University of Florida Journal of Law & Public Policy

Volume 5 | Issue 1 Article 4

1992

Drug Use During Pregnancy: State Strategies to Reduce the Prevalence of Prenatal Drug Exposure

Deborah Appel

DRUG USE DURING PREGNANCY: STATE STRATEGIES TO REDUCE THE PREVALENCE OF PRENATAL DRUG EXPOSURE

*Deborah Appel**

---

*J.D., 1992, Duke University; M.A., 1992 Duke University; B.A., 1987 University of California, San Diego. I would like to thank Beryl, Edie, Marci, Howard, and especially Victor, for their patience, support, and encouragement. I would also like to thank Micheline Malson for her assistance and guidance.

I. INTRODUCTION

The purpose of this article is to formulate an effective and comprehensive state policy to reduce the number of babies who are exposed to drugs in utero. The article will focus on what the state can do to reduce prenatal drug exposure while the woman is pregnant. Section II analyzes the extent of the problem of prenatal drug use: the number of babies who are prenatally exposed to drugs, a profile of women who use drugs during pregnancy, the effects of prenatal drug use on the fetus and the effects of prenatal drug use on the pregnant woman. Section III analyzes whether states have an interest in the future health of the fetus and when this interest becomes compelling. Section IV reviews and critiques policies to reduce prenatal drug exposure which have been implemented or proposed. Section V recommends policies that state governments can implement to combat this problem.

II. THE EXTENT OF THE PROBLEM

A. *The Number of Babies in the United States Exposed to Drugs in Utero*

The problem of drug abuse during pregnancy was recognized in the early 1970's. In 1977, the National Institute on Drug Abuse estimated that there were 4,742 infants born to drug-addicted women.[1] Nearly 70 percent of these women had no medical intervention during their pregnancies, and their first contact with the health care system was their arrival at the hospital after the onset of labor.[2] During the 1970's, almost all of the women who used drugs during pregnancy were using heroin.

Prenatal drug use became pervasive in the 1980's. Cocaine, particularly crack cocaine, and marijuana became the drugs of choice. The estimated number of women who use drugs during pregnancy varies. In 1988, Ira Chasnoff of the National Association of Perinatal Addiction Research and Education conducted a survey of 36 hospitals throughout the country and found that 11 percent of the 155,000 newborns studied had positive toxicology screens for illicit substances.[3] Based on this

---

1. *The Use of Drugs During Pregnancy: Hearings Before the House Select Comm. on Narcotics Abuse and Control*, 96th Cong., 2d sess. 1 (1980) (statement of Rep. Collins) [hereinafter *The Use of Drugs During Pregnancy*].

2. Id.

3. Congress, Senate Hearing 101-515, Committee on Governmental Affairs, *Missing Links: Coordinating Federal Drug Policy for Women, Infants, and Children*, 101st Cong., 1st sess., 31 July 1989, at 26 [hereinafter *Missing Link*].

study, it has been estimated that approximately 375,000 babies in the United States are prenatally exposed to drugs each year.[4]

Dr. Chasnoff conducted a second prevalence study in 1989 in Pinellas County, Florida. Pinellas County was an optimal study site for a study because the County's demographics could represent a microcosm of many communities across the United States. Urine samples were collected from all pregnant women who visited public health clinics or private obstetricians over a one month period. There were 715 women who participated in this study, 335 of whom were receiving private care. Dr. Chasnoff found that 14.8 percent of the women tested positive for alcohol, marijuana, cocaine and/or opiates.[5]

Official government estimates of the prevalence of prenatal drug use in the 1990's are inconsistent with each other. The National Institute on Drug Abuse estimated that 158,400 babies were exposed to cocaine in 1990[6] while the Office of National Drug Control Policy estimates that 100,000 babies are exposed to cocaine in utero every year.[7]

Accurately estimating the prevalence of drug use during pregnancy is problematic. Researchers frequently base their estimates on the results of toxicology tests administered either to newborns or to women just prior to delivery. Urine toxicology tests administered to women at the time of delivery or to newborns, detect only the recent use of drugs. A toxicology test will remain positive after the last use of cocaine for only 24 to 72 hours, after opiates for only 2 to 4 days, and after marijuana for only 7 to 30 days.[8] Toxicology screens adminis-

---

4. *Born Hooked: Confronting the Impact of Perinatal Substance Abuse: Hearings Before the House Select Comm. on Children, Youth, and Families*, 101st Cong., 1st Sess. 1 (1989) (statement of Rep. Miller) [hereinafter *Born Hooked*].

5. Kary Moss, *Substance Abuse During Pregnancy*, 13 HAR. WOMENS L.J. at 294 (1990).

6. *Cost of Care for Cocaine Babies Soars*, CHI. TRIB., Sept. 18, 1991, §1, at 8.

7. OFFICE OF NATIONAL DRUG CONTROL POLICY, STATE DRUG CONTROL STATUS REPORT ([Washington, D.C.]: U.S. Office of National Drug Control Policy, November 1990), 32.

8. Arthur T. Evans & Kathy Gillogley, *Drug Use in Pregnancy: Obstetrics Perspectives*, *in* CLINICS IN PERINATOLOGY, Mar. 1991, at 25. In fact, pregnant drug users tend to reduce their drug use in the later stages of pregnancy. A study of 679 new mothers showed that of the women who used drugs, 48% continued their usage during their first two trimesters, but only 15 percent continued using drugs during their entire pregnancies. *Born Hooked*, *supra* note 4, at 261 (testimony of Arne Schoeller) (citing D.A. Frank, et al., *Cocaine Use During Pregnancy: Prevalence and Correlates*, 82 PEDIATRICS at 888-895 (1988)). In a study of women who used marijuana during pregnancy, 32% of the women used marijuana in the first trimester, 20% used marijuana in the second trimester, and 16% used marijuana in the third trimester. Katherine Tennes, et al., *Marijuana: Prenatal & Postnatal Exposure in the Human*, *in* CURRENT RESEARCH ON THE CONSEQUENCES OF MATERNAL DRUG ABUSE 48, 51 (Theodore M. Pinkert ed., Washington D.C.: U.S. Dept. of Health and Human Services; 1985; NIDA Research Monograph 59).

tered to a newborn or a pregnant woman prior to or after delivery will miss the occasional user or one who did not use drugs in the later stages of pregnancy. Furthermore, newborns who may have been exposed to drugs but do not exhibit symptoms of the drug exposure may not be given a toxicology test because urine toxicology tests are not routinely administered to newborns.

B. *A Profile of Women Who Use Drugs During Pregnancy*

Women who use drugs during pregnancy tend to be older than pregnant women who do not use drugs. In a study of 354 babies at Harlem Hospital in New York, the average age of the women who used cocaine during pregnancy was 25.7 years while the average age of women who did not use cocaine was 24.8 years.[9] In another study, women who did not use drugs during pregnancy were on average three years younger than the women who used cocaine during pregnancy.[10]

Studies show that pregnant drug users often have other children. In one study of women who used cocaine during pregnancy, the women had an average of 2.3 children after their current pregnancies.[11] Another study of babies who were clinically identified as cocaine-exposed showed that 33 percent of their mothers had one or more cocaine-exposed infants already "known to the system."[12] Experts confirm that pregnant drug users are usually not first-time mothers. Lucia Meijer, a substance abuse education coordinator at the AIDS Education and Training Center at the University of Washington School of Medicine, reported that many female addicts are responsible for one or more children.[13] Mary Sheila Gall, the Assistant Secretary for the Office of Human Development Services, stated that pregnant women who are drug-addicted often have a number of children at home.[14]

Studies show that the rate of drug use among pregnant women is

---

9. Ciaran S. Phibbs, David A. Bateman, & Rachel M. Schwartz, *The Neonatal Costs of Maternal Cocaine Use*, 266 JAMA 1523 (Sept. 18, 1991).

10. Bertis B. Little, Laura M. Snell, Victor R. Klein & Larry C. Gilstrap, *Cocaine Abuse During Pregnancy: Maternal and Fetal Complications*, OBSTETRICS AND GYNECOLOGY, Aug. 1991, at 158.

11. *Id.* at 158.

12. Emmalee S. Bandstra & Gene Burkett, *Maternal-Fetal and Neonatology Effects of In Utero Cocaine Exposure*, 15 SEMINARS IN PERINATOLOGY 297 (1991).

13. *Born Hooked, supra* note 4, at 218 (testimony of Lucia Meijer, Substance Abuse Education Coordinator of the WAMI AIDS Education and Training Center, University of Washington).

14. *Missing Links, supra* note 3 at 44.

virtually the same across all racial and socioeconomic categories. Ira Chasnoff's study in Pinellas County showed that 15.4% of white women who participated in the study and 14.1% of African-American women used drugs during pregnancy.[15] African-American women were more likely to use cocaine, and white women were more likely to use marijuana during their pregnancies. While 7.5% of the African-American women used cocaine, 1.8% of white women used cocaine.[16]

The results of a prevalence study which was recently conducted in North Carolina were similar to the results of the Pinellas County study. Dr. Al Killam of Duke University who was involved in the study in North Carolina stated that "[r]ace is not the problem we thought it was. In random screens, the two races are very much the same in terms of drug use."[17]

Another characteristic of pregnant drug users is poor self-image.[18] These women fear they will be judged if they seek help for their addictions. They have less well-developed ego defenses and tend to demonstrate more pessimism and low morale.[19] Further, female drug addicts lack self-confidence and express dissatisfaction with their current situation.[20]

Many pregnant drug users do not seek prenatal care. Studies show that between 20 to 71% of pregnant women who use drugs seek prenatal care[21] while between 85% and 95.5% of non-drug using pregnant women seek prenatal care.[22] In a study by Wendy Chavkin, 42% of the women who participated in the study stated that they did not

---

15. Rorie Sherman, *Keeping Babies Free of Drugs*, NAT'L L.J., Oct. 11, 1989, at 1.

16. *Id.* Despite the fact that drug use was as prevalent among white women as African-American women, African-American women were 10 times more likely to be reported to authorities than white women and poor women were more likely to be reported than middle-class women. Gina Kolata, *Bias Seen Against Pregnant Addicts*, THE NEW YORK TIMES, July 20, 1990, at A13.

17. Dennis Patterson, *Study Urged on Drug Toll on Newborns: Initial Result: 3 Percent of Mothers Users*, CHARLOTTE OBSERVER, 27 Feb. 1991, at B3.

18. Congress, House of Representatives Serial No. 101-105, Subcommittee on Health and the Environment of the Committee on Energy and Commerce, *Antidrug Abuse Appropriations Authorization*, 101st Cong., 1st sess., Oct. 30, 1989, at 21 [hereinafter *Antidrug Abuse Appropriations Authorization*].

19. Marvin R. Burt, Thomas J. Glynn & Barbara J. Sowder, Department of Health, Education, and Welfare, National Institute on Drug Abuse, *Psychosocial Characteristics of Drug Abusing Women*, at 60.

20. *Id.*

21. *Born Hooked*, *supra* note 4, at 8; *see also* Phibbs, *supra* note 11, at 1523; Renee Graham, *Reaching Back to Help*, THE BOSTON GLOBE, Dec. 3, 1991, at 1; *Missing Links*, *supra* note 3, at 86.

22. *Born Hooked*, *supra* note 4, at 8 (statement of Rep. Miller); Phibbs, *supra* note 11, at 1523.

seek prenatal care because they felt guilt and shame for using drugs during their pregnancies.[23]

In addition, most pregnant drug users do not seek drug treatment. The Office of National Drug Control Policy reports that pregnant addicts are among the most reluctant groups to seek treatment.[24] A 1990 survey conducted by the General Accounting Office found that fewer than 11% of pregnant women who are in need of drug treatment actually receive the treatment.[25]

Pregnant women who use drugs frequently use more than one drug during their pregnancies. In a study of 53 women who used cocaine during pregnancy, 75% of the women also used other substances.[26] In another study of 114 neonates who were exposed to cocaine, researchers found that 70.2% of their mothers used other drugs during their pregnancy.[27] In addition to using cocaine, this study found that 51.8% of the women used alcohol, 42.1% used marijuana, and 10.5% used phencyclidine.[28] A study of 355 women who used cocaine during their pregnancies found that 22.5% of the women used more than one illicit substance.[29]

Pregnant drug users often come from families where one or both parents had abused drugs or alcohol. One study that compared drug-addicted with non-drug addicted pregnant women found that 83% of the drug-addicted women came from chemically dependent families.[30] Susie Miller stated that every addict that has been treated at Austin Family House over the eight years in which she was the director came from a family where the mother or one grandmother was an alcoholic or a narcotics addict.[31]

A final characteristic of pregnant drug addicts is a history of sexual or physical abuse. In a study comparing drug-addicted and non-drug-

---

23. Wendy Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 266 J. AM. MED. ASS'N 32 (1991).

24. Office of the National Drug Control Policy, *State Drug Control Status Report* 32.

25. Constance Matthiessen, *Offsetting the Effects of Crack on Babies: Early Stimulation Helps Children Who Were Exposed to Drugs in the Womb*, WASH. POST, Dec. 31, 1991, § Z (Health), at 12.

26. Little, *supra* note 10, at 158.

27. Jean M. Silvestri, Joyal M. Long, Debra E. Weese-Mayer, & Gary A. Barkov, *Effects of Prenatal Cocaine on Respiration, Heart Rate, and Sudden Infant Death Syndrome*, 111 PEDIATRIC PULMONOLOGY 329 (1991).

28. *Id.*

29. Phibbs, *supra* note 9, at 1523.

30. *Missing Links*, *supra* note 3, at 7.

31. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 8.

addicted pregnant women, over 70% of the drug-addicted women experienced early sexual abuse before the age of 16, whereas 15% of non-addicted women had been sexually abused.[32] Susie Miller reported that over 80% of pregnant drug users that were treated at Austin Family House were incest victims, and 95% were brought up in families where the children had been physically abused.[33] Shoni Welsch-Davis of the Orange County Perinatal Treatment Program stated that 98% of the patients came from dysfunctional families, 80% of the women were incest victims, and 90% of the women were battered as children or adults.[34]

C. *How Prenatal Drug Use Affects the Fetus*

In the absence of large scale epidemiological studies, it is not possible to precisely determine how the use of each drug will adversely affect the fetus. It is also difficult to separate the harmful effects of prenatal drug use on the developing fetus from the effects of other factors such as genetics, the lack of prenatal care, poor nutrition and the mother's lifestyle. Despite these problems, researchers have attempted to isolate how the use of specific drugs during pregnancy can adversely harm the developing fetus.

1. The Effects of Prenatal Heroin Exposure on the Fetus

Heroin was the most frequently used drug by pregnant women in the 1970's. In the 1980's and 1990's, pregnant women have used heroin far less than other illicit drugs. Dr. Ira Chasnoff found that .3% of the study population in Pinellas County used opiates.[35] A study at the University of California at Davis Medical Center found that 1.2% of the women studied were using opiates during pregnancy.[36] In another study, pregnant women who entered a New York hospital to deliver were given a toxicology test, and 1.4% tested positive for opiates.[37]

Pregnant heroin users are usually in poor health. Dr. Loretta Finnegan, the Associate Director of Nurseries at Jefferson Medical College in Philadelphia in 1980, reported that the heroin addict who is high is sedated and tranquilized, and the last thing she is thinking

---

32. *Missing Links*, *supra* note 3, at 62.

33. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 8 (statement of Susie Miller).

34. *Id.* at 12.

35. Evans & Gillogley, *supra* note 8, at 23.

36. *Id.* at 24.

37. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 14.

about is eating a good diet, sleeping well and obtaining medical care.[38] Many heroin addicts suffer from infections such as hepatitis A and B, non-A and non-B hepatitis, bacterial endocarditis, tetanus, cellulitis and sexually transmitted diseases as well as anemia and iron deficiency. Studies have shown that 60% of heroin addicts have persistent abnormalities of liver function due to chronic liver disorders.[39] In addition, heroin users also have a high risk of contracting AIDS.

The fetus will be exposed to heroin within about 30 minutes after its mother takes the drug. In fact, heroin may achieve a higher level in the fetal brain than the maternal brain since a fetus has an immature blood-brain barrier for heroin. A pregnant woman who is using heroin will go through periods of withdrawal and overdose. Both the pregnant woman and the fetus will experience this withdrawal. The withdrawal could cause uterine contractions which may lead to premature labor. Moreover, the fetus may experience symptoms of fetal distress when it is withdrawing from heroin.

As a result of being exposed to heroin, approximately 75% of these babies will have to be treated for withdrawal symptoms which can last up to six months.[40] Most of these newborns will have tremors, regurgitation, high pitched cries and poor feeding habits. They will sneeze frequently, frantically suck their fists, and sleep less than three hours after feeding.[41] Other symptoms of withdrawal include irritability, hyperactivity, vomiting, diarrhea, excessive mucous, tachypnea and fever. Approximately 50% of the babies will be small and jaundiced and have low sugar and calcium counts.[42]

Few studies have been conducted to determine the long-term effects of prenatal heroin-exposure. However, educators and health care providers report that these children have behavioral disturbances, brief attention spans, and temper outbursts and are frequently hyperactive.

2. The Effects of Prenatal Methadone Exposure on the Fetus

Some health care providers suggest that the pregnant heroin user substitute methadone for heroin since there is a high risk of miscarry-

---

38. *The Use of Drugs During Pregnancy, supra* note 1, at 29.

39. Department of Health and Human Services, National Institute on Drug Abuse, *Drug Dependency in Pregnancy: Clinical Management of the Mother*, at 34.

40. *The Use of Drugs During Pregnancy, supra* note 1, at 35 (testimony of Dr. Loretta P. Finnegan, Assoc. Professor of Pediatric Psychiatry and Human Behavior, Thomas Jefferson Univ.).

41. *Id.* at 71.

42. *Id.* at 31. Heroin-exposed newborns also have increased risk of Sudden Infant Death Syndrome (SIDS).

ing when a pregnant woman abruptly stops using heroin. However, methadone is also harmful to the fetus. Methadone will be widely distributed throughout the pregnant woman's body after she uses the drug, exposing the fetus to methadone shortly after the drug is consumed. The drug readily crosses the placenta and will remain in the amniotic fluid, cord blood and neonatal urine.

Newborns who have been exposed to methadone in utero will experience the adverse effects of the prenatal drug exposure shortly after birth. Approximately 75% of methadone-exposed newborns suffer narcotic withdrawal.[43] Withdrawal symptoms include tremors, shaking, vomiting and diarrhea. Most methadone-exposed newborns must be kept in a room with low light and minimal stimulation. In some cases, these infants must be given small doses of opium to counter the withdrawal symptoms. Methadone-exposed infants are less responsive to rattle sounds and inanimate visual orientation, are less alert, cuddly and consolable, and demonstrate less motor maturity and more tremulousness.

Children exposed to methadone in utero have a higher incidence of minor neurological abnormalities such as hypotonia and hypertonia, have lower scores on developmental evaluations between birth and their third year of life, experience delays in attaining developmental milestones, and have poor fine-motor coordination and poor language development. These children also suffer eye disorders.

Methadone-exposed children will continue to be adversely affected by the prenatal drug exposure. Neurological evaluations show a higher prevalence of abnormalities of fine and gross motor coordination, poor balance, decreased attention spans and speech and language delays. Children exposed to methadone in utero have a higher incidence of behavioral and academic problems in school.

3. The Effects of Prenatal Cocaine Exposure on the Fetus

As indicated above, women who use drugs during pregnancy frequently use cocaine. A study of 1,226 pregnant women in 1989 showed that 18 percent of the women had used cocaine during their pregnan-

---

43. Tove S. Rosen & Helen L. Johnson, *Long Term Effects of Prenatal Methadone Maintenance, in* CURRENT RESEARCH ON THE CONSEQUENCES OF MATERNAL DRUG ABUSE 73, 75 (Theodore M. Pinkert ed., Washington, D.C.: U.S. Dept. of Health and Human Services; 1985; NIDA Research Monograph 59). In addition, studies show that methadone-exposed children score significantly lower on both the Mental Development Index and Psychomotor Development at 12 and 18 months. At 36 months, studies show that methadone-exposed children have lower mean lengths of utterances.

cies.[44] In Philadelphia, 1,000 babies were tested for drug exposure shortly after birth, and researchers found that 16 percent of the infants had been exposed to cocaine.[45] A study in Fairbanks, Alaska, found that 2.4% of the women tested positive for cocaine use.[46] In another study at the University of California, Davis Medical Center, all women who received treatment were screened for drugs upon admission to the obstetrics department, and researchers found that 9.5% of the women had used cocaine during their pregnancies.[47] Approximately 8% of the women admitted to the obstetric services at the Chicago Osteopathic Medical Center tested positive for cocaine use.[48] Studies show that about one-third of the pregnant cocaine users are using crack cocaine, a concentrated, potent derivative of cocaine.[49]

Cocaine is rapidly metabolized in the body. Seconds after ingesting cocaine, both the pregnant woman's blood vessels and the fetus' blood vessels will constrict. This constriction will disrupt blood flow through the placenta and disrupt the flow of oxygen and nutrients to the fetus. A very large dose of cocaine can cause the blood supply to be cut so sharply that the placenta may tear loose from the uterus. Once the drug has crossed the placenta, it cannot be recirculated back to the mother's system.

After one "hit", the drug remains in the amniotic fluid for four to five days and becomes even more concentrated. As the drug passes through the fetus' blood stream, the fetus' blood pressure rises and the drug circulates to the fetus' brain. There is no blood-brain barrier in the fetus for cocaine.

The drug's effect on the pregnant woman will also endanger the fetus. Cocaine, particularly crack, is extremely addictive. Cocaine causes observable changes in a person's brain chemistry which makes addiction almost certain. Approximately 90% of crack users will become addicted to the drug.[50] Drug Enforcement Agency officials concluded that crack is so addictive that a person cannot stop using the

---

44. J.H. Khalsa & Joseph Gfroerer, *Epidemiology and Health Consequences of Drug Abuse Among Pregnant Women*, 15 SEMINARS IN PERINATOLOGY, Aug. 1991, at 266.

45. *Id.* at 267.

46. Ira J. Chasnoff, *Drugs, Alcohol, Pregnancy, and the Neonate: Pay Now or Pay Later*, 266 J. AM. MED. ASS'N 1567 (1991).

47. Evans & Gillogley, *supra* note 8, at 24.

48. *Id.*

49. Phibbs, *supra* note 11, at 1524; COST OF CARE, *supra* note 6 § 1, at 8; *see also Cocaine and Fetal Death*, 47 FORENSIC SCI. INT'L 185 (Sept. 1990).

50. *Born Hooked*, *supra* note 4, at 25 (testimony of Margaret L. Gallen, District of Columbia General Hospital).

drug once she starts.[51] Cocaine appears to be the pre-eminent focus in the life of the cocaine user. When cocaine becomes an obsession, the user's thoughts are disorganized, and her judgment fails. In addition, cocaine is also a strong appetite suppressant. As a result, prenatal cocaine use may prevent the pregnant woman from eating a balanced diet which may in turn cause the fetus to be undernourished. Women who have consumed cocaine during pregnancy weigh less before pregnancy and gain less weight during pregnancy than pregnant women who do not use the drug. Pregnant cocaine users often suffer from iron deficiency anemia and various infections. Moreover, crack has been reported to undermine the maternal instinct.

Prenatal cocaine use may cause permanent cognitive and neurological damage to the fetus. Between 20% and 45% of women who use cocaine during pregnancy will have premature deliveries.[52] The prematurity rate in comparable, non-drug exposed study populations is between 10% and 15%.[53] Prematurely delivered infants have an increased risk of breathing difficulties, brain hemorrhage and mental defects. Approximately 25% of cocaine-exposed babies will suffer from intrauterine growth retardation.[54] Babies who suffer from intrauterine growth retardation have poor subcutaneous tissue and have a high risk of aspiration pneumonia. These babies are starved in utero from the standpoint of nutrition and oxygen, have low sugar and calcium levels, and are at risk for long-term neurological problems. In addition, many cocaine-exposed babies will be born underweight. Low birth weight babies are forty times more likely to die when compared with full-term infants and ten times more likely to have cerebral palsy and mental deficiencies.[55]

---

51. *Id.* at 29.

52. *Born Hooked*, *supra* note 4, at 50, 66, 133 (statement of Dr. Neal Halfon, Director of the Center for the Vulnerable Child, Oakland Children's Hospital); Michelle Chouteau, Pearila Brickner Namerow, & Phyllis Leppert, *The Effects of Cocaine Abuse on Birth Weight and Gestational Age*, 72 OBSTETRICS AND GYNECOLOGY 352 (1988); Little, Snell, Klein & Gilstrap, *Cocaine Abuse During Pregnancy: Maternal and Fetal Complications*, 73 OBSTETRICS AND GYNECOLOGY 160 (1989); Silvestri, Long, Weese-Mayer & Barkov, *Effects of Prenatal Cocaine on Respiration, Heart Rate, and Sudden Infant Death Syndrome*, 11 PEDIATRIC PULMONOLOGY 329 (1991); Khalsa & Gfroerer, *Epidemiology and Health Consequences of Drug Abuse Among Pregnant Women*, 15 SEMINARS IN PERINATOLOGY 267 (1991).

53. *Born Hooked*, *supra* note 4, at 133 (statement of Dr. Neal Halfon).

54. Congress, Senate, Committee on Labor and Human Resources, *Substance Abuse in Pregnancy: Economic and Social Costs*, 101st Cong., 2d Sess., Apr. 11, 1990, at 7 [hereinafter *Substance Abuse in Pregnancy*]; *see also* Anthony J. Hadeed & Sharon R. Siegel, *Maternal Cocaine Use During Pregnancy: Effect on the Newborn Infant*, 84 J. PEDIATRICS 208 (Aug. 1989).

55. *Antidrug Abuse Appropriations Authorization*, *supra* note 21, at 30 (statement of Wendy Chavkin).

Furthermore, many cocaine-exposed babies will have cranial abnormalities. In a study of 74 neonates exposed to cocaine in utero, cranial abnormalities were detected in 35.1% of the cocaine-exposed infants while cranial abnormalities were detected in only 5.3% of non-cocaine exposed babies.[56] Another study found that approximately 20% of cocaine-exposed babies will suffer from retarded brain growth.[57]

The risk of major congenital cardiac anomalities and genitourinary tract malformations also is significantly increased with the amount of prenatal exposure to cocaine. Neurological complications and behavioral problems such as irritability, high pitched crying, tremulousness and difficulty in interacting may occur even if the pregnant woman stops using cocaine during her first trimester because cocaine use during the first trimester of pregnancy may adversely affect the neurological development of the brain. In general, cocaine exposed babies require extreme patience and are far more difficult to care for than non-cocaine-exposed infants.

Between birth and the second year of life, the cocaine-exposed child will continue to experience neurobehavioral problems. In a study by Drs. Griffen and Chasnoff, preliminary results showed that there was no difference at 24 months between 33 cocaine-exposed and 30 non-drug exposed infants with respect to mental and psychomotor developmental indices.[58] However, in a study of 263 two-year-old children at a Chicago clinic for pregnant abusers, the cocaine-exposed children scored poorly on developmental tests that measured the ability

---

56. Suzanne D. Dixon & Raul Bejar, *Echoencephalographic Findings in Neonates Associated With Maternal Cocaine and Methamphetamines Use: Incidence and Clinical Correlates*, J. PEDIATRICS 770 (Nov. 1989). Many cocaine-exposed infants also have central nervous system irritability. Cocaine-exposed newborns frequently experience drug withdrawal symptoms. These newborns are typically irritable, excessively jittery, extremely sensitive to noise and external stimuli, unpredictably moody, and lethargic. They feed poorly, sleep irregularly, suffer from diarrhea and have increased respiratory and heart rates. Some cocaine-exposed babies exhibit lack of coordination, developmental retardation and visual problems. These infants frequently cannot focus on a human face, are not alert enough to concentrate, and do not recover as quickly as non-cocaine-exposed babies from a bell or bright light. Cocaine-exposed newborns may be so stiff that they cannot bring their hands together. Tremors are commonly seen when the tiny infants reach for objects. Moreover, many cocaine-exposed babies have reduced eye coordination and visual tracking. Cocaine-exposed newborns also have a higher risk of Sudden Infant Death Syndrome.

57. *Substance Abuse in Pregnancy, supra* note 54, at 7.

58. Emmalee S. Bandstra & Gene Burkett, *Medical Issues for Mothers and Infants Arising from Perinatal Use of Cocaine, in* DRUG EXPOSED INFANTS AND THEIR FAMILIES: COORDINATING RESPONSES OF THE LEGAL, MEDICAL AND CHILD PROTECTIVE SYSTEM 23 (American Bar Association Center on Children and the Law, 1990).

to concentrate, interact with others in groups, and cope with an unstructured environment.[59] The study suggests that these children will require a highly structured learning environment and one-on-one attention from teachers. Most children exposed to cocaine in utero are probably subtly affected by the drug. These children will have subtle yet devastating dysfunctions which will reduce their developmental and learning potential.

While there are few longitudinal studies of cocaine-exposed children, educators and researchers report that these children may continue to experience learning difficulties and exhibit behavioral problems. A substantial number of cocaine-exposed children suffer from language and learning disabilities, and have shortened attention spans. Preliminary data from one longitudinal study of cocaine-exposed children found that the children were highly distractable and engaged in behavior that interfered with their test performance.[60] Data from another study that followed three-and four-year-old children who were prenatally exposed to cocaine showed that many of the children had problems with expressive and receptive speech.[61] Educators report that cocaine-exposed children have poorly developed fine motor skills. These educators further report that many of the children have tremors and have difficulty focusing their eyes and attention on people and objects. Moreover, the cocaine-exposed children may be hyperactive and be difficult to calm once they have become excited. Over 50% of cocaine-exposed children will likely need special education services both in pre-school and elementary school and will have to be taught in a structured environment.[62]

4. The Effects of Prenatal Marijuana Exposure on the Fetus

As noted earlier, a significant percentage of pregnant women throughout the country are using marijuana. At Boston City Hospital, 14.5% of pregnant women either tested positive for marijuana use or admitted using marijuana.[63] In a study at Yale-New Haven Hospital,

---

59. Michelle D. Wilkins, *Solving the Problem of Prenatal Substance Abuse: An Analysis of Punitive and Rehabilitative Approaches*, 39 EMORY L.J. 1402 n.20 (1990).

60. M. Catherine Freier, Dan R. Griffith & Ira J. Chasnoff, *In Utero Drug Exposure: Developmental Follow-Up and Maternal-Infant Interaction*, 15 SEMINARS IN PERINATOLOGY 312 (Aug. 1991).

61. *Id.* at 311-312.

62. *Fetal Protection: Drugs & Pregnancy*, 23 MD. B. J. 26 (1989); *Substance Abuse in Pregnancy*, *supra* note 54, at 44.

63. Peter A. Fried, *Marijuana Use During Pregnancy: Consequences for the Offspring*, 15 SEMINARS IN PERINATOLOGY (Aug. 1991).

it was estimated that 10% of pregnant patients were using marijuana.[64] While a study in California reported that 13% of pregnant women were using marijuana,[65] a study in Seattle showed that 16% of the pregnant women studied had used marijuana during pregnancy.[66] Ira Chasnoff's Pinellas County study found that 11.9% of the pregnant women were using or had used marijuana.[67]

The use of marijuana during pregnancy may harm the developing fetus. A study of 1,226 women who used marijuana during pregnancy found that marijuana use was associated with a decreased infant birth weight by an average of 79 grams and a decreased length by .5 centimeters.[68] Heavy marijuana use has been linked with a reduction in the length of gestation by 1.1 weeks.[69] However, studies have not established a relationship between either specific complications or major physical abnormalities and prenatal marijuana use.

Newborns who have been exposed to marijuana in utero will exhibit the effects of the marijuana exposure. One study found that almost half of the infants who were exposed daily to marijuana in utero did not respond to light when the light was repeatedly directed at their eyes, while only 16% of the babies born to non-marijuana users were unresponsive to this light.[70] Many marijuana-exposed infants have ab-

---

64. *Id.*

65. *Id.*

66. *Id.*

67. Evans and Gillogley, *supra* note 8, at 24. The fetus will be exposed to marijuana shortly after its mother consumes the drug. Cannabis, the major component of marijuana, crosses the placenta and is stored in the amniotic fluid. The fetus is partially protected from the harmful effects of cannabis because the placenta blocks the cannabis components. However, a single ingestion of marijuana will lead to a prolonged exposure to the fetus. The amount of marijuana ingested during one use may take as many as 30 days to be excreted. In addition, smoking marijuana may affect the fetus by elevating the carbon monoxide levels in the blood of the fetus and thereby impairing fetal oxygenation. Marijuana raises the heart rate and blood pressure of the pregnant woman, thereby causing a reduction in placental blood flood to the fetus.

68. P.A. Fried, *Postnatal Consequences of Maternal Marijuana Use, in* CURRENT RESEARCH ON THE CONSEQUENCES OF MATERNAL DRUG ABUSE 61, 65 (Theodore M. Pinkert ed., Washington D.C.: U.S. Dept. of Health and Human Services; 1985; NIDA Research Monograph 59).

69. *Id.*

70. *Id.* However, there has been no significant difference in the motor abilities of babies born to heavy marijuana users and babies born to non-marijuana users. In addition, marijuana-exposed infants are not fussy and are easily consoled. These infants also tend to score within a normal range on the Bayley Scales of Infant Development. Prenatal marijuana exposure does not seem to have adverse long-term effects. In a study of 99 pregnant marijuana users and non-users, no significant differences were found in the temperament of marijuana-exposed and non-marijuana-exposed infants. Tennes, *supra* note 10, at 55.

normal eye-hand coordination and eye problems which include crossed eyes and delayed development of the optical scale. These infants may also have heightened tremors and startles. Furthermore, marijuana-exposed infants frequently display poor habituation to visual stimuli and have an increased risk for Sudden Infant Death Syndrome.

D. *How Drug Use Affects Pregnant Women*

Experts report that most drug dependent pregnant women do not realize they are pregnant until their second trimester, since many female drug users have irregular menstrual cycles. Both cocaine and heroin use will interfere with the drug user's menstrual cycle. Between 60% and 90% of women dependent on heroin have menstrual abnormalities.[71] Furthermore, pregnant drug users frequently suffer from malnutrition, hepatitis, pelvic infections, stresses and other physical illnesses which contribute to the women's irregular menstrual cycles.[72]

Pregnant drug users frequently deny using drugs when asked by their health care providers. Numerous studies have shown that heroin, cocaine or marijuana users will deny using drugs.[73] A pregnant drug user may adamantly deny using drugs when first asked but admit using drugs when the results of clinically ordered urine toxicology studies are discussed with her.

There are various explanations of the denial practiced by pregnant drug users. Neal Halfon, Director of the Center for the Vulnerable Child in Oakland, stated that many women deny using drugs because they feel guilty and believe that by telling their health care provider of their drug use they will confirm their fear that their drug use will harm the fetus.[74] In addition, Anne Osborne, a attorney with the

---

71. *The Use of Drugs During Pregnancy*, *supra* note 1, at 79 (testimony of Dr. Loretta Finegan).

72. *Antidrug Abuse Appropriations*, *supra* note 18, at 9 (statement of Susie Miller), *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 20 (statement of Shoni Welsch-Davis).

73. In a 1988 study by Deborah Frank, 679 pregnant women were questioned about their drug use and 24% of the women denied using drugs when interviewed but tested positive for drug use when a urine toxicology test was administered. *Born Hooked*, *supra* note 4, at 261 (testimony of Anne Schoeller) (citing D.A. Frank, et al., *Cocaine Use During Pregnancy: Prevalence and Correlates*, 82 PEDIATRICS 888-95 (1988)). At the University of California, Davis Medical Center, 48% of the women testing positive for cocaine, amphetamines or opiates when a urine toxicology test was administered denied using drugs. *Id. Substance Abuse in Pregnancy*, *supra* note 54, at 85.

74. *Born Hooked*, *supra* note 4, at 55 (testimony of Dr. Neal Halfon).

Children's Law Center, stated that "a lot of these women are afraid to tell of the extent of their drug use because they're afraid of their children being taken away or being locked up."[75]

III. THE STATE'S INTEREST IN THE FETUS

Two preliminary questions must be addressed before analyzing whether a state can implement policies to reduce the number of babies prenatally exposed to drugs. The first question is whether the state has a legitimate interest in the future health of the fetus. If a state has a legitimate interest in the future health of the fetus, then a second issue that must be addressed is when this interest becomes compelling.

A. *Does the State Have a Legitimate Interest in the Future Health of the Fetus?*

The Supreme Court has not specifically defined the state's interest in the fetus when a pregnant woman decides to carry her fetus to term. In particular, the Supreme Court has not defined the state's interest in the fetus when a woman uses drugs or alcohol during her pregnancy.

1. The State's Interest in the Fetus When a Pregnant Woman Wants to Terminate Her Pregnancy

The landmark case of *Roe v. Wade* established that states have an interest in both the pregnant woman and her fetus.[76] In *Roe*, the Supreme Court dealt only with the state's interest in the fetus when the pregnant woman chooses to terminate her pregnancy. The Supreme Court held that "the state does have an important and legitimate interest in preserving and protecting the health of the pregnant woman."[77] The Court further held that the state has an "important and legitimate interest in protecting the potentiality of human life."[78]

In interpreting *Roe*, at least one lower court has found that the state's interest in the fetus is present during the entire pregnancy. *In the Matter of Gloria C.*, the Family Court of New York stated that the "[p]rotection of the fetus . . . has been definitively recognized

---

75. Karen Garloch, *How Do We Help the Children? Social Workers, Others Concerned About Babies of Addicted Women*, CHARLOTTE OBSERVER, Jan. 26, 1990, at 1C.

76. 410 U.S. 113, 1162 (1973).

77. *Id.*

78. *Id.*

as a legitimate State interest since *Roe v. Wade.*"[79] This court then stated that "[t]his significant State interest is present during the entire pregnancy."[80]

2. The State's Interest in the Fetus When a Pregnant Woman Wants to Carry Her Fetus to Term

In *In the Matter of Stefanel Tyesha C.*, the Supreme Court of New York recognized a distinction between the state's interest when a pregnant woman wants to terminate her pregnancy and when a woman wants to carry her fetus to term.[81] The court stated, "[W]e are concerned here not with a woman's privacy right in electing to terminate an unwanted pregnancy, but with the protection of a child who is born when a woman has elected to carry that child to term and deliver it."[82] The Court then stated, "[A] state may properly act to safeguard health, to maintain medical standards and to protect potential life."[83]

In the area of tort law, state courts have found that states have an interest in the health of the fetus. In *Stallman v. Youngquist*, the Supreme Court of Illinois stated that the court has previously recognized a common law right of action for personal injuries of a fetus when the fetus had been wrongfully injured because of the negligence of a third party.[84] The court stated that the fetus does not have to be viable when the injury occurred to bring an action for prenatal injuries inflicted by a third person.[85] In recognizing a recovery for a child who suffered prenatal injuries, this court cited the holding of other state courts that the fetus has a "legal right to begin life with a sound mind and body."[86]

3. The State's Interest in the Future Health of the Fetus

Based on the above case law, it seems that courts could find that states have an interest in the future health of the fetus throughout a woman's entire pregnancy.

---

79. 476 N.Y.S.2d 991, 1000 (1984).
80. *Id.*
81. 556 N.Y.S.2d 280 (1990).
82. *Id.* at 285.
83. *Id.*
84. 125 Ill. 2d 267, (1988).
85. *Id.* at 273.
86. *Id.* at 275.

B. When Does the State's Interest in the Fetus Become Compelling?

In *Roe*, the Supreme Court held that the Constitution protects the right to privacy which it found was a fundamental right. A state regulation that limits the right to privacy is justified only if there is a compelling state interest and the regulation is narrowly drawn to express only the legitimate state interest at stake.[87]

1. When Does the State's Interest in the Fetus Become Compelling if the Woman Wants to Terminate Her Pregnancy?

In *Roe*, the Supreme Court held that the right of personal privacy includes decisions regarding abortion, marriage, procreation, contraception, family relationships and child rearing.[88] The Court found that "the right of personal privacy includes the abortion decision."[89] The Court then held that the state's interest in the fetus becomes compelling at the end of the second trimester, at the point that the fetus becomes viable.[90] The Court reasoned, "This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb."[91] The Supreme Court held that, at viability, the state can prohibit a woman from having an abortion unless the mother's life is in jeopardy.[92]

In *Webster v. Reproductive Health Services*, however, the Supreme Court implied that the state's interest in protecting human life is compelling prior to the point the fetus is viable.[93] The Court stated that "[w]e do not see why the state's interest in protecting human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability."[94]

2. When Does the Sate's Interest in the Fetus Become Compelling if the Pregnant Woman is Using Drugs During Pregnancy?

If, as established in the previous section, the state has a legitimate interest in the future health of the fetus, it must then be determined

---

87. *Roe*, 410 U.S. at 155.
88. *Id.* at 152-153.
89. *Id.* at 153.
90. *Id.* at 163.
91. *Id.*
92. *Id.* at 164.
93. 492 U.S. 490, 519.
94. *Id.*

when this interest becomes compelling. It would seem that the interest would become compelling at conception since prenatal substance abuse can harm the fetus throughout pregnancy. The state's interest would seem to continue throughout pregnancy because drug use can harm the fetus at every stage of pregnancy. If the state's interest becomes compelling at conception, the state can enact laws to prevent a pregnant woman from using drugs, beginning in the first trimester.

Moreover, the Supreme Court may find that the right of personal privacy does not include the decision to use drugs during pregnancy (i.e., the "right" to commit an illegal act during pregnancy). If the use of drugs during pregnancy is not a constitutionally protected right, the previous analysis under *Roe* would be moot. It is not necessary to consider whether a state regulation that bars a pregnant woman from using drugs during pregnancy abridges a pregnant woman's constitutionally protected right to privacy if using drugs during pregnancy is not included in the personal right to privacy.

C. *At What Stage in a Woman's Pregnancy Can the State Enact a Law or Implement a Policy to Prevent the Pregnant Woman From Using Drugs?*

Two conclusions can be reached from the above analysis. First, the Supreme Court could find that the state has an interest in the future health of the fetus and that interest becomes compelling at the point of conception. Second, the Supreme Court also could find that the right of personal privacy does not include the use of drugs during pregnancy. Accordingly, a state can presumably enact a law or implement a policy to prevent a pregnant woman from using drugs throughout her pregnancy.

IV. ANALYSIS

A. *Legal Constraints on a State's Ability to Implement Policies to Prevent a Pregnant Woman From Using Drugs*

1. Can a State Extend its Child Abuse and Neglect Statutes to Protect a Fetus During Pregnancy?

All states have enacted child abuse laws. The purpose of these laws is to protect infants and children from abuse and neglect perpetrated by their parents or guardians. When someone reports to a state's division of child protective services that a child is being abused or neglected, a worker will usually conduct a preliminary investigation. If the neglect or abuse is substantiated, the worker may petition the court for temporary custody of the child. Child protective services

will then attempt to rehabilitate the child's parents or guardian while the child is in protective custody.

Child protective services in different states have petitioned the courts in order to get protective custody of fetuses. In these actions, it has been asserted that the child (fetus) is or will be abused or neglected. Courts have held that, for the state child protection laws to apply to the unborn fetus, the laws must specifically define "fetus" as a "child,"[95] or it must be clear that the state legislature intended an unborn fetus to be considered a child under the child abuse and neglect laws.

Some state divisions of child protective services have tried to obtain protective custody of a fetus in order to get custody of the child upon birth. *In re Dittrick Infant*, the Bay County Department of Social Services brought an action to get temporary custody of an unborn fetus so the Department would have custody upon the birth of the child.[96] The pregnant woman had permanently lost custody of her first child following allegations of continuing physical and sexual abuse, and the Department feared that this child would also be physically or sexually abused. The Bay County Probate Court issued an order directing the Bay County Department of Social Services to take temporary custody of the unborn fetus. The circuit court affirmed the order and the respondent appealed.

The Court of Appeals held that "[t]he probate court did not have jurisdiction to enter the contested order because it could not acquire jurisdiction over an unborn child."[97] The statute states that the probate court has "[j]urisdiction in proceedings concerning any child under 17 years of age found within the county."[98] The Court of Appeals stated that the word "child" could be read as applying to unborn persons.[99] However, the Court of Appeals found that it was not the legislature's intention to apply these provisions to unborn children.[100] The Court of Appeals suggested that the legislature may wish to consider amending the statute. Nevertheless, the court allowed the Bay County Department of Social Services to have temporary custody of the unborn fetus 60 days after the release of its opinion, noting that the Bay County

---

95. *Id.*
96. 263 N.W.2d 37, 38 (1977).
97. *Id.* at 38.
98. *Id.* at 39.
99. *Id.*
100. *Id.*
101. 178 Cal. Rptr. 525, 526 (1981).

Department of Social Services would then have time to get a proper protective order once the child was born.

A few state divisions of child protective services have attempted to get protective custody of fetuses in order to control the pregnant woman's behavior and thereby protect the future health of the fetus. In *In re Stevens S.*, the County of Los Angeles filed a dependency petition to get temporary custody of a fetus.[101] The county brought the petition to protect the fetus from the mother who, according to the county, had an undiagnosed psychiatric illness. The county wanted custody so it could force the pregnant woman to get psychiatric care. The juvenile court found that the fetus was a minor within the meaning of California's Welfare and Institutions Code and ordered the pregnant woman to be detained.

The Court of Appeals held that the County could not take custody of an unborn fetus or order this pregnant woman to receive mental health treatment.[102] Section 300 of the Welfare and Institutions Code states that the juvenile court has jurisdiction to adjudge any person under the age of 18 years to be a dependent child of the court.[103] The Court of Appeals refused to expand the meaning of "person" to include an "unborn fetus" and held that only the legislature, not the courts, can extend the definition of person.[104]

New Jersey is the only state that has enacted a child protection statute which is applicable to an unborn fetus. The statute provides,

> Whenever it shall appear that any child within this state is of such circumstances that his welfare will be endangered unless proper care or custody is provided, an application . . . may be filed . . . seeking that the Bureau of Childrens' Services accept and provide such care or custody of such child as the circumstances may require. The provisions of this section shall be deemed to include an application on behalf of an unborn child.[105]

The statute is vague and unworkable. First, how can a department of child protective services take custody of a fetus that is still within the mother's body? Second, if a dependency petition was granted prior to the time when the fetus was viable, what would happen if the

---

102. *Stevens S.*, 178 Cal. Rptr. at 528.
103. *Id.* at 529 n.3.
104. *Id.* at 527.
105. N.J. STAT. ANN. § 30:4C-11 (West 1981).

pregnant woman wanted to get an abortion? Under the current law, a pregnant woman can obtain an abortion until the fetus is viable. How could the pregnant woman terminate her pregnancy while the state department of child protective services has protective "custody" of the unborn fetus? Furthermore, if these dependency petitions were granted, these laws could allow the child protective services to forbid a pregnant woman from engaging in even benign conduct that the department deemed harmful to the fetus (i.e., working at certain jobs in the later stages of pregnancy, having sex in the later stages of pregnancy).

2. Can the State Require a Doctor to Administer a Toxicology Tests to a Pregnant Drug User?

Health care providers do not routinely administer urine toxicology tests to pregnant women. It has been suggested that all pregnant women should be tested for drugs so health care providers or departments of social services can identify which pregnant women are using drugs during pregnancy.

In *Skinner v. Railway Labor Executives' Association*, the Supreme Court determined when a state can require an individual to submit to a toxicology test.[106] The issue in *Skinner* was whether mandatory toxicology testing of a railroad company's employees abridges the employees' Fourth Amendment rights. The Fourth Amendment provides that "[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated."[107] The Supreme Court stated that "[this] Amendment guarantees the privacy, dignity and security of persons against certain arbitrary and invasive acts by officers of the government or those acting at their direction."[108] The right to be protected from unreasonable searches and seizures is a fundamental right. The Court found that the "collection of testing of urine intrudes upon expectations of privacy that society has long recognized as unreasonable" and "these intrusions must be deemed searches under the Fourth Amendment."[109] The Court then held that "the Fourth Amendment does not apply to a search and seizure, even an arbitrary one, effected by a private party on his own initiative."[110] However, "the Amendment protects

106. 489 U.S. 602, 620 (1989).
107. U.S. CONST. amend. IV, cl.1.
108. *Skinner*, 489 U.S. at 613-614.
109. *Id.* at 617. However, the court upheld testing in this case. *Id.*
110. *Id.* at 614

against such intrusions if the private party acted as an instrument or agent of the Government."[111] Whether the private party is acting as an agent of the Government depends on the "Government's participation in the private party's activities."[112] Accordingly, the Government's involvement in mandatory toxicology testing would abridge an individual's fundamental right.

In *Roe*, the Supreme Court then addressed the applicable standard when determining if government regulation can limit an individual's fundamental rights. The Court said, "Where certain 'fundamental rights' are involved, . . . regulation limiting these rights may be justified only by a 'compelling state interest' and . . . legislative enactments must be narrowly drawn to express only the legitimate state interest at stake."[113]

In the case of prenatal drug use, a state can require a physician to administer a toxicology test to a pregnant woman without her consent if both the state has a compelling interest which outweighs the pregnant woman's Fourth Amendment right and the statute regulating the pregnant woman's Fourth Amendment right is narrowly drawn to express only the state's interest. The state's interest is protecting the future health of the fetus. Under the *Roe* analysis, the state's interest in the fetus becomes compelling when the fetus becomes viable. Thus a state would be able to administer a toxicology test to a pregnant woman after her second trimester.

As discussed in section III, the Supreme Court also could find that the state has an interest in the future health of the fetus which becomes compelling at conception. If the Supreme Court finds that the state's interest in the future health of the fetus becomes compelling at conception, the state may be able to require pregnant women to submit to urine toxicology tests.

However, a statute requiring all pregnant women to submit to toxicology tests may not be considered narrowly drawn to express the state's interest in protecting the future health of the fetus. The Supreme Court could hold that only pregnant women who exhibit other symptoms of drug use could be tested for drugs.

Health care providers can, on their own initiative, administer a toxicology test to a pregnant woman without her knowledge or consent. In *In re Noah M.*, the plaintiff argued that the hospital violated

---

111. *Id.*
112. *Id.*
113. *Roe*, 410 U.S. at 155.

her Fourth Amendment rights when a urine toxicology screen was administered to her without her consent during her pregnancy.[114] The result of the toxicology screen was reported to Child Protective Services.

The Court of Appeals held that the Fourth Amendment "is wholly inapplicable to a search and seizure, even an unreasonable one, effected by a private individual not acting as an agent of the Government or with the participation or knowledge of any government official."[115] The Court of Appeals found that the hospital had a policy of performing toxicology tests on mothers who were at high risk for obstetric complications.[116] The Court of Appeals further found that the hospital was not required by California law to perform urine toxicology screens and did not perform the toxicology screen as an agent of the government or with the government as a joint participant in the hospital's exercises.[117] Accordingly, the Court of Appeals held that the woman's Fourth Amendment rights were not violated.[118]

Only one state has enacted a law requiring physicians to administer toxicology tests to pregnant women. In Minnesota, a physician is required to "administer a toxicology test to a pregnant woman under the physician's care . . . to determine whether there is evidence that she has ingested a controlled substance for a nonmedical purpose."[119] The language of this statute implies that the pregnant woman's consent is not required prior to administering the toxicology test. This statute has not been constitutionally challenged.

In Oregon, public officials are considering requiring health care providers to administer toxicology tests to all pregnant women. The Oregon Task Force on Pregnant Substance Abuse recommended that all pregnant women be routinely tested for drugs and alcohol, and that positive test results be reported to the Oregon Health Division.[120] The Task Force further recommended that a health nurse from the Oregon Health Division should then contact the pregnant woman and try to get her into a drug treatment program.[121]

---

114. 212 Cal. App. 3d 30 (Cal. Ct. App. 4 Dist. 1989).
115. *Noah M*, 212 Cal. App. 3d at 33.
116. *Id.*
117. *Id.*
118. *Id.*
119. Minn. Stat. Ann. § 626.5562(1) (West Supp. 1992).
120. Dave Hogan, *Panel Asks Drug, Alcohol Tests for Pregnant*, OREGONIAN, Dec. 21, 1990, at C4.
121. *Id.*

Medical and legal experts criticize the practice of administering toxicology tests to non-consenting pregnant women. These experts claim that administering a toxicology test to a pregnant patient without the her knowledge and/or consent may destroy the trust between the patient and the physician. Judith Rosen of the American Civil Liberties Union argued that "the testing of women without their knowledge ignores the doctrine of informed consent."[122] However, Ms. Rosen stated that she does not object to the administration of a toxicology test to a pregnant woman to determine her medical needs if the woman is informed.[123] Moreover, it has been suggested that many women who used drugs during pregnancy would be scared by the prospect of a toxicology test and may avoid medical treatment altogether.[124] If hospitals are known throughout a community to test pregnant women for drugs, drug-dependent women may be deterred from seeking medical care for fear of losing their children.[125]

3. Can Pregnant Drug Users be Civilly Committed to a Drug Treatment Program?

Some public officials and researchers have suggested that women who use drugs during pregnancy should be involuntarily committed to a drug treatment facility. Involuntary civil commitment is a legal process whereby an individual is found to pose a danger to herself or others and is forced to undergo care. Conditions that usually subject a person to civil commitment include mental illness, developmental retardation, mental retardation, alcoholism, drug dependency or some combination of these factors. Approximately 75% of the states have some statutory provision governing the involuntary commitment of drug dependent persons.[126] In these states, the "laws limit involuntary civil commitment to drug dependent persons who are in need of treatment and care, are likely to be dangerous to themselves or others, or who are unable to meet their basic needs for sustenance, shelter, and self-protection."[127] States have different requirements regarding

---

122. Tom Gorman, *Involuntary Drug Testing of New Mothers Gives Birth to Legal Debate*, LOS ANGELES TIMES, Apr. 14, 1988, at 1.

123. *Id.*

124. *ACLU Opposes Required Drug Tests for Pregnant Women*, UNITED PRESS INTERNATIONAL, Mar. 11, 1991.

125. Gorman, *supra* note 122.

126. Sandra Anderson Garcia & Ingo Keilitz, *Involuntary Civil Commitment of Drug-Dependent Persons With Special Reference to Pregnant Women*, 15 MEDICAL & PHYSICAL DISABILITY L. REP., July-Aug. 1991, at 418.

127. *Id.* at 419.

128. *Id.* at 426.

who may initiate a civil commitment proceeding and what supporting evidence is necessary. Most states typically require one or two physicians to make statements stating that the person is a danger to herself or others.

It may be possible to commit a pregnant drug user to a drug treatment facility involuntarily on the grounds that she is either a danger to herself or others. In order to civilly commit a woman who is using drugs during pregnancy, one of two events would have to occur. First, a state's legislature would have to amend its civil commitment laws to define the fetus as "other" under the civil commitment laws and thereby allowing prenatal drug abuse to be considered "a danger to others," or define the pregnant drug user as a "chemically dependent person." No state has enacted legislation to define an unborn fetus as an "other" under the civil commitment statutes.[128] Second, even if state legislatures do not amend the civil commitment statutes, a pregnant drug user could be civilly committed if a court either finds that the pregnant woman is a danger to herself or if the court interprets maternal addiction as conduct that endangers an "other" and defines the fetus as an "other." The opinions and dicta of several courts indicate that courts would support the position that a fetus is a "person" as in "other" with protectable rights for the purposes of a civil commitment proceeding.[129]

Only one state legislature has amended its laws to specifically allow pregnant substance abusers to be civilly committed. In Minnesota, a pregnant drug user is considered a chemically dependent person for the purposes of civil commitment: "'[c]hemically dependent person' also means a pregnant woman who has engaged in habitual or excessive use, for a nonmedical purpose, of any of the following controlled substance or their derivatives: cocaine, heroin, phencyclidine, methamphetamine, or amphetamine."[130] A second state is considering similarly amending its civil commitment laws. Governor John Ashcroft of Missouri recently introduced a plan whereby the civil commitment laws would be used to commit a pregnant woman who refused to get drug treatment to a drug treatment facility.

It has been argued that the civil commitment process should be used to commit pregnant drug users to a drug treatment facility.[131]

---

129. *Id.*

130. Minn. Stat. § 253B.02(2) (1992).

131. Kristen Rachelle Lichtenberg, *Gestational Substance Abuse: A Call for a Thoughtful Legislative Response*, 65 WASH. L. REV. 377 (1990).

Proponents of this policy argue that "civil commitment recognizes and furthers the state's interest in protecting the lives and health of both the woman and the fetus."[132] Proponents further state that this policy is justified because civil commitment protects the fetus' health while also addressing the woman's addiction.[133] Moreover, proponents argue that pregnant substance users would not be arbitrarily committed because a carefully written statute would provide that only pregnant *addicts* could be committed.[134]

Civilly commiting women who are using drugs during their pregnancies is a short-sighted, ineffective policy. Involuntarily committing pregnant women would protect the unborn fetus at the expense of possibly permanently disrupting the pregnant woman's family. Most pregnant drug users have children at home. If the woman is forced to enter a drug treatment program, it is very likely she will lose custody of her children. Since many pregnant drug users do not have support networks, their children may have to be placed in foster care while their mother was committed to the drug treatment facility. Not only would her children's lives be disrupted if they were forced to live in the homes of strangers but it may be difficult for the woman to get her children back once they have been placed in foster care.

Moreover, women may be scared away from the health care system if they believe their physician or another person will petition the court to get them civilly committed. Christine Lubinski, a spokeswoman of the National Council on Alcoholism and Other Addictions, warns that "[w]omen will go underground [and] [w]omen will not seek prenatal care if they think they will be subject to legal action."[135]

Furthermore, women who have been forced to receive treatment have lower treatment success rates. Teresa Hagan, the supervisor of clinical services at the Family Center at Jefferson Medical College in Philadelphia in 1980, stated that the women who are forced to attend treatment programs do less well than women who are voluntarily admitted to the program.[136] Dr. Reed Tuckson, who was the Commissioner of Public Health in the District of Columbia in 1989, agreed that persons forced to attend treatment programs are not highly motivated and will not have good outcomes.[137]

---

132. *Id.* at 394.

133. *Id.*

134. *Id.*

135. Robert Manor, *Drug Use in Pregnancy: Rights Groups Caution Against Punishment for Mothers*, ST. LOUIS POST DISPATCH, Nov. 18, 1989, at 1B.

136. *Missing Links*, *supra* note 3, at 23.

137. *Id.* at 24.

B. *Judicially-Created Policy*

1. Judges Use Their Discretionary Powers to Prevent a Pregnant Woman Who Is in the Legal System From Using Drugs During Pregnancy

a. Can a Court Order the Pregnant Drug User to Serve Her Sentence in a Drug Treatment Program?

When a person is convicted of a crime or has violated parole, state judges have the discretion to impose a punishment. Some judges are using these discretionary powers to sentence drug-dependent pregnant women to serve their sentences in a drug treatment facilities.

Judges throughout the country are sentencing pregnant offenders who are using drugs to enter drug treatment facilities. Judge Mudd of San Diego Superior Court stated that if a pregnant woman comes before his court and is either in custody on a drug related offense or admits to using drugs, the judge will do one of two things.[138] The judge will release the pregnant woman if she can show that she is receiving care for her pregnancy which includes regular toxicology testing and promises to continue to receive medical care. If the woman is not receiving medical care, the judge will try to get the woman into the pregnant inmate's program at Las Colinas.

In northwest Illinois, a pregnant cocaine user was charged with disorderly conduct. The prosecutors successfully argued that drug treatment should be made a condition of her release without bond. When she failed to appear for treatment, the prosecutor obtained a court order confining her to a drug treatment center for the last month of her pregnancy. The prosecutor stated the order was sought to protect the health of the unborn child.[139]

Federal officials acknowledge that sentencing a pregnant drug user to a drug treatment facility is a way to address the problem of prenatal drug use. The Office of the National Drug Control Policy acknowledged that pregnant addicts who are in the custody of the criminal justice system can sometimes be required to remain in residential treatment after the delivery.[140]

Judges probably can require a pregnant woman who is convicted of a crime to serve her sentence in a drug treatment facility because

---

138. *How a Judge Deals with the Addiction-Crime Link*, SAN DIEGO UNION, Jan. 27, 1991, at 6C [hereinafter *How a Judge Deals*].

139. Edward Walsh, *Illinois Court Orders Pregnant Woman Confined to Drug Treatment Center*, WASH. POST, Apr. 12, 1991, at 3(A).

140. Office of National Drug Control Policy, *State Drug Control Status Report* 32 (Nov. 1990).

the discretionary powers of judges are very difficult to challenge. Benjamin Wolf, who served as the director of the American Civil Liberties Union's Childrens' and Institutionalized Persons' Project in Chicago, stated, "[W]e don't dispute a judge's power . . . to enforce the terms of probation."[141] However, Mr. Wolf further stated that the American Civil Liberties Union has not taken a position on whether a judge can order a convicted pregnant woman to serve her sentence in a drug treatment facility.[142]

Even if judges can order a pregnant drug user to serve her sentence in a drug treatment facility, this policy may not be very effective. Studies show that mandatory drug treatment is less effective than voluntary treatment.[143] While most of these studies have focused primarily on male drug addicts, one multisite study reported that female addicts who entered a drug treatment program under legal pressure were less likely to remain in treatment than women who entered voluntarily.[144]

Benjamin Wolf believes this policy may not serve its goals. He stated that the American Civil Liberties Union "believes punitive, harsh treatment of people who are pregnant and having drug problems is counterproductive."[145] Mr. Wolf argued that this judicial policy will "end up driving people with drug problems away from treatment."[146]

b. Can a Court Impose a Longer Sentence on a Pregnant Drug User?

As an alternative to ordering pregnant drug users to serve their sentences in drug treatment facilities, judges are imposing longer sentences on pregnant drug users. Judges again invoke their discretionary powers to impose these sentences. A judge's decision to incarcerate a pregnant drug user for the duration of her pregnancy is difficult to challenge.

Imposing longer sentences for pregnant drug users has been popular among judges. Many judges believe that they can prevent a pregnant woman from using drugs and thereby prevent the fetus from being harmed if the woman is incarcerated for the duration of her pregnancy. Judge Mudd stated that he will give a pregnant woman who is drug-dependent a sentence of 180 or 270 days in jail if no

---

141. *Pregnant Addict No longer Under Armed Guard*, GANNETT NEWS SERVICE, Apr. 18, 1991.

142. *Id.*

143. Chavkin, *supra* note 26, at 1556.

144. *Id.* at 1557.

145. Marja Mills & Wilson Ring, *Women Held in Drug Unit to Protect Unborn Child*, CHI. TRIB., Apr. 11, 1991, at 1C.

146. *Id.*

treatment beds are available through the jail system or the pregnant woman is not receiving medical care.[147] The judge tells the woman's attorney to contact him if a treatment bed becomes available.[148]

In 1989, a District of Colombia court judge sentenced a pregnant woman convicted of second degree theft to 180 days in jail — an unusually harsh punishment for the crime — because she was pregnant and addicted to cocaine.[149]

This practice may in fact defeat the judge's purpose of protecting the developing fetus and may actually cause further harm to the fetus. Heroin detoxification can be safely conducted only between the 14th and the 28th week of pregnancy.[150] The pregnant heroin user could have a spontaneous abortion if she stops taking heroin prior to the 14th week of pregnancy and has an increased chance of premature delivery if she stops using heroin after the 28th week of pregnancy. If a judge orders a pregnant heroin user to be incarcerated for the duration of her pregnancy and the woman goes "cold turkey" while in jail, her withdrawal symptoms may cause her to either miscarry or deliver prematurely.

In addition, women who use drugs during pregnancy have a high risk of obstetric complications and require close medical attention. There is an increased chance that the fetus will suffer fetal distress when a pregnant woman stops using drugs while pregnant. Medical intervention may be immediately required under certain circumstances. These pregnant women may not get adequate medical attention because many jails and prisons have inadequate medical facilities and health care providers within the criminal justice system often do not have the necessary medical training. In fact, the only all-women prison in California had 1,850 prisoners, but did not have an obstetrician or gynecologist who provided care to the prisoners at the facility in 1985.

2. Judges May Issue Orders to Pregnant Women Who Are Not in the Legal System

a. Can a Court Order a Pregnant Woman to Follow Doctor's Orders?

A physician or hospital administrator may petition the court to order a pregnant woman to follow a physician's course of medical

---

147. *How a Judge Deals*, *supra* note 138.

148. *Id.*

149. Susan LaCroix, *Birth of a Bad Idea: Jailing Mothers for Drug Abuse*, THE NATION, May 1, 1989, at 587.

150. *Drug Dependency in Pregnancy: Clinical Management of the Mother*, *supra* note 42, at 32.

treatment. This type of order is sought when the pregnant woman refuses to follow her physician's medical recommendation. Physicians may petition the court when they believe that legal intervention is the only way to protect the life and well-being of the fetus. Physicians may also be motivated by a fear that the pregnant woman will bring a malpractice action if the fetus is harmed.

Case law defines when courts are able to order a pregnant woman to follow her physician's orders. Courts appear to issue these orders only when there is an emergency situation that requires immediate medical attention. In 88% of these cases, the court orders were obtained within six hours of bringing the petitions to the judge.[151] In addition, courts seem to require that doctors be reasonably certain that the fetus will be in mortal danger if the medical procedure is not performed. Courts also seem to issue these orders only if the risks of the medical procedure to the pregnant woman are minimal. Moreover, courts seem more willing to issue these orders when the fetus is viable.

In the following two cases, the courts issued orders allowing the physician to perform medical procedures on pregnant women who were carrying viable fetuses. In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, the Hospital brought an action to get a court order to administer a blood transfusion to a pregnant woman who was past her 32nd week of pregnant, in the event that such a transfusion should be necessary to save her life and the life of the fetus.[152] The pregnant woman refused to have the transfusion for religious reasons. The trial court refused to issue the order. The Supreme Court of New Jersey held that "the unborn child is entitled to the law's protection and . . . an appropriate order should be made to insure blood transfusions [be given] to the mother in the event that they are necessary in the opinion of the physician in charge at the time."[153]

In *Jefferson v. Griffen Spalding County Hospital Authority*, the Hospital petitioned the Superior Court in Butts County for an order authorizing it to perform a Caesarean section and any necessary blood transfusions upon the defendant, a pregnant woman in her 39th week of pregnancy.[154] The woman's physicians testified that there was a 99% certainly that the child could not survive natural childbirth

151. Kenneth Jost, *Mother Versus Child*, A.B.A. J., Apr. 1988, at 86.
152. 201 A.2d 537 (N.J. 1964).
153. *Id.*
154. 274 S.E.2d 457 (Ga. 1981).

The pregnant woman opposed surgery for religious reasons. The Supreme Court of Georgia stated, "[T]he power of a court to order a competent adult to submit to surgery is exceedingly limited."[155] The Court weighed the right of the mother to practice her religion and to refuse surgery on herself against her unborn child's right to live and concluded that the child's right to live outweighed the mother's right to refuse medical treatment.[156]

Even when the fetus is not viable, courts may order the unconsenting pregnant woman to undergo a necessary medical procedure. *In the Matter of Jamaica Hospital*, the Hospital brought an action to get a court order to give a patient a blood transfusion.[157] The patient was 18 weeks pregnant and refused the blood transfusion. She was bleeding internally and was in critical condition. She needed the transfusion to stabilize her condition and save her life and the life of the fetus. The woman's physician testified that the fetus would die if the mother did not have a transfusion. The mother refused to allow the transfusion because of her religious beliefs. The Supreme Court of New York recognized that, in the context of abortion, the state has a significant interest in protecting the potential human life and the interest becomes compelling when the fetus is viable.[158] However, Judge Lonscein stated that "the State has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion of religious grounds."[159] Judge Lonscein found that "the fetus can be regarded as a human being, to whom the court stands in *parents patriae*."[160]

In the following case, the court refused to order the pregnant woman to undergo the medical procedure. To justify its holding, the court noted that the fetus was not viable, and there was no evidence in the record to establish that the procedure was absolutely necessary to save the life of the fetus. In *Taft v. Taft*, the defendant's husband brought an action to order his pregnant wife to submit to an operation to suture her cervix to "hold her pregnancy."[161] The pregnant woman was in her fourth month of pregnancy at the time the action was

---

155. *Id.* at 460 (Hill, J., concurring).

156. *Id.* at 459-460. This woman left the hospital after the court issued the court-order and delivered a healthy baby naturally.

157. 491 N.Y.S.2d 898 (1985).

158. *Id.* at 899.

159. *Id.*

160. *Id.*

161. 446 N.E.2d 395 (Mass. 1983).

brought. She refused to have the procedure even though the procedure seemed to involve no danger to the pregnant woman. The judge of the Probate and Family Court entered a judgment ordering the pregnant women to submit to an operation to sustain her pregnancy. The Supreme Judicial Court did not uphold the lower court's order. The Supreme Judicial Court stated that the issue was whether the state's interest was compelling and outweighed the woman's constitutional right to privacy.[162] The Supreme Judicial Court found that the record in this case did not show circumstances so compelling as to justify curtailing this pregnant woman's constitutional rights.[163]

Based on case law, courts may refuse to issue orders requiring pregnant drug users to follow their physician's advice. Since prenatal drug use harms the fetus throughout pregnancy, a health care provider may try to petition the court for such an order prior to the 24th week of pregnancy. As discussed above, courts are reluctant to issue such orders if the fetus is not viable. Furthermore, courts seem to issue these orders only when physicians are asking to perform just a single medical procedure. In the case of pregnant drug abusers, the court order would effectively give the doctor free-reign to perform every medical procedure deemed necessary throughout a woman's pregnancy. Moreover, courts seem to issue these orders when there is overwhelming evidence that the fetus is in mortal danger. The damage to a drug-exposed fetus ranges from minimal to severe, and a physician could not maintain with reasonable certainty that the individual fetus is in mortal danger.

Many practitioners adamantly oppose ordering pregnant women to follow the physician's orders. The American College of Obstetricians and Gynecologists and the American Medical Association oppose court ordered medical treatment over a pregnant woman's objection to protect the fetus. The American College of Obstetricians and Gynecologists issued a policy statement in August 1987 stating that physicians were "almost never" justified in going to court to compel treatment of a pregnant woman.[164] The policy statement further stated, "[O]bstetricians should refrain from performing procedures unwanted by the pregnant women" and "[T]he use of judicial authority to implement treatment regimens in order to protect the fetus violates the

---

162. *Id.*

163. *Id.* at 397.

164. Tamar Lewin, *Courts Acting to Force Care on the Unborn*, N.Y. TIMES, Nov. 23, 1987, at A1.

pregnant woman's autonomy."[165] The Ethics Committee of the American College of Obstetricians and Gynecologists cite medical uncertainty as one of the reasons that "the use of the courts to resolve these conflicts is almost never warranted."[166]

Furthermore, orders requiring the pregnant woman to follow her physician's medical recommendation will likely have an adverse affect on the physician-patient relationship. Dr. Kenneth Ryan, Chairman of the Obstetrics and Gynecology Department at Bringham and Woman's Hospital in Boston, stated, "[G]oing to court has to be a last resort kind of thing since it destroys the physician-patient relationship."[167]

Some legal experts argue that the state's interest in protecting the fetus does not justify court ordered medical treatment. Experts claim that the woman has a right of autonomy, self-determination and privacy and these rights outweigh the state's interest in the life of the fetus. Civil Court Judge Margaret Taylor of New York City is convinced that "there is no legal basis for forcing a pregnant woman to undergo medical treatment when any other legally competent man or woman would be allowed to refuse surgery that would benefit a third party."[168]

Not all health care providers agree that these court orders are inappropriate. According to the *New England Journal of Medicine*, almost half of the maternal-fetal specialists surveyed in 1986 stated that pregnant women who refuse medical advice and endanger the life of the fetus should be detained in hospitals and forced to follow their physicians' orders.[169]

b. Can a Court Order a Pregnant Woman to Abstain From Using Drugs During Pregnancy?

It is not clear whether a judge can order a woman who has not committed a crime and is not in the criminal justice system to abstain from using drugs during pregnancy. In Tennessee, Bounty County Sessions Judge William R. Brewer, Jr. issued a restraining order in December 1989 prohibiting a pregnant woman who was five months pregnant from drinking alcohol or taking illegal drugs during the remainder of her pregnancy.[170] The order was requested by her husband

---

165. *Id.*

166. Jost, *supra* note 163 at 86.

167. Lewin, *supra* note 176, at A1.

168. *Id.*

169. *Id.*

170. Cynthia Mitchell, *Woman Is Told to Stay Sober While Pregnant: Tennessee Judge Slaps Ban on Alcohol, Illegal Drugs*, ATLANTA CONSTITUTION, Jan. 11, 1990, at 1A.

who had filed for divorce the same month in which he petitioned the court. In his order, Judge Brewer directed the woman to undergo further tests as her doctor deemed necessary.

However, in *Cox v. Court of Common Pleas in Franklin County*, the judge refused to order a pregnant woman to abstain from consuming drugs for the duration of her pregnancy.[171] In *Cox*, the pregnant woman was approximately seven months pregnant, used cocaine and opiates throughout her pregnancy, and refused to get prenatal care. The juvenile court ordered her to "not use any illegal drugs that will endanger the unborn child and to submit herself to a medical examination to determine the health of the unborn child."[172] The Court of Appeals addressed whether the juvenile court could compel a pregnant woman to take action for the benefit of her unborn fetus. The Court of Appeals held that the juvenile court had not been given jurisdiction over the body of a woman who is carrying an unborn child.[173] However, the court indicated that the juvenile court may get jurisdiction over a pregnant woman if the legislature amended the statute.

C. *Laws and Policies in Florida*

Since 1982, Florida has seen a dramatic increase in the number of infants prenatally exposed to drugs. In fiscal 1988-1989, 3,450 reports of babies exposed to drugs during pregnancy were received by the Department of Health and Rehabilitative Services.[174] Researchers estimate that over 10,000 newborns were prenatally exposed to drugs in that fiscal year and the number of reports to the Department of Health and Rehabilitative Services was lower than this estimate because all newborns are not routinely tested for drugs.[175] Florida had 2,512 infant reports to the Department of Health and Rehabilitative Services for possible cocaine exposure in the 1988 calendar year.[176] In the first quarter of the 1989 calendar year, 897 reports of prenatal drug exposure were made to the Department of Health and Rehabilitative Services, a 54% increase in the number of cases reported in the first quarter of 1988.[177] The Department of Health and Rehabilitative

---

171. 42 Ohio App. 3d 171, (1988).

172. *Cox*, 42 Ohio App. at 172, 537 N.E.2d at 723.

173. *Id.* at 174.

174. *Police Treatment of Cocaine Mothers Varies Widely*, UNITED PRESS INTERNATIONAL, Jan. 1, 1991.

175. *Id.* There is no law in Florida requiring health care providers to administer a toxicology test to pregnant women or new borns.

176. *Missing Links*, *surpa* note 3, at 85.

177. *Id.*

Services received 1,082 reports of drug-exposed newborns in the last quarter of 1989.[178] In Miami, 37% of all child and neglect cases filed between March and June of 1989 in the juvenile division of the Dade County Circuit Court involved babies born with cocaine related problems.[179] One out of three babies referred to child protective services in Florida cities is a child of a drug abusing parent.[180]

The Florida legislature has enacted laws to protect the newborn exposed to drugs in utero. In 1987, the legislature enacted a law requiring physicians to file a report with the Protective Services Abuse Registry of the Department of Health and Rehabilitative Services when a newborn has been exposed to drugs in utero. The newborn is usually identified as drug exposed through a urine toxicology test. These urine toxicology tests are generally ordered for infants deemed at greatest risk of prenatal substance exposure. Risk factors include maternal acknowledgements of past or present drug or alcohol abuse, sexually transmitted diseases, no prenatal care, *abruptio placentae*, fetal growth retardation, premature delivery, perinatal dysphyxia, congenital malformations and infections.

Upon notification to the registry, an investigator is contacted. The investigator conducts an investigation which includes the immediate notification of the Department of Health and Rehabilitative Services County Public Health Unit. The Department of Health and Rehabilitative Services must notify law enforcement agencies of the report of prenatal drug exposure. However, the statue also states "no parent of [a drug exposed] newborn infants shall be subject to criminal investigation solely on the basis of such infant's drug dependency."[181]

The Florida legislature has implemented policies to address the problem of prenatal drug abuse while the woman is pregnant. The legislature has instructed the Department of Health and Rehabilitative Services to "[p]rovide a statewide prenatal care program for low-income pregnant women, which includes early, regular prenatal care by practitioners trained in prenatal care and delivery."[182] The Department of Health and Rehabilitative Services was further been instructed to "[m]onitor the availability and accessibility of prenatal care services and the development of special outreach programs for medically underserved and rural areas."[183] The legislature has not specifically provided

178. *Police Treatment of Cocaine Mothers Varies Widely, supra* note 186.
179. *Missing Links, supra* note 3 at 120.
180. *Missing Links, supra* note 3 at 80.
181. Fla. Stat. Ann. § 415.503(9)(a)(2) (West 1986 & Supp. 1992).
182. Fla. Stat. Ann. § 383.013(1) (West Supp. 1992).
183. Fla. Stat. Ann. § 383.013(3) (West Supp. 1992).

that drug-dependent women can be involuntarily committed to a drug treatment program. However, a habitual user of a controlled substance can be ordered to receive care at an appropriate treatment facility upon a petition to the court.[184]

D. *Other Proposed Strategies*

1. Open More All-Women Drug Treatment Facilities That Provide Child Care and Obstetric Care Services for Pregnant Drug Addicts

Few drug treatment programs provide treatment to drug-dependent pregnant women. Eighty percent of drug treatment programs are privately owned, and government programs represent only 20% of all services.[185] Many drug using pregnant women do not have private health insurance and will not be admitted to the privately owned-drug treatment centers. Few drug treatment programs that accept patients who are receiving Medicaid will admit pregnant drug addicts.

Wendy Chavkin surveyed 78 drug treatment programs in New York City. Ms. Chavkin reported that 54% of the programs refused to treat pregnant women, 67% refused to treat pregnant women on Medicaid, and 87% had no services available to pregnant women who were receiving Medicaid and were addicted to crack.[186] Less than 22% of these programs provided or arranged for parental care.[187]

Christine Lubinsky of the National Counsel on Alcoholism and Other Addictions in Washington, D.C., reported that only about 50 drug treatment programs in the entire country provide female patients with child and obstetric care.[188] In a 1989 Select Committee survey, two-thirds of the hospitals questioned reported that they have no place to refer substance abusing pregnant women for treatment.[189]

Pregnant drug users frequently do not seek treatment even when treatment is available. Most residential programs do not admit children, and most outpatient settings lack child care.[190] The lack of child

---

184. Fla. Stat. Ann. § 397.052 (West 1986 & Supp. 1992).

185. *Born Hooked*, *supra* note 4, at 218 (testimony of Luria Meijer).

186. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 15.

187. *Id.*

188. Susan Diesenhouse, *Ideas and Trends: Drug Treatment is Scarcer Than Ever for Women*, N.Y. TIMES, Jan. 7, 1990, § 4 at 26.

189. *Missing Links*, *supra* note 3, at 120.

190. Molly McNulty, *Combatting Pregnancy Discrimination in Access to Substance Abuse Treatment for Low-Income Women*, CLEARINGHOUSE REV., May 1989, at 22.

care precludes the participation of pregnant addicts with children. In a study by the National Association of Junior Leagues in 1986, researchers found that the lack of child care was the number one barrier to women seeking drug treatment.[191] In one study, only 2 out of 78 programs provided child care.[192]

Studies have shown that transportation is also a major barrier to the treatment of substance abusing pregnant women.[193] In addition, Shoni Welsch-Davis of the Orange County Perinatal Treatment Program reports that pregnant addicts are reluctant to seek treatment because they are afraid of the attitudes they will receive when they enter the facility for treatment.[194]

Many female drug addicts who seek drug treatment often feel alienated by the treatment programs because most programs are aimed at treating male addicts. Decades ago substance abuse programs were set up mostly for men who were convicted criminals. Experts maintain that treatment methods that work for men often do not work for women. Eugene Williams, the coordinator of a treatment program in East Palo Alto, California, stated that, "[W]omen will not be spoken to harshly or in a condescending manner. Nor is it profitable to accuse them of lying or not toeing the mark as we do in men's programs. Many women addicts turned to drugs because they were sexually abused or raped as children and they need help repairing the damage."[195]

In summary, most treatment approaches are based on the characteristics and dynamics of addiction among male populations and comparatively little has been done to define the unique nature of addiction to women. These programs do not specifically address the needs of women and consequently undermine the woman's motivation to stop using drugs. Since many of the outpatient drug treatment programs treat men and women together, the success rate of treatment programs is predictably low.

Studies have indicated that the damage to the fetus can be reduced if pregnant women get drug treatment early in their pregnancies.

---

191. Michele L. Norris, *Cries in the Dark Often Go Unanswered: For Drug-Addicted Mothers, Treatment is Hard to Find, Even Harder to Stick With*, WASH. POST, July 2, 1991, at 1(A).

192. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 15.

193. Jo Ann Knox, *Exposed Infants Especially Vulnerable*, SAN DIEGO UNION, Jan. 27, 1991, at 5(C).

194. *Antidrug Abuse Appropriations Authorization*, *supra* note 18, at 13.

195. James Willwerth, *Should We Take Away Their Kids*, TIME, May 1991, at 63.

Research conducted by Ira Chasnoff indicates that women who stop taking drugs before their second trimester of pregnant are almost as likely to have healthy babies as women who do not use drugs.[196] Another study by Dr. Gibeon Koren of the University of Toronto had similar results. Dr. Koren studied 30 social users of cocaine, 30 social users of marijuana and 30 women who did not take drugs and found that there was no significant difference in the cognitive abilities of the babies born to these women when the pregnant women stopped using drugs upon learning they were pregnant.[197]

A third study was done at Northwestern University Medical School. The participants of this study included 52 women who used cocaine throughout pregnancy, 23 women who used cocaine in the first trimester but tested negative for drug use thereafter and 40 women who had no history of illegal drug use. This study found that the discontinued use of cocaine early in pregnancy may reduce the risks of malformations, intrauterine growth retardation and prematurity.[198] Babies born to mothers who stopped using cocaine after the first trimester were not significantly smaller than those of the drug-free women.[199] However, infants born to both groups of cocaine-using mothers showed increased neurological problems that could lead to long-term behavioral impairment.[200] There were also sharp differences between cocaine exposed babies and drug-free babies in measurements of motor ability, orientation and reflexes.[201]

2. Provide Training to Health Care Providers to Enable Them to Identify and Understand Prenatal Drug Use

Health care providers, particularly obstetricians, lack the skills and adequate training to identify pregnant drug users and understand the consequences of prenatal drug use. Studies repeatedly show that prenatal drug abuse is the most commonly missed obstetric diagnosis.[202] Researchers and experts agree that health care providers are

---

196. *Cost of Care for Cocaine Babies Soars*, CHI. TRIB., Sept. 1991, at 8(C).

197. Rebecca Wigod Vansun, *Cocaine Harm Limited*, VANCOUVER SUN, Aug. 21, 1991, at 6(B).

198. Michael Abramowitz, *Pregnant Cocaine Users Reduce Risk by Stopping: Danger to Fetus Can be Cut, Study Shown*, WASHINGTON POST, Mar. 24, 1989, at 1.

199. *Id.*

200. *Id.*

201. *Id.*

202. *See e.g.*, Robert M. Horowitz, *Drug Use in Pregnancy: To Test, To Tell — Legal Implications for the Physician*, 15 SEMINARS IN PERINATOLOGY 327 (Aug. 1991); *Substance Abuse in Pregnancy*, *supra* note 54, at 18.

not adequately trained to identify prenatal drug abuse in their pregnant patients. Susie Miller of the Orange County Perinatal Treatment Center reported that 50% of pregnant drug addicts who were receiving prenatal care at the county hospital were not identified by the health care providers as drug users.[203] This lack of education can result in the failure to provide the necessary care to pregnant drug users.

Gregory Coler, the Secretary of Florida's Department of Health and Rehabilitative Services, stated that many physicians, nurses and other health care personnel are unfamiliar with the physical and psychological effects of alcohol and drug use, and are particularly inexperienced in providing obstetric care for pregnant women who are substance abusers.[204]

Dr. Ira Chasnoff says that frequently the pregnant drug user is never referred to an intervention program because her doctor did not realize she was a drug user.[205] In addition, the resources that are available to pregnant drug users are frequently not even known to obstetricians.

Some health care providers avoid treating women who are using drugs during pregnancy. Many in the medical profession believe that addiction is a problem of the criminal justice system despite the fact that drug addiction is a chronic relapsing disease. Physicians are frequently frustrated when dealing with pregnant substance abusers and some have negative attitudes toward drug-dependent women. Moreover, some physicians may fear they will be sued for malpractice because prenatal drug users have high risk pregnancies.

A health care provider can identify prenatal substance use in a variety of ways. First, a physician can identify drug use by recognizing symptoms of drug use upon examining the pregnant woman. For instance, a pregnant heroin user may have dermatologic signs of injection such as track marks, thrombotic veins, subcutaneous abscesses or nodules, localized edema, superficial veins or infections such as hepatitis, tetanus, cellulitis or bacterial endocarditis. The pregnant cocaine user may have inflamed nostril membranes, track marks, impaired judgment or may be depressed, irritable, anxious, hypersensitive or underweight. A physician may also ascertain whether her patient is using drugs by inquiring about the woman's past medical history. However, administering a urine toxicology test is the most certain method of determining whether a pregnant woman is using drugs.

---

203. *Antidrug Abuse Appropriations Authorization, supra* note 18, at 20.
204. *Missing Links, supra* note 3, at 86.
205. *Id.* at 27.

There are many obvious advantages to identifying prenatal drug use. After a physician learns that her pregnant patient is using drugs, she can develop a health plan for the individual pregnant patient. The physician can encourage the pregnant women to seek treatment and direct the woman to a treatment facility.[206] A physician also can educate her patient about the medical risks to the fetus. Gregory Coler believes that without adequate screening for substance abuse, obstetrics personnel often approach delivery unaware that the mother and newborn are at risk for serious complications during and after labor.[207]

Once a physician realizes her pregnant patient is using drugs, she should provide sensitive and comprehensive care. The physician should convey as much concern about the woman's health as the health of the fetus. Pregnant drug users tend to believe that physicians are concerned only about the health of the fetus. Physicians should not be judgmental or punitive. Many pregnant drug users feel tremendous guilt about using drugs during pregnancy and a physician's judgmental attitude may cause the pregnant woman to avoid seeking further care.

3. Coordinate the Local Public Health Care, Drug Treatment and Welfare Systems

Researchers claim that pregnant drug users often are unable to obtain the necessary medical care because the public health care, the child welfare, and the drug and alcohol abuse systems are fragmented. Howard Fuller, the Director of Milwaukee County Department of Health and Human Services, stated that a major obstacle to serving this population is that cocaine-using pregnant women have to interact with separate services systems, all of which deal with a segment of the problem.[208] Elaine M. Johnson, the Director of the Office of Substance Abuse Prevention, agrees that the service delivery systems (health care and drug treatment) are often uncoordinated and inadequate.[209]

The pregnant drug user has a difficult time maneuvering through the system. The complexity of the treatment and bureaucratic system is a barrier for many drug-addicted pregnant women. The complexity of the system is too overwhelming to the pregnant drug user who may have limited skills and possibly impaired judgment. The fragmentation of the system is also confusing to health care providers who recommend treatment for pregnant drug users.

---

206. However, as discussed *supra*, there are not enough treatment facilities where the physician may refer her drug-dependent pregnant patient.

207. *Missing Links*, *supra* note 3, at 86.

208. *Id.* at 31.

209. *Id.* at 119.

4. Employ Outreach Workers Through the Drug Treatment or Prenatal Care Facility

It has been suggested that strong outreach efforts would bring pregnant drug users into prenatal facilities and/or drug treatment programs. Outreach workers can go into a community to individually bring pregnant drug users into a program. Some drug treatment programs have employed former addicts as outreach workers. These outreach workers can go to laundromats, grocery stores and crack houses searching for pregnant women on drugs, workers can stand on the street passing out information about drug treatment programs. The former addicts' backgrounds allow them to identify with the behaviors that lead to addiction and self-destruction. At a community-based drug treatment program in Boston, former addicts go into the community to find pregnant women who are using drugs and bring them into the program. These outreach workers receive training from the Boston Department of Health and Hospitals.

V. RECOMMENDATIONS

State legislatures should first issue a legislative directive stating that the problem of prenatal substance abuse will be treated as a public health problem.

The state legislatures should create a state agency to specifically address the problem of prenatal substance abuse. The legislatures should direct the agency to do the following. First, the agency should provide information regarding the location of drug treatment and prenatal care facilities. A health care provider should be able to contact this agency and obtain information regarding where to refer a patient for drug treatment and prenatal care.

Second, the agency should attempt to develop partnerships with private organizations and businesses. Through these public-private partnerships, drug treatment programs that exclusively serve pregnant women should be developed.

Third, the agency should compile information regarding how prenatal drug use affects both the developing fetus and the pregnant woman, the behavioral characteristics of women who use drugs during pregnancy and the most effective treatment of pregnant drug users. This information should be sent to every judge in the state.

Fourth, the agency should develop a system of mobile prenatal care facilities that can travel to communities throughout the state to provide health care. These mobile facilities should be equipped to provide screening of and medical treatment for pregnant women. The health care providers who work on these mobile units should dispense information regarding what medical benefits are available through the

state and where pregnant women can obtain drug treatment. A substance abuse counselor should travel with these mobile prenatal care units.

Fifth, the agency should establish a hot line that would provide callers with information about prenatal substance abuse and where to seek treatment.

Sixth, the agency should establish and operate a transportation system to take pregnant women to and from treatment and health care facilities.

Finally, the agency should implement a case management system to assist pregnant women with obtaining medical care, substance abuse treatment, prenatal care and medical assistance benefits. These case workers should work closely with the pregnant women and assist these women throughout their pregnancies.

Funds should be allocated to the newly created state agency to create pilot drug treatment programs for pregnant women in counties throughout the states. These pilot treatment programs should provide substance abuse treatment, prenatal care, group and individual counseling, child care and parenting education classes. Pregnant women should be permitted to remain at the treatment facilities for three months after giving birth. The pilot programs should offer incentives such as free meals to encourage pregnant women to come to the treatment facility. These pilot treatment programs should employ outreach workers to go into the community and dispense information about the facilities.

State legislatures should direct their departments of social services to shorten and simplify the Medicaid application forms. These departments should also be directed to conduct interviews for the purpose of determining Medicaid eligibility within five working days of the date of application by the pregnant woman. Moreover, these departments should be directed to make their eligibility determinations within ten working days of the date of application by the pregnant woman.

The application process for Medicaid is lengthy and complicated for all women. Women who are drug addicted particularly have difficulty understanding the Medicaid application process and filing the proper forms. If the process is simplified and women, especially pregnant drug users, are guided through the application process, it will be more likely that these women will receive Medicaid benefits and thus obtain health care services. Eligibility determinations should be made within two weeks so pregnant women who are using drugs can receive medical care as soon as possible.

Moreover, state laws should be enacted which direct public substance abuse treatment facilities to give pregnant drug users priority

over all other patients. There are too few drug treatment facilities and frequently persons in need of drug treatment must wait weeks or months to get admitted into a treatment program. When a pregnant drug user is forced to wait months, or even weeks, to begin the process of detoxification, her fetus will be that much more adversely affected. It is critical to get the pregnant woman who is using drugs into a treatment program as early in her pregnancy as possible in order to reduce the harm to the fetus.

Physicians who are likely to have contact with pregnant women should be required to take continuing medical education courses. State legislatures should direct the state medical licensing boards to develop the curriculum for these courses. The medical education courses should include information about the early detection of drug abuse in pregnant women, the behavioral characteristics of women who use drugs during pregnancy, the available drug treatment programs for pregnant drug users and the best medical treatment for women who use drugs during pregnancy. Physicians should be urged to provide information about the harmful effects of prenatal substance abuse to all of their patients. Physicians should also be encouraged to administer a toxicology test to all pregnant women after the women have been informed that the toxicology test will be administered. Physicians should be instructed to inform the pregnant women that the results of the test will only be used for medical purposes. Physicians should be further instructed to inform their pregnant patients of the services provided by case managers and offer to contact the state agency regarding the services of a case worker. It is imperative that pregnant women who are using drugs be given the choice of whether they want the assistance of a case worker. Pregnant women who are using drugs may not seek any care if they believe the positive toxicology test will automatically be reported to state authorities.

Women who are using drugs during pregnancy are unlikely to inform their physicians of their drug use. Moreover, many pregnant drug users deny using drugs when asked. Accordingly, physicians must be trained to identify which of their pregnant patients are using drugs. Physicians are currently failing to identify drug use in their pregnant patients. If physicians learn to recognize which patients are using drugs, the physicians can inform the women that they are aware of the drug use. A pregnant drug user is more likely to acknowledge that she is using drugs when her physician knows she is using drugs. The physician can then openly discuss the medical consequences of the drug use, inform the woman of her treatment options and provide the appropriate medical services to the pregnant woman and her fetus.

State laws should be enacted which provide that the involuntary civil commitment laws are not applicable to women who use drugs

during pregnancy. Committing pregnant women to drug treatment facilities is a counterproductive policy. Involuntarily commiting pregnant women will likely cause pregnant drug users to avoid having contact with the health care sytem altogether. In addition, the pregnant drug user's family may be permanently disrupted if the pregnant woman is committed to a treatment facility.

States' child and neglect laws should not be amended to define "fetus" as a "child." Child Protective Services should be precluded from bringing custody petitions to obtain "custody" of the fetus while the woman is pregnant. Expanding the civil child protection laws to include the fetus is an unworkable policy.

States should enact laws requiring drug abuse counselors to be employed at all public health and prenatal care facilities, family planning clinics and public hospitals. This drug abuse counselor should be consulted when a pregnant woman is identified as a drug user. The drug counselor should inform the woman of the services available to her, direct her to a drug treatment facility, and inform her that she can obtain the services of a case manager to assist her with obtaining the needed services.

All facilities that are operated through the criminal justice system and incarcerate women should be required to provide obstetric care, prenatal care and drug abuse treatment. State laws should also provide that both an obstetrician and a gynecologist be employed at the facility on a full-time basis. Obstetricians should be required to receive special training in the treatment of women who are using drugs during pregnancy.

A significant number of women who are using drugs during pregnancy have contact with the criminal justice system during their pregnancies. Many judges are inclined to either sentence these women to longer sentences to prevent the women from using drugs while pregnant or order the women to serve their sentences in drug treatment facilities. It makes no sense to order a woman who is using drugs during her pregnancy to serve a longer sentence in order to protect the fetus without providing the pregnant woman with adequate medical care while she is incarcerated. The fetus is likely to be more at risk of permanent harm if the pregnant drug user is not provided with medical care during her pregnancy. Finally, state legislatures should increase the taxes on beer, wine, liquor and cigarettes to provide funding for these programs.