National Advocates for Pregnant Women
N A P W

NAPW ANALYSIS OF TENNESSEE BILLS SB1065 AND HB0890

Pursuant to Tennessee bills SB1065 and HB0890, pregnant women who meet certain criteria will be tested for alcohol and drugs in order to encourage them to seek immediate treatment for an alcohol-related or drug- related problem. The bills would require testing when a woman experienced:

(1) No prenatal care;
(2) Late prenatal care after twenty-four (24) weeks gestation;
(3) Incomplete prenatal care;
(4) Abruptio placentae;
(5) Intrauterine fetal death;
(6) Preterm labor of no obvious cause;
(7) Intrauterine growth retardation of no obvious cause;
(8) Previously known alcohol or drug abuse; or
(9) Unexplained congenital anomalies.

Any woman who tests positive for alcohol or drugs on a test administered pursuant to this chapter would be referred to treatment for an alcohol or drug-related problem. Every physician, surgeon or other person permitted by law to attend a pregnant woman during gestation would be required to report each woman who refuses to seek treatment for an alcohol-related or drug- related problem or who misses two (2) or more appointments to the department of children's services.

We begin our analysis by noting that this legislation is proposed without the benefit of any state-sponsored research or commission appointed to:

- determine the need for or availability of appropriate alcohol and drug treatment programs for pregnant and parenting women;
- determine the degree to which mandated medical reporters, child welfare, social work, law enforcement and judicial officers have received appropriate training in addiction treatment, evaluation, testing, and screening;
- evaluate the ability of state child welfare agencies to address the needs of families with true drug and alcohol problems;
- gather or assess evidence-based research regarding the link between prenatal exposure to alcohol and drugs and risks of harm to children; or to
- gather or assess evidence-based research regarding the claimed links between evidence of use of any amount of alcohol or an illegal drugs and parenting ability.

The following information, some of it specific to Tennessee, makes clear that this legislation lacks foundation in evidence based research and is likely to undermine, rather than promote maternal, fetal, and child health.

Peer-reviewed research indicates that testing with the threat of child welfare interventions will actually undermine maternal, fetal, and child health by deterring women from seeking prenatal care and in-hospital births.

Regular prenatal care can improve birth outcomes whether or not a woman is able to stop using drugs in the short term of pregnancy.[1] Threats of exposure and loss of child custody deter women from seeking prenatal care and what little appropriate drug treatment might be available.

According to a report published by the U.S. Department of Health and Human Services, National Center on Substance Abuse and Child Welfare:

> One key reason for this lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use. Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women.[2]

Research by the Southern Regional Infant Mortality Project on barriers to substance abuse treatment for pregnant women found that "fear of losing their children" was the greatest deterrent to women.[3] Additional studies of drug-dependent pregnant women have found that fear of the loss of custody of their children, as well as arrest and prosecution, is a significant factor in deterring women seeking health care and disclosing drug use.[4] One recent study confirmed that child welfare reporting policies constituted a major barrier to prenatal care.[5]

The bill, if passed would deter those women who did seek such care from speaking honestly and openly about their drug or alcohol problems to their health care providers.

Even for those women who are not completely deterred from seeking care, fear of prosecution is likely to discourage them from being truthful about drug use, corroding the formation of trust that is fundamental to any health care provider-patient relationship. As the U.S. Supreme Court recognized, a "confidential relationship" is a necessary precondition for "successful [professional] treatment."[6] Medical treatment is greatly enhanced when patients feel comfortable divulging highly personal, stigmatizing, and potentially incriminating information.[7] Erosion of trust between doctor and patient in the context of prenatal care is recognized a potentially harmful to both the pregnant woman and fetus.[8]

Open communication between drug-dependent pregnant women and their doctors is especially critical. Feelings of shame, fear, and low self-esteem are significant barriers to establishing the trust prerequisite to patients' full disclosure of this medically vital information.[9] Additionally, the exceptionally high rates of depression among drug-

dependent women mean that their prospects of successfully completing treatment depend on their forming a strong "therapeutic alliance" with care providers.[10]

A report on prenatal care published by the Institute of Medicine also found that:

> Pregnant women who are aware that their life-styles place their health and that of their babies at risk may also fear seeking care because they anticipate sanction or pressure to change such habits as drug and alcohol abuse, heavy smoking, and eating disorders. Substance abusers in particular may delay care because of the stress and disorganization that often surround their lives, and because they fear that if their use of drugs is uncovered, they will be arrested and their other children taken into custody.[11]

There is no evidence-based research to indicate that this kind of testing and reporting statute in fact improves birth outcomes or the health of children or families.

The little research that we are aware of has not found that laws requiring reporting of positive drug tests on pregnant women or newborns leads to the provision of increased drug treatment or services to pregnant women, mothers or children.[12]

Tennessee does not currently have enough appropriate drug and alcohol treatment programs to meet existing the need for such services by pregnant and parenting women.

A 2006 US Department of Health and Human Services report showed that 13% of public and private drug treatment facilities nationwide *do not* accept any women into their programs. Of the facilities accepting women, only 41% offered programs or groups specific to women, and only 17% offered services for pregnant or postpartum women.[13] The 2006 National Survey on Drug Use and Health showed that in 2006, 7.4 million women aged 18 and over needed treatment for a substance use problem, but only 822,000 (11.2%) received treatment.[14]

While, Tennessee has at least one model residential treatment program for pregnant and parenting women, this program has space for fewer than 35 families, and cannot accommodate more than two children per family.[15] Like all other states, Tennessee does not have enough treatment to meet the needs of its residents, including pregnant women. For example as a story about people struggling with addictions to methamphetamine reported:

> [U]sers have a hard time kicking the drug because of lack of treatment facilities and support programs …According to the US Department of Health and Human Services, Cleveland, Tenn, has the only detox center in the Southeast Tennessee counties surrounding Hamilton county … When you get outside of Chattanooga, there's just not a great deal of detox centers available, Mr. Laymon said … Even where treatment is available,

addicts often can't afford it, said Sue Cottrell, a counselor at the Reality House, a Cleveland, Tenn, outpatient treatment center. [16]

Nothing in these bills provides additional funding for treatment services or related services recognized as necessary for successful treatment of pregnant and parenting women including transportation, child care, and mental health services.

It is widely recognized that access to treatment programs specifically targeted to women, especially pregnant and parenting women, improves treatment outcomes.[17] However, most pregnant and parenting women cannot access programs meeting their drug and alcohol treatment needs.[18] Currently, nine states give substance using pregnant women priority access to drug treatment (AZ, GA, KS, MO, OK, TX, WI), and 19 states created or funded treatment programs specifically for pregnant women (AR, CA, CO, CT, FL, IL, KY, LA, MD, MN, MO, NE, NY, NC, OH, OR, PA, VA, WA).[19] Tennessee is not among either category.

In recent years, increases in Tennessee's drug treatment funding has gone to programs specifically targeting groups such as adolescents and low-income DUI offenders, but has not, to our knowledge, increased funding for programs addressing the needs of pregnant or parenting women.[20] Moreover, it should be noted that Tennessee has significantly cut its medical programs for the needy since 2005.[21]

The legislation creates a "Catch 22." A positive drug test would be the basis for requiring a woman to "seek" treatment and apparently obtain it without missing more than one appointment, or be reported to child welfare authorities. Even assuming there were enough treatment programs for all the women who need it and even assuming such women could afford the treatment, it is likely that many women would not meet the criteria for admission to treatment. Treatment programs require an evaluation and determination of treatment needs and will not admit a person based merely on a single positive drug test.

Under this statute, a physician, based on a single positive drug test, must require a woman to seek and, apparently, obtain treatment. If she fails to obtain that treatment, or misses two appointments for any reason, the physician must report his or her patient to child welfare authorities. The woman however, may in fact seek treatment but find that no program will take her. This may be because, based on its own evaluation the program determines that she is not actually addicted or in need of scarce treatment resource.

Indeed, we contacted several Tennessee drug treatment facilities to ask whether a woman could be admitted to their programs based solely upon a positive alcohol or drug test. Our brief survey confirmed that a more robust assessment, including evaluation techniques and interviews, would be required before a women could be admitted to alcohol or drug treatment.[22] For example, Dr. Victor Pestrak, PhD and Licensed Psychologist at Professional Psychological Services of Goodlettsville, Tennessee, said he believed there was a consensus in the medical community that a recommendation for drug treatment "always takes more than a positive drug test – you have to take into

account other variables."[23] Tom Netherton, PhD, LADAC, LPC, at Crossroads Counseling Services in Crossville, Tennessee said he conducts 2 written assessments and an interview with each client and would not make any recommendations before that. He stated that if a person came in and said "I failed a drug screen," he would sit down and discuss it with them. "They may not need treatment – each case is so unique and you need to look at the whole picture," and "You just don't say a person needs treatment because they failed a drug test."

Under the proposed law, a physician would be mandated to report a woman to child welfare authorities for not obtaining treatment that the treatment provider determined she did not need.

The legislation assumes that the "physician, surgeon or other person permitted by law to attend a pregnant woman during gestation" will have a way of knowing if his or her patients has obtained treatment or has missed appointments. Drug Treatment Programs, by Federal law, may not disclose this information simply because a doctor asks.

The Federal Drug Treatment Confidentiality statute, 42 U.S.C. § 290dd-2 (2004), and its regulations, expressly prohibit disclosure of patient records by drug treatment programs under such circumstances. This law was passed because Congress recognized that the public disclosures of a person's drug or alcohol problems would jeopardize efforts to rehabilitate people with these problems.

> The conferees wish to stress their conviction that the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs. Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome.[24]

To our knowledge there is no evidence-based, peer-reviewed research that supports adopting the criteria established in the bill for testing certain pregnant women and new mothers.

Although the criteria for testing are among those used by many institutions,[25] no evidence-based research has in fact tested their reliability as compared to other criteria or to universal testing (testing all pregnant women). In contrast, there is evidence-based, peer-reviewed research indicating that selective testing and reporting of pregnant women to child welfare and police authorities results in race and class biased testing and reporting. For example, a study published in the New England Journal of Medicine found that, while rates of illegal drug use were similar for white women and African-American women, African American women were 10 times more likely to be reported to state authorities.[26]

A recent investigative report in California found that even when medical guidelines are used to decide who is tested, these guidelines do not eliminate the disparate impact.[27] Such criteria as "no," "late," and "limited pre-natal care" are going to have serious class/socioeconomic implications given the number of people who cannot afford health care in the state of Tennessee.

Finally, drug testing may be subject to significant numbers of false (simply wrong) or innocent (positive for a prescribed drug/ over the counter medication) positive.[28]

Recent and highly regarded evidence-based research fails to establish causal links between the use of such drugs as cocaine and methamphetamine with many of the criteria listed including *abruptio placentae*, intrauterine fetal death, and congenital anomalies.

Studies for example have not been able to establish a causal link between prenatal exposure to cocaine and stillbirths.[29] When asked about the association between cocaine use and placental abruption, leading research, Barry Lester, PhD, Professor of Psychiatry and Human Behavior and Pediatrics at the Warren Alpert Medical School of Brown University and the Director of the Brown Center for the Study of Children at Risk at Women and Infants Hospital of Rhode Island directed us to The Maternal Lifestyle Study[30] among others and informed us that research had not in fact born out this assumed causal connection. Other leading researchers on fetal cocaine exposure have also found that:

> [T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific findings of *in utero* cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment.[31]

Subsequent longitudinal and prospective studies confirm these researchers.[32] For example, one study in 2004 confirmed that "infant prenatal exposure to cocaine and to opiates was not associated with mental, motor, or behavioral deficits after controlling for birth weight and environmental risks."[33] Another study, where researchers prospectively studied from birth inner-city children who had been exposed to cocaine during gestation, and compared them with a control group of children who had not been exposed to cocaine found that cocaine-exposed children's school performance through the fourth grade did not differ from the unexposed control group.[34]

There is now a consensus that the widespread belief that babies exposed prenatally to cocaine faced unique and certain peril constituted an unjustified and "gross exaggeration."[35] Similarly a U.S. Sentencing Commission report concluding that "[t]he

negative effects of prenatal cocaine exposure are significantly less severe than previously believed" and those effects "do not differ from the effects of prenatal exposure to other drugs, both legal and illegal").[36]

A national expert panel also reviewed published studies concerning the developmental effects of methamphetamine and related drugs, and concluded, "the data regarding illicit methamphetamine are insufficient to draw conclusions concerning developmental toxicity in humans." [37] The American College of Obstetrics and Gynecology ("ACOG") created a special information sheet about methamphetamine use in pregnancy, noting that "the effects of maternal methamphetamine use cannot be separated from other factors" and that there "is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine."[38] In 2005, more than 90 leading medical doctors, scientists, psychological researchers, and treatment specialists released an open letter requesting that "policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice" and warning that terms such as "meth babies" lack medical and scientific validity and should not be used. [39]

Finally, a peer-reviewed research article concerning stillbirths concluded that "despite widespread reports linking methamphetamine use during pregnancy with preterm birth and growth restriction, *evidence confirming its association with an increased risk of stillbirth remains lacking*."[40]

The only kind of testing that can ensure fairness is universal testing of all pregnant women and new mothers.

Calling for universal testing or not testing at all, the New York Legal Aid Society Juvenile Rights Division noted:

> Currently, this determination is left to the physician or hospital staff based on their subjective judgment whether there is a risk the child has been prenatally exposed to drugs or alcohol. While independent medical judgment is usually an adequate basis for such decision-making, the reliability of doctors' testing choices has been shown to be seriously undermined by racial and class biases as well as economic and peer pressures.[41]

The legislation calls on the Commissioner of Health to adopt rules using criteria established by the United States Department of Health and Human Services as guidelines for drug and alcohol testing. To our knowledge the U.S. Department of Health and Human Services does not have guidelines for drug and alcohol testing specific to pregnant women, new mothers, or the child welfare context.

A DHHS, Substance Abuse Mental Health Administration expert consensus panel,

created to improve drug treatment for pregnant women, addressed the issue of drug testing. The panel's report recognizes that certain criteria are used by some programs but *does not actually recommend any* of them as a basis for testing pregnant women.[42] The panel also recognized that informed consent from the woman should be obtained before any testing is done.[43]

Moreover, if routine alcohol and drug testing is done, the consensus panel recommended the adoption of the standards used for urine drug testing in the workplace as proscribed by the federal workplace drug testing guidelines.[44] The most updated version of the federal guidelines is found here: http://www.workplace.samhsa.gov/fedpgms/Pages/HHS_Mand_Guid_Effective_Nov_04.aspx.[45]

The Tennessee Drug-Free Workplace law requires similar procedural safeguards. Under this law, employers must provide to employees and job applicants a written policy statement detailing the actions an employer can take as a result of a positive drug test. The statement must also inform the employee that he or she may contest a positive confirmed drug test and explain the results to a medical review officer and can further contest the drug result under Department of Labor regulations.[46]

Text of the Tennessee law states:

> *A statement that an employee or job applicant who receives a positive confirmed test result may contest or explain the result to the medical review officer within five (5) working days after receiving written notification of the test result; that if an employee's or job applicant's explanation or challenge is unsatisfactory to the medical review officer, the medical review officer shall report a positive test result back to the covered employer; and that a person may contest the drug or alcohol test result pursuant to rules adopted by the department of labor and workforce development*[.][47]

The American Hospitals Association recommends that hospitals' pre-employment and employee drug testing programs use NIDA-certified labs and follow NIDA's collection and chain of custody procedures. According to the AHA, all positive lab results should be sent to a medical review officer who should give the employee the chance to provide another basis for the positive result. Hospitals should also make available an Employee Assistance Program (EAP) or other support for the employee regarding substance abuse treatment referrals.[48]

If a testing regime is imposed on some or all pregnant women, pregnant women should have no fewer rights or guarantees of accuracy of their testing than hospital employees and applicants for jobs in hospitals.

Testing is costly, particularly if confirmatory tests are, as they should be, required. These expenses would be better spent on increasing drug treatment and family

preservation services.

Cases from around the country suggest that mandatory treatment can result in assignment of pregnant women and mothers to programs that create greater risk to the pregnant woman and child.

For example, in Wisconsin, a woman sought help for her drug problem during pregnancy and, pursuant to Wisconsin's special civil commitment law, was taken to another hospital where she was locked in a psychiatric ward, received no prenatal care and was put on psychotropic medications that could pose greater risks to fetal development than her drug use.[49]

A single positive test result for alcohol or drugs, even if it is a true positive, does not provide any information about whether or not a person is *abusing* alcohol or drugs, the issue the statute purports to seek to address.

Research fails to support the assumption that a parent who uses any amount of alcohol or an illegal drug will harm his or her children or will be unable to provide them with a loving home. A single, positive drug test cannot determine whether a person occasionally uses a drug, is addicted, or suffers any physical or emotional disability from that addiction. Indeed, there are many reasons why a person might be unable to parent, including mental illness, failure to take medication for chronic illnesses such as diabetes, and use of alcohol. But people are not generally reported as suspected child abusers or presumed unfit to parent based only on the knowledge that a person had a mental illness, is a diabetic, or drinks alcohol. The child welfare system is not meant to become involved with families that include parents who may once have had a problem, or even those who currently have a drug dependency or other health problem, *unless there is also evidence of an inability to parent*. A single drug test is simply not predictive of a person's parenting ability.

Moreover, as Susan C. Boyd reports in her book Mothers and Illicit Drugs: Transcending the Myths, there is no significant difference in childrearing practices between addicted and non-addicted mothers. This includes mothers who use cocaine, who have been found to look after and care for their children adequately.[50]

As a report published by the American Bar Association concluded, "many people in our society suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children."[51]

Research does not support the conclusion that mandated treatment will be effective, or that failure to obtain or succeed at treatment creates threats to children's wellbeing.

Evidence-based research indicates that mandated treatment orders are as likely to be

ineffective as they are effective in producing a parent's compliance with such treatment. Moreover, evidence-based research indicates that a parent's non-compliance with court-ordered drug treatment is not a reliable predictor of future neglect or abuse.[52]

Experience from other states makes clear that even though the bill's Sections 2(k) prohibit the use of test results in any criminal proceeding against the woman subject to the test, it is likely that passage of this law will result in the arrest of pregnant women and newly delivered mothers.

Prosecutors in criminal cases from Missouri and Kentucky argue that similar provisions in their state's laws should provide no bar to prosecution as long as there is some additional evidence of the woman's drug use.[53] For example, her admission of drug or alcohol use to a health care provider would provide such additional information.

A statutory regime that singles out women for a testing and reporting scheme, raises significant 14th Amendment (Equal Protection Clause) problems.[54]

Many positive alternatives exist to the proposed bill. Among these are:

- Establish a commission to study the issues raised by this proposed legislation.
- Ensure that drug treatment, prenatal care, and other reproductive and mental health services are widely available and fully accessible to pregnant and parenting women and their families.
- Create and fund treatment programs that follow the recommendations of experts on women's treatment including and those things women themselves identify as necessary for recovery.[55]
- Provide meaningful training to child welfare workers on issues of drug and alcohol use and treatment for drug addiction, as well as issues of post traumatic stress disorder that are highly associated with drug and alcohol problems.[56]
- Increase training for child welfare workers in related areas including how trauma affects parents as well as children; and reduce their caseloads so that they can identify and respond appropriately to all cases where a parent's behavior in fact indicates an inability to parent.
- Enforce anti-discrimination laws against existing drug treatment programs that deny access to pregnant women.
- Increase support for family preservation services generally so that expensive foster care is not the only option available to caseworkers who seek to protect children rather than punish families.

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

[2] NANCY K. YOUNG ET AL., NAT'L CTR. SUBSTANCE ABUSE & CHILD WELFARE, U.S. DEP'T HEALTH & HUMAN SERV., SCREENING & ASSESSMENT FOR FAMILY ENGAGEMENT, RETENTION, AND RECOVERY (SAFERR) C7-C8 (2007), *available at* http://www.ncsacw.samhsa.gov/files/SAFERR.pdf at C7-C8 (citing Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch up With Research*, 1 HARM REDUCTION J. 1477 (2004)).

[3] *See* SHELLY GEHSHAN, SOUTHERN REG'L PROJECT ON INFANT MORTALITY, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING (1993).

[4] *See* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003); M.L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 DRUG ALCOHOL DEPENDENCE 199 (1993); *Ferguson v. City of Charleston*, 532 U.S. 67, 80 n.14 (2001).

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

[6] *Jaffee v. Redmond*, 518 U.S. 1 (1997).

[7] *Id.,* (observing that a "patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage").

[8] Am. Coll. Obstetricians & Gynecologists, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG COMMITTEE OPINION, No. 422, Dec. 2008, at 6 (punitive measures "endanger the relationship of trust between physician and patient . . . [and can] actually increase the risks to the woman and the fetus rather than reduce the consequences of substance abuse.").

[9] *See* S. KANDALL, SUBSTANCE & SHADOW: WOMEN & ADDICTION IN THE UNITED STATES 278-79 (1996).

[10] *See* Center on Addiction and Substance Abuse (CASA), SUBSTANCE ABUSE & THE AMERICAN WOMAN 64 (1996); *Social Consequences of Substance Abuse Among Pregnant and Parenting Women*, 20 PEDIATRIC ANNALS 548 (1991).

[11] INSTITUTE OF MEDICINE, PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS 79 (Sarah S. Brown, ed. 1988).

[12] *See e.g.* AN ANALYSIS OF GARRETT'S LAW REFERRALS, JUNE 2005 THROUGH MAY 2006, PREPARED BY HORNBY ZELLER ASSOCIATES FOR THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF CHILDREN AND FAMILY SERVICES (2006). (In analyzing an Arkansas law that mandates doctors to report positive toxicology tests at birth to child welfare authorities, this report found that marijuana accounted for over half of reports, which were most commonly associated with no health problems. Only 64.1% of mothers received any social services or drug treatment after being reported. Additional drug screens accounted for the vast majority of these "services." The number of mothers receiving only drug screens, which are more of a source of information for

social service providers than a rehabilitative measure for parents, were more than the combined total of the next three types of services received.).

[13] *See* Office of Applied Studies, Substance Abuse & Mental Health Serv. Admin., *Facilities Offering Special Programs or Groups for Women: 2005*, DASIS REP., May 15, 2008 , *available at* http://www.oas.samhsa.gov/2k6/womenTx/womenTX.htm.

[14] Office of Applied Studies, Substance Abuse & Mental Health Serv. Admin., *Substance Use Treatment Among Women of Childrearing Age*, NSDUH REP., Oct. 4, 2007, *available at* http://oas.samhsa.gov/2k7/womenTX/womenTX.htm.

[15] *See* Renewal House description, *available at* http://www.renewalhouse.org

[16] *Meth Treatment Options Few*, CHATTANOOGA TIMES FREE PRESS, Jan. 31, 2004, at B2; *see also* Tennessee Commission on Children and Youth, *Substance Abuse and Child Welfare*, ADVOCATE, May 2008, at : http://www.tennessee.gov/tccy/adv0805.pdf (noting that an "estimated 63,013 young Tennesseans have a serious alcohol problem and 84.6 percent (54,802) of them need treatment but do not receive it.").

[17] *See* Center for Substance Abuse Treatment, Substance Abuse and Mental Health Serv. Admin., U.S. Department of Health and Human Services, *Pregnant, Substance-Using Women*, TREATMENT IMPROVEMENT PROTOCOL (TIP) 6-7 (1993), *available at* http://ncadi.samhsa.gov/govpubs/bkd107/2e15.aspx (discussing the services needed to address successfully the treatment of drug using women, noting that it "is imperative that programs include services designed specifically for women, particularly pregnant women"); *see also* Center for Substance Abuse Treatment, *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs* 124-26 (1994) (U.S. Dept. of Health & Human Servs. Publication No. (SMA) 94-3006) (providing guidance to treatment providers to meet the specific needs of women with substance abuse problems).

[18] For discussion of the lack of treatment programs designed for pregnant women generally, *see, e.g.*, Wendy Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 266 JAMA 1556 (1991); Julie Petrow, *Addicted Mothers, Drug Exposed Babies: The Unprecedented Prosecution of Mothers Under Drug-Trafficking Statutes*, 36 N.Y.L. SCH. L. REV. 573, 604-06 (1991) (arguing for an increase in federal and state funding for drug treatment programs for women); Molly McNulty, Note, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 292-303 (1987) (discussing the lack of access to adequate health care); Wendy Chavkin et al., *National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women*, 88 AM. J. PUB. HEALTH 117 (1998); Legal Action Center, *Steps to Success: Helping Women with Alcohol and Drug Problems Move From Welfare to Work* 3 (May 1999); *see also* Drug Strategies, *Keeping Score, Women and Drugs: Looking at the Federal Drug Control Budget* 16-17(1998); Vicki Breitbart et al., *The Accessibility of Drug Treatment for Pregnant Women: A Survey of Programs in Five Cities*, 84 Am. J. Pub. Health 1658 (1994); *see also Elaine W. v. Joint Diseases N. Gen. Hosp., Inc.*, 613 N.E.2d 523, 524 (N.Y. 1993) (discussing a New York hospital's refusal to admit pregnant women into its drug detoxification program); NANCY K. YOUNG ET AL., NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE, A REVIEW OF ALCOHOL AND OTHER DRUG ISSUES IN THE STATES; CHILD AND FAMILY SERVICE REVIEWS AND PROGRAM IMPROVEMENT PLANS, (2005), *available*

at http://www.ncsacw.samhsa.gov/files/SummaryofCFSRs.pdf ("Repeatedly, the comment was made that treatment resources are inadequate...and the lack of priority given to child welfare families in allocating treatment resources.").
[19] C. Dailard & E. Nash, *State Responses to Substance Abuse Among Pregnant Women*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Mar. 1, 2009, *available at* http://www.guttmacher.com/sections/pregnancy.php.
[20] *See* Tennessee Commission on Children and Youth, *Adolescents and Substance Abuse*, ADVOCATE, June 2008, *available at* http://www.tennessee.gov/tccy/adv0806.pdf.
[21] Julie Rovner, *Tennessee Health-Care Cuts Roil Poor Community*, NAT'L PUBLIC RADIO, June 19, 2006, *available at* http://www.npr.org/templates/story/story.php?storyId=5491337.
[22] *See* Memorandum of Allison Guttu, Equal Justice Works Fellow, National Advocates for Pregnant Women (Mar. 6, 2009) (on file with National Advocates for Pregnant Women).
[23] *Id*.
[24] *Commissioner of Social Services v. David R.S.,* 436 N.E.2d 451, 454 n.4 (1982) (quoting H.R. Rep. No. 92-920, 92nd Cong., 2d Sess., p. 33 [in U.S. Code Cong. & Admin. News, 1972, p. 2072] in reversing order to disclose drug abuse treatment records in paternity proceeding). *See also Local 738 Inter'l Bhd. Teamsters v. Certified Grocers Midwest*, 737 F. Supp. 1030 (N.D. Ill. 1990) (denying enforcement of arbitration subpoenas seeking disclosure of patient drug abuse treatment records).
[25] *See e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 73 n.4 (2001) (in anticipation of criminal prosecutions for child abuse, virtually identical criteria were used in a testing program that the U.S. Supreme Court found violated the constitutional rights of pregnant public hospital patients); Ferguson v. City of Charleston, 308 F.3d 380 (4th Cir. 2002) (finding that general medical consent forms did not constitute consent to submit results of urine test to police).
[26] *See* Ira Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENGLAND J. MED. 1202 (1990) (comparing results of universal testing with the number of cases reported to child welfare authorities Dr. Chasnoff concluded that pursuant discretionary testing "a significantly higher proportion of black women than white women were reported, even though we found that the rates of substance use during pregnancy were similar.").
[27] *See, e.g.*, Troy Anderson, *Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers*, L.A. DAILY NEWS, June 30, 2008.
[28] *See e.g.,* Troy Anderson, *False Positives Are Common in Drug Tests on New Moms*, L.A. DAILY NEWS, June 28, 2008.
[29] *See* T.A. Campbell & K.A. Collins, Pediatric Toxicologic Deaths: A 10 Year Retrospective Study, 22 Am. J. Forensic Med. & Pathology 184 (2001); M.A. Sims & K.A. Collins, Fetal Death: A 10-Year Retrospective Study, 22 Am. J. Forensic Med. & Pathology 261 (2001).
[30] C.R. Bauer et al., *The Maternal Lifestyle Study: Drug Exposure During Pregnancy and Short-Term Maternal Outcomes*, 186 Am. J. Obstetrics & Gynecology 487,492 (2002).

[31] D. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613, 1621 (2001). *See also* T.A. Campbell & K.A. Collins, *Pediatric Toxicologic Deaths: A 10 Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 184 (2001); M.A. Sims & K.A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 261 (2001) (Independent studies finding that they were unable to link cocaine use during pregnancy to an increased risk of stillbirth (intrauterine fetal death).
[32] S. Henrietta et al., *Impact of Prenatal Cocaine Exposure on Child Behavior Problems Through School Age*, 119 PEDIATRICS e348 (2007).
[33] D.S. Messinger et al., *The Maternal Lifestyle Study: Cognitive, Motor, and Behavioral Outcomes of Cocaine-Exposed and Opiate-Exposed Infants Through Three Years of Age*, 113
PEDIATRICS 1677 (2004).
[34] H. Hurt et al., *School Performance of Children with Gestational Cocaine Exposure*, 27 NEUROTOXICOLOGY & TERATOLOGY 203 (2005).
[35] NIDA Research Report, Cocaine: Abuse and Addiction, Nov. 2004, at 6, http://www.drugabuse.gov/ResearchReports/Cocaine/cocaine4.html
[36] U.S. SENTENCING COMMISSION, REPORT TO THE CONGRESS: COCAINE AND FEDERAL SENTENCING POLICY 21-22 (2002), *available at* http://www.ussc.gov/r_congress/02crack/2002 crackrpt.pdf. Courts have also recognized that "the phenomena of 'crack babies' . . . is essentially a myth."
United States v. Smith, 359 F. Supp. 2d 771, 780 n.6 (E.D. Wis. 2005). *See also McKnight v. South Carolina*, 661 S.E.2d 354 (S.C. 2008) (overturning a conviction because of ineffective assistance of counsel who failed to call experts to testify about "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor."). *See also* Susan Okie, *The Epidemic That Wasn't*, N.Y. TIMES, Jan. 26, 2009 (reporting on long-term studies confirming these conclusions).
[37] Center For The Evaluation Of Risks To Human Reproduction, Report Of The NTP-DERHR Expert Panel On The Reproductive & Developmental Toxicity Of Amphetamine & Methamphetamine (2005), 163, 174.
[38] ACOG, *Information about Methamphetamine Use in Pregnancy* (3/03/06).
[39] *See* CESAR Weekly Fax from the Center for Substance Abuse Treatment, Vol 14 Issue 33 (Aug 2005).
[40] Silver, *et al.*, *Workup of Stillbirth: A Review of the Evidence*, 196 AMER. J. OBSTETRICS & GYNECOLOGY, 433-444, 438 (May 2007) (emphasis added).
[41] New York Legal Aid Society, *Governmental Action in Cases of In Utero Drug or Alcohol Exposure: The Role and Responsibilities of Child Protective Authorities and the Family Court*, Position Paper, Dec. 1997.
[42] Center for Substance Abuse Treatment, Substance Abuse and Mental Health Serv. Admin., U.S. Department of Health and Human Services, *Pregnant, Substance-Using Women*, TREATMENT IMPROVEMENT PROTOCOL (TIP) 48 (1993), *available at* http://ncadi.samhsa.gov/govpubs/bkd107/2e15.aspx.
[43] *Id.* at 47.
[44] *Id.*

[45] Substance Abuse & Mental Health Serv. Admin., Dep't Health & Human Serv., *Mandatory Guidelines for Federal Workplace Drug Testing Programs*, Apr. 13, 2004, *available at* http://www.workplace.samhsa.gov/fedpgms/Pages/HHS_Mand_Guid_Effective_Nov_04.aspx.
[46] TENN. CODE ANN. § 50-9-105 (a) (B)(7) (1996).
[47] TENN. CODE ANN. § 50-9-105 (a) (B)(7) (1996).
[48] AM. HOSP. ASS'N, SUBSTANCE ABUSE POLICIES FOR HEALTHCARE INSTITUTIONS: MANAGEMENT ADVISORY 4 (1992).
[49] *See e.g.*, David Steinkraus, *"Cocaine Mom" Law Has Side Effects*, J. TIMES (Racine, Wis.), May 16, 2005; David Steinkraus, *Pregnant, Addicted Woman Asks for Help, Gets Locked Up*, J. TIMES (Racine, Wis.), May 11, 2005.
[50] SUSAN C. BOYD, MOTHERS AND ILLICIT DRUGS: TRANSCENDING THE MYTH (1999) (listing at least fourteen studies demonstrating that women who use illicit drugs can be adequate parents); *see also* M. Kearney et al., *Mothering on Crack Cocaine: A Grounded Theory Analysis*, 38 SOC. SCI. & MED. 351, 355 (1994).
[51] Am. Bar Ass'n, Foster Care Project, National Legal Resource Center for Child Advocacy and Protection, Foster Children in the Courts 206 (Mark Hardin ed., 1983). *See also* Nat'l Council of Juvenile and Family Court Judges, Permanency Planning for Children Project, Protocol for Making Reasonable Efforts to Preserve Families in Drug Releated Dependency Cases 17 (1992) (concluding that "Juvenile and family court proceedings are not necessary, and probably not desirable, in most situations involving substance-exposed infants").
[52] *See e.g.*, Barbara Rittner & Cheryl Dozier Davenport, *Effects of Court-Ordered Substance Abuse Treatment in Child Protective Services Cases*, 45 SOCIAL WORK 131, 136-137 (2000) (showing that non-compliant with mandated drug treatment was not a significant predictor of future abuse).
[53] *See e.g. State v. Wade*, 232 S.W.3d 663, 666 (Mo. Ct. App. 2007); *Commonwealth v. Ina Cochran*, No. 2006-CA-001561 (Ky. Ct. App. Jan. 11, 2008), *appeal docketed sub. nom*. Cochran v. Commonwealth, Case No. 2008-SC-000095-DG (Ky. Aug. 13, 2008).
[54] *See e.g.*, Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*. N.Y.U. REV. L.& SOC. CHANGE, Forthcoming. Available at SSRN: http://ssrn.com/abstract=1003683; *cf. Lovill v. State*, -- S.W.3d --, 2008 WL 5275531 (Tex. Ct. App. Dec. 22, 2008) (concluding that treating probationer differently on the basis of pregnancy was gender discrimination).
[55] *See* Judy Murphy, Background Information / Moms Off Meth Group, http://www.momsoffmeth.com/about.htm (last visited Mar. 10, 2009) (describing collaborative effort of recovering women, state officials, and child welfare authorities in forming the highly successful Moms Off Meth group).
[56] *See e.g.*, Patt Denning & Jeannie Little, *Harm Reduction in Mental Health*, HARM REDUCTION COMMUNICATION (Spring 2001) (One can also predict the likelihood of developing problems with drug use based on traumatic experiences: "up to 80% of people with a history of significant trauma will abuse substances."). *See also Women and Drug Abuse*, NIDA CAPSULES (June 1994) (Among drug using women, 70% report having been abused sexually before the age of 16; and more than 80% had at least one parent

addicted to alcohol or one or more illicit drugs); Marsha Rosenbaum, *Women: Research and Policy*, *in* WILLIAMS & WILKINS, SUBSTANCE ABUSE 654-65 (1997) ("Researchers have consistently found high levels of past and present abuse in the lives of women drug users. Many have suggested that there is a relationship, if not absolutely causal, between violence experienced by women and drug use"); Jahn L. Forth-Finegan*, Sugar and Spice and Everything Nice: Gender Socialization and Women's Addiction – A Literature Review, in* FEMINISM AND ADDICTION 25 (Claudia Bepko ed., 1991) ("Difficult and physically abusive childhood experiences are reported to be frequent, and the incidence of sexual abuse among alcoholics has been shown to be very high, often as high as 75% of the women in treatment.").