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PRENATAL AND MATERNAL SUBSTANCE ABUSE IN AMERICA: DEVELOPING A FRAMEWORK FOR THE FUTURE OF RECOVERING MOTHERS

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INTRODUCTION

The characterization of addiction as a moral failing has created a significant atmosphere of stigma, shame, and disgrace around individuals struggling with substance abuse in a manner that has produced immense obstacles for those who voluntarily attempt to seek treatment or resources. The lack of inclination or preference that addiction has for one group or individual over another has permitted it to become entrenched in the lives of millions of Americans, with the issue only continuing to expand and evolve in response to more prescription and synthetic substances being placed on medical and illicit markets alike.[1] For pregnant and parenting women, the consequences and harm stemming from their substance abuse affect not only them as individuals but also their fetuses or living children, which poses complex and highly individualized challenges for each situation.[2] The spread of the COVID-19 pandemic has further encouraged an increase in already-high rates of these women suffering from substance abuse to cope with the unique stresses associated with the pandemic and their pregnancy or motherhood in general, ushering in a new wave of urgency to address the problem appropriately.[3]

The alarming continuation of this problem in today's society has led legislators and policymakers to try to find a specific legal and social response distinctively catered to these women's circumstances but has also led them to be faced with serious obstacles that have yet to be overcome. An immensely inadequate national approach is currently in place for the women and children at the core of the problem, creating a hurdle for policymakers and advocacy groups with the hopes of addressing the real reasons why the issue has seen such little

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[1] *Drug Abuse Statistics*, NAT'L CTR. FOR DRUG ABUSE STAT., https://drugabusestatistics.org/ (last visited Dec. 14, 2021).

[2] *What is the U.S. Opioid Epidemic?*, U.S. DEP'T HEALTH & HUM. SERV., https://www.hhs.gov/opioids/about-the-epidemic/index.html (Feb. 19, 2021).

[3] Amanda Krupa, *Substance Abuse among Pregnant Women on the Rise During Covid-19*, VERYWELL HEALTH, https://www.verywellhealth.com/pregnancy-substance-use-disorders-during-covid-19-5116371 (Mar. 17, 2021). The COVID-19 pandemic has produced a slew of unique pressures for pregnant women including depression from social isolation, concern over increased financial costs, and anxiety over a more vulnerable health status. These pressures have led to a rise in use of cannabis and tobacco, as well as co-use of substances, throughout pregnancy. Preeti Kar et al., *Alcohol and Substance Use in Pregnancy During the COVID-19 Pandemic*, 225 DRUG & ALCOHOL DEPENDENCE 1, 2 (2021).

improvement over time. Each state handles drug use during pregnancy in a unique manner, each taking on a completely different approach to related components of the issue, such as the obligation of healthcare employees to report drug use during pregnancy and the grounds for civil commitment or criminal charges presented against these women.[4] For women who abused drugs while pregnant and extended their drug use past the birth of their child, it becomes increasingly more complex among states. The flexibility granted to states in adopting their own approach, with only a very basic federal framework upon which they are required to build has, in turn, created an uneven and unjust system oriented towards punishing women in certain states while assisting and supporting them in others.[5]

All of the women at the center of this issue are equivalent to one another in that they either are or were pregnant while suffering the consequences of substance abuse, with the only real difference between them determining whether they will be faced with harsh penalties or treatment options simply coming down to the state where they reside.[6] Pregnant and parenting women are faced with the impending reality that, in many states, voluntarily coming forward and seeking treatment and recovery services could immediately make them a target of laws and statutes asserting child abuse and child endangerment against them.[7] This follows closely in line with the persistence of the fetal protectionism movement from the early twenty-first century, encouraging a punitive-based approach against these women centered around criminal prosecution and civil commitment.[8] Creating unique

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[4] Leticia Miranda et al., *How States Handle Drug Use During Pregnancy*, PROPUBLICA (Sep. 30, 2015), https://projects.propublica.org/graphics/maternity-drug-policies-by-state. Each state in the nation has a unique approach to addressing prenatal substance abuse within its borders, considering factors such as the requirement of healthcare professionals to report suspected drug use, the creation or funding of drug treatment programs exclusively targeted to pregnant women, and the specific grounds upon which a pregnant woman or mother to a substance-exposed pregnancy will be charged with child abuse or civilly committed. *Substance Use During Pregnancy*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy (Dec. 1, 2022).

[5] Miranda et al., *supra* note 4.

[6] *See id.*

[7] CRIMINALIZING PREGNANCY: POLICING WOMEN WHO USE DRUGS IN THE USA, AMNESTY INT'L 17 (2017), https://www.amnesty.org/en/documents/amr51/6203/2017/en/ [hereinafter CRIMINALIZING PREGNANCY].

[8] Linda C. Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal*

punishments for these women who struggle with substance abuse yet voluntarily make the choice of seeking treatment only contributes to the criminalization of pregnant women in a way that makes it that much more challenging for others to step forward if they feel they will be targeted as well.[9] The need for real change and improvement on how this issue is addressed only continues to persist as it becomes abundantly clear how denying pregnant and parenting women the chance to willingly and safely recover from their addiction causes more harm than benefit to the woman, her child, and society as a whole. In a world where modern medicine and treatment for substance abuse have become so advanced and have such an incredible potential to be widely accessible among public health institutions everywhere, there is no excuse for the persistence of such an uneven and ineffective response to a public health concern this impending.

This Comment will argue that there must be a better way to respond to the daunting concern surrounding what has now become known as a genuine public health crisis. In emphasizing that the main goals of shifting the nation's approach to the problem rely upon the basic notions of equal access to healthcare and fairness, it becomes clear that the focus is not to allow pregnant and parenting women to avoid taking responsibility for their addiction, but rather to provide them with the specialized resources they need to help them overcome it in a healthy manner for themselves and their children. This Comment will identify how the harsh responses taken up by various states throughout the nation, specifically Wisconsin and Alabama, create an environment that only encourages the breadth of the problem to expand, setting forth a suggestion for a more uniform framework that would provide for a step in the right direction, as well as hopefully reduce some of the stigma associated with it.

This Comment will begin by providing a preliminary understanding of the problem of prenatal and maternal substance abuse by identifying the physical consequences of drug use during pregnancy that are the most relevant to the discussion of the issue, the complications

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Substance Abuse is Not the Answer – A Comparative Legal Analysis, 15 MICH. J. GENDER & L. 389, 391 (2009). The United States has been set distinctively apart from other developed nations with respect to prenatal and maternal substance abuse, relying on a punitive-based approach while simultaneously failing to produce adequate economic, legal, and social supports to help the women and children at risk or already at the center of the issue. *Id.* at 391-92.

[9] *Id.*

that emerge within society with this specific kind of addiction, and the unique role of the nationwide opioid crisis in considerably increasing rates of women who use drugs while pregnant. It will then focus on the federal response to the problem with the presentation of legislation specifically centered on the care of children in households affected by the substance abuse of the mother, attempting to provide some kind of framework but doing so in a way that still gives states immense flexibility on how much or little attention they want to give to the issue.

This Comment will then progress into an analysis, beginning by looking at some of the major problems that emerge as a result of each state adopting its own approach to addressing the issue. It will then present the steps taken by Wisconsin and Alabama as extreme examples of the harsher end of how the issue has been addressed among the states, leading to a discussion of the unintended consequences that arise as a result of effecting these kinds of overly harsh responses. Following, this Comment will lay out Texas' response to the issue and the programs it has created and utilized to express how nationally adopting a similar approach would create a positive and non-punitive, government-assisted, and interventive environment for women, concluding with additional alternatives to punitive responses that should also be complementarily adopted nationwide.

I. AN OVERVIEW OF PRENATAL SUBSTANCE ABUSE

Substance abuse among pregnant women in the United States continues to be a serious public health concern, specifically considering the risk that it poses to the child's health and the costs it poses to society as a whole.[10] Because of how quickly and easily substances are able to pass through the placenta, any substance a pregnant woman consumes can directly reach the fetus and cause severe health consequences before they are even born.[11] Some of the most common medical issues experienced by children born to mothers who consumed

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[10] Emily J. Ross et al., *Developmental Consequences of Fetal Exposure to Drugs: What We Know and What We Still Must Learn*, 40 NEUROPSYCHOPHARMACOLOGY REVS. 61, 61 (2015).

[11] SUBSTANCE USE IN WOMEN RESEARCH REPORT: SUBSTANCE USE WHILE PREGNANT AND BREASTFEEDING, NAT'L INST. ON DRUG ABUSE 10-11 (2020), https://nida.nih.gov/download/18910/substance-use-in-women-research-report.pdf?v=b802679e27577e5e5365092466ac42e8.

drugs while pregnant include decreased birth weight, congenital anomalies, abnormal neurobehavior, and other symptoms that mimic withdrawal.[12] More narrowly referred to as neonatal abstinence syndrome ("NAS"), infants exposed to drugs while still in the womb experience "a combination of physiologic and neurobehavioral signs" when they are born, ranging from increased muscle activity and issues latching for feeding to diarrhea and seizures.[13] Infants experiencing NAS often require prolonged hospitalization and treatment.[14] Between 2009 and 2017, the hospitalization rate of newborns with NAS rose from 2.9 to 7.3 per 1,000 newborn births, creating a genuine and renewed sense of urgency surrounding the problem.[15]

Additionally, the immediate social costs that emerge as a result of high rates of substance-exposed pregnancies and births primarily include "intervention costs, hospital facility costs, physician fees, and costs of psychotropic medications."[16] Recent studies indicate that hospital facility costs for the individual newborn stays of substance-exposed pregnancies average out to tens of thousands of dollars, as do the increased resources that must be allocated through maternal and newborn care for mothers and infants under these circumstances.[17] Because children born of substance-exposed pregnancies are also reported as having a higher risk of experiencing neglect, abuse, or abandonment than are children who were not, states simply have to spend more money on protective services and courts that are later allocated to them.[18] In considering the additional costs incurred by these increased expenses for public assistance and foster care, states ultimately end up taking on tens of thousands more dollars for each year after the

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[12] Marylou Behnke & Vincent Smith, *Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus*, 131 PEDIATRICS e1009, e1012-e1013 (2013).

[13] *Id.* at e1013.

[14] *Id.*

[15] Beth Giambrone, *Neonatal Abstinence Syndrome: State Considerations for 2021*, ASS'N STATE & TERRITORIAL HEALTH OFF. (Feb. 3, 2021), https://www.astho.org/communications/blog/neonatal-abstinence-syndrome-state-considerations-for-2021/.

[16] Xiao Xu et al., *Economic Evaluation of a Behavioral Intervention Versus Brief Advice for Substance Abuse Treatment in Pregnant Women: Results from a Randomized Controlled Trial*, 17 BMC PREGNANCY & CHILDBIRTH 1, 3 (2017).

[17] *Id.* at 5.

[18] Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, 1 HARM REDUCTION J. 1, 12 (2004).

birth of each individual child born to a substance-exposed pregnancy.[19]

One of the more significant factors contributing to the rise in rates of prenatal substance abuse is the presentation and growth of the opioid crisis in the 1990s, which continues to play a role in how many pregnant women there currently are addicted to drugs.[20] The particular characterization of oxycodone by the pharmaceutical company behind the drug allowed for them, and the FDA, to make public claims that the drug was an opioid classified under Category B, caused no harm to the fetus, and was non-addictive in comparison to other opioids.[21] This contributed massively to a relatively recent rise in prescribing opioids to pregnant women, as it incited an increased level of confidence or trust in prescribing higher dosages of the drug to a population that is typically excluded from even being considered for the use of opioids.[22] In fact, data gathered from pregnant women enrolled in commercial health plans across the nation demonstrates high rates of pregnant women filling prescription opioids during pregnancy between 2005 and 2011, at 14.4%, with the majority having received the prescription for the management of acute pain.[23]

However, it quickly became clear that these claims by the pharmaceutical company and their sales representatives were misleading and deceitful, rapidly leading to widespread misuse and addiction of the drug, as well as an inevitable parallel rise in NAS, even for those who began using it legitimately and had it prescribed to them by a licensed medical professional.[24] Opioid use disorder ("OUD") among pregnant women who deliver at hospitals in the United States has increased by 400% from 1999 to 2014; this statistic does not include pregnant women

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[19] *Id.*

[20] *What is the U.S. Opioid Epidemic?*, *supra* note 2.

[21] Mahsa M. Yazdy et al., *Prescription Opioids in Pregnancy and Birth Outcomes: A Review of the Literature*, 4 J. PEDIATRIC GENETICS 56, 57 (2015). These statements are supported by animal studies, but there is a lack of well-controlled human studies and pregnant women are typically excluded from clinical trials, all of which brings the validity of these statements into question. *Id.*

[22] *Id.*

[23] *Id.*

[24] Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 221 (2009), https://www-ncbi-nlm-nih-gov.ezproxy.lib.uh.edu/pmc/articles/PMC2622774/.

who deliver outside of hospitals.[25] Figures of opioid addiction among pregnant women are particularly high in rural areas, as these communities were specifically targeted by pharmaceutical representatives who encouraged doctors to prescribe high rates of these addictive opioids when they were first introduced into the market.[26] These are areas with a higher prevalence of patients suffering from chronic pain because of the high concentration of work reliant upon physical labor, which made them highly attractive to sales representatives marketing pain management.[27] As the inaccuracy of these claims has become more well-known over time, opioid prescribing has declined, but overdose deaths involving opioids continue to increase, especially in these rural areas.[28]

Maintenance therapy with buprenorphine and methadone has emerged as the standard of care for safely and effectively treating drug addiction, including for pregnant women, but rural areas have limited availability of these resources, and the few prescribers or clinics that are available frequently refuse to treat pregnant patients.[29] Mothers with OUD and their newborns frequently have to be transferred to hospitals outside of their rural communities following delivery in order to receive high-level, specialty substance use and neonatal care that they require, upon the reality of not having received proper treatment while pregnant.[30] These gaps and disparities are only the beginning of what illustrates the urgent need to develop and offer comprehensive, evidence-based treatment services for pregnant women struggling with substance abuse in a standardized manner.[31] However, this need is consistently overshadowed by inadequate or punitive legislation targeted toward punishing, as well as the inability of

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[25] M. Aryana Bryan et al., *Addressing Opioid Use Disorder Among Rural Pregnant and Postpartum Women: A Study Protocol*, 33 ADDICTION SCI. & CLINICAL PRAC. 1, 2 (2020).

[26] *More Opioids Being Prescribed in Rural America*, AM. ACAD. FAM. PHYSICIANS (Jan. 28, 2019), https://www.aafp.org/news/health-of-the-public/20190128ruralopioids.html. This continues to be a pressing concern in relation to the opioid crisis, as in 2017, 14 rural counties were among the 15 counties with the highest opioid prescribing rates in the nation. *Id.*

[27] *Id.*

[28] *Id.*

[29] Bryan et al., *supra* note 25.

[30] *Id.*

[31] *Id.*

the nation to present a uniform and collaborative approach to a widespread addiction problem.[32]

II. THE FEDERAL RESPONSE: A CURRENTLY STRIATED, SPLINTERED NATIONAL APPROACH

Congress produced key legislation in 1973 addressing rising concerns about child abuse and neglect, titled the Child Abuse Prevention and Treatment Act ("CAPTA"), but has amended it repetitively and significantly over the years.[33] In 2003, Congress began to incorporate more specific concerns about prenatal drug exposure into the legislation, requiring that in order for states to maintain their CAPTA grant funding, they had to ensure that healthcare providers were making timely reports to CPS of any substance-exposed pregnancy they encountered.[34] In 2016, over a decade later, Congress expanded the legislation to specifically include state plan requirements for "infants born and identified as being affected by substance use or withdrawal symptoms or fetal alcohol spectrum disorders," encompassing all possible substance abuse.[35] CAPTA was further amended by Congress in 2018, adding the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT for Patients and Communities Act"), authorizing grants to states for costs associated with substance use disorder treatment agencies, labor and delivery units and hospitalization, social services, and welfare agencies, and other agencies or resources contributing to states' plans of safe care.[36]

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[32] *Id.*

[33] ABOUT CAPTA: A LEGISLATIVE HISTORY, CHILD WELFARE INFO. GETAWAY 1 (Feb. 2019), https://www.childwelfare.gov/pubpdfs/about.pdf [hereinafter *About CAPTA*].

[34] *Id* at 2.

[35] *Id.* This came in alignment with the introduction of the Comprehensive Addiction and Recovery Act ("CARA") under CAPTA, targeted towards developing services plans for infants and their families or caregivers under individual state plans of safe care. *Supporting Pregnant & Postpartum Women*, NAT'L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE, https://ncsacw.samhsa.gov/topics/pregnant-postpartum-women.aspx (last visited Nov. 13, 2021).

[36] *About CAPTA*, *supra* note 33. The introduction of the SUPPORT for Patients and Communities Act came in response to the U.S. Department of Health and Human Services' declaration of a national opioid crisis in 2017, constituting a public health emergency. *What is the U.S. Opioid*

These plans of safe care provide a great deal of flexibility to individual states in terms of how they are to be implemented and what components go into them.[37] Pregnant or parenting women are paired with their providers to come up with plans of safe care together, defining which services they are going to utilize and how they can organize the care and support they will be receiving from the state.[38] There are guides and resources set forth for different states to consider when they begin planning for the safe care of affected infants within their borders, but overall, these resources have become known to just comprise general guidance rather than a form of mandate or directive.[39] Some examples of how states have defined their own unique approaches to developing plans of safe care include Connecticut's creation of an online notification portal for identifying families in need of plans of safe care or child welfare services, as well as Louisiana's creation of a two-pronged notification and reporting system designed to connect healthcare partners with the needs of child welfare.[40]

Currently, the basic framework of what plans of safe care require is that they must "address the immediate safety, health, and developmental needs of the affected infant" and "include the health and substance use disorder treatment needs of the affected parents or caregivers" in accordance with state requirements.[41] The only real obligation imposed upon states is that healthcare providers are required to notify CPS when they participate in the care of or delivery of an infant who has been prenatally exposed to drugs, and those healthcare providers have gathered evidence of such.[42] However, individual states are still

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Epidemic?, *supra* note 2.

[37] PLANS OF SAFE CARE FOR INFANTS WITH PRENATAL SUBSTANCE EXPOSURE AND THEIR FAMILIES, CHILD WELFARE INFO. GATEWAY 2 (Aug. 2019), https://www.childwelfare.gov/pubPDFs/safecare.pdf [hereinafter PLANS OF SAFE CARE].

[38] *Information about Plan of Safe Care (POSC),* MASS. DEPT. PUB. HEALTH, https://www.mass.gov/info-details/information-about-plan-of-safe-care-posc (last visited Dec. 11, 2021).

[39] *Plans of Safe Care*, NATI'L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE, https://ncsacw.samhsa.gov/topics/plans-of-safe-care.aspx (last visited Dec. 18, 2021).

[40] ON THE GROUND: HOW STATES ARE ADDRESSING PLANS OF SAFE CARE FOR INFANTS WITH PRENATAL SUBSTANCE EXPOSURE AND THEIR FAMILIES, NAT'L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE 2 (2019), https://ncsacw.samhsa.gov/files/on-the-ground-508.pdf.

[41] PLANS OF SAFE CARE, *supra* note 37.

[42] *Id.* at 3.

able to determine how much weight is given to this notification in determining whether child abuse or neglect is present and what kinds of future proceedings can be initiated against the mother.[43] States can pass their own legislation, assign the responsibility of developing plans of safe care to different individuals or providers, and focus as much or as little as they choose on the issues or concerns related to this problem that they believe to be the most pressing within their state walls.[44]

III. AN ANALYSIS OF FAILURES, INEFFECTIVE ACTION, AND RESULTING ISSUES AMONGST STATES

Providing such little federal guidance on how states should address the issue of prenatal substance abuse has created an incredibly uneven system that presents a slew of legislative, statutory, and legal consequences for the individuals at the center of the issue. To begin with, child protection statutes throughout the nation are formatted in a unique manner by each and every state, meaning that there is often a great deal of statutory ambiguity that revolves around trying to collectively define the key terms of these statutes.[45] Countless cases surrounding substance-exposed pregnancies have fallen through the cracks of court systems and been left unaddressed because of the ambiguity in these statutes, providing little to no guidance as to whether or not consuming drugs during the course of pregnancy is covered by them enough to sustain a civil or criminal case against the mother.[46] For example, the South Carolina Supreme Court held in 1997 that a fetus was to be considered a "person" and that "maternal acts endangering" a viable fetus was a form of "child abuse," while California courts have consistently determined since 1977 that their legislators did not intend to include unborn children within the meaning of the

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[43] *Id.* 14 states have policies that make it clear that this kind of notification to CPS does not constitute a report of child abuse or neglect unless there is also additional evidence that the child has been exposed to maltreatment or increased risk of harm. *Id.*

[44] *Id.*

[45] KEY LEGAL ISSUES IN CIVIL PROTECTION CASES INVOLVING PRENATAL SUBSTANCE EXPOSURE, A.B.A. 1 (Jan. 2021), https://www.americanbar.org/content/dam/aba/administrative/child_law/prenatal-substance-use-case-law-brief_full-508.pdf.

[46] *Id.*

word "child" under their statute, with these important definitions at the core of the issue varying from state to state on a frustrating scale.[47]

This nationwide confusion over how far statutory coverage goes in terms of whether or not a fetus is considered a "child" and to what extent consuming specific substances constitutes either "child abuse" or "child endangerment" has led each state to adopt its own definition and understanding in an incredibly uneven way.[48] This leaves the door open for some states to take up a very lenient and open approach that barely responds to the problem, others to put in the work to try to address the issue in effectively and authoritatively, and others to be as harsh and punitive as they please, with little to no federal intervention or guidance on where to draw the line. This creates disparities in how these women are treated, the resources they are given access to, and just about every other aspect that goes into determining how much support they will receive from the state to recover and be a mother to their children.

There is no single, uniform approach or framework to handling the issue across all fifty states, making it a crime for pregnant women to consume certain substances at certain points in their pregnancies in certain states but not in others.[49] Women in some states are immediately placed into civil commitment or have their child taken from them merely upon the presentation of allegations they consumed drugs while pregnant.[50] On the contrary, women in other states are provided with programs and treatment centers to recover safely and have the opportunity to demonstrate that they can create a safe home for their children.[51] Prosecutors also hold great discretion in how they choose to handle these cases when they are presented to them, making the enforcement of criminal laws on this issue incredibly uneven across jurisdictions, thus further creating patterns of inequality and discrimination and a patchwork of laws that make it impossible for the nation to attack the issue in a coherent, standardized manner.[52]

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[47] Miranda et al., *supra* note 4.

[48] *See id.*

[49] *Id.*

[50] *Id.*

[51] *See id.*

[52] CRIMINALIZING PREGNANCY *supra* note 7, at 15.

A. The Approach Taken in Wisconsin: *Beltran v. Strachota*

In 2014, 28-year-old Alicia Beltran visited a clinic for a prenatal checkup upon learning that she was about three months pregnant, where she was asked by the physician's assistant about her medical history.[53] Beltran answered questions about prior drug use and expressed that she had a history of Percocet dependency but that she had been prescribed Suboxone, an anti-addiction drug, by her physician and underwent guided treatment that led her to overcome her addiction.[54] The physician's assistant recommended that Beltran continue taking Suboxone, but Beltran declined, citing that it was no longer necessary.[55] Two weeks later, Beltran found five law enforcement officials at her door with a warrant authorizing her arrest, as the physician's assistant had reported her prior drug use to the authorities after the appointment.[56] Beltran was arrested, escorted into a police car, and transported to a hospital, where she would undergo a doctor's examination.[57] Even though the hospital concluded that both Beltran and her pregnancy were healthy, Beltran was still sent to Washington County Jail to await being presented in front of a courtroom, shackled and handcuffed, to determine if she would be civilly committed.[58]

The state of Wisconsin has a long-held codified statute that permits an expectant adult mother to be civilly committed by the state if she is determined to have "a habitual lack of self-control" in relation to alcoholic beverages or controlled substances and refuses to accept treatment and recovery services offered to her.[59] This "cocaine mom

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[53] Beltran v. Strachota, No. 13-C-1101, 2014 WL 4924668, at *1 (E.D. Wis. Sep. 30, 2014).

[54] *Id.*

[55] Alyson R. Schwartz, *Dangerous or Just Pregnant? How Sanism & Biases Infect the Dangerousness Determination in The Civil Commitment Context of Pregnant Women*, 3 IND. J. L. & SOC. EQUITY 233, 233 (2015).

[56] *Beltran* 2014 WL 4924668, at *2.

[57] *Id.*

[58] *Id.*

[59] An adult expectant mother can be taken into custody if a judge believes that due to her habitual lack of self-control in the use of alcoholic beverages, controlled substances, or controlled substance analogs, exhibited to a severe degree, there is a serious risk to her and the unborn child's physical health if she is not taken into custody, and that she is refusing or has refused to participate in any alcohol or drug abuse services made available to her. WIS. STAT. § 48.193 (2015).

act" quickly gained notoriety when it was passed in 1998, though medical professionals have claimed that the act's language, specifically the terms "habitual lack of self-control" and "substantial risk," are neither medically recognized nor clinically meaningful.[60] The physician's assistant that Beltran originally spoke to seemed to have come to the determination that Beltran met those requirements by refusing to continue with a prescribed regimen of Suboxone, with her report of such marking the starting point for Beltran's civil commitment.[61] At her initial court appearance, Beltran was granted no right to counsel, but her fetus had been appointed an attorney as guardian ad litem, and the district attorney's office was also appointed to represent the local child protective services agency.[62] Following in line with similar previous cases in Wisconsin, Beltran was not granted the opportunity to present medical expert testimony in a manner that has been alleged by advocacy groups as a denial of due process.[63] She was subsequently ordered by the commissioner of the court to be civilly committed to an inpatient drug treatment program.[64]

Beltran was brought to a halfway house immediately after the hearing, then shacked and handcuffed once again to be brought to Casa Clare Treatment Center, a private treatment center for women struggling with substance abuse.[65] Upon arrival, Beltran was subjected to a urinalysis test, which presented negative results for all drugs,

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[60] Sarah Lynne & Benjamin Ratliffe, *The Myth of the "Cocaine Mom"*, SOCIALIST WORKER (Nov. 14, 2013), https://socialistworker.org/2013/11/14/the-myth-of-the-cocaine-mom; Declaration of Sharon Stancliff, Beltran v. Strachota (E.D. Wis. 2014)(No. 2:13-CV-01101; renumbered No.13-C-1101), 2014 WL 4924668 , https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2019/10/Stancliff20Declaration2010-30.pdf.

[61] Schwartz, *supra* note 55, at 233.

[62] Jessica Mason Pieklo, *Advocacy Group Seeks Immediate Release of Involuntary Detained Pregnant Woman*, REWIRE NEWS GROUP (Oct. 3, 2013, 12:17 PM), https://rewirenewsgroup.com/article/2013/10/03/advocacy-group-seeks-immediate-release-of-pregnant-woman-detained-involuntarily-for-drug-treatment/; LINDA C. FENTIMAN, BLAMING MOTHERS: AMERICAN LAW & THE RISKS TO CHILDREN'S HEALTH 149 (2017).

[63] Schwartz, *supra* note 55, at 234-36.

[64] *Id.*

[65] *Beltran v. Strachota*, No. 13-C-1101, 2014 WL 4924668, at *1 (E.D. Wis. 2014). The program at Casa Clare provided neither prenatal care nor the kind of drug treatment that those who reported her claimed she needed. *NAPW: The Case of Alicia Beltran*, NAT'L ADVOCS. FOR PREGNANT WOMEN (Oct. 4, 2019), https://www.nationaladvocatesforpregnantwomen.org/napw-the-case-of-alicia-beltran/.

including Percocet and Suboxone.[66] Regardless, Beltran was detained at Casa Clare for over two months, leading her to file a habeas case requesting a temporary restraining order, a preliminary injunction to grant her release, and a permanent injunction against further enforcement of the Wisconsin statute that had been used against her.[67] She was eventually granted release from Casa Clare with restrictions by the Washington County Circuit Court judge, subsequently prompting the County District Attorney to withdraw the child-in-need-of-protection-services petition that had been originally used to initiate legal proceedings against her.[68]

Alicia Beltran's case gained notoriety among advocacy groups throughout the nation, many of which fought for her release from the treatment center and for more attention to be brought to the absurdity of Wisconsin's harsh approach – with her and with other similar mothers.[69] Major shock and concern arose around the fact that Beltran had no appointed counsel and no representation at her initial court appearance but that her fetus did.[70] The National Advocates for Pregnant Women had also filed a petition seeking that Beltran is immediately released from custody, asserting violations of multiple constitutional rights, including the rights to "physical liberty, due process notice, privacy in medical decision making, to carry a pregnancy to term, to have an abortion, privacy in medical and personal information, to be free of illegal searches and cruel and unusual punishment, and equal treatment under the law."[71] Beltran's case is considered to be the first real challenge to Wisconsin's harsh statute, garnering national concern over how many other cases like hers have been hidden under mountains of confidential proceedings and not granted the constitutionality guaranteed under the law.[72]

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[66] *Beltran*, 2014 WL 4924668, at *1.

[67] *Id.*

[68] *Id.*

[69] *See* Schwartz, *supra* note 55, at 234-35.

[70] *Id.*

[71] Pieklo, *supra* note 62.

[72] *Id.* Minnesota, Oklahoma, and South Dakota all have laws similar to Wisconsin's that permit the involuntary detention of pregnant women who are alleged to have used alcohol or drugs, with similar confidential proceedings. *Id.*

B. The Approach Taken in Alabama: Casey Shehi

An example of what happens when many decisions are left up to individual states and counties, as well as their institutions themselves, to determine the procedures and parameters to be applied to this issue resides in the state of Alabama.[73] In 2003, the federal government began requiring states to create strategies focused on addressing the rising rates of mothers giving birth to drug-dependent babies, specifically in relation to drug testing them in hospitals at birth; however, the law left gaps in terms of which babies and mothers were to be tested and what the proper procedure should be, leaving those parameters completely up to individual states and hospitals themselves.[74] Every hospital that delivers babies in Alabama has its own unique criteria as to under what circumstances they test mothers and babies, what they do with the results, and even whether or not they inform the mother that they are testing her and her child at all.[75]

The majority of these hospitals in Alabama are not open about their drug testing policies, neither to the public nor to the actual mothers involved, skipping out on getting quality informed consent from the mothers.[76] The admissions forms they give to the mothers can mask references to drug testing by using obscure and vague boilerplate language that leads them to give consent to things like "care considered advisable or necessary by the physician" and "diagnostic procedures," making for an incredibly unclear standard arguable by the hospitals as constituting a global form of consent to whatever they believe needs to be done.[77] In obtaining a signature from the mother, many of the hospitals then contend that their consent extends over to drug screenings, though this prompts no communication on behalf of the hospital or doctor to the mother in terms of what kind of screening she will

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[73] Nina Martin, *How Some Alabama Hospitals Quietly Drug Test New Mothers – Without Their Consent*, PROPUBLICA (Sept. 30, 2015, 11:00 A.M.), https://www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent.

[74] *Id.*

[75] *Id.*

[76] *Id.* 42 of the 49 hospitals that deliver babies in Alabama declined to answer an AL.com/ProPublica questionnaire about their testing policies, despite repeated requests over several months. Of the seven that did respond, three provided only partial information. *Id.*

[77] *Id.*

undergo and at what point.[78] Lastly, not a single consent form from these hospitals indicates that positive results from a drug test could trigger arrest and prosecution under Alabama's chemical endangerment statute.[79]

Countless advocacy and human rights groups have questioned the validity of these practices under the constitutional right to privacy, claiming that while limitations on individuals' human rights may be permitted if they are deemed to be necessary and proportionate to a legitimate aim, these practices are neither proportionate nor necessary.[80] The opacity of these hospital testing policies has led to massive confusion about the specifics and details of what they can and cannot do, leaving even state health officials unsure.[81] At the hand of so much liberty, Alabama hospitals have also gained the frightening reputation of producing false positive results with unreliable drug screens, causing serious complications for mothers and babies who may have never even been exposed to substances in the first place.[82]

Further illustrating the issues emerging from such an uneven approach, even from within the states themselves, is the case of Casey Shehi. Shehi gave birth to her son in August of 2014 at Gadsden Regional Medical Center, located in Alabama's Etowah County, having had a very difficult and painful pregnancy.[83] Upon turning back a positive screen for benzodiazepines, Shehi had her son taken from her immediately while she was still in the hospital, prompting the maternity nurses to ask her if she had taken any prescription medications.[84] Shehi recalled that a few weeks before, she had been feeling sick and could not sleep, which led her to take a Valium to try to feel better and get some rest, split into two halves over the course of a few hours.[85] After

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[78] Anna Claire Vollers, *New moms in Alabama face suspicion over error-prone drug screens*, ADVANCE LOC. (Feb. 9, 2020, 8:30 A.M.), https://www.al.com/news/2020/02/new-moms-in-alabama-face-suspicion-over-error-prone-drug-screens.html.

[79] Martin, *supra* note 73.

[80] CRIMINALIZING PREGNANCY, *supra* note 7, at 54.

[81] Martin, *supra* note 73.

[82] CRIMINALIZING PREGNANCY, *supra* note 7, at 54.

[83] Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), https://www.propublica.org/article/when-the-womb-is-a-crime-scene.

[84] *Id.*

[85] *Id.* Exposure to too much benzodiazepine during pregnancy can sometimes cause newborns

conducting a lab report on her son, the nurses returned him to Shehi and informed her that he had nothing in his system, assuring her that she had nothing to worry about.[86]

Shehi went home with her son that day, but just the next day, she received a visit from a social worker on behalf of the Department of Human Resources, Alabama's state child welfare agency.[87] She spoke with the social worker and re-told the details of the story, after which the social worker quickly concluded that Shehi clearly did not fall into the category of mothers who abused drugs that they were primarily targeting with these kinds of visits, also assuring her that she was not concerned with the situation and would not take her son out of her custody.[88] However, a few weeks later, as Shehi had gone back to work and left her son with a babysitter, investigators from the Etowah County Sheriff's Office showed up at the front desk and produced a warrant for her arrest, which claimed that she had "knowingly, recklessly, or intentionally" caused her baby to be exposed to controlled substances within the womb.[89] Shehi was subsequently handcuffed by the investigators, led to an unmarked car, and brought to jail.[90]

The 2006 "chemical endangerment of a child" Alabama statute under which Shehi was charged was specifically passed with the intention to penalize parents who build do-it-yourself ("DIY") meth labs in their homes, making it a felony to "knowingly, recklessly, or intentionally" expose a child to "a controlled substance, chemical substance, or drug paraphernalia."[91] The 'meth-lab' statute mandates one to 10 years in prison if the baby suffers no ill effects, 10 to 20 years if the baby shows signs of exposure or harm, or 10 to 99 years if the baby dies.[92]

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to be fussy or floppy-limbed, but occasionally, small doses of diazepam (the generic name for Valium) are considered safe. *Id.*

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *Id.*

[90] *Id.*

[91] Nina Martin, *Alabama's Meth Lab Law, Abortion Rights and the Strange Case of Jane Doe*, PROPUBLICA (July 31, 2015, 1:00 PM), https://www.propublica.org/article/alabamas-meth-lab-law-abortion-rights-and-the-strange-case-of-jane-doe#:~:text=In%202006%2C%20Alabama%20lawmakers%20passed,was%20quickly%20signed%20into%20law.

[92] *Id.*

Steve Marshall, District Attorney of Marshall County, stated that the goal of the legislation was not to throw pregnant women and mothers in prison but rather to use the threat of incarceration to force them into treatment, giving them the opportunity to have the charges dismissed once they were successful in getting clean.[93]

However, the statute has been stretched to the point where it has very clearly strayed from its original legislative intent in a manner that causes serious challenges and obstacles for women like Shehi.[94] Because no substances were found in her son's system, had Shehi resided in the neighboring Marshall County, nothing would have happened to her, as that particular county has a much less aggressive pursuit of these mothers under the statute.[95] Alternatively, law enforcement in Etowah County had publicly promised that they would aggressively pursue all chemical-endangerment cases, starting from pregnancy, and arrested more pregnant women and new mothers under the statute than any other Alabama county at that time.[96] The different scopes presented as to what is considered prosecutable behavior from one county to another in Alabama, just a short drivable distance from one another, only demonstrates how even when granted a narrower view on the states themselves, there is still absolutely no uniformity or standard to which counties and states can be held when it comes to dealing with this issue.[97]

C. The Unintended Consequences of a Punitive Response

The examples set forth by Wisconsin and Alabama create a concerning spectrum on which states are becoming increasingly harsher, with neither women in the cases discussed above falling into the category of the kind of women these statutes and approaches had

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[93] Martin, *supra* note 83. Marshall County was hit so hard by the meth crisis in the early 2000s that it was nicknamed 'Meth Mountain.' *Id.*

[94] *Id.*

[95] *Id.* In the span of nine years, authorities in Birmingham, within Marshall County, only charged two women with chemical endangerment of an unborn child. *Id.*

[96] Martin, *supra* note 73. The sheriff of Etowah County proposed a bill in 2015, the same year as Shehi's case, that would have required reporting within two hours whenever a pregnant woman or newborn tested positive, which would have created an incredibly stringent reporting requirement. *Id.*

[97] *See* Martin, *supra* note 83.

originally intended to target. Wisconsin's statute was focused on women who had a habitual lack of self-control, even though Beltran had already been treated for *and recovered* from her prior dependency; additionally, Alabama's statute targeted parents who were building DIY meth labs in their homes, even though Shehi was doing no such thing.[98] Alabama taking such an invasive approach to the issue, in a way that borders constitutional issues, also presents a major issue in how much power the state itself, its counties, and even its hospitals have been given to where they feel justified and legislatively protected in conducting these kinds of procedures and activities.[99] The consequences suffered by both Beltran and Shehi during and after the litigation they were exposed to were significant, ranging from the financial burden they faced for bond and lawyers and mandatory drug tests to the emotional and mental strain placed upon them by being separated from their children.[100]

While the intention behind imposing these harsh punishments upon pregnant women who use drugs is ultimately to reduce the number of substance-exposed pregnancies, studies consistently show that they are causing the opposite result.[101] Between 2004 and 2014, the incidence of NAS in the United States increased by 433%, jumping from 1.5 to 8 per 1,000 hospital births.[102] Not so coincidentally, a study published in the Journal of American Medical Association in November of 2019 tracked the rise of harsh laws related to substance-exposed pregnancies, finding that from 2000 to 2015, the number of states that implemented these kinds of policies rose from 12 to 25, while almost the same number of states also began requiring healthcare professionals to report any suspected drug use.[103] The study found a positive

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[98] *Id.*

[99] Schwartz, *supra* note 55, at 243.

[100] Martin, *supra* note 83.

[101] Emma Coleman, *Many States Prosecute Pregnant Women for Drug Use. New Research Says That's a Bad Idea*, VANDERBILT UNIV. MED. CTR. (Dec. 5, 2019), https://www.vumc.org/childhealthpolicy/news-events/many-states-prosecute-pregnant-women-drug-use-new-research-says-thats-bad-idea.

[102] Shahla M. Jilani et al., *Evaluation of State-Mandated Reporting of Neonatal Abstinence Syndrome – Six States, 2013-2017*, CTR. FOR DISEASE CONTROL & PREVENTION (Jan. 11, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6801a2.htm.

[103] Coleman, *supra* note 102. These specific laws centered around criminalizing drug use during pregnancy, as well as classifying drug use during pregnancy as child abuse that could result

correlation between rising rates in NAS and the imposition of more "punitive policies" in states that took up harsher approaches, demonstrating how, over the span of the ten years studied, these results were both consistent and concerning.[104]

Threat-based approaches have also been identified as deterring pregnant and parenting women from seeking healthcare rather than from using drugs, only furthering the problem down the road instead of resolving it.[105] For example, Tennessee imposed their infamous 'fetal assault' law in 2014, threatening incarceration of women for up to 15 years in prison for "the illegal use of a narcotic drug while pregnant;" a potential defense to the charge is enrollment in drug treatment, which is challenging for poorer women who cannot afford this route, even though they might be willing to take it.[106] In response to the passing of the law, pregnant women afraid of being targeted began to avoid seeking prenatal care to try to avoid detection this came in the form of switching hospitals at the last minute, leaving the state, or giving birth outside of hospitals to try to avoid prosecution and keep their children.[107] The legislation's harsh nature was intended to frighten women into getting treatment, but the maintenance-treatment options in the state were also scarce and expensive at the time, meaning that poorer women, who made up the majority of the population targeted by the law, were left to fend for their own to try to recover by the time

in the loss of custody rights or as grounds for civil commitment. *Id.*

[104] *Id.*

[105] Open Letter from the Nat'l Advocs. for Pregnant Women, Nat'l Advocs. for Pregnant Women (Aug. 1, 2018) (an open letter from the National Advocates for Pregnant Women and other similar state and national organizations describing the consequences that emerge as a result of harsh prosecution of pregnant women under these circumstances).

[106] Rosa Goldensohn & Rachael Levy, *The State Where Giving Birth Can Be Criminal*, THE NATION (Dec. 10, 2014), https://www.thenation.com/article/archive/state-where-giving-birth-can-be-criminal/. The Tennessee 'fetal assault' law is recognized as one of the state's most divisive and controversial criminal laws. The law has been associated with severe unintended consequences, with doctors and law enforcement officials identifying how many women were scared away from pursuing prenatal care in fear of being jailed. Additionally, the law and its enforcement coincided with a point in time when one of the state's drug courts was experiencing one of the nation's highest concentrations of drug-dependent births. Blake Farmer, *Tennessee Lawmakers Discontinue Controversial Fetal Assault Law*, NPR (Mar. 23, 2016, 4:24 P.M.), https://www.npr.org/2016/03/23/471622159/tennessee-lawmakers-discontinue-controversial-fetal-assault-law.

[107] Goldensohn & Levy, *supra* note 107.

they gave birth, all while hiding out and avoiding getting proper prenatal care.[108]

The forced removal of children from homes on the sole basis of reported or suspected substance abuse has also been proven to have negative effects on both the mother and child or children in the household, continuing with the trend of having the complete opposite effect of what was originally intended.[109] Substance-abusing mothers who have a child removed from their care are twice as likely to have a subsequent birth and three times more likely to have a subsequent substance-exposed pregnancy, as removal is oftentimes not accompanied by any form of treatment or recovery service options for the mother.[110] Specifically for children who are younger and placed into foster care under these circumstances, the trauma associated with the removal, combined with a lack of guidance and support tailored to this stage of development, can further complicate the transition.[111] Oftentimes, the main goal of professionals is just to remove these children from their households and place them into foster care, leading them to overlook the actual problems at the core, such as the continuation of substance abuse of the mother if not the worsening of it, as well as the harms imposed upon the child.[112]

A large part of the concern revolving around these harsh approaches is that they simply are not working the way that they were originally intended, leading women to disengage with the healthcare system rather than turn to it when they most need it.[113] There exists a major conflict between legislators and prosecutors wanting to punish

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[108] *Id.*

[109] THERESE GRANT & CHRIS GRAHAM, CHILD CUSTODY AND MOTHERS WITH SUBSTANCE USE DISORDER: UNINTENDED CONSEQUENCES (2015), https://adai.uw.edu/pubs/pdf/2015childwelfare.pdf.

[110] *Id.*

[111] *See* NATIONAL CENTER ON SUBSTANCE ABUSE & CHILD WELFARE, WORKING WITH ADOLESCENTS: PRACTICE TIPS & RESOURCE GUIDE 1 (2021), https://ncsacw.acf.hhs.gov/files/working-with-adolescents.pdf.

[112] *Id.* Approximately 28 states and 4 American territories have family law statutes that reference guiding principles used to determine what would be in the best interests of the child in these situations, citing "the importance of family integrity and preference for avoiding removal of the child from his/her home." *Determining the Best Interests of the Child*, CHILD WELFARE INFO. GATEWAY 2 (Jun. 2020), https://www.childwelfare.gov/pubpdfs/best_interest.pdf.

[113] Coleman, *supra* note 102.

women who put the health of their child at risk with their substance abuse and policymakers and advocacy groups wanting to prioritize the health of the mother and fetus equivalently and guide her to recovery. Moving in the right direction means focusing prosecution efforts on those women whose activities truly do meet the definition of child abuse and endangerment under reasonable statutes rather than stretching vague statutes in a way that goes against their original intent, as well as providing support and options for those who willingly want to recover and be good, healthy, clean mothers to their children. In other words, the debate over whether mothers should be held accountable for their drug use or treated with compassion for their addiction can converge into a collaborative policy-based approach to the problem that addresses both sides collectively rather than continue as a divided debate with no end in sight.[114]

IV. DEFINING A UNIFORM NATIONWIDE APPROACH

A. Lessons from Texas: Treatment and Intervention

A major concern for many pregnant or parenting women with young children struggling with substance abuse, in addition to the low availability of treatment centers that will accept them to begin with and the possibility of prosecution, is what to do with their children when they want to voluntarily seek treatment.[115] This creates major tension between the responsibility they feel as an individual to focus their entire attention on their recovery and the responsibility they feel as a mother to focus their entire attention on caring for their children. As a result of this, many of these women avoid seeking treatment because they cannot or do not want to leave their children, leading them to try to handle their addiction on their own, oftentimes extending and

[114] Grant & Graham, *supra* note 110, at 2.

[115] Natasha Elms et al., *Need for Women-Centered Treatment for Substance Use Disorders: Results from Focus Group Discussions*, 15 HARM REDUCTION J. 1, 2-3 (2018), https://link.springer.com/content/pdf/10.1186/s12954-018-0247-5.pdf. A study was conducted on two focus groups comprised of a total of 10 Canadian women with substance abuse history and children, revealing that 80% reported wanting to attend a treatment program at some point in their life, but not being able to. The most common reason for not attending the program was fear of losing their child(ren) (75%), with the second most common reason being that they had no care for their child(ren) (62.5%). All women stated that they would likely attend treatment if they were allowed to bring their child(ren). *Id* at 2.

exacerbating the problem further.[116] Despite having its own track record of punitive legislation and harsh case law around the issue, the state of Texas has laid out a network of unique resources that could be used to further the development of a national framework targeted toward keeping families together and considering the unique circumstances of mothers seeking treatment.

One of the more successful and increasingly-growing components of Texas' response to this particular problem was an increase in support for the establishment of Women & Children Residential Treatment, providing substance abuse treatment for women by allowing them and their children to live together in licensed residential facilities.[117] These residential programs are unique in that they recognize the effects young children experience by witnessing addiction and the role they can also play in the mother's recovery, providing skill-building programs throughout treatment that are intended to improve parenting and build an educational foundation for these women to leave with.[118] The baseline criteria for women to be eligible for this kind of residential treatment in Texas is that they must be a state resident over the age of 17 and have received a diagnosis of moderate or severe substance abuse disorder, as well as either be in their third trimester of pregnancy, have dependent children who can attend treatment with them, or have children in the custody of the state who are allowed to attend treatment with them.[119]

Some of the most common services provided by these programs include individualized therapy and medication management, consultation with psychiatrists and case managers, recreational activities and playrooms for children, and schedules focused on integrating family

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[116] *See id.* at 3. Most rehabilitation and treatment centers require limited to no outside communication, creating a deeper fear of separation from their children. For those who do enter treatment, even under those conditions, this fear often tends to undermine the effectiveness of the treatment. *Id.*

[117] *Adult Substance Use Women with Children Residential Treatment*, TEX. HEALTH & HUM. SERVS., https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-women-children-residential-treatment (last visited Nov. 18, 2021).

[118] Kathleen Wobie et al., *Women and Children in Residential Treatment: Outcomes for Mothers and Their Infants*, 27 J. DRUG ISSUES 585, 588-89 (1997).

[119] *Women & Children's Residential*, ALIVIANE, https://www.aliviane.org/services/treatment/women-childrens-residential-program/ (last visited Nov. 29, 2021).

support throughout treatment.[120] For example, the Santa Maria Hostel is Texas' largest multi-site, gender-specific residential and outpatient substance abuse treatment center for pregnant and parenting women, offering both intensive residential treatment and supportive residential treatment options.[121] This center specifically offers relapse prevention skill training, peer recovery support groups and coaches, play therapy and childcare, and GED and career development services.[122] Studies done on the efficacy of these residential programs have consistently yielded positive results, enhancing family function while also preventing and minimizing damage within these recovering families.[123]

Another unique resource implemented by the Texas Health & Human Services Commission is the Pregnant and Postpartum Intervention (PPI) program, intended to provide pregnant women and new mothers, either who currently have or are at risk of developing a substance use disorder, with specific intervention services.[124] These

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[120] *Id.*

[121] *Women with Children, Specialized Female and Single Women Intensive & Supportive Residential*, SANTA MARIA HOSTEL, https://www.santamariahostel.org/the-road-to-recovery-2/residential/ (last visited Dec. 02, 2021). Intensive residential treatment requires attendance of 30 hours per week of trauma-informed and evidence-based curricula to stabilize addictive behavior, primarily focusing on drug refusal and relapse prevention. Supportive residential treatment is a 30-day program for women who require fewer hours of treatment but still need structure in their lives, requiring the attendance of 10 hours of groups per week, still allowing them to seek employment and attend outside support groups during their residency there. *Id.*

[122] *Id.*

[123] Valera Jackson, *Residential Treatment for Parents and Their Children: The Village Experience*, 2 SCI. & PRAC. PERSPS. 44, 51 (2004); For pregnant women at a residential facility in Miami who delivered their children during the course of treatment, there were significantly lower rates of low-birth-weight babies, premature deliveries, and infant deaths than a national sample of pregnant women. *Id.*;A study done on mothers with young children at a residential facility in South Carolina found success in reversing maladaptive behavior in children exposed to their mother's substance abuse, in addition to significant improvements in the mother's drug abuse and habits. Therese Killeen & Kathleen T. Brady, *Parental Stress and Child Behavioral Outcomes Following Substance Abuse Residential Treatment*, 19 J. SUBSTANCE ABUSE TREATMENT 23, 28 (2020) https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(99)00078-1/fulltext.

[124] TEXANS CARE FOR CHILDREN, KEY HEALTH PROGRAMS AND SERVICES AVAILABLE TO TEXAS MOTHERS 6 (2019), https://static1.squarespace.com/static/5728d34462cd94b84dc567ed/t/5d9f8aabf6bd092b35d654c0/1570736812687/part1-maternal-health-programs.pdf.

programs extend outreach, screening, and referral services, with the ultimate goal of reducing prenatal substance exposure by getting to these women early and granting them access to prenatal care and treatment resources as quickly as possible.[125] Advocates within these programs target areas where women may be particularly at a higher risk of struggling with substance abuse, such as homeless shelters, crisis centers, and methadone clinics.[126] The services and resources provided by PPI programs provide a strong complement to general substance abuse treatment or residential treatment, creating an additional support network and generating a stronger connection between these women and the community they live in.[127] The positioning of local child protection agencies and legislators can allow for the quick detection of women who need these services and creating a plan of safe care with them, developing a foundation of collaboration intended to help guide these women to an early recovery rather than have to resort to harsher penalties or extreme consequences, such as future removal and incarceration.[128]

These types of programs establish a much-needed standard of equity by providing pregnant people and parents with young children the same opportunities to recover from their addiction as those who are not, making room for their unique circumstances by interfacing health and social service agencies in a manner oriented towards long-term recovery and safety.[129] There is a current need to reevaluate and restructure legislation to focus on prosecuting legitimate cases of child abuse, neglect, and endangerment, while also giving women who voluntarily would like to seek treatment the opportunity to do so.[130] For example, the Tennessee fetal assault law, while controversial in its

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[125] *Id.*

[126] *Id.*

[127] *Pregnant Postpartum Intervention*, ALIVIANE, https://www.aliviane.org/services/intervention/pregnant-postpartum-intervention-ppi/#:~:text=The%20Pregnant%20Postpartum%20Intervention%20(PPI,of%20developing%20substance%20use%20disorders (last visited Dec 14, 2021).

[128] The unique role and opportunity that child protection agencies hold will be discussed in depth in subsection C of this Comment. *See* discussion *infra* Part C.

[129] SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., FAMILY-CENTERED TREATMENT FOR WOMEN WITH SUBSTANCE USE DISORDERS - HISTORY, KEY ELEMENTS, & CHALLENGES 26 (2007), https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf.

[130] Elms, *supra* note 116, at 6.

current state, provides a strong opportunity for development in allowing women the opportunity to invoke an affirmative defense to prosecution by actively enrolling in an addiction recovery program before the child is born, remaining in the program after delivery, and successfully completing the program.[131] Allowing women to place both their health and children as a priority, rather than obligating them to choose one over the other, removes a great deal of the stigma and fear of prosecution that comes with them stepping forward and admitting they need help.[132] Legislators and policymakers hold the responsibility of distributing this said equity by following closely the approach laid out by the state of Texas, using these programs as a tool and reference to establish a reparative framework oriented towards long-term recovery, instead of continuing with the proven-unsuccessful yet traditional gateway to incarceration.

B. The Family First Prevention Services Act as a Framework

The Family First Prevention Services Act of 2018 ("FFPSA") allows states and tribes access to federal funding to provide low-income children and families with alternatives to foster care placements in situations where substance abuse and other potential issues may be involved.[133] The legislation's intent was to change the direction of the current child welfare system, rectifying these situations in a way that helps spare children the trauma that comes when they are placed in out-of-home care prematurely.[134] The law established the Title IV-E Prevention Services Clearinghouse, consisting of "a continuously updated comprehensive list of evaluated and tested prevention services and programs that states can use title IV-E funds toward to prevent

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[131] ORISHA A. BOWERS ET AL.TENNESSEE'S FETAL ASSAULT LAW: UNDERSTANDING ITS IMPACT ON MARGINALIZED WOMEN 8 (2014), https://www.pregnancyjusticeus.org/wp-content/uploads/2020/12/SisterReachFinalFetalAssaultReport_SR-FINAL-1-1.pdf.

[132] *Id.*

[133] CONNIE HICKMAN TANNER & HON. KAREN HOWZE, NAT'L COUNCIL JUV. & FAM. CT. JUDGES , THE ROLE OF THE COURT IN IMPLEMENTING THE FAMILY FIRST PREVENTION SERVICES ACT OF 2018 1, 3 (2019), https://familyfirstact.org/sites/default/files/NCJFCJ%20%20Families%20First%20Publication%20Final.pdf.

[134] *Family First Prevention Services Act*, CHILD WELFARE INFO. GATEWAY (2022), https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/family-first/ [hereinafter *Family First*].

disruption within families."[135] Additionally, the act requires judicial oversight for the various options it sets forth, including family reunification services, foster care placements, and qualified residential treatment programs.[136] The role that courts play in implementing the FFPSA on a nationwide basis ultimately works to create incentives for states to adhere to the recommended practices laid out by the act, as well as shift the nation's focus to work in the family's long-term best interests when working with pregnant and parenting women struggling with substance abuse.[137]

The act lays out a framework for the prevention of child maltreatment, setting up three levels of prevention and encouraging states to implement their respective strategies in a manner that would increase uniformity.[138] For primary prevention, these strategies focus primarily on providing public awareness and general parent education and support groups intended to establish deeper connectivity between families and the community resources around them.[139] Secondary prevention zones focus specifically on populations of higher risk children exposed to substance abuse within the home, utilizing home visiting programs and directions to family resource centers that can provide families with more information and referral services catered to their circumstances.[140] Lastly, tertiary prevention is exclusively for families where there is already some form of maltreatment occurring, such as exposure to substance abuse, hoping to reduce negative consequences and prevent its reoccurrence by using coupling more intensive family preservation and mental health services.[141]

From a federal standpoint, the act holds great potential for rectifying some of the major inconsistencies and discrepancies experienced by granting states the option to handle this issue however they see fit. To begin, the key terms in the legislation are uniform for all states, with

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[135] *Id.*

[136] TANNER & HOWZE, *supra* note 134, at 4-5.

[137] *Family First*, *supra* note 135.

[138] *Framework for Prevention of Child Maltreatment*, CHILD WELFARE INFO. GATEWAY (2022), https://www.childwelfare.gov/topics/preventing/overview/framework/.

[139] *Id.*

[140] *Id.*

[141] *Id.* These services are made available to families 24 hours a day for a short period of time, usually between six to eight weeks. *Id.*

court judges setting a standard for how they are to be applied under their state law and eliminating the opportunity for these terms to be interpreted differently across state borders.[142] Attorneys and legislators alike are granted the responsibility of developing state protocols in accordance with the model licensing standards set forth in the act, and Court Improvement Program Directors are tasked with training attorneys and judges on how to complete certain procedures in uniformity with the act, such as how to properly complete the non-family foster home setting review process.[143] Pushing states to align themselves with the FFPSA not only provides those states with significant funding to increase access to substance abuse services for these women but also lays out a framework in which state and federal agencies, intervention and treatment programs, courtrooms, and child protection services can use their roles to interface and collaborate on creating as close to a uniform nationwide approach to the problem as possible.[144]

C. CPS: A Shield, Not a Sword

In terms of how states employ the position of child welfare agencies to respond to cases concerning prenatal substance abuse within their jurisdictions, there is also very little federal guidance in terms of how they should best proceed, creating further unevenness. When CAPTA was amended in 2003, it required healthcare providers to make reports to their state's respective department of Child Protective Services ("CPS") on any substance-exposed pregnancy or newborn they encountered. Congress specifically outlined that any initial report of this kind made to CPS was not to be construed as on its own either establishing a presence of child abuse or creating a basis for prosecution for illegal action[145] The legislation also identified that following an

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[142] ABA CTR. ON CHILD. & L., LEGAL PROFESSIONAL ROLES: IMPLEMENTING THE FAMILY FIRST PREVENTION SERVICES ACT 2, https://www.americanbar.org/content/dam/aba/administrative/child_law/ffpsa-legal-roles.pdf.

[143] *Id.*

[144] On the act, the Texas Department of Family and Protective Services has stated: "The agency shares these goals and the State has made strides in addressing these as evidenced through the policy and funding decisions made during the recent biennia." *Family First Prevention Services Act*, TEX. DEPT. FAM. & PROTECTIVE SERV., https://www.dfps.state.tx.us/Child_Protection/Family_First/default.asp. (last visited Dec. 14, 2021).

[145] U.S. DEPT. HEALTH & HUM. SERV., SUBSTANCE-EXPOSED INFANTS: STATE RESPONSES TO THE PROBLEM, 3 (2009), https://ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf.

initial report to CPS, a plan of safe care should be drafted for the child at risk, in conjunction with procedures being initiated for immediate screening, risk and safety assessments, and prompt investigation.[146] In other words, additional steps must be taken by the state, its respective child welfare agency, and the healthcare providers involved to thoroughly understand whether or not child abuse or illegal action are even present.

However, the previously-established examples of more punitive states moving quickly to initiate removal and civil action against the mother based upon this initial report only demonstrate how Congress' intention for this legislation has not always been followed closely, laying out the necessity for change in how the position and power of CPS are being used. In the state of Texas, the process begins when the Texas Department of Family and Protective Services ("DFPS"), which includes Texas' branch of CPS, receives an initial report of child abuse or neglect and examines it to determine the validity of the claims.[147] This is predominantly done through conducting interviews and home visits with family members and others who may have knowledge of the situation that could help make this determination, resulting in the agency making a ruling on each allegation.[148] If the investigator concludes that the child or children in the household are unsafe, they are granted the discretion of either offering services to the family, referring the case to Family-Based Safety Services ("FBSS"), or filing a petition in civil court for the removal of the child or children from home.[149]

Turning the case over to FBSS is a common choice for many investigators due to the fact that the services provided can be customized and individualized for each case, attempting to work with family preservation before having to turn to removal.[150] FBSS is specifically designed to either make it possible for children to return home after a necessary period of removal or keep them within the home to begin with, focusing on stabilizing the family and reducing the risk of further

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[146] *Id.*

[147] *Child Protective Investigations (CPI)*, TEX. DEPT. FAM. & PROTECTIVE SERV. (2021), https://www.dfps.state.tx.us/Investigations/default.asp.

[148] *Id.*

[149] *Id.*

[150] *Family-Based Safety Services (FBSS)*, TEX. DEPT. FAM. & PROTECTIVE SERV., https://www.dfps.state.tx.us/Child_Protection/Family_Support/FBSS.asp.

abuse or neglect.[151] Some examples of services made available to families through FBSS include "family counseling, crisis intervention, substance abuse treatment, domestic violence intervention, and daycare," as well as resources for "one-on-one parenting and homemaker skills" in areas where it might be more challenging to access community-based services.[152] Services provided by FBSS may also be accompanied by Family Group Decision Making activities or Family Team Meetings, which are focused on establishing collaboration between the family and CPS by guiding meetings that enhance communication and learning between the two, as well as parenting classes providing individual training to parents based on their case.[153]

Child welfare agencies are also required by federal law to make reasonable efforts to reunify or achieve timely permanency for children to have been removed from their homes and placed into out-of-home care, with the words 'reasonable efforts' leaving room for a wide variety of options.[154] In the case that removal is determined as the safest option for the child or children at risk given the circumstances of the situation, specific goals should be set to ensure that those 'reasonable efforts' required by federal law are met, with the best interest of the whole family as the priority. For mothers who may have their sobriety or interest in continued treatment threatened by the removal of their children, allowing her to remain active in some of her roles and responsibilities as a mother throughout her recovery may be a productive option.[155] Further, for mothers who are able to demonstrate to the state's satisfaction that they have achieved sobriety and are engaged with proper outpatient treatment, monitored reunification should also be placed as a priority so as to allow for the child or children to return

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[151] *Id.*

[152] *Id.*

[153] *Child Protective Services (CPS)*, TEX. DEPT. FAM. & PROTECTIVE SERV., https://www.dfps.state.tx.us/child_protection/.

[154] ABA CTR. ON CHILD. & L., CHILD WELFARE COURT CASES INVOLVING PRENATAL SUBSTANCE USE: POLICY CONSIDERATIONS, 11 (2021), https://www.americanbar.org/content/dam/aba/administrative/child_law/prenatal-substance-use-case-law-policy-brief-508.pdf; 45 C.F.R. §1356.21(b)(2) (2012).

[155] Grant & Graham, *supra* note 110, at 2. Some options set forth could include "kinship/relative care with appropriate contingencies, foster care with increasing but supervised mother/child visitation, supervised transitional group home settings, or residential treatment facilities for mothers and children." *Id.*

to the mother's care on a contingent basis of the continuation of these activities.[156]

These agencies should make use of the position they have to truly investigate the unique circumstances and dynamics present in their cases in order to be as productive as possible, using their power as a shield to protect these children and families, not as a sword to bring them further harm. As states consider how to best establish a more uniform approach to the problem, the example set forth by Texas of how the state has successfully been able to engage this particular at-risk community with the services available to them is one that should be followed closely. Additionally, the continuative understanding that punitive approaches simply do not work as intended and that removal oftentimes causes more harm than benefit is one that should underlie the direction that states take in moving forward.

V. ADDITIONAL ALTERNATIVES TO PUNITIVE RESPONSES

A. Cooperation Between OBGYNs and State Legislators

Obstetrician-gynecologists ("OBGYNs") hold a unique position from which they are able to gain sensitive and intimate information about a woman's pregnancy and the condition of her fetus, giving them the opportunity to either use that information to expose the mother to harsh penalties or provide her with an individualized response upon the discovery of prior or current substance abuse.[157] Due to this unique position, OBGYNs are also particularly exposed to a set of opportunities to lead intervention for substance abuse treatment from within their clinics in a manner that is both private and tailored to each women's circumstances and needs.[158] In a safe and private setting, OBGYNs can work to actively create a space in which they can specifically provide mothers with a history of or currently struggling

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[156] *Id.*

[157] AM. COLL. & OBSTETRICIANS & GYNECOLOGISTS, SUBSTANCE ABUSE REPORTING & PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST 1-2 (2011), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist [hereinafter *Substance Abuse Reporting*] (a committee report from the American College of Obstetricians and Gynecologists outlining the role of OBGYNs in addressing the rising concern over prenatal substance abuse).

[158] *Id.*

with substance abuse access to the appropriate information they need on the topic, opening a discussion and establishing trust between the two to prioritize treatment and recovery.[159]

While mandatory drug screening and testing at appointments can help provide clarity past any potential shame or dishonesty the mother may have when discussing her drug use, healthcare providers should be given discretion in reporting to CPS rather than being required to do so immediately.[160] Privately referring these mothers to addiction treatment professionals quickly and creating an individualized, guided, and monitored program in which they receive active treatment throughout their pregnancy aligns with current research on the topic, identifying that these kinds of programs intertwined with regular prenatal care have been proven to significantly reduce maternal and fetal pregnancy complications and costs.[161] Additionally, working directly with researchers to address gaps in the literature and emerging issues within the field makes strong use of the unique position that OBGYNs hold with the access they have to these women, gaining a deeper understanding of how the problem continues to evolve over the years.[162]

Further, the insider perspective that OBGYNs have on the issue can significantly assist legislators and policymakers in addressing the drawbacks of punitive legislation, instead shifting the course to draft evidence-based strategies intended to help these women overcome their addictions in a manner that then allows for them to be strong and clean mothers for their children.[163] OBGYNs can better inform legislators on how they can create a structured framework that is supported by what they see as successful from within their own clinics, also helping them effectively pull back on what they have collectively seen to be unsuccessful.[164] Nurses, physicians, and OBGYNs themselves could serve as strong advocates for these women in court cases, attesting to

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[159] *Id.*

[160] *Id.;* Mary Anne Armstrong et al., *Perinatal Substance Abuse Intervention in Obstetric Clinics Decreases Adverse Neonatal Outcomes*, 23 J. PERINATOLOGY 3, 8 (2003), https://www.nature.com/articles/7210847.pdf.

[161] *Substance Abuse Reporting*, *supra* note 158.

[162] *Id.*

[163] *Id.*

[164] *Id.*

the efforts they have made to desist from substance use and the value they place on the health of their pregnancy.[165] Overall, the constructive and productive manner through which OBGYNs can use their position to guide women towards treatment rather than drive them away from receiving the proper prenatal care they need helps break against the harmful effects caused by punitive policies, instead helping act in alignment with the welfare of both the mother and fetus.[166]

B. The Potential of Telemedicine

The convergence of modern science and technology has permitted the presentation of telemedicine, with the growth of this resource leading more patients to accept its legitimacy and reliability on a daily basis.[167] Out of necessity to adhere to the conditions created by the spread of the COVID-19 pandemic, telemedicine has become that much more of a crucial component within the healthcare industry to ensure that patients are able to access the resources they need without having to leave their homes.[168] Prior to the pandemic, case studies were already indicating that a combination of telemedicine and in-person care for pregnant women struggling with substance abuse has proven to be successful in managing important aspects of treatment, including weekly medication management and relapse prevention, as well as prenatal care, establishing direct care with an obstetrician and addiction specialist at the same time.[169]

A concern many have with telemedicine is that it produces a diminished quality of healthcare in comparison to what an in-person visit can provide, but recent studies have directly responded to this concern. A normalized controlled trial was conducted with 98 women receiving perinatal treatment for OUD from September 2017 to December 2018, with some receiving their treatment and obstetric resources

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[165] Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 1, 14 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/pdf/40352_2015_Article_15.pdf.

[166] *Substance Abuse Reporting*, *supra* note 158.

[167] *See* Oleg Bestsennyy et al., *Telehealth: A quarter-trillion-dollar post-COVID-19 reality?*, MCKINSEY & CO. (July 9, 2021), https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

[168] *Id.*

[169] *Id.*

through telemedicine and others in person.[170] All women received the same addiction treatment during their pregnancy through 6 to 8 weeks postpartum, produced urine drug screens both at delivery and 6 to 8 weeks postpartum, and received a NAS diagnosis with electronic health records.[171] The results of the study indicated that there were virtually few to no differences between the maternal and newborn quality of care and outcomes produced by telemedicine in comparison with in-person care, also having no significant differences in rates of NAS in newborns.[172] In other words, the women who attended their appointments in person faced no greater benefit than the women who attended their appointments online.[173] While larger and more randomized clinical trials are required to continue solidifying this area of literature, the findings of the study present significant and notable public health implications for combatting this public health concern from within the home.[174]

Allowing women to hold onto the privacy and comfort that their home can provide them in getting help for an issue that is still largely stigmatized can ultimately make them more willing to receive treatment, as well as open availability and access to resources for women who might not have the ability to travel to clinics. This year, the Boston Medical Center was the first clinic to develop "BMC MAT," a mobile application focused on helping providers deliver evidence-based opioid addiction treatment, making various tools available for patients and providers, such as guidelines, scales, and tests intended to help with managing medication and measuring progress.[175] The app was

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[170] Constance Guille et al., *Treatment of Opioid Use Disorder in Pregnant Women via Telemedicine*, 3 JAMA NETWORK OPEN 1, 1 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7042863/.

[171] *Id.*

[172] *Id.*

[173] *Id.*

[174] *Id.*

[175] *BMC Launches App to Help Providers Treat Patients with Opioid Use Disorder*, BOS. MED. CTR. (Mar. 22, 2021), https://www.bmc.org/news/bmc-launches-app-help-providers-treat-patients-opioid-use-disorder. The Boston Medical Center has previously been a site for conducting studies on providing therapy to pregnant women with opioid use disorder, developing the Project RESPECT Clinic in 2006 to specifically provide prenatal and postpartum substance abuse resources. Kelley Saia et al., *Prenatal Treatment for Opioid Dependency: Observations From a Large Inner-city Clinic*, 12 ADDICTION SCI. & CLINICAL PRAC. 1, 1 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5237261/.

primarily developed to help address the opioid addiction crisis, hoping to use the scope of the app being completely mobile to reach hundreds of thousands more patients who might not be insured or might not otherwise have access to the resources they need, including women who are pregnant.[176] Telemedicine creates an entirely new space in which patients with specific needs, here precisely being pregnant and parenting women seeking to overcome their substance abuse, can have access to the medical professionals, information, medications, and other resources they need in a way that should be embraced as a recognition and appreciation of what modern science and technology can come together to provide.

CONCLUSION

The first step in resolving the problem of prenatal and maternal substance abuse in America has to do with recognizing that the real issue at the core is the addiction that these women are struggling with, driving the direct and indirect consequences and costs described in this Comment. The intention of this Comment is not to diminish the responsibility that these women have to be devoted mothers who prioritize the health and wellbeing of their children but rather to shed light on the fact that the traditional, incarceration- and punitive-oriented approach taken up by most states, simply has not worked. This, coupled with the lack of uniformity expressed by states throughout the nation, ultimately presents an incredibly unfair and disproportionate framework, one that only continues to enlarge existent disparities and exacerbate the problem by ignoring its real causes.

Each of the individual pieces of legislation, programs, and agencies mentioned hold significant value on their own but should be taken together as a collective to work towards the development of a nationwide framework intended to incite collaboration among states rather than continued disagreement. While it may be challenging, perhaps even near impossible, to bring all fifty states together in implementing completely equal laws and programs, the idea is to reduce the level of disparity and unevenness currently present as much as possible, giving all American women close to the same opportunity for recovery. Undoing the damage done by a timeline of misguided case law comes

[176] *Id.*

with understanding the genuine intention behind the creation of these pieces of legislation, programs, and agencies, moving forward from the apparent mistakes that are driving against progress, and providing states with the facts and incentives, they need to collaborate rather than attempt to tackle the issue on their own. Once the extremely high level of stigma and shame surrounding these women is diminished, the possibilities for attacking the real issue of addiction at the heart of American society are unlimited, making room for the emergence of a framework intended to help these mothers become clean, reliable care-givers for their children.