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Maternal Substance Use: How the MLP Model Can Address Issues Surrounding Mandatory Reporting Laws

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ABSTRACT

Prenatal exposure to controlled substances can have devastating effects on a child's life outcomes and development. The villainization of addiction has produced mandatory reporting laws that impose harsh civil and criminal penalties on women who use substances while pregnant. While politicians and policymakers claim to be acting in the best interest of children when enacting these laws, in reality, they harm children and decrease the likelihood that mothers will stop using controlled substances. While the political conception of addiction has evolved, the chilling effect of civil and criminal penalties on mothers has remained constant. While repealing mandatory reporting laws may be infeasible, Medical Legal Partnerships (MLPs) can neutralize the harmful effects of these laws, increase the likelihood mothers engage and stay engaged in treatment, and take the burden of navigating legal systems off medical providers.

MLPs are uniquely equipped to address the needs of substance-using pregnant women. Unlike Assertive Community Treatment or drug court programs, MLPs address health-harming legal needs, are multi-generational, are tailored to the needs of pregnant women, and take pressure off providers. MLPs address health-harming legal needs by providing legal solutions for housing, employment, custody, and disability issues contributing to a mother's substance use. MLPs serve the unique needs of both mothers and their families. Finally, MLPs take the pressure off medical providers who have neither the training nor the bandwidth to effectively guide patients through complex civil and criminal legal systems. In an environment without MLPs, mandatory reporting laws will discourage pregnant women from engaging in prenatal or substance use treatment, and harmful prenatal exposure to controlled substances will continue.

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I. Introduction

Exposure to controlled substances can have damaging effects on an infant's development. As substance use and the opioid epidemic rage through the United States, maternal substance misuse during pregnancy remains an issue.[1] It is impossible to discuss maternal substance use without discussing race, poverty, gender, mental illness, and mandatory reporting laws. For decades, state and federal legislators have required that medical providers report mothers who use controlled substances while pregnant to the child protective services system, and in some instances, the criminal justice system.[2] These laws were intended to decrease the likelihood an infant would be exposed to controlled substances in utero; however, they had the opposite effect.[3]

Medical Legal Partnerships (MLP) should be implemented to address the negative effects of laws and policies that require the mandatory reporting of

1. Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 Health & Just. 1, 1 (2015), https://doi.org/10.1186/s40352-015-0015-5.

2. *See* Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 Pediatrics 224, 226 (2004), https://doi.org/10.1542/PEDS.114.1.224.

3. Cara Angelotta et al., *A Moral or Medical Problem? The Relationship between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women*, 26 Women's Health Issues 595, 596 (2016), http://dx.doi.org/10.1016/j.whi.2016.09.002.

maternal substance use. MLPs incorporate legal services into the healthcare setting in a way that addresses health-harming legal needs, is multigenerational, can be specifically tailored to mothers, and takes pressure off medical providers.

This paper will first describe the legislative history behind mandatory reporting laws to explain why politicians enacted these policies. Then, it will describe and analyze the many negative effects of these laws. Finally, it will offer an argument for why MLPs can address the negative consequences of mandatory reporting laws and how implementing MLPs can accomplish the original legislative intent of these laws.

II. Legislative History: While the Chilling Effect of Civil and Criminal Penalties Remains Constant, the Political Conception of Addiction Evolves

The negative effects of prenatal exposure to controlled substances caused legislators to develop federal and state laws that require the mandatory reporting of mothers who use controlled substances. For decades, researchers, medical providers, and substance use specialists have defined addiction as "a chronic disease of the brain [that] develops as repeated drug administration triggers changes to portions of the brain involved with rewards and impulsivity."[4] These disorders are often precipitated by physical or sexual violence and occur in individuals who struggle with anxiety, depression, post-traumatic stress disorder, and other forms of mental illness.[5] The physiological and social components of substance use make it especially difficult to stop using substances, even when individuals recognize the negative effects of usage.[6]

While addiction is not a choice, state and federal legislators have created civil and criminal penalties for women who use controlled substances while pregnant. In the 1970s and 1980s, politicians argued choice was the root of addiction.[7] The crack cocaine scares and War on Drugs wove a narrative featuring Black mothers who gave birth to "crack babies."[8] This racialized rhetoric cast women of color experiencing poverty as selfish villains whose children would become burdens on the state.[9]

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4. *See* Darla Bishop et al., *Pregnant Women and Substance Use: Overview of Research & Policy in The United States*, Jacobs Inst. Women's Health, 5 (2017), https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf [https://perma.cc/MCS9-DJM9].

5. *Id*. at 5–6.

6. *See id.* at 8, 46.

7. Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 Cal. L. Rev. 781, 809 (2014).

8. *Id.* ("politicians speciously claimed crack caused more socially deleterious behavior than powder cocaine, such as violence, crime, and the birth of "crack babies" (supposed biologically inferior children permanently hampered by physical and cognitive disabilities).").

9. Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 Harv. L. Rev. 770, 816 (2020) ("Essentially, babies exposed to crack cocaine in utero were represented as the future problems of America. Further, the women who smoked crack cocaine while pregnant were portrayed as heartless, irresponsible, and selfish.").

A. The Chilling Effect of Civil and Criminal Penalties

In 1974, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), which required states to reform their child protective systems to align with federal guidelines to receive federal monies.[10] This statute allowed the federal government to exercise its police power over the states. CAPTA is the floor upon which each state must construct its own civil and criminal penalties for mothers who use controlled substances.

States that choose to address maternal substance use in civil systems understand this behavior as child abuse or neglect. These states classify exposing a fetus to substances in utero as child abuse because a pregnant woman actively harms the fetus or as child neglect because it is doubtful whether the pregnant woman is able to meet the child's basic needs.[11] A state survey conducted in July 2019 reported that twenty-three states and the District of Columbia define substance use during pregnancy as child abuse.[12] Illinois, Minnesota, North Dakota, Oregon, and Wisconsin mandate that providers report when they suspect substance use during pregnancy.[13] While state-by-state variations are numerous, each of these civil systems creates an environment that threatens to use the child welfare system to separate babies from their birth mothers.

In addition to civil penalties, mothers who use controlled substances may be criminally prosecuted. Politicians and prosecutors who think of mothers who use controlled substances as heartless and selfish argue that the only way to motivate a mother to receive treatment, protect her health, and protect the health of the fetus she carries is to threaten her with a criminal conviction and jail time.[14] To prosecute women who use controlled substances during pregnancy, prosecutors use criminal statutes such as those covering delivering drugs to a minor, criminal endangerment, assault with a deadly weapon, and even manslaughter and murder when a pregnancy loss occurs.[15] While the cases brought against these mothers are rarely successful, the few cases that do succeed have a chilling effect on mothers.[16]

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10. Child Abuse Prevention and Treatment Act, Pub. L. No. 93–247, 88 Stat. 4 (1974) (codified as amended at 42 U.S.C. §§ 5101–5106, 5108, 5116 (2012)).

11. Bridges, *supra* note 9, at 798.

12. Child Welfare Information Gateway, Parental Substance Use as Child Abuse 2 (2020), https://www.childwelfare.gov/pubPDFs/parentalsubstanceuse.pdf.

13. *Id.*

14. Bridges, *supra* note 9, at 806. ("[P]roponents of criminalization often justify criminalizing substance use during pregnancy with the claim that threatening a pregnant woman with a criminal conviction and jail time effectively protects her health and the health of the fetus that she carries.").

15. *Id.* at 807.

16. *See* State v. McKnight, 576 S.E.2d 168, 171 (S.C. 2003) (McKnight was convicted of murder by jury, and a judge sentenced her to twenty years in prison); *Ex parte* Ankrom, 152 So.3d 397, 421 (Ala. 2013) (upholding the criminal conviction of Ankrom and Kimbrough for the chemical-endangerment of a child); Whitner v. State, 492 S.E.2d 777, 778 (S.C. 1997) (holding that a "child" under the South Carolina child abuse and endangerment statute includes viable fetuses).

B. Changes in the Political Conception of Addiction

Over the past two decades, the opioid epidemic has changed the demographics of women who misuse substances while pregnant and consequently caused conversations surrounding addiction and substance abuse to evolve. The opioid epidemic caused an increase in the number of White women who used controlled substances during pregnancy.[17] Subsequently, the number of White women who were arrested and prosecuted for this behavior also increased.[18] The changing demographic of the population of people struggling with substance use disorders caused politicians to change the way they discussed addiction. The political conception of substance use began to rely more on medical knowledge and acknowledge that factors such as poverty, violence exposure, and mental illness contribute to a mother's substance use.[19] This new understanding of substance use caused slight changes in federal and state legislation.

The most recent iteration of CAPTA, which was enacted on October 30, 2020, specifically states that the mandatory reporting of maternal substance use should not be construed to "(i) establish a definition under Federal law of what constitutes child abuse or neglect; or (ii) require prosecution for any illegal action."[20] In addition, Illinois, Minnesota, North Dakota, Oregon, and Wisconsin require mandatory reporting so mothers can be referred for treatment.[21] The focus on treatment and rehabilitation in these state statutes reflects the acknowledgement that addiction is a disease and that women need support to stop using controlled substances.

While shifts in rhetoric are beneficial to both Black and White mothers, there are still civil and criminal consequences for mothers who use controlled substances while pregnant. Although CAPTA specifically states its language should not be construed to require that a mother's use of controlled substances result in prosecution, mothers continue to be prosecuted for using controlled substances. At least one thousand women have been arrested for drug use during pregnancy and more than half of those prosecutions have taken place in the last ten years.[22]

From 1970 to 2020, legislators have consistently claimed to fight for the best interests of infants while they are in utero. They have constructed byzantine bureaucratic civil and criminal systems to achieve this goal. Legislators are charged

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17. *See* Wendy A. Bach, *Prosecuting Poverty, Criminalizing Care*, 60 WM. & MARY L. REV. 809, 834–35 (2019), https://scholarship.law.wm.edu/wmlr/vol60/iss3/3. ("In Tennessee, '[f]rom 1995–2009, pregnancy-related use of opioid analgesics nearly doubled among [Medicaid] participants.'").

18. *Id.* at 851.

19. *See* Bridges, *supra* note 9, at 789 ("The whiteness of the opioid crisis, they say, explains why people with the ability to direct law and policy have been receptive to understanding substance dependence as a medical condition that needs treatment, as opposed to a moral failure that warrants punishment.").

20. 42 U.S.C. § 5106a(b)(2)(B)(ii)(I)–(II).

21. CHILD WELFARE INFORMATION GATEWAY, *supra* note 12, at 2.

22. *See* Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1174 (2017), https://www.gwlr.org/wp-content/uploads/2018/01/85-Geo.-Wash.-L.-Rev.-1163.pdf.

to create bureaucratic systems to solve nearly every problem; however, these systems are not the most effective way to protect children from the negative effects of prenatal exposure to controlled substances and make it less likely a mother will stop using.

III. The Problem: Mandatory Reporting Laws Decrease the Likelihood Mothers will Stop Using Controlled Substances

While mandatory reporting legislation and policies are intended to protect children from being affected by substance abuse, in practice, these laws create barriers to screening and referral for substance abuse treatment during the perinatal period and make it less likely a mother will receive the resources she needs to overcome her addiction. Many pregnant mothers do not choose to start using substances after they become pregnant.[23] Many women who misuse substances during pregnancy used substances long before they became pregnant.[24] Women may misuse substances to alleviate the symptoms of PTSD and other mental health disabilities.[25] Even women whose addictions are linked to intimate partner violence and poverty attempt to stop using controlled substances once they become pregnant.[26]

Exposure to controlled substances in utero can have many negative effects on infant development. Infants may experience fetal growth restriction, preterm birth, stillbirth, neonatal mortality, and Neonatal Abstinence Syndrome (NAS).[27] Mothers need consistent prenatal care to mediate these negative outcomes.[28] The sociodemographic characteristics of women who use controlled substances often include lower socioeconomic status and lower education levels.[29] These women face many barriers to receiving care other than their substance use, such as lack of insurance and transportation.[30] When the threat of civil and criminal consequences is added to these barriers, it is unlikely a mother will receive the

23. *See* Laura E. Miller-Graff et al., *Women's Cigarette and Marijuana Use in Pregnancy: Identifying the Role of Past Versus Recent Violence Exposure,* 36 J. Interpersonal Violence 3982, 3993, 3994 (2021), https://doi.org/10.1177/0886260518779068 ("[P]ast year sexual IPV is a unique predictor of marijuana use in [pregnant women]") ("[W]omen who have experienced recent IPV and past childhood adversity may experience a higher general stress burden, making cessation more difficult.").

24. *Id.* at 3991 (Table 3).

25. *See* Angela E. Waldrop et al., *Triggers for Cocaine and Alcohol Use in the Presence and Absence of Posttraumatic Stress Disorder*, 32 Addictive Behaviors 634 2007), https://doi.org/10.1016/j.addbeh.2006.06.001 (describing the "self-medication hypothesis").

26. *See* Miller-Graff et al., *supra* note 23, at 3991.

27. *Id.* ("[S]moking during pregnancy is associated with a host of negative effects on the mother and her baby, including fetal growth restriction, preterm birth, still birth, and neonatal mortality . . . ."); *see* Fran Smith, *Babies Fall Victim to the Opioid Crisis*, Nat'l Geographic (Sept. 2017), https://www.nationalgeographic.com/magazine/article/science-of-addiction-babies-opioids.

28. *See* Bridges, *supra* note 9, at 794.

29. *See* Miller-Graff et al., *supra* note 23, at 3985.

30. *See* Bridges, *supra* note 9, at 813.

medical care she needs to overcome her substance use and lower her pregnancy's risk.[31]

A. Health Care Avoidance

Mandatory reporting laws make it likely that these mothers will avoid seeking medical care altogether. Research has identified pregnant women's fears of prosecution and loss of child custody as significant barriers to bringing women into substance use treatment.[32] Consensus statements from numerous medical organizations, including the American College of Obstetrics and Gynecology, the American Medical Association, the American Academy of Pediatrics, the American Public Health Association, the American Nurses Association, the American Society on Addiction Medicine, and the American Psychiatric Association, argue that punitive policies increase potential neonatal harms by deterring pregnant women from seeking prenatal care and substance abuse treatment.[33,] A study published in 2015, which examined the fear and stigma surrounding pregnant mothers who use controlled substances, found that the most common strategy employed by women afraid of substance use detection was "avoidance of medical care."[34] 73.3% of the participants in this study reported being afraid of being identified as substance-users during their pregnancies.[35] A report published by Amnesty International shared the views of a mother who stated,

> "I'm scared as hell because I was a drug addict . . . it's not right that those of us who get help are going to get charged . . . It makes me scared because you can't really trust what they're really saying. If you're

31. *See* Norman Finkelstein, *Treatment Issues for Alcohol- and Drug- Dependent Pregnant and Parenting Women*, 19 HEALTH & SOCIAL WORK 7, 10, 14 (Feb. 1994), https://www-proquest-com.proxygt-law.wrlc.org/scholarly-journals/treatment-issues-alcohol-drug-dependent-pregnant/docview/210563160/se-2 ("The barriers that prevent women from seeking treatment include stigma, denial, and lack of gender-specific treatment services . . . Other systemic treatment issues for alcoholic and drug-abusing pregnant women and mothers include punitive attitudes . . .").

32. *See* Embry M. Howell et al., *A Review of Recent Findings on Substance Abuse Treatment for Pregnant Women*, 16 J. OF SUBSTANCE ABUSE TREATMENT 195, 196, 209 (1999), http://doi.org/10.1016/S0740-5472(98)00032-4 ("Pregnant women may be especially hesitant to volunteer information about drug use because of fears about losing custody of their children, being prosecuted, or being alienated socially. These fears are greatest in states that report suspected substance abuse to child welfare or other authorities.").

33. Angelotta et al., *supra* note 3, at 596; Lynn M. Paltrow, *Governmental Responses to Pregnant Women who Use Alcohol or Other Drugs*, 8 DEPAUL J. HEALTH CARE L. 461, 463–64 (2005), https://via.library.depaul.edu/jhcl/vol8/iss2/7 ("These organizations . . . have opposed the prosecutions of substance-using pregnant women in part because of the expectation that such prosecutions would deter women from obtaining necessary health care and would thus cause harm to both maternal and fetal health.").

34. Stone, *supra* note 1, at 7.

35. *Id.* at 5.

> pregnant and you go to rehab you can still get charged and they can take your baby . . . So why seek help if you're going to get a charge?"[36]

Amnesty International published numerous testimonials from women who expressed these same anxieties about seeking medical treatment.[37] As described in the previous section, the concerns of these mothers are real. Mandatory reporting laws were designed to ensnare mothers who use controlled substances while pregnant.

B. Biased and Overburdened Medical Systems

In addition, the subjective nature of screening leads to the under-identification of mothers who need help. A medical provider's decision to test a pregnant woman for controlled substances often hinges upon that provider's subjective perceptions.[38] This reality results in screening practices that perpetuate providers' subconscious biases. While the rate of drug use is similar among racial groups in the United States, women of color and women from lower socioeconomic groups are tested for drugs at higher rates than their White counterparts.[39] These subjective deductions disproportionately subject women of color to the civil and legal consequences of mandatory reporting and cause women who need treatment but do not fit the racist stereotype of a drug user to go unidentified.

Furthermore, mandatory reporting laws burden mothers and medical providers. These laws unfairly force medical providers and social workers to serve as legal specialists. Medical providers are not trained to understand and navigate complex legal systems such as the criminal code, housing code, Medicaid eligibility, or the child welfare system.[40] The mandatory reporting of mothers who use controlled substances can cause a crisis to spiral into homelessness, parental job

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36. Amnesty Int'l, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, 43 (2017), https://www.amnesty.org/en/documents/amr51/6203/2017/en/.

37. *Id.*

38. *See* Bridges, *supra* note 9, at 802 ("[T]he behavior or characteristics that raise a provider's suspicions are subjective, allowing for a great deal of variability as to whom a provider tests for substances in the first instance.").

39. *See, e.g.*, Ira J. Chasnoff et al., Special Article, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 New Eng. J. Med. 1202, 1206 (1990), https://www.nejm.org/doi/pdf/10.1056/NEJM199004263221706?articleTools=true ("[T]he preconception that substance abuse, especially during pregnancy, is a problem that affects minority groups, urban populations, and lower socioeconomic groups could bias physicians in identifying substance exposure in newborn infants. This would result in more frequent suspicion of intrauterine drug exposure and, thus, a higher rate of testing and reporting of infants born to Black and poor women."); Stone, *supra* note 1, at 1, 3.

40. *See* Yael Cannon & Dr. Andrew Hsi, *Mental Health, The Law, & The Urban Environment: Article: Disrupting The Path From Childhood Trauma To Juvenile Justice: An Upstream Health And Justice Approach*, 43 Fordham Urb. L.J. 425, 481 (2016), https://ir.lawnet.fordham.edu/ulj/vol43/iss3/1 ("Medical professionals are not trained to understand, for example, 'housing codes or the intricacies of food stamps or Medicaid eligibility.' Dr. Hsi recognized that while pediatricians and other healthcare providers are often taught to consider family and social contests of their patients, they may not have specific knowledge or access to resources to intervene effectively.").

loss, or justice system involvement for child abuse.[41] Doctors and social workers are tasked by legislators to trigger this process but are given no support when mothers look to them for counsel to address the fallout of their actions.[42]

Mandatory reporting laws have created a system that ostracizes and criminalizes mothers instead of connecting them to the resources they need to stop using, harming the very population policymakers claim to protect.[43] Repealing these laws is not likely to be politically feasible. Groups that advocate for the rights of infants in utero and legislators who ascribe to outdated definitions of addiction fight for these laws to remain in place.[44] Even if these laws could be taken away, the problems surrounding substance using pregnant women would still exist. Without mandatory reporting laws, these mother's needs still fall on an overwhelmed social services system that is not tailored to the needs of mothers.[45] The tight grasp of addiction makes it practically impossible for newly pregnant women to stop using substances without proper support. In 2017, researchers found that fewer than twenty percent of all substance use disorder treatment facilities had programs for pregnant or recently postpartum women, resulting in eighty-one to ninety-five percent of need going unmet.[46]

This unmet need has a tolling cost on both federal benefits programs and positive healthcare outcomes. Opioid use during pregnancy has increased nearly five-fold in recent years, which has contributed to a higher incidence of neonatal abstinence syndrome and increasing costs for state Medicaid programs.[47] The negative effects of mandatory reporting laws must be addressed to protect infants from the negative effects of prenatal exposure to controlled substances and achieve legislators' goals.

IV. The Solution: Medical Legal Partnerships are Best Equipped to Address the Negative Effects of the Mandatory Reporting of Maternal Substance Use

MLPs address health-harming legal needs, are multi-generational, can be specifically tailored to assist pregnant mothers, and take stress off providers; thus, they are optimally equipped to address the issues surrounding maternal substance use. This section will first use the University of New Mexico Medical-Legal Alliance as a case study to explain the MLP model and how it can be specifically

41. *See* Zuckerman, *supra* note 2, at 226.

42. Cannon & Hsi, *supra* note 40, at 481.

43. Angelotta et al., *supra* note 3, at 596.

44. Frank E. Vandervort, *Article: Prenatal Drug Exposure As Aggravated Circumstances*, 98 Mich. B.J. 24 (2019), https://repository.law.umich.edu/articles/2068 (arguing prenatal exposure is an aggravating circumstance and should result in immediate termination of parental rights when a petition is filed).

45. *See* Cannon & Hsi, *supra* note 40, at 468.

46. *See* Marian Jarlenski et al., *Characterization of U.S. State Laws Requiring Health Care Provider Reporting of Perinatal Substance Use*, 27 Women's Health Issues 264, 266 (2017), https://doi.org/10.1016/j.whi.2016.12.008.

47. Angelotta et al., *supra* note 3, at 595.

tailored to support mothers who use controlled substances. This section will then go on to describe the needs an effective program must address to serve mothers who use controlled substances, how MLP's can fill these needs, and why the MLP approach is preferable to other public health models, such as Assertive Community Treatment (ACT) and drug court programs.

A. Medical Legal Partnerships and the University of New Mexico Medical-Legal Alliance

MLPs embed lawyers into health care settings and make them critical members of medical teams. Generally, MLPs differ in their populations served, legal areas of focus, and delivery models; however, they all seek to provide legal assistance in healthcare settings, transform both health and legal institutions, and affect policy change.[48] MLP attorneys screen for legal needs by giving referred patients "legal checkups" and treat these health-harming legal needs through a variety of legal interventions.[49] Through this direct patient interaction, attorneys transform clinic practice to treat both medical and social issues that affect a person's health and well-being.[50] Other MLPs focus on serving larger communities and improving population health by using combined health and legal tools to address wide-spread social problems, such as housing conditions, that negatively affect a population's health and well-being.[51] Most MLPs incorporate aspects of both these methods.[52]

The University of New Mexico Medical-Legal Alliance (MLA) FOCUS program is an example of an MLP that serves women who use controlled substances while pregnant.[53] Dr. Andrew Hsi founded the MLA in 1996 after observing the use of illegal drugs, particularly heroin, by pregnant women and the negative effect this exposure had on pregnancies and the infants born of those pregnancies.[54] Dr. Hsi recognized that the health of the mothers and infants he treated was not only influenced by health care but also by their social situations.[55] MLA is

48. Cannon & Hsi, *supra* note 40, at 472.

49. Bharath Krishnamurthy et al., *White Paper: What We Know And Need To Know About Medical-Legal Partnership*, 67 S.CAL. L. REV. 377, 379 (2016), https://scholarcommons.sc.edu/sclr/vol67/iss2/12 ("Through the medical-legal partnership approach, hospitals and health centers partner with civil legal aid resources in their community to: (1) train staff at the hospitals and health centers about how to identify health-harming legal needs; (2) treat health-harming legal needs through a variety of legal interventions; (3) transform clinic practice to treat both medical and social issues that affect a person's health and well-being; and (4) improve population health by using combined health and legal tools to address wide-spread social problems, such as housing conditions, that negatively affect a population's health and well-being.").

50. *Id.*

51. *Id.*

52. Cannon & Hsi, *supra* note 40, at 472 ("While medical-legal partnerships differ in the populations served, legal areas of focus, and delivery models, they generally seek to provide legal assistance in healthcare settings, transform both health and legal institutions, and affect policy change.").

53. *Id.* at 463.

54. *Id.*

55. *Id.* at 470.

premised on three principles: first, the social, economic, and political context in which people live has a fundamental impact on health; second, these social determinants of health often manifest in the form of legal needs; and third, attorneys have the special tools and skills to address these needs.[56]

The MLA's involvement with a patient begins when a pregnant mother or newborn infant receives a positive drug test. These mothers and infants are referred to the MLA by the University of New Mexico Hospital newborn nursery, the child protection system, or other hospitals and healthcare providers serving newborns.[57] Early identification and referral to MLA trigger the healthcare team to examine whether there are any other health-harming legal needs or forms of trauma affecting the mother and child and allows for the deployment of legal resources to address those issues and their impact.[58]

Once these mothers and infants are identified and connected to the MLA, this MLP addresses the legal needs of the entire family. By treating the whole family, the MLA can address the many strings that underly a mother's addiction and impede her from effectively parenting. MLA attorneys schedule multiple family members for appointments in consecutive time slots.[59] Having a single attorney meet with all family members individually allows the attorney to get a full picture of the various legal needs that might impede a mother's ability to stop using and stay engaged in care.[60] This process will also guide the attorney toward resolving the particular issue a family may need addressed. Talking to an adult family member who describes poor housing conditions and the family's struggle to pay rent will direct the attorney to look at housing codes and subsidized housing options that will eliminate the threat of homelessness for the mother. Talking to an older child of the mother who is struggling in school will direct the attorney to initiate any legal proceedings needed to implement an individual education plan for that child and eliminate stress for the mother.

MLA attorneys schedule numerous appointments with a mother to ensure they are addressing her and her newborn infant's needs as they evolve over time. The MLA not only ensures a mother's access to substance use treatment, but also addresses employment, domestic violence, or criminal legal issues that might contribute to her addiction and impede her ability to receive care.[61] In addition to meeting with a mother and her family, MLA attorneys host weekly team meetings with physicians and social workers working on the mother's case to ensure their

56. *Id.* at 472–73.
57. *Id.*
58. *Id.* at 473–74.
59. *Id.* at 475.
60. *See id.*
61. Yael Cannon, *A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise*, 17 YALE J. HEALTH POL'Y L. & ETHICS 253, 282 (2017).

approach is coordinated.[62] The holistic, interdisciplinary approach of the MLA provides comprehensive care to the affected families, making it a model program.

For mothers to stop using and for infants to succeed, mothers must get access to services early and stay engaged in care. Early intervention can prevent the consequences of early adversity, while later interventions are likely to be less successful.[63] In addition, increased attendance in treatment is critical to treatment success.[64] Mandatory reporting laws cause mothers to seek treatment late in their pregnancies, if ever, and disengage in care. A public health program must be implemented to address the negative effects of these laws. To engage mothers in care, a program must address health-harming legal needs, be multi-generational, be tailored to the needs of pregnant women, and take pressure off providers.

B. MLPs Address Health-Harming Legal Needs

Mothers who use controlled substances have needs that go beyond their medical conditions. Health-harming legal needs are social, financial, environmental, or other problems in patients' lives that have a negative impact on their health and are amenable to legal solutions.[65] Researchers have estimated that fifty to eighty-five percent of patients at health centers experience unmet health-harming legal needs.[66] Mothers who use controlled substances face many of the same legal issues as other women from low socioeconomic strata, but also face the negative civil and criminal consequences of mandatory reporting laws. In addition, research has demonstrated that women who struggle with substance disorders are more likely to come from "drug-abusing and disorganized families."[67] As a result of this history, women who come from these families may require legal assistance related to involvement in the criminal system or exposure to domestic violence. These women's substance use must be addressed on more than a physiological level. Factors such as housing, employment,

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62. Cannon & Hsi, *supra* note 40, at 476.

63. Harv. Univ. Ctr. on the Dev. Child, In Brief: The Impact of Early Adversity on Children's Development (2007), http://developingchild.harvard.edu/wp-content/uploads/2015/05/inbrief-adversity-1.pdf ("The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later.").

64. Janet W. Steverson & Traci Rieckmann, *Legislating for the Provision of Comprehensive Substance Abuse Treatment Programs for Pregnant and Mothering Women*, 16 Duke J. Gender L. & Pol'y 315, 320 (2009) (arguing that that increased attendance in treatment is critical to treatment success).

65. Cannon & Hsi, *supra* note 40, at 471.

66. Krishnamurthy et al., *supra* note 49, at 378 ("[B]etween 50–85% of health center users experience such unmet health-harming civil legal needs.").

67. Jeanne C. Marsh et al., *Increasing Access and Providing Social Services to Improve Drug Abuse Treatment for Women With Children*, 95 Addiction 1237, 1238 (2000) ("Women substance abusers bring a different set of problems to treatment than do men. They are more likely to come from drug-abusing and disorganized families and to be isolated from other sources of support.").

custody, and disability contribute to a mother's substance use. Without a permanent solution to these legal problems, a mother may not permanently overcome her substance use issues. Mothers who use controlled substances require trauma-informed support programs that offer legal solutions to their health-harming legal needs.

MLPs are designed to help patients address their health-harming legal needs. Attorneys at MLPs are uniquely equipped to stabilize the dynamics of these mothers and address the multifaceted nature of their substance use. MLPs help a mother overcome her substance use issues and also help her navigate the complex child welfare system.[68] By providing holistic legal supports as part of a clinical care team's individualized intervention, MLPs can prevent a crisis from triggering the involvement of the child welfare system.[69] If the child welfare system is already involved, support from an MLP can make it easier for a mother to maintain custody of her child by helping her meet her child's basic needs, including food, housing, education, and access to medical care.[70] Studies have shown that removing a child from his or her home for even thirty days or less can harm the child.[71]

Drug courts are a promising program for this population because these services would address some of a mother's legal needs while giving her access to substance use treatment. Drug courts are specialized courts that offer an alternative criminal process for drug-dependent offenders.[72] These courts may serve parents with pending child welfare cases having alcohol and other drug dependency problems and focus on treatment rather than punishment.[73] While drug courts may effectively address a mother's criminal legal needs and give her access to substance use treatment, these programs do not have the mechanisms to satisfy a mother's civil legal needs such as housing, employment, or disability legal needs.

Similarly, Assertive Community Treatment (ACT) programs cannot meet a mother's health-harming legal needs because they do not provide legal services to their patients. ACT is a team-based treatment model that provides multidisciplinary, flexible treatment to individuals with mental illness and substance use disorders who require assistance with medication, therapy, social support,

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68. Kara R. Finck, *Medical Legal Partnerships and Child Welfare- An Opportunity for Intervention and Reform*, 28 WIDENER COMMW. L. REV. 23, 49 (2019) (arguing existing pediatric MLPs can expand their focus to incorporate child welfare issues and partners, and thereby move upstream to prevent neglect proceedings in court).

69. *See id.* at 25 ("MLPs can prevent a crisis triggering the involvement of the child welfare system by providing holistic legal supports as part of the clinical care team's intervention.").

70. *Id.* at 38.

71. Vivek Sankaran & Christopher Church, *Easy Come, Easy Go: The Plight of Children Who Spend Less than Thirty Days in Foster Care*, 19 UNIV. PA. J. L. & SOC. CHG. 207, 211–13 (2016) (arguing that removing children from a parent for even a short time can have lasting harm).

72. U.S. DEP'T OF JUST., DRUG COURTS (2022), https://www.ojp.gov/pdffiles1/nij/238527.pdf.

73. *Id.*

employment, or housing.[74] ACT programs are similar to MLPs in many ways; however, they have one glaring difference: ACT's do not have lawyers.

C. MLPs Are Multi-Generational

Maternal substance use is inherently a multi-generational issue. Multi-generational is defined as affecting multiple generations of the same family.[75] When a mother uses controlled substances, she impacts her and her child's health. While maternal substance misuse affects mothers and their children simultaneously, these interests are often pitted against one another. Medical and social service systems that separately address the needs of a mother and the needs of her child are not multi-generational.[76] An effective program must accommodate and acknowledge that mothers are required to balance their own often failing health, the health of their unborn child, and the well-being of their existing children.[77] Multi-generational problems require multi-generational solutions.

MLPs are perfectly equipped to meet this need. MLPs, such as MLA, serve members of a mother's entire family. These programs shoulder the burden of coordinating a mother's health needs, the health needs of her unborn child, and the well-being of her existing children. The MLP model, like maternal substance use, is intrinsically multigenerational.

ACTs are somewhat multi-generational because they help participants maintain stable housing and employment.[78] While parental involvement in an ACT positively affects an infant's health, these effects are byproducts of a parent's care rather than treatment goals. ACTs do not prioritize and manage a child's health as MLPs do. In addition, drug courts only serve the mother facing charges from drug use and are thus not multi-generational, unable to address the legal needs of her child.

D. MLPs Can be Specifically Tailored to Mothers

An effective program must be tailored to specifically address the barriers and needs of mothers who misuse substances. This population must overcome unique stigmas to receive treatment and, once in treatment, has needs that other

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74. National Alliance On Mental Illness, *Psychosocial Treatment*, https://www.nami.org/About-Mental-Illness/Treatments/Psychosocial-Treatments (last visited Oct. 30, 2022) (describing the structure and use of the Assertive Community Treatment (ACT) model).

75. Cannon & Hsi, *supra* note 40, at 469.

76. *Id.*

77. Steverson & Rieckmann, *supra* note 64, at 317–18. ("Pregnant and parenting women encounter the same minefield of issues as non-pregnant and childless women, but must also face a heightened level of risk in terms of physical and sexual abuse, extensive social stigma, and of course the complexity of balancing their own often failing health, the health of their unborn child, and the wellbeing of their existing children.").

78. William R. Waynor & Joni N. Dolce, *Improving Employment Outcomes in Assertive Community Treatment (ACT): The Role of the ACT Nurse,* 53 J. of Psychosocial Nursing & Mental Health Servs., 31, 32 (2015), https://doi.org/10.3928/02793695-20150623-05 ("Evidence-based ACT services are effective at increasing community tenure by reducing hospital use, increasing housing stability, and improving the quality of life for individuals with serious mental illness.").

individuals in substance use treatment do not have. A program must help a mother overcome the stigma associated with using as a woman and, more particularly, a pregnant woman.[79] Women-only programs increase the likelihood that these mothers will overcome societal barriers to treatment. Women in women-only drug abuse treatment programs were more than twice as likely to complete treatment as women in mixed-gender programs, and pregnant women in women-only drug abuse treatment programs averaged more days in treatment than those in mixed-gender programs.[80] Women also experience a greater rate of co-occurring medical, psychiatric, and psychosocial problems than their male counterparts.[81]

Women who misuse substances have different needs than men who misuse substances and thus require separate programs. In addition to cognitive and social barriers, an effective program must help mothers overcome unique logistical barriers to receiving treatment, such as coordinated childcare and transportation services, prenatal care, mental health services, support services, and contingency management services.[82] A program must address the unique needs of mothers who misuse substances to be most effective.

MLPs like the MLA are uniquely designed to address the needs of mothers who misuse substances. To be referred to the MLA, a participant must be a pregnant woman who has substance misuse issues.[83] These MLPs are women-only programs and thus increase the likelihood these mothers will overcome societal barriers to treatment. In addition, MLPs incorporate the whole family into care. Mothers are given access to transportation to attend treatment at health facilities and are encouraged to bring their children to appointments. MLP programs can be specifically designed to meet the unique needs of pregnant women and thus are likely to keep mothers engaged in care.

In contrast, drug court programs are not specifically tailored to the needs of women. While drug courts focus on treatment and provide intensive supervision, random and frequent drug testing, individual and group counseling, and participation in

79. Steverson & Rieckmann, *supra* note 64, at 318 ("More specifically, the affected women face personal barriers to treatment such as fear of reprisal from significant others and family members, fear of not being able to care for children, a fear of losing custody of their children, stigma associated both with using as a woman and, more particularly as a pregnant woman, fear about confidentiality, and finally, a fear of making life changes.").

80. Cynthia I. Campbell & Jeffrey A. Alexander, *Availability of Services for Women in Outpatient Substance Abuse Treatment: 1995-2000*, 33 No. 7 J. Behav. Health Servs. & Res. 1, 2 (2006), https://doi-org.proxygt-law.wrlc.org/10.1007/s11414-005-9002-2 (arguing the provision of women's services is associated with longer treatment duration and improved outcomes, such as reduced substance use).

81. Steverson & Rieckmann, *supra* note 64, at 318 ("Evidence also suggests that women experience a greater rate of cooccurring medical, psychiatric and psychosocial problems as compared with their male counterparts.").

82. *Id.* at 319.

83. Cannon & Hsi, *supra* note 40, at 473.

twelve-step treatment, these programs are not women-only programs.[84] While each drug court may differ in its construction, none are sex-specific. In addition, drug courts are not equipped to accommodate the childcare needs of mothers who have older children. Similarly, ACT's are not specifically tailored to women or pregnant women though the small sizes of treatment groups may positively impact women.

E. MLPs Take Pressure Off Medical Providers

If a medical provider does not understand how to screen for substance use in pregnant women or feel confident in his or her ability to offer assistance, the patient's needs will go unmet. Providers often feel powerless and overburdened when attempting to help mothers who misuse substances navigate complex legal systems. Medical providers understand the contribution that social determinants of health play in their patients' lives, but they do not have the training to recognize the explicit connection between specific health care needs and legal services.[85] Medical providers are these mothers' first points of contact with a system that can connect them to the services they need to stop using. A patient's legal circumstances can thwart even the best health care services.[86] Doctors need support from attorneys when serving mothers who misuse substances during pregnancy.

The MLP model can combat providers' biases in screening and take pressure off these medical providers. A core component of the MLP model is training. Attorneys at an MLP train physicians, nurses, medical staff, and other critical service providers on how to recognize health-harming civil legal needs and how to effectively refer their patients to an attorney so they can access civil legal aid services.[87] A series of initial training sessions for clinical staff occur when the MLP begins, with follow-up sessions for new employees, on-going coaching, technical assistance, and consultation that is embedded in the health care team.[88] Training from an MLP can help eliminate some of the biases that result in the disparities in screening between Black and White mothers.

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84. Andrew Fulkerson, *How Much Process is Due in the Drug Court?*, 48 No. 4 Crim. L. Bull. 655, 655–56 (2012), https://www.researchgate.net/publication/262262464_CRIMINAL_LAW_BULLETIN_Volume_48_Number_4_How_Much_Process_is_Due_in_the_Drug_Court (provides a description of drug court).

85. Krishnamurthy et al., *supra* note 49, at 381. ("Physicians, nurses, medical staff, and other critical service providers inherently understand the contribution that social determinants of health play in their patients' lives, especially when those health professionals are caring for patients with extremely limited financial resources. Often, however, those same health professionals need training to recognize the explicit connection between civil legal aid services and health care needs.").

86. *Id.* ("Each year, thanks to MLPs comprised of legal and health team members, thousands of clinicians and other health staff learn about "health-harming civil legal needs"-those legal circumstances that can thwart even the best health care services, preventing individuals from benefiting from the programs, services, opportunities, and legal protections that are designed to improve their health and well-being.").

87. *Id.*

88. *Id.*

In addition, having a provider in the hospital or medical setting removes pressure from providers to explain legal issues to their patients. Many health conditions with which children present can be traced to legal issues that can impact a medical diagnosis; therefore, having a lawyer in a medical facility provides access to more holistic and preventative solutions to these problems.[89] When a provider's actions create a legal problem, such as when mandatory reporting is required, it is particularly important to have a lawyer on site who can guide a mother through the civil and criminal ramifications of this reporting. Demystifying the civil and criminal consequences of mandatory reporting laws will decrease a mother's fear and increase the likelihood she will stay engaged in care. MLPs bring health and legal professionals together in a health clinic setting, increasing providers' ability to identify patients in need of assistance before crises arise, and the effects on health worsen.[90]

In contrast, drug courts in no way alleviate the burdens on medical providers. Drug courts do not provide legal training or legal assistance to providers. Furthermore, drug courts perpetuate the same racial biases as medical providers regarding screening pregnant women for substance use. ACTs coordinate care between different medical providers, likely relieving some of the stress that comes with treating a patient with many medical needs. While ACTs may decrease a provider's stress while providing medical care, these programs are not likely to decrease the pressure surrounding legal issues because lawyers are not members of ACT teams.

V. Conclusion

The MLP model provides for the best interest of the mothers and infants while avoiding the negative effects of mandatory reporting laws. Providers and legislators know that prenatal exposure to substances can have devastating effects on a child's life outcomes and development. Mandatory reporting laws have a counterproductive effect on preventing these negative outcomes. MLPs function to incorporate legal services into the healthcare setting in a way that addresses health-harming legal needs, which are multigenerational, often specifically tailored to mothers, while also alleviating pressure on medical providers. MLPs provide services that are not available at drug courts or ACT programs, making it more likely a mother will stay engaged in care at an MLP than at either of these other programs. MLPs can protect infant health and accomplish the goals legislators intended when they required the mandatory reporting of women who use substances during pregnancy.

89. Zuckerman et al., *supra* note 2, at 226 (arguing having lawyers as part of the treatment team leads to preventative care).

90. Cannon & Hsi, *supra* note 40, at 483.