CREATING A CAUSAL CONNECTION: FROM PRENATAL DRUG USE TO IMMINENT HARM

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I.
INTRODUCTION

It has been over ten years since the National Association of Perinatal Addiction Research and Education (NAPARE)[1] concluded that as many as eleven percent of children born in this country (about 375,000 annually) are negatively affected by their mothers' substance abuse.[2] Eleven years have passed since the National Drug Control Strategy reported an estimated 100,000 infants were exposed to cocaine each year.[3] Although subsequent studies have cast doubt upon the accuracy of these early statistics,[4]

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1. NAPARE opened its doors in 1986 with Dr. Ira Chasnoff as director. In 1995 the organization changed its name, substituting "Family" for "Perinatal."

2. *See generally* NAPARE, PERINATAL RESEARCH AND ADDICTION UPDATE: A FIRST NATIONAL HOSPITAL INCIDENCE SURVEY (1988). This is the most frequently cited statistic because it is one of few currently available national estimates based on a study. However there are at least two problems with the estimate. First, although the study is often used in discussions of infants exposed prenatally to crack cocaine, the survey upon which the estimate is based defined substance abuse to include use of heroin, methadone, cocaine, amphetamines, PCP, and marijuana, but not alcohol. Second, the survey was based on responses from 36 hospitals, representing only 5% of all United States live births in 1987. Additionally, these hospitals were not representative of the nation as a whole because they were disproportionately located in large cities.

3. OFFICE OF NAT'L DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, NATIONAL DRUG STRATEGY 44 (1989). This study does not mention the number of infants exposed to other drugs, and its estimates are not based on a national representative sample of births.

4. National studies regarding the extent of prenatal drug exposure are conflicting. One analyst has suggested that at least with regard to crack, a figure of 30,000–50,000 babies would be more accurate. Douglas Besharov, *Crack Babies: The Worst Threat Is Mom Herself*, WASH. POST, Aug. 6, 1989, at B1 [hereinafter Besharov, *The Worst Threat*]. Yet another study suggests that in United States cities about 1 in 5 to 10 newborns is exposed prenatally to cocaine. Claudia A. Chiriboga, *Neurological Correlates of Fetal Cocaine Exposure: Transient Hypertonia of Infancy and Early Childhood*, 96 PEDIATRICS 1070 (1995). In 1992, the most recent year for which statistics are available, the National Institute on Drug Abuse reported that 5.5% of all newborns were exposed to illegal drugs during pregnancy (222,000 drug-exposed births in 1992). NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH, PREGNANCY AND DRUG USE TRENDS (last modified Nov. 5, 1999)

media depictions of mothers abusing drugs and bleak predictions of "crack babies" have contributed to the common belief that prenatal drug use creates medical and psychological problems for children and burdens society.[5] No matter what the actual numbers may be, one can hardly deny that the problem of drug use and abuse among pregnant women is a phenomenon that has caught the attention of the public, legislators, and child protection officials.

The recent increase in the number of child protective services (CPS) reports related to substance abuse reflects the growing recognition of the link between maternal drug use and child well-being.[6] Between 1982 and 1989, one year after publication of the NAPARE study, the number of substance abuse-related CPS reports filed with New York City's Administration for Child Services (ACS) doubled.[7] In 1988 alone, nearly 5,000 newborns were reported to CPS because they tested positive for exposure to drugs.[8]

The assumption that drug use during pregnancy causes "imminent" danger to the child reinforces the general notion that prenatal drug use must be punished, and shapes legal decisions that correlate a pregnant woman's drug use with child abuse or neglect. Studies indicate that three-fourths of child neglect cases involve parental problems with drugs or alcohol.[9] Furthermore, New York City's 1994 Fatality Review Panel[10] reported

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<http://www.nida.nih.gov/Infofax/pregnancytrends.html>. As of 1989, it had been estimated that over five million women of child-bearing age (15–44) have used illicit drugs, including almost one million who reported using cocaine. John J. Lieb & Claire Sterk-Elifson, *Crack in the Cradle: Social Policy and Reproductive Rights Among Crack-Using Females*, CONTEMP. DRUG PROBS. 687, 688 (1995). Studies concentrating on New York suggest 15,371 newborns in New York City tested positive for cocaine between 1988 and 1994. Christopher S. Wren, *For Crack Babies, a Future Less Bleak*, N.Y. TIMES, Sept. 22, 1998, at D1. One study estimated that 7,000 babies who were exposed to cocaine as fetuses are born each year in New York City. Besharov, *The Worst Threat*, *supra*, at B1. Another estimated that more than one in five babies have been exposed to legal or illegal drugs before birth. *See generally* CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIV., SUBSTANCE ABUSE AND URBAN AMERICA: ITS IMPACT ON AN AMERICAN CITY (1996).

5. *See, e.g.*, Lynne Duke, *For Pregnant Addict, Crack Comes First*, WASH. POST, Dec. 18, 1989, at A1; Catherine Foster, *Fetal Endangerment Cases Increase*, CHRISTIAN SCI. MONITOR, Oct. 10, 1989, at 8; Charles Krauthammer, *Put Cocaine Babies in Protective Custody*, ST. LOUIS POST-DISPATCH, Aug. 6, 1989, at 3B; A.M. Rosenthal, Editorial, *The Poisoned Babies*, N.Y. TIMES, Jan. 16, 1996, at A17; Cathy Trost, *Babies of Crack Users Crowd Hospitals, Break Everybody's Heart*, WALL ST. J., July 18, 1989, at 1.

6. The organization in New York City responsible for such reports is the Administration for Children's Services (ACS), created by Mayor Rudolph Giuliani on January 11, 1996. Administration for Children's Services (visited Jan. 12, 2000) <http://www.ci.nyc.ny.us/html/acs/home.html>. This agency replaced the Children's Welfare Administration (CWA). Throughout this article, the names ACS and CPS will be used interchangeably.

7. Alma J. Carten, *Mothers in Recovery: Rebuilding Families in the Aftermath of Addiction*, 1996 SOC. WORK 214, 214 (1996) (citing CHILD WELFARE ADMIN., FOSTER CARE OVERVIEW: FISCAL YEARS 1992-1993 (1993)).

8. *Id.*

9. *See* Robert Gearty, *Family Drug Court's a First*, N.Y. DAILY NEWS, Dec. 11, 1997, at 12 (quoting New York Court of Appeals Chief Judge Judith Kaye, Address at the Suffolk

that twenty-eight percent of the children who died of abuse or neglect each year were born exposed to some illicit drug.[11] As a result of such studies, legislators have concluded that drug addiction at birth is a potent early warning that a child may die of abuse.[12]

Driven by the desire to prevent fetal impairment or death, state and local authorities have employed a variety of techniques to detect and prosecute cases of maternal substance abuse.[13] Several states have passed civil child abuse and neglect statutes that declare drug or alcohol use during pregnancy to be constitutive or indicative of child abuse.[14] Prior to 1988, the New York City Department of Social Services permitted social workers to remove children from their homes based solely on traces of drugs in a newborn's urine.[15] Furthermore, "the majority of lower and appellate civil court rulings have supported the state's removal of infants from their mothers' custody based on a positive drug toxicology."[16]

In 1988, however, the Bronx Family Court held in *In re Fletcher* that a mother's prenatal drug use did not establish her inability to parent.[17] In that case, a newborn child tested positive for drugs, and the neglect petition and proceedings were based solely on the prenatal conduct of the mother. Recognizing that a positive toxicology result indicates neither the extent of

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County First District Drug Treatment Court Program graduation ceremony (Dec. 10, 1997)).

10. The New York City Fatality Review Panel was an independent panel comprised of social scientists, doctors, and other professionals. In the event of the death caused by abuse or neglect of a child known to the ACS, the Panel conducted an in-depth review of the child's case history. In 1996, when the CWA was replaced by the newly created ACS, the work of the Fatality Review Panel was taken up by the Accountability Review Panel. *ACS Commissioner Scopetta Announces Completion of the New York City Child Fatality Review Panel's Findings Concerning Circumstances of the Death of Eliza Izquierdo* (visited Jan. 22, 2000) <http://www.ci.nyc.ny.us/ html/acs/html/pr26.html>.

11. CHILD FATALITY REVIEW PANEL, CITY OF NEW YORK HUMAN RESOURCES ADMIN., ANNUAL REPORT FOR 1994, at 13 (1995). Additionally, the Panel found that of child fatalities investigated from 1990 to 1994, 66.8% occurred in families with a history of substance abuse. *Id.* at 41 tbl.7.

12. *See generally* N.Y. FAM. CT. ACT § 1012, Douglas J. Besharov, *Introductory Practice Commentaries* (McKinney 1999).

13. *See* Gloria M. Dabiri & George Bundy Smith, *Prenatal Drug Exposure: The Constitutional Implications of Three Governmental Approaches*, 2 SETON HALL CONST. L.J. 53, 88–99 (1991) (including as examples mandatory reporting of drug-exposed newborns to child protection authorities, acceptance of drug exposure as de facto child neglect without other evidence, and involuntary drug testing of pregnant women, newborns, and postpartum women).

14. *See generally Substance Abuse & Pregnancy: State Lawmakers Respond with Punitive & Public Health Measures*, LEGIS-LETTER (Am. College of Obstetricians and Gynecologists, Washington, D.C.), Fall 1990; Katherine Beckett, *Fetal Rights and "Crack Moms": Pregnant Women in the War on Drugs*, CONTEMP. DRUG PROBS. 587 (1995); Wendy Chavkin, Vicki Breitbart, & Paul H. Wise, *National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women*, 88 AM. J. PUB. HEALTH 117 (1998).

15. Judith Larsen, Robert M. Horowitz, Ira J. Chasanoff, *Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure*, 18 PEPP. L. REV. 279, 315–16 (1991).

16. Beckett, *supra* note 14, at 604.

17. 533 N.Y.S.2d 241 (Fam. Ct. 1988).

the mother's drug use nor whether the child's physical, mental, or emotional condition is actually impaired or at risk of impairment, the court held that such a result cannot on its own lead to a finding of neglect in New York family courts.[18] In order to sustain a cause of action for neglect based on prenatal drug use, the petitioner must plead and prove a direct link between the drug use and the child's safety. For example, a finding of neglect might be based on a showing of current addiction or on expert testimony indicating that a non-addicted parent's past drug use places the child in imminent danger.[19]

Responding to *Fletcher* and other challenges to official policy, the City's Child Welfare Administration (CWA) of the Human Resources Administration clarified the procedures to be followed when caseworkers discovered that a newborn had been exposed to drugs. A CWA memorandum to caseworkers dated June 3, 1991, announced that while a newborn's positive toxicology or drug withdrawal symptoms should be reported to the statewide central register of child abuse and maltreatment, those factors alone were not sufficient cause either for removal of a child from her mother or for court action.[20] The amended policy made clear that a positive toxicology alone could not be the basis for a temporary or permanent removal of a child from her mother, but that admission of repeated drug use by the mother or other evidence of drug addiction or dependency could provide adequate foundation for a court intervention request.[21]

Although the agency policy enumerated the factors that may justify removal and the initial filing of a neglect petition, it did not indicate exactly how the court should decide whether to sustain the petition and find that

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18. *Id.* at 243.

19. *Id.* at 243–44.

20. Memorandum from the Executive Deputy Commissioner, General Counsel of the Child Welfare Administration (June 3, 1991) (on file with author). The memorandum reads in pertinent part:

> [A] report of positive toxicology, drug withdrawals symptoms, fetal alcohol effect or fetal alcohol syndrome will be accepted by the State Central Register, but no such report can be indicated, or serve as the basis for the taking of the child into protective custody, if the only known fact is the positive toxicological test result, the drug withdrawal symptoms, fetal alcohol effect or fetal alcohol syndrome. This is because such a result is indicative of neither the extent of drug or alcohol use by the mother nor whether the child's physical, mental or emotional condition is at risk of impairment by the parent's failing to exercise a minimum degree of care. However, if there has been a parental admission of chronic or repeated drug or alcohol use by the mother, and there is reasonable cause to believe that such addiction or dependency will continue, or there are other indicators of neglect, a hold (detaining the child) for 24 hours or until the next court day is possible pending further investigation. This determination should be made if there is reasonable cause to believe there is imminent risk or danger to the child's life or health. It should be noted that lack of prenatal care, notwithstanding the positive toxicology result, drug withdrawal symptoms, fetal alcohol effect or fetal alcohol syndrome is not a sufficient basis for removal.

Id.

21. *Id.*

neglect exists. As a result, judges have employed various different frameworks to make these determinations. These judicial constructs not only lack consistency, but also do little more than reflect the attitudes that provided an impetus for the removal practices that prevailed before *Fletcher*.

This article highlights the problems implicit in reconciling statutory neglect provisions with judicial findings of neglect involving cocaine-exposed infants. I will examine New York family court decisions involving child neglect proceedings that were initiated after agency officials found evidence of drug use at the time of birth, focusing on the factors considered in making a neglect determination. I will also discuss recent medical developments relating to the effects of drug use on infants and argue for the adoption of a comprehensive assessment model which functions to protect children, predict true parental ability, and more accurately reflect legislative intent.

II.
CHILD PROTECTIVE PROCEEDINGS IN NEW YORK FAMILY COURT

The welfare and best interests of children are the paramount concerns in child protective proceedings.[22] The family courts are required by statute to consider potential threats to the child's health and safety. The court is bound to determine not only whether there had been neglect or abuse but also the likelihood of such conduct in the future.[23] To commence a child neglect proceeding, a petitioner must allege facts sufficient to establish that a child is "neglected" as defined in article 10 of the Family Court Act.[24] Under the terms of section 1012(f), a finding of neglect can be based upon either actual impairment of a child's physical condition or imminent danger of such impairment.[25]

According to the Family Court Act, a prima facie case of child abuse or neglect may be established by demonstrating either: (1) a causal connection between the alleged harm to the child and the act or omission of the person responsible for the child, or (2) repeated misuse of drugs or alcoholic beverages by the person responsible for the child. At fact-finding

22. *See, e.g.*, N.Y. FAM. CT. ACT § 1011 (McKinney 1999) (stating that purpose of Act is "to establish procedures to help protect children from injury or mistreatment and to help safeguard their physical, mental, and emotional well-being").

23. *See id.* §§ 1051, 1012(e), (f) (requiring court to specify grounds for findings of abuse or neglect and defining abused or neglected child as child who has been or who is at risk of being injured or impaired).

24. *Id.* § 1031(a) ("[A] proceeding under this article is originated by filing of a petition in which facts sufficient to establish that a child is an abused or neglected child under this article are alleged.").

25. *Id.* § 1012(f)(i).

hearings on neglect petitions, the child protection agency has the burden of proving neglect by a preponderance of the evidence.[26]

Neglect proceedings in New York family court involving cocaine-exposed infants most often arise from an initial urine toxicology. If a mother or newborn tests positive for benzoyl ecgonine, a cocaine metabolite, the mother must have used cocaine within the previous seventy-two hours.[27] However, the test results provide no indicia of earlier or repeated drug use.[28]

Although a positive toxicology points to recent prenatal drug use, such a test result alone cannot be the basis for a finding of child neglect. A positive screen is not indicative of the extent of drug use by the mother or of any surrounding circumstances that would impair or pose a risk of impairment to the child's physical, mental, or emotional well-being.[29] However, a positive toxicology report combined with other evidence may support a neglect finding.[30] According to the Family Court Act, to support a finding of neglect, the mother's prenatal conduct must be causally connected to a post-birth detriment to the newborn.[31]

Family court judges lack an authoritative framework within which to formulate their decisions involving cocaine-exposed infants because no single controlling rule of law has emerged. However, family court decisions have reflected consideration of a common set of factors in establishing the necessary link between a positive toxicology and child neglect. Included among the issues that judges will take into account are admitted drug use, enrollment in a drug rehabilitation program, prenatal care, low birth weight, and prior neglect of an infant's siblings. In the following section, I examine and critique each of these factors.

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26. *Id.* § 1046(a)(ii)–(iii). The express purpose of child abuse and neglect proceedings is to help protect children from injury or mistreatment and to help safeguard their physical, mental, and emotional well-being. Matter of Cindy J.J., 484 N.Y.S.2d 249, 250 (App. Div. 1984). Accordingly, the Family Court Act allows for the removal, when necessary, of an abused child from the parent while prosecution of a parent is pending in either Family Court or an appropriate criminal court. People v. Webb, 382 N.Y.S.2d 369, 371 (App. Div. 1976).

27. Abigail Baxter, Linda S. Butler, Richard P. Brinkler, Wynetta A. Frazier, & Delores M. Wedgeworth, *Effective Early Intervention for Children Prenatally Exposed to Cocaine in an Inner-City Context, in* MOTHERS, BABIES AND COCAINE: THE ROLE OF TOXINS IN DEVELOPMENT 333, 337 (Michael Lewis & Margaret Bendersky eds., 1995).

28. U.S. GEN. ACCOUNTING OFFICE, REPORT NO. GAO/HRD-90-138, DRUG-EXPOSED INFANTS: A GENERATION AT RISK 20 (1990) [hereinafter GAO, DRUG-EXPOSED INFANTS].

29. *In re* Nassau County Dep't of Soc. Servs., 661 N.E.2d 138, 139–40 (N.Y. 1995).

30. *Id.*

31. N.Y. FAM. CT. ACT §§ 1011, 1012(f)(i)(B), 1031 (McKinney 1999).

III.
CONTRIBUTING FACTORS

A. Admitted Drug Use

The Family Court Act does not state or imply that mere use of a controlled substance by a pregnant woman prior to her child's birth puts that child in danger of imminent harm.[32] While family courts are not completely ignorant of the potentially damaging effects of regular drug use on one's parenting ability,[33] drug use alone fails to establish the link necessary to conclude that neglect exists. In *Fletcher*, the court held that the petitioner's allegations of prenatal drug use and a positive toxicology for cocaine at birth did not, in the absence of allegations of continued and repeated use of drugs, establish a cognizable claim for child neglect under the law.[34] The court stated that the petitioner was required to present evidence of regular and excessive drug use by the mother before and after birth in order to establish a prima facie case of neglect.[35] The court dismissed the neglect petition because it failed to allege and the court refused to infer continued and repeated drug use on the basis of a positive toxicology test and a nonspecific admission of drug use alone. In its current form, the court described the neglect petition as attempting to establish a direct connection between some occurrence of drug use during pregnancy and harm to the child's well-being, but did not allege or offer any information as to the time, dosage, and frequency of the drug use during pregnancy.[36]

However in *In re Stefanel Tyesha C.*, the appellate court found this reasoning flawed.[37] In *Stefanel*, a mother admitted she had used cocaine during the fifth month of her pregnancy, as well as two days before the child was born—facts confirmed by toxicology tests.[38] Using the *Fletcher*

32. *In re* Fletcher, 533 N.Y.S.2d 241, 244 (Fam. Ct. 1988).

33. *Id.* at 243. The New York Family Court Act also states that:

> [P]roof that a person repeatedly misuses a drug or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing in the user thereof a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment, or a substantial manifestation of irrationality, shall be prima facie evidence that a child of or who is the legal responsibility of such person is a neglected child except that such drug or alcoholic beverage misuse shall not be prima facie evidence of neglect when such person is voluntarily and regularly participating in a recognized rehabilitative program.

N.Y. FAM. CT. ACT § 1046 (a)(iii) (McKinney 1999).

34. *Fletcher*, 533 N.Y.S.2d at 244.

35. *Id.* at 242.

36. *Id.* at 242, 243. In its conclusion, the court attempted to illustrate why such details were necessary for a neglect determination: "One can only speculate as to how many good parents had occasionally used marijuana, for example, prior to the birth of their children. This court would be over-reaching by far to infer that each of them is a neglectful parent." *Id.* at 244.

37. *In re* Stefanel Tyesha C., 556 N.Y.S.2d 280, 284 (App. Div.), *appeal dismissed sub nom. In re* Sebastian M., 565 N.E.2d 1267 (N.Y. 1990).

38. *Id.* at 281.

court's rationale, she argued that the neglect petition brought against her should nonetheless be dismissed because it failed to allege specific impairment of the child's health at birth or any parental misconduct after birth. The court rejected this position and sustained the petition explaining that "[t]he presumption contained in [New York Family Court Act section] 1046 (a)(iii) operates to eliminate a requirement of specific parental conduct vis-à-vis the child and neither actual impairment nor specific risk of impairment need be established."[39] In contrast, the *Fletcher* court denied that precisely such a statutory inference existed.[40] After *Stefanel*, a mother's admitted use of drugs during pregnancy, her failure to complete drug rehabilitation at the time of their children's births, and the children's positive toxicology results "were sufficient to state a cause of action for neglect."[41] The *Stefanel* court emphasized that it was not making a determination of neglect but was only sustaining the petition against a dismissal motion. The statutory presumption of neglect in the Family Court Act was refutable at the subsequent fact-finding hearing where the mother would have an opportunity to show that she was not a repeat or habitual user and that she could properly care for her child.[42]

A mother's admission of past drug use or dependency is completely irrelevant to making a finding of neglect. Admitted past or prenatal drug use that does not reflect upon the nature or frequency of current use is subject to the same criticism that applies to the significance of a positive toxicology: it is not indicative of the extent of maternal drug use or of any actual or risk of imminent harm to the child. Furthermore, the mother's admission of drug use serves only to verify the positive toxicology; weighing such an admission as a factor against the mother confuses the existence of a contributing fact with evidence of a fact previously ascertained. Thus the court must venture past any evidence of past drug use and consider (a) whether such use will continue and (b) how future maternal drug use will effect the child and the mother's parental ability.

B. Enrollment in Drug Rehabilitation Program

Proof that a mother is regularly abusing cocaine constitutes prima facie evidence of neglect, but a woman's regular participation in a recognized rehabilitative drug program rebuts this statutory presumption.[43] In *In re Miranda H.*, the mother could not prove such participation, and so the family court temporarily removed the children from her custody, concluding

39. *Id.* at 284 (citing *In re* Male R., 422 N.Y.S.2d 819 (Fam. Ct. 1979)).

40. *See Fletcher*, 533 N.Y.S.2d at 242–43 (refusing to find statutory support in section 1046(a)(iii) to accept petitioner's inference of continued and repeated drug use by the mother based on unparticularized evidence of pre-natal drug use and positive toxicology results).

41. *Id.* (citing *In re* Teresa J., 551 N.Y.S.2d 219 (App. Div. 1990)).

42. *Fletcher*, 533 N.Y.S.2d at 283.

43. N.Y. FAM. CT. ACT § 1046(a)(iii) (McKinney 1999).

that her drug problem had not lessened since a prior finding of neglect.[44] After the filing of the petition in *Stefanel*, the mother enrolled in but never completed a drug rehabilitation program.[45] Again, the court reiterated its position that the statutory presumption contained in section 1046(a)(iii) of the Family Court Act could be rebutted by proving participation in a drug rehabilitation program, but absent such proof, prima facie evidence of neglect existed.[46]

Although the statute does not specify what type of drug rehabilitation is necessary to rebut evidence of neglect, the court has narrowly interpreted the language of section 1046(a)(iii) of the Family Court Act to exclude nontraditional treatment options. For instance, in *In re Nassau County Department of Social Services*, evidence that the mother was voluntarily receiving counseling at a general education and support program run by the Family Service Association did not rebut the statutory presumption.[47]

Just as demonstrated willingness to seek treatment can be used to rebut the presumption of neglect, demonstrated unwillingness to rehabilitate can be relied upon to sustain a conclusion of neglect. In *In re Milland*, although the mother stated a desire to discontinue alcohol use, she continuously refused rehabilitative assistance.[48] The court in *Milland* based its finding of neglect partly on the mother's refusal, interpreting her unwillingness to receive help as proof that she had continued to use alcohol throughout her pregnancy and would be unable to care for her child's special needs.[49]

Inconsistencies arise, however, in cases such as *In re Theresa J.*, in which the court considered a mother's willingness to enter a drug rehabilitation program as evidence supporting a prima facie case of neglect.[50] The court essentially construed her desire to seek treatment as an admission of continued drug use, without explaining further. The court made the same unsupported assumption in *In re Male R.*, in which the mother testified that she planned to enroll in a drug program the day after the hearing.[51]

Contrary to these courts' reasoning, evidence indicates that a woman's failure to seek or enroll in a drug rehabilitation program may reflect her inability to find an adequate program rather than her unwillingness to seek treatment to overcome her addiction. In *Male R.*, for example, the mother complained of not being able to locate a program for her particular drug

44. 595 N.Y.S.2d 97, 98 (App. Div. 1993).
45. *Stefanel*, 556 N.Y.S.2d at 282.
46. *Id.* at 283.
47. *See In re* Nassau County Dep't of Soc. Servs., 661 N.E.2d 139, 140 (N.Y. 1995).
48. *In re* Milland, 548 N.Y.S.2d 995, 999 (Fam. Ct. 1989).
49. *Id.* at 999 (also taking into consideration the mother's alcohol use during pregnancy, her unwillingness to accept help to fight alcohol dependency, and the behavior of child's father).
50. *In re* Theresa J., 551 N.Y.S.2d 219, 220 (App. Div. 1990).
51. *In re* Male R., 422 N.Y.S.2d 819, 821 (Fam. Ct. 1979).

problem. After being referred to a "suitable" program, she intermittently attended meetings but eventually stopped going.[52] Neither the caseworker nor the judge asked whether the mother's actions resulted from unwillingness or inability. If courts continue to fail to draw such a distinction, mothers will not know whether their willingness to seek treatment will be viewed favorably or held against them. In addition, regardless of how a court may construe it, a mother's desire to seek treatment may be undermined by the absence of effective treatment options.[53]

A 1991 General Accounting Office (GAO) report found that the most critical barrier to women's participation in drug rehabilitation programs is the lack of adequate treatment capacity and appropriate services among programs that treat pregnant women and mothers with young children.[54] Although drug treatment programs tailored for pregnant and parenting women help them overcome their addiction problems,[55] greatly improve birth outcome,[56] and are cost-effective,[57] they remain extremely rare and overburdened.[58] The demand for free or publicly funded drug treatment exceeds the supply of such programs.[59]

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52. *Id.* at 821.

53. Other contributing factors include the fact that those who need drug treatment most often do not carry adequate health insurance, and that waiting lists, inconvenient hours, and out-of-the-way locations make public assistance clinics unavailable and inaccessible to many who might otherwise use them. U.S. GEN. ACCOUNTING OFFICE, REPORT NO. GAO/HRD-91-80, ADMS BLOCK GRANT, WOMEN'S SET-ASIDE DOES NOT ASSURE DRUG TREATMENT FOR PREGNANT WOMEN 4 (1991) [hereinafter GAO, WOMEN'S SET-ASIDE].

54. *Id.* at 34–35 (finding that women also cite as significant barriers inconvenient siting of new facilities, transportation problems, attitudes and behaviors of health care providers, limited community outreach, and legal obstacles).

55. *See* Barrie L. Becker, *Order in the Court: Challenging Judges Who Incarcerate Pregnant, Substance-Dependent Defendants to Protect Fetal Health*, 19 HASTINGS CONST. L.Q. 235, 240–41 (1992) (reporting that treatment centers claim high success rates when programs are designed to meet women's individual needs).

56. *See, e.g.*, Cynthia Chazotte, J. Youchah, & M.C. Freda, *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19 SEMINARS IN PERINATOLOGY 293–300 (1995) [hereinafter Chazotte, *Low Birth Weight*] (finding that comprehensive prenatal and drug treatment programs are associated with better birth weight outcomes).

57. *See, e.g.*, Michelle Oberman, *Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs*, 43 HASTINGS L.J. 505, 514–15 (1992) (indicating that treatment and delivery costs for an addict who obtains prenatal care average $7000 as compared to the treatment, delivery, and additional neonatal intensive care costs for an addict who does not receive prenatal care average up to $31,000). *See also* ABANDONED INFANTS ASSISTANCE RESOURCE CTR., AIA FACTSHEET NO. 2, PERINATAL SUBSTANCE EXPOSURE (1995) (reporting that postdelivery hospital costs for the children of mothers who did not receive prenatal care and drug treatment may be as much as ten times greater than the cost of treating children whose mothers did receive prenatal medical care).

58. *See generally* CENTER FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PRODUCING RESULTS: A REPORT TO THE NATION 5–15 (1995).

59. Veronique Mistiaen, *Legal Haze: Is Drug Abuse During Pregnancy Child Abuse?*, CHI. TRIB., Oct. 11, 1992, Womenews, at 1.

A 1989 study of seventy-eight drug treatment programs in New York City revealed that 54% refused services to pregnant women addicted to drugs, while 67% denied treatment to pregnant women both addicted to drugs and on Medicaid, and 87% denied treatment to pregnant women both addicted to crack and on Medicaid.[60] Among the hospital treatment programs refusing to admit pregnant women were New York public hospitals. In 1992, charges were brought against one such hospital on behalf of both (1) women who had sought treatment for alcohol or drug dependency but were denied treatment because they were pregnant, and (2) all pregnant women who had sought or in the future would seek alcohol or drug treatment from the defendant hospital.[61] The plaintiffs argued that the defendants' blanket policy of excluding all pregnant women from detoxification services violated the New York Human Rights Law.[62] The Court of Appeals held that the hospital policy would be unlawful unless the defendant could show at trial that (a) the blanket exclusion was medically warranted, or (b) the hospital could not identify with reasonable medical certainty before admission the women who could be treated without requiring on-site obstetrical services.[63] The impact of this decision on the future supply of treatment options available to pregnant women has yet to be determined.

Evidence suggests that pregnancy is a time when women are more apt to tackle problems of addiction.[64] Denying services at such a pivotal moment to pregnant women who truly desire help for their babies and themselves makes recovery even more difficult.[65] The problem is only exacerbated when, under these circumstances, it is discovered that a newborn has been exposed to an illicit drug, and the child's mother is punished

60. Wendy Chavkin, Editorial, *Help, Don't Jail, Addicted Mothers*, N.Y. TIMES, July 18, 1989, at A23.

61. Elaine W. v. Joint Diseases N. Gen. Hosp., 613 N.E.2d 523 (N.Y. 1993).

62. *Id.* at 524. The defendants argued that pregnant women could not be treated safely because the hospital lacked necessary equipment, did not have any obstetricians on staff, and was not licensed to provide obstetrical care. *Id.* at 524. Plaintiffs argued this practice violated Article 15 of New York Executive Law (the Human Rights Law), which provides that it is "an unlawful discriminatory practice for any . . . place of public accommodation . . ., because of . . . sex . . ., directly or indirectly, to . . . deny to such person any of the accommodations, advantages, facilities or privileges thereof." *Id.* at 524–25 (quoting N.Y. EXEC. LAW § 296(2)(a) (McKinney 1999)).

63. *Elaine W.*, 613 N.E.2d at 526. The court stated that that if the hospital "establishes it is medically unsafe to treat pregnant women at its facility, either because all pregnant addicts require immediate on-site obstetrical services or because it cannot be predicted with reasonable medical certainty which ones might require such services, the Human Rights Law does not compel it to do so." *Id.*

64. Wendy Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 266 JAMA 1556, 1559 (1991).

65. *See* GAO, WOMEN'S SET-ASIDE, *supra* note 53, at 17 (citing experience of women waiting as long as one month for appointments and entrance into treatment).

for allegedly not having sought treatment. Family court judges, overzealous in their attempts to create a causal connection between positive toxicology and "imminent harm" to drug-exposed children, often fail to consider reasons other than neglect that would explain a failure to enroll in a treatment program. This judicial unwillingness to consider alternative explanations is illustrated by family courts' treatment of prenatal care.

C. *Prenatal Care*

The quality of prenatal care varies tremendously but usually includes a package of medical care services provided over a set schedule of visits. In addition to medical care, prenatal care programs often include comprehensive educational, social, and nutritional services associated with healthy fetal development.[66] However valuable such services may be, many pregnant women do not have access to adequate prenatal care due to financial and systemic barriers.[67] In fact, a 1987 GAO Report found that 76% of Medicaid recipients and uninsured women in New York City received inadequate prenatal care.[68]

Although barriers completely unrelated to drug use may restrict access to prenatal care, "inadequate prenatal care has been correlated with substance use, particularly with the use of cocaine."[69] In New York City, women who use cocaine have been found to be seven times less likely to receive prenatal care than women who do not use cocaine.[70] These data do not indicate that a failure to obtain prenatal care is probative evidence of drug use.[71]

Nevertheless, despite the lack of a definitive causal relationship between drug use and inadequate prenatal care, hospitals have designed testing protocols that base decisions to test pregnant women or infants for drug exposure on whether the pregnant woman or new mother received prenatal

66. U.S. GEN. ACCOUNTING OFFICE, PRENATAL CARE, MEDICAID RECIPIENTS AND UNINSURED WOMEN OBTAIN INSUFFICIENT CARE, REPORT NO. GAO/HRD-87-137 12 (1987) [hereinafter GAO, PRENATAL CARE].

67. *Id.* at 18 (additionally noting national study finding 71% of surveyed low-income women experienced difficulties accessing prenatal care services because of lack of finances, transportation, and child care). An estimated 74,000 American pregnant women per year receive no prenatal care. *Id.*

68. *Id.* at 23.

69. JAMES A. INCIARDI, HILARY L. SURRATT, & CHRISTINE A. SAUM, COCAINE-EXPOSED INFANTS: SOCIAL, LEGAL, AND PUBLIC HEALTH ISSUES 31–32 (1997) [hereinafter INCIARDI, COCAINE-EXPOSED] (citing one study reporting that 30–50% of urban pregnant women who lack prenatal care will have a positive urine toxicology for cocaine at time of delivery).

70. VALERIE GREEN, DOPED UP, KNOCKED UP, AND. . . LOCKED UP? THE CRIMINAL PROSECUTION OF WOMEN WHO USE DRUGS DURING PREGNANCY 76 (1993).

71. Kimani Paul-Emile, *The Charleston Policy: Substance or Abuse?*, 4 MICH. J. RACE & L. 325, 352 (1999).

care.[72] These decisions disproportionately impact poor and minority women and their children, subjecting them to civil neglect proceedings more frequently than their wealthy, white counterparts.[73]

Although lack of prenatal care is an important factor in initiating a neglect proceeding against a mother, it is not consistently considered by judges during fact-finding hearings. For example, in *In re Fathima Ashanti K.J.*, after the mother experienced complications during delivery, the attending physician noted there had been no prenatal care and ordered a urinalysis.[74] While the court viewed the infant's low birth weight and below average length and head circumference as evidence of drug use during pregnancy, the court did not consider lack of prenatal care as a contributing factor to or possible cause of the infant's condition. For example, the judge did not attribute the infant's condition to the lack of sufficient prenatal care, although it is widely known that early prenatal care plays an important role in preventing low birth weight and poor pregnancy outcomes.[75]

In addition to identifying the symptoms displayed by the infants, petitioners in neglect proceedings must provide evidence of a link between these symptoms and the mother's cocaine use. In the past, courts simply relied on media propaganda and medical data; now that these early statistics on the effects of cocaine on newborns are being challenged, such reliance is less tenable. Although findings from a number of older studies support the contention that prenatal drug exposure has a negative impact on newborns, recent research challenges these conclusions.[76] The research

72. GAO, DRUG-EXPOSED INFANTS, *supra* note 28, at 5 (also noting that hospitals serving primarily non-Medicaid patients often do not consider this problem serious enough to warrant implementation of drug-testing protocol).

73. *See* Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH L. REV. 938, 945–54 (1997) (discussing disparity in testing, reporting, and criminal and civil prosecution between white and black women).

74. *In re* Fathima Ashanti K.J., 558 N.Y.S.2d 447, 447 (Fam. Ct. 1990).

75. Chazotte, *Low Birth Weight*, *supra* note 56, at 293–300. The March of Dimes Birth Defects Foundation has documented nationally that a woman who has thirteen to fourteen prenatal visits has only a 2% chance of having a low birth weight baby. GAO, PRENATAL CARE, *supra* note 66, at 13-14. Without any prenatal care, the risk is over 9%. *Id.* Further, the National Center for Health Statistics reported that in 1985 the low birth weight rate was 18.9% among infants born to women with no prenatal care compared with an overall incidence of low birth weight of 6.8%. *Id.*

76. *See* sources cited *supra* note 4; *see also* The Lindesmith Center, *Research Brief: Cocaine & Pregnancy* (visited Nov. 13, 1999) <http://www.lindesmith.org/cites_sources/brief12.html> (finding methodological flaws in early studies that had concluded prenatal cocaine use led to fetal and child development problems; highlighting other studies linking poor fetal and child development to substandard prenatal care and alcohol and tobacco use); Nigel S. Paneth, *The Problem of Low Birth Weight* (visited Jan. 20, 2000) <http://www.futureofchildren.org/LBW/03LBWPAN.htm> (citing EXPERT COMM. ON MATERNAL AND CHILD HEALTH, WHO, WHO TECHNICAL REPORT SERIES No. 27, PUBLIC HEALTH ASPECT OF LOW BIRTH WEIGHT (1950)) (concluding that "[a]lthough it has been popular to link illicit drug use to low birth weight, a high low birth weight rate was characteristic of the United States for decades before the cocaine epidemic of the 1980s").

on this subject is complex and conflicting, and many studies do not control for the compounding effects of poor medical care, improper nutrition, and the use of alcohol and/or tobacco. Moreover, recent studies indicate that the nature and permanence of the damage caused by prenatal exposure to cocaine have been exaggerated; the effects attributed to cocaine exposure are more likely a result of poverty and other environmental factors.[77] Studies reveal that cocaine-using women are exposed to a number of conditions that put them at greater risk of infections than other women. For instance, cocaine-using women suffer from poor nutrition and poor overall health and have a greater exposure to violence and poor or unsanitary living conditions.[78] Because characteristics of premature infants are not unlike the characteristics of infants exposed to crack cocaine in utero, it is often difficult, if not impossible, to separate the effects of cocaine exposure from the effects of other elements of the disadvantaged maternal lifestyle, including the inability to seek prenatal care.[79]

In several New York Family Court cases, judges have shown a high degree of concern for the national epidemic of prenatal substance abuse and the effects of cocaine on the fetus. In *In re Stefanel Tyesha C.*, the court cited to newspaper and journal articles to support its reversal of the Bronx Family Court's dismissal of a neglect petition.[80] In *In re Fathima Ashanti K.J.*, a Bronx Family Court judge noted that low birth weight and below average length and head circumference are potential learning disability risk factors.[81] The court relied on several articles written by Ira Chasnoff, who was director of NAPARE when the 1989 study was conducted and publicly announced.[82]

In neither aforementioned case did the court question the accuracy of the articles or the studies upon which the decisions relied.[83] Nevertheless,

77. The Lindesmith Center, *supra* note 76 (citing study showing that 10–15% of all birth defects are due to environmental agents, another 10–15% are hereditary, and 1–5% are from chemical exposure, including exposure to drugs).

78. INCIARDI, COCAINE-EXPOSED, *supra* note 69, at 31.

79. *Id.* at 32.

80. *See In re* Stefanel Tyesha C., 556 N.Y.S.2d 280, 286 (App. Div.), *appeal dismissed sub nom. In re* Sebastian M., 565 N.E.2d 1267 (N.Y. 1990) (citing Douglas J. Besharov, *Let's Give Crack Babies a Way Out of Addict Families*, NEWSDAY, Sept. 3, 1989, at 4; Besharov, *The Worst Threat*, *supra* note 4; Barbara Kontrowitz, *The Crack Children*, NEWSWEEK, Feb. 12, 1990, at 62; Sue Miller, *Moms: No 'Safe' Time for Cocaine*, L.A. TIMES, Nov. 28, 1989, at E1).

81. *See In re* Fathima Ashanti K.J., 558 N.Y.S.2d 447, 448 (Fam. Ct. 1990) (examining scientific and social science texts on this topic).

82. *Id.* at 448–49. For a discussion of NAPARE's 1989 study, see *supra* note 2. Ira J. Chasnoff is the President of the National Association for Families and Addiction Research and Education (previously NAPARE) and is one of the leading authorities on the subject of fetal drug exposure. Susan E. Rippey, *Criminalizing Substance Abuse During Pregnancy*, NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 69, 106 n.15 (1991).

83. *See Fathima*, 558 N.Y.S.2d at 448 (taking judicial notice of articles and accepting authors' contentions as facts without further analysis).

the court relied on the articles to support a weak causal connection to justify its finding that the children were neglected. Another example of the use of this technique is the lower court's decision in *In re Nassau County Department of Social Services*, which also failed to take into account all the surrounding circumstances that may produce impairment or imminent risk of impairment in the newborn child in reaching its conclusion that the child had been neglected.[84] As discussed in the previous section, by assuming a causal relationship between drug use and low birth weight, the court routinely overlooks more obvious causes, such as lack of prenatal care or poor nutrition. Judges in neglect proceedings too often fail to examine the complex interaction of a variety of factors impacting birth weight, often without attempting to access all relevant evidence.[85]

D. Prior Neglect of Infant's Siblings

Under the New York Family Court Act, proof of abuse or neglect of one child is "admissible evidence on the issue of the abuse or neglect of any other child" under the care of the respondent.[86] The presumption of neglect is rebuttable by the respondent.[87] In *In re Miranda H.*, the lower court issued a finding of child neglect by a preponderance of the evidence after having considered, among other factors, prior findings of neglect against the mother concerning her other children. The court took judicial notice of the fact that at the time the petition in *Miranda H.* had been filed, the mother's three other children had been in foster care for eleven months as a result of prior findings of neglect. On appeal, the Appellate Division held that the lower court properly considered the mother's prior neglect of the infant's siblings in reaching its determination.[88]

A mother's demonstrated ability to care for other children has also been considered by courts in dispositional hearings, after a finding of child neglect has been issued.[89] In *In re Nassau County Department of Social*

84. *In re* Nassau County Dep't of Soc. Servs., 661 N.E.2d 138, 139–40 (N.Y. 1995) (affirming lower court's finding of neglect where infant was born prematurely and underweight, but finding that it erred in relying solely on positive toxicology report, ignoring additional evidence of neglect in record).

85. Bonnie E. Rabin, *Violence Against Mothers Equals Violence Against Children: Understanding the Connections*, 58 ALB. L. REV. 1109, 1114–15 (1995).

86. N.Y. FAM. CT. ACT § 1046(a)(i) (McKinney 1999) (stating that "proof of the abuse or neglect of one child shall be admissible evidence on the issue of the abuse or neglect of any other child of, or the legal responsibility of, the respondent.").

87. *Id.*

88. *In re* Miranda H., 595 N.Y.S.2d 97, 98 (App. Div. 1993).

89. Under the New York Family Court Act, at the dispositional hearing the court hears testimony and reviews reports recommending what should be done for the child. N.Y. FAM. CT. ACT §§ 1045, 1046, 1052. Possible dispositions include releasing the child to the parents or guardian on the condition that they not commit further neglectful or abusive acts, *see id.* at §§ 1052(a)(ii), 1054(a), 1056(c), (g), releasing the child to the parent or guardian, with supervision and services provided by child protective agencies, *see id.* at §§ 1052(a)–(v), 1057, or placing the child in foster care for a period of time while services are provided to

Services, the trial court considered testimony that the respondent provided a clean, well-ordered environment for her children and that she interacted appropriately with them.[90] Although the social worker had provided such evidence during the fact-finding hearing as well, the court had found it irrelevant whether the mother had previously neglected her children. The court considered it only in determining what level of supervision to order.[91] The court's decision was based, in part, on the fact that the mother had demonstrated an inability to care adequately for her children while abusing drugs.[92]

Under the Family Court Act, evidence of a mother's neglect of her other children is admissible in any type of neglect proceeding, not only in cases involving women who use drugs and their children.[93] The statute also creates a presumption of neglect that is not dependent on the existence of a positive toxicology test. Nevertheless, in neglect proceedings involving cocaine-exposed infants, the court's focus should be whether the particular child is in imminent danger of future harm rather than what harm, if any, the child has previously endured. Neglect determinations should be based on a comprehensive evaluation that examines the child's well-being and best interests in light of her parent and family situation. This "complete assessment" test is discussed at length in Part IV.

IV.
COMPLETE ASSESSMENT TEST

Because, as demonstrated previously, it is nearly impossible to prove current harm associated with prenatal drug use, judges must concentrate on the effects of current and continuous conditions on the child. Decisions based on a comprehensive assessment of the parent, child, and family will better serve drug-exposed infants and their families, as well as assist judges in identifying conditions that contribute to the likelihood of maltreatment.

Judicial decisions should be based upon the actual situation of the child and the specific circumstances of each individual case. Rather than presuming neglect because of a mother's use of drugs while pregnant, intervention should be based on the correlation between child neglect and abuse and maternal drug use. Therefore in neglect proceedings involving drug-using mothers, courts should consider the following: (1) the extent of the mother's current drug use and treatment history, (2) the mother's history of abuse or neglect of other children, (3) the special needs of the child

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the parents to allow for a possible return of the child at a future date, *see id.* at §§ 1052(a)(iii), 1055.

90. *In re* Nassau County Dep't of Soc. Servs., 661 N.Y.2d 138, 140 (N.Y. 1995).

91. *Id.* at 141 (noting evidence presented at trial indicated that appellant's mother had custody of two of appellant's children because of appellant's inability to care for them while abusing drugs).

92. *Id.* at 140–41.

93. N.Y. FAM. CT. ACT § 1046(a)(i) (McKinney 1999).

(regardless of their cause), and (4) the strength of internal and external family support.

A. *Parent Assessment: Current Drug Use and Treatment History*

Section 1046(a)(iii) of the New York Family Court Act creates a presumption of neglect where there is evidence that a parent repeatedly misuses a drug to the extent that it could substantially impair judgment.[94] The statute does not presume that the pattern of drug use established during pregnancy will continue and does not refer to occasional use. Judges must ascertain whether a mother is currently using drugs and the extent of that use.[95]

Even if judges appropriately consider the difficulties women face in obtaining drug treatment and the nature of recovery, a woman's treatment history may be an important factor in determining the adequacy of her ability to care for her infant in the future. A woman's current enrollment in a rehabilitation program may indicate her willingness to overcome her drug problem for the sake of her children. Acknowledging this, New York's statute indicates that voluntary and regular participation in a rehabilitation program can counter evidence indicating impairment to the child from drug misuse.[96]

In many neglect proceedings, section 1046(a)(iii) of the Family Court Act will serve merely as a starting point. If the standard for the statutory presumption is not met or is rebutted, the court may evaluate other factors to determine whether a neglect finding is nevertheless warranted. Since the statutory standard for a neglect finding is a preponderance of the evidence, the court must look beyond the prima facie case.[97]

B. *History of Abuse or Neglect of Other Children*

Past treatment of other children can be a predictor of how a particular mother will treat her newborn. Accordingly, as discussed in Part III, prior neglect of an infant's siblings and a mother's history of abuse or neglect is an independent basis for jurisdiction.[98] Consideration of the mother's past

94. N.Y. FAM. CT. ACT § 1046(a)(iii) (McKinney 1999) (stating that rebuttable presumption of neglect is created when person misuses drugs or alcohol "to the extent that it has or would ordinarily have the effect of producing in the user thereof a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment, or a substantial manifestation of irrationality.").

95. *Id.* (finding that drug or alcohol abuse cannot be used as prima facie evidence of neglect when person is voluntarily and regularly participating in rehabilitation program).

96. *Id.* at §§ 1012(f)(i)(B) (defining "neglected child" as one whose physical, mental, or emotional condition is impaired as result of parent misusing drugs or alcohol to extent that she loses self-control, unless parent "is voluntarily and regularly participating in a rehabilitative program"), 1046(a)(iii) (allowing participation in rehabilitative program to rebut presumption of abuse due to parental misuse of drugs).

97. *Id.* at § 1046(b)(i).

98. *Id.*

behavior becomes particularly relevant when prior proceedings involved drug use and when the impact of such use upon the mother's ability to parent was an issue before the court. Examination of such evidence is relevant to determining parental ability and fitness.

C. *Child Assessment: Special Needs*

A mother's continued drug use may itself contribute to an inability to care for her child, even if the child has no special needs. However, judges should take notice of whether the infant has particular medical problems that make caring for her more difficult. Consideration of the additional strains of caring for medically fragile children, especially when the mother is simultaneously recovering from drug addiction, is extremely important in such proceedings. Such conditions include premature birth, mental retardation, physical handicap, and mental illness.

Infants born prematurely have been shown to have a significantly greater chance of subsequent abuse than those carried to full term. Studies of abused children have identified from twelve percent to thirty-three percent as prematurely born. These children tend to have a low birth weight and may be more restless, distractible, unresponsive, and demanding than the average child.[99]

Similarly, developmentally delayed children are "at risk," both because they require more attention than mothers in recovery can provide and because they may not respond to parental direction and affection as quickly as other children."[100] Although children with special needs disproportionately are victims of child abuse and neglect, researchers have not been able to determine whether this correlation results from the frequency with which maltreatment causes disabilities or from the special vulnerability of children with disabilities.[101] In either case, these child-specific factors, in addition to the mother's condition, greatly increase the likelihood of neglect and therefore should be carefully considered by family court judges.

D. *Family Assessment: Strength of Support*

In addition to the aforementioned factors, a family court judge must also recognize characteristics of the family that may diminish the likelihood of abuse or neglect. Among other things, these characteristics can include

99. ROBIN E. CLARK & JUDITH FREEMAN CLARK, THE ENCYCLOPEDIA OF CHILD ABUSE 9 (1989) (noting that many experts believe treatment for low birth weight and other medical problems can interfere with natural mother-infant bonding process, placing child at increased risk of abuse).

100. *Id.* at 10.

101. James Garbarino, *The Abuse and Neglect of Special Children: An Introduction to the Issues*, *in* SPECIAL CHILDREN, SPECIAL RISKS: THE MALTREATMENT OF CHILDREN WITH DISABILITIES 3, 10 (James Garbarino, Patrick E. Brookhouser, Karen Autheir, & Associates eds., 1987).

relatives or other parent substitutes living in or near the home who assist with care-giving responsibilities or other community and family resources that otherwise provide a "safety net" for children.[102]

On the other hand, situations in which no stable relative is in close proximity may present an additional risk for children of women who use drugs. The presence of other substance abusers or persons involved in illegal or violent activities may also intensify the threat to the child. However, the existence of the latter may be difficult, if not impossible, for a judge to ascertain.

This list of factors is neither perfect nor exhaustive, but it provides some guidance to family courts in making neglect or abuse determinations. When evaluating the potential for abuse, judges must consider the number of risk factors present and the severity of each factor. Since no one factor or combination of factors makes abuse or neglect inevitable, judges should weigh them against one another, considering all their various and complex interactions. Intervention on behalf of a drug-exposed infant should be predicated upon the correlation between an infant's health and behavioral problems and all the factors contributing to child neglect, including chronic drug use.

V.
CONCLUSION

Although a showing of harm or imminent harm to the child is a prerequisite for a finding of child abuse or neglect, New York courts frequently assume that prenatal drug use inevitably leads to harm. In most cases, concrete examination of whether harm to the child has occurred is replaced by assumptions about prenatal drug use and exposure. In doing so, New York courts circumvent the *Fletcher* safeguards to which drug-using mothers are entitled despite appearing to consider other indicators of neglect, reaching the same conclusions made by courts in states with automatic removal provisions. The current system not only fails to protect families but also perpetuates stereotypes and erroneous notions about the effects of prenatal drug use on children. Only when family court judges look at evidence actually relevant to the connections between drug use and harm to children and more accurately assess care-giving capacity will their decisions be based on reality and true parental ability.

102. In recent years, states including New York have adopted kinship care programs designed to keep children with family members when possible. Although these programs affect drug-exposed children only after determinations of neglect and a dispositional hearing, the public policy providing foundation for these programs is promising. Accordingly, family court judges should look to the familial resources available to mothers charged with neglect. For more information about kinship care programs, see Jill Duerr Berrick, *When Children Cannot Remain Home: Foster Family Care and Kinship Care*, *in* FUTURE OF CHILDREN 72 (1998).