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Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure

Judith Larsen; Robert M. Horowitz; and Ira J. Chasnoff*

I. INTRODUCTION

In the past few years drug and alcohol-exposed infants have added significantly to the tidal wave of neglect cases sweeping over the family courts. Large urban courts report staggering increases in their juvenile and family dockets. For example, the New York City Family Court experienced a 471% increase in neglect filings between 1984 and 1989, mostly attributable to drugs.¹ In Dade County (Miami), in 1989, 35% of all abuse and neglect petitions filed in the Model Dependency Court involved babies born drug-exposed with crack related problems.²

In response, many states' legislators have rushed to refurbish old

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1. Committee on Family Court and Family Law and the Committee on Juvenile Justice, *The New York City Family Court*, 44 *The Record of the Ass'n of the Bar of the City of New York* 865, 866-67 (1989).

2. Conversation with Doris Capri, Court Administrator, Dade County Model Dependency Court (March 18, 1991). This court handled 1460 petitions of the 1871 filed in the county for the calendar year of 1990. Only neglect filings (39%) outnumbered petitions related to drug-exposed newborns.

civil statutes with new drug or alcohol-specific definitions of neglect and abuse.³ In other states, very general definitions of neglect and abuse are being stretched in the courtroom to cover the new situation.⁴

Petitions that allege neglect and abuse from the time of birth (often relating back to impaired fetal development) pose new evidentiary problems for prosecuting and defense attorneys. In the early stages of a case, there tends to be a reliance on positive urine toxicologies of the mother and the infant to make the government's case. However, as both the judiciary and the bar become more aware of the medical environment in which these cases develop, it is apparent that positive urine toxicologies are not a sufficient, sole support for a

3. In 1989, the Illinois civil neglect statute was amended to read in pertinent part:

(1) Those who are neglected include:

....

(c) any newborn infant whose blood or urine contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act, as now or hereafter amended, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances, the presence of which in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

The Indiana civil neglect law states:

A child is a child in need of services if:

(1) The child is born with fetal alcohol syndrome or an addiction to a controlled substance or a legend drug; or

(2) the child . . .

(C) Is at a substantial risk of a life threatening condition; that arises or is substantially aggravated because the child's mother was addicted to alcohol, a controlled substance, or a legend drug during pregnancy; and needs care, treatment, or rehabilitation that the child is not receiving, or that is unlikely to be provided or accepted without the coercive intervention of the court.

IND. CODE ANN. § 31-6-4-3.1 (Burns 1987). A number of other states have amended civil neglect statutes to specifically address drugs and alcohol. At this point, no particular wording or approach predominates.

4. An example of the typical general definition of a neglected child which courts must adapt to cases involving drug and alcohol impairment can be found in Louisiana Statutes as follows:

(2) "Neglected child" is a child whose parent or parents, although financially able to do so, have consistently refused to provide reasonably necessary food, clothing, shelter, or medical service

(7) "Child in need of care" means a child:

(a) Whose parent inflicts or allows the infliction of physical injury or sexual abuse upon the child which seriously endangers the physical, mental, or emotional health of the child. (b) Whose physical, mental, or emotional condition is threatened or impaired as a result of the refusal or neglect of his parent to supply the child with necessary food, clothing, shelter, or medical care, or as a result of the parent's neglect or imposition of cruel punishment.

(c) Who is without necessary food, clothing, shelter, or medical care because of abandonment by, or the disappearance of, his parent.

(d) Who has been placed in the custody of the Department of Health and Human Resources or other persons for a period of three years due to the parent's mental illness, mental retardation, or substance abuse.

LA. REV. STAT. ANN. § 1600 (West Supp. 1991).

case involving a substance-exposed infant. Some of the reasons why this is so include the following:

1. Infants can be severely impaired by drugs or alcohol yet have negative urine toxicologies. This is principally because urine toxicologies only measure a mother's drug use within a few days prior to the birth.
2. Urine toxicologies, alone, cannot prove harm to the infant. It is possible for drugs to be in an infant's system with no observable effect on the infant's health.
3. Urine toxicologies do not indicate the amount of drugs in the infant's or mother's system, or whether the mother's drug use was habitual.
4. Urine toxicologies are not the medically-accepted way to detect alcohol. Blood or breath tests are the ways to determine alcohol use.
5. Urine toxicologies may show false positives and (more frequently) false negatives. A positive urine toxicology alone does not meet scientific standards of accuracy. It needs to be confirmed by another method, usually gas chromatography/mass spectrometry.
6. Urine toxicologies do not shed light on the mother's current parenting capabilities or on whether the infant is at risk of future harm due to parental abuse or neglect.

In order for the state to make a civil neglect case, or the parents to refute it, attorneys must search neonatal nurseries and intensive care units in hospitals, as well as medical literature, for information that goes beyond positive urine toxicologies. This article identifies the kind of evidence found in hospitals and clinics that can reveal, or disprove, infant drug and alcohol exposure.

First, prenatal indicators of drug problems are examined. This section, entitled "Fetal Predictors," surveys drug tests, but gives more emphasis to information that has been less available to attorneys: medical aspects of both the current pregnancy and past pregnancies which may raise red flags about drug use.

Second, the section entitled "Evidence of Drugs or Alcohol in the Neonate's Body," examines the legal differences between drug and alcohol tests for infants and for their mothers.

Third, the authors look at "Problems in Common to Substance-Exposed Infants" to help attorneys understand what characteristics in a newborn should be warning signs to the court that some substance-caused damage may have occurred.

Sections Four, Five and Six make distinctions between neonatal responses to narcotics, cocaine, and alcohol, as these are the most common substances litigated in neglect courts.

Section Seven examines releases of confidentiality for medical records in neglect cases as compared to the protections offered through drug and alcohol-focused laws.

II. FETAL PREDICTORS

Typically, information about a woman's prenatal use of drugs or alcohol becomes important after the infant is born. It is offered as part of proof that the now-living infant was damaged during its fetal development. The issue of when a fetus takes on "personhood" has been widely discussed, to some extent in the context of civil cases having to do with drug-exposed infants.⁵ The most thorough discussions occur in the *Roe v. Wade*⁶ line of cases relating to abortions. At least one statute,⁷ and a few cases,⁸ have attempted to fix civil responsibility for drug impairment on the mother at the stage of fetal development. For the most part, however, state civil neglect statutes continue to define neglect and abuse in terms of damage to the *child*, with the result that only living infants can be petitioned successfully.

Courts are often able to establish jurisdiction over a substance-using pregnant woman through a clause in the civil neglect statute that may refer to "imminent endangerment of the child" or some similar phrase.⁹ The theory of jurisdiction is that the mother's current drug

5. Examples of civil cases include: *In re Troy D.*, 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1989); *Department of Soc. Serv. ex rel. Mark S. v. Felicia B.*, 144 Misc. 2d 169, 543 N.Y.S.2d 637 (N.Y. Fam. Ct. 1989); *In re Ruiz*, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (1986).

6. 410 U.S. 113 (1973); see also *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989). Law Review articles discussing this issue include: Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse"*, 101 HARV. L. REV. 994, 995-98 (1988); Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 10-21 (1987); McNulty, *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, 276-88 (1987-88); Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Caesareans*, 74 CALIF. L. REV. 1951, 1989-94 (1986); Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 600-09 (1986).

7. For example, a 1989 amendment to the Minnesota civil neglect statute states: Neglect includes prenatal exposure to a controlled substance . . . used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

MINN. STAT. ANN. § 626.556, Subd. 2(c) (West Supp. 1991).

8. See, e.g., *In re Troy D.*, 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1989); *In re Ruiz*, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (1986).

9. The District of Columbia civil neglect statute states that a "neglected child"

or alcohol use is damaging her existing children (over whom the court may already have established control), so that as soon as the current fetus is born, the court can take jurisdiction of the infant as a neglected "imminently endangered" child.

Except where a statute gives direct authority to a court to establish jurisdiction over a pregnant woman,¹⁰ information about fetal development will be introduced in court only after the birth of a child in order to relate the endangering behavior of the mother to the damaged condition of the infant.

A. *Drug Tests of the Mother*

Evidence of a pregnant woman's drug or alcohol use can come from tests of her body fluids — typically urine, in the case of drugs, or blood, in the case of alcohol. Breath can also be tested for volatile substances like alcohol and solvents; saliva is an additional, less usual, medium for testing. Scientists do not accept hair as a testing medium. While alcohol can most effectively be tested in blood or breath, urine has come to be the common medium to test for illicit drugs. This is chiefly because an inexpensive enzyme immunoassay test has been developed, called EMIT (an acronym for Enzyme Multiplied Immunoassay Technique), manufactured by the Syva Company.

An unfortunate reliance on the results of the EMIT test has arisen in many courts¹¹ which ascribe to the test greater powers of divination than scientists or even the company that produces it feel are jus-

includes one "who is in imminent danger of being abused and whose sibling has been abused." D.C. CODE ANN. § 16-2301(9)(E) (1981).

The Florida civil neglect statute describes "neglect" to include permitting a child to live in an environment of deprivation when that causes "the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired." FLA. STAT. ANN. § 39.01(37) (West 1988).

Other states have other formulas to encompass prospective neglect.

10. In Minnesota, the government can exercise jurisdiction over a pregnant substance-using woman through the welfare laws, by first offering her drug treatment and then civilly committing her to treatment if she refuses to accept the offer. Restrictions on the pregnant woman occur through mandatory testing of pregnant women who are suspected of drug use and mandatory reporting of all positive urine toxicologies. For complete provisions of the Minnesota law, see Omnibus Crime Bill, ch. 290, Art. 5, H.F. No. 59 (1989).

11. *United States v. Jones*, 548 A.2d 35, 39-46 (1988). *But see* *National Fed'n of Fed. Employees v. Weinberger*, 640 F. Supp. 642 (D.D.C.1986), *rev'd*, 818 F.2d 935 (D.C. Cir. 1987), *cert. denied*, 110 S. Ct. 864 (1990), which makes favorable reference to a drug-screening procedure mandating confirmation of EMIT tests by GC/MS. This case references the EMIT test as 97% to 99% accurate.

tified. An enzyme immunoassay test alone, without confirmation by another method of analysis, has at least a 5% chance of yielding a false positive result.¹² In addition, some commentators say that false negatives occur up to 50% of the time,¹³ because a relatively high concentration of the drug must be present to be detected at all.

In broad outlines, immunoassay urine tests measure changes in the amount of light that the urine sample absorbs when it is attached to antibodies or a chemically-tagged reagent. The cloudiness of the sample is compared to a calibrated response of a known amount of the drug. If it is cloudier than the control sample, it is considered a positive test; if it is less cloudy, it is labeled negative.¹⁴ This simple urine test should be considered to be a drug *screen* from which the positive samples are selected for further testing.

Among a number of different confirmatory tests currently available, a combination of gas chromatography and mass spectrometry (GC/MS) is considered to be the most practical and specific. Nitrogen or helium transports the vaporized drug or drug metabolite through a gas or metal column; if the drug or drug metabolite is present an electric signal is given.¹⁵ The immunoassay test is thus double-checked by a method that is completely different and much more precise than the immunoassay. It is also an expensive procedure, making courts disinterested in footing the bill for criminal suspects, and throwing a financial burden on hospitals, insurance companies, and patients.

A greater problem with GC/MS is that interpretation of the results is an art, not a science, requiring high levels of skill, competence, attention to detail, and experience, with both the instruments and test procedures involved. In one expert's opinion, only forensic toxicologists certified by the Board of Forensic Toxicology, or persons certified in Toxicological Chemistry by the Board of Clinical Chemistry, would absolutely qualify to interpret results. On a case-by-case basis, physicians and medical scientists might also be shown to have the knowledge, experience, and training to interpret the results.¹⁶ This view throws into grave contrast the indiscriminating way that decisions are made to separate families and imprison people based on the immunoassay urine screen itself.

12. See *Drug Testing for Fed. Employees Before the Subcomm. on Gov't Operations of the House Comm. on the Post Office and Civil Service*, 100th Cong., 1st Sess. § 1 (1987) (testimony of Lawrence H. Mike).

13. Greenblatt, *Urine Drug Testing*, 23 *NEW ENG. L. REV.* 651, 657 (1988-89).

14. See SYVA COMPANY, FREQUENTLY ASKED QUESTIONS ABOUT SYVA AND DRUG ABUSE TESTING (unpublished manuscript available upon request from Syva Company).

15. Dubowski, *Drug-Use Testing: Scientific Perspectives*, 11 *NOVA L. J.* 416, 479-84 (1987). The author is Distinguished Professor of Medicine and Director of Toxicology Laboratories at the University of Oklahoma Health Sciences Center.

16. *Id.* at 486.

In sum, positive urine toxicologies, even when properly confirmed, do not yield information on *how much* of the drug was taken, *when* the drug was ingested, *how long ago* the drug was taken, or whether it has been used *chronically*. Moreover, a drug test cannot distinguish between passive and intentional ingestion.¹⁷ As different drugs and drug metabolites are excreted at different rates from the body (for example, metabolites of cocaine may stay in the system forty-eight to seventy-two hours, marijuana can be detected for up to two weeks and alcohol is excreted almost at once), a urine toxicology indicates only that some of the drug at issue was taken some hours or days before the test was performed.

It is no wonder then, that urine toxicologies have such limited use in predicting drug-related problems in the newborn. Of course, when the urine toxicology is positive, the neonatologist will look for impairment in the newborn. However, more sweeping indicators are needed if impairment from drugs or alcohol ingested early in the pregnancy is to be discovered. The most helpful indicators consist of skillfully taken medical and drug histories,¹⁸ observations by the obstetrician and prenatal health care workers, and admissions by the pregnant woman, who is usually anxious to provide for the coming infant.

Where drug tests are part of the evidence in a civil neglect case, attorneys will be alert to fourth amendment problems. The fourth amendment to the United States Constitution prohibits unreasonable searches and seizures. Invasive procedures, like those required to obtain blood¹⁹ and urine,²⁰ have been deemed to fall within "searches and seizures." Whether or not seizing urine is "reasonable" depends on whether there is probable cause to believe that a wrong against society has been committed, that it can be proved through the test, and that the government's need for it outweighs the individual's right to privacy. "Probable cause" may be proved either before the search and seizure, when a search warrant is obtained, or in the absence of a search warrant, when the issue arises as to whether the results are admissible in court.

17. *Id.* at 527.

18. Chasoff, *Drug Use and Women: Establishing a Standard of Care*, 562 ANNALS N.Y. ACAD. SCI. 208 (1989).

19. See *Schmerber v. California*, 384 U.S. 757 (1966) (drawing blood held to be invasive, yet excusing officer from first obtaining a search warrant based on fact that the alcohol would dissipate in the time required to obtain a warrant).

20. See *Skinner v. Railway Labor Executives Ass'n*, 109 S. Ct. 1402 (1989); *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384 (1989).

The drama and punitive nature of a fourth amendment search and seizure issue is considerably diminished when one realizes that the fourth amendment is applicable to the states through the fourteenth amendment, only with regard to government actions. Therefore, in the absence of a right to privacy separately established by the state, only patients in government-funded hospitals treated by government-funded physicians would arguably be covered by fourth amendment protections.²¹

In any case, the way around the search and seizure issue is for the testing agency to obtain the informed consent of the patient. The informed consent contemplated for drug testing is definitely more than the general consent to necessary medical procedures which all patients sign as part of the hospital admission form. It is one that is "unequivocal, specific, and intelligently given, uncontaminated by any duress and coercion."²² The reason for emphasizing the need for informed consent for drug testing procedures is that if positive urine toxicologies are reported to the state agency, the consequences can be the eventual loss of one's children, if civil or criminal neglect is proven.

B. Current Pregnancy

In the absence of a positive drug test of the mother, or as additional information to give weight and meaning to a positive drug test, inferences about drug or alcohol use in the current pregnancy may be made from existing medical data. The characteristics described here can be challenged individually by a parent's defense attorney. That is, none of these characteristics prove conclusively, by themselves, that a woman has ingested drugs. Each characteristic may be explained as having originated in some other way. However, if many of these factors occur together, a conclusion that there has been drug use would be difficult for a judge to avoid.

Signs of a drug or alcohol-affected pregnancy typically include poor weight gain, either an inactive or hyperactive fetus, spotting or vaginal bleeding, and early contractions. These symptoms may be accompanied by sexually transmitted diseases such as HIV seropositive status, and general infections that occur when a person is not receiv-

21. California, for example, does have its own state-protected right to privacy. *But see In re Noah M.*, 212 Cal. App. 3d 30, 260 Cal. Rptr. 309 (1989) (holding that as long as a California clinic is not required by law to test, no privacy right is infringed by the testing policy of a prenatal clinic) (opinion ordered not to be published). By analogy, *Blum v. Yaretsky*, 457 U.S. 991 (1982), held that acceptance of Medicaid benefits and the existence of extensive state regulations were not sufficient state involvement to subject a private nursing home to the fourteenth amendment's due process clause.

22. *Feliciano v. City of Cleveland*, 661 F. Supp. 578, 594 (N.D. Ohio 1987) (citing *United States v. Williams*, 754 F.2d 672, 674 (6th Cir. 1985)).

ing proper care.²³ Evidence of accompanying infections could be found in the following positive tests:²⁴

- . chest X-ray
- . tuberculin skin test
- . hepatitis B antigen and antibody
- . venereal disease reaction level (VDRL) and fluorescent treponema antibody (FTA) test for syphilis
- . cervical culture for chlamydia trachomatous
- . human immunodeficiency virus (HIV) antibody screen
- . cervical, rectal cultures for neisseria gonorrhoea

The results of positive tests are recorded in the woman's medical chart under "Progress Notes," and the report of the positive result itself would be included in the laboratory section of the medical chart.

Obstetricians often gain clues to a woman's drug habits by observing her appearance closely. Lack of neatness and cleanliness, frequent emergency room visits (which may well show anxiety about the fetus), and late or inconsistent prenatal care are markers. The patient may look physically exhausted; her pupils may be extremely dilated or constricted; there may be track marks, abscesses, or edema on her arms and legs; the nasal mucosae may be inflamed or indurated; and the patient may look physically exhausted overall, and not be well-oriented. Because of poor nutrition and delayed fetal development, the appearance of pregnancy and the woman's own statement of gestational age may be at odds.²⁵ Notes on the appearance of a patient would usually be found in the physician's progress notes, especially those taken in the initial prenatal exam.

The great pitfall in evidence of this kind is that most of these characteristics can also be correlated to poverty or to a lifestyle, for example, prostitution. One's age, for example, adolescence, may also be a factor where casual, unprotected sexual activity may be the standard among peers. Fear and denial of pregnancy may also account for a lack of prenatal care. Here we enter into the murky world of environmental risk factors. That is, there are certain lifestyles with which drugs are a frequent, but not inevitable, accompaniment. Recent surveys²⁶ and a 1989 population-based study of one county in

23. Chasnoff, *Perinatal Effects of Cocaine*, CONTEMP. OB/GYN, 163-179 (May 1987).

24. *Id.* at 164.

25. *Id.*

26. *Born Hooked: Confronting the Impact of Perinatal Substance Abuse: Hearings Before the Select Committee on Children, Youth and Families, U.S. House of Representatives*, 101st Cong., 1st Sess. (1989) (opening statement of Rep. George Miller).

Florida,²⁷ have shown that drug use is not limited to certain socioeconomic or ethnic groups. Therefore, while these characteristics might predict a likelihood of drug use, they might also discriminate against poor, minority women by eliminating from scrutiny women who are economically better off and who have continued their prenatal care while their drug and alcohol use remained undetected and unreported. Thus, it must be urged that evidence drawn from this category be used very carefully, and probably only in conjunction with actual proof of drug use, such as a confirmed positive drug test, eyewitness accounts, or patient admissions.

C. *Prior Pregnancies and Medical Histories*

A pattern in prior pregnancies typical of those associated with drug and alcohol-exposed infants can be a strong indicator of substance use when coupled with similar problems in a current pregnancy. A substance-using woman will often go into labor prematurely. The membrane or placenta may rupture, there may be spontaneous abortion or fetal death. Even if the infant survives labor, sudden infant death syndrome may occur,²⁸ or any of a cluster of symptoms described elsewhere in this article. While there may be other medical explanations for any of these factors, a repetition of these kinds of births — particularly when accompanied by positive drug tests or clusters of drug or alcohol-related symptoms in the infants themselves — strongly suggests long-term substance use by the woman.

It must be emphasized that the substances which cause this kind of fetal distress are not necessarily illegal. Cigarette smoking is a significant cause of low birthweight babies.²⁹ There are prescription medicines, such as amphetamines used as diet pills, which have the same effect on the fetus as cocaine. Of course alcohol is not an illegal substance. Therefore, standing alone, a pattern of miscarriages, abruptio placentae, fetal deaths, and low birthweight babies cannot be presumptively correlated with use of an illegal substance.

Medical records which are likely to be the most fruitful sources for a history of prior pregnancies include the information gathered by

27. Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, NEW ENG. J. MED. 1202 (April 26, 1990).

28. Chasnoff, Burns, Schnoll & Burns, *Cocaine Use in Pregnancy*, 313 NEW ENG. J. MED. 666, 669 (Sept. 12, 1985); Chasnoff, *Prenatal Drug Exposure: Effects on Neonatal and Infant Growth and Development*, 8 NEUROBEHAVIORAL TOXICOLOGY AND TERA TOLOGY 357, 357-62 (1986); MacGregor, *Cocaine Use During Pregnancy: Adverse Perinatal Outcomes*, 157 AM. J. OB/GYN 686, 686-90 (Sept. 1987).

29. Kuhnert & Kuhnert, *Placental Transfer of Drugs, Alcohol, and Components of Cigarette Smoke and Their Effects on the Human Fetus*, 60 N.I.D.A. RES. MONOGRAPH 98, 103-05 (1985); Khoury, *Does Maternal Cigarette Smoking During Pregnancy Cause Cleft Lip and Palate in Offspring?*, 143 A.J.D.C. 333, 333-37 (Mar. 1989).

the physician or nurse at the first prenatal visit. Some hospitals, clinics, or individual practitioners may use a standard check-off chart.

There are certain diseases and medical problems that are so clearly associated with drug and alcohol use that they can be considered "fellow travelers." It must again be stated, however, that the association is not inevitable and that each of these occurs separately from drug and alcohol use as well. These diseases and problems include:³⁰

- . Acquired Immunodeficiency Syndrome (AIDS) (passed by shared needles, or through sexual activity)
- . Cellulitis (infection of the skin, associated with drug injection)
- . Cirrhosis of the liver (associated with alcohol use)
- . Endocarditis (inflammation of the heart)
- . Hepatitis (associated with drug injection)
- . Pancreatitis (inflammation of the pancreas, usually associated with alcohol abuse or injection of drugs)
- . Pneumonia (AIDS patients are particularly vulnerable)

In addition, sexually transmitted diseases are part of the medical pattern, especially for crack-cocaine users. Evidence of these diseases or medical problems would be found in the on-going progress notes with accompanying laboratory results in the lab section of the medical record.

III. EVIDENCE OF DRUGS OR ALCOHOL IN THE NEONATE'S BODY

The testing techniques for drugs and alcohol in the newborn are the same as those already described for testing the mother during her pregnancy, with one addition. It has recently been discovered that the first stool (meconium) of the infant is easily tested by radioimmunoassay and yields very accurate results over the first three days of life.³¹ Meconium accumulates gradually in the infant's bowel during fetal development and is evacuated predominately after birth. Thus, the advantage of testing meconium is that it provides a window to the infant's drug exposure for the two to three months prior to delivery, as opposed to the forty-eight to seventy-two hours provided by neonatal urine toxicology.

The only difficult additional issue with newborns is whether stool and urine samples can be taken without the permission of their parents. There are two ways to look at this issue, and attorneys will argue either way, depending on whether they are representing the

30. Chasnoff, *supra* note 23, at 164.

31. Ostrea, *A New Method for the Rapid Isolation and Detection of Drugs in the Stools (Meconium) of Drug-Dependent Infants*, 562 ANNALS N.Y. ACAD. SCI. 372 (1989).

child or the nonconsenting parents. From the child's point of view, collecting urine or stool arguably is not an invasive procedure. The infant is not conscious of parting with body fluids. There is no embarrassment, and no expectation of privacy.³² It is only the parents whose privacy could be invaded by an analysis of the drug content in the infant's bodily wastes. The physician looks at the urine or stool tests as just one more of the many tests to assure the survival and health of the infant. While parents may have religious scruples about replacing an infant's blood with the blood of someone else,³³ there should be no freedom of religion issues attached to analysis of waste fluids. However, there may be an argument about whether the tests are required to save the infant's life, or merely desirable to promote good health.³⁴

Parents, however, may insist on their right to direct the course of medical treatment for their children. If the parent has a disagreement with the life-saving measures proposed by the physician, the physician has recourse to ask the court to appoint a guardian for the child.³⁵ From the parent's point of view, this is a risky course, because it brings the entire family under the scrutiny of the court and may mean that the court ultimately will separate the infant from the parents.

In the absence of an informed consent for testing the infant obtained from the parents prior to the birth (always a hospital's best policy), the law is probably weighted on the side of the hospital conducting the test. Federal and state child abuse and neglect statutes, legislation to reduce infant mortality, and public health laws are indicators of a strong state interest in the infant's well being.

IV. PROBLEMS IN COMMON TO SUBSTANCE-EXPOSED INFANTS

In the absence of an absolute indication of drugs or alcohol in a newborn's system, the neonatologist will be alerted to problems if certain other characteristics occur. Many different substances may cause a few similar obvious problems. Those substances may include amphetamines and methamphetamines, cannabis, cocaine, hallucinogens, opiates, phencyclidine, sedatives, and alcohol. The character-

32. *United States v. Chadwick*, 433 U.S. 1, 7 (1977) (stating that the fourth amendment protects an individual's reasonable expectations of privacy from unreasonable intrusions by the state).

33. See Annotation, *Power of Court or Other Public Agency to Order Medical Treatment for Child over Parental Objections Not Based on Religious Grounds*, 97 A.L.R.3D 421 (1980).

34. *Id.*; see also Annotation, *Medical Practitioner's Liability for Treatment Given Child without Parent's Consent*, 67 A.L.R. 3D (1989).

35. For a recent discussion of this issue from the parent's point of view, see Moss, *Legal Issues: Drug Testing of Post-Partum Women and Newborns as the Basis for Civil and Criminal Proceedings*, 1990 CLEARINGHOUSE REV. 1408.

istics of a drug or alcohol-affected newborn — one might call them archetypal or common characteristics — include:

- . premature birth
- . low birthweight
- . small head circumference
- . abnormal neurobehavioral development

To the eye, these infants may look normal, but very tiny and vulnerable. If there were no obvious indications in the pregnant woman during prenatal care or at labor that drugs or alcohol were being used, the obstetrician may have missed a diagnosis of substance use. This may happen if the mother's drug or alcohol use predates prenatal care; if there were no drug or alcohol tests or the tests were negative; if the woman did not fit any profile for testing in the hospital's or clinic's protocol.

An infant may be considered premature if born less than thirty-seven weeks gestational age. A full term infant may be considered of low birthweight when he or she weighs less than 2500 grams.³⁶ A small head circumference in a term infant would be less than thirty-three centimeters. A small head circumference often indicates a small brain, and thus can imply abnormal or delayed development of the brain.³⁷

There are a number of ways to measure abnormal neurobehavioral development. Visually, the neonatologist may be able to see that the infant is trembling, screaming, irritated, and abnormally responsive to stimuli (either over-reacting or withdrawing from it). One well-respected test is called the Brazelton Neonatal Behavioral Assessment Scale (NBAS).³⁸ Using lights, bells, and familiar stimuli such as placing a blanket on the infant's face, reactions are measured and a neurobehavioral score is given. For older infants, other developmental assessment tests include the Movement Assessment of Infants (MAI), a sixty-five item test that measures muscle tone, primitive reflexes, automatic reactions, and volitional movements, and the Bayley Scales of Infant Development. One strategy the at-

36. See SACKSON MEMORIAL MEDICAL CENTER, UNIVERSITY OF MIAMI, GUIDELINES FOR PERINATAL URINE TOXICOLOGY SCREENING (specifying weights and measurements that indicate prematurity). These guidelines can be found in an appendix to *Drug Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protections Systems*, A.B.A. MONOGRAPH at 97 (1990).

37. Chasnoff, *Prenatal Drug Exposure*, *supra* note 28, at 361; Gross, *Head Growth and Developmental Outcome in Very Low-Birth-Weight Infants*, 71 *PEDIATRICS* 70, 70-75 (1983).

38. BRAZELTON, *CLINICS IN DEVELOPMENTAL MEDICINE* (1973); BRAZELTON, *NEONATAL BEHAVIORAL ASSESSMENT SCALE* (1968).

torney may use is to ask the court to order that such a test be performed. Obviously, either the neonatologist or pediatrician who performed the test, or an expert who understands the results, would have to describe the process, explaining how the results compare to those for a normally developing infant.

V. NEONATE'S WITHDRAWAL FROM NARCOTICS

Today, most drug use involves combinations of drugs and alcohol. Recently there has been a re-emergence of heroin to extend and modify the effects of crack-cocaine. While many substance-exposed infants will show a variety of effects from this drug mixture, there are certain characteristics particularly associated with withdrawal from narcotics. Most commonly, the identified narcotic will be heroin, methadone, "T's" (so-called, from the brand name Talwin), and "Blues" (so-called from the color of the drug capsules of pyribenzamine).

Most evident in the newborn are:³⁹

- . a high-pitched cry
- . sweating
- . tremulousness
- . excoriation of the extremities
- . gastrointestinal upset

The pattern of an infant who is withdrawing from narcotics will be hyperactivity and irritability. The excessive movement (rubbing against bedclothes) causes skin abrasions on the knees, toes, elbows, and nose. The infant has disturbed sleeping patterns and poor feeding.

This pattern can be analyzed for a judge in terms of the following categories:⁴⁰

Size

- . small head circumference (less than 33 cm) in a full-term infant (38-42 weeks gestation)
- . low birthweight (less than 2500 grams)

Emotions

- . unpredictable fluctuations

Neurobehavior

- . hyperactivity
- . hypertonicity (stiffness of muscles)
- . high-pitched cry
- . hyperactive reflexes
- . restlessness
- . convulsions (these also occur in babies exposed to barbiturates, sedatives or cocaine)
- . sneezing
- . Rhinorrhea (runny nose)

39. Chasnoff, *Newborn Infants with Drug Withdrawal Symptoms*, 9 PEDIATRICS REV., 273, 273-77 (Mar. 1988).

40. *Id.*

- . sweating
- . tearing
- . tremulousness
- . voracious sucking
- . yawning

Gastrointestinal

- . fever unrelated to infection
- . vomiting
- . diarrhea

Skin

- . mottling
- . abrasions on extremities

Respiratory

- . Tachypnea (rapid breathing)
- . meconium aspiration syndrome (resulting when the fetus, due to distress, inhales amniotic fluid contaminated with meconium)
- . neonatal pneumonia

An attorney will also be looking for evidence of medicines that are typically used to treat withdrawal from narcotics. These would include: *paregoric*, used to improve sucking and weight gain; *Diazepam* (Valium), which suppresses most symptoms of narcotic withdrawal but which has significant side effects such as depressing the sucking reflex, complicated by the inability of the infant to excrete it; and *phenobarbital*, which is used when a mixture of drugs cause the symptoms. Phenobarbital also possesses significant side effects, such as impaired sucking, and fails to resolve the gastrointestinal problems.⁴¹ The neonatal progress notes in the medical records would describe the narcotic withdrawal symptoms as well as the medicines prescribed to treat them.

An often overlooked aspect of drug withdrawal symptoms is that certain symptoms do not manifest themselves immediately after birth. This has obvious implications for the timing of a petition and the development of a defense. Depending on when the mother ingested drugs prior to her delivery and on how much of the drugs she took, the full array of symptoms may not be present in the first two days after birth. Typically, symptoms reach a peak on the third or fourth day of life and can persist for two or three weeks. However, the infant may then display a subacute form of symptoms for four to six months of age, including poor feeding, irritability, slow weight gain and irregular sleep patterns.⁴² These subacute symptoms often peak at approximately six weeks of age. This may affect the decision

41. *Id.*; see also American Academy of Pediatrics, *Neonatal Drug Withdrawal*, PEDIATRICS 895-905 (1983).

42. Chasnoff, *Newborn Infants*, *supra* note 39, at 273-77.

to file a neglect petition. More importantly, however, it serves as a warning to the attorneys before trial that they should obtain the latest medical records to ascertain whether the symptoms have continued and are even expanding, or whether their manifestation was brief and now concluded.

VI. COCAINE-EXPOSED INFANTS

It has already been indicated that a newborn seldom shows symptoms that can be exclusively associated with cocaine use. Women who are substance abusers nearly always mix cocaine use with the use of alcohol, marijuana, heroin, or any other mixture. The quick litmus test of substance exposure in the newborn infant is premature birth, low birthweight, small head circumference, and abnormal neurobehavioral development. Cocaine-exposed infants fall into the same pattern. A recent medical study showed that women who had used cocaine during pregnancy had infants who on average, weighed ninety-three grams less than infants of nonusers in the same hospital, were 0.7 centimeters shorter, and had head circumferences that were 0.43 centimeters smaller.⁴³ In the judgment of the authors, this amounts to a significant difference in the infants of mothers who were users from those who were not users.

If one searches for a cocaine-exposure syndrome, one finds many elements of the same pattern found in narcotic withdrawal, as well as some distinct differences. Broadly stated, the symptoms appear as follows in newborns and infants, respectively:⁴⁴

In the Newborn

- . irritability
- . poor feeding patterns
- . high respiratory and heart rates *
- . increased tremulousness and startles
- . irregular sleeping patterns
- . depressed interactive abilities *
- . poor organizational response to environmental stimuli

Two differences between narcotic withdrawal and cocaine withdrawal can be observed: high respiratory and heart rates, and depressed interactive abilities. (The asterisked factors denote those symptoms specific to cocaine). Whereas cocaine speeds up heart rates and blood pressure, narcotics may suppress them. High blood pressure and heart rate can result in cerebral and myocardial infarctions,

43. Zuckerman, *Effects of Maternal Marijuana and Cocaine Use on Fetal Growth*, 320 N. Eng. J. Med. 762-68 (1989).

44. Schneider & Chasnoff, *Infants Exposed to Cocaine in Utero: Implications for Developmental Assessment and Intervention*, 1989 INF. YOUNG CHILDREN 25-36 (July 1989).

which may in turn cause death.⁴⁵ There exists an increased rate of Sudden Infant Death Syndrome in cocaine-exposed infants, which is comparable to the rate of Sudden Infant Death Syndrome for heroin or methadone-exposed infants.⁴⁶

The second difference is in the depressed interactive abilities. Cocaine-exposed infants have a tendency to avoid stimuli, to avert their gazes and withdraw. Thus, when a blanket is placed gently on an infant's face in the NBAS, a cocaine-exposed infant may fall asleep, while an infant who had not been exposed to drugs would try to shake the blanket off or cry. While most infants wish to engage in the world around them, follow moving objects with their eyes, and interact with their caregivers, cocaine-exposed infants reject such interaction. They do not want to be tightly held, petted, or talked-to; instead, they prefer to remain in a quiet, dark room. As newborns develop from neonatal status into infancy, their characteristics tend to include the following:⁴⁷

Infant

- . frequent tremors (especially in the arms)
- . increased muscle tone (stiff muscles)
- . prolonged newborn reflexes such as the sucking reflex and the startle reflex
- . stiffly held legs
- . arched back
- . overly extended postures
- . irritable

The rigid posture of the infants and their irritability make them physically difficult to handle and potentially emotionally unsatisfying to their caregivers. Such infants tend to reject interaction with the caregiver, and if the caregiver is emotionally needy and requires affirmation from the infant, an opportunity for abuse exists. Data on cocaine-exposure symptoms can be found in the infant's medical records, under "Physician's Progress Notes." Any consultations provided by social workers or child protection team members should be especially noted.

The problems are not over when the child outgrows infancy, although they could be, if drug use in the mother was light and the child has a strong genetic makeup and excellent care. Quite often, however, drug-related symptoms persist at least into the toddler

45. Chasnoff, *Perinatal Cerebral Infarct and Maternal Cocaine Use*, 108 J. PEDIATRICS 456-59 (1986).

46. Chasnoff, *supra* note 23.

47. Schneider & Chasnoff, *supra* note 44.

stage. There is a small but growing body of medical and psychosocial literature which can inform the attorneys and the court of the problems that cocaine-exposed children experience. Some of the more obvious problems include fluctuating emotions and unstable patterns of attachment (either overly rapid attachment to adults or an inability to bond). More subtly, their play may show much scattering, batting, and throwing, with little imagination or representation. These children tend to find it difficult to do more than one thing at a time, and tend to shift their attention from one activity to another.⁴⁸

Only unusual civil cases would begin at the toddler stage and attempt to relate a toddler's symptoms back to birth and infancy. More typically, information about the toddler's development would be probative at the neglect review stage, for example, when a determination is being made about whether the family should be reunited.

VII. FETAL ALCOHOL SYNDROME

The most striking effect of alcohol on the fetus is the alteration of facial features on the newborn. Eyelids are turned into an epicanthal fold, giving a vaguely oriental cast to the features. The nose is short and turned up so that it may look slightly snubbed. The philtrum between the lips and the nose — a usually well-marked groove in the skin — is outlined only slightly. The upper lip is thin and the ears are placed low on the head.⁴⁹

These altered facial features make striking evidence in a courtroom, because they are easily presented and easily grasped. In fact, facial features are keys to problems in other parts of the body. For example, when such facial dysmorphology appears, physicians know that it is correlated to a low intelligence quotient (hereinafter IQ). Although facial dysmorphology is a marker for low IQ, the severity of IQ impairment is not necessarily correlated to the severity of the abnormality of features. The average IQ in children with fetal alcohol syndrome is seventy, with wide variations. Because the effects of alcohol on children have been studied for a long time, it is known that the IQ of a child with fetal alcohol syndrome, in most cases, does not substantially improve as the child matures.⁵⁰ Another example is

48. Howard, *The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research*, 1989 ZERO TO THREE 8-12 (June 1989).

49. Streissguth, *Teratogenic Effects of Alcohol in Humans and Laboratory Animals*, 209 SCI. 353-61 (July 1980). Streissguth, *Psychological and Behavioral Effects in Children Prenatally Exposed to Alcohol*, 10 ALCOHOL HEALTH AND RES. WORLD 6-12 (Fall 1985).

50. Streissguth, *Neurobehavioral Dose-Response Effects of Prenatal Alcohol Exposure in Humans from Infancy to Adulthood*, 562 ANNALS N.Y. ACAD. SCI. 145-46 (1989).

that the low placement of the ears, and their large, strange shape, indicate problems in the kidneys because the kidneys and the ears develop embryologically at the same time.

Other neonatal characteristics in an alcohol-exposed child include:⁵¹

- . frequent body tremors
- . hyperactivity
- . head turning to left
- . hand-to-face activity
- . poor sucking responses
- . poor emotional control
- . poor adaptation to negative stimuli
- . low weight, short length, small head circumference

As neonates grow into infancy, and then into childhood, they may experience problems with their hearts, kidneys and skeletal structures.⁵²

Children with fetal alcohol syndrome (FAS), which is the most severe manifestation of alcohol effects, and fetal alcohol effects (FES), which is the less severe complex of factors, tend to suffer from poor concentration and attention during their entire lives. Other common behaviors include a withdrawn attitude in social situations, impulsiveness, dependency, periods of high anxiety, and sullenness.⁵³

VIII. CONFIDENTIALITY

The potential evidence discussed in this article includes medical records and the testimony of treating health care providers. The former include hospital and physician records of pregnant and postpartum women and infants, including prenatal care, other health care, and drug and alcohol treatment records. Under a variety of laws, this information is usually confidential and beyond the reach of the state. Yet this "evidence" is critical to a child protection investigation and resulting court intervention. Lay witness observations of the parent, child, and their interactions, are important. They do not, however, answer the critical questions of: how impaired the infant is, what the mother's current physical and mental capacity to care for the child is, and what her prognosis is.⁵⁴ The answers are often buried under confidentiality shields. Without answers to these questions, many

51. Streissguth, *supra* notes 49 and 50.

52. *Id.*

53. *Id.*

54. The mere fact of drug or alcohol use, by itself, will not usually answer whether a parent is unfit to care for a child. See *In re S.D.*, 549 P.2d 1190, 1196 (Alaska 1976); *In re William B.*, 73 Md. App. 68, 533 A.2d 16 (Md. Ct. Spec. App. 1987), *cert.*

cases of abuse and neglect could not be litigated. Rather than reach such a draconian result, society has made exceptions to confidentiality when the safety of children is at issue. This section discusses the relationship between confidentiality laws and child abuse and neglect proceedings, with special attention given to drug and alcohol related information.

"Testimonial" confidentiality of medical records and communications, nonexistent at common law, is now recognized by statute or case law in all states.⁵⁵ It is a privilege held by the patient. The provider, absent the patient's consent, cannot reveal confidential communications at trial or during the discovery phase.

The purpose of the privilege is to instill trust in the professional relationship. Without trust, a patient is less likely to pursue help, or less likely to be frank, open, and candid with the provider. Absent such openness, diagnosis and treatment will be less effective.

Many states have extended this privilege to other "helping" professional relationships, such as with psychiatrists,⁵⁶ psychologists,⁵⁷ psychotherapists,⁵⁸ and social workers.⁵⁹ Confidentiality in these relationships may be more critical than in the doctor-client context. Open disclosure of a mental illness, emotional problem, or drug or alcohol abuse, leaves one vulnerable to public ridicule and embarrassment. Confidentiality seeks to avoid these reactions, which may devastate the protected relationship. As one court stated, "[m]any physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him."⁶⁰ Revelation of drug use also places the patient at risk of criminal prosecution, or a young mother at risk of losing her children.⁶¹ Adverse public reaction helps explain why, in the physical disease context, HIV infection merits special confidentiality consideration.⁶²

In addition to evidentiary privileges, confidentiality requirements

denied, 311 Md. 719, 537 A.2d 272 (1988). *In re Phifer*, 67 N.C. App. 16, 312 S.E.2d 684 (N.C. Ct. App. 1984).

55. MCCORMICK, EVIDENCE § 98 (2d ed. 1972).

56. *See, e.g.*, OHIO REV. CODE ANN. § 2317.02(b) (Anderson 1981 & Supp. 1989).

57. *See, e.g.*, WASH. REV. CODE § 18.83.110 (1989).

58. *See, e.g.*, CAL. EVID. CODE §§ 1010-1028 (West 1991).

59. *See, e.g.*, MASS. GEN. LAWS ANN., ch. 112, § 135 (West 1983).

60. *Taylor v. United States*, 222 F.2d 398, 401 (D.C. 1955). *See also*, *State v. Munyon*, 240 Kan. 53, 58-59, 726 P.2d 1333, 1337 (1986) (confidentiality is "essential for the psychotherapist's effective diagnosis and treatment of the patient's mental and emotional problems").

61. *See generally*, Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278 (1990).

62. *See generally*, Turkington, *Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases*, 3 VILL. L. REV. 871 (1989); S. Rennert, *AIDS/HIV and Confidentiality: Model Policy and Procedures*, 1991 A.B.A. 2 (the "interrelationship between confidentiality and discrimination — ef-

are lodged in numerous federal and state laws, and professional ethics codes. Indeed, this mix of laws and ethics, often with ambiguous and sometimes conflicting terms, can create confidentiality chaos and confusion.⁶³ As a result, programs often misuse confidentiality restraints, and tend to err in favor of confidentiality.⁶⁴ Unfortunately, this can hinder the supply of services as agencies fail to cooperate and coordinate their efforts to their fullest abilities.⁶⁵

At the state level, confidentiality may derive from medical records acts,⁶⁶ or laws which regulate different types of medical practices, facilities, and services. These "nondisclosure" laws⁶⁷ might cover, for example, clinical laboratories,⁶⁸ alcoholism treatment facilities,⁶⁹ facilities for the developmentally disabled,⁷⁰ health maintenance organizations,⁷¹ state institutions,⁷² and mental health facilities.⁷³ Some laws specifically address confidentiality of certain types of medical information, such as venereal diseases⁷⁴ or HIV infection.⁷⁵ Professional standards and ethics also support confidentiality. Almost

forts to maintain the former in order to prevent the latter — has been the cornerstone of public health efforts to control the spread of the disease").

63. [A] review of relevant law and ethics . . . demonstrates that the available confidentiality guidance generally fails to satisfy the comprehensiveness test [i.e., can a physician find an answer to any disclosure question with which he is faced] . . . [E]xisting guidance does not meaningfully address all disclosure questions that can arise in the modern practice of medicine. As a result, physicians generally are left to resolve complex confidentiality problems on their own.

Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L. REV. 255, 266-67 (1984).

64. See Weisberg & Wald, *Confidentiality Laws and State Efforts to Protect Abused or Neglected Children: The Need for Statutory Reform*, 18 FAM. L.Q. 143, 165, 179 (1984).

65. Lack of agency coordination, often attributed to perceived confidentiality constraints, is increasingly cited as a major barrier to services for children and families. See generally Soler & Shauffer, *Fighting Fragmentation: Coordination of Services for Children and Families*, 69 NEB. L. REV. 278 (1990).

66. See, e.g., CAL. CIV. CODE §§ 56-56.37 (Deering Supp. 1991); MD. HEALTH-GEN. CODE ANN. 4-302 (Supp. 1991); MINN. STAT. § 144.651 (16) (West 1989); R.I. GEN. LAWS § 5-37.3-1 - 5-37.3-11 (1987).

67. This was the term used to describe these laws in WEISBERG & WALD, *supra* note 64, which provides an excellent overview of this topic.

68. See, e.g., N.J. STAT. ANN. § 45:9-42.39 (West 1978).

69. See, e.g., N.J. STAT. ANN. § 26:2B-20 (West 1987).

70. See N.J. STAT. ANN. § 30:6D-4 (West 1981).

71. See N.J. STAT. ANN. § 26:2J-27 (West 1987).

72. See N.J. STAT. ANN. § 26:8-5 (West 1987).

73. See N.J. STAT. ANN. § 30:4-24.3 (West 1981).

74. See, e.g., N.C. GEN. STAT. § 130A-163 (repealed 1988).

75. See, e.g., FLA. STAT. ANN. § 381.609 (West 1990); N.Y. PUB. HEALTH LAW §§ 2780 - 2787 (McKinney Supp. 1991).

every such standard includes a strong confidentiality pronouncement as the bedrock of the professional relationship.⁷⁶

Similar to the laws of privilege, these ethical principles and nondisclosure statutes aim to encourage full and frank conversations. Compared to testimonial privileges, these ethical principles are more comprehensive and stringent. The nondisclosure laws cover more types of disclosures, bind more persons to confidentiality, (all employees of a licensed facility and not just professional providers), and include civil or criminal penalties for improper disclosures.⁷⁷ Most importantly, both ethical standards and nondisclosure laws apply beyond the courtroom. Thus, while an evidentiary privilege does not apply to an act of child abuse reporting, these other restrictions might.

At the federal level, confidentiality provisions typically reside in funding statutes. Provisions in the Aid to Families with Dependent Children Act,⁷⁸ the Family Educational Rights and Privacy Act,⁷⁹ and the Federal Child Abuse Prevention and Treatment Act⁸⁰ should be familiar to those who work with children and families. Most germane to this article are those found in the Drug Abuse Office and Treatment Act of 1972⁸¹ and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.⁸²

Under these laws, disclosure of a "patient's"⁸³ drug and alcohol diagnosis, treatment, and referral records are strictly controlled for "programs"⁸⁴ that receive "federal financial assistance."⁸⁵ Given the

76. See, e.g., Am. Psychological Ass'n, *Ethical Principles of Psychologists*, 36 AM. PSYCHOLOGIST 633, 635-36 (1981). ("Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists"). See also CODE OF ETHICS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, app. F, at 482 (available at the Nat'l Ass'n of Social Workers, Inc., Silver Spring, MD) ("The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.").

77. For example, under the federal drug and alcohol treatment acts, violators of the confidentiality provision may be fined up to \$500 for the first breach, and up to \$5,000 per additional offense. 42 U.S.C. §§ 290dd-3(f), 290ee-3(f) (1988). While privilege laws and ethics standards do not contain penalty clauses for violations, persons may cite them in tort and contract actions. The New York courts have relied in part on the evidentiary privilege law to sustain a suit against a physician for unlawful disclosure of confidential information, based on an implied contract of secrecy. See *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (N.Y. Sup. Ct. 1977).

78. 42 U.S.C. § 602(a)(9) (1988).

79. 20 U.S.C. § 1232(g) (1988).

80. 42 U.S.C. § 5106a(b)(4) (1988).

81. 42 U.S.C. § 290ee-3 (1988).

82. 42 U.S.C. § 290dd-3 (Supp. 1990) (amending 42 U.S.C. § 4582 (1982)).

83. A "patient" is anyone who applied for or received drug or alcohol services "at a federally assisted program." 42 C.F.R. § 2.11 (1990). Records of former patients are also protected. 42 U.S.C. §§ 290dd-3(d) and 290ee-3(d) (Supp. 1990).

84. Programs which provide drug and alcohol abuse diagnosis, treatment, or referral for treatment include facilities having either an "identified unit" or "[m]edical personnel or other staff whose primary function" is to provide these services. 42 C.F.R. § 2.11 (1990).

broad definition of these terms, the acts cover most facilities which provide special drug or alcohol related services. Furthermore, the regulations provide a broad definition of "record" which includes verbal communications as well as recorded information.⁸⁶

Like their state law confidentiality counterparts, the federal laws were meant to be strictly followed because without confidentiality, "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 [drug] problem is to be overcome."⁸⁷ Even the manner for obtaining patient consent to release information is tightly regulated. Unlike most state laws which fail to specify which procedures must be followed in order for a patient to waive confidentiality, the federal laws and regulations enumerate specific elements for acquiring a patient's informed, written consent.⁸⁸

Confidentiality, as a statutory phenomenon, is not inviolate.⁸⁹ While the laws promote confidentiality, none are absolute. Most confidentiality laws contain exceptions for nonconsensual disclosures. These exceptions derive from compelling societal interests. Thus, physicians may be required to report persons with certain contagious diseases to a public health agency, because society's interest to check the spread of such diseases outweighs the benefit of confidentiality. Professional ethics also recognize compelling exceptions as well as legal limitations. The American Psychological Association, for example, permits revelations "in unusual circumstances in which not to do so would result in clear danger to the person or to others."⁹⁰ Even

85. Alcohol or drug abuse programs are covered if they directly or indirectly receive federal assistance. Federal assistance is broadly interpreted, including programs that are certified as a provider under the Medicare program, assisted by the IRS which grants tax exempt status or allows income tax deductions for contributions to the program, or is a recipient of federal financial assistance, in any form and from any federal agency, whether or not related to alcohol and drug abuse diagnosis, treatment, or referral. 42 C.F.R. § 2.12(b) (1990).

86. 42 C.F.R. § 2.11 (1990).

87. H.R. CONF. REP. NO. 920, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. CODE CONG. & ADMIN. NEWS 2072.

88. The patient's consent must be in writing. It cannot be part of a routine medical records release form or those provided by the commercial form publishers. The release must include the identity of the parties for whom disclosure is requested and is to be made, the patient's name and signature, date of execution, extent or nature of information to be disclosed, and a legend that it is subject to revocation at any time. 42 C.F.R. § 2.31(a) (1990).

89. *State v. Rollinson*, 203 Conn. 641, 652-59, 526 A.2d 1283, 1289-93 (1987) (referring to the federal drug and alcohol confidentiality provisions).

90. Am. Psychological Ass'n, *supra* note 76, at 635-36. Many states have codified this exception, permitting breaches where necessary to protect the life or well-being of

attorney-client confidentiality, rooted in common law, may be breached to prevent the commission of a serious crime,⁹¹ including child abuse and neglect.⁹²

Combatting child abuse is a compelling state interest that clashes with confidentiality laws. Doctors, psychiatrists, social workers, and others frequently unearth indicators of child abuse and neglect in their professional capacity. For instance, a child brought to an emergency room with suspicious injuries may suggest abuse;⁹³ the parent, in turn, may confess the abuse to a therapist; the parent's drug counselor may fear that the parent's abusive addiction prevents the counselor from providing for the infant's minimal needs.

The emergency room physician, therapist, and drug counselor would not be able to share their suspicions of abuse if silenced by confidentiality laws and professional codes of ethics. Such a result would contradict the state's interest in limiting child abuse. Largely in response to the Federal Child Abuse Prevention and Treatment Act of 1974,⁹⁴ each state has enacted child abuse and neglect reporting laws.⁹⁵ The federal law requires that a state must enact a statute detailing specific methods of reporting child abuse in order to qualify for federal funds for child abuse programs.⁹⁶

Every state, in its reporting law or evidentiary codes,⁹⁷ has ex-

the patient or a third party. See, e.g., CAL. EVID. CODE § 1024 (West 1966); MICH. COMP. LAWS ANN. § 330.1748(6)(c) (West 1980). Failure to report to a third party life threatening information learned in the course of a confidential communication could also result in civil liability. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 440-41, 551 P.2d 334, 346-47, 131 Cal. Rptr. 14, 26-27 (1976).

91. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.6(b) (1980); MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 4-101 (c)(3) (1980).

92. See Indiana Bar Ass'n Comm. on Legal Ethics, Op. 1-1986 (1986); Wisconsin Bar Ass'n Comm. on Professional Ethics, E-88-11 (1988). See generally R. THURMAN, CLIENT INCEST AND THE LAWYER'S DUTY OF CONFIDENTIALITY (1985); Stuart, *Child Abuse Reporting: A Challenge to Attorney-Client Confidentiality*, 1 GEOR. J. LEGAL ETHICS 243 (1987).

93. The origins of contemporary child abuse and neglect law can be traced to an influential article published in the *Journal of the American Medical Association* in which the battered child syndrome was first described. Kempe, Silverman, Steele, Droegenmueller & Silver, *The Battered Child Syndrome*, 181 J.A.M.A. 17 (1962). This syndrome identifies injuries to children which are inconsistent with the explanation for their cause given by the caretakers. For example, a spiral fracture of the arm is highly unlikely to occur from falling out of bed. One year after the publication of this influential article, California became the first state to require certain persons to report suspected child abuse. 1963 Cal. Stat. c. 576, § 1, at 1453.

94. 42 U.S.C. §§ 5101-07 (1988).

95. For an overview of these laws, see DAVIDSON & HOROWITZ, *Protection of Children and Family Maltreatment*, in LEGAL RIGHTS OF CHILDREN, 286-94 (R. Horowitz & H. Davidson ed. 1984).

96. 42 U.S.C. § 5106a(b) (1988).

97. The location of the waiver may vary from state to state and may be found in several places within a particular state's laws. For example, the child abuse reporting law may waive the privilege for child protection proceedings while an evidentiary code may cover other types of proceedings. See, e.g., TEX. R. CIV. EVID. 510(d)(6) (Vernon

pressly opted to favor child abuse reporting over medical confidentiality. The reporting laws specify that certain privileges shall not bar or prevent the making of a report. Medical, mental health, and social worker-related privileges are routinely included in this waiver.⁹⁸ As a matter of statutory construction, these waivers, which are situation specific and often post-date medical confidentiality laws, have been held to defeat state law based confidentiality claims.⁹⁹ As a result, a physician who knowingly fails to report suspicions of abuse could face liability.¹⁰⁰

Under federal preemption, these state statutory waivers, until recently, had little effect upon communications and records protected by the federal drug and alcohol laws.¹⁰¹ In light of the significant overlap between substance abuse and child abuse,¹⁰² there existed a

1971) (disclosure of confidential communications may be made when "relevant to any suit affecting the parent-child relationship").

98. This waiver was encouraged by the federal government. Shortly after passage of the Federal Child Abuse Prevention and Treatment Act, the National Center on Child Abuse and Neglect distributed a model act which became the basis for much state child abuse and neglect reporting legislation. MODEL CHILD PROTECTION ACT § 11 (draft 1977). *See, e.g.*, ARIZ. REV. STAT. ANN. § 8-546.04(B) (1989); HAW. REV. STAT. § 350-5 (Supp. 1988); KAN. STAT. ANN. § 38-1354(a) (1986). This model act provided for a waiver of privileged communications. Today, the attorney-client privilege is the only one that most states still preserve for child abuse reporting. *But see supra* note 91 and accompanying text.

99. *See, e.g.*, *State v. Fagalde*, 85 Wash. 2d 730, 735-36, 539 P.2d 86, 90 (1975); 68 Op. Wis. Att'y Gen. 342, 346 (1979).

100. All states impose criminal, and in some cases civil, penalties for such failures to report. *See, e.g.*, ALA. CODE § 26-14-13 (1986) (up to six months imprisonment or a fine not to exceed \$500); COLO. REV. STAT. § 19-3-304(4) (Supp. 1989) (class 3 misdemeanor and "liable for damages proximately caused thereby"). These laws have been upheld against a variety of constitutional challenges. *See, e.g.*, *People v. Cavaiani*, 172 Mich. App. 706, 432 N.W.2d 409, 412 (1988) (statute requiring psychologists to report suspicions of child abuse did not violate the family's right to privacy); *State v. Motherwell*, 114 Wash. 2d 353, 362-64, 788 P.2d 1066, 1070-72 (1990) (statute requiring religious counselors to report suspicions of child abuse did not violate the counselors' first amendment free exercise rights).

101. At least one court, however, found that the federal drug and alcohol confidentiality requirements did not preempt a state child abuse reporting law. The court reasoned that Congress could not have intended this outcome. *State v. Andring*, 342 N.W.2d 128, 131 (Minn. 1984). *See also Fagalde*, 85 Wash. 2d at 737, 539 P.2d at 91 (interpreting state reporting law and state alcohol and drug confidentiality acts to enable the reporting of child abuse without disclosing the substance abuse problem).

102. While the exact contribution of substance abuse to child abuse is unknown, few would doubt that "overuse of alcohol or other drugs may 'dull cognitive functioning'" and make parents "unable to care well for their children, inevitably disregarding their needs, and produce a typical picture of neglect." STEELE, *Violence Within the Family*, CHILD ABUSE AND NEGLECT 13 (R. Halfer & C. Kempe ed. 1976). Most would agree that the "chronic use of alcohol or taking of hallucinogenic drugs can cause severe distortion of mental functioning with delusional thinking and the lowering of the

large and significant loophole which was closed by Congress in 1986.¹⁰³ Today, persons privy to drug or alcohol prevention and treatment referral records must follow the child abuse and neglect reporting law requirements in their states. In effect, this means that medical and mental health professionals engaged in drug and alcohol treatment must report reasonable suspicions of child abuse. In the last few years, several states have even amended their child abuse reporting statutes to include drug counselors on the list of mandated reporters.¹⁰⁴

In cases where children born in utero are exposed to drugs,¹⁰⁵ the mix of child abuse reporting and confidentiality laws raises two important questions: first, does evidence of a mother's prenatal substance abuse or drug exposure in a newborn constitute grounds for a child abuse report; and second, if it does, how much confidential information may be revealed in the actual report or during either the investigatory or judicial phase of a case?

A report based on a mother's prenatal substance abuse or an infant's drug exposure is only mandated under state child abuse reporting laws if it may be construed as grounds to "reasonably suspect"¹⁰⁶ child abuse or neglect. Legislatures have purposely created a low threshold for reporting; mandated reporters are asked to err, if they

threshold for the release of violence . . . including child abuse." *Id.* A prominent child abuse researcher observed that "researchers in the United States have found consistent relationships between caretaker use and abuse of alcohol and drugs and the abuse and neglect of children." GELLES, *What to Learn from Cross-Cultural and Historical Research on Child Abuse and Neglect: An Overview*, CHILD ABUSE AND NEGLECT: BIOSOCIAL DIMENSIONS 27 (R. Gelles & J. Lancaster ed. 1987). In a recent national survey, many child protection agencies reported that up to 80 percent of their caseload involves elements of substance abuse. NATIONAL COMM. FOR THE PREVENTION OF CHILD ABUSE, CURRENT TRENDS IN CHILD ABUSE REPORTING AND FATALITIES (1990). See also OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., CRACK BABIES 6 (1990) (finding similar results).

103. Children's Justice Act, Pub. L. No. 99-401, 100 Stat. 903 (1986).

104. See, e.g., CONN. GEN. STAT. § 17-38a(b) (Supp. 1990) (1988 amendments added "certified substance abuse counselors" to list of mandated reporters); N.D. CENT. CODE § 50-25.1-03 (1989) ("addiction counselor").

105. For the purposes of this article, the discussion will be limited to child abuse reports following the birth of a child. To date, no state child abuse law specifically covers prenatal reporting. Without this requirement, courts have interpreted the reporting laws to apply only to post-birth situations. See, e.g., *In re Steven S.*, 126 Cal. App. 3d 23, 29-30, 178 Cal. Rptr. 525, 528 (1981); *In re Dittrick Infant*, 80 Mich. App. 219, 263 N.W.2d 37, 39 (1977). While a 1989 Minnesota law requires a pre-birth report based on a pregnant woman's substance abuse, it is not made to a child protection agency. Rather, the report goes to a local welfare department and any involuntary state intervention follows a civil commitment model. MINN. STAT. ANN. § 626.5561(1) (West Supp. 1991).

106. The Federal Child Abuse Prevention and Treatment Act, as a condition for federal child abuse funds, requires states to have provisions for the reporting of known and "suspected" instances of child abuse and neglect. 42 U.S.C. § 5106a(b)(1) (1988). Following enactment of this act, most states use one of the following standards for reporting: "reasonable suspicion," "reasonable belief," or "cause to suspect."

must, on the side of over-reporting. A reporter need not "be sure that a child is being abused or neglected or to have absolute proof of maltreatment."¹⁰⁷ Nor must a reporter conduct an independent investigation, make home visits, or interview parents.¹⁰⁸ It is the job of child protection services to conduct such investigations. Rather, the reporter simply needs an objective basis, which is usually circumstantial, upon which to make a report.¹⁰⁹

Whether infant drug exposure constitutes this objective basis has been a subject of dispute.¹¹⁰ A few state child abuse reporting laws specify that an infant born drug-exposed must be reported.¹¹¹ The majority of state laws, however, are silent on the subject, leaving it to the individual reporter's discretion.¹¹² The reporter must determine

107. D. BESHAROV, *RECOGNIZING CHILD ABUSE* 55 (1990). *See also* *Thomas v. Beth Israel Hosp. Inc.*, 710 F. Supp. 935, 941-42 (S.D.N.Y. 1989) (statutes providing immunity for child abuse reporters are based upon reasonable cause to suspect abuse, not actual or conclusive proof of abuse).

108. Opponents of mandatory reporting based solely on the fact that a child is born manifesting signs of drug exposure would place some preliminary fact finding obligations on the reporting source. To date, only California has legislatively gone this route. 1990 amendments to the state child abuse and neglect reporting law specifically provide that a positive toxicology screen of an infant is not by itself reasonable suspicion of child abuse. Rather, an assessment of the needs of the mother and child must be made; if there is an indication of risk to the child, then a report must be made to the county child welfare department. SB 2669, 1990 Legislative Session.

109. D. BESHAROV, *RECOGNIZING CHILD ABUSE* 56 (1990).

110. *See generally supra*, note 6. One argument against mandatory reporting is that it will deter women from seeking prenatal care and hospital deliveries, and that it interferes with the doctor-patient relationship. It should be noted that interference with therapeutic relationships has been historically cited as a reason why physicians underreport abuse and neglect, notwithstanding legal mandates to the contrary. *See, e.g.*, G. ZELLMAN & R. BELL, *THE ROLE OF PROFESSIONAL BACKGROUND, CASE CHARACTERISTICS, AND PROTECTIVE AGENCY RESPONSE IN MANDATED CHILD ABUSE REPORTING* 30-31 (1990); Besharov, *The Legal Aspects of Reporting Known and Suspected Child Abuse and Neglect*, 23 VILL. L. REV. 458, 479 (1977-78).

111. *See, e.g.*, FLA. STAT. ANN. § 415.503(9)(a)(2) (West Supp. 1990); ILL. ANN. STAT. ch. 23, para. 2053 (Smith-Hurd Supp. 1990); MASS. GEN. LAWS ANN. ch. 119, § 51A (West Supp. 1990); MINN. STAT. ANN. § 626.5562(2) (West Supp. 1991); OKLA. STAT. ANN. tit. 21, § 846(A) (West Supp. 1990); UTAH CODE ANN. § 62A-4-504 (1961). These laws are usually based upon either a positive toxicology of the infant, or more often medical or behavioral symptoms of drug exposure. The drugs are limited to "controlled substances" and do not typically include drugs properly taken under medical supervision. A few states include evidence of fetal alcohol syndrome as a reportable condition. *See, e.g.*, IND. CODE ANN. § 31-6-4-3.1(1)(a) (Burns Supp. 1987).

112. In a study of 12 cities, the reporting policies of hospitals with regard to newborns born "drug exposed" varied widely, although none seemed to mandate reports unless required by state law. OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 102. "Discretionary" reporting is hardly unique to the situation of drug exposed newborns.

The child abuse reporting laws provide only limited guidance concerning the

whether the condition falls within the reporting act's general definition of abuse and neglect.¹¹³ Absent additional factors, such as a mother who is violent or mentally unable to care for the infant's minimal needs, a failure to report will not likely result in liability to the mandated reporter. Conversely, a report based solely on prenatal drug use or infant drug exposure will likely be protected by good faith immunity, which has been statutorily extended to reporters in all states.¹¹⁴ Thus, at this time, most abuse and neglect reporting laws permit, but do not require, a report based upon an infant's drug exposure or a mother's prenatal drug use.

How much confidential information should be revealed in the child abuse report or during the investigation or judicial proceeding is a more difficult question. The decision often hangs on the wording of the relevant child abuse and neglect law, the party whose records are at issue, and the purpose for which the information is being sought.

Child abuse and neglect reporting laws are often imprecise regarding reporting requirements, sharing of information, and confidentiality waivers. Consequently, the following critical questions recur: How much confidentiality, if any, is waived?¹¹⁵ Does the waiver

factors that make an incident reportable [references omitted]. Vague, nonbehavioral definitions of what constitutes abuse and neglect under the law leave reporters considerable latitude in deciding whether the available evidence translates into a reasonable suspicion that abuse or neglect has occurred and, if so, whether or not it is reportable.

G. ZELLMAN & R. BELL, *supra* note 110, at 2 (citations omitted).

113. All child abuse and neglect reporting laws define abuse and neglect for reporting purposes. The definitions tend to be expansive and even vague to capture as many possible instances of child abuse and neglect as possible. Kentucky, for example, follows a common scheme by defining "abused or neglected child" as one whose

health or welfare is harmed or threatened with harm when his parent . . . : inflicts or allows to be inflicted upon the child physical or emotional injury by other than accidental means; creates or allows to be created a risk of physical or emotional injury to the child by other than accidental means . . . does not provide the child with adequate care, supervision, food, clothing, shelter and education or medical care necessary for the child's well-being.

KY. REV. STAT. ANN. § 600.020(1) (Michie/Bobbs-Merrill 1990). Under this definition, the mandated reporter must decide whether the woman's prenatal drug use inflicted an injury on the child or places the child at risk of future injury.

114. This immunity is another condition of state eligibility for federal child abuse funds. 42 U.S.C. § 5106a(b)(1)(B) (1988). Since reporters are not obligated to conduct independent investigations, any reasonable, articulable suspicion should support the good faith requirement. For example, the fact that a minor tested positive for a sexually transmitted disease, by itself, would merit a report and subsequent immunity from liability, even when a later test proved negative. *Criswell v. Brentwood Hosp.*, 49 Ohio App. 3d 163, 165, 551 N.E.2d 1315, 1317 (1989).

115. Two California cases demonstrate how literal readings of abuse and neglect reporting laws can limit disclosure. In California, the courts have decided that the law does not compel disclosure beyond the *initial* report. Thus, if a client or patient made revelations subsequent to this report, it would remain confidential, unless it involved new incidents of abuse. *People v. Stritzinger*, 34 Cal. 3d 505, 513-14, 668 P.2d 738, 744, 194 Cal. Rptr. 431, 437 (1983); *People v. John B.*, 192 Cal. App. 3d 1073, 1077-79, 237 Cal. Rptr. 659, 662-63 (1987).

mandate cooperation in child abuse and neglect investigations?¹¹⁶ Does it require the surrender of confidential records? Does such a waiver apply to the mother's confidential information, or just the child's?¹¹⁷ Does the waiver extend to criminal proceedings concerning the child's well-being?¹¹⁸ These questions present just a few of the problems raised by the confidentiality laws. Surprisingly, there is little case law addressing these issues. Therefore, in the absence of precise statutory authority, holders of confidential information tend to preserve confidences. Thus, agencies must resort to subpoenas and court compelled disclosures or do without this critical data. This situation has led some proponents to argue for greater clarity in state law and easier access for a child protection agency to obtain critical information.¹¹⁹

At this time, some generalities can be made. The child abuse report itself need not include the child's or mother's medical records.

116. While the laws mandate certain persons to report suspected abuse or neglect, they are largely silent as to a person's obligation during an investigation. Thus, while many laws grant good faith immunity to those who cooperate with an investigation. *See, e.g.*, ILL. ANN. STAT. ch. 23, para. 2059 (Smith-Hurd supp. 1990), they do not compel cooperation. Additionally, while most child abuse and neglect laws waive confidentiality for the purposes of reporting or testifying, they tend to be silent with respect to participating in an investigation. *See, e.g.*, KY. REV. STAT. ANN. § 620.050(2) (Michie/Bobbs-Merrill 1990); IND. CODE ANN. § 31-6-11-8 (Burns Supp. 1987). Thus, a holder of confidential information may logically conclude that, in light of the express confidentiality waivers, the legislature did not intend to cover the investigatory phase. Even when confidentiality is waived during this stage, interpretational difficulties may concern whether it is limited to persons who reported the abuse, or includes anyone else.

117. Some reporting laws seem to bind only professionals who directly care for or provide services to a child. In turn, the waiver of confidentiality provision, which applies to mandated reporters, could be limited to these professionals. In such states, one can question whether a professional who learns of possible child abuse through treating a parent is obliged to make a report. *See, e.g.*, Op. Wis. Att'y Gen., OAG 10-87 (1987). Other states seem to limit the waivers to the extent that it allows reporters of child abuse to testify; thus, the waiver might not cover other persons. *See also In re O.L.*, No. N-528-87 (D.C. Super. Ct. Fam. Div. Nov. 16, 1988) (1990 WL 237-333). Still other reporting laws waive testimonial privileges with respect to evidence "relating to the condition of a child." KAN. STAT. ANN. § 38-1554(a) (1986). Whether a mother's drug use would fall under this exception is far from clear.

118. This is one of the more litigated questions. Courts tend to favor disclosure in all related judicial proceedings unless the statute clearly excludes this outcome. *See, e.g.*, *State ex rel. Leas*, 303 N.W.2d 414, 419-20 (Iowa 1981) (statute waiving privilege in juvenile court proceedings applied to termination of parental rights case); *State v. Brydon*, 626 S.W.2d 443, 451 (Mo. Ct. App. 1981) ("any judicial proceeding" included criminal cases concerning abuse and neglect). *See generally*, Annotation 44 A.L.R. 4th 649 (1986).

119. *See Weisberg & Wald, supra* note 64, at 195; Hardin, *Legal Barriers in Child Abuse Investigations: State Powers and Individual Rights*, 63 WASH. L. REV. 496, 586-87 (1988).

Most state laws require that the report include statements identifying the child, injuries, and information which might help explain the source or cause of the injuries.¹²⁰ The federal drug and alcohol laws, which now permit covered programs to report suspicions of abuse, are consistent with this viewpoint. While covered programs may report abuse, they cannot surrender protected records as part of the routine reporting process.¹²¹

Some states, by statute, expressly authorize agency access to the child's medical records as part of the investigatory process, without the need for court orders or parental consent.¹²² A few courts have concluded that hospitals, as part of the child abuse report, are obliged to turn over the child's medical records.¹²³ These statutes and holdings reflect both logical and practical considerations.

Logically, it would make little sense to allow a parent accused of child abuse to delay or interfere with the child abuse investigation by withholding consent to release the child's medical records.¹²⁴ Courts might well interpret the reporting law's purpose, to protect children,¹²⁵ together with the child protection agency's mandate, to conduct investigations into the causes of a child's injury, to reach this result. As a practical matter, few child protection agencies have subpoena power or may obtain a subpoena from court, without first bringing an abuse and neglect petition.¹²⁶ If the agency had to resort to the court each time it sought a child's records, it would delay investigations (at potential peril to the child) and a new burden would be added to an already crowded child protection docket.¹²⁷

120. See, e.g., CAL. PENAL CODE § 11167(a) (West 1982 & Supp. 1991); CONN. GEN. STAT. ANN. § 17-38a(c) (West 1988).

121. See *infra* note 138.

122. See, ARIZ. REV. STAT. ANN. § 13-3620(C) (1989 & Supp. 1990) (person having custody or control of minor's medical records shall make them available to law enforcement or child protective services worker investigating child abuse; such records are confidential and may be used for investigatory and judicial purposes); HAW. REV. STAT. § 350-1.1(a) (1990); MD. FAM. CODE ANN. § 5-711 (Supp. 1990).

123. See *Schuyler County Dep't of Social Serv. v. Schuyler Hosp. Inc.*, 144 Misc. 2d 250, 543 N.Y.S.2d 872 (1989).

124. See, e.g., *In re Troy D.*, 215 Cal. App. 3d 889, 900, 263 Cal. Rptr. 869, 874 (1989).

125. Most child abuse and neglect reporting laws, as their *sine qua non*, identify the protection of children from harm at the hands of their parents or caretakers. See, e.g., CONN. GEN. STAT. § 17-38a (West 1988).

126. Currently few states have statutory authority for a child protection agency to seek subpoenas for the express purpose of conducting an investigation. See *Hardin, Legal Barriers in Child Abuse Investigations: State Powers and Individual Rights*, 63 WASH. L. REV. 493, 587 (1988).

127. Contributing to the growth of these dockets has been the skyrocketing of child abuse and neglect reports. In the 1980s, these reports more than doubled, from 1.15 million in 1980 to 2.4 million in 1989. Additionally, the last half of the decade witnessed a surge in foster care cases. In June 1987 there were an estimated 280,000 foster care cases; by June of 1990 this number increased 29% to 360,000. These cases demand even more court time to allow for periodic court reviews of each child in foster care. While court resources have not kept pace with either development, critics charge that

At trial, confidential communications and records concerning the child are admissible, over objections of privilege, under most state waiver of confidentiality provisions.¹²⁸ This is supported by good faith immunity granted to persons who testify in these matters.¹²⁹

Access to confidential information concerning the mother is more difficult. The amount that should be revealed in a child abuse report must take into account both the confidentiality statutes and reporting laws. The purpose of reporting abuse is to alert child protection agencies to dangerous situations so that an investigation may commence.¹³⁰ To initiate this response, the report may be limited to the identity of the allegedly abused child and the basis for the suspicion. At the same time, the details of confidential information may be largely withheld. For example, a psychiatrist who treated a patient for many years, and only recently had cause to suspect that the patient was abusing his child, should not be required to reveal client communications that are unrelated to the suspected incidents of abuse. If the investigating agency requires more, and the mother will not waive her confidentiality right, it will probably have to obtain a court subpoena.

Once at trial, however, a stronger case can be made that the

judges are unable to conduct proper hearings and meet the mandates of the Federal Adoption Assistance and Child Welfare Act. See Hardin, *Ten Years Later: Implementation of Public Law 96-272 by the Courts*, in THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980: THE FIRST TEN YEARS 58-59 (North American Council on Adoptable Children, ed. 1990).

128. See, e.g., FLA. STAT. ANN. § 415.512 (West 1986) (communication privileges do not apply in child abuse situations); MINN. STAT. ANN. § 626.556(B) (West 1990) (evidence related to the neglect or abuse of a child shall not be excluded on the basis of a physician, patient, or husband-wife privilege). Even if confidentiality of medical records is overcome, the records are not admissible unless they satisfy business records requirements. For a review of admissibility requirements in the context of medical records in a child abuse proceeding, see *State v. Ziegler*, 14 Wash. 2d 533, 789 P.2d 79 (1990).

129. Most states today extend this good faith immunity to persons who testify in judicial proceedings arising from abuse and neglect. See, e.g., MINN. STAT. § 626.556(4) (West 1990) (extending immunity to one who cooperates with the investigation); KY. REV. STAT. ANN. § 620.050(1) (Michie/Bobbs Merrill 1990). Depending on the wording of the statute, this may apply to all judicial proceedings related to abuse and neglect, or just those related to the child protection case.

130. State child abuse and neglect reporting laws typically require the child protection agency to commence an investigation shortly after a report of abuse is received, and if necessary take steps to protect the child. This statutory obligation has resulted in courts finding that these agencies owe a duty to children for purposes of tort litigation. See, e.g., *Turner v. District of Columbia*, 532 A.2d 662 (D.C. 1987); *Dep't of Health and Rehabilitative Servs. v. Yamuni*, 529 So.2d 258 (Fla. 1988); *Coleman v. Cooper*, 366 S.E.2d 2 (N.C. Ct. App. 1988).

mother's confidentiality and waiver rights can be overcome. This may be based on either an express statutory waiver for child abuse cases or a showing that such waiver is in the child's best interest.¹³¹ The latter basis comports with the view that certain societal interests in the proper resolution of litigation outweigh particular confidentiality concerns.¹³² The importance of correct dispositions in abuse and neglect¹³³ and child custody cases,¹³⁴ have caused courts to waive the parent's claim of privilege when his or her mental or physical abilities are questioned.

The question remains, however, whether state law reporting requirements and waivers of confidentiality apply to drug and alcohol-related records. The answer is twofold: yes, if the information is not protected by the federal drug and alcohol confidentiality requirements; no, if it is. These federal laws cover patient information of a "program" as defined in the acts and regulations. Under 1987 changes to the regulations, the definition of "program" no longer extends to records of substance abuse diagnosis, treatment, or referral made at a general hospital or health care facility, unless this service was provided by a special drug or alcohol unit or by identified substance abuse personnel.¹³⁵ Thus, for example, a newborn treated for drug exposure only in a neonatal intensive care unit and not by staff whose primary function is to provide substance abuse treatment, is not covered by the federal law. Similarly, a pregnant woman receiving routine prenatal care from her obstetrician, cannot expect protection under federal law for results of urine toxicology tests the doctor may have conducted. While the federal law might not apply, the woman may still have protection under a state confidentiality or privilege law, unless waived for child abuse purposes.¹³⁶

131. See, e.g., *In re M.C.*, 391 N.W.2d 674 (S.D. 1986) (statute on its face, coupled with the best interests of the child, resulted in waiver of the mother's physician-patient privilege).

132. 8 WIGMORE ON EVIDENCE § 2285 (McNaughton's rev. ed. 1961).

133. See, e.g., *In re Bender*, 366 Pa. Super. 363, 531 A.2d 504 (1987).

134. See, *People v. Fitzgerald*, 40 Misc. 2d 966, 244 N.Y.S.2d 441 (1963) (patient-physician privilege maybe disregarded to protect best interests of the child); *M. v. K.*, 186 N.J. Super. 363, 452 A.2d 704 (N.J. Super. Ct. Ch. Div. 1982) (statute granting privilege held unconstitutional in child custody cases); *D. v. D.*, 108 N.J. Super. 149, 260 A.2d 255 (1969) (flexibility required when applying patient-physician privilege in child custody cases).

135. 42 C.F.R. § 2.11 (1990). See also 52 Fed. Reg. 21796 (1987).

136. See, e.g., *In re Teddler*, 150 Mich. App. 688, 389 N.W.2d 149, *reh'g denied*, 426 Mich. 873, 394 N.W.2d 926 (1986). The court upheld the mother's psychologist-patient privilege in a termination of parental rights action, finding that because the psychologist's testimony did not concern a report of child abuse or provide evidence of neglect or abuse, the privilege was not waived under the reporting act. In so holding, the court noted that there was no "good cause" exception in the state law for abrogating the privilege. *But cf. In re Baby X*, 97 Mich. App. 111, 293 N.W.2d 736 (1980) (applying good cause exception in the federal drug confidentiality law).

If the information is protected by federal confidentiality laws, however, any state law requiring that the infant's or mother's drug and alcohol records be shared with the investigative agency or courts does not apply.¹³⁷ Comments to the federal regulations expressly state that "although the new law excepts reports of suspected child abuse and neglect from the statutory restrictions on disclosure and use, it does not affect the applicability of the restrictions to the original alcohol and drug abuse patient record maintained by the program."¹³⁸ In other words, it is sufficient for a program to report suspicions of abuse without turning over the records.

The mother's and child's drug or alcohol records may still be obtained, however, under the court-order exception found in both the federal drug and alcohol acts.¹³⁹ These laws permit nonconsensual disclosures by a court order upon notice to the treating institution, after a finding of good cause. In deciding whether to compel disclosure, the court must "weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."¹⁴⁰ There is, to date, little case law that has looked at this issue in a child abuse or neglect context. Those that have permit disclosure of parental drug/alcohol information, provided it is material and relevant to the issue in question.¹⁴¹

In authorizing disclosure, courts have held that the "public interest" in ensuring the safety and welfare of allegedly abused and neglected children outweighs any possible injury to either the patient or to the physician-patient relationship.¹⁴² Additionally, courts have observed that the potential "injury to the patient" is minimized in civil abuse and neglect actions because the records are not generally open to public inspection; public ridicule and embarrassment is thus less likely to occur.¹⁴³ Courts have applied this same rationale to

137. 42 C.F.R. § 2.12(c)(6) (1990).

138. 52 Fed. Reg. 21, 796-01 (1987). See also 42 C.F.R. § 2.12(c)(6) (1990).

139. 42 U.S.C. § 290dd-3(b)(2)(C) (1990). See also 42 U.S.C. 290ee-3(b)(2)(C) (1990).

140. 42 U.S.C. § 290dd-3(b)(2)(C) (1989), 290ee-3(b)(2)(c). See also 42 C.F.R. § 2.64 (1990).

141. See, e.g., *In re Baby X*, 97 Mich. App. 111, 293 N.W.2d 736 (records must be necessary and material to issue of neglect) (1980); *In re Dwayne G.*, 97 Misc. 2d 333, 411 N.Y.S.2d 180 (records containing evidence of alcoholism were necessary and material in neglect case) (Fam. Ct. 1978). *In re Doe Children*, 93 Misc. 2d 479, 402 N.Y.S.2d 958 (counselor's testimony must be relevant and material to issue of neglect) (Fam. Ct. 1978). *In re Stephen F.*, 118 Misc. 2d 655, 460 N.Y.S.2d 856 (Fam. Ct. 1982) (however, records must be material, necessary, and relate to the relevant time period).

142. *In re Baby X*, 97 Mich. App. at 120, 293 N.W.2d at 741.

143. *Id.* This factor was cited favorably in *Susan W. v. Ronald A.*, 147 Misc. 2d 669,

child custody cases, where the public interest argument is potentially weaker. In a Louisiana custody dispute, the father had sought the mother's medical records pertaining to her treatment for drug abuse. The trial court denied the request, citing the federal confidentiality provision. In reversing this decision, a Louisiana appellate court observed that the state joint custody law, which depended upon parental cooperation, put the parents' mental health in issue. Analogizing to the federal drug law's court-order exception, the appellate court found that the trial court could protect confidentiality by inspecting the records in camera, soliciting related testimony in chambers, and sealing the records.¹⁴⁴

If any doubt existed that the interests in child protection trump the patient's right to confidentiality, the 1987 changes in the federal drug and alcohol confidentiality acts' regulations put it to rest. The regulations permit court-ordered disclosures if necessary to protect against or prevent a significant threat to life or serious bodily injury. Under the new regulations, "circumstances which constitute suspected child abuse and neglect"¹⁴⁵ are now identified as such a situation. Additionally, on the criminal side, the regulations now permit court-ordered disclosure where it is "necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including . . . child abuse or neglect."¹⁴⁶ Comments to these new regulations make crystal clear that the "therapeutic benefits [of confidentiality] cannot take precedence over [these] circumstances."¹⁴⁷ In short, the regulations now strongly support, but do not require,¹⁴⁸ the release of drug and alcohol records in civil and criminal child abuse cases. Before authorizing disclosure, the regulations require that certain

558 N.Y.S.2d 813 (Sup. Ct. 1990), where the court ordered that a mother's drug treatment records be submitted for in camera inspection in a matrimonial action.

144. *Richard v. Tarzetti*, 510 So. 2d 1361 (La. Ct. App. 1987). See also *Susan W.*, 147 Misc. 2d 669, 558 N.Y.S.2d 813 (important public interest in ensuring a proper decision on custody outweighs any potential injury to the parent or to the physician-patient relationship so that father was entitled to in camera inspection of wife's alcoholism treatment records). But see *In re Comm'r of Social Serv. of N.Y. v. David R.S.*, 55 N.Y.2d 588, 436 N.E.2d 451, 451 N.Y.S.2d 1 (1982) (public interest in drug records is not overcome in paternity action where litigant desires evidence to impeach the credibility of another, especially when such evidence is cumulative of other testimony).

145. 42 C.F.R. § 2.63(a)(1) (1990).

146. 42 C.F.R. § 2.63(a)(2) (1990).

147. 52 Fed. Reg. 21, 796-01 (1987).

148. While the federal law permits court ordered disclosure of confidential information in extraordinary circumstances, it does not compel this result. 42 C.F.R. § 2.3(b)(1) (1990). A court must still determine whether disclosure is appropriate under the procedures and criteria described. See *infra* notes 154-65 and accompanying text. The decision is left to the judge's discretion and will not be overturned absent manifest injustice or a clear abuse of discretion. See *State v. Rollins*, 203 Conn. 641, 526 A.2d 1283 (1987).

procedures be followed.¹⁴⁹ Also, as with any evidentiary matter, the records must be shown to be relevant to the issue in dispute.

Both the woman's prenatal and infant's drug records may meet the relevancy standard in a child abuse and neglect case. In cases of abuse and neglect, the health of the child is often at issue. Courts have held that, when a parent's fitness to raise a child is at issue, the parent's physical and mental health records are relevant,¹⁵⁰ and that the best interests of the child overcome any objection based on the physician-patient privilege.¹⁵¹ While a woman's drug use cannot sustain a child abuse report prior to birth, once the child is born courts have found prenatal drug use probative of future abuse and neglect.¹⁵² In some jurisdictions, this may even establish a *prima facie* case of abuse and neglect.¹⁵³

As stated above, the regulations set forth explicit procedures and criteria to be used in obtaining court-ordered disclosures. Additionally, a court order alone cannot compel disclosure. The order must be accompanied by a subpoena or other similar legal mandate.¹⁵⁴ If the request does not have both parts, a drug or alcohol "program" cannot respond in any way that would reveal that an identified individual is or has been diagnosed or treated for alcohol or drug abuse.¹⁵⁵ The program's response must be noncommittal, for exam-

149. See *infra* notes 154-65 and accompanying text.

150. See, e.g., *In re Estate of Becton*, 130 Ill. App. 3d 763, 474 N.E.2d 1318 (1985) (parent's drug use is relevant to issue of custody if it is shown to affect the parent's mental and physical health and relationship with the child).

151. See, e.g., *Koshman v. Superior Court*, 111 Cal. App. 3d 294, 168 Cal. Rptr. 558 (1980); *People ex rel. Chitty v. Fitzgerald*, 40 Misc. 2d 966, 244 N.Y.S.2d 441 (1963); *D. v. D.*, 108 N.J. Super. 149, 260 A.2d 255 (N.J. Super. Ct. Chi. Div. 1969).

152. See *In re Stephen W.*, 211 Cal. App. 3d 629, 271 Cal. Rptr. 319 (1990); *In re Troy D.*, 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1989); *In re Stefanel Tyesha C.*, 157 A.D.2d 322, 556 N.Y.S.2d 280 (N.Y. App. Div. 1990); *In re Baby X*, 97 Mich. App. 111, 293 N.W.2d 736 (1980). The rationale for these cases is that the court need not wait for harm before intervening. An analogy is made to the situation where courts will admit evidence of prior abuse of a sibling as probative of future harm to a child. See, e.g., *In re D.L.R.*, 638 P.2d 39 (Colo. 1981); *In re William B.*, 73 Md. App. 68, 533 A.2d 16 (1987).

153. See, e.g., ILL. ANN. STAT. ch. 37, §§ 802-18(2)(c) & (d) (Smith-Hurd 1990).

154. 42 C.F.R. § 2.61(a) (1990).

155. 42 C.F.R. § 2.13(c)(2) (1990). For example, a response might include "records of a patient other than the substance abuse records, plus a custodian of records affidavit . . . [stating] that no effort was made to determine the existence or nonexistence of records maintained in connection with substance abuse diagnosis, treatment or referral, with [a] citation to the federal law." Slaven, *Who Holds the Key? Lawyers' Access to Drug and Alcohol Abuse Treatment Records*, 23 ARIZ. B.J. 8, 37 (1988).

Since noncompliance with a court subpoena can result in some kind of sanctions, one author suggests the following procedure that his office has used. Upon subpoena of confidential information, the presiding judicial officer of the court is advised of the

ple, by giving the inquiring party "a copy of [the drug and alcohol confidentiality] regulations and advising that they restrict the disclosure of alcohol or drug abuse patient records," without affirming that a specific individual has records that are confidential.¹⁵⁶ If a program only treats drug or alcohol problems, then it may not even acknowledge that the person ever applied for or received services.

If the party still seeks the records, he must apply to the court, in a John Doe request,¹⁵⁷ and give the patient and holder of the confidential communication notice and the opportunity to respond.¹⁵⁸ A hearing on the request will be held in chambers or by another means ensuring privacy, and may include an in camera inspection of the records.¹⁵⁹ The criteria for ordering disclosure differ depending upon whether the request is for criminal or noncriminal purposes. In either case, the court must weigh the public interest against the patient and patient-physician interests, as required by the statutes.¹⁶⁰ However, as stated above, the 1987 regulations put the public interest first with respect to child abuse and neglect. In criminal cases, the court must additionally determine whether the crime involved is "extremely serious."¹⁶¹ Again, the regulations remove the guess work by identifying child abuse and neglect as such a crime.¹⁶²

The court must also determine whether there are other effective ways of obtaining the information. In the case of prenatal drug abuse, it might be argued that a mother's admission or family members' acknowledgement of her substance abuse would suffice. While this would identify her as a substance abuser, it would not necessarily answer other critical questions potentially relevant to her fitness to care for the child. Her confidential record might provide, for example, her history of both drug use and participation in treatment and her knowledge of the effects of substance abuse on fetal development.

Finally, in keeping with the purpose of confidentiality, the regulations place limits on the court's disclosure order. The order must

federal law and regulations, without identifying any patients by name. The portions of the record believed to be confidential are marked by the program and its attorneys and transmitted in a sealed envelope to the presiding judge, together with a letter describing the subpoena and advising that a response is being made by submission of the sealed record with parts marked which may be privileged. No reference is made to drug or alcohol abuse, to the statutes, nor to any communication with the attorney issuing the subpoena. Anderson, *New Federal Regulations Concerning Confidentiality of Alcohol and Drug Abuse Records*, 3 THE HEALTH LAW. 2 (1987).

156. *Id.*

157. 42 C.F.R. §§ 2.64(a), 2.65(a) (1990).

158. 42 C.F.R. §§ 2.64(b), 2.65(c) (1990).

159. 42 C.F.R. §§ 2.64(c), 2.65(c) (1990).

160. 42 C.F.R. §§ 2.64(d)(2), 2.65(d)(4) (1990).

161. 42 C.F.R. § 2.65(d)(1) (1990).

162. *Id.*

limit disclosure of the record to parts relevant to the underlying inquiry and to persons who have a need for the information.¹⁶³ In civil matters, the court must also take steps to shield disclosure from public view, such as sealing the record.¹⁶⁴ Public disclosure for criminal matters can also be limited within constitutional limitations.¹⁶⁵

IX. CONCLUSION

This article provided an overview of the medical evidence of prenatal substance abuse. No attempt was made to quantify its probative value or to suggest that such evidence, by itself, can sustain either a child protection agency's¹⁶⁶ or juvenile court's finding of abuse or neglect.¹⁶⁷ To the contrary, such evidence is but a piece of the puzzle. Whether the mother is or will be abusive or neglectful takes into account a variety of other factors.

These factors are increasingly being identified in protocols and agency policies. For example, the New York State Department of Social Services, in 1990, adopted the following policy:

Evidence that a newborn infant tests positive for a drug or alcohol in its bloodstream or urine; is born dependent on drugs or with drug withdrawal symptoms, fetal alcohol effect or fetal alcohol syndrome; or has been diagnosed as having a condition which may be attributable to in utero exposure to

163. 42 C.F.R. §§ 2.64(e)(1)-(2), 2.65(e)(1)-(2) (1990).

164. 42 C.F.R. § 2.64(e)(3) (1990).

165. 42 C.F.R. § 2.65(e)(3) (1990).

166. Following a report of abuse or neglect, child protection agencies will conduct an investigation. As a result of such an investigation, the agency will decide whether or not it believes abuse occurred (often termed "substantiated" or "confirmed" case) or did not occur ("unsubstantiated"). Sometimes, due to lack of evidence, the agency can not make a determination ("uncertain"). These agency decisions are unrelated to judicial findings of abuse or neglect.

167. There is, admittedly, some statutory and case law authority that such evidence may establish a prima facie case of neglect. See, e.g., ILL. ANN. STAT. ch. 37, § 704-6 (Smith-Hurd 1977). *In re Troy D.*, 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1989). Other cases, while purporting to reach this conclusion, seem to rely upon additional evidence. See, e.g., *In re Stefanel Tyesha C.*, 157 A.D.2d 322, 556 N.Y.S.2d 280 (N.Y. App. Div. 1990) (mother's prenatal drug use and her failure to be enrolled in a drug treatment program at the time of the petition, is sufficient to show neglect due to her repeated use of the drug and actual impairment of the child). Furthermore, at this time there is no substantive crime of using drugs while pregnant, notwithstanding some legislative efforts to the contrary. See, e.g., H.R. Res. 1146, Reg. Leg. Sess. (1990 Ga. Laws) (would have made the distribution of a controlled substance to an unborn child a crime); H.R. Res. 90, 57th Gen. Sess. (1990 Colo. Laws) (would have made prenatal substance abuse of a controlled substance or assisting a pregnant woman to use such a substance criminal child abuse); H.R. Res. 90-976, Reg. Sess. (La. 1990 Laws) (would have made it unlawful to give birth to an infant who is addicted to heroin or cocaine as a result of prenatal use). The Louisiana bill went on to require the testimony of a least two neonatologist as to prenatal exposure to sustain a conviction.

drugs or alcohol is not sufficient, in and of itself, to support a determination that the child is maltreated [or] to take protective custody of such a child.¹⁶⁸

The policy goes on to state that such evidence constitutes grounds for a child abuse report. Upon receipt of such a report, a child protective services investigation must occur. This investigation is to "assess the ability of the parent to care for the child,"¹⁶⁹ taking into account the infant's needs and the parent's ability or capacity to meet these needs. This policy is especially notable since it appears to be an about face. Prior to this policy, various child protective agencies in New York were notorious for removing newborns from their mothers' care solely on this medical evidence of prenatal substance abuse.¹⁷⁰

The policy is also consistent with a growing consensus, as other agencies, associations, and study groups set forth their policies and procedures in this area. The Washington State Department of Social and Health Services' policy, for example, requires its child protective services to accept reports based solely on medical evidence of prenatal substance abuse, once the child is born. The policy, however, goes on to enumerate additional factors the investigation must address, including the history and pattern of parental substance abuse, parental mental health and physical condition, the home environment (including presence of other substance abusers), the physical condition and medical needs of the child, support available to the parent(s), prior history of abuse and neglect by parents, and chemical dependency testing and monitoring of the parents.¹⁷¹

The National Association of Public Child Welfare Administrators, in a January 1991 policy statement, likewise took this more cautious approach, stating that:

A positive drug test of a newborn or the child's mother will precipitate a report to the public CPS agency to determine if the child is at risk of harm or in need of protection. A positive drug test is a factor in such an investigation, but should not be used in and of itself as the sole basis for court action or the involuntary removal of the child.¹⁷²

168. New York State Dep't of Social Servs., Child Protective Servs. Program Manual, app. at I-11 (June 27, 1990) (unpublished memorandum).

169. *Id.*

170. See Baquet, *Hearings on Neglect Upheld In Newborn Cocaine Cases*, N.Y. Times, May 30, 1990, at B3. An earlier New York City agency policy was described as "generally [requiring] a neglect hearing whenever a hospital informs the Human Resources Administration that a child has been born with illegal drugs in its system." *Id.* See also Sherman, *Keeping Babies Free of Drugs*, NAT'L L.J., Oct. 16, 1989, at 28, in which a similar policy was attributed to Nassau County, N.Y.

171. See WASHINGTON STATE DEP'T OF SOCIAL AND HEALTH SERVS., TREATMENT PROTOCOL FOR CHEMICAL-USING PREGNANT WOMEN 78 (Jan. 1990). See, OREGON DEP'T OF HUMAN RESOURCES, WOMEN, DRUGS AND BABIES: GUIDELINES FOR MEDICAL AND PROTECTIVE SERVICES RESPONSE TO INFANTS ENDANGERED BY DRUG ABUSE DURING PREGNANCY, 23-27 (Oregon Children's Services Division 1989).

172. National Ass'n of Public Welfare Admins., Guiding Principles for Working

In short, the emerging view tends to support the use of the medical evidence of prenatal drug use for purposes of reporting child abuse and neglect, but limits its role in the proof of neglect and abuse to that of one factor among many.

with Substance Abusing Families and Drug-Exposed Children: The Child Welfare Response at 3 (Jan. 1991) (unpublished report). This view is also shared by many other groups that have examined this issue. See, e.g., Ohio Task Force on Drug-Exposed Infants, *Final Report* at 11 (May 1990) (unpublished report).

