

KEEPING MOTHERS AND THEIR INFANTS TOGETHER: BARRIERS AND SOLUTIONS

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INTRODUCTION

Our society has been shocked by the growth of cocaine use among pregnant women in the past decade. While the overall use of cocaine, including crack, has dropped in the 1990s,¹ its use by women of childbearing age has grown.² A study in one Florida county found that approximately

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1. See NATIONAL INSTITUTE ON DRUG ABUSE, DIVISION OF EPIDEMIOLOGY AND PREVENTION RESEARCH, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE: MAIN FINDINGS 1990 13 (1991) (noting that from 1988 to 1990, the use of most drugs decreased or remained stable for all age groups 12 and older); Linda C. Mayes, Richard H. Granger, Marc H. Bornstein, & Barry Zuckerman, *The Problem of Prenatal Cocaine Exposure: A Rush to Judgement*, 267 J. AM. MED. ASS'N 406 (1992) (noting that the number of individuals reporting cocaine use dropped from 12 million in 1988 to 6.6 million in 1990); Joseph B. Treaster, *The 1992 Campaign: Candidates' Records; Four Years of Bush's Drug War: New Funds but an Old Strategy*, N.Y. TIMES, July 28, 1992, at A1 (noting that federal survey of households showed a drop of cocaine use from 12 million in 1985 to 6.2 million in 1990 and 6.4 million in 1991).

2. See Ira J. Chasnoff, Dan R. Griffith, Catherine Freier & James Murray, *Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-Up*, 89 PEDIATRICS 284 (1992) (noting that women of childbearing age continue to use cocaine at a significant rate); Byron C. Calhoun & Peter T. Watson, *Cost of Maternal Cocaine Abuse: I. Perinatal Cost*, 78 OBSTETRICS &

thirteen percent of women tested positive for alcohol or drugs during pregnancy.³ In 1990, women addicted to cocaine gave birth to an estimated 300,000 infants.⁴

The government and the medical, legal, and social service communities have been hampered by lack of experience with and lack of reliable data regarding the pregnant cocaine user. Thus, these communities have responded toward pregnant women's cocaine abuse with a number of strategies which have varied in their effectiveness. With a significant outpouring of federal funds, some state and federal authorities have laid a foundation for a realistic treatment approach.⁵ These combined state and federal efforts have helped some women and children.⁶ Society has also responded, however, by viewing a pregnant woman's cocaine abuse as a crime against the unborn rather than as an illness in need of treatment.⁷ Under this view, social service and legal agencies, often with the aid of the medical community, seek to punish the drug-using pregnant woman with incarceration and the removal of her newborn and other children.⁸

Such retributivist reactions are unlikely to benefit either the child or society. Current scientific evidence does not conclusively demonstrate that maternal drug use directly or substantially causes the poor development found in children of drug-using mothers.⁹ Additionally, research into the long term behavioral and developmental effects of prenatal drug exposure is scant.¹⁰ There is likewise no evidence that shows that a drug addict is necessarily a bad parent.¹¹ In fact, the reality that the foster care system is

GYNECOLOGY 731 (1991) (noting increase in maternal cocaine abuse since 1980); Marci J. Hanson & Judith J. Carta, *Addressing the Challenge of Families with Multiple Risks: Families of Children and Adolescents with Special Needs*, 62 EXCEPTIONAL CHILDREN 201 (1995) (estimating that 4.5 million women who are users of illegal drugs are of childbearing age); Patricia A. King, *Helping Women Helping Children: Drug Policy and Future Generations*, 69 THE MILBANK Q. 595, 596 (1991) (estimating that 5 million women of childbearing age currently use illicit drugs).

3. Ira J. Chasnoff, Harvey J. Landress & Mark E. Barrett, *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy & Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202 (1990).

4. See Jan Bays, *Substance Abuse and Child Abuse*, 37 PEDIATRIC CLINICS N. AM. 881 (1990).

5. See *infra* notes 89-95 and accompanying text.

6. *Id.*

7. See generally, Walter B. Connolly, Jr. & Alison B. Marshall, *Drug Addiction, Pregnancy, and Childbirth: Legal Issues for the Medical and Social Service Communities*, 18 CLINICS IN PERINATOLOGY: CHEMICAL DEPENDENCY & PREGNANCY 147 (1991) (citing instances where mothers faced felony charges surrounding their use of cocaine during pregnancy).

8. See *infra* notes 39-46, 56-71 and accompanying text.

9. See *infra* notes 16-20 and accompanying text.

10. See *infra* notes 21-38 and accompanying text.

11. See Janet L. Dolgin, *The Law's Response to Parental Alcohol and "Crack" Abuse*, 56 BROOK. L. R. 1213, 1225 (1991) (discussing lack of research on the effects of drug use on parental motivation, but suggesting that several factors other than drug use lead to neglect); Bonnie I. Robin-Vergeer, *The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention*, 42 STAN. L. R. 745, 768 (1990) (reviewing studies of drug addicted parents

ill-equipped to care for the special needs of a drug-exposed child may mean that the removal of such a child from her mother could harm her long-term recovery.¹²

Furthermore, separation of a child from her drug-addicted mother results in added costs to an already over-burdened judicial and foster care system.¹³ This unnecessary expense diverts funds from treatment and prevention programs. Finally, criminalization or stigmatization of prenatal drug use deters pregnant women from seeking drug treatment and prenatal care.¹⁴ Regarding pregnant women's drug use as a crime, therefore, is both ineffective and counterproductive to the goals of mother, child, and society.

Instead, the governmental, medical, social, and legal entities involved in drug treatment and child protection should treat pregnant women's drug abuse as an illness. Efforts should focus on developing treatment and prevention programs carefully tailored to the individual case of mother and child.¹⁵ These programs must view the pregnant drug user nonjudgmentally and provide the comprehensive services she needs. Along with drug treatment and pre- and postnatal care, such services may include vocational training, parenting training, mental health evaluation, and social support after treatment. Given the inefficacy of punishing drug use during pregnancy, the overwhelmed state of the courts and foster care system, and the lack of scientific evidence regarding the precise effects of prenatal cocaine exposure, such comprehensive treatment, prevention, and support programs for pregnant substance abusers benefit mothers, children, and society.

I.

PRENATAL COCAINE EXPOSURE: EFFECTS ON THE NEWBORN

The link between prenatal drug exposure and poor child development is not conclusive, as shall be shown below. While cocaine is a pharmacological agent and as such may possibly have toxic effects on the fetus, it is also a marker for a number of social factors which contribute to poor child

and concluding that "it cannot be said that there is a *strong* correlation between drug use that falls short of addiction and child neglect. . .").

12. See *infra* notes 56-71 and accompanying text.

13. See HOUSE COMM. ON WAYS & MEANS, 103D CONG., 2D SESS., OVERVIEW OF ENTITLEMENT PROGRAMS, 1994 GREEN BOOK, MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMM. ON WAYS & MEANS 636-640 (Comm. Print 1994)[hereinafter 1994 GREEN BOOK] (reporting on the dramatic increase in the number of children entering the foster care system during the 1980s).

14. See Connolly & Marshall, *supra* note 7, at 179-80 (analyzing impact of criminalization on pregnant women).

15. For a description of innovative treatment programs, see *infra* notes 89-95 and accompanying text.

development.¹⁶ Early studies concluded that cocaine use during pregnancy resulted in serious fetal problems harmful to child development.¹⁷ Methodological problems, however, limit these studies' usefulness. The authors of these studies employed poor methodologies which included using anecdotal data, failing to use control groups, inadequately controlling for other variables that could cause the same adverse effects,¹⁸ and identifying users and non-users with unreliable methods.¹⁹ While these studies adequately demonstrated a *link* between poor child development and drug-using mothers, their dubious methodologies cast serious doubt on whether prenatal cocaine exposure *caused* the adverse effects.²⁰

The long-term behavioral and developmental effects of prenatal drug exposure are also unknown. Medical researchers have published few prospective longitudinal studies and have studied children only up to three years of age.²¹ While more drug-exposed children in this study had an IQ outside the normal range and/or had lower scores in some function areas such as language, they also showed the same average IQ as the control group of non-exposed children.²² Thus, the significance of prenatal cocaine exposure remains undetermined largely because scant and methodologically limited available data precludes definitive conclusions.²³

The difficulty in determining prenatal cocaine exposure's effect on child development is complicated by some pregnant women's multiple substance use and some mothers' inability to offer a stable environment to their children. Pregnant cocaine users commonly use alcohol, marijuana,

16. See Bays, *supra* note 4, at 883-93 (discussing other risk factors in homes of families with drug-abusing caregivers); see also Arnold J. Sameroff & Michael J. Chandler, *Reproductive Risk and the Continuum of Caretaking Casualty*, 4 REV. OF CHILD DEV. RES. 187 (1975).

17. Mayes, Granger, Bornstein, & Zuckerman, *supra* note 1, at 406.

18. *Id.* at 407.

19. Beatrix Lutiger, Karen Graham, Thomas K. Einarson, & Gideon Koren, *Relationship Between Gestational Cocaine Use and Pregnancy Outcome: A Meta-Analysis*, 44 TERA-TOLOGY 405, 409-10 (1991).

20. Studies of the relationship between cocaine use during pregnancy and fetal outcome show that, when cocaine users were compared with polydrug users who did not use cocaine, only an increased prevalence of genital and urinary organ malformations were associated with cocaine use. However, when the control group consisted of non-drug users, cocaine was associated with a significantly higher risk of spontaneous abortion, shorter gestational age, smaller head circumference, shorter birth length, and lower birth weight. This demonstrates the fallacy that cocaine use in particular, rather than factors linked to any drug use during pregnancy, adversely effects the newborn. Lutiger, Graham, Einarson & Koren, *supra* note 19, at 409-411.

21. See, e.g., Scott D. Azuma & Ira J. Chasnoff, *Outcome of Children Prenatally Exposed to Cocaine and Other Drugs: A Path Analysis of Three-Year Data*, 92 PEDIATRICS 396 (Sept. 1993) (studying effects in three year period following birth); see also Chasnoff, Griffith, Freir & Murray, *supra* note 2, at 284.

22. Azuma & Chasnoff, *supra* note 21, at 398 (presenting study results that mean IQ scores did not differ statistically between groups of drug-exposed and drug-free children).

23. See Chasnoff, Griffith, Freir & Murray, *supra* note 2, at 284 (explaining that there is little information on prenatal cocaine exposure's impact on long-term infant development).

and cigarettes in addition to cocaine, and may use drugs such as heroin as well.²⁴ Polydrug use, that is multiple drug use, affects child development in a variety of ways unrelated to the purely physiological effects of cocaine use on a fetus.²⁵

Indeed, numerous environmental factors apart from prenatal drug exposure may adversely affect child development in drug users' children. Most studies have focused on prenatal drug exposure's effects upon children of women of lower socio-economic class, despite studies demonstrating that overall illegal drug use was similar in middle and lower income women.²⁶ Because low-income women primarily rely on inner city public hospitals for their prenatal care, they are more likely to be selectively screened for drug use, publicly identified as drug users, and limited in their access to both prenatal care and drug treatment.²⁷ The perceived adverse effects on children born of cocaine-using mothers, therefore, may be more attributable to problems affecting poor pregnant women than to drug use.

In addition, the often detrimental surroundings in which drug-exposed children are raised will lead to poor child development. Typical problematic home environments of substance-abusing parents involve inadequate or disruptive forms of parenting, poverty, high stress, and exposure to violence.²⁸ Drug-using parents also have a reported higher incidence of physical illness, and more frequently have experienced physical abuse, sexual abuse, psychiatric disorders, affective disorders, and depression.²⁹ These

24. See Terry A. Adirim & Nandini Sen Gupta, *Nat'l Survey of State Maternal & Newborn Drug Testing & Reporting Policies*, 106 PUB. HEALTH REP. 292, 293 (1991) (noting clinical studies show that pregnant women who used illicit substances usually used more than one substance); Bays, *supra* note 4, at 882 (1990) (noting that maternal use of other drugs, alcohol, and cigarettes in addition to cocaine is frequent); Ira J. Chasnoff, *Cocaine, Pregnancy & the Neonate*, 15 WOMEN & HEALTH 23, 33 (1989) ("[P]olydrug abuse has . . . become more common, with the majority of cocaine users abusing marijuana and/or alcohol and/or cigarettes in addition."); Lutiger, Graham, Einarson & Koren, *supra* note 19, at 410-11.

25. See Bays, *supra* note 4, at 883-84 (describing the prenatal and long term effects of cocaine use on the cocaine-exposed fetus and child), 887-93 (discussing the increased risks of child abuse and neglect associated with parental drug use); Lutiger, Graham, Einarson & Koren, *supra* note 19, at 410-11 (noting the effects of polydrug use on reproductive outcomes and the difficulty of separating the effects of cocaine use from other reproductive risk factors).

26. See, e.g., Chasnoff, Landress & Barrett, *supra* note 3, at 1202 (study showing that rates of substance abuse among women of different racial groups and socio-economic status are similar, despite statistics which indicate the contrary).

27. See *id.* at 1206 (arguing that the preconception that pregnant mothers belonging to minority groups, urban populations, and/or lower socio-economic groups are more prone to substance abuse could bias physicians and result in higher rates of drug testing and reporting of infants born to black or poor women).

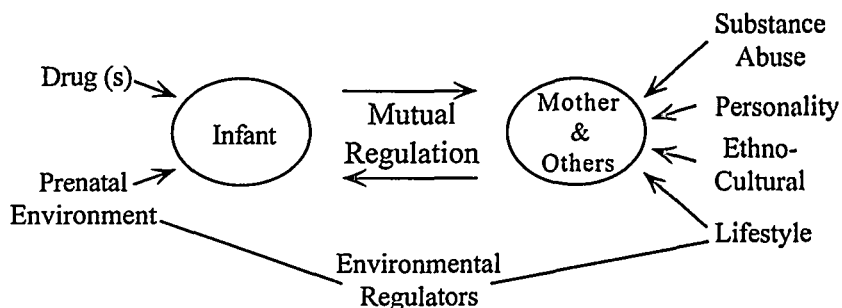
28. See generally, Bays, *supra* note 4, at 888-93 (discussing risk factors in families that abuse alcohol or drugs).

29. *Id.* at 889.

independent factors affecting drug-using mothers are known also to contribute to poor child development,³⁰ and are only compounded by the effects of a mother's continuing drug use. Thus, the child of a cocaine-using woman may show poor development due to either cocaine exposure, polydrug exposure, a poor parenting environment, or due to some combination of these factors.³¹

Cocaine use, therefore, is not the direct and primary cause of poor child development, but rather is a marker for polydrug use and a parenting style or home environment that may jeopardize normal child development. Figure 1, a model systems approach, shows maternal cocaine use in the context of the multiple interacting forces that affect child development. The combination of prenatal drug exposure and other factors such as poor prenatal care and a complicated reproductive history may combine to produce neurobehavioral vulnerability in some infants.³² Many of these infants are probably not physiologically damaged and appear quite healthy, but a significant proportion will display stress behaviors and will have difficulty regulating their actions.³³ The totality of the prenatal and postnatal environment, however, rather than drug exposure alone, causes and perpetuates these behaviors.

FIGURE 1
SYSTEMS APPROACH TO STUDY OF COCAINE



30. See Sameroff & Chandler, *supra* note 16.

31. See Bays, *supra* note 4, at 883-84, 887-93.

32. See Barry M. Lester, Michael J. Corwin, Carol Sepkoski, Ronald Seifer, Mark Peucker, Sarah McLaughlin, & Howard L. Golub, *Neurobehavioral Syndromes of Cocaine-exposed Newborn Infants*, 62 *CHILD DEV.* 694, 702 (1991) [hereinafter *Neurobehavioral Syndromes*]. Neurobehavioral vulnerability exists when the baby is at increased risk for abnormal outcome.

33. *Id.* at 695-96, 701; see also Azuma & Chasnoff, *supra* note 21, at 400-01 (finding poor interactive capability, poor state regulation, and poor habituation of drug-exposed infants at three years of age).

In a reasonably supportive environment, these infants may recover and achieve normal development. An infant who is already neurobehaviorally vulnerable, however may recover poorly in an unsupportive environment.³⁴ A mother's drug problem and psychological problems related to her use of drugs may compromise her ability as a caretaker and hamper the infant's ability to recover from any drug effects.³⁵ Lack of social support and larger environmental problems associated with growing up in poverty may also jeopardize an infant's recovery.³⁶ In the end, a drug-exposed infant's home environment, whether helpful or harmful, will critically influence her long term development.³⁷

Much research must still be done to explore fully the problem of prenatal exposure to drugs. The first wave of research in this area exaggerated direct drug effects and led to the scientific community's and the public's misperception that a generation of children was doomed.³⁸ It would be equally dangerous to assume that the maternal lifestyle alone is to blame. Rather, it is more accurate to assert that, as determined by the multiple factors affecting development, the children of cocaine-using mothers are at increased biological and social risk. Criminally or socially punishing pregnant drug users proceeds on the false assumption that the toxic effects of cocaine or other illegal drugs are the sole cause of poor child development. Punitive measures are, therefore, an incomplete response to the many factors which may lead to poor development in children of drug-using mothers.

II.

CURRENT APPROACHES TO PRENATAL DRUG USE

Although the evidence linking prenatal drug exposure to childhood developmental damage is inconclusive, a 1992 poll found that forty-four percent of Americans viewed the drug-addicted pregnant woman as criminally inflicting permanent damage on her child.³⁹ At least 167 women in 24 states have been prosecuted for their newborn child's fetal drug exposure, although most convictions challenged have been dismissed or overturned.⁴⁰ In addition, many states now treat prenatal drug exposure as child abuse. As a result, state social service agencies responsible for the child's welfare

34. See Barry Zuckerman & Deborah A. Frank, *Crack Kids: Not Broken*, 89 PEDIATRICS 337 (1992)(warning against assuming prenatal exposure to cocaine will inevitably impair development); see also *Neurobehavioral Syndromes*, *supra* note 32, at 702.

35. See Bays, *supra* note 4, at 883-84, 887-93; *supra* notes 28-31 and accompanying text.

36. Bays, *supra* note 4, at 883-84, 889-93.

37. Sameroff & Chandler, *supra* note 16, at 187.

38. See Mayes, Granger, Bornstein & Zuckerman, *supra* note 1 and accompanying text.

39. Lynn Paltrow, *When Becoming Pregnant is a Crime*, 9 CRIM. JUST. ETHICS, 41, 42 (1990).

40. THE CENTER FOR REPRODUCTIVE LAW AND POLICY, *PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: A PUBLIC HEALTH DISASTER* (1993).

usually remove the child from the drug-using biological mother.⁴¹ These severe sanctions permanently stigmatize the mother and perhaps irremediably disrupt her relationship with her child. Ironically, prosecution of the drug using pregnant woman and the removal of her child are not in the best interests of child or society.

TABLE I⁴²

STATE LAWS REGARDING PRENATAL SUBSTANCE ABUSE

LAW	# OF STATES
Mandatory Prenatal Testing/Screening for Substance Use	2
Mandatory Reporting of Prenatal Substance Use	1
Mandatory Neonatal Testing of Newborn for Drugs	1
Mandatory Reporting of Prenatal Substance Use as Abuse or Neglect	8
Mandatory Reporting of Prenatal Substance User for Assessment/Services	4
Mandatory Priority Access to Substance Treatment for Pregnant Women	9
Provision of Program or Coordination of Services for Pregnant Substance Users	18
Mandatory Posting of Warning Signs Regarding Alcohol Use During Pregnancy	11
Establishment of Perinatal Substance Abuse Task Force	15
None of the Above	19

Table I shows the variety of state mandated child-protective responses to drug use during pregnancy and the number of states which employs each response. Nineteen states have no specific specifically designated child-protective laws or policies addressing prenatal drug exposure.⁴³ In addition, mandatory reporting or drug testing is relatively uncommon.⁴⁴ However, many states use existing child welfare policies or child abuse laws to support the criminal or civil prosecution of women who use cocaine and other drugs during pregnancy.⁴⁵ In addition, many health and social service providers have interpreted existing laws or policies as mandatory reporting requirements of pregnant women's drug use.⁴⁶

In Rhode Island, for example, prenatal drug exposure may constitute abuse and neglect under existing laws. Rhode Island defines abuse as, and

41. See Adirim & Gupta, *supra* note 24, at 295 (noting states which consider positive drug test as statutory evidence of child abuse or neglect); Bays, *supra* note 4, at 882 (noting that many states now include drug-affected infants in their child abuse reporting statutes).

42. Review of relevant state laws through 1995.

43. Table I, *supra* note 42.

44. Table I, *supra* note 42.

45. Adirim & Gupta, *supra* note 24, at 295.

46. *Id.* at 295-96.

requires the reporting of, "situations or conditions such as, but not limited to, social or psychiatric problems or disorders, mental incompetency, or the use of a drug, drugs, or alcohol to the extent that the parent or other person responsible for the child's welfare loses his or her ability or is unwilling to properly care for the child. . . ."⁴⁷ Under such a definition of inadequate parenting, drug use by a pregnant woman may be automatic grounds for the medical community's reporting of prenatal drug exposure and the subsequent removal of the child from her mother.

Women who use drugs, however, are not automatically bad parents. While many drug using mothers cannot adequately care for their children, many other drug-users, with treatment and support, can do so.⁴⁸ When a punitive law is employed, a drug-using pregnant woman will fear seeking drug treatment, health care services, and postnatal social support.⁴⁹ This fear puts the infant at even greater risk.⁵⁰ For example, drug-using women commonly appear at an Emergency Room in labor having had no prenatal care.⁵¹ High-risk infants who receive adequate prenatal care, however, show a higher birth weight and fewer medical problems in the first year.⁵² Prenatal care undoubtedly has the same positive effects on infants of drug-using pregnancies.⁵³ Similarly, infants of women who do not fear seeking drug treatment and support services will recover better from any drug effects.

Punitive legislation, therefore, may actually hamper an infant's recovery from a mother's drug use during pregnancy. In fact, evidence does not show that punitive legislation either acts as a deterrent to maternal substance use or improves the mortality or morbidity rates of infants.⁵⁴

47. R.I. GEN. LAWS § 40-11-2 (1)(c) (1990).

48. See Maureen M. Black, Prasanna Nair, Cynthia Kight, Renee Wachtel, Patricia Roby, & Maureen Schuler, *Parenting and Early Development Among Children of Drug-Abusing Women: Effects of Home Intervention*, 94 PEDIATRICS 440 (1994); Chasnoff, Griffith, Freier, & Murray, *supra* note 2, at 284; see also Pamela Kato Klebanov, Jeanne Brooks-Gunn, & Marie C. McCormick, *Classroom Behavior of Very Low Birth Weight Elementary School Children*, 94 PEDIATRICS 700 (1994)(concluding positive home environments are more significant than low birth weight); Robin-Vergeer, *supra* note 11, at 768.

49. See generally Connolly & Marshall, *supra* note 7, at 179 (analyzing impact of criminalization on pregnant women).

50. *Id.* at 179-80.

51. *Id.* at 179.

52. INSTITUTE OF MEDICINE, PREVENTING LOW BIRTHWEIGHT 146 (1985).

53. *Id.*

54. See Marilyn L. Poland, Mitchell P. Dombrowski, Joel W. Ager and Robert J. Sokol, *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 DRUG & ALCOHOL DEPENDENCE 199, 201-02 (1993)[hereinafter *Punishing Pregnant Drug Users*](discussing results of study showing most pregnant women feel criminal punishment would make a pregnant substance-abusing women less likely to seek treatment or prenatal care or that it would have no impact); see also Connolly & Marshall, *supra* note 7, at 179 (discussing the belief of experts in the field that criminalization will not deter pregnant women from using drugs but will deter women from seeking prenatal care and drug treatment and that drug-abusing women are "victims of their addictions and are frequently helpless to overcome their addictions without drug treatment.").

Moreover, incarcerated pregnant women or mothers may continue to have access to more drugs rather than treatment and support.⁵⁵

Removal of a drug-exposed infant from her mother may also hamper her recovery. Children removed from drug-using mothers are usually placed into the state foster system, which, through inappropriate placements, may damage the child.⁵⁶ Such a placement may be more detrimental, in fact, than allowing the child to remain with her mother. Inconsistent guidelines govern the placement of drug-exposed children in foster homes, and foster care case planning routinely ignores available expertise.⁵⁷ Many foster parents have fears regarding drug-exposed infants based on negative stigmas and stereotypes from the press.⁵⁸ Thus, agencies may be less selective in their placement of these infants with foster parents and may be less demanding of foster parents for fear of losing the placement altogether.⁵⁹ Even where a child may appropriately return to her mother, inconsistent foster care guidelines often govern reunification.⁶⁰

Social service agencies also inadequately train and monitor foster parents and child welfare workers to ensure that the needs of drug-exposed children are met.⁶¹ Many child welfare workers and foster parents lower their expectations for drug-exposed infants because they view them as irrevocably damaged.⁶² As a result, foster care often addresses the drug-exposed child's minimal needs but fails to provide the training, support, and services to ensure the child's recovery from prenatal drug exposure.⁶³ Moreover, foster children are often shuffled between foster homes.⁶⁴ Multiple placements may damage any child's ability to form appropriate relationships and jeopardize the child's long term mental health.⁶⁵ In the case

55. See Susan M. Chandler & Gene G. Kassebaum, *Polydrug Use and Self Control Among Men and Women in Prisons*, 24 J. DRUG EDUC. 333 (1994); Connolly & Marshall, *supra* note 7, at 181; *Punishing Pregnant Drug Users*, *supra* note 54, at 202.

56. See Gale Berkowitz, Neal Halfon, & Linnea Klee, *Mental Health Service Utilization by Children in Foster Care*, 89 PEDIATRICS 1238 (1992).

57. OSAP NATIONAL RESOURCE CENTER, CROSS SITE EVALUATION INTERIM REPORT (1992).

58. Lutiger, Graham, Einarson, & Koren, *supra* note 19, at 407.

59. D.S. Gomby & P.H. Shiono, *Estimating the Number of Substance Exposed Infants*, 1 FUTURE OF CHILDREN 1, 17-25 (1991).

60. *Id.*

61. Cf. Mayes, Granger, Bornstein, & Zuckerman, *supra* note 1, at 408.

62. *Id.* at 406-07.

63. Cf. *id.* at 408 (discussing societies responsibility to begin providing necessary and comprehensive services for drug-exposed children).

64. Children may have as many as eight placements in the first two years of life. Carol Rodning, Leila Beckwith, & Judy Howard, *Characteristics of Attachment Organization and Play Organization in Prenatally Drug-Exposed Toddlers*, 1 DEV. & PSYCHOPATHOLOGY 277, 282 (1989).

65. See *id.* at 286 (finding only a few of the drug-exposed toddlers studied exhibited the attachment behavior expected and shown by their non drug-exposed counterparts).

of drug-exposed children, continual shuffling between caretakers may itself preclude recovery from the effects of prenatal drug exposure.⁶⁶

The foster care system's inability to deal with drug-exposed infants will only worsen. Children under five are the fastest growing population in foster care.⁶⁷ In 1983, approximately 269,000 children were in the foster system.⁶⁸ In 1992, that number had increased to 442,000,⁶⁹ partially as a result of the introduction of crack-cocaine in the mid-1980s.⁷⁰ Child abuse reports due to prenatal substance exposure have increased as well. In Los Angeles, for example, reports to social services of infants testing positive for illegal drugs at birth nearly doubled from 1985 to 1986.⁷¹

The growing number of children entering the foster care system will make the appropriate placement and monitoring of drug-exposed infants even more difficult than it is now. The punitive approach, inasmuch as it makes separation of child from mother mandatory, will increasingly tax this already overburdened system. Given the inadequacies of the foster care system, separation of the child from the mother may not be in the child's best interest. However, such determinations must be made on a case-specific basis. Mandatory separation, under the current state of the foster care system, will further harm the exposed child in cases where the drug-using mother, with help, could have provided a more appropriate environment for the child's recovery.

III.

BARRIERS TO TREATMENT

Instead of recognizing that the punitive approach offers few solutions to the problem of prenatal drug exposure, our society has continued to invest more money in criminalizing rather than treating the drug user, including the drug-using pregnant woman. Figure 2 shows federal funding for anti-drug programs since 1981. The current government drug strategy is reactive, directing more money towards punishment than towards treatment or prevention. Federal spending for the enforcement of drug laws has risen from \$2.4 billion in 1984 to \$12.1 billion in 1994.⁷² In contrast, the funding for treatment and prevention programs has risen only one and one-half billion over the same time period.⁷³ Successful prevention would diminish the need for both enforcement and treatment, but prevention clearly has not been given the priority necessary to make a difference.

66. *Id.* at 286-87.

67. 1994 GREEN BOOK, *supra* note 13, at 637.

68. *Id.* at 639.

69. *Id.* at 640.

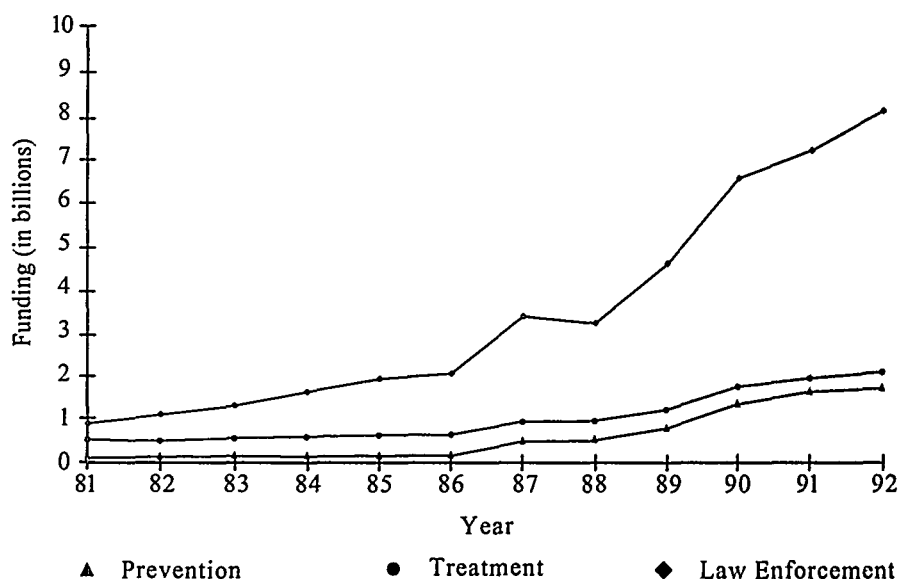
70. *Id.* at 636.

71. IRA J. CHASNOFF, CLINICS IN PERINATOLOGY: CHEMICAL DEPENDENCY & PREGNANCY, at ix (1991).

72. BUREAU OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS, 19 (1993).

73. *Id.*

FIGURE 2
FUNDING FOR ANTI-DRUG PROGRAMS



Source: National Drug Control Strategy Budget, 1992.

Present treatment programs are insufficient and inaccessible to many drug-using mothers. In 1990, the National Association of State Alcohol & Drug Abuse Directors estimated that 280,000 pregnant women need drug treatment each year and less than eleven percent received substance abuse treatment.⁷⁴ A New York City survey showed that fifty-four percent of drug abuse programs denied treatment to pregnant women and eighty-seven percent turned away pregnant crack users.⁷⁵

The barriers to establishing treatment programs for pregnant drug users are substantial. Most of the available addiction treatment models were developed for the treatment of alcoholic men.⁷⁶ Few programs are equipped to deal with the special physical and mental health needs of women, and treatment models developed for alcoholism may not be applicable to drug abuse.⁷⁷ Currently, most substance abuse treatment centers will not provide detoxification treatment to pregnant women for fear of harming the fetus, nor do such centers have the specialized equipment and staff needed to do so. The fear of malpractice suits also deters current programs

74. See 1990 U.S.G.A.O. REPORTS, App. IV at 36 (June 28, 1990).

75. *Id.*

76. JOSETTE MONDANARO, *CHEMICALLY DEPENDENT WOMEN* 1 (1989).

77. See *ADDICTIONS: CONCEPTS AND STRATEGIES FOR TREATMENT* 37 (Judith A. Lewis ed., 1994); see generally Shoni Davis, *Effects of Chemical Dependency in Parenting Women*, in *ADDICTIVE BEHAVIORS IN WOMEN* 381-413 (Ronald R. Watson ed., 1994).

from accepting pregnant addicts.⁷⁸ In-house treatment programs, furthermore, often face neighborhood opposition to their establishment and/or expansion.⁷⁹

Practical barriers also prevent addicted pregnant women and mothers from taking advantage of the few existing drug treatment services. These barriers include a lack of child care, an unavailability of treatment services in multiple locations, a lack of transportation, and long waiting lists.⁸⁰ Women in need of residential treatment may lose Aid For Dependent Children or Medicaid eligibility during treatment if their children are not with them.⁸¹ Finally, pregnant women and mothers seeking help may experience the significant social stigma currently associated with drug use among women.⁸² In areas where there are punitive policies, protective services may separate these women from their infants and courts may order them to get treatment.⁸³ However, those women who attempt to abide by court orders may be unable to find available and appropriate treatment programs.

IV. SOLUTIONS

In order to overcome these substantial barriers to successful treatment, the medical, mental health, legal, and social service systems must establish a multidisciplinary infrastructure to develop new policies for drug-involved mothers and their children. To do so, these communities must view the use of cocaine during pregnancy as an illness and accordingly

78. VALERIE E. GREEN, *DOPED UP, KNOCKED UP AND... LOCKED UP: THE CRIMINAL PROSECUTION OF WOMEN WHO USE DRUGS DURING PREGNANCY*, 78-83 (1993); see also 1990 U.S.G.A.O. REPORTS, App. IV at 36 (reporting that of the estimated 280,000 pregnant women nationwide in need of drug treatment, less than 11% received care, and that 54% of pregnant women were denied treatment primarily because of legal liability concerns).

79. See generally Tom Barnes, *Backyard getting crowded North Siders, led by Onorato, oppose yet another facility in their neighborhood*, PITTSBURGH POST-GAZETTE, Dec. 12, 1995, at B3; Michael Isikoff, *U.S. Wins Test Case on Bias in Housing; Jury in Alexandria Finds Firm Broke Law by Refusing to Rent to Drug Treatment Program*, WASH. POST, Sept. 27, 1990, at D3; John Polich, *Residents March Against Phoenix House Proposal Called "Inappropriate" for Neighborhoods*, L.A. DAILY NEWS, Aug. 10, 1992, at N3.

80. See Julia E. Hanigsberg, *Homologizing Pregnancy and Motherhood: A Consideration of Abortion*, 94 MICH. L. R. 371, 412 n.169 (1995); Page McGuire Linden, *Drug Addiction During Pregnancy: A Call for Increased Social Responsibility*, 4 AM. U. J. GENDER & L. 1104, 1136-38 (1995).

81. See L.P. Finnegan, K. Kaltenbach, S.R. Randall, B. M. Lester, L.M. Paltrow, & L.C. Mayes, *The Conflicts for Parenting Drug Dependent Women - What Does Research Show Us?*, in NIDA RESEARCH MONOGRAPH 162: PROBLEMS OF DRUG DEPENDENCE, 67-69 (1996).

82. Sheila B. Blume, *Chemical Dependency Issues in Women: Important Issues*, 16 AM. J. DRUG & ALCOHOL ABUSE 297, 298-99 (1990).

83. See Linden, *supra* note 80, at 1133.

earmark funds and resources for prevention and treatment rather than punishment.

While prevention and treatment programs will undoubtedly require more funds than they currently receive, such programs will, in the long run, better benefit the mother, child, and society than a punitive approach. Both the social service system and courts are overwhelmed, and neither prisons nor the foster care system have the resources necessary for assisting both mother and child. Currently, hospital charges for both the cocaine-addicted mother and her newborn are much higher than in drug-free pregnancies. In one study, the average hospital cost for the cocaine-exposed newborn was \$13,222 compared with \$1,297 in the unexposed control group.⁸⁴ Another study found that the hospital costs for newborn infants are \$5,200 more for cocaine-exposed infants than for unexposed infants.⁸⁵ The costs of infants remaining in the nursery for social evaluation or foster care placement adds another \$3,500.⁸⁶ The costs of infant cocaine exposure may persist or increase over time if these infants continue to require special medical care or special education to address learning or developmental disabilities.⁸⁷ Thus, although the proposed comprehensive treatment may be costly, the present cost of cocaine exposure is neither small nor static.

Successful prevention and treatment programs, moreover, will reach more children by encouraging mothers to seek help, removing the obstacles to doing so, and by keeping children out of the overwhelmed foster care system. Pregnancy offers a window of opportunity to engage the mother in drug treatment, especially since the mother's wish to be a good parent to her child may increase the mother's motivation to change.⁸⁸ In addition, the relatively simple provision of case management services, transportation, and child care can greatly facilitate a mother's drug rehabilitation.

Successful programs, however, must address the varied and complex needs of women with substance abuse issues. In addition to evaluating the infant from a medical perspective, programs should evaluate the severity and chronicity of the mother's substance use problem, her mental health, her parenting skills, and her available family and social support. In this way, a treatment plan can be developed in which treatment is matched to the individual needs of each mother, child and family. New programs for

84. Calhoun & Watson, *supra* note 2, at 733; see also Julia A. Gladstone, *The Dilemma of the Drug-Exposed Newborn: An Analysis of the Trend Away from Punitive Actions Toward Treatment Intervention*, 42 R.I. BAR J. 15 (1994).

85. Ciaran S. Phibbs, David A. Bateman, & Rachel M. Schwartz, *Neonatal Costs of Maternal Cocaine Use*, 266 J. AM. MED. ASS'N. 1521 (1991).

86. *Id.* at 1521.

87. See Calhoun & Watson, *supra* note 2, at 734 (noting that additional costs are a certainty once infants of cocaine-abusing mothers are born).

88. See Black, Nair, Kight, Wachtel, Roby, & Schuler, *supra* note 48, at 448; Gladstone, *supra* note 84, at 21 n.55.

treating maternal substance abuse, along with other services such as educational and vocational training, nutrition services, medical and mental health care, and parenting classes, should be provided in one location. Social support and self-help groups would allow the mother to alter her social network and rely on herself and supportive friends to resist using drugs. Finally, programs must teach mothers and other caregivers how to interact appropriately with the drug-exposed infant so that the child may overcome any developmental vulnerability resulting from drug exposure.

Fortunately, a variety of realistic and practical approaches to the problem of pregnant women's cocaine use have developed. The Office for Substance Abuse Prevention (now Center for Substance Abuse Prevention (CSAP)) has started a program of demonstration grants.⁸⁹ The Office of Treatment Improvement (now Center for Substance Abuse Treatment (CSAT)) targeted 113 Pregnant and Postpartum Women and Infants Grants towards developing and evaluating the effectiveness of various treatment models for pregnant substance users.⁹⁰ Rhode Island, for instance, has five federally funded unique programs attempting to address substance abuse and perinatal issues of women and their children. Child Health and Development (CHAD) of Providence, Rhode Island, is a hospital-based research and clinical service program providing a variety of medical and social services in one location.⁹¹ Project Link of Providence is a hospital-based outpatient treatment and case management program.⁹² Stanley Street Treatment and Resources (SSTAR Birth) of Providence, Rhode Island, provides residential treatment and case management for pregnant and postpartum mothers where their children may live and receive services along with them.⁹³ The Women, Insight, Nurturing, Growth and Sobriety Program (WINGS), based in Pawtucket, is a health center-based program providing outpatient substance abuse and mental health assessment, short term counseling, and referral services for women.⁹⁴ Project Connect, a program of Children's Friend and Service of Providence, Rhode Island, provides intensive, home-based social work and nursing services to

89. See *ADAMHA Reorganization; Changes Effective October 1st; Drug Abuse and Mental Health Administration becomes the Substance Abuse and Mental Health Services Administration*, 20 ALCOHOLISM REP., July, 1992, at 2.

90. See generally *CSAT Announces Program for 1995 Treatment Grants*, 7 ALCOHOLISM & DRUG ABUSE WEEK, Jan. 16, 1995, at 6; *Flurry of CSAT Grants Aimed at Women, Other Populations*, 5 ALCOHOLISM & DRUG ABUSE WEEK, Apr. 19, 1993, at 7.

91. *Effects of Maternal Lifestyle During Pregnancy on Acute Neonatal Events and Long-Term Neurodevelopmental Outcome of Infants: A Prospective, Multisite, Randomized, Controlled, Clinical Trial. "Cocaine Project" 1992-1997*, NICHD Grant # SRC 1U10-HD27904-1.

92. Women & Infants Hospital of Rhode Island Project Link, CSAP Demonstration Grant # 1 H86 SP02316-01A.

93. *Residential Treatment for Substance Abusing and Postpartum Women*, CSAT Grant #1 HS4 T100558-03.

94. *Substance Abuse Intervention and Treatment for the Perinatal Population in Blackstone Valley*, funded by Division of Substance Abuse, Rhode Island Department of Health.

substance abuse-affected families who are involved in the state child protective system.⁹⁵

CONCLUSION

While programs such as these located in Rhode Island and elsewhere have begun addressing pregnant substance abusers' need for comprehensive treatment services, much work still needs to be done. The medical, legal, and social systems must continue to develop innovative programs and to resist viewing the pregnant substance abuser as a criminal. Medical research must probe the effects of prenatal cocaine exposure and work to develop new models for the treatment of pregnant drug users and their future children. Unless these steps are followed, society will remain unable to address effectively the problem of prenatal cocaine exposure, and another generation of children will suffer.

95. Funded by a Demonstration grant from the National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services.