COPY

IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

STATE OF NEW MEXICO,

Plaintiff-Petitioner,

v.

No. 29,775

CYNTHIA MARTINEZ, a/k/a
CYNTHIA NAVARETTE,

Defendant-Respondent.

APPENDIX TO BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION OF NEW MEXICO, PLANNED PARENTHOOD OF NEW MEXICO, and NEW MEXICO WOMEN'S JUSTICE PROJECT IN SUPPORT OF DEFENDANT-RESPONDENT

On Writ of Certiorari to the New Mexico Court of Appeals
Following Direct Appeal from the Fifth Judicial District Court
The Honorable William McBee, District Judge
Lea County, New Mexico

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Helene M. Cole, MD, *Section Editor*

Legal Interventions During Pregnancy

Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women

ORDINARILY, the pregnant woman, in consultation with her physician, acts in all reasonable ways to enhance the health of her fetus. Indeed, clinicians are frequently impressed with the amount of personal health risk undertaken and voluntary self-restraint exhibited by the pregnant woman for the sake of her fetus and to help ensure that her child will be as healthy as possible.[1] In a limited number of situations, however, a pregnant woman may reject a medical treatment or procedure that her physician believes would benefit the health of her fetus. For instance, she may refuse to submit to a cesarean section when her physician believes that a cesarean section is in the best interests of the fetus. Or a pregnant woman may behave in ways that are potentially detrimental to fetal well-being, for example, taking illegal drugs while pregnant.

Increasingly, legal interventions are being sought in cases in which the decisions or actions of pregnant women do not accord with medical recommendations that could benefit fetal health. Physicians have sought, and some courts have granted, permission to override refusals of pregnant women to submit to medical procedures. Public officials have tried to impose legal penalties on women whose behavior is not in the best interest of the fetus. This report, which is based on the deliberations of the Committee of Medicolegal Problems, discusses the various legal and policy concerns and makes recommendations regarding legal interventions in pregnancy.

SEEKING COURT ORDERS TO OVERRIDE THE MEDICAL PREFERENCES OF PREGNANT WOMEN

Recent Medical Advances Enable Physicians to Address the Health of the Fetus More Directly

Until recently, promoting fetal well-being was generally not a separate endeavor from promoting the health of the pregnant woman. Advances in medicine and surgery, however, have increased the ability of physicians to direct medical procedures specifically at the fetus. Diagnostic tools, such as ultrasonography, amniocentesis, or chorionic villus sampling, can be used to detect fetal abnormalities that, in some cases, may be treated through prenatal therapy or fetal surgery.[2]

The ability to treat the fetus more directly than in the past has given rise to the question of whether a pregnant woman has a legal obligation to undergo medical treatments that could benefit the fetus. When a pregnant woman refuses treatment or procedures that could benefit fetal health, a conflict arises between her right to make medical decisions that affect the health of her fetus and herself and the state's desire to intervene on behalf of the fetus.

Questions and concerns over a pregnant woman's legal obligations to accept medical care are exacerbated by the unique physical relationship that exists between a pregnant woman and her fetus. Invariably, one cannot be treated without affecting the other. Performing medical procedures against the pregnant woman's will violates her right to informed consent and her constitutional right to bodily integrity.[3,4] These rights are among the most basic and are well established in both society and medicine. However, preservation of these rights may come at the risk of preventable fetal impairment or death.

Moral and Legal Responsibilities of the Pregnant Woman Toward Her Fetus

A woman who chooses to carry her pregnancy to term has a moral responsibility to make reasonable efforts toward preserving fetal health. This moral responsibility, however, does not necessarily imply a legal duty to accept medical procedures or treatments in order to benefit the fetus.

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Legal Precedent.—Several courts have considered the issue of legal interventions to impose medical treatments on pregnant women. However, few requests for court-ordered obstetrical interventions have been reviewed by appellate courts. Only two appellate courts have considered a decision to override a pregnant woman's refusal of a blood transfusion. In 1964, the New Jersey Supreme Court ordered a blood transfusion for a pregnant woman who refused the transfusion on religious grounds.[7] Also in 1964, an appeals court in the District of Columbia ruled that a pregnant woman could be forced to undergo a blood transfusion for the sake of her fetus.[8] However, both of these cases were decided in the early 1960s, before the current legal emphasis on the integrity of the individual and the right to refuse treatment.

Approximately two dozen courts have been asked to order cesarean sections.[9] Only two of these cases have reached the appellate level. In one, a trial court judge in the District of Columbia ordered a cesarean section on a woman who was terminally ill.[10] The woman's treatment desires and her competency were major points of controversy in this case. The District of Columbia Court of Appeals, en banc, ruled that the lower court was in error for ordering the cesarean section. The court of appeals ruled that rather than weighing the interests of the state (in protecting the potential life of the fetus) against the interests of the pregnant woman, the lower court should have used "substituted" judgment and proceeded according to what it could best ascertain the pregnant woman's wishes would have been.

In 1981, a trial court in Georgia ordered a cesarean section performed on a woman who had refused the operation for religious reasons. The physician involved diagnosed placenta previa, with a 99% to 100% chance of fetal demise if vaginal delivery occurred.[11] The Georgia Supreme Court, with minimal explanation or policy discussion, refused to stay the trial court's order. A few days after the court's denial of a stay, the woman had a safe vaginal delivery.

The remainder of this section of the report provides an analysis of relevant law and policy considerations and recommends guidelines on the extent to which a pregnant woman's moral duties toward the fetus should be legally enforced.

Distinctions Between Moral and Legal Responsibilities.—Society places a positive moral value on aiding those who may need help or be in danger, yet it does not ordinarily impose a legal duty on specific individuals to render that needed assistance.[12] This reluctance to impose a legal duty on the individual is especially strong where rendering aid would pose a risk to the health of the individual or would require an invasion of his or her bodily integrity.[4,12,13]

There is also no legal duty for an individual to render aid even if a life would be saved and the assistance rendered would incur minimal risk to the health of the person providing the aid. For example, a person need not donate bone marrow to a cousin who is dying of aplastic anemia.[13]

Yet the responsibility of a pregnant woman to her fetus is stronger than that of one individual to another. The duty of a pregnant woman to her fetus is more akin to the obligations of a parent to his or her child. And in fact, a parent's duty to his or her child is enforced with legal sanctions. The parent-child relationship is considered a "special relationship" under "Samaritan" law.[12] Samaritan law, which applies to duties to render aid, provides that those people who have a special relationship to another person, such as innkeeper to guest or common carrier to passenger, have a legal obligation to come to the aid of that person.[12]

Even in cases of special relationships, however, the obligation to render aid is minimal and cannot require the rescuer to endanger him or herself.[12] For example, if a child needed a bone marrow transplant, but the only compatible donor was the child's father, the father would not be legally required to donate his bone marrow to his child.

There are other situations in which a parent's obligation to his or her child is legally enforced. Parents clearly have both a moral and legal duty to provide reasonable medical care for their children. All states legally require parents to provide such care.[14] A pregnant woman who refuses a surgical intervention, treatment, or therapy that might benefit fetal health is, in practical terms, withholding medical care from her fetus. However, in the case of a pregnant woman, in order for her *not* to withhold medical treatment, she generally must accept a risk to her life or health, as well as bodily invasion of her person. Just as parental legal obligations to provide medical care to children do not include compelled acceptance of risk to life or health, neither should a pregnant woman's obligations to her fetus include the acceptance of such risk.

Current procreative law reflects this principle. Under *Roe v Wade*, the state's interest in potential life becomes compelling at the point of viability.[15] It is at that point, therefore, that the state may prevent a woman from having an abortion. Nevertheless, the state may not adopt postviability abortion regulations that trade off risks to the health of the pregnant woman against benefits to the health of her fetus.[16]

In addition, legally enforcing a pregnant woman's moral obligation to the fetus creates a burden or penalty on pregnancy itself.[17] The right to bear a child is constitutionally protected.[2] Forcing a pregnant woman to undertake a health risk or to accept an invasive procedure against her will burdens her decision to have a child.[2]

Even a viable fetus does not generally receive the same legal recognition as a child. Consequently, the legal enforcement of a pregnant woman's moral responsibility to her fetus should not exceed the legal enforcement of a parent's moral duty to his or her child.[18] Society does not legally require parents to undergo a risk of life, health, or bodily invasion in order to carry out their moral obligations to provide medical care for their children. Few, if any, medical procedures meant to benefit the fetus would entail no risk to a pregnant woman's health. Thus, while a pregnant woman should be resolutely encouraged to fulfill her moral responsibilities to her fetus, a legal duty to accept medical procedures meant to benefit her fetus generally should not be imposed.

Ethical Obligations of the Physician in Instances of Treatment Refusal

A physician's ethical duty toward the pregnant woman clearly requires the physician to act in the interest of the fetus as well as the woman. Arguably, adherence to a pregnant woman's refusal of treatment that is intended to benefit the fetus would violate that ethical obligation, particularly when the physician believes that the potential benefit to the fetus outweighs the health risk to the mother. While some physicians find adherence to a pregnant woman's wishes morally untenable in situations of fetal endangerment,[1] the duty to protect the health of both the pregnant woman and the fetus precludes balancing one against the other. The physician's

onsibilities in other settings provide a useful analogy, eg, e is no situation (other than perhaps the case of conjoint s) when it is appropriate for a physician to impose a ical risk on one patient in order to preserve the health of her. A physician cannot force one patient to donate blood nother patient, even if the donation would save the second ent's life. Similarly, such a balancing should generally not ndertaken in the context of pregnancy.

he doctrine of informed consent also indicates that a preg- woman's refusal of treatment should not be overridden the benefit of the fetus. Principles of informed consent ire a physician to respect the wishes of a mentally compe- adult in situations of medical decision making.[3] These ciples recognize that decisions that would result in health s are properly made only by the individual who must bear risk.[1,19] Considerable uncertainty can surround medical uations of the risks and benefits of obstetrical interven- s.[19-22] Through a court-ordered intervention, a physician rives a pregnant woman of her right to reject personal risk replaces it with the physician's evaluation of the amount sk that is properly acceptable.[1] This undermines the very cept of informed consent.

erse Consequences of Seeking Court-Ordered tetrical Interventions in Instances of atment Refusal

here are additional reasons why seeking a court order is necessarily an appropriate response to a pregnant wom- treatment refusal.

Court Is an Inappropriate Forum for Resolving Treat- nt Disputes.—Courts are ill-equipped to resolve conflicts cerning obstetrical interventions. The judicial system or- arily requires that court decisions be based on careful, ised deliberation and the cautious consideration of all facts related legal concerns. In addition, there is always an ortunity for review on appeal. Court-ordered obstetrical rventions, on the other hand, are likely to be requested on remely short notice and require immediate judicial action. tudy done of court-ordered obstetrical interventions re- ted that in 70% of cases in which orders were considered, pital administrators and attorneys were aware of the situ- n only a day or less before seeking a court order; 88% of the ers were obtained in less than 6 hours, and in 19%, less n an hour.[9] It is unlikely that most judges would already be iliar with the policy concerns or relevant legal precedents uired to make a carefully considered decision on such short ice.[20] Decisions made under these immediate deadlines and ense pressures are likely to be hasty and lack well-rea- ied conclusions. In the case of an improperly reached con- sion, there is no meaningful appeal available.[20]

n addition, such court proceedings may be unfairly weight- against the pregnant woman. A woman in such a situation robably under considerable psychological stress and may suffering from substantial physical pain as well. Her ability articulate her interests may be seriously impaired. It is ther unlikely that the woman will be able to find adequate nsel on such short notice, and it is even more unlikely that nsel will have time to prepare properly for the hearing.

When a decision must be rendered almost immediately, re will be little or no time to obtain the full range of medical nions or facts. The inability of a court to understand the full ge of the relevant medical evidence may lead to error with serious and irreversible consequences.

The Bases for Selecting Cases for a Court Order May Result in the Inconsistent Application of Compelled Treatment.—A physician's decision to pursue a court order reflects his or her personal evaluation of the importance of a pregnant woman's autonomy vis-à-vis the importance of fetal health. Accordingly, whether a woman must undergo judicial review of her decision regarding medical care will vary from physician to physician.

A troubling fact is that court-ordered obstetrical interventions seem to be sought more often in cases where the woman is either a member of a minority group or of a lower economic background. According to an initial study,[9] in 81% of the instances in which a court-ordered intervention was sought, the woman belonged to a minority group. Every request for a court order involved a woman who had received care at a teaching hospital or who had received public assistance.

Women from lower socioeconomic groups and from differing ethnic backgounds may have religious and other personal beliefs or circumstances that vary greatly from those of their physicians or the judges who decide their cases.[20] A woman's reasons for refusing care may be misunderstood or disregarded by the physician seeking the court-ordered override of her decision or by the judge who decides the case.

Creating Impermissible Legal Obligations for the Physician.—An important consideration for physicians is the extent to which they should encourage or contribute to state or court intervention in the medical decision-making process in general. Physicians have traditionally rejected outside intrusion into the physician-patient relationship. Imposing legal duties to accept medical care on pregnant women may result in concomitant legal duties for the physician. Such duties may require the physician to act as an agent of the state rather than as an independent patient counselor.

Judicial intervention is often sought in part to minimize either physician or hospital liability. However, seeking such interventions could ultimately serve to expand rather than limit liability.[1] The tendency to resort to judicial intervention in cases of treatment refusal may create an obligation for the physician to obtain a court order in any situation in which a pregnant woman's preference does not accord with the physician's evaluation of the fetus' needs. If a pregnant woman's obligations to the fetus become legally enforceable, then it is up to the physician to decide in which situations a woman is shirking her legal obligations by rejecting proposed care. Courts may therefore consider a physician negligent for not seeking a court order in situations where a pregnant woman's decision led to fetal impairment.

Another consideration is the extent to which a physician would be required to participate in the practical aspects of enforcing an override of a pregnant woman's treatment decision.[23] In one case in which a court granted permission to a hospital to perform an unwanted cesarean section, the pregnant woman left the hospital before delivery.[7] Should a court choose to enforce an override by compelling the woman to accept treatment, severe methods of restraint may be required. A pregnant woman may have to be forcibly restrained to prevent her from leaving the hospital or physical force may have to be used in order to administer a particular medicine to her. Inviting the state to override a pregnant woman's decision legally may also be inviting government-mandated participation by physicians in administering the treatment. The

physician-patient relationship would certainly be damaged by physician participation in the forcible administration of medical care.[23]

A physician's role is as a medical adviser and counselor. Physicians should not be responsible for policing the decisions that a pregnant woman makes that affect the health of herself and her fetus, nor should they be liable for respecting an informed, competent refusal of medical care. In the interest of preserving fetal health, the physician must ensure that a pregnant woman's decision is a fully informed, competent, and considered decision. A physician should make sure that the pregnant woman understands the nature of the proposed treatment and the implications of treatment and nontreatment for both herself and her fetus. A physician may encourage the pregnant woman to consult other sources, such as family members, health professionals, social welfare workers, or the clergy, to provide her with additional information regarding her decision. When a pregnant woman makes an informed refusal of a procedure meant to benefit fetal health, the physician cannot be held morally responsible for the consequences of the pregnant woman's decision.

Adverse Effects on the Physician-Patient Relationship.—Requests for court intervention may interfere with the physician-patient relationship in other ways. Physician willingness to override a pregnant woman's decision creates an adversarial relationship between physician and patient.[17] In a specific case, the damage to the physician-patient relationship may appear to be outweighed in relation to the benefit to the fetus. However, it may also precipitate general distrust of physicians on the part of pregnant women. Once it becomes known a particular physician or physicians in general are willing to override a pregnant woman's preferences, women may withhold information from the physician that they feel might lead the physician to seek judicial intervention. Or they may reject medical or prenatal care altogether,[7] seriously impairing a physician's ability to treat both the pregnant woman and her fetus. While the health of a few infants may be preserved by overriding a pregnant woman's decision, the health of a great many more may be sacrificed.

Conclusions

The Physician's Professional Duty.—The physician's duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to dictate the woman's decision.

Physicians Should Not Have a Legal Duty to Seek Court-Ordered Obstetrical Interventions.—There may be no other case where patient rejection of medical advice is as frustrating as when a pregnant woman rejects a procedure designed to benefit her fetus.[1] Yet, physicians should refrain from using the courts to impose personal value judgments on a pregnant woman who refuses medical advice meant to benefit her fetus. As a corollary, a physician should not be liable for injuries sustained as a result of honoring a pregnant woman's informed refusal of treatment designed to benefit the fetus.

Justification for Seeking Court-Ordered Interventions May Be Permissible Only in Exceptional Circumstances.—An absolute rule that a pregnant woman has no legal duty to accept any medical treatment that would substantially benefit her fetus would be problematic. For example, a woman conceivably could refuse oral administration of a drug that would cause no ill effects in her own body but would almost certainly prevent a substantial and irreversible injury to her fetus. Given the current state of medical technology, it is unlikely that such a situation would occur. In addition, as a practical matter, it is unlikely that a woman would refuse treatment in that situation.

If an exceptional circumstance could be found in which a medical treatment poses an insignificant—or no—health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should be a control in all cases that do not present such exceptional circumstances.

RESPONSES TO HARMFUL BEHAVIOR BY THE PREGNANT WOMAN

Alarm at the Rising Percentages of Infants Exposed to Harmful Substances In Utero

Currently, attention is increasingly being drawn to instances where the behavior of pregnant women is potentially harmful to fetal well-being. There has been particularly great concern with the incidence of babies born with cocaine in their systems as a result of cocaine use by pregnant women. Hospitals are reporting an alarming rise in the number of births of these drug-exposed infants.[24] The unprecedented rise in cocaine use among women of childbearing age is primarily due to the current popularity of the use of "crack," a concentrated, inexpensive, and highly addictive form of cocaine. Experts estimate that as many as 11% of pregnant women have used an illegal drug during pregnancy, and of those women, 75% have used cocaine.[25-27] The American Medical Association (AMA) Board of Trustees[27] profiled the current problem of substance abuse among pregnant women and discussed the clinical challenges involved in identifying and providing comprehensive treatment for these women.

The alarm with which these figures have been met is not unwarranted. The effects of cocaine use by a pregnant woman on her fetus and subsequently on her infant can be severe. Cocaine can cause in utero strokes, spontaneous abortion, and abruptio placentae.[28-30] It also results in increased infant mortality. On the average, cocaine-exposed babies have lower birth weights, shorter body lengths at birth, and smaller head circumferences than normal infants.[31] They also have a higher incidence of physical abnormalities, including deformed kidneys and neural tube defects.[32] Cocaine-exposed babies often experience withdrawal symptoms that make them more irritable and resistant to bonding than other babies.[33,34] Researchers believe that cocaine-exposed babies will be more likely to experience learning disabilities.[34]

Although drug and other substance abuse by the pregnant woman attracts intense media attention, there are actually a large variety of behaviors that can adversely affect the fetus. Cigarette smoking by pregnant women results in higher rates of spontaneous abortion, premature birth, increased perinatal mortality, low birth weight, and negative effects on later growth and development in infants.[35-37] Many prescription or over-the-counter medicines will cross the placenta and affect fetal health.[35] Exposure to hazardous chemicals heightens the risk for spontaneous abortion, premature birth, stillbirth, low birth weight, and birth defects.[36]

Special mention should be made of alcohol use. Many studies have confirmed the dangerous effects of alcohol use by

ınt women on their infants.[39-41] Babies born with fetal | syndrome suffer from prenatal and postnatal growth ation; cardiovascular, limb, skull, and facial defects; ed fine- and gross-motor function; and impaired intel- . function.[37,38] Despite the serious health effects of alco- ısumption, the legal and social acceptance of alcohol its use particularly difficult to prevent. Further, while ive alcohol use during pregnancy *certainly* can cause s fetal harm, no minimum level of alcohol use has yet stablished as safe.[39-41] The AMA, former Surgeon Gen- oop, and a number of other experts have concluded that bstinence is the only way to ensure no ill effects from l consumption during pregnancy.[42]

Penalties as a Response to Substance e by Pregnant Women

rising percentage of babies born with cocaine in their ns has been matched by the rising frustration of the ı care and legal communities in finding ways to prevent oblem. A growing number of jurisdictions have tried to e legal penalties, often criminal sanctions, in an attempt er drug use by pregnant women.[43] Women have been ed under statutes against child abuse and neglect and livery of a controlled substance to a minor,[44,45] or given l penalties for an unrelated conviction because they pregnant and suspected of cocaine use.[46] Evidence of abuse by pregnant women is being used as grounds for tate's assuming immediate custody of newborns.[47] In ion, other legal interventions, such as civil detention, been sought in order to monitor or control the behavior pregnant woman when her behavior was considered itially dangerous to her fetus.[48,49] For the most part, attempts to criminalize or legally penalize behavior by ıant women have been unsuccessful. Several courts have that existing statutes against child abuse and neglect ɔt be applied to the fetus.[44,50]

me public officials believe that imposing criminal sanc- will deter substance abuse by pregnant women. Howev- any health and social welfare experts feel that the prob- s more effectively addressed as a health concern rather as a legal problem.[51] They further maintain that criminal ions will not only fail to deter pregnant women from ance abuse, they will in fact prevent them from seeking atal care or medical help for their dependency.

carceration or Detention During Pregnancy.—Incar- ion or detention might seem to be the most effective ıs of preventing a specific harmful behavior. Ostensibly, tate could force an incarcerated or detained woman to t behavior that would promote the health of her fetus. ever, incarcerating pregnant women in order to pre- e fetal health may prove counterproductive.

ry attempt at detecting and managing the potentially ıful behavior of pregnant women through legal interven- is likely to require substantial participation on the part of nedical community. For instance, if a pregnant woman's ıns are classified as child abuse, legal obligations are ted for the physician. All states require physicians to rt suspected abuse.[14] Most, in fact, hold health care per- el liable for failure to report, and some states even main- liability for failure to diagnose child abuse properly.[14]

is not unreasonable to assume that at-risk pregnant ıen would be deterred from seeking contact with those people or institutions who might take action leading to their incarceration. Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment. This fear is not unfounded; recently, a pregnant woman who sought medical care for injuries received as a result of a spousal beating was reported to the authorities, arrested, and charged with criminal child abuse for drinking during her pregnancy.[52] The case was subsequently dismissed. In addition, the number of women who are convicted and incarcerated for potentially harmful behavior is likely to be relatively small in comparison with the number of women who would be prompted to avoid medical care altogether. As a result, the potential well-being of many infants may be sacrificed in order to preserve the health of a few.

Imposing criminal or civil sanctions on pregnant women for potentially harmful behavior may also encourage women to seek abortions in order to avoid legal repercussions. In addition, incarceration would be of only limited value since a considerable amount of damage could be done to the fetus before a woman even realized she was pregnant.[32]

Further, while the incarceration of pregnant women would be intended to benefit the fetus, the reality of the environment in which pregnant women would be placed would do little to ensure fetal health. Prisons in general have inadequate health care resources. Moreover, prison health experts warn that prisons are "shockingly deficient" in attending to the health care needs of pregnant women.[53] Most prisons have inadequate protocol, staff, or training to properly attend to the special needs of pregnant prisoners. The result has been widespread deficiencies in prenatal diet, nutrition, and exercise and seriously inadequate, if any, prenatal care. Pregnant women in jail are routinely subject to conditions that are hazardous to fetal health, such as gross overcrowding,[53] 24-hour lock-up with no access to exercise or fresh air, exposure to tuberculosis, measles, and hepatitis, and a generally filthy and unsanitary enviroment. Additionally, it is unclear that incarceration would prevent drug use by pregnant women because drugs are readily available in prison.[46,54]

Legal Penalties Imposed After Birth.—*Criminal Sanctions.*—The most compelling reason that has been proposed for instituting postnatal criminal sanctions in cases of substance abuse by pregnant women is to prevent damage to fetal health. The actual efficacy of criminal sanctions as a method for preventing substance abuse is doubtful, however. Obviously, fetal harm caused by substance abuse is averted only by effecting abstinence from harmful substances by pregnant women. Punishing a person who abuses drugs or alcohol is not generally an effective way of curing their dependency or preventing future abuse. The AMA has stated that "it is clear that addiction is not simply the product of a failure of individual willpower."[55] Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance dependent have impaired competence in making decisions about the use of that substance.

Punishing a person for substance abuse is generally ineffective because it ignores the impaired capacity of substance-abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance. If a preg-

nant woman suffers from a substance dependency, it is the physical impossibility of avoiding an impact on fetal health that causes severe damage to the fetus, not an intentional or malicious wish to cause harm.

A woman's socioeconomic position may further affect her ability to carry out her moral responsibility to provide reasonable care in preserving fetal health. The women most likely to be prosecuted for exposing their fetuses to harmful substances are those from the lower economic levels.[56] These women are more likely to lack access to both prenatal care and substance abuse treatment because of financial barriers.[57] They are often uninsured or underinsured.[58] Even when Medicaid is available, women may still lack access to medical care because of inadequate system capacity.[59]

Access to care does not guarantee that pregnant women will receive drug treatment; one of the most commonly missed diagnoses in obstetric and pediatric medicine is drug abuse.[61] Additionally, many prenatal care facilities do not have the capacity to treat substance abuse.

Pregnant substance abusers also tend to have other severe life stresses that may contribute to their substance abuse. An AMA Board of Trustees[57] report states that female substance abusers tend to have more dysfunction in their families than nonabusers. They have high levels of depression, anxiety, sense of powerlessness, and low levels of self-esteem and self-confidence.[61] A study done by a center that treats female substance abusers found that 70% of them were sexually abused as children, as compared with 15% of nonsubstance abusers.[61] Eighty-three percent had had a chemically dependent parent, as opposed to 35% of the nonabusers.[61] Seventy percent of female substance abusers report being beaten.[61] Ten percent of female substance abusers in one study were homeless, while 50% had occasional housing problems.[61]

Substance dependence and contributing factors cannot be used as an excuse for disregarding the consequences of dependent behavior on fetal and infant health. However, the magnitude of the problem and the influence of aggravating factors may preclude criminal sanctions from being an effective deterrent. For example, the use of illegal substances already incurs criminal penalties. Pregnant women who use illegal substances are obviously not deterred by existing sanctions; the reasons that prompt them to ignore existing penalties might also prompt disregard for any additional penalties. Furthermore, in ordinary instances, concern for fetal health prompts the great majority of women to refrain from potentially harmful behavior. If that concern, generally a strong impetus for avoiding certain actions, is not sufficient to prevent harmful behavior, then it is questionable that criminal sanctions would provide the additional motivation needed to avoid behaviors that may cause fetal harm.

Civil Liability as a Remedy for Harmful Behavior by Pregnant Women.—Regardless of the inefficiency of criminal sanctions, a woman who uses harmful substances during her pregnancy often gives birth to a child who is either impaired or less healthy than the child would have been had the mother abstained from substance abuse. It is widely accepted that if a person other than the pregnant woman acts in such a way that fetal health, and consequently a child's health, is impaired, then that person can be held civilly liable for the impairment.[62] While recovery in such situations is meant to compensate the parents of the impaired child, it may also be used to compensate the subsequent child for injuries resulting from negligent actions during the prenatal period

The consequences of harm may be similar regardless whether the responsible party is the pregnant woman hers or another person (a third party). Some commentators ha stated that to punish third parties but not pregnant wom for actions that result in harm to the fetus would be inconsi tent.[63] However, a pregnant woman and her fetus share physical interdependency that a third-party tort-feasor ar the fetus do not. The nature of the relationship between tl pregnant woman and her fetus makes problematic tort liab ity against the mother for prenatal injuries.

Third-party liability protects both the pregnant woman ar her fetus from behavior that is normally unacceptable und any circumstances.[17] For instance, a drunk driver is liable f his or her actions because they are a menance to all, the bo and unborn alike. However, *every* action on the part of pregnant woman can have substantial impact on fetal healt Maternal liability would severely restrict a pregnant womar freedom to act in even normally innocuous ways.

Causes of action would arise much more frequently th instances where the mother would actually be at fault. Th difficulty in determining the cause of infant impairment cou give rise to numerous unfounded claims of maternal liabilit Many women who behaved in an acceptable manner durin pregnancy would be unfairly subjected to liability procee ings, just as presently many physicians who practice goc obstetrical medicine are subjected to unfounded liabilit claims.

Even if it could be proven that a pregnant woman's behav ior caused infant impairment, intense scrutiny of the mo intimate details of a pregnant woman's life would be require to evaluate the extent to which she could be held responsib for her actions.[17] A judicial investigation to determine whic action caused the harm and its reasonableness would have t include a determination of whether the harm was cause before or after the woman realized she was pregnant an whether she realized the behavior could affect fetal healtl The court would also have to determine whether she coul have reasonably prevented the harm or whether the actio taken was reasonable in the context of other circumstance Even the most insignificant decision on the part of the preg nant woman could be subsequently called into question.

The imposition of civil liability on women whose infants ar born impaired would pose too great a burden and too great a intrusion into the lives of innocent women to justify it as remedy to harmful behavior by the pregnant woman.

The Most Effective Method of Preventing Harmful Behavior by Pregnant Women Is Through Treatment and Education

Many health and public welfare officials feel that the mos effective way of preventing substance abuse in pregna women is through education about potential harms and th provision of comprehensive treatment for their abuse.[61,62] In portant methods for preventing or minimizing fetal harm du to substance abuse by pregnant women include identificatic of women who are at high risk for being substance abuser early medical and psychotherapeutic intervention in the pre nancies of substance-abusing women, and access to progran that address the full range of social and health care nee associated with substance abuse.[61] The National Associati for Perinatal Addiction Education and Research has doc

ɪd the efficacy of programs that follow these methods.[51]
ɔontrast, criminal penalties may exacerbate the harm
:o fetal health by deterring pregnant substance abusers
obtaining help or care from either the health or public
re professions, the very people who are best able to
nt future abuse. The California Medical Association[62]
oted:

unhealthy behavior cannot be condoned, to bring criminal
s against a pregnant woman for activities which may be harm-
ıer fetus is inappropriate. Such prosecution is counterproduc-
the public interest as it may discourage a woman from seeking
al care or dissuade her from providing accurate information to
care providers out of fear of self-incrimination. This failure to
ɹroper care or to withhold vital information concerning her
could increase the risks to herself and her baby.

da's secretary of Health and Rehabilitative Services has
ɪbserved that potential prosecution under existing child
ː or drug use statutes already "makes many potential
ters reluctant to identify women as substance
ers."[51]

may seem that a pregnant substance abuser has an
ation to obtain treatment for her dependence. However,
ning treatment is not currently a practical alternative
regnant substance abusers. Even the most persistent
an is likely to fail to find a treatment program for her
cance dependency. Rehabilitative centers for substance
ers are in short supply.[61] The majority of those facilities
do treat substance abuse refuse to accept pregnant wom-
ı part due to concerns over liability.[59] Of the few centers
do treat pregnant women, most have long waiting lists.
rther, the majority of substance abuse treatment facili-
operate on an adult-male centered model.[65] They are not
ned to address problems specific to women's psychologi-
r physiological needs. Nor are they equipped to handle
r problems that substance-dependent women often have,
as how to arrange day-care for older children or counsel-
or a woman who is abused by a spouse or partner. It
d be an injustice to punish a pregnant women for not
lving treatment for her substance abuse when treatment
t an available option to her.

nally, societal efforts to educate pregnant women and
ide accessible treatment for those who may be substance
ers promote relationships and attitudes that are benefi-
to fetal health in general. Criminal penalties levied
nst pregnant women for their actions would posit physi-
s as government agents with enforcement responsibilities
er than as concerned patient advocates.[63] Criminal penal-
would also emphasize conflict between the pregnant
ıan and her fetus, which does not encourage a healthy
tionship between the pregnant woman and her future
l. On the other hand, providing education and treatment
ɪhasizes cooperation and trust between the pregnant
ıan and her physician and facilitates a more emotionally
tive relationship after birth.[63]

te-Assumed Custody of Exposed Infants

nother response to harmful behavior by pregnant women
aking the woman's baby into state custody after birth.
bably the most widely accepted action for preterm sub-
ıce abuse is state-assumed custody of infants who show
s of prenatal exposure to harmful substances.[14] Legal
alties for behavior while pregnant are problematic be-
cause a pregnant woman and her fetus cannot practically be treated as separate entities. Once an infant is born, this is not a consideration. In addition, evidence shows that parental substance abuse and child abuse are highly correlated.[64] Children who have been impaired due to in utero exposure to harmful substances are likely to be especially difficult to care for, requiring above normal parenting skills.[50,51] Courts have ruled that the potential for abuse implied by substance abuse by a woman while pregnant is adequate justification for allowing the state to assume at least temporary custody of these infants.[14]

Ordinarily, the state cannot impose punishment for potential, rather than actual, actions. Presumably, the termination or suspension of parental rights is an exception because it is primarily a protection for the child and not a penalty directed at the parent.[14] In the interest of preserving family unity wherever reasonably possible, courts should be careful to ensure that such actions are actually protective of the child.

Consideration of Criminal or Civil Sanctions in Exceptional Cases

Some commentators have argued that legal penalties or state intrusion into the lives of pregnant women are legally justifiable because once a pregnant woman forgoes her right to have an abortion she has a "legal . . . duty to bring the child into the world as healthy as is reasonably possible."[60] This duty includes restrictions that "may significantly limit a woman's freedom of action and even lead to forcible bodily intrusion."[60] The implication is that once a woman has become pregnant and does not take affirmative steps to terminate her pregnancy, then she has forfeited her constitutional rights to bodily integrity and privacy.

However, this legal argument has been criticized as misplaced.[2] One commentator notes that such a waiver of constitutional rights never actually takes place because "women do not appear before judges to waive their rights at any time during pregnancy."[2] The fact that a woman does not abort her fetus cannot be construed as the willing forfeiture of her constitutional rights. Further, if the decision to have a child automatically precipitates a waiver of constitutional rights, then the state has created a penalty for choosing to bear a child.[2] The right to procreate is constitutionally protected and its exercise cannot be penalized.[2] In addition, state-imposed penalties upon the decision *to* bear children would be troubling as a policy matter.

Absolutely prohibiting legal penalties for all potentially harmful actions by a pregnant woman may seem extreme. For instance, if a situation arose in which a woman willingly engaged in an elective behavior that would clearly cause severe and irreparable injury to the future child, it seems incongruous to suggest that society should have no legal recourse for such behavior.

Yet, it is difficult to imagine that such circumstances might occur in significant numbers, if at all. More important, the conscious infliction of certain and severe harm to the fetus would generally pose a serious risk of harm to the pregnant woman as well. Therefore, counseling, psychiatric treatment, or other support services would probably be a more appropriate response than criminal punishment. In addition, it is difficult to imagine a situation in which legal rules would be the best policy choice as legal penalties or liability may be ultimately detrimental, rather than beneficial, to fetal health.

RECOMMENDATIONS

The AMA Board of Trustees recommends adoption of the following statement:

1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.

If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.

2. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.

3. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

4. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

6. To minimize the risk of legal action by a pregnant patient or an injured child or fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.

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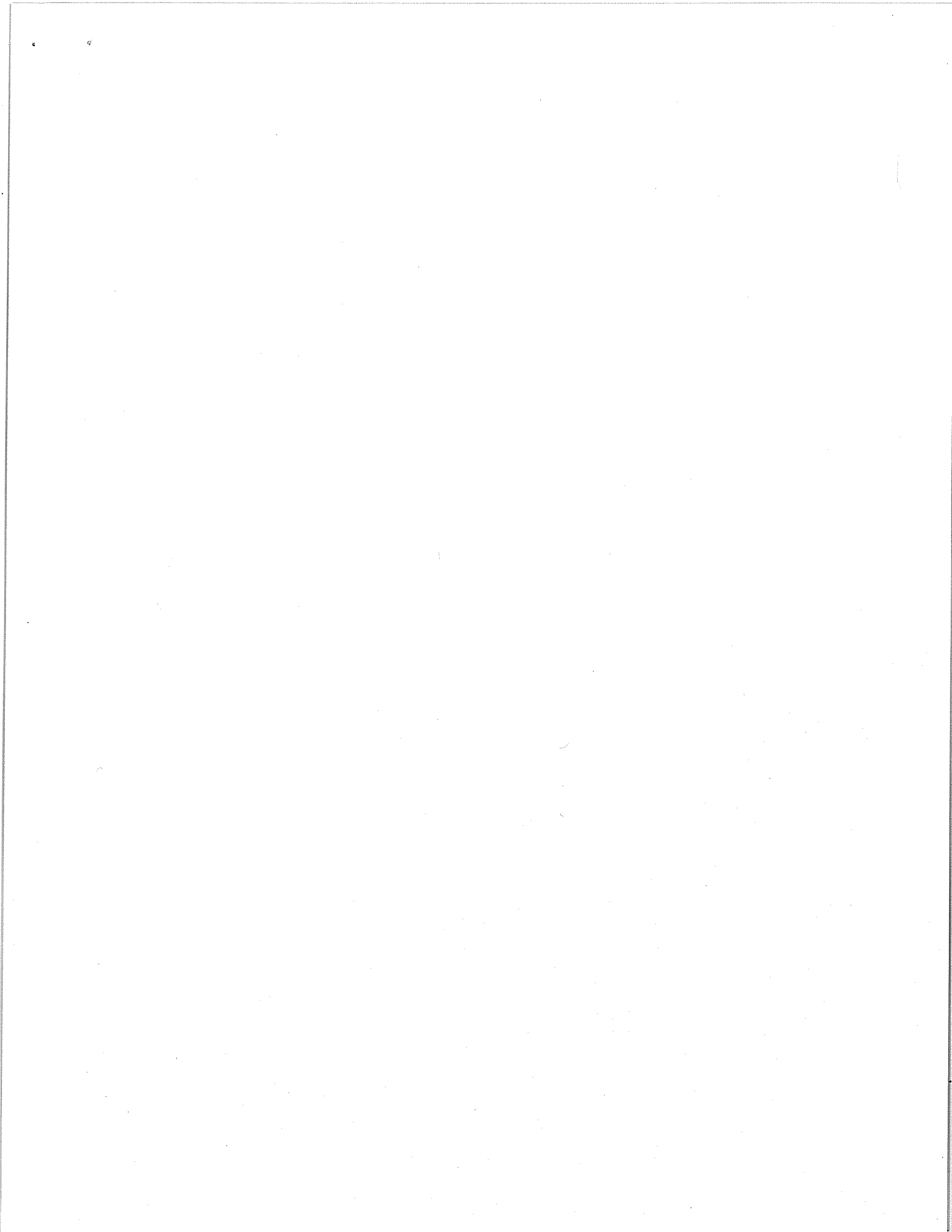

AMERICAN NURSES ASSOCIATION

Position Statement
on

Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age

Summary: Perinatal alcohol and other drug abuse has serious consequences for mothers and children. ANA supports treatment services for women of childbearing age that are alcohol and drug-dependent and is in opposition to criminal prosecution and punishment of these women.

Perinatal alcohol and other drug abuse is a major societal problem with serious consequences for the nation's mothers and children. Addiction is primary disease requiring specialized treatment to achieve a process of long-term behavior change known as recovery. ANA is also opposed to the application of current laws for criminal prosecution of alcohol and drug dependent women solely because they were pregnant when they used alcohol or other drugs and opposes any legislation that focuses on the criminal punishment of the mothers of drug-exposed infants. ANA recognizes alcohol and other drug problems as treatable illnesses. The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems. There are presently few alcohol and other drug abuse treatment services available for pregnant women and few programs designed specifically for women of childbearing age, and due to perceived risk of liabilities of care for the unborn child and/or regulations at state levels of care. ANA supports a marked increase in funding at federal, state and local levels for development and expansion of alcohol and other drug abuse treatment services tailored to meet the special needs of women of childbearing age.

ANA is committed to prevention and treatment as primary solutions to perinatal substance abuse and 'diction. There is an urgent need for nursing and other research designed to improve the knowledge base on which prevention and treatment efforts are based and to test innovative interventions tailored to women of childbearing age.

The Coalition on Alcohol and Drug Dependent Women and Their Children reports that an increasing number of women are being arrested and prosecuted solely because they used drugs while they were pregnant. Laws are being applied that were never intended to pertain to the behavior of pregnant women. Pregnant women also find themselves receiving stiffer sentences than those being imposed on men and women who are not pregnant. Some states are considering new laws to make drug use during pregnancy a felony subject to a punishment of imprisonment. ANA joins the Coalition on Alcohol and Drug Dependent Women and their Children in opposing these trends toward criminalization of drug use during pregnancy as constituting extreme, inappropriate, and ineffective responses to health problems. In order for pregnant women to receive health care that is sensitive to potential or existing drug problems, women must feel that they can seek care and give information regarding their drug use or other problematic behavior without fear or punishment.

Rationale

Government surveys of hospital discharges show a range of 13 drug exposed births per thousand to 181 per thousand births. Recent studies show that early identification of pregnant women at risk, anticipatory guidance and rapid initiation of treatment can prevent birth defects, developmental disabilities and provide significant positive effects in the health of the infant. Perinatal alcohol and drug abuse are currently responded to with punitive measures and incarceration. These approaches to problems constitute extreme, inappropriate, and infective responses to health problems.

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AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement on Chemically Dependent Women and Pregnancy

Background

Because of the adverse effects on fetal development of alcohol and certain other drugs (including nicotine, cocaine, marijuana, and opiates) the chemically dependent woman who is pregnant or may become pregnant is an especially important candidate for intervention and treatment. Similarly, prevention programs should target all women of childbearing age.

Recently, public concern for preventing fetal harm has resulted in punitive measures against pregnant women or women in the postpartum period. These measures have included incarcerating pregnant women in jails to keep them abstinent and the criminal prosecution of mothers for taking drugs while pregnant and thereby passing these substances to the fetus or newborn through the placenta.

The American Society of Addiction Medicine is deeply committed to the prevention of alcohol and other drug-related harm to the health and well-being of children. The most humane and effective way to achieve this end is through education, intervention, and treatment. The imposition of criminal penalties solely because a person suffers from an illness is inappropriate and counterproductive. Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing, harm to children and to society as a whole.

Policy Recommendations

The American Society of Addition Medicine supports the following policies:

1. Prevention programs to educate all members of the public about the dangers of alcohol and other drug use during pregnancy and lactation. These should include:

    - Age appropriate school-based education throughout the school curriculum.

    - Public education about alcohol and other drug use in pregnancy and lactation, including health warning labels and posters as well as radio and television messages, educational programs and written materials.

- Prenatal education about alcohol and other drugs for all pregnant women and significant others, as part of adequate prenatal care.

- Professional education for all health care professionals, including education of obstetricians and pediatricians in the care of chemically dependent women and their offspring.

2. Early intervention, consultation, and case finding programs specifically designed to reach chemically dependent women:

   - Screening for alcohol and other drug problems in all obstetric care services, as well as in all medical settings.

   - Adequate case finding, intervention, and referral services for women identified as suffering from chemical dependency.

3. Treatment services able to meet the needs of chemically dependent women:

   - Appropriate and accessible chemical dependency treatment services for pregnant women and women of childbearing age and their families, including inpatient and residential treatment. Services to care for the children and newborns of these patients should be provided. Without adequate child care arrangements, chemically dependent women are often unable to engage in the treatment they need.

   - Adequate facilities for the outpatient and aftercare phases of treatment for chemically dependent women.

   - Adequate perinatal care for chemically dependent women in treatment, sensitive to their special needs.

   - Adequate child protection services to provide alternative placement for infants or children of persons suffering from chemical dependency who are unable to function as parents, in the absence of others able to fulfill the parent role.

4. Research:

   - Basic and clinical research on the effects of alcohol and other drugs used during pregnancy.

   - Model programs, with evaluation component, for case finding intervention and treatment of chemically dependent pregnant women, and for case finding, intervention, and treatment of infants and children affected by maternal alcohol and/or other drug use.

5. Law enforcement:

- State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as "prenatal child abuse," and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services for these women.

6. Preservation of patient confidentiality:

- No law or regulation should require physicians to violate confidentiality by reporting their pregnant patients to state or local authorities for "prenatal child abuse."

Adopted By ASAM Board of Directors 9/25/89

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MARCH OF DIMES STATEMENT ON MATERNAL SUBSTANCE ABUSE

The March of Dimes is committed to improving the health of babies. We strongly support the full range of health programs and policies that assist pregnant women in receiving appropriate comprehensive health care. The interests of mothers and their babies are interdependent and similar, and health policies should serve to strengthen the health of mother and child. Medical conditions that threaten the health of either a mother or her baby demand and deserve to be addressed expeditiously by professionals and by society with compassion for both mother and child.

Drug abuse and addiction, and the use of drugs by pregnant women, has recently increased at an alarming rate. The pervasive and seriously harmful effects of substance abuse during pregnancy for both a mother and her infant are well documented by scientific studies. Increasingly state legislatures are enacting or considering legislation which criminalizes substance abuse during pregnancy. The March of Dimes is concerned that legal action, which makes a pregnant woman criminally liable solely based on the use of drugs during pregnancy, is potentially harmful to the mother and to her unborn child. While it is important that society express concern with the increase in maternal substance abuse, we believe that criminalization of substance-abusing pregnant women may be inappropriate for a number of reasons:

- Addiction is an illness and there is no evidence currently available to demonstrate that the threat of criminalization will deter addictive behavior.
- We believe that the proper treatment of drug addiction requires comprehensive medical, educational and psychological and social intervention to address the etiology of the problem and to support recovery from addiction.
- Punitive approaches to drug addiction may be harmful to pregnant women because they interfere with access to appropriate health care. Fear of punishment may cause women most in need of prenatal services to avoid health care professionals.

- Drug abuse treatment programs are largely unavailable to women, and especially are in short supply for pregnant women.. Many programs are designed to serve men and many refuse to treat drug dependent women or are not able to provide women with essential services they need during pregnancy. Few accept women without private insurance coverage.

For these reasons the March of Dimes strongly recommends action which will result in appropriate rehabilitative services for drug dependent women. Further, we call upon the American people to work together to support efforts that will:

1) Harness and coordinate community and governmental resources necessary to eliminate the social dynamics that spawn and contribute to the abuse of substances by women of childbearing age.

2) Assist the pregnant woman in making the appropriate behavioral choices that are consistent with her best health and that of her developing child.

3) Make available upon demand the comprehensive therapeutic interventions which meet the specific needs of the pregnant woman suffering from the disease of addiction.

4) Develop model treatment environments that provide the best opportunities for successful outcomes and that support the best interests of the entire family.

5) Advance the level of scientific and clinical knowledge in the medical management of this disease and the special considerations of its management during pregnancy.

In summary, in the absence of evidence to the contrary, it is obvious to us that criminal sanctions will serve as a significant barrier and disincentive to pregnant women seeking care. The March of Dimes is opposed to the use of such sanctions as a method of facilitating good pregnancy outcomes and generally considers such approaches to be contrary to the best interests of the mother and child.

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NAPARE POLICY STATEMENT -- NUMBER 1

The National Association for Perinatal Addiction Research and Education is a national not-for-profit organization dedicated to ensuring the health and well-being of mothers, babies, and their families.

Criminalization of Prenatal Drug Use: Punitive Measures Will Be Counter-Productive

Over the past twelve months, there has been increasing debate over whether women who use drugs during pregnancy, including both controlled substances and alcohol, should be criminally prosecuted for their conduct. To date, over forty women have been charged nationwide with felony crimes, ranging from delivery of a drug to a minor, to use or possession of a controlled substance, based on their prenatal drug use. Many of these charges carry mandatory prison terms. In addition, numerous states are considering legislation which would impose punitive measures on women who use drugs during pregnancy.

The issues raised by criminalization are difficult, and because newborn babies are involved, the debate is fraught with emotion. It is necessary, therefore, to look beyond one's immediate emotional response and determine what is in the best interest of both mothers and babies in the long term. Ultimately, it must be recognized that prenatal drug use is a health care issue, not a legal issue. Indeed, criminal justice intervention is likely only to make a serious problem worse.

From a health care perspective, it appears likely that criminalization of prenatal drug use will be counter-productive. It will deter women who use drugs during pregnancy from seeking the prenatal care which is important for the delivery of a healthy baby. This is of special concern since recent studies show that if a woman enters treatment and becomes drug free, the medical and obstetrical complications can be eliminated for mother and child.[1]

If a woman knows that her doctor must report her to the state authorities if the doctor learns she has used drugs during pregnancy and that she will then be prosecuted for her drug use, she is likely simply to forego prenatal care. This does not serve either the baby's or the mother's interest in the long-term. It is well documented that the lack of prenatal care has substantial adverse consequences for the infant, such as low birth weight. Prenatal care can improve the outcome for babies even of women who do not overcome their substance abuse problems during pregnancy. A likely consequence of criminalization is that we will have babies who not only were exposed to drugs in utero but also are born to women who had no prenatal care, which will only compound the long-term health problems for the babies.

If a woman does go for prenatal care or delivery, she will be less likely to disclose her drug or alcohol use to her health care provider if she believes she will be subject to criminal prosecution. Thus, her doctor or nurse will not have all of the information he or she needs to treat the woman and her subsequently born child. Again, this will only serve to impede the long-term goal of ensuring the health and well-being of mothers and babies.

The prospect of criminal prosecution, in many instances, also places health care practitioners in a conflict position, forcing them to choose between maintaining their patient's confidentiality or reporting them, ultimately to the police, a position many doctors and nurses find intolerable. Moreover, there is already evidence of selective reporting.

Generally, the only way that a state prosecutor learns that a woman has used drugs during pregnancy is if the medical facility to which she goes for treatment or delivery reports that fact to the state. If health care practitioners selectively choose whom to report, the women identified for prosecution will reflect the reporting bias. As a NAPARE/Operation PA[illegible] study recently conducted in Pinellas County, Florida revealed, despite the fact black and white women had simi[illegible] rates of substance abuse, black wome[illegible] were reported at approximately ten times the rate of white women.[2]

Those who advocate criminaliz[illegible]tion also frequently ignore the fact th[illegible] by criminally prosecuting women wh[illegible] have used drugs during pregnancy, th[illegible] state is punishing women who are themselves victims -- victims of their addictions. As the United States Supreme Court recognized more tha[illegible] sixty years ago, drug addiction is a medical not a criminal matter.[3] Mos[illegible] pregnant women addicted to cocaine are concerned about the babies they carry, but, without help, they are unal[illegible] to overcome their addictions.

Thus, although it is likely that t[illegible] prospect of criminal prosecution [illegible] deter women from seeking prena[illegible] care, it is unlikely that criminalizatio[illegible] will have the deterrent effect for whic[illegible] it is intended. The threat of criminal prosecution alone will not deter wom[illegible] in most instances from using drugs during pregnancy. These women are addicts who become pregnant, not pregnant women who decide to use drugs and become addicts. They do n[illegible] want or intend to hurt their unborn children by using drugs. But, they nee[illegible] help, not threats, to overcome their problems. To date, such help has not been easily accessible.

It is unreasonable to punish a woman who needs society's help whe[illegible] society has done little to assist her. F[illegible] a variety of reasons, until recently, ve[illegible] few drug treatment programs have be[illegible] willing to accept pregnant women wh[illegible] have substance abuse problems. The consequence has been that women wh[illegible] are motivated to overcome their abus[illegible] problems when they learn that they ar[illegible] pregnant have had no place to go. [illegible] when a program will accept a pregna[illegible] woman, it frequently does not provide childcare services, is prohibitively

expensive and/or not covered by Medicaid, and is inaccessible by public transportation. What is needed, therefore, is expanded and improved treatment and education opportunities, not punitive measures.

A basic economic analysis of the situation further argues in favor of proactive, preventive or ameliorative measures and against reactive, punitive measures. A dollar spent today in improved drug treatment programs and prenatal care for pregnant addicts may save up to ten or fifteen dollars in future expenses to care for and educate the child who was born having been exposed to drugs in utero. The cost of caring for these drug-exposed children from birth through age five has been estimated to be at least five billion dollars. The resources now being spent on prosecutions would be better spent on expanded drug treatment and education programs.

In sum, the solution to the problem presented by drug use during pregnancy is to increase funding for prevention and treatment programs and to develop health care systems that will answer the need of the highest risk populations. The key to intervention will be access to health care for high risk women, not the threat of criminal prosecution.

1. Chasnoff, Ira J., M.D.; Griffith, Dan R., Ph.D.; MacGregor, Scott, D.O.; Dirkes, Kathryn, B.M.A.; Burns, Kayreen A., Ph.D.: Temporal patterns of cocaine use in pregnancy, *JAMA*, Vol. 261 (March 24/31, 1989).

2. Chasnoff, Ira J., M.D.; Landress, Harvey J., A.C.S.W.; Barrett, Mark E., Ph.D.: "The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida," *The New England Journal of Medicine*, Vol. 322, No. 17 pp. 1202-1206 (April 26, 1990).

3. Lindar v. United States, 268 U.S. 5 (1925).

4. Crack babies. Report of the Office of the Inspector General, February 1990.

NCADD POLICY STATEMENT

Women, Alcohol, Other Drugs and Pregnancy

Approved by the Delegate Assembly (April 28, 1990) and adopted by the Board of Directors of the National Council on Alcoholism and Drug Dependence, Inc. (April 29, 1990).

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test of physical functions, and die within the first year of life. *It is not known exactly how* the ingredients in tobacco smoke affect fetal development. It is known that tobacco smoke reduces oxygen flow to the fetus. It is clear that cessation of smoking during pregnancy will contribute to a positive pregnancy outcome.

There are risks associated with the use of other drugs during pregnancy such as PCP, **barbiturates and other prescription medications.** These risks vary depending on the extent and time of use. In general, all drugs are contraindicated during pregnancy unless deemed absolutely necessary and administered under the supervision of a trained health professional.

Although different drugs have different prenatal effects, the drugs discussed above have some similar effects when they are used during pregnancy. They all tend to contribute to low birth weight. They all may influence the way in which children are able to learn and interact socially. Some cause severe damage, including mental retardation and physical deformities. All contribute to heightened nervousness and irritability in newborns which may impede parent-child bonding and exacerbate post-partum stress for mothers.

It is well-known that the United States has an extraordinarily high rate of infant mortality--one of the highest in the western world. Efforts to reduce the incidence of alcohol and other drug use during pregnancy would undoubtedly contribute to a reduction in infant mortality in the nation.

Treatment for Alcoholic and Other Drug-Dependent Women

A great deal of progress has been made in the United States in our approaches to preventing and treating alcoholism and other drug addictions among women. Prior to the 1970's there were virtually no treatment options for women with alcoholism and other drug addictions. Women rarely came into treatment and when they did, the treatment that they received was based on the male experience of alcoholism with no adjustments for the fact that a woman's life experience and physiology are different from a man's.

The 1970's was a time of dramatic change for women in need of treatment for alcoholism and other drug addictions. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) funded the first wave of women's treatment programs across the nation. Later, in 1984, the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant required that states spend 5% of their block grant award on new prevention and treatment efforts designed for women. The set-aside requirement was raised in 1988 to 10%.

Only a few prevention and treatment efforts have focused specifically on pregnant alcoholic and other drug-dependent women. There are tremendous fears among service providers about liability problems associated with treating pregnant, addicted women. There is also a great need for additional training of treatment providers about how to proceec with safe detoxification and treatment. To date, much of the reaction to treating pregnant alcoholic and other drug-dependent women has been guided by fear, lack of knowledge and lack of experience. The sad irony is that pregnancy offers an opportunity to intervene and provide treatment; yet it is at this very time that the least amount of treatment is available.

The Anti-Drug Abuse Act of 1988 included a provision to establish prevention, education, intervention and treatment demonstration projects administered through the Office for Substance Abuse Prevention for pregnant and postpartum alcohol- and other drug- dependent women. This program has stimulated the development of some of the first programs in the nation to address the needs of pregnant women.

Services for Children

Children born to alcoholic and other drug-dependent women and children living in homes where parents and family members are alcoholic and dependent on other drugs deserve special mention. Children born with alcohol- and other drug-related birth defects often go unrecognized. We need to improve identification and intervention services for these children. They must have access to services for ongoing treatment and special education. Children growing up in alcoholic and other drug-dependent families also need a range of prevention, intervention and treatment services. Intervention and treatment can be powerful tools in preventing future problems for these children. Child welfare services should be enhanced so that alternative living situations are available for children who need temporary foster care and permanent placement. In all cases, efforts should be made to intervene and treat families with the goal of keeping them together if appropriate and possible.

on alcoholic beverage containers regarding the risks of drinking during pregnancy be clearly legible to alcoholic beverage consumers.

■ The Children's Bureau housed in the Office of Human Development Services of the Department of Health and Human Services should fund grants and contracts that address the issues of foster care placement for children of alcoholic and drug-dependent women.

■ The Justice Department, in collaboration with the Department of Health and Human Services should be required to develop and fund training programs for police and other law enforcement officers on the nature of alcoholism and other drug dependence, intervention processes, treatment principles, and the availability of local treatment resources.

State Legislative and Executive Bodies

■ States should mandate coordination of available health and social service resources to include but not be limited to: Alcoholism and Drug Treatment Programs, especially those agencies which provide services to women and their children; Crippled Children's Services (CCS); Early Periodic Screening Diagnosis and Treatment Programs (EPSDT); Developmental Disabilities services; Special Education programs; Family Planning; Aid to Families with Dependent Children (AFDC) and Women, Infants and Children (WIC).

■ State agencies which manage publicly funded alcohol and drug addiction programs should offer funding for up to three years for demonstration projects which provide services to women and their children with sufficient funds to entice providers to initiate such programs and to allow for adequate start-up time.

■ Each state should develop a task force of state executive branch agencies to coordinate provision of alcohol and drug prevention and treatment services, maternal and child health care, and child welfare services and training to health and social service professionals who serve as gatekeepers to women and their children.

■ States should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing or other punitive measures which would serve to discourage women from seeking health care services and which might be offered as a substitute for health care services.

■ States should resist the enactment of laws which identify alcoholism or other drug dependency or alcohol and other drug use as prima facie evidence of child abuse or neglect.

■ States should resist the enactment of laws or regulation which require the automatic removal of an infant from the mother solely on the basis of a positive toxicology screen of the infant.

■ States should appropriate additional funds for the development of comprehensive, multidisciplinary prenatal care and alcoholism and other drug addictions treatment services to pregnant women with alcohol and other drug problems. The continuum of services should include prenatal care, alcoholism and other drug addictions treatment, housing, job training, educational and support services.

■ States should encourage linkages between alcoholism and drug treatment programs and the criminal justice system so that alcoholic and drug-dependent women who enter the criminal justice system can receive appropriate identification, referral and treatment services.

■ States should enact legislation requiring the posting of warning signs at points of purchase of alcoholic beverages alerting the public to the dangers of drinking during pregnancy. These signs should be available in other languages, if appropriate, to meet the needs of ethnic populations.

Research

■ Research is needed on the long-term impact of drug exposure on the health and development of children; comparisons between children raised in foster care to those supported in their biological homes; cost/benefit analyses of the efficacy of various prevention strategies on health and social welfare costs.

■ Research is needed on the male contribution to birth abnormalities related to alcohol and other drug use.

Prevention

■ Schools should offer age-appropriate alcohol and other drug education programs which include specific information on the dangers associated with drinking alcohol, smoking cigarettes, and using other drugs during pregnancy. Appropriate programming for pregnant teens should also be made available in schools.

MCH

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Association of Maternal and Child Healtl

STATEMENT

SUBMITTED TO THE

SENATE FINANCE COMMITTEE

CONCERNING

VICTIMS OF DRUG ABUSE

BY THE

ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

June 28, 1990

RESOLUTION ON PROSECUTION

Statement of the Problem: An increasing number of women are being arrested for a new crime: being dependent on alcohol or other drugs while pregnant. Courts are holding women liable for criminal conduct solely because they used drugs while they were pregnant, applying laws which were never intended to address prenatal behavior. Courts are also imposing stiffer sentences on pregnant-women than they would otherwise impose on men and non-pregnant women. In addition, new laws have been introduced in the state legislatures which would make drug use during pregnancy a felony, thus subjecting alcohol and drug-dependent women to imprisonment. In each of these instances, it is the fact that the women are pregnant that triggers prosecution.

WHEREAS...

addiction is an illness and has been shown to persist despite adverse consequences;

many alcohol and drug treatment programs refuse to provide care to alcohol and drug dependent women or lack services essential to their treatment;

criminal prosecutions have been directed against women who engage in both illegal and legal behavior;

women of color, poor women, and battered women are the primary victims of these criminal prosecutions;

criminal prosecutions may inadvertently encourage women to have abortions because of the lack of treatment options;

there is no evidence that criminal prosecutions will deter alcohol or drug use during pregnancy;

there is evidence that criminal prosecutions will drive women away from prenatal and health care which is not in the best interest of the child or the mother;

criminal prosecution is the most extreme and intrusive of government responses and is inappropriate given that insufficient attention and resources have been directed towards development of effective and nonpunitive treatment responses;

alcohol and drug dependent women should not be punished for their alcohol or drug dependency alone;

we, the undersigned, oppose the criminal prosecution of alcohol and drug dependent women solely because they were pregnant when they used alcohol or drugs. The threat of criminal prosecution prevents many women from seeking prenatal care and early intervention for their alcohol or drug dependence, undermines the relationship between health and social service workers and their clients, and dissuades women from providing accurate and essential information to health care providers. The consequence is increased risk to the health and development of their children and themselves.