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'Of Sound Mind and Body': A Call for Universal Drug Screening for All Newborns

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“Of Sound Mind and Body”: A call for universal drug screening for all newborns

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Abstract and Keywords

Substance abuse is a major medical and social problem. Estimates suggest that each year some 15 percent of the 4 million babies born in the United States are exposed to drugs or alcohol. Research demonstrates that exposure to these substances is harmful to the children in both the short term and across their developmental trajectory. This chapter summarizes the harms that might result from such prenatal exposure and considers the ways that both federal and state law respond to this. The chapter argues for universal drug testing of newborns in an effort to ascertain whether they have been prenatally exposed to such substances so that treatment and other services can be provided.

Keywords: drugs, newborn, substance abuse, tobacco, alcohol, children’s rights, health care, child protection, screening, CAPTA

SUBSTANCE abuse is a major health and social problem in the United States. The National Institute on Drug Abuse (NIDA) estimates that in 2013, 24.6 million Americans used an illicit drug within the month of being surveyed, amounting to 9.4 percent of the population; more than 17 million Americans abused alcohol; more than 4 million met diagnostic criteria for dependence on marijuana; 1.9 million were dependent on or abused prescription pain relievers; some 855,000 used cocaine; and more than 22.5 million Americans were in need of substance abuse treatment. Many are women of childbearing age, and pregnant women engage in a substantial portion of this substance abuse. Survey evidence suggests that 15.8 million women used illicit substances (e.g., cocaine or heroin) or used licit substances illicitly (i.e., used prescription medication without a prescription) in 2014, which equated to 12.9 percent of women over 18 years of age.[1] A woman’s risk for substance abuse is highest during the same years that she is most likely to become pregnant.[2] Substance use by childbearing age women is rising. From 2002 to 2014, for example, the prevalence of self-reported, past-month marijuana use among US adult pregnant women increased from 2.4 percent to 3.9 percent, while 14.6 percent of pregnant adolescents in the United States aged 13 to 18 reported past-month marijuana use.[3]

Each year in the United States, approximately four million babies are born.[4] The National Center on Substance Abuse and Child Welfare estimates that 15 percent of those children are born having been exposed to alcohol or illicit drugs.[5] Drug exposure (p. 66) during pregnancy poses a number of immediate and long-term dangers to the physical and emotional well-being of an infant and child, and the effects vary from prenatal death to lifetime neurodevelopmental delays. These are moderated by the type of drug, the timing and frequency of exposure during gestation, other substances present, maternal health, and factors in the infant. One serious immediate effect, neonatal abstinence syndrome, increased substantially in the early years of the twenty-first century. In 2012, the syndrome was diagnosed in 21,732 infants in the United States, representing an increase by a factor of five since the year 2000.[6] This is an underestimate because there is no foolproof method to determine with certainty whether a pregnant woman has used drugs or alcohol, and infants are not reliably identified in the neonatal period.[7]

The most inclusive means of identifying prenatally exposed newborns is to test their meconium (the first feces of a newborn), but this captures only drugs used during the latter stages of pregnancy. Toxicology tests of newborns’ urine are less accurate, capturing only more recent infant exposure to maternal drug use. Some have begun testing umbilical cords, but this practice is not universal. Many health care professionals rely on the identification of potential risk factors during the prenatal or perinatal periods which have been associated with maternal drug use before they order drug testing on a newborn child. Risk factors that trigger testing might include inadequate prenatal care, delivery outside the hospital, a history of drug use, removal of other children by child protective services (CPS), or the identification of intrauterine findings such as unexplained neonatal stroke or growth retardation. Medical history-taking, which plays a critical role in this assessment, is problematic; there is considerable evidence that pregnant women underreport their use of alcohol and illicit drugs because they fear the consequences that might flow from that use, such as social ostracism, involvement of CPS and, in some jurisdictions, criminal prosecution.[8] For example, a study involving more than 8,500 mother-newborn dyads found that more than one-third of the drug-using pregnant women failed to self-disclose their drug use—even when a structured interviewing protocol was used—which was only later discovered with meconium analysis.[9] Another study in a community hospital found that clinical indicators identified less than one-fourth of exposed babies when compared to meconium test results.[10] Thus, most newborns are currently not identified by history or testing to determine whether they were prenatally exposed. Even when testing occurs, the results are imperfect at identifying all substance use during pregnancy.

Public authorities have long been concerned about substance abuse. Prenatal exposure to alcohol has been of concern to medical professionals since at least the early 1830s.[11] Concern about particular substances comes in waves as the public’s taste for a particular drug waxes and wanes, with alcohol and tobacco being more constant. Concern by public authorities is often racially tinged, and there are racial and socioeconomic disparities in substance abuse reporting and treatment. For example, in the 1890s concern was focused on the use of opium by Chinese immigrants. In the 1930s there was concern about “reefer

madness,” which was focused on the Latino (p. 67) community. In the 1980s, use of cocaine captured the public’s attention. Although there was increased use of both the powdered form of the drug and the cheap, smokable form known as “crack,” public authorities’ concern was focused more on crack, which was predominantly used by impoverished African Americans, than on the powdered form preferred by the middle classes and whites. Methamphetamine use, primarily by rural whites, rose sharply in the late 1990s and early 2000s.[12] Later in the 2000s, prescription opioid abuse rose to concerning levels. When officials began to crack down on opioid prescription mills, heroin usage increased, and methamphetamine use has also recently resurged.[13] As this chapter is being written, opioid use (including prescription opioids, heroin, and synthetic forms such as fentanyl) is at epidemic levels. As this summary makes plain, concern about prenatal exposure to drugs and alcohol is not a recent phenomenon. Over the past half-century we have learned a great deal about how prenatal substance use and abuse impacts inchoate children and about its increased risks for later child abuse and neglect.

Yet the law provides few options to protect children from the harmful impact of prenatal substance exposure. With few exceptions, state criminal law does not provide a mechanism for compelling a substance-abusing pregnant woman into treatment, because most courts have interpreted various provisions of their criminal statutes (e.g., murder, manslaughter, child abuse, child endangerment) to be inapplicable to the inchoate child.[14] And, of course, prosecution alone does little or nothing to prevent her use of drugs, to treat her underlying addiction, or to address the needs of her unborn baby. Though incarceration might interrupt a woman’s substance use, both incarceration itself and, in the case of an addicted pregnant woman, withdrawal from that substance induce stress that presents its own set of harms to the developing child.

A few states have enacted statutes authorizing courts to civilly commit a pregnant woman for the purpose of receiving drug treatment.[15] These statutes are infrequently used, however, and they present a host of challenges such as inadequate treatment facilities to care for the women who are committed and a lack of financial resources to pay for needed treatment. Additionally, there are active constitutional challenges to these statues, and it is unclear whether they will pass constitutional muster.[16] As a result, children will continue to be born having been prenatally exposed and to suffer a variety of harms due to maternal use of illicit drugs and alcohol.

1. Impact of Prenatal Drug Exposure on Children

Prenatal exposure to drugs of abuse often has deleterious effects upon inchoate children that include “long-lasting changes to brain structure and function.”[17] The precise impact on an individual child will vary depending on the substance used, the frequency of use, the amount used, and when during the pregnancy it was used. A crucial factor is whether the pregnant woman engaged in polysubstance abuse (p. 68) while pregnant, which is typical (e.g., use of alcohol and marijuana, heroin and cocaine, or cocaine and alcohol). Addi-

tionally, a host of environmental factors such as timing and amount of prenatal medical care, quality of nutrition, and the presence of other life stressors in the pregnant woman’s environment (e.g., poverty or domestic violence) may influence how the developing child is impacted by the substance use.

Medical and social science researchers have identified a number of short- and long-term harmful impacts of prenatal exposure to illicit drugs and alcohol. The specific impacts on individual children vary, ranging from intrauterine death and increased risk for sudden infant death syndrome to long-term neurodevelopmental disabilities.[18] Post-birth environmental factors play an important role in how a particular child is impacted by prenatal exposure. For example, children with prenatal alcohol exposure and subsequent trauma fare worse neurodevelopmentally than children who have experienced only post-birth trauma.[19] What follows is a brief summary of the research as it relates to each identified substance.[20]

1.1. Tobacco

Cigarette smoke and nicotine are the most commonly used substances during pregnancy. Estimates suggest that some 18 percent of pregnant women smoke cigarettes. Smoking deprives the inchoate child of vital nutrients and oxygen while exposing him or her to harmful compounds. The carbon monoxide and nicotine in cigarettes impede the supply of oxygen to the developing child. The chemicals in cigarettes—lead, arsenic, and similar substances—may have a more harmful impact on the inchoate child than on the mother. After crossing the placenta, nicotine accumulates in the child such that the child will have higher concentrations of the drug than the mother. Smoking has been definitely linked to infant low birth weight, premature delivery, and birth defects, as well as a variety of post-birth medical and emotional problems, decreased pulmonary function, sudden infant death syndrome, and behavioral problems such as attention deficit hyperactivity disorder.[21] Children exposed to tobacco smoke prenatally are more likely to smoke themselves even after controlling for later maternal smoking.[22]

1.2. Alcohol

Between 10 percent and 15 percent of pregnant women report using alcohol while pregnant, with 3.9 percent reporting binge drinking and 0.7 percent reporting heavy alcohol use.[23] Estimates suggest that 1 percent of children suffer deleterious impacts as a result of prenatal exposure to alcohol, approximately 400,000 children each year.[24] The impacts of prenatal exposure to alcohol have been studied for decades and so are more well known and well documented than those from other drugs of abuse. Fetal death is the most extreme outcome from drinking alcohol during pregnancy. In 1973, “fetal alcohol syndrome” entered the medical lexicon and has since been refined to fetal (p. 69) alcohol spectrum disorder (FASD), reflecting gradations in the impact of prenatal exposure on the developing child. Different terms are used to describe FASD depending on the type of symptoms.[25] Fetal alcohol syndrome (FAS) represents the most involved end of the FASD spectrum, with anatomic and neurologic effects. Many people with FAS have abnormal fa-

cial features, growth problems, and central nervous system (CNS) problems. FAS can cause problems with learning, memory, attention span, communication, vision, or hearing. People with FAS might have a mix of these problems. Many have a hard time in school and trouble getting along with others. People with alcohol-related neurodevelopmental disorder (ARND) have intellectual disabilities and problems with behavior and learning. They tend to do poorly in school and to have difficulties with math, memory, attention, judgment, and poor impulse control.

People with alcohol-related birth defects (ARBD) typically have problems with the heart, kidneys, or bones or with hearing. Prenatal exposure to alcohol is a leading cause of mental retardation in North America.[26] Prenatal exposure to alcohol has been associated with impairments as wide-ranging as attention deficit disorder, difficulties with memory, verbal fluency, and executive functioning of the prefrontal cortex, among other deficits.[27] Children exposed to alcohol *in utero* are at heightened risk for mood disorders and psychopathology.[28] Psychologist Dr. Tina Birk Irner summarizes the impact of prenatal alcohol exposure as resulting in “cognitive and behavioral deficits that impair both the social and occupational future of the person exposed with a need in severe cases for lifelong assistance in order for that person to function at an optimal level.”[29] Among children in the foster care system, there is evidence that the incidence of FASD has been either underestimated or the diagnosis has simply been missed, yet it is identified in a disproportionate number of children in care.[30]

1.3. Marijuana

Marijuana has long been among the most commonly used illicit drugs by pregnant women.[31] Approximately 5 percent of pregnant women report using marijuana during the first trimester of pregnancy, with 2.9 percent reporting second trimester usage and 1.4 percent use during the third trimester.[32] In recent years, there has been movement to legalize marijuana for either medical or recreational purposes, and usage has increased significantly.[33] Marijuana has historically been considered an illicit drug and remains a Schedule I substance under federal law. The movement to legalize it may portend increased use by pregnant women, which is problematic, in part because of higher concentrations of THC (tetrahydrocannabinol), the active ingredient in marijuana, in recent years.[34] Regardless of its legal status, when used during pregnancy, marijuana has been linked to a number of negative impacts on child development. First, these children experience sleep disturbances at higher rates through the first three years of life. They also manifest lower than normal verbal and memory acuity, increased impulsivity, decreased attention, hyperactivity, and impaired cognitive development (lower IQ scores) and executive functioning. By age six, children exposed to (p. 70) marijuana *in utero* show increased attention deficits, impulsivity, and hyperactivity.[35] Exposure to marijuana *in utero* has been linked to increased problems with attention, learning, and memory and to juvenile delinquency by age ten. At age fourteen, even when controlling for maternal substance use, household income, home environment, maternal IQ, and race, youth exposed to marijuana *in utero* had significantly higher levels of juvenile delinquency. Heavy use of marijuana during pregnancy nearly doubles the possibility that a child will be delinquent by

age fourteen.[36] After reviewing the research regarding marijuana’s impact on the inchoate child, Ross and her colleagues concluded that the “data indicate that prenatal marijuana exposure has significant effects on multiple neurobehavioral outcomes—deficits that are enduring, particularly at the level of executive function [i.e., the cognitive and intellectual function of the brain that enhances one’s ability to exercise judgment and to control impulses].”[37]

1.4. Cocaine

Cocaine use during pregnancy has been linked to numerous prenatal complications as well as long-term developmental problems post-birth. Use in the early stages of pregnancy is associated with reduced gestational age, lower weight at birth, and smaller head circumference even when other possible causes are controlled for.[38] Children whose mothers used cocaine during pregnancy experience “generalized growth retardation.”[39] In terms of behavior, Ross et al. summarize the impact on newborns prenatally exposed to cocaine as experiencing “abnormalities related to lower arousal, poorer quality of movement and self-regulation, higher excitability, jitteriness, and more non-optimal reflexes,” circumstances that persisted, and in some cases worsened, after one year.[40] These children experience growth deficiencies, which in some children have been found to persist until at least the age of ten. While cocaine itself “does not appear to lower global intelligence, there is consistent evidence of poor cognitive performance in language skills, behavior, and executive functioning.”[41] A secure emotional attachment to a primary caregiver is crucial to healthy child development. Children exposed to cocaine *in utero*, however, may demonstrate increased incidence of insecure attachment to a primary caregiver.[42] Cocaine exposure has been correlated with increased aggression and juvenile delinquency by age nine. More recent research utilizing structural and functional magnetic resonance imaging (MRI) have identified long-term, structural abnormalities to the cortical and limbic regions of the brains of children prenatally exposed to cocaine.

1.5. Methamphetamine

While the prevalence of use of methamphetamine (meth) is uncertain, our best information is that about 5 percent of women report using meth during pregnancy.[43] In the United States, the early 2000s saw a dramatic upswing in the use of meth, which (p. 71) seems to have been reduced in the following decade as prescription opioid misuse increased substantially. By 2017, meth use was again on the rise. Although meth is a commonly abused drug, less is known about its long-term impact on child development.[44] What is known is that continuous meth use during pregnancy is associated with premature birth and low birthweight.[45] It is also associated with growth restrictions, shorter length at birth and smaller head circumference. Some meth-exposed newborns display cardiac and cranial anomalies similar to those experienced by neonates who experienced asphyxiation during pregnancy.[46] Meth exposure *in utero* appears to have a number of harmful effects on a child’s brain development, including development of visual-motor integration, verbal and spatial memory, and attention. Specific regions of meth-exposed children’s brains are smaller than those of non-exposed but otherwise comparable chil-

dren.[47] Critically, the research suggests that discontinuing meth use at any point during pregnancy has a positive impact on the resultant child, so intervention with pregnant meth users is crucial.[48]

1.6. Opioids

Estimates suggest that the number of children born experiencing neonatal abstinence syndrome as a result of prenatal opioid exposure in the United States tripled between 2000 and 2009.[49] The number of children born prenatally exposed to opioids has strained the nation’s health care systems and overwhelmed children’s protective services agencies around the country.[50] Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Use of opioids during pregnancy has a number of negative impacts on the inchoate child. During the pregnancy, these might include premature labor, preeclampsia (increased maternal blood pressure), placental insufficiency, intrauterine growth deficits, or death. In addition to experiencing withdrawal, many children born to mothers who use opioids have low birth weights and smaller head circumference than non-exposed children. Children exposed *in utero* to opioids have “smaller for age intracranial and brain volumes” and other physical deformities.[51] Opioid-exposed children show increased rates of motor and cognitive impairments, hyperactivity, and inattention.[52] In summarizing the research regarding the impact of *in utero* heroin exposure, Irner explained that children born opioid-dependent scored higher on tests of attention deficits (regardless of whether the children were raised in their biological homes or in adoptive homes); those born exposed and raised at home scored worse than those who were exposed and adopted or a comparison group of children who grew up in low socioeconomic status households.[53] Children exposed to opioids demonstrated an increased incidence of insecure attachment.[54] Recent research utilizing MRI and functional MRI technology has begun to isolate specific locations in the brains of newborns that are impacted by the use of various substances. “Structural brain deficits have been observed in children exposed to opioids prenatally,” according (p. 72) to Irner.[55] Ross and her colleagues concluded, “The damage of prenatal opiate exposure is debilitating and long lasting.”[56]

Maternal opioid addiction might be treated with other opioid-based medications (e.g., methadone, buprenorphine). When used under close medical supervision, these prescription opioids are less harmful than the illicit drugs of choice (e.g., heroin). However, “they are not without substantial risk, as they can cross the placenta and alter development.”[57] There have also been differences noted in which drug is used based on racial and socioeconomic factors. Use of these prescription opioids may result in the same complications as illicit opioid use: premature birth, decreased birthweight, smaller head circumference, respiratory difficulties, and other complications at birth. After birth, a number of children whose mothers are treated with these drugs experience neonatal abstinence syndrome, a withdrawal syndrome, although it appears that cognitive deficits may not be as prevalent as with illicit opioid use.

In a review of the literature on the impact of various substances on child development, Dr. Tina Birk Irner concluded that “the evidence is convincing on consequences of prenatal alcohol, but also of other substance exposure and developmental consequences into adolescence…. [C]hildren born to substance-using women have been shown to be vulnerable across cognitive, emotional and social function into adolescence.”[58] Irner’s summation reflects the medical consensus that children born to substance-abusing mothers suffer both short- and long-term effects that in any other context would, without hesitation, be considered child maltreatment. In addition to the drugs listed here, there are a number of other illicit substances such as phencyclidine and “designer” drugs and high-potency THC that may have other even more dangerous effects, but these are less well studied and long-term outcomes are not yet available.

2. Children’s Rights in the Health Care Context

Historically, the civil law viewed a child’s legal interests as synonymous with those of his or her parents. Thus a child could not bring suit against a parent for damages caused by parental behavior or decision-making.[59] Since 1963, however, courts have steadily eroded the intrafamilial tort immunity doctrine, allowing children to sue their parents for injurious conduct.[60] It was through tort law that a child’s right to be born healthy entered American legal doctrine, entitling him or her to a remedy if some negligent actor violated that right.[61] “[J]ustice requires,” the New Jersey Supreme Court wrote in 1960, “that the principal be recognized that a child has a legal right to begin life with a sound mind and body.”[62] The right to be born of sound mind and body was eventually applied to harm to a child by his or her mother during pregnancy. Courts today permit children to bring suit against their mothers if they are harmed by the mother’s behavior during pregnancy. Courts have extended this principle to a pregnant (p. 73) woman’s negligent use of prescription medications, even where those drugs were recommended by and administered under the supervision of her treating physician.[63]

In *Parham v. J. R.*, the U.S. Supreme Court addressed the rights of a minor child to an adversarial hearing before being committed to a mental health facility by his or her parents. While holding that no adversarial hearing was required pre-admission, the majority of the justices acknowledged that a child has the right to be free from unnecessary bodily restraint that accompanies psychiatric hospitalization. The Court made clear its view that parents generally are charged with both the right and the “high duty” to make medical decisions on behalf of their children free of interference by the state.[64] “The law’s concept of the family rests,” Chief Justice Burger wrote for the Court’s majority, “on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions…[and] that natural bonds of affection lead parents to act in the best interests of their children.”[65] The majority, however, recognized that in some instances parents will not act with their children’s best interests at heart: “[T]he incidence of child neglect and abuse cases attests to this.”[66]

When the child’s interests might diverge from those of the parents, the *Parham* Court acknowledged, children are entitled to some process before being committed to a psychiatric facility. The process due the child was embodied in an independent medical judgment by a qualified member of the hospital’s medical staff. This demonstrates that health care professionals owe an independent duty of care to the child-patient that is separate from any duty owed to the child’s parents. In *Grodin v. Grodin*,[67] this separate duty provided a basis on which a child, who was harmed by the physician’s allegedly negligent administration of medication during the prenatal period, could bring suit.[68] The physician’s separate duty to the child-patient is implicated when a pregnant woman uses drugs or alcohol. Thus, for example, the Court of Appeal of California has held that because of the conflict of interest present in such a case, a parent cannot assert a child’s physician-patient privilege in order to exclude from evidence in a child protection proceeding the child’s medical records regarding the child’s prenatal exposure to illicit drugs and postnatal medical condition.[69] However, such protections for sharing maternal information in child protection cases is not uniform across the United States.

This principle—that a child has a right to be born of sound mind and body—has migrated into the child protection context, which provides the state the opportunity to effectuate its *parens patriae* interest in the welfare of the child.[70]

3. Child Protection and the Right to Be Born of Sound Mind and Body

A 2003 federal law, the Keeping Children and Families Safe Act of 2003, required states to mandate that birthing facilities report to child protection services a positive (p. 74) toxicology test result in any newborn, and to have a “plan of safety” for addressing the newborn child’s predicament of having a substance-using mother. But roughly half the states ignored the mandate. Before enactment of the Comprehensive Addiction and Recovery Act in 2016, only twenty states (corresponding to 31 percent of U.S. births) had laws requiring health care providers to report perinatal substance use to child protective authorities, and four states (18 percent of births) had laws requiring reporting only when a health care provider believed the substance use was associated with some other act of child maltreatment. About one-half of states with any reporting law (thirteen states) have had a provision promoting substance use disorder treatment in the perinatal period, typically by requiring CPS to refrain from any coercive response to prenatal drug exposure if the mother received or even simply made some effort to receive treatment.[71] The 2016 act aimed to improve compliance and establish more detailed elements of a plan of safety.

Most courts in the United States that have considered the issue have concluded that state child protection authorities may not assert authority over an unborn child, despite Roe v. Wade’s (1973) recognition that the state has a compelling interest in the well-being of a child late in pregnancy.[72] Once a child is born, however, the state’s authority is universally acknowledged. In numerous cases, courts have addressed the newborn’s rights when he or she is born having been prenatally exposed to alcohol or drugs of abuse (for exam-

ple, *New Jersey Division of Child Protection and Permanency v. Y.N.* (2013); *In the Interests of H.* (2003); *In re Baby Boy Blackshear* (2000); *In re Ruiz* (1986); *In re Baby X* (1980)).[73] A number of courts have held that the mere use of alcohol or illicit drugs by a pregnant woman is insufficient to provide child protective authorities a basis to act to protect a newborn. Rather, they have required the showing of a demonstrable, harmful impact upon the child, such as experiencing withdrawal.[74] Even when a harmful impact is demonstrable, some courts have held that exposure to a legally prescribed narcotic, such as methadone, taken as a result of maternal addiction and as part of a medically supervised rehabilitation program, is an insufficient basis for a child protection court to assert authority over a newborn. Thus, in *New Jersey Division of Child Protection and Permanency v. Y.N.*, that state’s Supreme Court ruled that although the newborn at issue had been born physiologically dependent on methadone and experienced withdrawal symptoms, the mother’s use of the methadone as part of a bona fide treatment program for her heroin addiction was not alone a reason for the child protection court to find that the child had been maltreated.[75] A number of other courts, however, have held that a child has a right to be born of sound mind and body.[76] When demonstrable harm to the child is shown, that is, the child is not born “of sound mind and body,” these courts have ruled that prenatal exposure alone is a sufficient basis for child protection courts to act to remove children from their parents’ home and place them into the protective custody of the state.[77] Still other courts, while not employing this specific formulation of the right, have held that a woman’s substance use while pregnant alone provides a sufficient basis for child protection authorities to act to secure the newborn’s safety. Even where prenatal substance abuse might provide a basis for protective intervention, standing (p. 75) alone it might be an insufficient rationale to support permanent termination of parental rights.[78]

However framed, newborns lack agency to be able to act to protect their own interest. John E. B. Myers, a law professor and advocate for abused and neglected children, has noted that “[a]n interest stripped of a method of enforcement is a feckless thing.”[79] For the state to act on behalf of children, legal authorization needs to be clear and child welfare agencies need to learn about newborns for whom parental substance abuse has created special needs and put them at further risk if they go home with the parent.

4. The State’s Interest

While universal screening should be considered a right of the newborn child, it also serves to protect important state interests. The state possesses a “substantial interest” in the possibility of life represented by a developing child “throughout pregnancy.”[80] At the point of viability, the state’s interest evolves from “substantial” to “compelling.”[81] Once the child is born, the state’s compelling interest in the child’s safety and well-being has been described as “urgent.”[82] Somewhat similarly, the state has a legitimate interest in identifying and providing services for its adult citizens needing mental health and substance abuse treatment, and in ensuring community safety.[83]

When the state provides health care, the *Parham* Court noted, the “State obviously has a significant interest” also in the conservation and wise use of its financial resources.[84] Nearly half of each year’s births are publicly financed by Medicaid.[85] Those births that are privately financed are also of significant interest to the state because the increased long-term costs associated with giving birth to a child prenatally exposed to these substances drives up health care costs. Earlier identification would allow for earlier treatment of symptoms to prevent progression and long-term harm. It also would reduce long-term costs by providing medical and developmental services to optimize child development, educational achievement, and productivity as adults.

Given the impact of prenatal exposure, the state’s interest in the conservation and wise use of its resources extends far beyond the immediate postnatal period. Indeed, it is now clear that children born prenatally drug-exposed disproportionately utilize publicly funded services—e.g., mental health, social, specialized educational—across much of their lifespan.

The U.S. Congress has mandated that, as a contingency to the states’ receipt of funds pursuant to the Child Abuse Prevention and Treatment Act (CAPTA), each state must have in place a mandatory reporting procedure that requires medical personnel to report when a newborn is “affected by substance abuse or withdrawal symptoms from prenatal drug exposure, or fetal alcohol spectrum disorder.”[86] While the federal law does not explicitly define prenatal exposure in and of itself as child maltreatment, its mandate that these children be reported to children’s protective services is a frank recognition of the parents’ harmful behavior toward their children. By including this (p. 76) provision in CAPTA, Congress has made clear that an independent judgment by child protective authorities is necessary to assure the protection of the state’s interest and at least a minimal level of parental care for these exposed children. Thus, just as the Supreme Court concluded in *Parham*’s context of civil commitment that parents were not entitled to “absolute and unreviewable discretion,” it is entirely rational in order to protect the child’s interests and the interests of the state that parents not have unlimited discretion in the context of testing at birth for *in utero* exposure.[87]

Despite enactment in 2016 of the Comprehensive Addiction Recovery Act, fortifying CAPTA’s mandate to address the needs of substance-exposed newborns, as of 2018, only twenty-three states and the District of Columbia mandated that CPS be notified by health care providers who suspect prenatal substance exposure.[88]

Furthermore, targeted testing of individual mother-child dyads fails to identify many exposed children. Targeted testing has been criticized as disproportionately targeting poor and minority-race women, leaving white newborns less protected. Because of this limitation, a more robust response is essential to protect the child’s right to be born of sound mind and body and to effectuate the state’s interest in the child’s health and well-being. A program of universal testing would be an effective method of protecting both the child’s right and the state’s interest. Prompt identification is associated with improved outcomes for the child and holds the potential for reducing health care costs in the short term and

associated public spending in the longer term. As the government has become more involved in private health care markets with the enactment of the Affordable Care Act, its interest in identifying those children prenatally exposed to drugs and alcohol who are served by private insurance has likewise increased. An important step toward protecting the rights of children and the interests of the state is through mandated universal screening of neonates for prenatal exposure to alcohol and drugs of abuse.

5. Universal Screening of Newborns

Lester et al. have observed, “The prevalence of prenatal drug exposure is very difficult to estimate because of flaws in all methods of identification.”[89] As noted earlier, research suggests that women often mislead their healthcare providers about their substance use and abuse when pregnant. That may be, in part, because they fear the non-medical consequences attendant to disclosure, referrals to CPS, or criminal prosecution. For example, in one large study of 11,800 mother-child dyads at four different hospitals around the country, researchers analyzed the meconium of 8,527 children. They found that 10.7 percent of the children tested positive for cocaine and/or opioids. In 38 percent of the cases in which the meconium was positive for cocaine or an opioid, the mother denied use.[90] In another study, 43 percent of the women tested positive for illegal drugs during their pregnancies while only 11 percent admitted drug use. Urine drug screening of mothers and babies is problematic because most substances break down and leave the body relatively quickly (for example, cocaine metabolites can be (p. 77) identified for only 96 to 120 hours after ingestion). Meconium testing, which is the most inclusive method for testing newborns, only captures drug use in the second half of pregnancy.[91]

Clearly, self-reporting and targeted testing are ineffectual in identifying children exposed *in utero* to these toxins. A more certain means of identifying exposed children is necessary if a violation of their right to be born of sound mind and body is to be remedied. Postbirth screening of infants for prenatal exposure to substances must become universal. States currently mandate a number of procedures and tests for newborns based on public health and other laws. States should amend their public health statutes to require that newborns be tested for the presence of alcohol, tobacco, and other drugs of abuse. To incentivize states to do so, Congress should amend CAPTA to require that each state implement universal drug screening of newborns as part of its state plan.

The use of universal screening as a means of identifying substance-exposed newborns has been discussed for some time among medical care providers. The American College of Obstetricians and Gynecologists (ACOG) recommends that “[b]efore pregnancy and in early pregnancy, all women should be asked about their use of tobacco, alcohol, and other drugs, including marijuana.”.[92] Rather than biologic testing of mothers and newborns, the ACOG has recommended use of structured interviews, although even these are known to under-identify drug-using pregnant women.[93] It is clear, however, that in making these recommendations, the ACOG views the pregnant woman and not the newborn as the primary, if not the exclusive, recipient of the physician’s professional care and attention.

Beyond the ACOG, the American Academy of Pediatrics (AAP) has recommended that this universal questioning of pregnant women about substance use should occur at routine health care visits and at several points throughout prenatal care and be applied equally to all women, regardless of age, race, ethnicity, or socioeconomic status. That recommendation should be supported,[94] but it does not go far enough.[95]

Medical commentators have from time to time discussed the possibility of conducting universal screening of newborns for prenatal exposure,[96] and they have advanced two rationales for universal testing: 1) it would eliminate the race and class bias that seems to be inherent in targeted testing regimes; and 2) since early identification is critical to providing effective treatment, universal testing would ensure that exposed children receive the array of services they may need as quickly as possible.[97] In 2016, the U.S. Department of Health and Human Services, Administration on Children, Youth and Families (ACF) issued policy guidance regarding the implementation of the Comprehensive Addiction and Recovery Act in which it implied that universal testing was best practice. Unfortunately, the ACF neither required nor incentivized states to provide universal testing for newborns.

Despite its identified benefits, commentators and those in positions of authority have expressed reluctance regarding universal testing of neonates.[98] While there may be other concerns (cost, chain of evidence of specimens, false positives, and false identification of drugs administered by medical professionals), the primary reservations focus (p. 78) on the potential legal and social impacts to the mother when she delivers an exposed child. For instance, Barry M. Lester and colleagues have written:

> [U]niversal testing of infants places hospitals in a precarious position.…[I]f a newborn exhibits a positive toxicology screen and the state has a mandatory reporting law, the hospital has a responsibility to report that fact to the necessary authorities in order to ensure the protection of the welfare of the child. In cases such as this there is a conflict between the hospital’s responsibility to protect the confidentiality of the mother and the responsibility to protect the welfare of the infant.[99]

This perspective is deeply flawed for several reasons. First, it fails to acknowledge that the child is a separate patient from the mother, a patient to whom the medical professionals and hospitals owe a separate legal duty. This separate duty is what forms the foundation of a child’s separate cause of action in tort against a physician for prenatal injuries. Second, that a physician would intentionally fail to understand the medical condition of one patient because of some possible non-medical implication to another person would seem to be an egregious violation of that physician’s responsibilities—both legal and as a matter of professional medical ethics—to that infant-patient. Finally, the general duty of confidentiality in this context is a legal duty, one that is overridden and vitiated in the specific context of child maltreatment by the enactment of mandatory reporting statutes.[100] Moreover, confidentiality between a doctor and her patient is a statutory creation in derogation of the common law. The rationale for confidentiality laws is that they encourage patients to fully disclose information to their physician in order to obtain can-

did medical advice. But this rationale plainly does not apply in the context of substance-abusing pregnant women. Courts have held that these legislatively created rights of confidentiality and the evidentiary privilege that flows from them should be narrowly construed.[101] Congress and state legislatures have explicitly eliminated the confidential relationship between the physician and patient in the circumstance of a child being born exposed to illicit drugs or alcohol.

None of these commentators has addressed universal screening from the perspective of the child’s legal right to be born of sound mind and body. Early identification of prenatal exposure portends real and important benefits for newborn children and their families, such as earlier identification of NAS, referral for specialized assessment and treatment of developmental delays, providing services to address risks in the home associated with drug use and abuse that place the infant at further risk, and the earlier identification of mothers (and fathers) needing substance abuse treatment. Identifying these children early maximizes the possibility of a positive medical outcome and decreases the chances of medical complications. As with many medical conditions, early identification of prenatal exposure is key to improving both short- and long-term outcomes for the child-patient.[102] Early identification also enhances the patient’s treatment options and enhances patient self-determination.

Patient self-determination is fundamental to the ethical delivery of health care services to patients, and it includes a duty to be honest with the patient about diagnosis (p. 79) and prognosis.[103] While this duty to the neonate-patient is typically met through the parent, when there is a conflict between the interests of the parent and the child in the context of child maltreatment, as *Parham* made clear, the medical provider’s duty is squarely with the child-patient. That duty is further reinforced by state child protection laws that provide for civil and criminal penalties when mandated reporters fail to notify child protection authorities when they reasonably suspect maltreatment. These young children’s lack of agency, their utter helplessness, would also seem to militate strongly in favor of a rule that medical providers have the highest duty to ensure that their condition be identified and treated.

Despite the lack of legal mandate, hospitals could adopt a policy of universal testing. Yet few do because of costs and fear of liability under the current legal framework. A 2017 survey of Iowa birthing hospitals found that no hospital in the state conducts universal testing of newborns.[104] A survey of Maryland birthing hospitals found that only two of thirty-one hospitals conducted universal screening of newborns for prenatal exposure.[105] Thus, all drug-affected newborns are not identified and reported.

In response to the present opioid epidemic, seven hospitals in the Cincinnati area began in 2013 a program of testing all pregnant women and their newborns. A study of 2,995 pregnant women at one of the hospitals found that 159 (5.4 percent) of the women tested positive for drugs, with 96 of those women testing positive for opioids. Of the women who tested positive for opioids, 19 (20 percent) lacked any identified risk factors and so would likely have been missed by any targeted testing protocol, and 33 percent of infants ex-

posed to drugs other than opioids would not have been identified absent the policy of universal testing.[106] This program illustrates the utility of universal testing in identifying more children prenatally exposed, thereby providing a mechanism to remedy violations of their right to be born of sound mind and body and an opportunity to intervene earlier with treatment and services for the infant and family.

For all the reasons outlined in this chapter, CAPTA should be amended to require universal screening of newborns. Consistent with that mandate, states should enact laws requiring universal screening. Children testing positive should be reported to CPS as is consistent with state reporting laws.

6. Conclusion

Each year in the United States, large numbers of children are born exposed to drugs and other dangerous substances. This exposure is harmful to children and violates their right to be born “of sound mind and body.” It also puts undue strain on public systems, which disproportionately bear the financial burden for the medical, child protective, education, and mental health services these children and families will need, sometimes across their entire lifespan. Universal newborn drug testing should (p. 80) be implemented in order to protect the rights of the child and the interests of the state. To do this, the states should amend their laws regarding child birth to mandate such testing, and the federal government should amend CAPTA to provide states an incentive to do so.

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(90.) Shankaran et al., “Maternal Substance Use,” 143–150.

(91.) Lester, Andreozzi, and Appiah, “Substance Use During Pregnancy,” 1–44.

(92.) American College of Obstetricians and Gynecologists, “Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders Ethical Issues in Obstetric and Gynecologic Practice,” *Obstetrics & Gynecology* 125, no. 6 (June 2015): 1529–1537.

(93.) American College of Obstetricians and Gynecologists, “Committee Opinion No. 637: Marijuana Use During Pregnancy and Lactation,” *Obstetrics & Gynecology* 126, no. 1 (July 2015): 234–238.

(94.) AAP also recommends that, if urine drug testing is performed, a reasonable effort to obtain a woman’s informed consent should be made before collecting the sample, and the woman should be aware of the results and who will have access to the results. They add that access should be improved for comprehensive prenatal care for pregnant women with substance use disorders, including medication-assisted treatment and gender-specific substance use treatment programs that provide nonjudgmental, trauma-informed services.

(95.) Stephen W. Patrick, Davida M. Schliff, and APA Committee on Substance Use and Prevention, “A Public Health Response to Opioid Use in Pregnancy,” *Pediatrics* 139, no. 3 (March 2017): e20164070.

(96.) Steven J. Ondersma, Sharon M. Simpson, Elizabeth V. Brestan, and Martin Ward, “Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response,” *Child Maltreatment* 5 no. 2 (May 2000): 97–98; Lester, Andreozzi, and Appiah, “Substance Use During Pregnancy.”

(97.) Lester, Andreozzi, and Appiah, “Substance Use During Pregnancy,” 1–44.

(98.) E.g., Sebunia and Fearon, “Opioid Abuse in Pregnancy,” 1–21; Lester, Andreozzi, and Appiah, “Substance Use During Pregnancy,” 1–44; Ondersma, Simpson, Brestan, and Ward, “Prenatal Drug Exposure and Social Policy,” 97–98.

(99.) Lester, Andreozzi, and Appiah, “Substance Use During Pregnancy,” 33.

(100.) E.g., In re Brock, 499 N.W.2d 752 (Mich. 1993). In re Troy D., 263 Cal. Rptr. 869 (Ct. App. 1989).

(101.) E.g., In re Brock, 499 N.W.2d 752 (Mich. 1993).

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