How Punishing Pregnant Women Endangers Children

Presented to the Colorado Alliance for Drug-Endangered Children
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1. Exposure to alcohol or an illegal drug does not necessarily cause certain, unique, and substantial harm to newborns.

In the 1980s and 1990s, the popular media were ablaze with stories about babies born exposed to, and allegedly addicted to, the new drug “crack cocaine.” According to articles in Time magazine, columns in the New York Times, and segments on 60 Minutes, these frail, jittery infants were doomed to suffer a lifetime of ill health and misery. Worse, they would bring misery to the rest of the nation when they grew, spreading crime and depravity because of their drug-poisoned brains.

Scary picture, isn’t it?

Fortunately, as more research was conducted, the picture came into clearer focus. As it turns out, the media prematurely jumped to conclusions that were not supported by science. 1

Dozens of carefully-constructed studies revealed that many of the ills attributed to cocaine were actually caused by other factors, most specifically poverty. 2 After reviewing all of the leading studies of

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1 See, e.g., Susan Okie, The Epidemic that Wasn’t, N.Y. TIMES, Jan. 26, 2009, available at http://www.nytimes.com/2009/01/27/health/27coca.html. As the National Institute for Drug Abuse has reported, “Many recall that ‘crack babies,’ or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation. . . . It was later found that this was a gross exaggeration.” NIDA Research Report, Cocaine: Abuse and Addiction, 6 (2004), available at http://www.drugabuse.gov/ResearchReports/Cocaine/cocaine4.html.

2 Research has found that crack-exposed children are not doomed to suffer permanent mental or physical impairment, and that whatever effects may result from the use of this drug are greatly overshadowed by poverty and its many concomitants – poorer nutrition, inadequate housing, health care and stimulation once the child is born. See Deborah A. Frank, MD et. al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review, 285 JAMA 1613 (Mar. 28, 2001); Wendy Chavkin, MD, MPH, Cocaine and Pregnancy – Time to Look at the Evidence, 285 JAMA 1626 (Mar. 28, 2001); Hallam Hurt, M.D. et al., Problem-Solving Ability of Inner-City Children With and Without In Utero Cocaine Exposure, 20 DEV. & BEH. PEDIATRICS 418 (Dec. 1999); Alan Mozes, Poverty Has Greater Impact Than Cocaine on Young Brain, Reuters Health, Dec. 6, 1999. See also Linda C. Mayes et al., The Problem of Prenatal Cocaine Exposure: A Rush to Judgment, 267 JAMA 406 (1992). As yet other researchers explain:

The “crack baby” on which drug policy is increasingly based does not exist. Crack babies are like Max Headroom and reincarnations of Elvis – a media creation. Cocaine does not produce physical dependence, and babies exposed to it prenatally do not exhibit symptoms of drug withdrawal. Other symptoms of drug dependence – such as “craving” and “compulsion” – cannot be detected in babies. In fact, without knowing that cocaine was used by their mothers, clinicians
the effects of in utero cocaine exposure, even the prestigious Journal of the American Medical Association (JAMA) concluded that:

[T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors. 3

Researchers now agree that the dire predictions of unique and certain peril from crack were an unjustified and “gross exaggeration.” 4 Courts have also recognized that “the phenomena of ‘crack babies’ . . . is essentially a myth.” 5

What the research showed was that when studies are controlled for prenatal exposure to tobacco and alcohol, there is no association between prenatal cocaine exposure and deficits in physical growth, cognitive development, problem-solving abilities, or language. In fact, the oldest group of children studied to date have shown no effect from in utero cocaine exposure on any IQ scales or on academic achievement. 6

It was once also commonly believed that even minimal exposure to alcohol in pregnancy places a child at immediate risk of fetal alcohol syndrome or other birth defects. However, the best epidemiological evidence strongly indicates otherwise. Most babies born to the very few women who are unable to control their drinking during pregnancy are unaffected by fetal alcohol

could not distinguish so-called crack-addicted babies from babies born to comparable mothers who had never used cocaine or crack.


5 United States v. Smith, 359 F. Supp. 2d 771, 780 n.6 (E.D. Wis. 2005). See also McKnight v. South Carolina, 661 S.E.2d 354 (S.C. 2008) (overturning a conviction because of ineffective assistance of counsel who failed to call experts to testify about “recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.”); Susan Okie, The Epidemic That Wasn’t, N.Y. TIMES, Jan. 26, 2009 (reporting on long-term studies confirming these conclusions).

syndrome, and prospective studies find that less than five percent of such babies have fetal alcohol syndrome.7

Of all illegal drugs, marijuana is the one most often used by pregnant women, parents, and people living in the U.S. generally. A leading researcher who has studied in the field has stated unequivocally:

Based on my 30-plus years of experience examining the newborn, infants, toddlers, children, adolescents and young adults born to women who used marijuana during pregnancy it is important to emphasize that to characterize an infant born to a woman who used marijuana during pregnancy as being ‘physically abused’ and/or ‘neglected’ is contrary to all scientific evidence (both mine and subsequent work by other researchers). The use of marijuana during pregnancy (in the absence of other factors that may put a child at risk for physical abuse and/or neglect) has not been shown by any objective research to result in abuse or neglect.

There have been a few reports of mild negative effects in high-risk populations on the birth weight or birth length of newborns but, in those studies, these effects were no longer present after a few months. This is in contrast to many other substances that are commonly used during pregnancy, including alcohol and cigarettes, where the effects on growth are much more pronounced.8

For those concerned about the effect of drug use on newborns, this is all very reassuring news indeed. This is not to say, however, that newborns are never harmed by conditions or substances to which their mothers are exposed during pregnancy. Infants who may suffer short- or long-term effects include those whose mothers lacked access to quality prenatal care and adequate nutrition, smoked cigarettes while pregnant, worked in certain occupations,9 used Accutane,10 or used fertility-enhancing medications that cause multiple births associated with prematurity and other life-threatening hazards.11 The very worst risks (including prematurity, low birth weight,
sudden infant death syndrome, placental abnormalities, miscarriage, and stillbirth) are linked not to illegal drugs, but to cigarettes.12

2. Parents who use illegal drugs will not necessarily harm their children or be unable to provide them with a loving and adequate home.

Much like the dire popular media predictions for cocaine-exposed newborns, news reports claiming that parental drug use causes, or is highly associated, with child abuse and neglect turned out to be incorrect in light of evidence-based research. Many of the news articles reporting on this supposed association were relying on surveys of opinions of people in the child welfare system. In fact, one of these surveys found that the people in the system who had been surveyed were actually the ones least qualified to draw conclusions about causation and associations since so few of them actually had any training in issues concerning drug use and addiction.13

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12 See K. Wisborg et al., Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life, 154 Am. J. Epidemiology 322, 323 (2001) (finding that, in a controlled study of 25,102 women, smokers had about twice the risk of stillbirth and infant death as compared to nonsmokers and that approximately 25 percent of all stillbirths and 20 percent of all infant deaths could be avoided if all pregnant smokers stopped smoking by the sixteenth week in a population with 30 percent pregnant smokers); T.A. Slotkin, Fetal Nicotine or Cocaine Exposure: Which One is Worse?, 285 J. Pharmacology & Experimental Therapeutics 931, 937 (1998) [hereinafter Fetal Nicotine or Cocaine Exposure] (“The conclusion is inescapable that smoking itself . . . is responsible for tens of thousands of perinatal deaths and for like numbers of infants whose debilities may range from outright brain damage to subtle cognitive defects.”); J. DiFranza & R. Lew, Effect of Maternal Cigarette Smoking on Pregnancy Complications and Sudden Infant Death Syndrome, 40 J. Fam. Prac. 385 (1995) (“A national medical analysis on cigarette effects indicates that “Each year the use of tobacco products by women results in the deaths of 19,000 – 141,000 fetuses . . .”); L.C. Castro et al., Maternal Tobacco Use and Substance Abuse: Reported Prevalence Rates and Associations with the Delivery of Small for Gestational Age Neonates, 81 Obstetrics & Gynecology 396 (1993); Office on Smoking and Health, The Health Consequences of Smoking: Nicotine Addiction, 602 (1988). According to the Campaign for Tobacco Free Kids:

A more recent comprehensive study found that parental smoking causes 2,8000 deaths at birth and 2,000 deaths from SIDS. Fetal mortality rates are 35 percent higher among pregnant women who smoke than among nonsmokers.

Smoking during pregnancy creates a more serious risk of spontaneous abortion and a greater threat to the survival and health of newborns and children than using cocaine during pregnancy. It is also a much more pervasive problem.


For a subject that has resulted in significant public policy, there is surprisingly little evidence-based research. To the extent that research exists, it does not support the conclusion that evidence of a parent’s drug or alcohol use establishes harm or a likelihood of actual mistreatment or abuse.\(^\text{14}\) Related research examining parents who are using drugs has also found that drug use alone does not provide the basis for assuming an inability to parent.\(^\text{15}\) As an article published by the American Bar Association concluded:

\[M\]any people in our society suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children.\(^\text{16}\)

### Does Drug Testing Pregnant Women Help Babies?

At NAPW, one of the questions that we receive most frequently, from L&D nurses to state government officials, is how drug tests can be used to help babies and pregnant women. Since many DEC members are direct-service providers, here are some research findings in the hope that they may answer some of the questions DEC members may have.

Of all the things we know about pregnancy, the one on which there is the most consensus is that good prenatal care is associated with good birth outcomes. The value of prenatal care is seen across the board, whether or not a woman is able to stop using drugs during the nine short months of pregnancy.\(^\text{17}\) Unfortunately, some hospitals may unwittingly undermine this positive effect by performing drug tests on pregnant women without their consent, without any evidence based guidelines for determining which women are tested and without consistent procedures for ensuring accurate testing.\(^\text{18}\)

#### What does a positive drug test tell a provider?


\(^\text{15}\) See e.g. Susan C. Boyd, supra n.15 at 14-16 (summarizing numerous studies and concluding that there is no significant difference in childrearing practices between addicted and non-addicted mothers); see also M. Kearney et al., *Mothering on Crack Cocaine: A Grounded Theory Analysis*, 38 SOC. SCI. & MED. 351, 355 (1994).

\(^\text{16}\) American Bar Association, Foster Care Project, National Legal Resource Center for Child Advocacy and Protection, *Foster Children in the Courts* 206 (Mark Hardin ed., 1983). See also Nat’l Council of Juvenile and Family Court Judges, *PERMANENCY PLANNING FOR CHILDREN PROJECT, PROTOCOL FOR MAKING REASONABLE EFFORTS TO PRESERVE FAMILIES IN DRUG RELATED DEPENDENCY CASES* 17 (1992) (concluding that “Juvenile and family court proceedings are not necessary, and probably not desirable, in most situations involving substance-exposed infants”).

\(^\text{17}\) See e.g., A. Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 JAMA 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal care visits significantly reduce their chances of delivering low birth weight babies).

Surprisingly little. A positive drug test cannot determine whether a person occasionally uses a drug, is addicted, or suffers any physical or emotional disability from that drug use or addiction.\textsuperscript{19} In fact, without established cutoffs for positive results, or procedures for retesting and identifying innocent positives, a positive drug test may not even tell a provider whether a pregnant woman has in fact used an illegal drug.\textsuperscript{20}

\textit{Who should be tested?}

There are no national standards delineating specific criteria for drug testing pregnant women and new mothers. Moreover, the guidelines and recommendations specific to pregnant women that do exist are not necessarily evidence-based, vary widely, and rely on a variety of assumptions that may or may not be true.

In 1993, the U.S. Department of Health and Human Services Substance Abuse Mental Health Services Administration (SAMHSA) convened an expert consensus panel to improve drug treatment for pregnant women. The panel addressed the issue of drug testing and specifically addressed the question of whether or not pregnant women and new mothers should routinely be tested for evidence of drug use.\textsuperscript{21} While the panel recognized that certain criteria were used by some health care institutions to test some women, the panel did not recommend adopting any of these criteria as a basis for testing pregnant women nor did it endorse the routine drug testing of pregnant women.\textsuperscript{22}

Some hospitals or jurisdictions\textsuperscript{23} test based on criteria such as maternal history of substance abuse in pregnancy, preterm labor, placental abruption, behavior consistent with acute intoxication, and inadequate prenatal care.\textsuperscript{24} Use of inadequate prenatal care as a criterion is particularly likely to lead to race- and class-biased testing since there are a multitude of factors that impact a woman’s ability to obtain prenatal care besides drug use – including lack of insurance coverage, inability to take sick leave from work, or lack of linguistically or culturally

\textsuperscript{19} See, e.g. A. J. McBay, \textit{Drug-Analysis Technology-Pitfalls and Problems of Drug Testing}, Clinical Chemistry 33.11 (B) (1987) (“Even if a drug . . . is positively identified and precisely quantified, there is as yet no scientific basis for forming options as to when, how often, and how much drug was used – or on the past, present, or future effect of the drug on the performance, health or safety of [the person tested].”)

\textsuperscript{20} Fonda Davis Eyler et al., \textit{Relative Ability of Biologic Specimens and Interviews to Detect Prenatal Cocaine Use}, \textit{Neurotoxicology & Teratology} 677 (2005).


\textsuperscript{22} Id. at 48.

\textsuperscript{23} See e.g., Ferguson v. City of Charleston, 532 U.S. 67, 73 n.4 (2001) (in anticipation of criminal prosecutions for child abuse, virtually identical criteria were used in a testing program that the U.S. Supreme Court found violated the constitutional rights of pregnant patients). See also \textit{Washington State Department of Public Health Guidelines for Screening Substance Abuse during Pregnancy}. Available at http://www.doh.wa.gov/Publicat/Screening_Guidelines.pdf

appropriate health services – which disproportionately affect poor women and women of color. Placental abruption, a well-known condition that occurs in women who have not used any illegal drug, is similarly problematic. Although it is believed by some to be caused by or associated with methamphetamine and cocaine use by pregnant women, research has not proven this to be the case.  

Unfortunately, it appears that many of the criteria used for drug testing pregnant women, new mothers, and newborns were selected and put into place in response to alarmist and inaccurate claims about the potential harms from prenatal exposure to illegal drugs, particularly cocaine. These criteria remain in place in spite of the fact that no evidence-based research has tested their value or their reliability as compared either to other criteria or to universal testing of all pregnant women.

What research does show is that implementing testing protocols leads to racially-biased testing and reporting to state authorities. For example, a study published in the New England Journal of Medicine found that while rates of illegal drug use were similar for white women and African-American women, African American women were 10 times more likely to be reported to state authorities. Similar results were found in Illinois, California and New York.

Creating guidelines for who is tested has not reduced the racial disparity in testing. We were excited to find an abstract introducing one article about drug testing, which asserts that “applying specific written guidelines to select newborns for drug testing decreases bias and protects the physicians and hospitals involved.” However, the article itself states that “[g]uidelines protect the physician who orders the drug screening.” In fact, the article does not suggest written guidelines as a means of reducing bias, but rather the appearance of bias by doctors, apparently to protect them from patients who are upset for having been “singled out.”

Because of these racial disparities, some groups recommend universal testing. Calling for universal testing or no testing at all, the New York Legal Aid Society Juvenile Rights Division

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28 Ira Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENGLAND J. MED. 1202 (1990) (comparing results of universal testing with the number of cases reported to child welfare authorities Dr. Chasnoff concluded that pursuant discretionary testing “a significantly higher proportion of black women than white women were reported, even though we found that the rates of substance use during pregnancy were similar.”).
31 Id.
32 Id.
(an organization devoted to advocating on behalf of children) noted:

Currently, this determination [of who will be tested] is left to the physician or hospital staff based on their subjective judgment of whether there is a risk the child has been prenatally exposed to drugs or alcohol. While independent medical judgment is usually an adequate basis for such decision-making, the reliability of doctors’ testing choices has been shown to be seriously undermined by racial and class biases as well as economic and peer pressures.33

The American College of Obstetricians and Gynecologists (ACOG) endorses what they call universal screening.34 ACOG’s Committee on Ethics issued an opinion in 2008 finding that:

[T]here is much evidence to suggest that women who abuse alcohol or use illicit drugs have coexisting or preexisting conditions (i.e., mental health disorders, domestic violence, stress, childhood sexual abuse, poverty, and lack of resources) that put them in a vulnerable status. Universal application of screening questions, brief intervention [by physicians], and referral to treatment eliminates these disparities related to justice.35

It should be noted that “screening” is not necessarily synonymous with “testing.” Moreover, the ACOG recommendation concerning universal screening rests on an assumption of confidentiality. ACOG notes:

[E]ffective intervention with respect to substance abuse by a pregnant or a non pregnant woman requires that a climate of respect and trust exist within the physician–patient relationship. … Effective intervention also requires that universal screening questions, brief intervention, and referral to treatment be conducted with full protection of confidentiality. Patients who fear that acknowledging substance abuse may lead to disclosure to others will be inhibited from honest reporting to their physicians.36

While universal screening and/or testing as opposed to selective, criteria-based testing would be necessary to ensure some measure of fairness, it would be extremely expensive. A 1994 cost estimate in New York concluded that it would cost New York state 26.1 million dollars a year to perform Urine Drug Screens alone and an estimated 95.9 million to include alcohol and confirmatory drug tests.37

How should testing be carried out?

35 Id. at 5.
36 Id.
37 Memorandum from Dr. Wendy Chavkin to Jane Spinak and Danny Greenberg; “Position Paper on Government Action of In Utero Drug or Alcohol Exposure” (May 24, 1996) (on file with NAPW).
The SAMHSA expert panel advised that if health care institutions do conduct routine alcohol and drug testing, they should do so in accordance with the standards used for urine drug testing in the workplace as required by the federal workplace drug testing guidelines.  

Federal workplace drug testing guidelines provide certain protections that are not afforded to pregnant women, new mothers, and newborns. These include:

- cut-off levels to establish a true positive result
- guaranteed confirmatory testing
- opportunity to challenge results and have a re-test.

Without these safeguards, there is a high incidence of false (simply wrong) or innocent (positive for a prescribed drug/ over the counter medication) positives among pregnant women and newborns.

Drug testing of hospital employees or applicants is governed by guidelines of the American Hospitals Association (“AHA”). AHA guidelines recommend use of National Institute of Drug Abuse (NIDA)-certified labs and NIDA collection/chain-of-custody procedures. AHA also recommends that all positive lab results be sent to a medical review officer who should give the employee the chance to provide another basis for the positive result. Pregnant women, new mothers, and newborns should have, at minimum, the same protections as hospital applicants and employees.

Is it necessary to obtain informed consent to drug test pregnant women?

The SAMHSA expert consensus panel specifically concluded that informed consent from the woman should be obtained before any testing is done. Indeed, the legal and ethical requirement of informed consent applies to pregnant women just like all other people. A competent pregnant woman has the right to make an informed decision about the course her treatment and care will take, and she may refuse any medical treatment. Further, treating pregnant women differently from non-pregnant patients could constitute gender discrimination or a violation of fundamental rights.

As a matter of both law and ethics, principles of informed consent require that patients be made

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43 See, e.g., In re A.C., 573 A.2d 1235 (D.C. Cir. 1990) (en banc).
44 Id.
aware of all possible consequences of the medical procedure or test, including potential legal consequences of a report to child welfare or criminal justice authorities. Failing to obtain informed consent for testing done to gather incriminating evidence may leave hospital staff individually liable in federal civil rights actions.

How are tests used?

One of the published articles we found that discusses criteria for testing pregnant women or newborns observed that the “[p]ossible benefits of identifying IUDE [intrauterine drug exposure] infants could include programs for improvement of parenting skills, maternal drug treatment, [and] home assistance, . . . .” These are huge assumptions that do not acknowledge the extent to which lack of health insurance and lack of appropriate drug treatment services make such benefits purely hypothetical. According to the little research available, laws requiring reporting of positive drug tests on pregnant women or newborns have not led to a significant increase in the provision of meaningful drug treatment or other health services to pregnant women, mothers or children.

An article about drug screening practices in Iowa raises some related concerns. This article looked at testing protocols and asserted “that having a structured protocol in place improves the rates of neonatal screening and positive test results.” This same article, however, explicitly cautions:

[r]eporting of in utero exposure to illicit drugs should in no way result in legal consequences for the mother. This approach has proven to be devastating to pregnant women’s use of health services with subsequent worsening medical outcomes for both the mothers and offspring.

This comment points to a common limitation in the research we found regarding testing criteria. Discussion of those criteria is based on numerous assumptions that the research does not actually test or address. In this case, the article fails to address the question: If routine testing (with or without criteria) inevitably leads to legal consequences, do the benefits of such testing outweigh the costs? An investigative reporting series about testing and reporting in certain regions of

45 Id.
47 See e.g. AN ANALYSIS OF GARRETT’S LAW REFERRALS, JUNE 2005 THROUGH MAY 2006, PREPARED BY HORNYBY ZELLER ASSOCIATES FOR THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF CHILDREN AND FAMILY SERVICES (2006). (In analyzing an Arkansas law that mandates doctors to report positive toxicology tests at birth to child welfare authorities, this report found that marijuana accounted for over half of reports, which were most commonly associated with no health problems. Only 64.1% of mothers received any social services or drug treatment after being reported. Additional drug screens accounted for the vast majority of these “services.” The number of mothers receiving only drug screens, which are more of a source of information for social service providers than a rehabilitative measure for parents, were more than the combined total of the next three types of services received.).
California (even with a law explicitly rejecting reporting based on testing alone) indicates the significant and potentially dangerous consequences can result from such testing.\(^\text{49}\)

**What are the risks of testing?**

Threats of exposure and loss of child custody deter women from seeking prenatal care and what little appropriate drug treatment might be available.\(^\text{50}\) According to a report published by the U.S. Department of Health and Human Services, National Center on Substance Abuse and Child Welfare:

> One key reason for this lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use. Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician’s office is seen as a safe and supportive resource to all pregnant women.\(^\text{51}\)

Research on barriers to substance abuse treatment for pregnant women found that “fear of losing their children” was the greatest deterrent to women.\(^\text{52}\) One recent study confirmed that child welfare reporting policies constituted a major barrier to prenatal care.\(^\text{53}\)

Even when women are not completely deterred from prenatal care, fear of exposure and loss of their children may discourage them from being honest with their health care providers. This destroys the trust necessary for the doctor-patient relationship. As the U.S. Supreme Court recognized, a “confidential relationship” is necessary for “successful [professional] treatment.”\(^\text{54}\)

> Patients must feel comfortable divulging highly personal, stigmatizing, and potentially incriminating information.\(^\text{55}\) Feelings of shame, fear, and low self-esteem are significant barriers to establishing the trust prerequisite to patients’ full disclosure of this medically vital

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\(^{53}\) Sarah Roberts, *“You Have to Stop Using Before You Go to the Doctor”*: Barriers to Prenatal Care for Women Who Use Drugs During Pregnancy, Presentation at Am. Public Health Ass’n Annual Meeting (Nov. 6, 2007), available at http://apha.confex.com/apha/135am/techprogram/paper_149351.htm (“For women who want a healthy baby and want to reduce or stop their drug use, fear of being reported to CPS is an additional barrier to care.”); See also S. J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 CHILD MALTREATMENT 93 (2000).


\(^{55}\) Id., (observing that a “patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage”).
A lack of trust between a pregnant woman and her provider is recognized as potentially harmful to both maternal and fetal health. Furthermore, an exceptionally large proportion of drug-dependant women suffer from depression, and their prospect of success in treatment depends on forming a strong “therapeutic alliance” with care providers.

The risks inherent in disrupting the provider-patient relationship are so great that the Center for the Future of Children recommends that "[a]n identified drug-exposed infant should be reported to child protective services only if factors in addition to prenatal drug exposure show that the infant is at risk for abuse or neglect.”

**Separating Babies From Their Mothers Before and After Birth**

Other speakers have talked about the potential trauma of separating a child from its mother after it is born, and why it should be avoided to the extent that it is at all possible. Equally dangerous is the attempt to legally separate babies from their mothers before they are born. An example of this comes from Alabama, which has engaged in such a campaign to disastrous effect.

In 2008, Amanda K. was six months pregnant and went into early labor with a prolapsed umbilical cord. This is a condition that is extremely life-threatening to a fetus, requiring delivery within a matter of minutes. She went to a local hospital for care where she underwent emergency cesarean surgery to save her son. Unfortunately, the extremely premature baby died shortly after delivery. Ms. K and her family were devastated by the loss. Rather than providing the support and compassionate care she and her family needed, the hospital drug tested her. The positive result was used as a basis for reporting her to the police and having her arrested for the crime of “chemical endangerment” of a child. Ms. K was convicted and sentenced to 10 years in prison. She is currently out on bail while she challenges the charge and raises her two older children and a beautiful nine-month old.

Ms. K is one of at least 35 pregnant women in Alabama who have been charged with the crime of “chemical endangerment.” Most of these women have given birth to healthy children but were arrested when they carried their pregnancies to term in spite of a drug problem. Some, like Ms. K, have suffered losses that, as a matter of science, are not linked to the use of illegal drugs.

In 2006, the Alabama Legislature passed a “chemical endangerment” law that was designed to provide special criminal penalties for “responsible persons” who allow their children in or around methamphetamine labs—essentially to address the Baby Brandon problem. You might wonder what the basis for the charge was and whether Ms. K perhaps lived in a meth lab. Covington County District Attorney Greg Gambril decided that the word “child” in the chemical

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57 Am. Coll. Obstetricians & Gynecologists, **At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice**, ACOG COMMITTEE OPINION, No. 422, Dec. 2008, at 6 (punitive measures “endanger the relationship of trust between physician and patient . . . [and can] actually increase the risks to the woman and the fetus rather than reduce the consequences of substance abuse.”).
58 See **Center on Addiction and Substance Abuse (CASA), Substance Abuse & The American Woman 64** (1996); **Social Consequences of Substance Abuse among Pregnant and Parenting Women, 20 Pediatric Annals 548** (1991).
endangerment statute should include fetuses, and that a pregnant woman is a “location” containing methamphetamine. According to the state, Ms. K herself was the meth lab.

The director of the Alabama Women’s Resource Network, Catherine Roden-Jones, recently published a commentary about these cases, in which she explains:

Women, upon becoming pregnant, do not suddenly have greater access to health care, better housing, safer environments or enhanced capacity to overcome behavioral health problems such as addiction. Any woman in Alabama looking to overcome substance use can attest to the difficulty in finding a treatment center they can afford, that will provide child care, and that is local to their place of residence and job. How can we prosecute those whom we have only just begun to help by way of services and outreach?  

As it happens, while Alabama prosecutors are relying on radically expansive reinterpretations of the law, there is a measure on the Colorado ballot that would explicitly authorize these types of counterproductive measures. After Amendment 48, which would have declared that the rights of personhood attach at the moment of fertilization, was defeated by 73 percent of voters in 2008, Personhood Colorado sponsored Amendment 62. This amendment would add the following section to the Colorado Constitution's Bill of Rights:

**Section 32. Person defined.** As used in sections 3, 6, and 25 of Article II of the state constitution, the term "person" shall apply to every human being from the beginning of the biological development of that human being.

While the measure’s proponents created it as a means of limiting abortion, and most likely contraception, in-vitro fertilization, and stem cell research, it would have an unprecedented impact on women carrying their pregnancies to term. It would, for example, expose women to the counterproductive investigations and prosecutions like those in Alabama. Personhood Colorado denies that it will impact women who wish to carry their pregnancies to term in the “Scare Tactic Alert” section of their webpage. They claim that “for a woman to be charged for a miscarriage she would have to acted with the criminal culpability which includes the performance of an act and a matching criminal intent. These standards would be the same as would be applied to any mother who harms her children, born or preborn.” This response does

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61 “Section 3. Inalienable rights. All persons have certain natural, essential and inalienable rights, among which may be reckoned the right of enjoying and defending their lives and liberties; of acquiring, possessing and protecting property; and of seeking and obtaining their safety and happiness.”
62 “Section 6. Equality of justice. Courts of justice shall be open to every person, and a speedy remedy afforded for every injury to person, property or character; and right and justice should be administered without sale, denial or delay.”
63 “Section 25. Due process of law. No person shall be deprived of life, liberty or property, without due process of law.”
not touch on the possible ramifications for a mother who knowingly engages in something
believed—whether correctly or incorrectly—to be unhealthy or dangerous to the fetus.

The unfortunate truth is that when laws are passed that legally separate a fetus from the woman
who is carrying it, these laws are almost invariably used to punish pregnant women. This occurs
even when the law does not authorize, or even specifically prohibits such a use. This happened in
my home state of Texas in 2003 when the state passed the Prenatal Protection Act (SB 319) at
the request of groups similar to Personhood Colorado. Among other things, this law established
that for the purposes of the penal code, including murder and aggravated assault, an individual is
defined as “human being who is alive, including an unborn child at every stage of gestation from
conception to birth.” The bill was supposedly written to protect pregnant women and their
babies from attacks by third parties that harm or kill the fetus, such as a drunk-driving accident
or an incident of domestic violence.

We do not know whether that law was ever used in the way that it was intended, but we do know
that almost immediately after it was passed, a letter went out from District Attorney Rebecca
King to all the doctors in Potter County. This letter told the doctors that under the new law it was
“now a legal requirement for anyone to report a pregnant woman who is using or has used illegal
narcotics during her pregnancy.” Despite the fact that SB 319 was crafted to protect the mother
from criminal or civil liability, King claimed that a “clear reading” of the statute justified using
doctors as a tool of law enforcement for the arrests of women carrying their pregnancies to term
in spite of a drug problem. According to King, the statute, which was added to the Penal Code
among others, directly affected the Controlled Substances Act. The Controlled Substances Act
provides punishment for “delivery” of narcotics (including marijuana) to children, and thus now
to fetuses. Over forty-five women believed to have drug problems were turned in by their
doctors and prosecuted.

This occurred even in spite of U.S. Supreme Court precedent establishing that doctors may not
collect evidence in the guise of medical care to further criminal investigations. Some
physicians, however, saw the serious public health consequences of such a policy, and public

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67 Senate Comm. on State Affairs, Bill Analysis, S.B. 319, 78th Leg., R.S. (Tex. 2003) (“S.B. 319 amends the Penal
Code to allow the prosecution of a person who harms or kills an unborn child, unless the death is . . . the result of an
action by the mother.”); Jordan Smith, Naked City, Save the Fetus --From Mom?, AUSTIN CHRON., Sept. 10, 2004,
68 Jordan Smith, Naked City, Save the Fetus --From Mom?, AUSTIN CHRON., Sept. 10, 2004, available at
69 Mary Alice Robbins, Woman to Go on Trial for Delivering Cocaine to Unborn Child: Defense Lawyer Claims
http://www.law.com/jsp/article.jsp?id=1090180206979 (noting that Ms. Ward was prosecuted under Potter County
District Attorney’s interpretation of 2003 laws passed to amend Penal Code to include “unborn child[,]” also
known as the Prenatal Protection Act); Sean Thomas, Women Await Freedom: Legal Process Slows for Six Cleared of
Delivering Drugs to Unborn Babies, AMARILLO GLOBE NEWS, Oct. 31, 2006,
http://www.amarillo.com/stories/103106/new_5846884.shtml(“Forty-five cases were pending the outcomes of the
appeal cases and have since been dropped.”)
70 Ferguson v. City of Charleston, 532 U.S. 67, 81-86 (2001) (considering the constitutionality of a public hospital’s
policy, implemented in coordination with law enforcement, of drug testing pregnant women and holding that
notwithstanding the State’s asserted interest in protecting the fetus, the full protections of the Fourth Amendment
applied).
denounced the interpretation as a major disincentive for pregnant women to seek appropriate prenatal care, and as potentially encouraging some women to terminate otherwise wanted pregnancies. 71 Although we were eventually able to overturn some of the convictions, women spent years in jail while the cases worked their way through the court system, 72 and it remains unknown whether all of the women’s convictions were overturned.

WHAT SHOULD BE DONE?

There are many measures intended to help substance-exposed newborns that have either not been shown to be effective, or which may have risks that outweigh any possible benefit. Here are some recommendations for what providers and advocates can do to help ensure healthy babies and healthy mothers in Colorado.

- Ensure that evidence and compassion-based drug treatment, prenatal care, and other reproductive and mental health services are widely available and fully accessible to pregnant and parenting women and their families on a voluntary basis.
- Create and fund treatment programs that are informed both by evidence based research about successful women’s treatment and by the women who use drugs.
- Maintain the hallmarks of successful treatment modalities, including guarantees of provider-patient confidentiality that are usually denied to people mandated to treatment through drug courts and child welfare systems. 73
- Provide meaningful training to health care providers and child welfare workers on issues of drug and alcohol use and treatment for drug addiction. Not only is training on drug issues extremely limited, it is often superficial and misleading. Training must include discussion of the difference between use, dependency, and addiction. It should also include honest discussion of differences within the treatment, recovery, and advocacy worlds about what approaches work and how different people and communities might benefit from different approaches.
- Provide meaningful training on issues of post-traumatic stress disorder that are highly associated with drug and alcohol use that becomes problematic. 74

73 See Center for Substance Abuse Treatment, Pregnant, Substance-Using Women 6 (1993) (U.S. Dept. of Health & Human Servs. Publication No. (SMA) 93-1998) (discussing the services needed to address successfully the treatment of drug using women, noting that it “is imperative that programs include services designed specifically for women, particularly pregnant women”); see also Center for Substance Abuse Treatment, Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs 124-26 (1994) (U.S. Dept. of Health & Human Servs. Publication No. (SMA) 94-3006) (providing guidance to treatment providers to meet the specific needs of women with substance abuse problems).
74 See e.g., Patt Denning & Jeannie Little, Harm Reduction in Mental Health, HARM REDUCTION COMMUNICATION (Spring 2001) (One can also predict the likelihood of developing problems with drug use based on traumatic experiences: “up to 80% of people with a history of significant trauma will abuse substances.”). See also Women and Drug Abuse, NIDA CAPSULES (June 1994) (Among drug using women, 70% report having been abused sexually before the age of 16; and more than 80% had at least one parent addicted to alcohol or one or more illicit drugs); Marsha Rosenbaum, Women: Research and Policy, in WILLIAMS & WILKINS, SUBSTANCE ABUSE 654-65 (1997) (“Researchers have consistently found high levels of past and present abuse in the lives of women drug users.
- Increase training for child welfare workers in related areas including how trauma affects parents as well as children; and reduce their caseloads so that they can identify and respond appropriately to all cases where a parent’s behavior in fact indicates an inability to parent.
- Enforce anti-discrimination laws against existing programs that deny access to pregnant and parenting women.
- Increase support for family preservation services generally so that expensive foster care is not the only option available to caseworkers who seek to protect children from families that in fact are struggling with dysfunction.

Many have suggested that there is a relationship, if not absolutely causal, between violence experienced by women and drug use”); Jahn L. Forth-Finegan, Sugar and Spice and Everything Nice: Gender Socialization and Women’s Addiction – A Literature Review, in FEMINISM AND ADDICTION 25 (Claudia Bepko ed., 1991) (“Difficult and physically abusive childhood experiences are reported to be frequent, and the incidence of sexual abuse among alcoholics has been shown to be very high, often as high as 75% of the women in treatment.”)