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Drug-Exposed Newborns &
Family Drug Treatment Court

SUBSTANCE-EXPOSED INFANTS: POSSIBLE POLICY AND LEGISLATIVE RESPONSES IN MASSACHUSETTS

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I) INTRODUCTION

The following is a discussion of various state responses to the problem of substance-exposed infants. I consider whether these responses should be implemented in Massachusetts. I conclude by recommending amendments to Massachusetts' child welfare statute, as well as the establishment of a family treatment drug court.

It is important to note that state responses to the problem of substance-exposed infants raise constitutional issues. Opponents of coercive state action rely on *Roe v. Wade*[1] to argue that state intervention violates a woman's right to reproductive freedom. Others contend that *Planned Parenthood v. Casey*[2] leaves room for carefully crafted state intervention that promotes the health and wellbeing of future children. This second group relies on *Casey*'s softening of the strict scrutiny standard for restrictions on abortion and the finding that the state's interest in fetal health begins post-conception and pre-viability. It has also been suggested that while the decision to abort may be constitutionally protected, there cannot be a similar right to endanger a fetus a woman chooses to bring to term. The state has an interest in preventing damage to future children it may have to care for.

II) CRIMINALIZATION

One option for managing the problem of substance-exposed infants has been to criminally prosecute women who abuse drugs or alcohol during pregnancy. Courts and policy makers have largely rejected this response. No state defines prenatal maternal substance abuse as a crime under statute. And while prosecutors have attempted to use existing criminal provisions to attach liability, only one appellate court has upheld a conviction based on prenatal maternal substance abuse. In *Whitner v. South Carolina*,[3] the South Carolina Supreme Court upheld a conviction of child abuse based on the defendant's use of cocaine while pregnant. The Court reasoned that the statutory definition of "child" included a viable fetus. Thus, South Carolina is the only state in which drug (and potentially alcohol) use during the latter stages of pregnancy may result in criminal charges.

III) CIVIL COMMITMENT OF PREGNANT SUBSTANCE ABUSERS

[1] *Roe v. Wade*, 410 U.S. 113 (1973).
[2] *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).
[3] *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997).

Civil commitment of drug and alcohol-dependent persons is provided for by statute in a number of states. Generally, an individual qualifies on the basis of harm posed to themselves or others. Until recently, harm to others encompassed only those already born. However, a handful of states have recently amended their legislation in an attempt to prevent harm to fetuses from prenatal substance exposure, including Minnesota, South Dakota, and Oklahoma. A fourth state, Wisconsin, chose to amend its child welfare legislation, as opposed to its civil commitment statute, to permit forced custody of pregnant substance abusers. In contrast, New York has passed legislation specifically prohibiting the civil commitment of pregnant women on the basis of a risk of harm to the fetus.

Like many states, Massachusetts has legislation providing for the commitment of substance-dependent individuals. Under Massachusetts General Law chapter 123, section 35, civil commitment can be imposed where the court finds (a) that the respondent is an "alcoholic" or "substance abuser" and (b) that "there is a likelihood of serious harm as a result of his alcoholism or substance abuse".[4] An alcoholic or substance user is one whose (a) use of alcohol or substances either "substantially injures his health or substantially interferes with his social or economic functioning", or (b) is an individual who has "lost the power of self-control over the use of [alcohol or substances]".[5] Presumably a drug or alcohol-dependent pregnant woman could meet the definition of an alcoholic or substance abuser. However, it is not clear whether threat to a fetus from drug/alcohol consumption would satisfy the "likelihood of serious harm" requirement. There have not been any reported cases in Massachusetts where civil commitment of a pregnant woman was ordered.

Research suggests that damage to fetuses from alcohol and drug exposure can occur at any stage of the pregnancy.[6] Thus, while some degree of damage is inevitable prior to commitment, further damage can be avoided after a woman is committed.

The case for civil commitment may be stronger with respect to alcoholic women, as the link between *in utero* exposure to alcohol and harm to fetuses is well established. The link between fetal harm and exposure to illegal drugs is less clear. And some research suggests that a positive post-birth environment can ameliorate many of the negative effects of illegal drug exposure.[7] Much of this research focuses on cocaine usage.

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[4] MASS. GEN. LAWS ANN. ch. 123 § 35 (2008).

[5] *Id.*

[6] *See e.g.* Gale A. Richardson et al., *The Effects of Prenatal Cocaine Use on Infant Development*, 30:2 NEUROTOXICOLOGY AND TERATOLOGY 96 (2008); and Marit Korkman et al., *Neurocognitive Impairment in Early Adolescence Following Prenatal Alcohol Exposure of Varying Duration*, 9:2 CHILD NEUROPSYCHOLOGY 117 (2003).

[7] Krista Drescher-Burke & Amy Price, *Identifying, Reporting, and Responding to Substance Exposed Newborns: An Exploratory Study of Policies & Practices* (2005), *available online at*: http://aia.berkeley.edu/media/pdf/rwj_report.pdf.

According to the Massachusetts' civil commitment statute, custody can be ordered for up to 30 days. Where treatment facilities are not available, the respondent may be ordered to prison. In that case, the respondent must be housed and receive treatment separate from prisoners. The Criminal Justice Policy Coalition reports that recent funding cuts in Massachusetts have reduced the number of treatment spaces available for individuals civilly committed.[8] They suggest that as a result many women (it is not clear if this includes pregnant women) are being held and treated in women's prison.

IV) CHILD WELFARE RESPONSE

A. Infants identified as warranting report to DCF

In 2003, Congress passed amendments to the Child Abuse Prevention and Treatment Act (CAPTA), requiring states in receipt of federal funding to implement reporting laws for drug-affected newborns. Health care workers involved in the delivery and care of an infant "identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure" must report the case to child welfare authorities (emphasis added).[9] Alcohol-affected infants are not mentioned.

Massachusetts had a mandated reporting statute for substance-exposed infants prior to the 2003 CAPTA amendments. In 2002, s. 51A(a) of Massachusetts' child welfare statute read, in part:[10]

> Any [listed professional], who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department (emphasis added)…

The provision was amended in 2008 to its current form, which states:[11]

> A mandated reporter who, in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from: … (iii) physical dependence upon an addictive drug at birth, shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect (emphasis added).

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[8] *Civil Commitment*, Criminal Justice Policy Coalition (April 21, 2010), *available online at*: http://www.cjpc.org/i_civil_commitments.htm.

[9] Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5106 (2006).

[10] MASS. GEN. LAWS ANN. ch. 119 § 51A (Effective to May 2, 2002).

[11] MASS. GEN. LAWS ANN. ch. 119 § 51A (2008).

The current version of s. 51A(a) suggests that a report is contingent on (a) the child suffering physical or emotional injury, *and* (b) the child being physically dependent on an addictive drug. CAPTA reporting requirements are less demanding. The child must only be identified as "affected by illegal substance abuse or withdrawal symptoms (emphasis added)".

Like CAPTA, the Massachusetts statute does not seem to contemplate alcohol exposure. Children cannot be physically dependent on alcohol at birth. This omission is problematic given the clear relationship between *in utero* exposure and harm to children. In fact, the relationship between prenatal maternal alcohol use and ailments such as Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders is better established than the relationship between illegal drug exposure and harm to infants. If a purpose of the provision is to ensure adequate care for suffering infants, those with alcohol-related disorders should not be ignored.

Moreover, alcoholic parents may suffer the same parenting deficiencies as parents addicted to drugs. Statistics concerning the numbers of children entering the foster care system identify both parental drug *and* alcohol use as major concerns.[12] If children of alcohol-dependent parents are not being reported, child protective workers miss an opportunity to engage with families at high risk of abuse and neglect.

Because the provision only targets infants "physically dependent" on a drug, infants experiencing symptoms other than withdrawal could go unreported. Again, this could result in a failure of child welfare authorities to intervene where future abuse or neglect is likely.

B. Identifying infants warranting a report – universal testing of infants

It has been reported that an estimated 75-90% of substance-exposed infants born in the United States leave the hospital undetected.[13] This is a problem for two reasons. First, substance-exposed infants typically require more specialized care. Identifying these infants allows additional support to be provided to families. Second, parents that abuse drugs or alcohol are more likely to abuse or neglect their children. Failure to identify substance-abusing parents places infants at greater risk of maltreatment. This risk is exacerbated in the case of infants that are difficult to parent, such as those suffering the effects of *in utero* substance exposure.

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[12] *See e.g.* The United States Government Accounting Office, *Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers* (September 1998), *available online at*: http://www.gao.gov/archive/1998/he98182.pdf.

[13] Nancy K. Young, *Substance Exposed Infants: Policy and Practice* (2005), *available online at*: http://www.ncsacw.samhsa.gov/files/508/SubstanceInfants.htm.

Neither CAPTA nor s. 51A of Massachusetts' child welfare statute require testing of infants for substance exposure.[14] Instead, policies on testing are set by individual hospitals. Few of these policies mandate universal screening for targeted testing, and none mandate universal testing. Testing of infants is often done on the basis of subjective criteria.[15]

Mark Testa and Brenda Smith argue that lack of consistency in screening and testing of infants creates the potential for discrimination. They say the current system of screening puts African American infants at disproportionate risk of CPS detection and involvement.[16] Universal testing would ameliorate this concern.

At present, testing of meconium (an infant's first bowel movement) is the most effective means of detecting *in utero* drug exposure. Meconium may provide information about a mother's drug use as far back as the beginning of the second trimester (at approximately the twelfth week of gestation). Meconium testing is also emerging as a reliable method for detecting significant alcohol use during pregnancy (more than 2 drinks per day, or more than 5 drinks per occasion).[17] While universal meconium testing would be expensive,[18] early detection of substance-exposed children could reduce future costs to the state.[19]

C. Universal screening and/or testing of pregnant women

Substance-exposed infants may also be identified through screening or testing of pregnant women. There are currently a number of instruments available to screen pregnant women for substance abuse.[20] Each involves a series of questions

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[14] This is consistent with other states. No state has implemented mandatory drug testing of newborns or pregnant women by statute.

[15] National Center on Substance Abuse and Child Welfare, *Substance-Exposed Infants: State Responses to the Problem* 17 (2009), *available online at*: http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf [hereinafter State Responses].

[16] Mark F. Testa and Brenda Smith, *Prevention and Drug Treatment*, 19:2 FUTURE OF CHILDREN 147, 161 (2009).

[17] Daphne Chan et al., *Recent Developments in Meconium and Hair Testing Methods for the Confirmation of Gestational Exposures to Alcohol and Tobacco Smoke*, 37:6 CLINICAL BIOCHEMISTRY 429 (2004).

[18] According to one testing provider, the cost of one meconium test for alcohol exposure is $129.00. If combined with drug testing, the cost is $149.00 per test. This figure may be high, as discounts are provided for hospitals with large specimen loads: FAQs: MecStat EtoH℠, USDTL, *available online at*: http://www.usdtl.com/faq_mecstat_etohsm.html.

[19] One Canadian study found that universal meconium testing for alcohol in infants with an older sibling diagnosed with fetal alcohol spectrum disorder was more cost effective and resulted in a greater quality of life for the infant, as compared to targeted testing: Hopkins *et al.*, *Universal or Targeted Screening for Fetal Alcohol Exposure: A Cost-Effectiveness Analysis*, 69:4 JOURNAL OF STUDIES ON ALCOHOL AND DRUGS 510 (2008).

[20] These screening tools include the TWEAK, T-ACE, 4P's Plus©, and Modified 5P's.

designed to assess risk and facilitate referral for more comprehensive assessments.[21] The 2004 prenatal care guidelines issued by the American College of Obstetricians and Gynecologists (ACOG) state that, "all pregnant women should be questioned at their first prenatal visit about past and present use of alcohol, nicotine, and other drugs".[22] However, screening instruments are not universally administered. Screening is often at a physician's discretion, usually employed when substance abuse is suspected.[23] The problem with targeted screening is that certain pregnant substance abusers, and their future children, can go unidentified.

Prenatal screening is important for identifying women for further assessment and treatment. Treatment obviously reduces the risk of damage to the fetus that may be caused by substance exposure. However, not all women who need treatment will access it voluntarily. In 2007, pregnant women represented 1% of admissions to substance abuse treatment programs in Massachusetts.[24] This number is lower than national estimates of the number of pregnant women who use drugs (approximately 5.2%) or alcohol (approximately 11.6%).[25]

Neither CAPTA nor Massachusetts law require testing of pregnant women. Policies on drug and alcohol testing of pregnant women are again set by individual hospitals.[26] Physicians are typically responsible for ordering drug tests, and discretion plays a key role.[27] If testing is done for medical purposes, a mother's consent may not be required. However, in *Ferguson v. City of Charleston*,[28] the Supreme Court found that non-consensual testing of pregnant women for law enforcement purposes violates the Fourth Amendment. It is not clear whether tests performed on a pregnant woman for the purpose of reporting drug use to child protection authorities would also be unconstitutional. A 2009 publication by the

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[21] Elizabeth K. Anthony et al., *Early Detection of Prenatal Substance Exposure and the Role of Child Welfare*, 32 CHILDREN AND YOUTH SERVICES REVIEW 6, 9 (2010).

[22] State Responses, *supra* note 13.

[23] Drescher-Burke and Price, *supra* note 7.

[24] *Substance Abuse Treatment Annual Report – FY 2007: Pregnant Women Admissions*, Bureau of Substance Abuse Services, Department of Public Health (2007), *available online at*: http://www.mass.gov/Eeohhs2/docs/dph/substance_abuse/population_pregnant_women_fy2007.pdf.

[25] Substance Abuse and Mental Health Services Administration, *Results from the 2007 National Survey on Drug Use and Health: National Findings* (2008), *available online at:* http://www.oas.samhsa.gov/NSDUH/2k8NSDUH/2k8results.cfm#7.3.1.

[26] *Id.*

[27] *Id.*

[28] *Ferguson v. City of Charleston*, 532 U.S. 67 (2001).

Washington state government cautions that maternal testing without consent for CAPTA purposes could run afoul of *Ferguson*.[29]

Testing of an infant without the mother's consent may be less problematic. In *Ferguson*, the Court suggested that evidence of drug use obtained through diagnostic tests designed to help the patient could be turned over to law enforcement agencies without implicating the Fourth Amendment. If testing of an infant is done primarily for diagnostic and treatment purposes, reporting these results to child protection authorities may be constitutional.

D. Substance exposure as abuse or neglect

Fifteen states consider substance abuse during pregnancy to be child abuse under civil child welfare statutes. Massachusetts does not. Prenatal maternal substance abuse is instead mentioned in s. 51A of Massachusetts' child welfare statute (cited above). Under s. 51A, a mandated reporter must report to DCF where "a child is suffering physical or emotional injury resulting from… (iii) physical dependence upon an additive drug at birth".

Upon receiving a report under s. 51A, DCF must investigate the case and complete a written report (s. 51B(a)). This report considers the safety of the child, and whether the abuse or neglect is substantiated (s. 51B(b)). If DCF substantiates the abuse or neglect – a "child is suffering physical or emotional injury resulting from… physical dependence upon an addictive drug" – it may file a care and protection petition with the court (s. 24). A care and protection petition must be filed if a drug-exposed infant is taken into temporary custody following a s. 51A report (s. 51B(c)). DCF can remove a drug-exposed infant from the custody of its parent(s) where it has "reasonable cause to believe the child's health is in immediate danger from abuse or neglect" *and* that removal is "necessary to protect the child from abuse or neglect."

In filing a petition under s. 24, DCF must allege one of four grounds. That the child,

> (a) is without necessary and proper physical or educational care and discipline;
> (b) is growing up under conditions or circumstances damaging to the child's sound character development;
> (c) lacks proper attention of the parent, guardian with care and custody or custodian; or
> (d) has a parent, guardian or custodian who is unwilling, incompetent or unavailable to provide any such care, discipline or attention.

[29] Washington State Department of Health, *Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State* (2009), *available online at*: http://www.doh.wa.gov/cfh/mch/documents/HospTestDrug.pdf.

Although not explicitly mentioned in the statute, drug and alcohol use by a parent is a relevant consideration for the court under subsection (d).[30]

If any of the four grounds in s. 24 are met, the court may find the child in need of care and protection (s. 26(b)). Once a child is found in need of care and protection, a custody order can be made under s. 26, including an order for agency supervision, agency custody (foster care), or an order to dispense with the need for consent to adoption, which terminates parental rights. This order is made in accordance with the child's best interests.

V) FAMILY TREATMENT DRUG COURT

A. Overview

Family Treatment Drug Courts (FTDCs) (or Dependency Drug Courts) are specialized courts designed to work with substance-abusing parents involved in the child welfare system. Parents enroll in FTDCs to avoid child protection proceedings that could lead to termination of their parental rights. FTDCs provide parents with priority access to substance abuse treatment and other services aimed at improving parenting. Decisions about whether a child will be returned to a parent's custody or remain in a parent's custody depend on the parent's success in completing treatment and accessing services to improve parenting.

Modeled after adult (criminal) drug courts, FTDCs include regular (often weekly) court hearings, intensive judicial monitoring, provision of substance abuse treatment and other services (sometimes including counseling, health care, housing assistance, and domestic violence programming), frequent drug testing, and rewards and sanctions linked to service compliance (the ultimate reward being reunification, the ultimate sanction being termination of parental rights). In addition to the judge and their staff, FTDC hearings typically involve a child welfare caseworker, a case manager, treatment provider, the parent, and the parent's attorney. The team may also include a guardian *ad litem* for the child.

In 2006, there were 183 FTDCs operating in 43 states, with an additional 100 programs in development.[31] Although Massachusetts does have adult and juvenile criminal drug courts, it does not have any FTDCs.

Time of entry into the program depends on the program design. Most programs screen and enroll clients at the neglect petition stage (in Massachusetts, this would be at the time of filing a s. 24 petition). Different programs have different criteria for enrollment. For example, many exclude parents with significant mental health

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[30] *See e.g. Adoption of Anton*, 72 Mass.App.Ct. 667 (2008).

[31] NPC Research, *Family Treatment Drug Court Evaluation: Final Report*, Substance Abuse & Mental Health Services Administration (2007), *available online at*: http://www.npcresearch.com/Files/FTDC_Evaluation_Final_Report.pdf.

problems. Once a parent is enrolled, the team develops a treatment plan, which typically requires judicial approval. Compliance with this plan is then monitored. Sanctions are imposed for violations, and rewards are given for compliance. Rewards are generally in the form of increased visitation, graduation ceremonies, or vouchers for local stores. Sanctions depend on the number of violations. For a first violation, the typical sanction is a reprimand from the judge. A second violation may include increased treatment services and therapeutic activities (such as essay writing). A third violation *can* involve a period of incarceration. Incarceration is imposed as punishment for civil contempt.

Reports on the effectiveness of drug courts are cautiously optimistic. One 2007 study of four FDTCs suggests that mothers enrolled in FDTCs are more likely to enter treatment, enter treatment more quickly, spend more time in treatment, and are more likely to complete treatment than mothers not enrolled in FDTCs.[32] The authors also found that FDTC children were more likely to be reunited with their mothers than non-FDTC children, although reunification took longer in the FDTC cases. Significantly, FDTC cases resulting in termination of parental rights did not take longer than non-FDTC cases. FDTC mothers also had less incidents of non-compliance with their treatment/service plans than non-FDTC mothers.

Funding for FDTCs may come from a number of sources. A publication of the U.S. Department of Justice based on input from FDTC administrators identifies the following options for funding: the Substance Abuse Prevention and Treatment Block Grant (managed by the federal Substance Abuse and Mental Health Services Agency); discretionary funds from SAMHSA's Targeted Capacity Expansion Program; Medicaid; TANF; funding from the Administration for Children and Families, such as from the Court Improvement Program; and the federal Social Services Block Grant.[33]

B. FTDC's and substance-exposed infants: the Jackson County model

In the 1980's, a series of cocaine-related infant deaths in Kansas City, Missouri prompted the creation of a task force to investigate the problem of substance-exposed newborns. The task force recommended a program establishing linkages between hospitals, child protection authorities, and family courts. This led to the creation of the Newborn Crisis Program, administered by the Children's Division of the Department of Social Services. It also spurred the creation of the Jackson County Family Drug Court to handle cases involving substance-exposed infants and their families. The Court has since broadened its mandate to include abuse and neglect cases involving older children of drug or alcohol-using mothers.

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[32] *Id.*

[33] *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model*, U.S. Department of Justice (December 2004), *available online at*: http://www.ncjrs.gov/pdffiles1/bja/206809.pdf.

One function of the Newborn Crisis Program is to evaluate the safety of infants born to drug or alcohol-using mothers. Where an infant tests positive for an illicit drug at delivery, a mother tests positive for an illicit drug at delivery, or a physician has reason to believe that there are serious concerns for an infant due to illicit drug use by a parent, a medical social worker, nurse or physician may activate a Newborn Crisis Assessment request by calling the Children's Division Child Abuse Hotline. A Newborn Crisis Assessment may also be activated where there are concerns about a mother's alcohol use. Requests related to alcohol use are typically made when a mother presents at the hospital in an obviously intoxicated state (specific indicators include slurring of speech, "glassy-eyed" appearance, inability to walk normally, presence of alcohol odor).[34]

The Newborn Crisis Program and Family Drug Court work with Kansas City Hospitals to ensure consistent identification and reporting of substance-exposed newborns. Local hospitals have drafted policies for identifying and testing suspected substance-exposed infants. These policies are not publicly available.

Although hospitals do not release individual testing policies, a number of states offer guidelines for screening or testing of infants. An Arizona document recommends testing of a mother where one of the following factors is present: history of previous or current substance abuse by mother and/or significant others living in the home, or history of a previous delivery of a substance-exposed newborn; non-compliance with prenatal care; evidence of unexplained poor weight gain during the pregnancy; medical non-compliance; medical symptoms of withdrawal in the mother; signs of substance use/abuse; maternal medical history of Hepatitis B or C, HIV infection, or 2 or more sexually transmitted diseases; previous or current history of placental abruption or unexplained vaginal bleeding; and cardiovascular accident.[35] If a mother tests positive for alcohol or an illicit drug, the same document recommends that the infant be tested. It is recommended that an infant also be tested where one of the following factors is present: signs of neonatal abstinence syndrome which may include marked irritability, high-pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea (runny nose), or diaphoresis (excessive sweating); unexplained apnea (suspension of breathing); microcephaly (small head); low birth weight (under the 5th percentile for gestational age); cerebral vascular accident (stroke); and necrotizing enterocolitis (a serious intestinal illness).

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[34] Testing of mothers may not indicate the presence of alcohol, as alcohol typically leaves the body within 12 to 24 hours. And unlike newborns exposed to illicit drugs who may show obvious signs of withdrawal or drug-related distress, infants suffering the effects of alcohol-exposure tend not to be diagnosed until approximately 6 months of age.

[35] The Governor's Action Plan on Child Protective Services Reform: Substance-Exposed Newborn Committee, *Guidelines for Identifying Substance-Exposed Newborns*, *available online at*: http://www.azgovernor.gov/cps/documents/SenGuidelines.pdf.

Following an assessment request to the Newborn Crisis Program, a newborn crisis worker immediately attends at the hospital to assess whether the child can be safety placed in its mother's care. The average assessment is completed within 24 to 36 hours of delivery. The infant is not released from the hospital until the assessment is complete. The assessment addresses the following factors: family composition, prenatal care, paternity, pregnancy complications, physical, emotional and intellectual functioning of the parent(s), attachment and bonding, parenting skills and sibling assessment, prior history of abuse and neglect, planning/preparation for the infant's birth/hospital discharge, behavior associated with drug and alcohol use, criminal history (e.g. a criminal background check is run on all adults residing in the home over the age of 18), mother and infant's toxicology at birth, infant's withdrawal signs or medical complications, special health needs of the infant, family supports, condition of the home, history of domestic violence, other concerns/strengths, safety plan and a recommendation for disposition/placement. The assessment includes a visit to the mother's home while the infant is still at the hospital. If the mother has agreed to seek treatment, the crisis worker, prior to the mother's discharge, has also often arranged an assessment appointment for the mother at a drug treatment facility.

The completed assessment is then faxed to the Child Protection Attorney (CPA) at the Family Court for review. The CPA reviews the assessment to determine legal eligibility for Family Drug Court. Mothers may not be eligible to participate in drug court because of certain factors, such as age (i.e. under 16 years of age), severe mental illness, or where termination of parental rights will be sought.[36] If the mother is eligible, the assessment is passed on to the Program Manager (PM), who meets with the mother to explain the program. The PM may then recommend the case for assignment in the Family Drug Court at the protective custody hearing stage (when the abuse/neglect petition is filed).[37] (Note: referral to an accredited treatment facility is actively pursued *prior* to the protective custody hearing). A case management hearing date is then scheduled, followed by an initial status review hearing, which typically occurs within one week of the case management hearing.

There are four stages to the Family Drug Court program, tied to the level of required treatment. These are not fixed, and participants may have to repeat stages if they do

[36] There are other circumstances in which a case may not be referred to the Family Drug Court. For example, where a mother is likely to comply with treatment or where the drug in question is marijuana. Typically, a "family centered services" file is opened and child welfare authorities monitor the family for a period of three months. The file may be referred to the Court if circumstances change during this period.

[37] In the first quarter of 2010, 59 drug-exposed infant cases were screened by a CDA. Of these 59, 41 were deemed legally eligible. Of the 41 legally eligible cases, 36 were considered clinically eligible and referred to the Family Drug Court. The program manager of the Court suspects that there are approximately 40 drug-exposed infant cases brought to the attention of a CDA per month.

not comply with treatment. The stages determine the number of hearings per week/month and frequency of random urinalysis. Noncompliance may result in sanctions. Jail time for civil contempt is not administered in the Jackson County Family Drug Court. It was explained to me that overcrowding in area jails makes this option implausible.

Graduation from the program is contingent upon a minimum of 12 months participation in the Family Drug Court. Participants must demonstrate 8 months clean time, successful discharge from a substance abuse treatment program, and documented consistent attendance at a 12-step aftercare program or community-based support program. Stable housing must be attained, restitution issues resolved (i.e. community service, fines, etc.), and outstanding warrants resolved. The participant must have an established support system and relapse management plan in place, as well as a life plan initiated and in place (i.e. employment, education, etc.). Finally, the children of the participant must be living in her home.

Between 1998 and 2005, the percentage of women graduating from the Jackson Country Family Drug Court Program ranged from 27 to 38 percent.[38] In these cases, the children were either never removed or were returned to their mother's care. The average time to graduation was 14 months. The bulk of the remaining cases were "terminated" from the program. Termination can result from any of the following: continued usage by the mother without periods of sobriety, refusal to engage in services, inability to locate the mother, or arrest of the mother where there is reason to believe that she will be held for an indefinite period of time. Although removed from the Family Drug Treatment Court docket, terminated cases continue in regular Family Court. In the majority of terminated cases, the children are not returned to their mother's custody.[39] Between 1998 and 2005, terminations accounted for between 55 and 64 percent of all cases.[40] Most terminations occurred within a year and a half of program entry.

As compared to children not enrolled in the program,[41] program children fared better in certain respects. Looking at final placement outcomes, program children were more likely to achieve some form of permanency after three years: 5 percent of program children remained in a residential facility or foster care placement

[38] Data from the Jackson County Family Drug Court was provided by Penny Clodfelter, Program Manager.

[39] Children that do not return to their mother's custody are either adopted, become the subject of legal guardianship, achieve independent living, or are placed with a fit and caring relative.

[40] Terminations refer to cases no longer in the program. They do not include cases that have been dismissed, referred to another court, or voluntarily withdrawn.

[41] These findings are based on a comparison of 958 program children and 125 non-program children. Non-program children were those who were unable to enroll in the drug court program because the program was full at the time of their eligibility, as well as those who were the subject of abuse and neglect proceedings prior to the creation of program.

without legal guardianship or adoption, compared to 13 percent of non-program children. In cases involving out-of-home placements, program children were also less likely to experience multiple movements. For example, 4 percent of program children experienced five or more changes in outside placements, compared to 26 percent of non-program children. A greater percentage of program children were also never removed from their home (18 percent, compared to 8 percent), although rates of removal have been comparable in recent years. Finally, for children initially removed from the home, those in the program were more likely to be returned to a parent than non-program children (31 percent, compared to 23 percent).

Missouri did not enact legislation to facilitate the creation and operation of the Newborn Crisis Program and Jackson County Family Drug Court. Missouri does not have a mandated reporting provision like s. 51 of Massachusetts' child welfare statute. Also like Massachusetts, Missouri does not define *in utero* substance exposure as a ground of child abuse or neglect. These omissions do not affect the operation of the programs. Hospitals report substance-exposed infants despite there being no law requiring them to do so. The Drug Court also substantiates abuse and neglect where an infant is born substance-exposed, despite the fact that *in utero* substance exposure is not a ground of abuse or neglect under Missouri's child welfare law. This substantiation is important as it allows parents to participate in and be monitored by the Drug Court. It was explained to me that there are usually a number of other concerns the Court can rely on to find abuse or neglect as defined by Missouri's child welfare statute.

Recommendations:

The criteria for making a report under s. 51A of Massachusetts' child welfare statute ought to be expanded. **A proposal could be made to amend s. 51A of the child welfare law to mandate reporting of infants exposed to alcohol *in utero*.** In addition, reporting should not be limited to infants suffering from physical dependence. **Reports should be made for all infants testing positive for alcohol or drugs at birth.**

Testing of infants could be governed by Massachusetts' child welfare law. If the statute requires substance-exposed infants to be reported, it would be reasonable for it to also explain how substance-exposed infants are to be identified. **A proposal could be made to amend s. 51A to require universal testing or to require universal screening with a list of conditions that would require testing.** Such legislation would also have to consider methods of testing.

An alternative to legislative change would be to encourage the development of hospital policies regarding drug testing of infants. This would require

collaboration with health care professionals and hospital administrators. In addition, staff training would be required to ensure consistent testing practices.[42]

A family drug treatment court focusing on substance-exposed infants should be established in Massachusetts. This would involve collaborating with a variety of agencies, including courts, members of the judiciary, DCF, and local hospitals. Funding will also need to be secured.

Section 51A should be amended to require DCF to report all substance-exposed infants to the new family drug treatment court. This report should include a copy of the written report DCF is required to complete under s. 51B. DCF's decision to file a s. 24 petition, which would give jurisdiction to the FTDC, would need to be made in consultation with the FTDC.

Where DCF and the FTDC agree that a s. 24 petition should not be filed, **s. 51A should be amended to require at least one year of DCF monitoring of the substance-exposed infant and its family.**

In my view, amending s. 24 to incorporate *in utero* substance exposure as a ground of abuse or neglect is a good idea. FTDCs typically assume jurisdiction at the s. 24 petition stage. Amending s. 24 to include *in utero* substance exposure as a ground of abuse or neglect would allow the FTDC to hear cases involving *in utero* substance exposure alone. Although Missouri has not found such an amendment necessary, I believe it is important in Massachusetts where the judiciary has been reluctant to interfere with parental rights based on substance abuse alone.[43]

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[42] See Drescher-Burke & Price, *supra* note 7. Even where policies exist, staff may not follow them consistently.

[43] *See Adoption of Katherine*, 42 Mass.App.Ct. 25 (1997), where the Appeals Court of Massachusetts found it was not in the best interests of a child to terminate parental rights under s. 26(4) on the basis of drug use alone.