserve tremendous praise from everybody in society for working with this.

And I can see how you can disagree on how people are going to react, because you are listening to them and you are very concerned. As policymakers, we have to look at a broad perspective, but never take anything that we say and any questions other than as praise for your willingness to sacrifice and work in your life trying to help people who are really hurting. And I wanted to say that for the official record.

And with that, thank you all for being here. If you have additional comments or information to insert into the record, we are going to leave the hearing record open for 2 weeks. With that, this hearing from the National Security Subcommittee is adjourned.

[Whereupon, at 5:45 p.m., the subcommittee adjourned subject to the call of the Chair.]

[Additional information submitted for the hearing record follows:]

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 505 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

MEMORANDUM

TO: Michael Yeager, Minority Counsel, House Government Reform and Oversight Committee, Subcommittee on National Security, International Affairs and Criminal Justice

FR: Jenny Collier McColl, Director of National Policy

RE: Request to enter material into hearing record

Date: August 5, 1998

Please enter the attached article into the record for the subcommittee hearing on pregnant and parenting women who use alcohol and drugs. The hearing took place on July 23, 1998.

If you have any questions or concerns please feel free to give me a call at (202) 544-5478. Thank you for your help. I look forward to speaking with you soon.

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

Drug and Alcohol Dependence, 31 (1993) 199–203
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Punishing pregnant drug users: enhancing the flight from care

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(Accepted May 29, 1992)

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 convenience sample was primarily black (85.2%) and single (81%) and 14.8% admitted use of illicit drugs during pregnancy. A goodness-of-fit chi-square analysis revealed that subjects believed a punitive law would be a significant deterrent to substance-using gravida seeking prenatal care, drug testing or drug treatment ($P < 0.01$). Comments indicated that substance-using pregnant women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of their children.

Key words: pregnancy; substance use; incarceration

Introduction

Drug abuse in the United States has increased alarmingly over the last decade. Illicit drug use is associated with adverse pregnancy outcomes including an increased incidence of perinatal mortality, prematurity, intrauterine growth retardation, abruptio placentae and other complications. (Dombrowski et al., 1991) It is clear that effective intervention is necessary to reduce the morbidity and mortality due to drug use. However, there is no consensus whether to treat drug addiction as a criminal or medical matter (Moore, 1990).

Many believe that punitive legislation is the best response to the growing problem of drug abuse during pregnancy because it is seen as keeping mothers away from drugs. As a result, several states have recently enacted laws which consider positive drug toxicologies from neonates or their mothers as prima facie evidence of child neglect or abuse (Chavkin, 1990). An alternative view is that punitive laws would worsen pregnancy outcomes due to chemically-dependent women avoiding prenatal care and drug treatment in an effort to prevent detection. Unfortunately, major policy decisions are being made in a virtual absence of pertinent data.

The purpose of this study was to investigate the attitudes of women from an at-risk population regarding whether or not pregnant drug-abusing women should be prosecuted and the potential effects of a punitive law involving incarceration on the likelihood of these women obtaining prenatal care and participating in drug testing and treatment programs.

Patients and Methods

Sample

A convenience sample of 142 low-income women who received varying amounts of prenatal care and who delivered at Hutsel

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0376-8716/93/$06.00

Hospital in Detroit were studied 2–5 days postpartum. We attempted to survey a similar sample in a state with a punitive law involving incarceration; but all known chemically-dependent women refused to participate. The Detroit women were all English speaking, had been delivered of viable singleton infants and agreed voluntarily to participate. The sample, collected over a 6-month period, consisted of women who were listed as 'walk-ins,' i.e. did not have a physician associated with the hospital and patients who were pre-registered at the hospital through an associated prenatal clinic; we attempted to interview the same number of walk-ins and pre-registered patients in any given week. Our strategy was to oversample for women who received little prenatal care and, in line with our previous studies, would be more likely to use illicit drugs (Poland et al., 1990).

Procedures

Data collection consisted of a 1-h interview with open ended and fixed choice questions and review of the mother's medical chart. We choose the interview over a self administered questionnaire due to the length of the questionnaire and to overcome problems of illiteracy. Two interviewers were trained by one person for consistency of approach. The research protocol was approved by the Institutional Review Boards of the University and the Hospital.

The interview was similar to the one used in our previous study as reported in detail elsewhere (Poland et al., 1987). It assessed sociodemographic information, attitudes toward the pregnancy, barriers to prenatal care, use of cigarettes, alcohol and illicit drugs, the amount and sources of prenatal care and contained four questions relating to how women would behave if laws were changed in Michigan to prosecute women who used illicit drugs during pregnancy. The questions were prefaced by a statement that described a law in another state where women who had a baby born addicted to drugs went to jail. We added that 'while this was not a law in Michigan at this time, we were wondering if a law like this one was enacted, how it might affect drug-using pregnant women: seeking prenatal care, having a test for drug use and seeking drug treatment.' Answers were recorded as 'more likely,' 'no difference,' and 'less likely,' with comments. The final question asked was: 'Do you think pregnant women who use drugs should be put into jail? Answers were recorded as 'yes,' or 'no' and 'don't know,' with comments.

Measures

Variables from the interview were reduced to scales as described below.

Drug use

Use of illicit drugs was assessed over pregnancy. Amount of drugs used was scored as none, light and heavy based upon amounts above and below the sample mean score.

Amount of prenatal care

Amount of care was derived from a modified Kessner Index as described previously and scored 1–4 with one representing no care and four representing adequate prenatal care (Poland et al., 1987).

Punitive laws

Responses to the three questions relating to opinions about a change in behavior of substance using pregnant women were scored: less likely (−1), no difference (0) and more likely (+1). Since these responses were significantly intercorrelated, they were added together to yield a total score. The question about incarcerating women was scored: yes (1) and no (2).

Statistical analysis

Univariate frequency distributions along with descriptive sample statistics were calculated for all variables. Intercorrelations of the sociodemographic variables, quality of prenatal care, drug use, the composite score for the three change in behavior questions and the fourth question regarding whether or not women should be jailed, were computed. Significance was established at $P < 0.05$ level and care was taken to avoid over-interpretation of the results. A goodness-of-fit chi-square analysis was used to test the

Table I. Frequency distribution of sociodemographic and pregnancy variables (N = 142).

Variable	Mean	S.D.	Range
Age	23.7	6.5	13–38
Parity	1.5	1.7	0–8
Education (years)	11.3	1.9	2–16
Birthweight (grams)	3122	703	535–5160
Length Gestation (weeks)	38.7	2.9	29–42
Kessner Index	2.94	0.56	1–4
Drug Use Score	0.22	0.56	0–2

null hypothesis that less likely (−1) and more likely (+1) answers to each of the three questions would be evenly distributed.

Results

Sample

Table I reports the frequency distributions of the major sociodemographic and pregnancy variables. The average age of the subjects was 23.7 years, 81% were single, 85.2% were Black and they had an average 11th grade education. Thirty percent received inadequate amounts of prenatal care and 14.8% admitted use of illicit drugs during pregnancy. All of the women were Medicaid eligible. Of the 21 women in the sample who used drugs during pregnancy: 13 were motivated by the pregnancy to stop before the last trimester and four others sought drug treatment without success; 47.6% received inadequate prenatal care compared with 27.5% of non-users.

Punitive laws

Frequency distributions and intercorrelations were examined for the questions about changes in behavior in response to a punitive state law. Figure 1 describes the responses to the three questions relating to a change in behavior. For all three, most subjects felt that pregnant substance-using women would be less likely to seek prenatal care, drug testing and drug treatment or it would make no difference ($P < 0.01$). The higher the education of the respondent, the less likely she was to believe that drug using pregnant women would seek care in response to

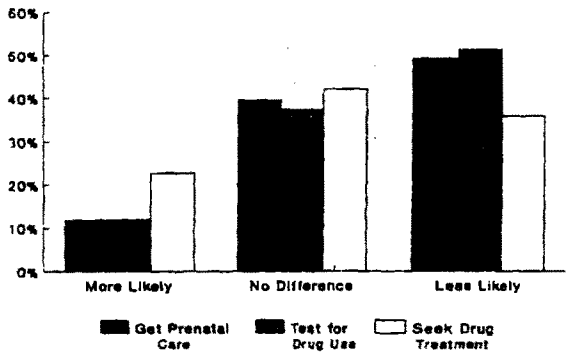

Fig. 1. Behavioral responses to a punitive state law (N = 142).

a punitive law ($r = -0.2, P < 0.05$). There were no other significant correlations with the first three questions.

Comments made in response to these questions indicated, in general, that substance using pregnant women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of their children. Women who used drugs felt that a law threatening incarceration would discourage women from seeking medical care, but one that helped women receive drug treatment may be viewed as an incentive.

Interestingly, 46.5% of the respondents felt pregnant chemically dependent women should go to jail. Women who answered 'yes' had lower parity ($r = 0.26, P < 0.01$) and were younger ($r = 0.30, P < 0.01$). We compared responses of acknowledged drug users ($N = 21$) with non-users. No significant differences were noted although there was a trend toward drug using women answering 'no' ($r = 0.15$). Comments to 'yes — women should go to jail' — included: 'Women should be punished, especially if they hurt their baby,' 'It's the only way to get them to stop,' and 'It will get them out of my neighbourhood.' One respondent who used drugs during pregnancy and answered 'yes' to this question saw jail as a form of domiciliary care that she had been unable to obtain. Three other women who used drugs during pregnancy and answered 'yes' all stopped using drugs on their own in the first trimester and felt other women should also. Comments under 'no, women should not be jailed' — included: 'They need rehabilitation and treatment, not jail,' 'Most of these women don't want or need babies, so just take the baby away and help them from getting pregnant,' 'There are drugs in jail too,' and 'These laws are just for poor Black women, not rich White ones!'

Comment

The American College of Obstetricians and Gynecologists opposes legislation which would impose criminal sanctions on women who use illicit substances during pregnancy (Moore, 1990). However, legislation in several states has been enacted which mandates testing without informed consent and subsequent reporting to authorities of drug use by pregnant women (Moore, 1990). Similar legislation requires testing of newborns and assumes child abuse for those who test positive (Chavkin, 1990). The problem with these opposing views is that they are not based upon empirical data.

The key finding in this survey is that our sample of low-income mothers in Detroit strongly believed that punitive legislation would further alienate pregnant substance-using women from needed health care. Further, this opinion was held by women who did and those who did not use drugs themselves during pregnancy.

Several caveats must be noted. First, this was a convenience sample with over-representation from those who received little or no prenatal care and exclusion of women with non-viable infants. Therefore, it may not be representative of most pregnant women. Nonetheless, we studied the population truly at risk for chemical dependency and for prosecution under a new state law. Second, responses to the questions about the punitive law represent beliefs and attitudes and do not represent actual behavior in response to a change in state law. We used an extreme example of a legal response in order to encourage discussion following each answer. Of considerable note is that we attempted to conduct an identical study in a state with a law threatening incarceration, but all postpartum women who were known to use drugs refused to participate in that survey for fear of further incrimination.

This study has important program and policy implications. The ultimate intention of policymakers who support criminalization of drug use during pregnancy is to decrease perinatal morbidity and mortality by isolating offenders in prison. This study suggests that punitive laws may have the opposite effect. For example, it can be speculated that women who receive prenatal care will be less candid when answering questions pertaining to drug-use if they are under the threat of incarceration. The most important question is how a law mandating

incarceration might affect access to care. Women who use illicit drugs are significantly less likely to seek prenatal care even without punitive laws (ACOG, 1990). They do so due to their involvement in a drug lifestyle and to avoid being labeled as drug users by professionals who are often seen as judgmental (Finnegan, 1991). Our survey confirms that women who use drugs receive less prenatal care. However, for some in our survey, pregnancy is an incentive to reduce or stop drug use. It is these women who may avoid medical care if punitive laws are in effect. It is of interest to note the number of women who used drugs who felt women should go to jail ($N = 4$). Three managed to stop on their own and wanted to punish women who could not. One was a chronic user who wanted jail as a form of mandated domiciliary care. It is unknown what effect policies would have that mandate drug treatment in the form of domiciliary care. This and not jail, may provide the external control needed to help those who cannot reduce drug use any other way. Future studies should examine attitudes and behaviors of women before and after a variety of laws are implemented to better understand their impact on drug use and prenatal care.

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NAADAC
National Association of Alcoholism and Drug Abuse Counselors

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STATEMENT FOR THE RECORD

on behalf of
THE NATIONAL ASSOCIATION OF
ALCOHOLISM AND DRUG ABUSE COUNSELORS

on

Expectant Mothers and Substance Abuse:
Intervention and Treatment Challenges For State Governments

House National Security, International Affairs and Criminal Justice Subcommittee
of the Government Reform and Oversight Committee

Hearing Held on July 23, 1998

On behalf of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), please accept the following comments regarding state policies for pregnant women who require alcohol and drug treatment. NAADAC, with more than 17,000 members, is the largest national organization representing the interests of alcoholism and drug abuse treatment and prevention professionals across the United States.

Alcoholism and drug addiction are chronic diseases that are treatable by professionals who are licensed or certified as treatment counselors. Alcohol and drug addiction treatment effectively reduces the incidence of alcoholism and addiction, having positive effects on even the most difficult populations, such as the homeless and the unemployed. Treatment reduces homelessness by 42.5% and increases employment by 18.7%. (Center for Substance Abuse Treatment, *National Treatment Improvement Evaluation Study*, September 1996).

NAADAC is concerned that South Carolina's laws requiring clinical counselors to report their patients' alcohol or drug use, or other activity which may adversely affect the health of the fetus, to authorities for possible prosecution is having negative consequences. This law deters pregnant women who require alcohol and/or drug treatment from seeking such treatment for fear of prosecution and it damages the ability to provide effective treatment. NAADAC filed an amicus brief with the Supreme Court in the highly controversial case of *Cornelia Whitner vs. The State of South Carolina* for just these reasons.

At least two programs in the Columbia, SC area, have experienced drops in admission for pregnant women as a result of the state law. The Women's Community Residence is a 24 bed halfway house for women substance abusers. The facility opened in 1992 and accepts applications for an average of 237 women per year, admitting approximately 133 women, with priority admission for pregnant women. The history of the facility's admissions shows a constant increase until 1996 in the proportion of pregnant women since the facility opened (from 3% to 10%). For the July 1, 1996 - June 30, 1997 record keeping period, admissions of pregnant women dropped from 10% of the total to 2%, an 80% decline.

Similarly, the Women's Intensive Outpatient program (co-located with the Women's Community Residence in West Columbia, SC) is an intensive day program which additionally provides child care. It treats an average of 95 women per year and gives priority admission to pregnant women. In 1995 - 96, 13% of admissions were pregnant women. Whitner was decided by the South Carolina Supreme Court on July 15, 1996 in a decision which was highly publicized in the Columbia area. The following year, from 1996-1997, only 6% of admissions were for pregnant women, a 54% decline in admissions.

In addition to slipping enrollment, South Carolina's reading of the statute is preventing NAADAC's professional counselor membership in the state from providing the most effective treatment. Effective alcohol and drug treatment requires the trust of patients who frequently reveal secrets of the most private nature to alcohol and drug counselors. It is impossible to build such trust when the law requires counselors to report pregnant patients who currently engage in the use of alcohol and/or illicit drugs for possible prosecution by the state. Such a situation burdens the provider-patient relationship during treatment. Treatment professionals are constrained from asking questions about a pregnant patient's current drug use for fear of learning information which would require a report to the state. Likewise, patients are constrained from forthright and honest participation in treatment they seek for fear of legal retribution. The South Carolina law ensures these negative consequences by using the ordinary confidences of patients in treatment as fodder for the state's prosecution.

Predictably, we are already witnessing these unfortunate consequences. NAADAC has learned from South Carolina providers that intake nurses in Columbia, SC area hospitals have simply begun to stop questioning pregnant patients about their use of alcohol and other illegal drugs. Such providers are acting defensively to avoid having to report such patients to the state. In addition, some alcohol and drug treatment providers have stated that pregnant women have learned to avoid answering alcohol and drug treatment questions truthfully in light of the publicity surrounding the Whitner case.

NAADAC is pleased that the committee has tackled this difficult topic. However, we feel compelled to point out the real-world difficulties in an approach which was highlighted at the hearing. NAADAC members are working in the front lines of the battle throughout America to help end the diseases of addiction and alcoholism. They are committed to helping pregnant women fight the disease of addiction and become responsible parents. However, we ask the committee to ensure that they are not hampered by well-meaning regulations which place the relationship of the patient and therapist at risk.

The Ability of Pregnant Women to Complete Treatment on a Detoxification Service

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ABSTRACT

Objective: Given the risk of prenatal drug exposure and the rising number of drug exposed infants, this investigator set out to assess if pregnant substance abusers were more or less likely to complete a detoxification program as compared to their nonpregnant counterparts.

Methods: A retrospective analysis of all detoxification patients who left Against Medical Advice (AMA) in a large county hospital was measured from 1987 through 1997. Of all 19,963 patients admitted for detoxification, 6,169 (31%) were female. Of these women, 527 (9%) were pregnant. Patient's analyzed either left AMA from the acute detoxification program and/or the inpatient rehab program. This data also included patients with subsequent admissions.

Results: There was no difference in the AMA rate of women who were pregnant compared to their nonpregnant counterparts. When these women were separated for primary drug of choice (alcohol, heroin, cocaine) there was also no difference in completion rate.

Conclusions: These findings imply that there is no increased retention in detoxification programs among pregnant women despite the fact that their drug abuse can have a profound effect on their unborn babies. Some have argued that the access to detoxification programs for this selective group of women is difficult. Therefore, it is unfortunate to find that those who manage to get admitted are no more likely to remain in treatment than their nonpregnant counterparts.

INTRODUCTION

Major Public Health Concern

Substance use disorders during pregnancy are prevalent and multidimensional problems

- The prevalence of perinatal substance users in 1993 ranged from 11% in a survey of 36 delivering hospitals representing all geographic areas of the US to 15% in a study of 17 prenatal clinics serving both public and private patients in Western Florida.
- Consequences of substance use on fetal and neonatal development include fetal alcohol syndrome, spontaneous abortions, low birth weight, congenital malformations, and Sudden Infant Death Syndrome.
- Many drug agencies will not continue women in treatment when they become pregnant. In 1989, of 78 drug treatment facilities in New York City, 54% refused to treat pregnant women, and 87% denied treatment to pregnant women addicted to crack cocaine.
- A large number of pregnant substance abusers live in poverty with potential barriers to adequate medical and obstetric care. Poverty is also associated with use of alcohol, tobacco, and illicit substances.

Pregnant Substance Abusers are Currently Understudied

The few studies that exist in the literature focus primarily on small clinical samples. Such samples may have selection bias (i.e., samples may include only those women showing treatment seeking behaviors).

Purpose of this Study

This study investigated whether there was a difference between pregnant women who were discharged from a county hospital against medical advice (AMA) when compared to their nonpregnant counterparts on a treatment service for chemical dependency.

Hypothesis

We assumed that a discharge status of AMA would not be affected by pregnancy status (null hypothesis).

METHODS AND MATERIALS

Study Sample and Procedures

A retrospective cohort of patients (over a ten year time frame) was assembled by Medical Record Review (January, 1987, through December, 1997).

- Admissions to a chemical dependency unit (detoxification and/or rehabilitation service) took place at a large county hospital with regional draw in Buffalo, New York. In-house transfers among services were counted as a single admission.
- Of all 19,963 patients admitted to either service, 31% were female (n = 6,169).
- Analysis were done on a subset of women aged 18-41 years (n = 4,497), including 527 women who were pregnant at the time of admission.

Measures

__Pregnancy status__: A clinically recognized pregnancy (positive HCG screen or MD diagnosis) at time of admission. Pregnancy included ICD codes of abortion, cervical incompetence, threatened labor, and preeclampsia, but excluded pregnancy (possible but not confirmed) and pregnancy (post-partum observation).

__Against Medical Advice__: AMA included patients who left the hospital prior to appropriate discharge as per the treating physician. The reasons for leaving AMA included patients who did not want to continue withdrawal from drugs, as well as patients who refused further treatment once physical withdrawal was complete.

__Primary Diagnosis__: Substance use disorder was based on criteria from DSM III-R and DSM-IV. Specific substance use disorders included alcohol, cocaine, opiates, and sedatives. Diagnosis was made by an attending physician within 24 hours of admission.

Statistical Analysis

- Univariate analysis consisted of frequency distributions. Characteristics of the distributions (mean, standard deviation, median) were determined.
- Bivariate cross tabulations were used to examine relationships between dichotomous variables. Continuous variables were compared using the t-test for independent samples, whereas categorical variables were compared using the Chi-square test statistic. Results from multivariate logistic regression models (not shown) were not additionally informative.

DISCUSSION

- More than one quarter of all pregnant substance abusers were discharged AMA from a treatment service for chemical dependency at a large county hospital over a ten year time frame.
- Findings from this study provide no evidence that pregnant women differ from their nonpregnant counterparts in relation to AMA status over a ten year time frame. Furthermore, no associations were demonstrated when analyses were restricted to single admissions or repeat admissions (e.g., women with two admissions, women with three admissions, etc.).
- Length of stay was associated with pregnancy and AMA status. Statistically significant differences were observed within the first week of treatment ($p < .001$). When length of stay was between days three through five, 29% more pregnant women were discharged AMA when compared to nonpregnant women (51% and 22% respectively) ($p < .001$).
- Among whites, pregnant women were 17% more likely to be discharged AMA when compared to nonpregnant women (44% and 27% respectively) ($p < .001$). A greater proportion of white (44%) than black (23%) pregnant women left AMA ($p < .001$, not shown).
- Pregnant women who were discharged AMA were slightly more likely (5.6%) to have Medicaid insurance compared to nonpregnant women ($p < .05$).

Study Implications

Pregnant women with substance use disorders may represent a particularly vulnerable subgroup for intensive intervention strategies during the first few days of admission (specifically days three through five) to avoid leaving the hospital against medical advise. Findings from this study may serve as a basis to evaluate the need for a specialized treatment program targeted to the needs of these women. This may particularly apply to white pregnant women.

Study Limitations

- This clinical dataset contained a limited number of variables. Data on additional sociodemographics (education, number of children at home, marital status) and established risk factors were not available.
- There may be limited external validity.
  (1) Pregnancy status was based on clinically recognized pregnancy.
  (2) The investigator was unable to exclude women not at risk for pregnancy (e.g., tubal ligations, hysterectomies, etc.).
- Analysis did not include systematic adjustment for any repeat admission(s) per individual.

ACKNOWLEDGEMENTS

Mya Swanson from the Department of Social and Preventive Medicine, State University of New York at Buffalo, provided programming and technical assistance.

RESULTS

Table I. Selected Sociodemographic and Treatment Characteristics of Pregnant and Nonpregnant Women on a Detoxification and/or Rehabilitation Service

	Pregnancy Status Among Females (N = 4,497)					
	Yes (n=527)		No (n=3970)		[illegible]	
Characteristic[a]	%	(n)	%	(n)	[illegible]	[illegible]
Age (yrs)						
18-19	3.4	(18)	1.2	(50)		
20-24	24.1	(127)	10.6	(420)		
25-29	33.8	(178)	21.8	(864)		
30-34	20.7	(109)	30.1	(1194)		
35-39	9.1	(48)	27.3	(1086)		
40-41	.8	(4)	9.0	(356)	[illegible]	<.001
x̄ ± SD	[illegible] ± 4.8		[illegible] ± [illegible]		[illegible]	[illegible]
Median	[illegible]		32.0			
Race						
Black	77.2	(407)	[illegible]	[illegible]		
White	20.5	(108)	[illegible]	[illegible]		
Other[b]	2.3	(12)	3.5	(138)	[illegible]	<.001
Payer						
Self	17.0	[illegible]	[illegible]	[illegible]		
Private	[illegible]	[illegible]	[illegible]	[illegible]		
Medicaid	[illegible]	[illegible]	70.3	[illegible]		
Other[c]	[illegible]	[illegible]	2.9	(116)	[illegible]	<.001
Year of Admission						
1987	[illegible]	[illegible]	[illegible]	[illegible]		
1988	[illegible]	[illegible]	[illegible]	[illegible]		
1989	[illegible]	[illegible]	[illegible]	[illegible]		
1990	10.1	(53)	8.1	[illegible]		
1991	12.8	[illegible]	[illegible]	[illegible]		
1992	[illegible]	[illegible]	[illegible]	[illegible]		
1993	[illegible]	[illegible]	[illegible]	[illegible]		
1994	[illegible]	[illegible]	[illegible]	[illegible]		
1995	[illegible]	[illegible]	[illegible]	[illegible]		
1996	[illegible]	[illegible]	[illegible]	[illegible]		
1997	[illegible]	(22)	7.8	[illegible]	[illegible]	<.001
Length of Stay						
≤ One week	42.3	(223)	52.4	[illegible]		
> One week	57.7	(304)	47.6	[illegible]	[illegible]	<.001
x̄ ± SD	10.1 ± 7.7		[illegible] ± [illegible]		[illegible]	[illegible]
Median	[illegible]		7.0			
Treatment Service						
Acute	[illegible]	[illegible]	[illegible]	[illegible]		
Rehab	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Primary Diagnosis						
Sedative	[illegible]	[illegible]	[illegible]	[illegible]		
Opiates	[illegible]	[illegible]	[illegible]	[illegible]		
Cocaine	[illegible]	[illegible]	[illegible]	[illegible]		
Alcohol	[illegible]	[illegible]	[illegible]	[illegible]		
Other[d]	4.8	[illegible]	4.3	[illegible]	[illegible]	<.001

Table II. Relation Between AMA Status and Pregnancy Status

	Discharge Status							
	AMA [illegible]		Other [illegible]		Total [illegible]		[illegible]	
Pregnancy Status	%	(n)	%	(n)	[illegible]	[illegible]	[illegible]	[illegible]
Yes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table III. Discharge Status of Pregnant and Nonpregnant Women: Selected Sociodemographic and Treatment Characteristics

	Pregnancy Status								
	Yes (n=527)				No (n=3970)				
	Discharge Status				Discharge Status				
	[illegible]		[illegible]		[illegible]		[illegible]		[illegible]
Characteristic[a]	%	(n)	%	(n)	%	(n)	%	(n)	[illegible]
Age (yrs)									
18-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-41	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Race									
Black	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
White	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Other[b]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Payor									
Self	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Private	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Medicaid	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Other[c]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Length of Stay									
≤ One week	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1-2 days	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
3-5 days	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
6-7 days	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
> One week	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Service									
Acute	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Rehab	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Primary Diagnosis									
Sedative	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Opiates	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Cocaine	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Alcohol	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Other[d]	34.9	[illegible]	[illegible]	(17)	91.3	[illegible]	[illegible]	[illegible]	[illegible]

The Following Symbols Appear in the Tables:

[a] No more than four women had missing data for any sociodemographic or treatment variables
[b] Included Asian, Hispanic, or Indian.
[c] Included Compensation, Medicare, Other Government, or No Fault.
[d] Included Hallucinogens or Other Substances not listed
[e] Included home, jail, psychiatric hospital, or rehabilitation center
[f] The Chi-square statistic was used to test for differences between pregnant and nonpregnant women who were discharged AMA versus other discharge

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July 22, 1998

The Honorable J. Dennis Hastert
Chairman, Subcommittee on National Security, International Affairs and Criminal Justice
Committee on Government Reform and Oversight
United States House of Representatives
B373 Rayburn House Office Building
Washington DC 20515

Dear Chairman Hastert:

The American Academy of Pediatrics (AAP) is pleased that the Subcommittee on National Security, International Affairs and Criminal Justice is holding hearing to discuss the issue of substance abuse and pregnant women. This is an issue of great importance to the AAP and its 53,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well being of infants, children, adolescents, and young adults. The AAP requests the opportunity to offer this letter as a written statement for inclusion in the hearing record.

Prenatal alcohol and drug exposure are preventable causes of such complications as premature birth, low birth weight, impaired fetal growth, as well as birth defects and neonatal seizures, mental retardation, neurodevelopmental deficits and developmental and learning problems. Studies have documented that an increasing number of women of childbearing age are using licit and illicit substances. Although statistical data are insufficient, there are indications that approximately 1 in 10 infants may have been exposed to illicit drugs in utereo.

These statistics are of grave concern to pediatricians. Once a child is born, pediatricians act as primary medical caregivers to those who were exposed to drugs and alcohol during pregnancy. These children face long-term manifestations of their exposure.

However, the Academy is concerned with some approaches states are taking to address this issue. In general, a coordinated multidisciplinary approach, such as involvement of Child Protective Services, in the development of a plan without criminal sanctions has the best chance of helping children and families. The Academy believes that substance-abusing pregnant women must be assured of nonpunitive access to healthcare. Punitive measures may have the affect of deterring women from seeking prenatal care, thereby reducing their ability to access substance abuse treatment.

Meeting the need for effective substance abuse therapy must be a national priority. The health policy issues posed by women who abuse substances during pregnancy can be divided into two components:

How to prevent infants from being exposed to potentially harmful substances before birth. There is an increased need to explore more effective ways to help prevent women from abusing substances during pregnancy.

How to address the needs of exposed infants and children and their families. The most basic problem is that demand for treatment programs far exceeds availability.

When considering federal policy to tackle the problem of substance abuse in pregnant women, the Academy offers several recommendations as a starting point:

- Funds for substance abuse prevention and treatment programs that have been evaluated for effectiveness must be available for women of childbearing age, their infants and families.

- Substance abusing pregnant women must be assured nonpunitive access to comprehensive care that meets their needs and that of the infant. The Child Protective Services system seems well suited to helping these women and their infants. There is no evidence that substance abuse interventions that are enforced by criminal sanctions prevent in utereo drug exposure or help drug-exposed children. Without strong evidence that involvement with the criminal justice system serves to prevent prenatal substance exposure or to improve the health of children, such interventions are unjustifiable.

- Universal neonatal drug testing is not recommended. Screening for illicit drug use provides only a narrow window on drug use and does not reveal information about the pattern, frequency, and timing of the use.

- Funds for research, education, and treatment should be made available for infants who are exposed to alcohol and drugs during pregnancy.

The Academy remains committed to ensuring that children are born healthy and we look forward to working with you on this issue. We welcome the opportunity to provide our expertise at future hearings, meetings or briefings. Thank you for your consideration of these recommendations.

Sincerely,

Joseph R. Zanga, MD, FAAP
President

JRZ:meh/kbf