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Abolish and Reimagine: The Pseudoscience and Mythology of Substance Use in the Family Regulation System

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Abstract

Substance use is one of the favorite justifications for the family regulation system to remove children and prevent reunification with their parents, especially if those parents are women, people in poverty, or people of color. This Article reviews decades of scientific research, hundreds of scientific articles, revealing that almost all the assumptions justifying removal and prevention of reunification for alleged substance use are pseudoscientific myths—revealing a system dedicated not to family preservation, but to family punishment.

The family regulation system disproportionately targets women, people of color, and people in poverty. In many instances, a single drug test with no corroborating medical opinion or scientific analysis is sufficient to affix the label "substance use disorder." Children are removed for alleged maltreatment on the unfounded assumption any substance use automatically causes maltreatment. Children are returned conditioned upon the completion of general services and treatment which are known to not address the true material financial needs of families or substance users. Abstinence is the rule. Relapse, the normal process of recovery, will be punished. Pregnant people and infants face legal punishment and compelled services opposed by almost every major medical association because they do not contribute to proper care or improved outcomes for the parent or the child.

Because the expanding family regulation system inappropriately relies upon pseudoscientific myths to oppress Black, indigenous, immigrant, poor, and other marginalized communities, we must reject these myths, abolish the family regulation system, and embrace the science and reality of substance use and family

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welfare. To build a more humane and democratic society, nothing short of abolishing and reimagining a new family welfare system that embraces science and reason, and no longer relies upon draconian practices that remove children from homes and target society's most vulnerable people, will do.

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I. INTRODUCTION

When Ms. Pizarra saw the ultrasound and knew it was a boy, she decided to name him after Luke Skywalker from Star Wars.[1] In anticipation of the birth, she decorated his half of his future bedroom with stuffed characters from the franchise. Luke would never see his bedroom. Upon his birth, rather than laying Luke in his mother's arms, the nurses immediately removed him from the delivery room. Later, upon her discharge, Ms. Pizarra would find out that Luke would not be allowed to leave the hospital. Shortly after, two Child Protective Services (CPS) caseworkers stood over her bed. They said that Luke had tested positive for marijuana and asked Ms. Pizarra if she uses drugs. She truthfully responded that she smokes marijuana from time to time to deal with the vomiting and nausea of pregnancy. She quickly explained that it was legal in the state and that she purchased it legally. That's when they handed her the piece of paper stating she was being charged with neglecting Luke for exposing him to marijuana, and she would have to go to court on her court date if she wanted to challenge the findings.

She returned home alone to her daughter, Heaven, four years old, crying, angry, ashamed, and confused from the encounter. A few days later a CPS caseworker showed up at her house unannounced and insisted on being let inside to see her apartment. Ms. Pizarra allowed her in. The caseworker looked through the kitchen, opening every cabinet, every closet door, every room with a judgmental eye, making little noises when she saw how little they had. She went to the bedroom split down the middle with Heaven's toys, horses, and Legos on the right and Luke's crib and stuffed Star Wars toys on the left.

Ms. Pizarra explained that she loved Heaven and that they don't have much and can't always have full cabinets of food or closets full of clothes. She works nights as a security guard to pay for this apartment on her own. She had used marijuana for vomiting and other issues during her first pregnancy. She had thought

1. This is a fictional story integrating multiple sources including my experiences as an intern with the Neighborhood Defenders of Harlem in Manhattan Family Court in New York City. LISA SANGOI, MOVEMENT FOR FAM. POWER, "WHATEVER THEY DO, I'M HER COMFORT, I'M HER PROTECTOR." HOW THE FOSTER SYSTEM HAS BECOME GROUND ZERO FOR THE U.S. DRUG WAR 5–6 (2020); Stephanie N. Gwillim, *The Death Penalty of Civil Cases: The Need for Individualized Assessment & Judicial Education When Terminating Parental Rights of Mentally Ill Individuals*, 29 ST. LOUIS UNIV. PUB. L. REV. 341, 341 (2009).

about talking to her doctor or nurses about it, but was terrified that they would take her child away. Since it had helped her during her first pregnancy and had helped her sleep for her overnight schedule, she continued to use it. The CPS worker left and said she would see Ms. Pizarra again on the court date.

There Ms. Pizarra stood, weeks after giving birth to a healthy baby boy, in court as Judge Daniels told her that she was charged with neglecting Luke because of the positive test and admission of her use – nothing more. She would be prohibited from visiting Luke until she made progress on her "family service plan," which combined "state supervision" (i.e., state surveillance) and "treatment services." Judge Daniels also told her that if he ultimately found that she neglected her son, if she did not complete the family service plan to his liking, he would find her to have derivatively neglected her daughter, Heaven, too, and remove her from the home. Again, in shock, Ms. Pizarra tried to argue that she loved Heaven and Luke, she would never try to hurt them, and she does everything for them. Judge Daniels cut her off to quickly describe her family service plan which included: parenting classes (though there was no evidence that she had neglected her children), anger management classes (though there was no evidence that she had anger management issues), parenting classes for children with special needs (though neither of her children had special needs), participation in a drug treatment program, submission to random drug screenings, refraining from alcohol (though there was no evidence that she had a substance use disorder), submission to unannounced visits from CPS during which she had to allow full access to the apartment for inspection, and participation in all family court conferences and hearings (regardless of her work schedule).[2]

Ms. Pizarra tried to follow all the demands and tried to negotiate times for court and supervised visits which worked for her overnight job and sleep schedule, but neither CPS nor Judge Daniels would budge. She again tried to explain that she was working to keep the roof over her family's head; that she's worked her whole life to become self-sufficient; that she takes a train to a bus 45 minutes one-way to get to her night job; and that the family court is nearly an hour in the other direction, but they did not want to hear it.

The treatment, random drug testing, and unannounced visits felt like various forms of interrogation and condemnation. She increasingly felt anxious in her own home wondering when they would knock again. She became deeply ashamed of her actions and that she ever needed marijuana in the first place for her pregnancy nausea. At treatment, she had to say in front of strange men and women that she smoked marijuana while pregnant and she knew they looked down on her for that. It was like a public interrogation.

Ultimately, her life became a tortured spiral downward. She would successfully avoid marijuana for weeks, but the pressure would prove too great—only seeing her baby Luke once a week for supervised visits in the middle of when she

2. Sangoi, *supra* note 1, at 5.

should be sleeping—so she would lapse and smoke in order to help her sleep. That failed test would put her in court, again, where Judge Daniels would criticize her, again, and add a few more months to her "family service plan," again.

Eventually, Judge Daniels removed Heaven from Ms. Pizarra's home due to a charge of derivative neglect and placed her in foster care, too, and at a separate foster home from her baby brother where the foster parents did not even speak the same language. Crying and exhausted, standing alone in the courtroom, she was told that if she failed to make the required visits to Luke or Heaven, she would be prohibited from visiting her children completely. When she attempted to explain the difficulties of transportation, sleep, and her job, Judge Daniels got angry, took his glasses off, and crossed his arms. Looking at the CPS attorney, ignoring Ms. Pizarra altogether, he said with arms extended and feigned bewilderment, "It's her children. She should be doing everything she can. It's not the agency's children." Ms. Pizarra finally accepted that the state did not wish for her to improve her parenting abilities, but to comply and submit to their control. So, she quit her job, canceled her lease, and moved back in with her mother—upending her entire life, and that of her daughter, so she might comply with the judge's orders.

A few months later, despite her enormous efforts, the state moved to terminate Ms. Pizarra's parental rights. Her state's statute allowed for termination of parental rights where there exists clear and convincing evidence of prenatal substance exposure or if a parent has a prior finding of neglect coupled with a failure to fully participate in treatment.[3] Despite the potential to terminate her parental rights permanently and irrevocably, she was not entitled to an attorney by state statute or by the U.S. Constitution.[4] This would be one of the most consequential events in her life, and she would be completely alone.

At the hearing, Ms. Pizarra was shocked to see not only the CPS attorneys arguing for the termination of her parental rights but attorneys for her children's foster care agencies, too. For nearly an hour, she faced an endless barrage of interrogation about why she would decide to use marijuana in the first place, why she did not talk to her doctor, why she would harm her children that way, why she did not attend services, and why she did not stop using marijuana after all the treatment they provided her free of charge. The CPS attorney repeatedly asked, "Why don't you admit you have a disorder?" Ms. Pizarra denied that she had a disorder, but the attorney repeated, as she hit the podium with her fist and shook her glasses

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3. *See infra* Section II (discussing state laws in North Dakota, Texas, Illinois, Missouri, and Maryland which allow for termination of parental rights under these conditions).

4. As of 2016, in six U.S. states, there is no state statutory or constitutional right to counsel in a termination of parental rights hearing: Delaware, Minnesota, Mississippi, Nevada, Vermont, and Wyoming. Vivek Sankran & John Pollock, *A National Survey on a Parent's Right to Counsel in State-Initiated Dependency and Termination of Parental Rights Cases*, NAT'L COAL. FOR C.R. COUNS., http://civilrighttocounsel.org/uploaded_files/219/Table_of_parents__RTC_in_dependency_and_TPR_cases_FINAL.pdf (last updated Oct. 10, 2016). There is no federal statute or U.S. Constitutional right to counsel in a termination of parental rights hearing, though trial courts may determine whether the right exists on a case-by-case basis. *See* Lassiter v. Dep't Soc. Servs., 452 U.S. 18, 25–35 (1981).

at her: "You clearly can't stop. You have a disorder, don't you?" At this point, the CPS attorney was not even posing questions, just yelling at Ms. Pizarra, walking to and from the podium with pride after asking questions and with disgust after hearing answers.

In that small, tiled courtroom downtown, Judge Daniels ultimately found by clear and convincing evidence that Ms. Pizarra was an unfit parent for Luke due to the prenatal substance exposure, an unfit parent for Heaven because of the prior finding of neglect coupled with a failure to fully participate in treatment, and that termination of parental rights was in Luke and Heaven's best interests. Ms. Pizarra let out a shriek of immeasurable grief, "Heaven and Luke are a product of me! They're an image of me! They are me!"

As of that moment, according to the state, Ms. Pizarra had never had any children. According to the state, she had never raised a little girl named Heaven who loved horses and Legos. According to the state, she had never given birth to a boy named Luke. According to the state, her parent-child relationships no longer existed. She has no right to visit Heaven or Luke ever again and they would be placed for adoption by foster agencies.[5] Ms. Pizarra's name was erased from both Heaven and Luke's birth certificates. Ms. Pizarra returned home to the bedroom filled with Luke's stuffed Star Wars toys and Heaven's horses and Legos— two children that the state tells her were never hers.

This is the family regulation system.[6] It is a racist and classist institution that oppresses Black, indigenous, immigrant, poor, and other marginalized communities in the name of protecting children.[7] Sanctioned by lawmakers, buttressed by the enthusiasm of Child Protective Services (CPS) caseworkers and attorneys, and perpetuated by the apathy of judges, the family regulation system continues

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5. *Overview of Terminating Parental Rights*, FAM. L. SELF-HELP CTR., https://www.familylawselfhelpcenter.org/self-help/adoption-termination-of-parental-rights/overview-of-termination-of-parental-rights (last visited Jan. 11, 2023).

6. The term "family regulation system" was coined by Emma Williams. *See* Emma Peyton Williams, *Dreaming of Abolitionist Futures, Reconceptualizing Child Welfare: Keeping Kids Safe in the Age of Abolition*, OBERLIN COLL. HONORS PAP. 712, 5, 55 (2020). It was since adopted by the Movement for Family Power and Dorothy Roberts. Dorothy Roberts, *Abolishing Policing Also Means Abolishing Family Regulation*, IMPRINT (June 2020), https://imprintnews.org/child-welfare-2/abolishing-policing-also-means-abolishing-family-regulation/44480 [hereinafter *Abolishing Policing*]; Movement for Family Power (@movfamilypower), TWITTER (June 11, 2020, 9:54 PM), https://twitter.com/movfamilypower/status/1271259572938985472?s=20; *see also* Dorothy Roberts & Lisa Sangoi, *Black Families Matter: How the Child Welfare System Punishes Poor Families of Color*, THE APPEAL (Mar. 26, 2018), https://theappeal.org/black-families-matter-how-the-child-welfare-system-punishes-poor-families-of-color-33ad20e2882e/ [hereinafter *Black Families Matter*].

7. DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE ix (2001) ("One hundred years from now, today's child welfare system will surely be condemned as a racist institution– one that compounded the effects of discrimination on Black families by taking children from their parents, allowing them to languish in a damaging foster care system or to be adopted by more privileged people. School children will marvel that so many scholars and politicians defended this devastation of Black families in the name of protecting Black children. The color of America's child welfare system is the reason Americans have tolerated its destructiveness. It is also the most powerful reason to finally abolish what we now call child protection and replace it with a system that really promotes children's welfare.").

to thrive. This is the system that parents, advocates, scholars, and lawyers are trying to abolish.[8] Abolitionists often describe how those in power use differences of race, gender, sexuality, nationality, and class to divide and exploit.[9] Following in the footsteps of those advocating for abolition, this Article will make three central arguments: First, the family regulation system relies upon pseudoscientific myths about substance use. Second, the expanding family regulation system uses these pseudoscientific myths to oppress Black, indigenous, immigrant, poor, and other marginalized communities. Third, by rejecting these myths and embracing the science of substance use and family welfare, we can imagine and build a more humane and democratic society that no longer relies on the removal of children and prevention of reunification to solve social problems.

The family regulation system is a battleground for the war on drugs. It utilizes the tools of carceral technology and its moral and scientific justifications for punishment that are myths and do not protect children and only serve to harm parents and ultimately children themselves. Protecting families from substance use allegations and consequences lies at the intersection of three systems contributing to the oppression of Black, indigenous, immigrant, poor, and other marginalized communities: the family regulation system, the war on drugs, and carceral technology. Effective defense in individual cases and advocacy for institutional change require an understanding of each of these systems, their independent mechanisms and consequences, and how they reinforce each other. Moreover, understanding the intersection of these three systems of oppression reveals how advocates and organizers focused specifically on one can be informed by and find allies in the others.

In the family regulation system, children removed from their homes face numerous emotional and physical harms (including separation and attachment disorders, trauma inherent in the act of removal, and the grief and confusion due to separation from one's family, all of which are uniquely harmful for minority children).[10] Children also face harms from foster care itself (including abuse and neglect in foster care, foster care placement instability, physical and sexual health problems, damaging mental health effects, and worse long-term outcomes than children who remain with their families).[11] The caregivers who lose their children through the family regulation system are also harmed by the grief, guilt, and

8. *See generally id.;* Anna Arons, *An Unintended Abolition: Family Regulation During the COVID-19 Crisis*, 11 COLUM. J. RACE L. 24 (2022); Williams, *supra* note 6; *Abolishing Policing*, *supra* note 6; Ashley Albert et al., *Ending the Family Death Penalty and Building a World We Deserve*, 11 COLUM. J. RACE L. 861 (2021).

9. *Manifesto for Abolition*, ABOLITION: J. INSURGENT POLS., https://abolitionjournal.org/frontpage/ (last visited Jan. 11, 2023).

10. Shanta Trivedi, *The Harm of Child Removal*, 43 N.Y.U. REV. L. & SOC. CHANGE 523, 527 (2018).

11. *Id.* at 541.

social stigma that ripple through family networks.[12] There are, of course, further harms of a single neglect finding including enabling the state to bring derivative neglect allegations justifying the removal of other or future children, prohibiting the parent from working professionally with children or being a resource for other family members who need a temporary home for their children, and ultimately, opening the door to the termination of parental rights.[13]

The family regulation system is a "central battle-ground in the war on drugs."[14] The most significant federal legislation addressing the family regulation system in the past few decades is the 1997 Adoption and Safe Families Act (ASFA), which was adopted at the height of the War on Drugs. It prioritized child removal and adoption over reunification with families.[15] Amnesty International explains how the War on Drugs has resulted in criminalizing pregnant women through laws like the Tennessee "fetal assault" law and the Alabama "chemical endangerment" law.[16] This has created an America where "pregnant and postpartum women and their newborn babies are typically drug tested in medical settings without their knowledge or explicit, informed consent" in order "to support criminal and civil child abuse or neglect prosecutions, custody decisions, and other non-medical interventions."[17]

Both family regulation and the War on Drugs are carried out using carceral science and technologies. The purpose of carceral technologies is to "control, coerc[e], capture, and exile of entire categories of people."[18] Examples of carceral science and technology include facial recognition technology, DNA and biometric identification, acoustic gunshot detection electronic surveillance, and risk assessments which "function as weapons in the hands of law enforcement or prison administration."[19] In practice, they are almost always cloaked with an air

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12. *See generally* Karen Broadhurst & Claire Mason, *Birth Parents and the Collateral Consequences of Court-Ordered Child Removal: Towards a Comprehensive Framework*, 31 INT. J. LAW POL'Y & FAM. 41 (2017).

13. Leslie Doty Hollingsworth, *Birth Mothers*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 424 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

14. SANGOI, *supra* note 1, at 15; *see generally* AMNESTY INT'L, CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA (2017); BIRTH RIGHTS BAR ASS'N, BIRTH RIGHTS: A RESOURCE FOR EVERYDAY PEOPLE TO DEFEND HUMAN RIGHTS DURING LABOR AND BIRTH (2020); LENORA LAPIDUS ET AL., CAUGHT IN THE NET: THE IMPACT OF DRUG POLICIES ON WOMEN AND FAMILIES (2005).

15. *See* Ava Cilia, *The Family Regulation System: Why Those Committed to Racial Justice Must Interrogate It*, HARV. C. R.-C.L. L. REV. (Feb. 17, 2021), https://harvardcrcl.org/the-family-regulation-system-why-those-committed-to-racial-justice-must-interrogate-it/; Adoption and Safe Families Act of 1997, Pub. L. No. 105–89, 111 Stat. 2115. For more information about ASFA and related laws, *see infra* Section II.

16. AMNESTY INT'L, *supra* note 14, at 7–8.

17. BIRTH RIGHTS BAR ASS'N, *supra* note 14, at 18.

18. Sarah Hamid, *Community Defense: Sarah T. Hamid on Abolishing Carceral Technologies*, 11 LOGIC MAG. (Aug. 31, 2020), https://logicmag.io/care/community-defense-sarah-t-hamid-on-abolishing-carceral-technologies/.

19. *Id.*

of pseudo-"objectivity" and trustworthiness on behalf of the powerful while in truth being unreliable, inscrutable, with their operation and even existence often hidden from public.[20] In the family regulation system, the carceral science and technologies are the drug tests, the false-diagnoses of addiction, the mandatory treatments and services, and the standardized protocols for testing pregnant people that disproportionately target marginalized groups.

The family regulation system's carceral science and technologies are built upon myths around substance use. Their structures of testing and surveillance reveal two key aspects of carceral technologies that are too often overlooked. First, carceral systems exist well beyond the criminal punishment system.[21] The family regulation system is every bit as interested in controlling, coercing, capturing, and exiling poor people and people of color as the criminal punishment system. Rather than being called law enforcement officers with badges and uniforms, in the family regulation system, law enforcement is in diverse places; for example, they work in doctors' offices and schools with the cleansing, guilt-free title of "mandated reporter" or bureaucratic title of "sentinel."[22] And rather than taking away people's life and liberty, their primary effect is taking away people's children.[23]

Second, seemingly low-tech or no-tech systems like drug testing or mandatory drug treatment are in dire need of criticism for the same reasons as high-profile technologies. The success of most carceral technologies in perpetuating systems of oppression is law enforcement's ability to embellish their pseudo-scientific claims in court with a veneer of real science. The operator's goal is typically to add breadth and certainty to any scientific premise. Taking DNA identification as an example, the criminal legal system has broadened the use of DNA from blood and semen samples to touch DNA far beyond where scientists have shown it to be truly reliable, and then rather than describing the inherent uncertainty and prevalence of error in touch DNA analysis, they project over-

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20. *See e.g.,* Marc Canellas, *Defending IEEE Standards in Federal Criminal Court*, 54 IEEE COMPUT. 14, 21 (2021); Lauren Kirchner, *Traces of Crime: How New York's DNA Techniques Became Tainted*, N.Y. TIMES (Sept. 4, 2017), https://www.nytimes.com/2017/09/04/nyregion/dna-analysis-evidence-new-york-disputed-techniques.html; Stacy Cowley & Jessica Silver-Greenberg, *These Machines Can Put You in Jail. Don't Trust Them.*, N.Y. TIMES (Nov. 3, 2019), https://www.nytimes.com/2019/11/03/business/drunk-driving-breathalyzer.html.

21. *See* Alec Karakatsanis, *The Punishment Bureaucracy: How to Think About "Criminal Justice Reform,"* YALE L.J.F. 848, 851 (2019); Alice Speri, *The Criminal Justice System Is Not Broken. It's Doing What It Was Designed to Do*, THE INTERCEPT (Nov. 9, 2019), https://theintercept.com/2019/11/09/criminal-justice-mass-incarceration-book/; Sharon Beckman, *The Criminal 'Punishment' System*, B.C. L. SCH. MAG. (July 14, 2020), https://lawmagazine.bc.edu/2020/07/the-criminal-punishment-system/.

22. ANDREA J. SEDLAK ET AL., FOURTH NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS–4): REPORT TO CONGRESS, at 7–10 (2010). Famously, nurses and medical facilities acting as de-facto law enforcement was the central issue in *Ferguson v. City of Charleston*, 532 U.S. 67 (2001).

23. *See, e.g.*, ROBERTS, *supra* note 7; *Abolishing Policing*, *supra* note 6; *Black Families Matter*, *supra* note 6; Sangoi, *supra* note 1.

confident certainty.[24] They force judges and defense attorneys to identify the chasm between their over-broad and over-confident claims and the narrow, often uncertain, realities of science. But this responsibility is left solely in the hands of the too-often underfunded, under-resourced defense attorney as courts have largely abdicated their role as arbiters of reliable evidence.

Section II describes how caseworkers exaggerate their understanding of the relationship between substance use and child abuse and neglect. Then, it surveys the numerous ways that state statutes encourage overzealous investigations and allegations related to substance use and then defines overly punitive measures for parents caught up in the family regulation system.

Section III takes on and rejects five myths surrounding substance use in the family regulation system: (1) parents' gender, race, and class do not affect how the family regulation system operates, (2) positive tests for substances mean the parent has a substance use disorder, (3) parental substance use means children are neglected and abused, (4) compulsory treatment and abstinence are the only ways to be a fit parent and protect children, and (5) testing pregnant mothers and their infants for law enforcement is a fairly used and necessary method of ensuring the welfare of the child.

Section IV summarizes how the pseudoscience and mythology underlying the family regulation system's testing, treatment, and punishment of substance use not only demands its abolition but reveals how we can imagine and build a more humane and democratic society.

II. Mechanisms for Stealing Children and Punishing Families[25]

Parental substance use (PSU) is one of the primary reasons that the family regulation system targets a family: 53% of all infants diagnosed with prenatal substance exposure at birth in California in 2006 were reported to family regulation system services,[26] PSU is identified as a risk factor in as high as 40% to 80% of family regulation system cases,[27] and PSU-related problems account for more than half of all foster care placements.[28] Studies of Child Protective Services (CPS) investigators, referred to as caseworkers, have revealed the zealous lengths that caseworkers will go to leverage even the most attenuated drug use evidence into allegations against parents in order to remove children from their homes: they labeled missed tests and positive tests, used terms like substance abuse or

24. *See* Canellas, *supra* note 20, at 15–17; Kirchner, *supra* note 20; *see generally* Erin E. Murphy, Inside the Cell: The Dark Side of Forensic DNA (2015).

25. Roberts, *supra* note 7, at ix. ("Today, the Black nationalist charge of racial genocide from the 1970s sounds hopelessly extremist, yet many of the mothers I talked to were convinced that the child welfare system is waging a war to steal Black children . . . [T]hey are right that they are the victims of a racist system").

26. E. Putnam-Hornstein et al., *Prenatal Substance Exposure and Reporting of Child Maltreatment by Race and Ethnicity*, 138 Pediatrics e20161273, 4 (2016).

27. Colleen Henry et al., *Parental Substance Use: How Child Welfare Workers Make the Case for Court Intervention*, 93 Child. & Youth Servs. Rev. 69, 70 (2018) (internal citations omitted).

28. *Id.* (internal citations omitted).

substance dependence, highlighted any use as chronic and problematic, without ever describing the parents as having a diagnosable substance use disorder or refer to any diagnostic criteria.[29]

A family's interaction with CPS is determined by the mere perception of caseworkers that a member of the family uses substances—regardless of the child, family, and case characteristics, or the caseworker's perception of other maltreatment.[30] Specifically, caseworker-perceived substance use substantially increases the "likelihood that the caseworker perceived the child to have suffered severe risk of harm and severe harm as a result of the alleged maltreatment, . . . that the family received services from CPS, was substantiated for maltreatment, and experienced child removal."[31]

These caseworkers are not acting as mercenaries outside the law. They operate within state-level legal frameworks that encourage their behavior through incredibly low-thresholds for punitive action. Below is a summary of representative statutes[32] from 2020 in eighteen states[33] and Washington, D.C., which explicitly address parental substance use in proceedings regarding child abuse, neglect, or termination of parental rights.

Abuse and neglect charges can be filed against a parent for using controlled substances,[34] exposing their child to controlled substances or having their child present during the use or manufacture of controlled substances,[35] or their child testing positive for a controlled substance.[36] Within the birth and prenatal context, abuse and neglect charges can be filed in some states if either the birth mother or her infant test positive for controlled substances,[37] but many states only mention

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29. *Id.* at 74; John B. Saunders, *Substance Use and Addictive Disorders in DSM-5 and ICD 10 and the Draft ICD 11*, 30 CURRENT OP. PSYCHIATRY 227, 233 (2017); *see generally* Deborah S. Hasin et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 AM. J. PSYCHIATRY 834 (2013).

30. *See generally* Lawrence M. Berger et al., *Caseworker-Perceived Caregiver Substance Abuse and Child Protective Services Outcomes*, 15 CHILD MALTREAT. 199 (2010).

31. *Id.* at 9.

32. Based on reports by the Movement for Family Power and the Guttmacher Institute. SANGOI, *supra* note 1; *Substance Use During Pregnancy,* GUTTMACHER INST. (Jan. 1, 2023), https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.

33. Alabama, Arizona, Arkansas, Colorado, D.C., Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Missouri, Nevada, Massachusetts North Dakota, Oklahoma, South Carolina, and South Dakota.

34. FLA. STAT. ANN. § V-39.01(35)(g)(2)) (West 2021); OKLA. STAT. ANN. tit.10A, § 1-1-105v2 (23) (West 2021); KY. REV. STAT. ANN. § 600.020(1)(a)(3) (West 2022).

35. ALA. ADMIN. CODE r. 660-5-34-.02 (3)(a)(12); ARK. CODE ANN. § 9-27-303(3)(A)(vii)(h)(1) (West 2021) (requiring physical injury); COLO. REV. STAT. ANN. § 19-1-103(1)(a)(VI) (West 2019); D.C. CODE ANN. § 16–2301(9)(A)(x) (West 2021); 705 ILL. COMP. STAT. ANN. 405/2-18(2)(g) (West 2013); N.D. CENT. CODE § 27-20-02(8)(g) (2020); S.D. CODIFIED LAWS § 26-8A-2(10) (2019).

36. IOWA CODE ANN. § 232.68(2a)(6) (West 2022).

37. States with explicit discussions of birth mother or child testing positive for controlled substances include S.C. CODE ANN. § 63-7-1660(F)(1)(a) (2019); ARK. CODE ANN. § 9-27-303(37)(B)(i) (a-b) (2016). States with implicit discussions of birth mother or child testing positive for controlled substances include ARIZ. REV. STAT. ANN. § 8-201(25)(c) ("A determination by a health professional that a newborn infant was exposed prenatally"); UTAH ADMIN. CODE r. § R512-80-2(16) (West 2022) ("child

the infant testing positive[38] or the infant showing signs of addiction or withdrawal.[39] Moreover, Maryland presumes that a child is not receiving care within 1 year of birth if the birth mother refuses to successfully complete recommended drug treatment.[40]

Substance use is also a justification for the "death penalty" of civil law: termination of parental rights.[41] North Dakota can terminate a mother's parental rights if there is prenatal substance exposure[42] while Texas only needs evidence of a mother's use during pregnancy.[43] In Illinois, termination of parental rights can occur if the infant tests positive for substances, the mom has a prior finding of abuse or neglect, and she was previously given an opportunity for treatment.[44] In Missouri, if either the mom or infant tests positive at birth and there is either a prior finding of neglect or failed treatment, then the mother's parental rights can be terminated.[45] In Maryland, simply not accepting offered substance use treatment within 90 to 135 days after the birth or failing to fully participate in treatment are grounds for termination of parental rights.[46] This all occurs within the backdrop of the 1997 Adoption and Safe Families Act's (ASFA) "15 of 22" rule compelling states to terminate the parental rights of any parent whose child has been in foster care for fifteen of the most recent twenty-two months.[47]

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has been exposed to or is dependent upon harmful substances as a result of the mother's use of illegal substances or abuse of prescribed medications during pregnancy"); WIS. STAT. ANN. § 48.02(1)(am) (West 2021) ("When used in referring to an unborn child, serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree"). In South Carolina, this suffices for derivative neglect as well, meaning that charge of neglect with regard to one child can be used as the basis for a charge of neglect with regard to any other children in the family. S.C. CODE ANN. § 63-7-1660(F)(1)(c) (2019) ("a blood or urine test of another child of the mother or a blood or urine test of the mother at the birth of another child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance unless the presence of the substance or the metabolite was the result of medical treatment administered to the mother of the infant or the infant.").

38. ALA. ADMIN. CODE r. § 660-5-34-.02(3)(b)(9) (2022); COLO. REV. STAT. § 19-1-103(1)(a)(VII) (2016); D.C. CODE ANN. § 16–2301(9)(A)(viii-ix) (West 2021); FLA. STAT. ANN. § Title V-39.01(34)(g)(1) (West 2021); 705 ILL. COMP. STAT. § 405/2-18(2)(h) (2013); IND. CODE ANN. § 31-34-1-10 (West 2017); LA. CHILD. Code art. 603(24) (2012); N.D. CENT. CODE ANN. § 27-20-02(8)(f) (West 2020); OKLA. STAT. ANN. tit. § 10A § 1-1-105(21) (West 2021); S.D. CODIFIED LAWS § 26-8A-2(9) (2020).

39. 110 MASS. CODE. REGS. 2.00 (Physical injury (d)) (2022); NEV. REV. STAT. ANN. § 432B.330.4 (West 2012) (under these conditions "may be in need of protection if the child is identified . . . as having withdrawal symptoms resulting from prenatal substance exposure").

40. MD. CODE ANN., CTS. & JUD. PROCS. § 3-818(2) (West 2007).

41. Gwillim, *supra* note 1.

42. N.D. CENT. CODE ANN. § 27-20-02(3)(g) (2020).

43. TEX. INVOLUNTARY TERMINATION OF PARENT-CHILD RELATIONSHIP CODE ANN. § 161.001 (b)(1)(R), (a)(1), and (a)(2)(c) (West 2021).

44. 750 ILL. COMP. STAT. ANN. 50 §1(D)(t) (West 2022); FLA. STAT. ANN. § Title V-39(1)(k) (West 2019) (seems to limit the prior finding of abuse or neglect related to controlled substances allegations, e.g., due to chronic use or infant positive test).

45. MO. ANN. STAT. § Title XII 211.447(5)(5)(b)(b-c) (West 2021).

46. MD. CODE ANN., FAM. LAW § 5-710(b)(1) (West 2012).

47. Adoption and Safe Families Act of 1997, Pub. L. No. 105–89, 111 Stat. 2115 § 103(a)(3) (codified at 42 U.S.C. 675(5)(E)) ("a child who has been in foster care under the responsibility of the

States have grounds to terminate parental rights outside of the context of birth as well, including a parent exposing the child to a controlled substance;[48] having a history of substance use and refusing or failing to complete treatment;[49] using controlled substances which endangered the child and failing to complete a recommended drug treatment program or failing to stop using the substance.[50]

In states where PSU is not automatically sufficient by statute for a finding of child abuse, neglect, or termination of parental rights, caseworkers use PSU to presume that substance use inevitably causes harm to the child. A study of California caseworkers showed that they "construed PSU-related acts and omissions as neglect, arguing that. . . parents had 1) failed to protect their children by directly exposing them to substances and/or substance-use related activities (e.g., exposure to toxins, paraphernalia, and criminal activity) and/or 2) failed to adequately provide for their children (e.g., inadequate food, care, and supervision)."[51]

For families with substance abuse allegations in particular, the draconian nature of these laws and the zealous methods by which they are enforced reveals the family regulation system as designed to promote taking children from families, placing them in foster care, terminating parental rights, and securing adoptions. Once a substance-abusing parent is involved in the family regulation system, they are more likely to experience subsequent allegations of maltreatment as compared to non-substance-abusing parents.[52] Often they are not given access to treatment. When they are given access to treatment, substance use disorders cannot be solved in the timelines that CPS, statutes, and the courts often require. But even access to and successful completion of mandatory services and treatment is insufficient to achieve reunification.[53] "'One day at a time for the rest of my life' is an adage commonly repeated in recovery groups. [R]ecovery is never complete. Substance-abusing parents will always be striving to achieve and maintain sobriety."[54] As a result "children of substance-abusing parents remain in substitute care for significantly longer periods of time and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system."[55]

State for 15 of the most recent 22 months . . . the State shall file a petition to terminate the parental rights of the child's parents.").

48. N.D. CENT. CODE ANN. § 27-20-02(3)(h) (2020).

49. FLA. STAT. ANN. § Title V-39(1)(j) (West 2021).

50. TEX. INVOLUNTARY TERMINATION OF PARENT-CHILD RELATIONSHIP CODE ANN. § 161.001 (b)(1)(P) (West 2021).

51. Henry et al., *supra* note 27.

52. *See generally* Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 CHILD ABUSE & NEGLECT 97 (2002).

53. Jeanne C. Marsh et al., *Integrated Services for Families with Multiple Problems: Obstacles to Family Reunification*, 28 CHILD. & YOUTH SERV. REV. 1074, 1082 (2006).

54. Joseph P. Ryan & Hui Huang, *Substance Abuse Issues*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 299, 308–09 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

55. *Id.* at 304 (internal citations omitted).

Ultimately, the fifteen months required by ASFA making the "15 of 22" rule operate as a means of terminating the parental rights of substance-using parents.[56] Due to ASFA "parents who cannot resolve the problems that led to placement and may require longer treatment, e.g., substance abusers, are at risk of having their rights terminated no matter what the age of the child or the degree of parent-child attachment."[57] Not only are these parents at risk of having their rights terminated and children adopted, historical and legal analysis shows this is exactly what ASFA was designed for.[58] Through ASFA, the federal government provides financial incentives to states to keep children in foster care ("the longer the child remains in foster care, the more money the state receives"[59]) and, for the first time, provided financial incentives to states to have those children in foster care permanently adopted away from their families.[60] In a country where the answer to every question is money, given the reduced federal assistance to support families, the expense of substance use treatment programs, and the incentive to remove and adopt out children, states often decide it is simply more cost-effective for states to break a family apart than reunify it.[61]

Even the Associate Commissioner of the Children's Bureau of the U.S. Department of Health and Human Services has expressed deep concern with the realities of ASFA and related laws:

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56. CORNELIA M. ASHBY, FOSTER CARE: STATES FOCUSING ON FINDING PERMANENT HOMES FOR CHILDREN, BUT LONG-STANDING BARRIERS REMAIN 15 (2003) (surveying child welfare officials who explained that parents must have access to substance abuse treatment immediately after child enters care "if reunification is a realistic goal by the time a child has been in care for 15 months" but "the lack of appropriate substance abuse treatment programs that address the needs of parents makes it difficult to get parents in treatment and stable by the 15th month.").

57. Brenda G. McGowan, *Historical Evolution of Child Welfare Services*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 11, 39 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

58. DeLeith Duke Gossett, *The Client: How States Are Profiting from the Child's Right to Protection*, 48 U. MEM. L. REV. 753, 820 (2018) ("The Act's financial incentives have disrupted families permanently by the speedy termination of parental rights, without the accompanying move from foster care to adoptive homes. Thus, the programs that the Adoption and Safe Families Act govern thwart its very purpose as children continue to languish in foster care waiting for permanent adoptive homes, often until they age out of the system into negative life outcomes."); *ASFA: The racist child welfare law from the 1990s that almost no one talks about*, NCCPR CHILD WELFARE BLOG (Nov. 8, 2020), https://www.nccprblog.org/2020/11/asfa-racist-child-welfare-law-from.html; McGowan, *supra* note 57, at 39 (concluding that ASFA "seemed designed primarily to promote adoptions").

59. Gossett, *supra* note 58, at 820 n.425 (internal citations omitted).

60. *Id.* at 783 n.171 (internal citations and quotations omitted).

61. *Id.* at 804–05 (explaining how ASFA and state and federal funding realities are incompatible with family reunification in the context of the opioid epidemic). As Judge Marilyn Moore, who presides over the juvenile court in Marion County, Indiana, explained, the key legal reform question was "money. And that is sadly what the necessity is . . . How much in the way of resources should be devoted to trying to reunify children with parents who cannot conquer their addiction?" Scott Simon, *The Foster Care System Is Flooded with Children of The Opioid Epidemic*, NAT'L PUB. RADIO (Dec. 23, 2017), https://www.npr.org/2017/12/23/573021632/the-foster-care-system-is-flooded-with-children-of-the-opioid-epidemic.

> In more recent times in public child welfare—with the passage of laws that place short time limits on efforts to help families regain custody of their children—we have created more legal orphans than children entering care without living parents. The underlying philosophies behind such laws placed value in getting tough on parents facing difficulties and has disproportionately affected poor parents, Black parents, and Native parents. We have fed a culture of blame. This should give us considerable pause. We have effectively tied parenting and family relationships to a calendar, and in so doing, one of the most sacred life experiences and purposes a human being can serve has been placed on a timer.[62]

Within this legal reality, "judges lack the sufficient knowledge base and understanding of substance abuse in general and the recovery process more specifically. A limited knowledge base helps to create a risk-aversive atmosphere and consequently contributes to reunification delays."[63] But the destruction left in the wake of the family regulation system is not merely because of judicial misunderstanding. It is a system of laws, judges, lawmakers, caseworkers, and others who, intentionally or not, leverage myths of substance use to harm families. The following sections on substance use identify and expel the pseudoscientific, carceral myths the family regulation system depends on.

III. Defending Parents Against Substance Use Myths

Faced with the types of systems and statutes discussed in the preceding section, this section develops arguments for advocates and litigators to defend parents in individual cases or in policymaking against the five myths of substance use used in the family regulation system: (1) parents' gender, race, and class does not affect how the family regulation system operates, (2) positive tests for substances mean the parent has a substance use disorder, (3) parental substance use means children are neglected and abused, (4) compulsory treatment and abstinence are the only ways to be a fit parent and protect children, and (5) testing pregnant mothers and their infants for law enforcement is a fairly used and necessary method of ensuring the welfare of the child.

A. Myth: Parents' Gender, Race, and Class Does Not Affect How the Family Regulation System Operates

The family regulation system is racist, classist, and sexist. The default belief of many people is to reject this claim and uphold the myth that one's gender, race, and class do not affect how the family regulation system operates. The rest of this

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62. David Kelly & Jerry Milner, *Apoyamos a las familias (We Support Families)*, 21 Child. Bureau Express (Nov. 2020), https://cbexpress.acf.hhs.gov/article/2020/november/apoyamos-a-las-familias-we-support-families/3938c0031b92c150517620efe54bcbbf.

63. Ryan & Huang, *supra* note 54, at 308–09.

Article provides broad evidence that one's race, class, and gender not only affect how the family regulation system operates but that the family regulation system disparately targets people based on their race, class, and gender. However, this section focuses on two specific realities. First, despite women being the primary focus of the family regulation system, women are particularly misunderstood as substance users and are underserved in substance use treatment. Second, study after study shows that Black, Hispanic, Native American, and poor children are overrepresented in the family regulation system.

1. Reality: Women are Particularly Misunderstood as Substance Users and are Underserved in Substance Use Treatment

Gender plays a prominent role in the family regulation system.[64] To understand the myths that follow in this Article, it is essential to understand how one's gender can determine how PSU manifests: the socioeconomic issues, the patterns of drug use, the onset of drug use, the psychosocial characteristics, the physiological impact of drug use, the response to drug treatment, and relapse.[65] While much of this Article applies to both men and women equally, this section focuses on women as they are the preferred target of the family regulation system.[66] It is the New Jane Crow.[67] Said differently, while the criminal punishment system comes for men, the family regulation system comes for women. Despite the knowledge that traditional substance use treatment programs are designed for men and that women do not respond well to those traditional methods,[68] few

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64. This section uses the term "women" to conform to the research literature which does not distinguish between women, transgender women, intersex people, or other non-binary people. Different parts of the biological, psychological, and social differences listed here will apply to different people depending on their individual biology, psychology, and societal presentation and interactions. It is hoped that the term will be understood merely as a reference point to which any reader can readily understand how they relate.

65. *See, e.g.*, SANGOI, *supra* note 1; Irene Kuo et al., *Substance Use Among Women in Poverty*, *in* POVERTY IN THE UNITED STATES 93 (Ann O'Leary & Paula M. Frew eds., 2017), http://link.springer.com/10.1007/978-3-319-43833-7_6 (last visited Apr. 11, 2023); LAPIDUS ET AL., *supra* note 14. Even the United Nations is now calling for the need for governments "to consider incorporating female-oriented programmes in their drug policies and strategies" and "to integrate essential female-specific services in the overall design, implementation, monitoring and evaluation of policies and programmes addressing drug abuse and dependence." Alessandra Liquori O'Neil & Jonathan Lucas, *Project DAWN: Mainstreaming Gender in the Prevention, Treatment and Recovery of addiction, a policy and operational agenda*, *in* PROMOTING A GENDER RESPONSIVE APPROACH TO ADDICTION 12 (Alessandra Liquori O'Neil & Jonathan Lucas eds., 2015) ("nowadays ample evidence in the literature that biological and psychosocial differences between men and women influence the prevalence, presentation, comorbidity, and treatment of substance use disorders").

66. *Black Families Matter, supra* note 6.

67. Stephanie Clifford & Jessica Silver-Greenberg, *Foster Care as Punishment: The New Reality of 'Jane Crow,'* N.Y. TIMES (Jul. 21, 2017), https://www.nytimes.com/2017/07/21/nyregion/foster-care-nyc-jane-crow.html.

68. Cynthia I. Campbell et al., *Tailoring of Outpatient Substance Abuse Treatment to Women, 1995-2005*, 45 MED. CARE 775, 775–80 (2007).

women-centered outpatient substance abuse treatment programs exist,[69] and the number of such treatment programs or any tailoring of treatment to women is decreasing.[70] For a system that primarily targets women and often mandates treatment completion as a precondition for reunification with their children, this myth contributes to a system that promises hope but ensures the destruction of families.

Substance use, historical trauma, everyday violence, poverty, discrimination, racism, gendered relations of power and legal policies and practices all combine to affect women's relationship with substances, the health care system, and the family regulation system.[71] Women's substance abuse "cannot be situated solely within the realm of individualized behavior. Knowledge of structural and interpersonal contexts of women's lives is essential to understanding these interrelationships."[72] From a socioeconomic perspective, in recent decades there has been a "feminization of poverty" in the U.S. such that in 2019 25% of female-led families were in poverty, as compared to 13% of male-led families, and 5% of married-couple families.[73] These single mothers, and low-income single mothers in particular, experience significantly greater stress than other groups, including low well-being, inadequate support networks, and high levels of depression.[74] For women using substances their lives are "often characterized by inadequate financial resources, substandard housing, and lack of marketable job skills and adequate support systems."[75]

> [There is a] heartbreaking human struggle faced by the women attempting to confront the ravages of substance abuse in their day-to-day lives. Given the widespread scourge of illegal substances embedded in local neighborhoods, participants described conditions akin to feeling immersed or trapped in living situations where contact with illicit substances, directly or indirectly, was virtually inescapable . . . . Structural racism, sexism, and classism allow illicit drug use in open-air markets, minimal access to gainful employment, or advanced education opportunities . . . . The women described stressful, demanding life circumstances and efforts to break the continuous cycle of drug involvement for themselves, their family, and future generations.[76]

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69. Natasha Elms et al., *Need for Women-Centered Treatment for Substance Use Disorders: Results from Focus Group Discussions*, 15 HARM. REDUCT. J. 1, 6 (2018).

70. Campbell et al., *supra* note 68, at 775.

71. Vicky Bungay et al., *Women's Health and Use of Crack Cocaine in Context: Structural and 'Everyday' Violence*, 21 INT. J. DRUG POL'Y 321, 327 (2010).

72. *Id.*

73. Jessica Semega, *Pay is Up. Poverty is Down. How Women are Making Strides*, U.S. CENSUS BUREAU: PAYDAY, POVERTY, AND WOMEN (2019).

74. Norma Finkelstein, *Treatment Issues for Alcohol- and Drug-Dependent Pregnant and Parenting Women*, 19 HEALTH SOC. WORK 7, 9 (1994).

75. *Id.*

76. Kuo et al., *supra* note 65, at 110.

These structural differences in the lives of women also relate to the typical causes of the onset of drug use. Women are more likely to attribute the start of their drug use to traumatic events like incest, rape, sexual and physical abuse,[77] or child abuse.[78] Women are also more likely to experience traumatic events like rape, severe sexual assault, and severe assault from intimate partners.[79] Beyond the traumatic events, young women may start using substances as coping mechanisms for social anxiety or depression, while curiosity is the primary driver starting substance use in young men.[80] Other correlates of women's substance use that differ from men's include being over-responsible for caregiving,[81] earlier caregiving responsibilities (such as for siblings or relatives), rigid and regular domestic responsibilities (e.g., cleaning the house, cooking, and supporting the family financially), early parenthood,[82] or growing up in a family that had substance abuse.[83]

Women's patterns of substance use and physiological effects also have some significant differences from men's. Women are more likely to use substances in isolation and in private.[84] While men are more likely than women to become addicted to substances,[85] women's substance use tends to have a "telescoping" effect where they have a more rapid progression from onset to dependence than men—especially for opioids, marijuana, and alcohol.[86] They experience more detrimental consequences of drug use at lower levels and in a shorter amount of time, in addition to the gender-specific reproductive and gynecological consequences.[87] Even in studies where the severity of drug and alcohol dependence did not differ by gender, women reported more severe psychiatric, medical, and employment complications.[88]

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77. Lani Nelson-Zlupko et al., *Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women*, 40 SOC. WORK 45, 46 (1995); Finkelstein, *supra* note 74, at 11.

78. Tammy L. Anderson, *Drug Use and Gender, IV: Self-destructive behavior and dis-valued identity*, *in* ENCYCLOPEDIA OF CRIMINOLOGY AND DEVIANT BEHAVIOR 286, 288 (C. E. Faupel & P. M. Roman eds., 2001).

79. Ron Acierno et al., *Health Impact of Interpersonal Violence 1: Prevalence Rates, Case Identification, and Risk Factors for Sexual Assault, Physical Assault, and Domestic Violence in Men and Women*, 23 BEHAV. MED. 53, 62 (1997).

80. O'Neil & Lucas, *supra* note 65, at 13 (citations omitted).

81. Nelson-Zlupko et al., *supra* note 77, at 46.

82. Anderson, *supra* note 78, at 288.

83. Nelson-Zlupko et al., *supra* note 77, at 46.

84. *Id.*

85. O'Neil & Lucas, *supra* note 65, at 13 (citations omitted).

86. Carlos A Hernandez-Avila et al., *Opioid-, Cannabis- and Alcohol-Dependent Women Show More Rapid Progression to Substance Abuse Treatment*, 74 DRUG ALCOHOL DEPEND. 265, 269–70 (2004); Carla A Green, *Gender and Use of Substance Abuse Treatment Services*, 29 ALCOHOL RES. HEALTH 55, 56 (2006).

87. Nelson-Zlupko et al., *supra* note 77, at 47.

88. Hernandez-Avila et al., *supra* note 86; *see also* O'Neil & Lucas, *supra* note 65, at 13 (citations omitted).

Substance use also has different psychological and social effects on women than men. When using substances women are more likely to experience affective disorders than men, who are more likely to demonstrate sociopathic behavior.[89] With respect to criminal acts while using substances, women are less likely to engage in criminal behavior, and when they do the acts are typically petty larceny, solicitation of prostitution, and shoplifting as compared to men's typical acts of robbery and burglary.[90] Women are more likely to experience guilt, shame, depression, and anxiety about their addiction, along with negative feelings about their bodies.[91] This is particularly true for mothers who are overwhelmed by childbirth recovery and parenting. "Many women have unrealistic expectations for themselves as parents in early sobriety and believe that they must instantly become 'perfect' mothers. In addition, any physical, emotional, or learning problems in her children may increase a woman's feelings of inadequacy and guilt and lead to hopelessness, helplessness, and relapse."[92] These feelings are not surprising. Our society has intentionally stigmatized substance-using pregnant women and mothers for "failing to live up to preconceived gender-role expectations"[93] and as inherently immoral and deficient caregivers deserving of criminal and other legal punishments.[94] Even the focus of obstetric medicine in recent decades has shifted to focus on fetal protection over the well-being of pregnant women.[95]

As a result of all of these differences, even if women attend drug treatment, they "disproportionately face barriers to treatment related to children and child care" compared to men and "differ from men in their SUD treatment initiation and participation behaviors and needs . . . . The treatment barriers and socioeconomic burdens facing women with either SUDs or mental illness alone are multiplied for women with both conditions, leading to substantial challenges that make recovery more difficult and relapse more likely."[96] Starting from the highest level of abstraction, federal and state bureaucracies are not focused on families as a whole and instead focused on individuals—either the parent's substance use or the child's health.[97] Within drug treatment centers sexism is commonplace, where female patients are viewed in negative ways, described as "difficult,"

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89. Nelson-Zlupko et al., *supra* note 77, at 46.

90. *Id.*

91. *Id.* at 47; Finkelstein, *supra* note 74, at 9; O'Neil & Lucas, *supra* note 65, at 13–14 ("Gender differences, as recommended in the principles for the treatment of drug addiction elaborated by UNODC/WHO in 2008 and in the NIDA guidelines of 2012, should also keep into account the stigmatization of addicted women and the need for services to take the necessary actions to address this issue in all aspects of care.").

92. Finkelstein, *supra* note 74, at 11 (internal citations omitted).

93. Carolyn S. Carter, *Perinatal Care for Women Who Are Addicted: Implications for Empowerment*, 27 HEALTH SOC. WORK 166, 167 (2002).

94. *Id.* at 166–67.

95. *Id.* at 167.

96. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., TIP 42: SUBSTANCE USE TREATMENT FOR PEOPLE WITH CO-OCCURRING DISORDERS, 173–75 (2020).

97. Finkelstein, *supra* note 74, at 12.

"noncompliant" or "unresponsive to treatment."[98] The method of substance use treatment often uses aggressive, confrontational styles designed primarily by men for men,[99] which can be counterproductive for women by increasing acute feelings of shame and guilt.[100] Treatment centers often have low female representation in both staff, positions of authority, and patients, such that, especially in group settings, the methods requiring disclosure of secrets or trauma can feel particularly reviolating.[101] Focusing on the women themselves, they often have primary responsibility for caregiving, making childcare and other economic considerations into major obstacles.[102] Those family obligations have other damaging effects as women are more likely to be discouraged from participating by family members who perceive treatment as a threat to caregiving duties.[103]

Despite these barriers, men and women seem to engage in and complete treatment at the same rates with some studies showing women have a lower likelihood of relapse[104] while others say they have a higher rate or relapse.[105] Notably, the causes of relapse are different for women in that they are particularly more likely to relapse when their romantic partners are substance users or when they experience significant personal problems.[106]

None of the above, nor any of the following should give the impression that women are not resilient or hyper-aware of what they truly need. In interviews, women consistently articulate an "innate desire to move forward and overcome their circumstances."[107] The problem is that the family regulation system's failure to understand women substance use and treatment makes reunification nearly impossible.

2. Reality: Black, Hispanic, Native American, and Poor Children are Overrepresented in the Family Regulation System

Children belonging to Black, Hispanic, Native American, and poor communities are overrepresented in the family regulation system.[108] While the rest of this Article will evidence how the family regulation system disproportionately targets the poor and poor people of color,[109] most of the research on race and ethnicity has focused on Black children, which will be the focus of this section. Simply

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98. Nelson-Zlupko et al., *supra* note 77, at 48.

99. Kuo et al., *supra* note 65, at 95 (citing LAPIDUS ET AL., *supra* note 14, at 14).

100. Nelson-Zlupko et al., *supra* note 77, at 49.

101. *Id.*

102. *Id.* at 48; Green, *supra* note 86, at 57.

103. Nelson-Zlupko et al., *supra* note 77, at 46.

104. Green, *supra* note 86, at 58.

105. O'Neil & Lucas, *supra* note 65, at 13 (citations omitted).

106. Green, *supra* note 86, at 60.

107. Kuo et al., *supra* note 65, at 109.

108. Ruth G. McRoy, *Disproportionate Representation of Children and Youth*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 680 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

109. *See* discussion *infra* Sections I.C.2, I.D.4, and I.E.3.

put, evidence suggests that Black children are not at greater risk for abuse and neglect. The official NIS-3 data from 1996 found no statistically significant racial differences in the incidence of child maltreatment,[110] meaning that Black children are not at a greater risk of maltreatment over white children.[111] Despite this reality, nationally, Black children are "overrepresented at every stage of the child welfare intervention process, and these disproportionalities grow as children move deeper into the system."[112] Black children are more likely to be removed from parents, placed in foster care, and stay in foster care for longer periods of time; less likely to be returned home or adopted; and more likely to be emancipated (i.e., "age out") from the family regulation system.[113]

These disparities among Black children and other children of marginalized groups in the family regulation system are not new.[114] The Federal Aid to Families with Dependent Children (AFDC) Program established in 1935, allowed states to rule out "immoral" families from receiving public welfare benefits.[115] Policymakers designed rules to "maintain racial oppression [and] deny benefits to, or expel, Black families" such that, for example, in 1959, Florida "removed more than fourteen thousand children from their welfare program, more than 90 percent of whom were Black."[116] Once children and their families were ineligible for public assistance, the children were labeled "neglected" due to lack of financial resources and the family regulation system brought their families to court.[117] When the U.S. Department of Health, Education, and Welfare in the 1960s required states to provide services for such families, the workers were more likely to push for removal of Black children from their families, and their foster families were given less access to services.[118]

B. Myth: Positive Tests for Substances Mean the Parent has a Substance Use Disorder

Too often a single positive test falsely labels someone as a substance abuser, substance dependent, or with a substance use disorder. Simply put, drug tests are often unreliable and even a single, accurate, positive drug test cannot identify

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110. *See* ANDREA J. SEDLAK & DIANE D. BROADHURST, THIRD NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS–3): REPORT TO CONGRESS 4–28–4–29 (1996).

111. Sheila Ards et al., *The Effects of Sample Selection Bias on Racial Differences in Child Abuse Reporting*, 22 CHILD ABUSE & NEGLECT 103, 103–04 (1998).

112. Yolanda Anyon, *Reducing Racial Disparities and Disproportionalities in the Child Welfare System: Policy Perspectives About How to Serve the Best Interests of African American Youth*, 33 CHILD. & YOUTH SERV. REV. 242, 242 (2011).

113. McRoy, *supra* note 108, at 681, 684.

114. *Id.* at 683–86.

115. *See* Claudia Lawrence-Webb, *African American Children in the Modern Child Welfare System: A Legacy of the Flemming Rule*, 76 CHILD WELFARE 9, 11 (1997).

116. Alan J. Dettlaff & Reiko Boyd, *Racial Disproportionality and Disparities in the Child Welfare System: Why Do They Exist, and What Can Be Done to Address Them?*, 692 ANNALS AM. ACAD. POL. & SOC. SCI. 253, 263 (Nov. 2020).

117. McRoy, *supra* note 108, at 683–84.

118. Lawrence-Webb, *supra* note 115, at 13–14.

substance abuse or dependence, child maltreatment, or even the potential of maltreatment.[119] The reasonable and appropriate response by caseworkers would be to use a combination of drug testing, self-report, and observational strategies.[120] "The literature is clear—what happens in the family home is a more accurate predictor of long-term child well-being as compared with a single positive drug screen . . . The response from caseworkers and judges should reflect such findings."[121]

Nevertheless, drug testing is a widely prevalent method in the family regulation system. "Some child welfare agencies conduct drug tests on all parents under court supervision. The results are used to inform decisions on child placement, family support services, family reunification, and termination of parental rights."[122] The prevalence of drug testing, especially urine testing, in the family regulation system is easily explained: it is cheap, can be completed in or out of a laboratory setting, rejects all the nuance and complexities that scientists have shown to truly influence substance use disorders, and replaces nuance with a single "neutral" or "objective" test. This is the standard role of carceral technology.

1. Reality: Drug Tests are Often Unreliable

Drug tests are often treated as infallible despite their high "potential for false-positive results."[123] False positives on drug tests have long been used to unduly punish people. In 2016, ProPublica reported on the thousands of criminal convictions and pleas for drug possession across the U.S. that were based on false positives from unreliable roadside drug tests.[124] In Massachusetts, a judge granted incarcerated people's statewide preliminary injunction against the use of a drug test that was revealed during litigation to return a false-positive approximately 38% of the time.[125] In 2022, the Inspector General for the State of New York reported that their Department of Correction drug testing policies were "in direct contravention of manufacturer instructions and resulted in preliminary testing results being used to impose significant penalties on incarcerated individuals . . . [Tests were] highly unreliable, producing rampant false positives, yet more than 1,600 incarcerated individuals suffered sanctions as a result, including 140 people

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119. Ryan & Huang, *supra* note 54, at 303–04.

120. *Id.* at 304.

121. *Id.*

122. *Id.* at 301 (citing U.S. DEP'T HEALTH AND HUM. SERVS., DRUG TESTING IN CHILD WELFARE: PRACTICE AND POLICY CONSIDERATIONS (2010)).

123. Rebecca Thompson et al., *Marijuana Use in Pregnancy: A Review*, 74 OBSTET. GYNECOL. SURV. 415, 418 (2019) ("Positive screening tests for marijuana are presumptive and have the potential for false-positive results."); *see also* C.J. Ciaramella, *The $2 Drug Test Keeping Inmates in Solitary*, REASON (July 2021), https://reason.com/2021/06/13/the-2-drug-test-keeping-inmates-in-solitary/.

124. Ryan Gabrielson & Topher Sanders, *Busted: How a $2 Roadside Drug Test Sends Innocent People to Jail*, PROPUBLICA (July 7, 2016), https://www.propublica.org/article/common-roadside-drug-test-routinely-produces-false-positives.

125. Deborah Becker, *Judge Rules Against Massachusetts Prison Mail Drug Tests*, WBUR (Dec. 2, 2021), https://www.wbur.org/news/2021/12/02/department-of-correction-mail-drug-testing-ruling.

who were subjected to solitary confinement."[126] In the family regulation system, women have been drug tested without their consent by hospitals during and after childbirth, then based on a false-positive denied the opportunity for a confirmatory test, investigated for months by case workers, only to ultimately have the case against them dismissed.[127]

The rest of this section focuses on marijuana as that is one of the most common substances used to justify the removal of children because of its increased legal availability;[128] the length of time it stays detectable in someone's system; the prevalence of use during pregnancy;[129] and, the perceived and recommended benefits of marijuana use during pregnancy.[130] In general, research shows that THC is not a reliable indicator of intoxication, there are numerous reasons for false positives, tests cannot identify when marijuana was used, and multiple baby products can produce false positives.

First, THC is not a reliable indicator of marijuana intoxication. Experimental studies correlating specific THC levels to effects of intoxication are limited by their lack of controlled trials, reliance on self-reported use, variance in time

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126. *Inspector General Investigation Determines Hundreds Of Incarcerated New Yorkers Denied Due Process And Endured Severe Punishments As A Result Of Egregious Administrative Failures In Drug Testing Program*, N.Y. ST. OFFS. INSPECTOR GEN. (Jan. 4, 2022), https://ig.ny.gov/news/inspector-general-investigation-determines-hundreds-incarcerated-new-yorkers-denied-due.

127. *See* Anne Branigin, *A False Positive on a Drug Test Upended These Mothers' Lives*, WASH. POST (Jul. 2, 2022), https://www.washingtonpost.com/lifestyle/2022/07/02/false-positive-drug-test-mothers/.

128. *State Medical Cannabis Laws*, NAT'L CONF. OF ST. LEGIS. (Sep. 12, 2021), https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx (stating that adult, non-medical use of marijuana is legal in 21 states, two territories, and the District of Columbia, and allowed for medical use in 37 states, three territories, and the District of Columbia).

129. *See* SUBSTANCE ABUSE AND MENTAL HEALTH ADMIN., 2019 NATIONAL SURVEY ON DRUG USE AND HEALTH: WOMEN 25 (2020) (stating that in 2019, pregnant women reported use following substances in the past month: 198,000 used tobacco, 197,000 used alcohol, 112,000 marijuana, 8,000 used opioids, and 3,000 used cocaine); *id.* at 27 (stating that approximately 1.7% of pregnant women reported daily or almost daily marijuana use); Kelly C. Young-Wolff et al., *Trends in Marijuana Use Among Pregnant Women With and Without Nausea and Vomiting in Pregnancy, 2009–2016*, 196 DRUG ALCOHOL DEPEND. 66, 68 (2019) (studying 220,510 pregnant women in California, showing that prevalence of marijuana use during the first trimester increased from 2009 to 2016 from 6.5% to 11.1% among women with nausea and vomiting and increased from 3.4% to 5.8% among women without nausea and vomiting).

130. Marian Jarlenski et al., *Media Portrayal of Prenatal and Postpartum Marijuana Use in an Era of Scientific Uncertainty*, 187 DRUG ALCOHOL DEPEND. 116, 116 (2018) ("portrayal of risks and benefits [of marijuana are] somewhat equivocal, consistent with the current scientific debate"); *id.* at 119 (showing that 40% of surveyed online media items portrayed the benefits of prenatal or postpartum marijuana use as greater than the risks or neutral); Betsy Dickson et al., *Recommendations From Cannabis Dispensaries About First-Trimester Cannabis Use*, 131 OBSTET. GYNECOL. 1031, 1035 (2018) (in a survey of 400 licensed Colorado marijuana dispensaries, 69% recommended marijuana for nausea with 65% recommending it based on personal experience, and 36% stating flatly that marijuana was safe); Marian Jarlenski et al., *Trends In Perception of Risk of Regular Marijuana Use Among US Pregnant and Nonpregnant Reproductive-Aged Women*, 217 AM. J. OBSTET. GYNECOL. 705, 706 (Dec. 2017) (using the U.S. National Survey on Drug Use and Health data, from 2005 through 2015, women 18-44 increasingly perceive that marijuana use both during pregnancy and outside of pregnancy has "no risk" of harming themselves).

periods and THC-detection cutoffs assuming they were even used.[131] Even a study by the National Institute of Justice determined that "although THC has been proven to affect areas of the brain that control movement, balance, coordination, memory, and judgment . . . THC levels in biofluids were not reliable indicators of marijuana intoxication for their study participants."[132]

Second, there are numerous ways to test positive without using marijuana. Multiple legal medicines and foods are known to have the possibility of causing false positives.[133] For example, chronic use of pain relievers (e.g., Advil, Midol, and Ibuprofen), antiviral medicine used to treat HIV, and hemp-based foods and products (though less likely).[134] It is also possible, though unlikely, that second-hand marijuana smoke inhalation can cause THC levels high enough for a positive test.[135]

Assuming marijuana was ingested there is no definitive way that one test can determine when the marijuana was ingested. Marijuana could have been used the day of the test, 30 days before, or even 93 days before.[136] Factors that influence detection of marijuana include pharmacological factors (e.g. route of administration, dosage and potency of marijuana, frequency of use, body mass, and one's metabolic rate) and analytical factors of the laboratory test (e.g. test sensitivity, cutoffs selected, specificity, and accuracy).[137] During the terminal elimination phase, consecutive urine specimens may fluctuate between positive and negative, especially as concentrations approach the cutoff concentration delineating positive and negative.[138] Not to mention that the amount of marijuana metabolites and THC required to indicate a sample is positive is not standardized outside of the federal level.[139]

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131. Rebecca L. Hartman & Marilyn A. Huestis, *Cannabis Effects on Driving Skills*, 59 CLIN. CHEM. 478, 489 (2013); Mark Asbridge et al., *Acute Cannabis Consumption and Motor Vehicle Collision Risk: Systematic Review of Observational Studies and Meta-Analysis*, 344 BR. MED. J. 536, 340 (2012).

132. Field Sobriety Tests and THC Levels Unreliable Indicators of Marijuana Intoxication, NAT'L INST. JUST. (Apr. 5, 2021), https://nij.ojp.gov/topics/articles/field-sobriety-tests-and-thc-levels-unreliable-indicators-marijuana-intoxication.

133. *See generally* Karen E. Moeller et al., *Clinical Interpretation of Urine Drug Tests*, 92 MAYO CLIN. PROC. 774 (2017) [hereinafter Clinical Interpretation of Urine Drug Tests]; Karen E. Moeller et al., *Urine Drug Screening: Practical Guide for Clinicians*, 83 MAYO CLIN. PROC. 66 (2008); Joseph A Woelfel, *Drug Abuse Urine Tests: False-Positive Results*, SUBST. ABUSE 6 (2005); A. Saitman et al., *False-Positive Interferences of Common Urine Drug Screen Immunoassays: A Review*, 38 J. ANAL. TOXICOL. 387 (2014).

134. *Id*.

135. Edward J. Cone et al., *Non-Smoker Exposure to Secondhand Cannabis Smoke. I. Urine Screening and Confirmation Results*, 39 J. ANAL. TOXICOL. 1, 9–10 (2015) (providing that such positive tests are likely to be rare, limited to the hours immediately post-exposure, and occur only under environmental circumstances with high exposure such as close proximity, no ventilation, and smoke from high-percentage-THC products).

136. Pierre Lafolie et al., *Importance of Creatinine Analyses of Urine When Screening for Abused Drugs*, 37 CLIN. CHEM. 1927, 1929 (1991).

137. *See* Clinical Interpretation of Urine Drug Tests, *supra* note 133, at 778; Marilyn A. Huestis, *Human Cannabinoid Pharmacokinetics*, 4 CHEM. BIODIVERS. 1770, 1777 (2007).

138. Huestis, *supra* note 137.

139. *See* Clinical Interpretation of Urine Drug Tests, *supra* note 133, at 776.

There is an especially high likelihood of false positives for certain methods of newborn drug testing. Baby wash products have been shown to cause false-positive screening results in newborn urine testing in hospital settings.[140] For this reason, even if there is a positive marijuana test of the maternal or newborn urine, medical doctors clearly state that it "should be confirmed by gas chromatography/mass spectrometry or liquid chromatography-tandem mass spectrometry" or alternatively by "newborn testing includ[ing] meconium or umbilical cord sampling."[141]

2. Reality: Substance Use Disorder is a Clinical Diagnosis that Must Be Based on the Standard Diagnostic Criteria Focused on Substance Use, in Addition to Employment, Medical and Psychiatric Symptoms, and Family and Social Relationships

Drug tests, let alone a single test, cannot determine substance use disorder.[142] Substance use disorders are so much more than the mere presence of substances in a person's system, but that is all that drug tests can provide.[143] To this end, methods addressing more than just the presence of drugs are needed to determine abuse or dependence, including diagnostic instruments or multidimensional assessments. Nevertheless, the family regulation system uses these labels to make allegations against parents without any reference to the official diagnostic instruments or multidimensional assessments when justifying family separation and termination of parental rights.[144]

The most popular assessment is diagnostic instruments which use a "categorical approach to differentiate substance abusers from non-abusers. In contrast with a measure of severity, the categorical approach simply indicates the presence or absence of a particular problem."[145] Despite the family regulation system's addiction to terms like "abuse" and "dependence," among the American population, actual substance abuse disorder is extremely rare. For example, less than one in seven marijuana users can be categorized as substance abusers using the diagnostic criteria in the Diagnostic and Statistical Manual of Mental

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140. *Id.*; Steven W. Cotten et al., *Unexpected Interference of Baby Wash Products with a Cannabinoid (THC) Immunoassay*, 45 CLIN. BIOCHEM. 605, 608 (2012) (where false positives are referred to as cross-reactivity; finding false positives for several baby wash products, including CVS Night-Time Baby Wash, Aveeno Soothing Relief Creamy Wash, and Aveeno Wash Shampoo).

141. Thompson et al., *supra* note 123, at 15–16.

142. Ryan & Huang, *supra* note 54, at 303–04 ("Yet it is important to note that a single test is often insufficient with regard to the absolute determination of child maltreatment, the extent of potential maltreatment, or the extent of substance abuse/dependence.").

143. *See e.g.*, *id.* ("experts encourage using a combination of random drug tests, self-reports, and observations of behavioral indicators by substance abuse treatment providers or professionals and child welfare workers") (internal citations omitted).

144. A. Thomas McLellan, *Substance Misuse and Substance Use Disorders: Why Do They Matter in Healthcare?*, 128 TRANS. AM. CLIN. CLIMATOL. ASSOC. 112, 120 (2017) [hereinafter *Substance Misuse*].

145. Ryan & Huang, *supra* note 54, at 300.

Disorders 5 (DSM-5).[146] This should not be surprising because substance use disorder is a medical diagnosis and should be determined by medical doctors, not juris doctors.[147]

In the hierarchy of substance use under the DSM-5, people can be categorized as non-user, low-risk use, hazardous (or risky) use, substance abuse and substance dependence. Under the DSM-5's diagnostic criteria, for someone to be classified as having substance use disorder, they must have at least two of the following within a twelve month period, whereas to meet the now-outdated label of "dependence," [148] they must have four or more:[149]

- Craving or a strong desire or urge to use the substance; persistent desire or unsuccessful efforts to cut down or control substance use;
- Substance is often taken in larger amounts or over a longer period than was intended;
- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home;
- A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects;
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., loss of personal relationships, frequent physical domestic altercations);
- Tolerance as defined by either a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or a markedly diminished effect with continued use of the same amount of the substance;
- Withdrawal, manifested by either a characteristic withdrawal syndrome for the substance, or the substance (or a closely related substance) is taken to relieve, or avoid withdrawal symptoms;
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by that substance;
- Recurrent use in situations in which it is physically hazardous (e.g., driving an automobile or operating machinery when impaired); and,
- Important social, occupational or recreational activities are given up or reduced because of substance use.

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146. *Substance Misuse*, *supra* note 144.

147. For example, a person must be medically diagnosed as dependent upon opioid before they can be medically prescribed methadone or buprenorphine. John B. Saunders, *Substance Use and Addictive Disorders in DSM-5 and ICD 10 and the Draft ICD 11*, 30 CURR. OPIN. PSYCHIATRY 227, 232 (2017).

148. Luise Lago et al., *Concordance of ICD-11 and DSM-5 Definitions of Alcohol and Cannabis Use Disorders: A Population Survey*, 3 LANCET PSYCHIATRY 673, 679 (2016).

149. Saunders, *supra* note 147, at 233; Deborah S. Hasin et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 AM. J. PSYCHIATRY 834, 836 (2013). Examples included from Ryan & Huang, *supra* note 54, at 300.

Looking at these factors, there is no way that a single positive test or even multiple positive tests can possibly indicate substance abuse or the need for substance abuse treatment.

Multidimensional assessments (MDAs) instead focus on substance use in addition to employment, medical and psychiatric symptoms, and family and social relationships.[150] MDAs are used because of the acknowledgement by researchers in substance use and child welfare that other health and social difficulties increase the risk of substance abuse and relapse[151]—if these co-occurring problems are not addressed, progress cannot be made. One of the most commonly used MDAs is the Addiction Severity Index which measures seven functional domains: alcohol use, drug use, medical health, psychiatric health, employment and self-support, family relations, and illegal activity.[152] Due to its understanding of the broader co-occurring problems with substance use, the ASI "is a standard in virtually all clinical trials of addicted patients, and it is part of the standard clinical assessment of alcohol- and drug-abusing patients in more than twenty states and fifty cities in the United States, as well as the Veterans Administration, the Indian Health Service, and the federal prison system."[153]

C. Myth: Parental Substance Use Means Children are Neglected and Abused

Our society terminates parental rights based on substance use alone. We drug-test infants without consent from parents. These extreme policies, deeply opposed by medical experts,[154] are justified by the myth that substance use alone indicates that children are neglected and abused. The myth rejects the reality that not all parents who use alcohol or drugs mistreat their children[155] and not all people who mistreat their children use alcohol or drugs. This section shows first that substance use has not been shown to conclusively affect parenting quality. Moreover, despite the vast research and resources devoted to surveilling, judging, and forcing parents to comply, studies of parental substance use too often do not even attempt to examine the effects of the alleged maltreatment on the children.[156] Secondly, substance use is often only a small part of parents' complex social, behavioral, and economic challenges. Because these "families typically struggle with a toxic, cascading mix of . . . issues, which in concert progressively overtake already fragile parental and family coping systems,"[157] researchers

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150. Ryan & Huang, *supra* note 54, at 301–02 (internal citations omitted).

151. *See infra* Section I.D.1.

152. Ryan & Huang, *supra* note 54, at 301–02 (summarizing ASI and relevant studies).

153. A. Thomas McLellan et al., *The Addiction Severity Index at 25: Origins, Contributions and Transitions*, 15 AM. J. ADDICT. 113, 123 (2006).

154. *See infra* Section III.E.2.

155. Brynna Kroll, *Living With an Elephant: Growing Up with Parental Substance Misuse*, 9 CHILD FAM. SOC. WORK 129, 129 (2004).

156. *Id.*; Michele Staton-Tindall et al., *Caregiver Substance Use and Child Outcomes: A Systematic Review*, 13 J. SOC. WORK PRACT. ADDICTIONS 6, 24 (2013).

157. Susan P. Kemp et al., *Family Support Services*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 51, 54 (Gerald P. Mallon & Peg

explain that no single risk factor is as powerful of a predictor of maltreatment as the "total accumulation of adversities faced by families."[158]

1. Reality: Substance Use has Not been Shown to Conclusively Affect Parenting Quality

Social science research on the effects of parent substance use on abuse and neglect reports mixed, uncertain results.[159] In distinguishing between physical abuse, emotional abuse, neglect, and substance use versus DSM-defined substance abuse disorders, there is only one clear relationship: substance abuse disorders can potentially increase the prevalence of physical abuse[160] – and even that is driven overwhelmingly by alcohol abuse.[161] In 2010, the U.S. Department of Health and Human Services presented the Fourth National Incidence Study of Child Abuse and Neglect (NIS–4), which "serves as the nation's needs assessment on child abuse and neglect."[162] According to the NIS-4, substance use problems are only reported as even being present in 17.9% of all physical abuse and 17.5% of all sexual abuse.[163] Said differently, in over 82% of child physical and sexual abuse cases, there are no reported alcohol or drug use problems. Moreover,

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McCartt Hess eds., 2d ed. 2014) (citing Marianne Berry et al., *Promising Practices in Understanding and Treating Child Neglect*, 8 CHILD FAM. SOC. WORK 13 (2003); *see generally* Dee Wilson & William Horner, *Chronic Child Neglect: Needed Developments in Theory and Practice*, 86 FAM. SOC. 471 (2005) (summarizing the research of how issues related to social marginality, exclusion, neighborhood, and family and household including poverty, housing, social isolation, personal).

158. Niel B. Guterman et al., *Prevention of Child Abuse and Neglect*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 207, 212 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014) (citing Michael J. MacKenzie et al., *Toward a Cumulative Ecological Risk Model for the Etiology of Child Maltreatment*, 33 CHILD. & YOUTH SERV. REV. 1638 (2011) ("That is, risk of child maltreatment is heightened when placed in the context of other household and neighborhood adversities, including intimate partner violence, parental substance abuse, parental criminal history, and neighborhood disadvantage.") (citing Carolyn Copps Hartley, *The Co-occurrence of Child Maltreatment and Domestic Violence: Examining Both Neglect and Child Physical Abuse*, 7 CHILD MALTREAT. 349 (2002); Todd I. Herrenkohl et al., *Intersection of Child Abuse and Children's Exposure to Domestic Violence*, 9 TRAUMA VIOLENCE ABUSE 84 (2008); Emiko A. Tajima, *Correlates of the Co-Occurrence of Wife Abuse and Child Abuse Among a Representative Sample*, 19 J. FAM. VIOLENCE 391 (2004); Abigail H. Gewirtz & Jeffrey L. Edleson, *Young Children's Exposure to Intimate Partner Violence: Towards a Developmental Risk and Resilience Framework for Research and Intervention*, 22 J. FAM. VIOLENCE 151 (2007)); Ryan & Huang, *supra* note 54, at 307–08 ("Within the child welfare system, co-occurring mental health, domestic violence, and inadequate housing are frequently documented.").

159. Nancy J. Kepple, *Does Parental Substance Use Always Engender Risk for Children? Comparing Incidence Rate Ratios of Abusive and Neglectful Behaviors Across Substance Use Behavior Patterns*, 76 CHILD ABUSE & NEGLECT 44, 52 (2018); SANGOI, *supra* note 1, at 21.

160. Sandra M. Stith et al., *Risk Factors in Child Maltreatment: A Meta-analytic Review of the Literature*, 14 AGGRESSION VIOLENT BEHAV. 13, 25 (2009).

161. SEDLAK ET AL., *supra* note 22, at 6–16 Figure 6–3 (showing that for children who experienced physical abuse, 11.1% of the perpetrators were using alcohol as compared to 6.8% that were using drugs).

162. *Id.* at 1.

163. *Id.* at 6–16 Figure 6–3 (for sexual abuse, alcohol abuse was present in 8.4% of cases and drug use was represented in 9.1% of cases).

when harm is "inferred" from other factors, 14.7% have drug use problems compared to 8.2% for alcohol use problems.[164] Through numerous studies, social scientists have not found a significant association between mere substance use and physical abuse, emotional abuse, or neglect. Further, even the findings on substance abuse disorders requires clarification as alcohol abuse disorders have far stronger associations with abuse and neglect than drug abuse disorders.[165] For example, in 2011, 18.6% of unique maltreated children had parent drug abuse as a risk factor and of those children, 98% had parent alcohol abuse as a risk factor.[166]

The issue parents face in the family regulation system is that where social science researchers hesitate to make findings of abuse and neglect given such uncertain evidence, caseworkers and courts have no such issue. In a study "accounting for 21 caseworker-perceived maltreatment-related risk factors across 7 domains at the child, caregiver, and family levels, in addition to child and family characteristics and maltreatment types and severity," researchers found strong evidence "that families perceived by caseworkers as having caregiver substance abuse experience more intensive CPS intervention solely because perceptions of substance abuse trigger such differential treatment."[167]

There are three key flaws in parental substance abuse/use research, based on how we define each of the three words. First, studies group together all alcohol and other drugs into the "substance" making it overbroad and vague. Second, parental "use," "misuse," or "abuse" is too often a determination made by caseworkers, not medically trained professionals, without any legitimate relationship to medical science. Third, the focus is almost always on the parents and rarely on the actual effects of substance abuse on children.

First, while researchers often group together "alcohol and other drug abuse" (AODA)[168] into "substance abuse," the diversity of these "substances" and their short- and long-term effects are extreme:

> Illicit drugs may include marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type drugs, of which there are four categories: pain relievers, tranquilizers, stimulants, and sedatives. Prescription-type drugs include some substances that are manufactured and distributed illegally, such as the stimulant methamphetamine. Hashish is considered marijuana, and crack is considered

164. *Id.* at 6–18 Figure 6–5.

165. Stith et al., *supra* note 160.

166. Ryan & Huang, *supra* note 54, at 302 (internal citations omitted).

167. Berger et al., *supra* note 30.

168. J. P. Ryan et al., *Integrating Substance Abuse Treatment and Child Welfare Services: Findings from the Illinois Alcohol and Other Drug Abuse Waiver Demonstration*, 30 SOC. WORK RSCH. 95, 95 (2006); Marsh et al., *supra* note 53; Sam Choi et al., *Substance Abuse Treatment Completion in Child Welfare: Does Substance Abuse Treatment Completion Matter in the Decision to Reunify Families?*, 34 CHILD. & YOUTH SERV. REV. 1639, 1641 (2012).

> cocaine. Peyote, LSD, PCP, mescaline, psilocybin mushrooms, and "Ecstasy" (MDMA) comprise the hallucinogens. Inhalants refer to many substances, including nitrous oxide, amyl nitrite, cleaning fluids, gasoline, spray paint, other aerosol sprays, and glue.[169]

In reviewing the major studies of the effect of PSU on children below, researchers repeatedly fail to distinguish between substances or account for the lack of expertise and bias of caseworkers who label parents as substance users or abusers—rendering their conclusions effectively worthless. The 2010 NIS-4 groups all "drug use" together when HHS determines the prevalence in abuse and neglect cases[170] and relies on "CPS investigators and NIS-4 sentinels [(i.e., mandated reporters)]" to determine whether alcohol use, drug use, and mental illness are factors in the child maltreatment.[171] In the 1994 GAO report titled "Parental Drug Abuse Has Alarming Impact on Young Children," researchers studied foster care programs in California, New York, and Pennsylvania and alleged that "78 percent of the young foster children reviewed had at least one parent who was abusing drugs or alcohol in 1991 compared with 52 percent in 1986."[172] However, they based their results on caseworker casefiles where the caseworkers identified whether children had a parent who was using drugs with no mention of a review by medical professionals.[173] In a follow-up report by the GAO in 1997, they merely interviewed family regulation system officials to confirm "that the majority of foster care cases . . . involve parental substance abuse."[174]

Almost all the specific mythological claims levied against parents who use alcohol or drugs by courts are based on these flawed studies. High-profile reviews of the research literature just summarize all studies into a single statement of "substance abuse," arguing that it creates problems in the parent-child relationship by decreasing emotional involvement, decreasing parental flexibility, and creates an environment not responsive to the material and emotional needs of children.[175] Take a study that allegedly shows that PSU disrupts family stability and cohesion, but just uses the all-encompassing "parental alcohol and other drug abuse" term (AODA) as defined by Illinois case workers.[176]

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169. *See* Ryan & Huang, *supra* note 54, at 299 (internal citations omitted).

170. SEDLAK ET AL., *supra* note 22, at 6–16.

171. *Id.* at 15.

172. U.S. GENERAL ACCOUNTING OFF., GAO/HEHS-94-89, FOSTER CARE: PARENTAL DRUG ABUSE HAS ALARMING IMPACT ON YOUNG CHILDREN 7 (1994).

173. *Id.* at 18, 21. (indicating that the researchers reviewed only "foster care case files," "performed limited tests of the completeness of the case files," and did not independently verify [their] accuracy").

174. U.S. GENERAL ACCOUNTING OFF., GAO/T-HEHS-98-40, PARENTAL SUBSTANCE ABUSE: IMPLICATIONS FOR CHILDREN, THE CHILD WELFARE SYSTEM, AND FOSTER CARE OUTCOMES 5 (1997).

175. Ryan & Huang, *supra* note 54, at 304.

176. *Id.* at 299.

Separately, take the claim by Henry et al., that PSU "affect[s] children's short- and long-term physical and emotional health and cognitive development."[177] That statement cites three papers which, upon inspection, reveal that the proposition is overbroad and unsupported by the citations. The first citation is to a study by Bountress and Chassin which shows that parents with "substance use disorders" may not provide consistent support to their children, impairing the quality of caregiving and properly relies on medical determinations of substance abuse. However, the study only includes alcohol substance use disorder and not any other drugs.[178]

The second study, by Fellitti et al., which has been cited over 9,914 times, concludes that there is "a strong [cumulative] relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults."[179] But this has almost no value for discussions of the effects of substance abuse on children. Exposure to abuse or household dysfunction grouped together everything from psychological, physical, and sexual abuse to substance abuse and mental illness, and then determined the effect of the number of these "exposures" on their long-term health.[180] The study was not focused on the effect of substance abuse so there was no attempt to isolate substance abuse and determine how substance abuse specifically affects long-term health. Moreover, the reports of PSU were based on adults' self-reported recollections of childhood experiences which the researchers described as a serious limitation.[181]

The third citation is to a clinical report from the American Academy of Pediatrics (AAP) that summarized the breadth of research on how families are affected by parental substance use across numerous substances.[182] It describes the incredibly varied effect of different substances. Alcohol has a known, strong relationship with impairing fetal growth and childhood anomalies, and long-term effects on growth, behavior, cognition, and achievement.[183] Marijuana has no known effect on fetal anomalies, withdrawal or long-term growth and only some effect on long-term behavior, cognition, and achievement.[184] But perhaps surprisingly, nicotine, which is completely legal, has equal or stronger negative short- and long-term effects than marijuana.[185] As for opiates, there are known strong

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177. Henry et al., *supra* note 27, at 69.

178. *See generally* Kaitlin Bountress & Laurie Chassin, *Risk for Behavior Problems in Children of Parents with Substance Use Disorders*, 85 AM. J. ORTHOPSYCHIATRY 275 (2015).

179. Vincent J Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, 14 AM. J. PREVENTIVE MED. 245, 245 (1998).

180. *Id.* at 251.

181. *See id.*

182. Vincent C. Smith et al., *Families Affected by Parental Substance Use*, 138 PEDIATRICS e1, e1 (2016) [hereinafter *Families Affected by Parental Substance Use*].

183. *Id.* at e3 Table 1.

184. *Id.*

185. Marylou Behnke et al., *Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus*, 131 PEDIATRICS e1009, e1016 Table 2 (2013).

effects for withdrawal but no known effects on fetal anomalies, and for methamphetamine, most effects are simply unknown.[186]

These fundamental flaws in the literature are not new. Even as far back as 1996, researchers knew that most of the research on maltreatment was vulnerable to biases.[187] The official identification and referral patterns to the family regulation system were (and remain) biased as low-income Black children were more likely to be seen in public hospitals and incorrectly reported for abuse relative to middle-class white children.[188] Most of the studies were based on people recalling their childhood and focused on whether maltreatment occurred at any time in their childhood, making it difficult to adequately determine risk and causal factors.[189] And lastly, most of the studies did not include social or mental health variables which are known today to be significant determinants of maltreatment.[190]

More recently in 2013, Stanton-Tindall et al. explained that while research studying the effects of PSU on child abuse and neglect had made progress in some of its methodologies, it was still plagued by a fundamental flaw: studies continued to rely on caseworker files (referred to as "secondary data") and whether those caseworkers recorded the presence of any substance use at all.[191] They described this reality as "disturbing" because

> [T]here are a wealth of sophisticated measures of adult substance misuse that can be readily employed in studying this problem. The reliance on child welfare data at this stage of the investigative process is equally disturbing. Entry of data by child welfare workers lacks validity or reliability as well as specificity. Thus, even sophisticated analysis of secondary data is likely working from poor data sources that will not allow exploration of complex associations, let alone cause-effect inferences.[192]

Ultimately, despite the immense research and resources of the family regulation system on parental substance use, the field too often does not even attempt to examine the effects of the alleged maltreatment on the children. As Kroll described it, PSU is the "'elephant in the living room'... lead[ing] to children remaining 'invisible' to those whose role it is to ensure their welfare."[193] Like many family defense attorneys and parent advocates, Kroll emphasizes the need

186. *Families Affected by Parental Substance Use*, *supra* note 182, at e3 Table 1.

187. *See e.g.* Mark Chaffin et al., *Onset Of Physical Abuse And Neglect: Psychiatric, Substance Abuse, And Social Risk Factors From Prospective Community Data*, 20 CHILD ABUSE & NEGECT 191, 193–94 (1996) (internal citations omitted).

188. *Id.*

189. *Id*. at 194.

190. *Id*.

191. Staton-Tindall et al., *supra* note 156, at 23 (internal citations omitted).

192. *Id.* at 23.

193. Kroll, *supra* note 155, at 129.

to expand the focus from just the allegedly harm-causing parent to the well-being of the entire family:

> [b]ecause the focus of intervention is often the elephant, on the basis that, if this can be managed more effectively or removed altogether, this will solve the problem, it is easy to miss anyone lurking in its shadow. To tackle the elephant without exploring what it has left in its wake is to ensure that children of substance misusing parents remain invisible.[194]

Stanton-Tindall's review showed that researchers continue to render the lives of children invisible as the majority of reviewed studies do not even consider the implications of substance use on children—"[b]ecause the phenomenology of addiction-related maltreatment points to children as the 'target,' their systematic exclusion from these investigations and implications is striking and puzzling."[195]

2. Reality: Substance Use is Often Only a Small Part of Parents' Complex Social, Behavioral, and Economic Challenges

While there have been endless issues with imprecise definitions of both substance and abuse, there has been one overwhelming consensus among researchers that parents and attorneys already know: substance use, if any, is rarely the single or dominant cause of challenges the family may be facing. In fact, the family regulation system can become the biggest source of challenges.[196] "From a practice perspective, it is important to recognize that problems with substance abuse rarely occur in isolation."[197] "Neglectful families typically struggle with a toxic, cascading mix of severe economic stress, social marginality, lack of social supports, and long-term family issues, which in concert progressively overtake already fragile parental and family coping systems."[198] "Indeed, no single risk factor (parental substance abuse, child temperament, culture) may be as powerful a predictor of maltreatment as the total accumulation of adversities faced by families."[199]

Although the link between child abuse and neglect and substance use is well-documented, it is not necessarily a direct causal relationship, because a significant

194. *Id.* at 138.

195. Staton-Tindall et al., *supra* note 156, at 24.

196. Trivedi, *supra* note 10, at 550.

197. Ryan & Huang, *supra* note 54, at 307–08.

198. Kemp et al., *supra* note 157, at 54 (citing Berry et al., *supra* note 157; Wilson & Horner, *supra* note 157); *see also* Kemp et al., *supra* note 157, at 54 (summarizing the research of how issues related to social marginality, exclusion, neighborhood, and family and household including poverty, housing, social isolation, personal).

199. Guterman et al., *supra* note 158, at 212 (citing MacKenzie et al., *supra* note 158); Ryan & Huang, *supra* note 54, at 307–8 ("Within the child welfare system, co-occurring mental health, domestic violence, and inadequate housing are frequently documented."); Guterman et al., *supra* note 158, at 212 ("That is, risk of child maltreatment is heightened when placed in the context of other household and neighborhood adversities, including intimate partner violence, parental substance abuse, parental criminal history, and neighborhood disadvantage.") (citing Hartley, *supra* note 158; Herrenkohl et al., *supra* note 158; Tajima, *supra* note 158; Gewirtz & Edleson, *supra* note 158).

portion of adults with SUDs also have concurrent mental illness, including anxiety, depression, and posttraumatic stress disorder. Parents with SUDs often experience financial instability, food and housing insecurity, a chaotic living environment, inconsistent employment, domestic violence, social stigma or isolation, incarceration, and stress. Collectively, these factors all contribute to substance use and child mistreatment. Any single factor, such as prenatal substance exposure, may be less salient to the overall developmental outcome of these children than the cumulative effects of exposure in the context of multiple home environmental and circumstantial risks.

Exemplar studies of PSU reveal this toxic, cascading mix of accumulating adversities. A 1991 study of 414 foster children in three counties in New York, California, and Philadelphia showed that while 83.4% had drug abuse in their family, 75.3% had at least one parent absent, 33.3% had both parents absent, 83.9% had siblings in foster care in review year, 37.4% were homeless or in unstable residency, and 12.9% had domestic violence in their family.[200] A 2006 study of 724 families with substance abuse in Cook County, Illinois, showed that 83% were African American, 56% had less than a high school education, 78% were unemployed, and caseworkers reported that 60% had mental health problems, 81% had housing problems, and 42% had domestic violence problems.[201] Notably, the primary substances used in these families were cocaine (43%), alcohol (25%), and heroin (20%).[202] In a 2018 study of 463 mothers who reported prenatal use of marijuana, the highest predictors of using marijuana were: having 3 or more stressful life events in the 12 months before the baby was born (e.g., hospitalized family member, homelessness), being a single parent, prenatal WIC enrollment, Medicaid health insurance, and annual household income under $20,000—each far more predictive than race and education.[203] A 2018 qualitative study of parents in the California family regulation system further reveals the toxic, cascading mix of accumulating adversities:

> The parents in the sample experienced an array of complex social, behavioral, and economic challenges. In court documents, workers documented parental struggles with substance use, domestic violence, mental illness, and homelessness. While PSU was the focus of this study, the co-occurrence of substance use with one or more other social problems was the rule rather than the exception. Ninety-percent (n = 17)

200. U.S. General Accounting Off., *supra* note 172, at 25 (using upper bounds).

201. Marsh et al., *supra* note 53, at 1080.

202. *Id.*

203. Jean Y. Ko et al., *Marijuana Use During and After Pregnancy and Association of Prenatal Use on Birth Outcomes: A Population-Based Study*, 187 Drug & Alcohol Dependence 73, 75–76 (2018) (where stressful life events include "hospitalized family member, separation/divorce, moved, homeless, partner or respondent lost job, argued with partner more often, partner did not want pregnancy, bills that could not be paid, physical fight, partner or respondent went to jail, someone close had drinking or drug problem, someone close died").

> of cases were co-indicated for substance use and at least one other social problem. These social problems were further compounded by family structure, poverty, and involvement in multiple government systems (e.g., criminal justice). Seventy-nine percent (n = 15) of families in the case records were headed by single-mother households, placing these families at higher risk of poverty and related stressors. Many parents had difficulty meeting basic needs (e.g., securing adequate food or paying rent) and maintaining utility services (e.g., disconnected cellular phone service, unreliable transportation). Two families experienced homelessness during their cases.[204]

As the research above shows, there is one predominant stressor for maltreatment risk: poverty.[205] As explained by Leroy Pelton, "there is overwhelming and remarkably consistent evidence . . . that poverty and low income are strongly related to child abuse and neglect and to the severity of child maltreatment."[206] In 2011, Shook Slack and colleagues reviewed three major longitudinal studies of family wellbeing totaling 2,622 parents: the Fragile Families and Child Wellbeing (for families in large U.S. cities), Healthy Families New York, and Illinois Families Study-Child Wellbeing.[207] Across all three studies, the following factors had no statistically significant effect on whether families were contacted by CPS regarding neglect allegations: severe physical domestic violence, emotional domestic violence, heavy drinking, drug use, spanking, or child low weight at birth. However, families who were contacted by CPS for neglect allegations were statistically significantly more likely to have received public benefits like TANF or Food Stamps, received recent financial assistance from family members, used a food pantry,[208] been unable to see a doctor when a family member was sick,

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204. Henry et al., *supra* note 27, at 72 (internal citations omitted).

205. Guterman et al., *supra* note 158, at 211 ("One of the central stressors identified in maltreatment risk is that of family poverty. . . Studies have found that families reported to child protective service systems are more likely to have single mothers, unemployed fathers, receive public assistance, and/or live in poor neighborhoods.") (citing Claudia J. Coulton et al., *Community Level Factors and Child Maltreatment Rates*, 66 CHILD DEV. 1262 (1995); Claudia J. Coulton et al., *How Neighborhoods Influence Child Maltreatment: A Review of the Literature and Alternative Pathways*, 31 CHILD ABUSE & NEGLECT 1117 (2007); Brett Drake & Shanta Pandey, *Understanding the Relationship Between Neighborhood Poverty and Specific Types of Child Maltreatment*, 20 CHILD ABUSE & NEGLECT 1003 (1996); R. L. Hampton & E. H. Newberger, *Child Abuse Incidence and Reporting by Hospitals: Significance of Severity, Class, and Race.*, 75 AM. J. PUB. HEALTH 56 (1985); Susan J. Zuravin, *The Ecology of Child Abuse and Neglect: Review of the Literature and Presentation of Data*, 4 VIOLENCE VICTIMS 101 (1989)).

206. Leroy H. Pelton, *The Role of Material Factors in Child Abuse and Neglect.*, *in* PROTECTING CHILDREN FROM ABUSE AND NEGLECT: FOUNDATIONS FOR A NEW NATIONAL STRATEGY 131, 166–67 (Gary B. Melton & Frank D. Barry eds., 1994).

207. *See generally* Kristen Shook Slack et al., *Risk and Protective Factors for Child Neglect During Early Childhood: A Cross-Study Comparison*, 33 CHILD. & YOUTH SERV. REV. 1354 (2011).

208. *Id.* at 1359 ("Two findings—that receiving financial assistance from family members and receiving food from a food pantry are associated with increased neglect—may, at first, seem counterintuitive if these behaviors are interpreted as evidence that a family has social support or a

difficulty paying rent, lived in their current residence for less than one year, a utility shut-off, cut the size or frequency of their meals due to economic hardship, child health problems, parental depression, parental health problems, a lack of involvement in focal child's activities, and parenting stress.[209] As the authors summarized, even when controlling for demographics, "the most consistent findings on the predictors of child neglect across the three studies relate to the role of economic hardship."[210]

But there are two important caveats with this correlation between poverty and maltreatment. First, the vast majority of families in poverty do not maltreat their children. The NIS-4 reported the incidence rate for harm from neglect and abuse in the U.S. at 2.25% for children in low socio-economic status (SES) families and 0.44% for children not in low SES families.[211] But this difference largely stems from significant differences in incidence of neglect (1.61% for low SES children versus 0.22% for not low SES children) as compared to abuse (0.77% versus 0.25%).

Second, one must be careful when using any statistics to infer causation between poverty and maltreatment.

> The relation between poverty and child abuse and neglect is a fact, but in itself does not establish causation. . . . [Various] factors undermine one's ability to cope with poverty and its stressors, which include its various material hardships. Moreover, the stressors of poverty environments, if not reduced through material supports, can engender dysfunctional modes of coping, such as alcohol and drug abuse, that can destroy parental competence.
>
> [Thus] the probability of child abuse and neglect may be *indirectly* related to material hardship, through the stresses on parents that such hardship may generate. However, the probability of child abuse and neglect is also *directly* related to material hardship, being largely dependent upon the extent of the dangerousness and inadequacy of the material conditions of one's environment. That is, to the extent that people's environments and living conditions are made less dangerous,

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willingness to ask for help (both of which suggest protective capacities). However, they also may reflect that families resort to these forms of assistance only when economic stressors reach a heightened level. It is possible that they may serve as 'red flags' that a family is struggling to get by.").

209. Considering variables to be statistically significant at $p < .05$. *Id.* at 1358.

210. *Id.* at 1362 (summarizing the research literature) (internal citations omitted).

211. SEDLAK ET AL., *supra* note 22, at 5–12. Where "if they were in the bottom tier on any indicator: household income was below $15,000 a year, parents' highest education level was less than high school, or any household member participated in a poverty-related program." *Id.* at 5–10. In 1993, the incidence rate for harm from abuse and neglect in the U.S. was 4.7% for children with family incomes less than $15,000 per year, 2% for children with family incomes between $15,000-29,000 per year, and 0.2% for children with family incomes over $30,000. SEDLAK & BROADHURST, *supra* note 110, at 5–3.

> the quality of care that parents with the least ability to cope with poverty are capable of giving – although the same as before – will be less inadequate.[212]

Additionally, while poverty certainly increases the stressors likely contributing to maltreatment, families in poverty—especially those who are immigrants or people of color—are surveilled and targeted in ways that others are not.[213] This is made obvious by the comparisons between the incidence rates among and between low-SES families and non-low-SES families. Low SES children are less than half as likely to have incidents of abuse (0.77%) as compared to neglect (1.61%) but somehow non-low SES children are *more* likely to have incidents of abuse (0.25%) than neglect (0.22%).[214] Among low SES children sexual abuse has the lowest incidence rate (0.17%) among any category: physical abuse (0.44%), emotional abuse (0.26%), physical neglect (0.69%), emotional neglect (0.38%), or educational neglect (0.71%).[215] But among non-low SES children, the incidence rate of sexual abuse (0.06%) is higher than emotional abuse (0.05%) and nearly as high as physical neglect (0.08%) and emotional neglect (0.08%).[216] Moreover, the highest incidence rate for neglect and abuse was educational neglect among low SES families (0.71%), seven times higher than educational neglect among non-low SES families (0.10%) and nearly double the incidence rate for all maltreatment among non-low SES families.[217]

These disparities and seeming contradictions are unsurprising in a system where the two most common sources reporting maltreatment are schools (38% of reports) and law enforcement (19%).[218] It is those families who are most likely to

212. Leroy H. Pelton, *The Continuing Role of Material Factors in Child Maltreatment and Placement*, 41 CHILD ABUSE & NEGLECT 30, 31 (2015). For more regarding the importance of material support to address child maltreatment, *see infra* Section III.D.4.

213. *See, e.g.*, Virginia Eubanks, *Want to Predict the Future of Surveillance? Ask Poor Communities.*, AM. PROSPECT (Jan. 15, 2014), https://prospect.org/power/want-predict-future-surveillance-ask-poor-communities./ ("A decade ago, I sat talking to a young mother on welfare about her experiences with technology. When our conversation turned to Electronic Benefit Transfer cards (EBT), Dorothy said, 'They're great. Except [Social Services] uses them as a tracking device.' I must have looked shocked, because she explained that her caseworker routinely looked at her EBT purchase records. Poor women are the test subjects for surveillance technology, Dorothy told me ruefully, and you should pay attention to what happens to us. You're next. Poor and working-class Americans already live in the surveillance future. The revelations that are so scandalous to the middle-class data profiling, PRISM, tapped cellphones–are old news to millions of low-income Americans, immigrants, and communities of color."); *see also generally*, VIRGINIA EUBANKS, AUTOMATING INEQUALITY: HOW HIGH-TECH TOOLS PROFILE, POLICE, AND PUNISH THE POOR (2018); Mark F. Testa & Brenda Smith, *Prevention and Drug Treatment*, 19 FUTURE OF CHILD. 147 (2009) (describing discriminatory surveillance practices); Anna Arons, *Jenny Mollen, Jason Biggs, and How Race and Class Shape the Aftermath of Childhood Accidents*, PASTE (May 3, 2019), https://www.pastemagazine.com/politics/child-welfare/jenny-mollen-shows-how-race-and-class-shape-the-af/.

214. SEDLAK ET AL., *supra* note 22, at 5–12.

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.* at 7–10.

interact with punitive-oriented schools and law enforcement that are most likely to be investigated. Moreover, additional reporters including public health, mental health agencies, social service agencies, shelters, public housing, welfare departments, and juvenile probation are responsible for another 14% of the reports—in total, 71% of all reports.[219] So children in non-low SES families, the neglect is likely not seen, not reported, or not investigated until it rises to the level of abuse—and even then, explained away as accidents or acceptably different styles of parenting.[220] Alternatively, for children in low SES families, their parents are in constant contact with mandated reporters, or caseworkers and judges, who may be from different communities who do not understand or who are not willing to give certain types of parents the benefit of the doubt.[221]

Ultimately, this toxic, cascading mix of accumulating adversities, often for people of color and families in poverty, "decreases the likelihood of achieving family reunification."[222] Translation: reunification is nearly impossible. As a study of 724 Illinois families showed, if the problem is substance abuse only, then the likelihood of reunification was 21% (still a shockingly low number) but once any other single problem area (such as domestic violence, mental health or housing issue) co-occurs, the reunification rate cuts in half to 11-12%.[223] In this study, caseworkers were asked to record a progress code for parents ranging from unsatisfactory, reasonable, substantial, and complete. The results showed that parents who make reasonable progress will not meaningfully increase the odds of reunification. Only 9% of parents who made reasonable progress with substance abuse problems were reunified, 10% for domestic violence, 12% for housing, and 8% for mental health.[224] For the family regulation system, making substantial progress in the face challenges in areas like mental health, housing, and substance abuse is insufficient for reunification; reunification requires perfection – and sometimes that is not even enough. Complete progress in the alleged problem

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219. *Id.*

220. *See* Arons, *supra* note 213.

221. *Id.*

222. Ryan & Huang, *supra* note 54, at 307–08 (citing Laudan Y. Aron & Krista K. Olson, *Efforts By Child Welfare Agencies to Address Domestic Violence: The Experiences of Five Communities*, URB. INST. (1997); Deborah Hoffman & Robert Rosenheck, *Homeless Mothers with Severe Mental Illnesses and Their Children: Predictors of Family Reunification*, 25 PSYCHIATRIC REHAB. J. 163 (2001); Loring Jones, *The Social and Family Correlates of Successful Reunification of Children in Foster Care*, 20 CHILD. & YOUTH SERV. REV. 305 (1998); John Landsverk et al., *Impact of Child Psychosocial Functioning On Reunification From Out-Of-Home Placement*, 18 CHILD. & YOUTH SERV. REV. 447 (1996); Marsh et al., *supra* note 53; Rae R. Newton et al., *Children and Youth in Foster Care: Disentangling the Relationship Between Problem Behaviors and Number of Placements*, 24 CHILD ABUSE & NEGECT 1363 (2000); Jung Min Park et al., *Child Welfare Involvement Among Children in Homeless Families*, 83 CHILD WELFARE 423 (2004); Peg McCartt Hess et al., *Effectiveness of Family Reunification Services: An Innovative Evaluative Model*, 37 SOC. WORK 304 (1992)).

223. Marsh et al., *supra* note 53, at 1081.

224. *Id.* at 1082 Table 4.

areas of substance abuse, domestic violence, housing, and mental health only resulted in reunification in 26%, 25%, 31%, and 42% of cases.[225]

The reality is that substance abuse rarely occurs in isolation (representing only 8% of parents in the Illinois study above).[226] The typical parent targeted by the family regulation system is living in a toxic, cascading mix of accumulating adversities with little chance to achieve reunification once they have been targeted no matter the amount of "progress" they achieve.

D. Myth: Compulsory Treatment and Abstinence are the Only Ways to Be a Fit Parent and Protect Children

The default response of the family regulation system for a parent accused of substance use is to require substance use treatment and abstinence. Any failure to complete treatment or failed drug tests is considered a failure to comply, further threatening family reunification. This section shows that this approach is completely divorced from reality and only serves to ensure families are never reunified. First, substance use disorders are chronic illnesses, often co-occurring with mental disorders, where no cure exists, and relapse is normal. Second, there is no clear evidence that the family regulation system's general services help resolve parents' substance use challenges. There are methodological flaws with our current research and what evidence does exist shows that the family regulation system is not currently designed to address the toxic, intractable problems that families face. Third, compulsory treatment or services are unlikely to help families and coercive, court-ordered programs may actively harm families. Lastly, to strengthen families and protect children, parents need material support: money, housing, employment, etc. The federal government recognizes this and research shows that material support is a precondition for improving family safety, permanency, and well-being—especially for families with substance use challenges.

1. Reality: Substance Use Disorders are Chronic Illnesses, Often Co-Occurring with Mental Disorders, Where No Cure Exists and Relapse is Normal

Substance use disorders should be understood as chronic illnesses, not as acute care issues.[227] As stated by the American College of Obstetricians and Gynecologists, "[a]ddiction is a chronic, relapsing biological and behavioral disorder with genetic components."[228] "There is no reliable cure for drug dependence"[229] just as there is no cure for chronic illnesses like diabetes, hypertension, or asthma, which means relapse is normal and patients need continuing care. When doctors observe relapse after temporary treatment, they view it as evidence

225. *Id.*

226. *Id.* at 1081 Table 2.

227. A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness*, 284 JAMA 1689, 1694 (2000) [hereinafter *Drug Dependence*].

228. *Committee Opinion No. 722: Marijuana Use During Pregnancy and Lactation*, 130 OBSTET. GYNECOL. e205, e207 (2017) [hereinafter *Marijuana Use During Pregnancy and Lactation*].

229. *Drug Dependence*, *supra* note 227, at 1693.

of the success of those treatments and the need for continuing care to achieve progress.[230] But when courts order, deliver, and evaluate treatments for substance use disorders, they perceive any relapse as a failure of the person, a lack of motivation, a justification for more punishment.

As an example of this misguided perspective, most substance abuse treatment is delivered in an acute manner, receiving detoxification only, or maybe even through specialty treatment but with no continuing care. These treatment centers believe that their goal is to "rehabilitate and discharge [people in need of substance use treatment] as one might rehabilitate a surgical patient following a joint replacement. Outcome evaluations are typically conducted 6 to 12 months following treatment discharge . . . evaluating whether the patient has been continuously abstinent after leaving treatment."[231] As a result of this lack of structured support, for even the best treatment centers and programs, only about 40% to 60% of patients are continuously abstinent at the one-year mark.[232]

Relapse rates for people with substance use challenges should not be viewed in isolation—in fact, they are nearly identical to patients with chronic illnesses like hypertension, diabetes, and asthma. Less than 60% of patients with Type I diabetes fully adhere with their medication schedule and for hypertension or asthma, the rate of adherence is less than 40%.[233] Ultimately, approximately 30% to 50% of adults with Type I diabetes and 50% to 70% of adults with hypertension or asthma "experience recurrence of symptoms each year to the point where they require additional medical care to reestablish symptom remission."[234] Or should we call these people "failures," too?

Parents who have substance use disorders and want to stop or abstain from use (often called remission), as discussed above in Section I.C.2, face incredible barriers. Unsurprisingly, for both substance use disorders and other chronic illnesses, the highest rates of the illness and relapse are consistently among those facing low socioeconomic status, comorbid psychiatric conditions, and a lack of family and social supports.[235] Barati and her colleagues conducted a systematic review exploring how intrapersonal, interpersonal, organizational, environmental, and community, all contribute to the likelihood that someone will relapse and return to substance use.[236] At the core are the (1) intrapersonal factors, including unpleasant emotions (including mental strain, depression, stress, despair, and

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230. *Id.* at 1694 ("In this regard, it is interesting that relapse among patients with diabetes, hypertension, and asthma following cessation of treatment has been considered evidence of the effectiveness of those treatments and the need to retain patients in medical monitoring. In contrast, relapse to drug or alcohol use following discharge from addiction treatment has been considered evidence of treatment failure.").

231. *Id.*

232. *Id.* at 1693 (internal citations omitted).

233. *Id.* (internal citations omitted).

234. *Id.* (internal citations omitted).

235. *Id.* (internal citations omitted).

236. Majid Barati et al., *An Ecological Approach to Exploring Factors Affecting Substance Use Relapse: A Systematic Review*, 31 J. PUB. HEALTH 135, 135 (2021).

anxiety), unemployment, temptation, low economic status and poverty, and low educational level.[237] Next, (2) the interpersonal factors (like being rejected by families or family disputes, violent situations, and addicted friends).[238] Then, (3) organizational factors (including the inefficiency of therapeutic services and poor follow-up after a relapse).[239] Next, (4) an unhealthy environment, such as easy access to substances and the prevalence of people using substances, can undermine remission.[240] Lastly, (5) community factors, such as being rejected or criticized as an addict and not being welcomed back into the community.[241]

Women facing substance use challenges are well aware of these intersectional barriers and when interviewed "described their personal experiences and observations of the influence of drugs in their lives and in so doing articulated the multidimensional, systemic nature of substance use and abuse in impoverished neighborhoods and the impact of larger structural forces within local communities, neighborhoods, families, and individuals."[242] With these factors contributing to relapse, there is no question that the family regulation system is a unique barrier all its own, further contributing to relapse with its ever-present surveillance and punishment causing stress and fear of losing one's children.

One particular barrier to addressing SUD is that mental disorders are extremely common among those with SUDs. As stated by the U.S. Substance Abuse and Mental Health Services Administration, "[p]eople with SUDs are more likely than those without SUDs to have co-occurring mental disorders . . . Addiction counselors encounter clients with [co-occurring disorders] as a rule, not an exception."[243] This co-occurrence creates an additional barrier as SUD and mental disorders are "highly comorbid . . . and associated with low rates of treatment engagement, retention, and completion"[244] and "an elevated risk for self-harm, especially if they have a history of trauma."[245] The problem is that "[s]erious gaps exist between the treatment and service needs of people with [co-occurring disorders like SUD and mental disorders] and the actual care they receive."[246] If the family regulation system is truly dedicated to helping families, then it cannot fail to understand and address the co-occurring diagnoses of SUD and mental disorders.

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237. *Id.* at 137.
238. *Id.* at 138.
239. *Id.* at 138.
240. *Id.* at 138.
241. *Id.* at 145.
242. Kuo et al., *supra* note 65, at 110.
243. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., *supra* note 96, at ix ("Mental disorders likely to co-occur with addiction include depressive disorders, bipolar I disorder, posttraumatic stress disorder (PTSD), personality disorders (PDs), anxiety disorders, schizophrenia and other psychotic disorders, ADHD, and eating and feeding disorders.").
244. *Id.* at x.
245. *Id.*
246. *Id.* at ix.

Even with all these barriers, once again, the through line of need for material supports (discussed thoroughly in Section I.D.4) such as housing and employment are some of the few factors that consistently predict whether someone successfully stops using substances or relapses. A study of substance abusers with severe mental illness in urban settings found that 48% relapsed within the first year.[247] The strongest factors predicting who did not relapse were participation in a residential treatment program, age (being older), and holding a job.[248] The authors explain that one of the critical values of the residential treatment program was housing, which is too often lacking for those with substance abuse. Similarly, employment can provide meaningful daily activity, helping to avoid relapse.

A separate study in a predominantly rural state with relatively low availability of illicit drugs and little racial diversity showed that a majority of the relapses occurred within the first year after attaining remission.[249] Cumulatively, 31% relapsed within the first year, 47% by the second year, 56% by the third year, and by the end of the study in year nine, 86% had relapsed.[250] The independently statistically significant predictors of relapse were gender (men), education (having less than a high-school education), housing status (living independently), and employment (unemployed).[251] The study explains that independent living is particularly difficult even for those who achieved full remission from substance abuse. Why? Because the people in the study were "forced by poverty and housing policies to live in high-risk neighborhoods, where they remain extremely vulnerable to substance abuse and other endemic problems."[252] The housing and substance abuse treatment becomes a vicious cycle: if someone is not motivated enough at first, or despite their best efforts relapse or otherwise falter, they are often expelled from critical support systems like housing, treatment, child care, and employment that give them the best chance to avoid relapse or restart their sobriety.[253]

2. Reality: There is No Clear Evidence that the General Services at Large in the Family Regulation System Help Resolve Parents' Substance Use Challenges

There is no clear evidence that services work in general, and there is great skepticism that services can solve the intractable problems shown above in Sections I.C.2 and I.D.1. This section begins with the issue that most of the research on the effectiveness of services for families is littered with so many

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247. Angela L. Rollins et al., *Substance Abuse Relapse and Factors Associated With Relapse in an Inner-City Sample of Patients With Dual Diagnoses*, 56 PSYCHIATRIC SERV. 1274, 1277 Table 1 (2005).

248. *Id.* at 1280.

249. Haiyi Xie et al., *Substance Abuse Relapse in a Ten-Year Prospective Follow-Up of Clients with Mental and Substance Use Disorders*, 56 PSYCHIATRIC SERV. 1282, 1285–86 (2005).

250. *Id.* at 1284 Figure 1.

251. *Id.* at 1285.

252. *Id.* at 1286.

253. *Id.*

methodological flaws as to make most conclusions impossible. What evidence is available shows that "[m]any child welfare service plans are generic, one-size-fits-all, and behaviorally-focused: inadequate, in other words, as responses to the complex needs of child welfare-involved families."[254]

a. Methodological Flaws in Research on the Effectiveness of Services Undermine Any Ability to Know What Works for Families

Currently, there is little clear description of variations in services and their outcomes. For instance, parents are referred to many different parent training programs. Are they all equally effective? Are any effective? Are certain types of parent training better for certain types of parenting problems? At present, there is little clear information about what services are offered to what effect. [255]

The methodological flaws in the research undermine almost any ability to know what works. First, "[v]ery few studies have had the resources and wisdom to measure improvements in family functioning beyond the prevention of placement and re-abuse. [R]at[ing] family well-being . . . and detect[ing] change[s] in families . . . are daunting tasks in a clinical setting, much less in the world of highly stressed families . . ."[256] In addition, "there is considerable lack of precision in the literature. Reviews often clump disparate interventions together, making it difficult to determine which programs are most effective (and how), and potentially washing out within-group differences.[257]

Researchers too have some responsibility for the patchiness in the knowledge of what works, in that they tend to measure what is easily measurable rather than what we really want or need to know. They choose qualitative methods because these are generally less challenging to implement than rigorous quantitative designs, rather than because the issues lend themselves best to qualitative methods. They sample parents, rather than children, because children are harder to reach. They sample mothers because fathers are harder to reach, and they use either pre-existing tools that may not always fit the purposes fully or untested new instruments rather than invest time and money in developing reliable and valid tools. The situation is further compounded by the bias against publishing results that are negative or inconclusive . . . despite the valuable messages that can be learned from "failures" as well as successes.[258]

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254. Kemp et al., *supra* note 157, at 56–57 (citing JILL DUERR BERRICK, TAKE ME HOME: PROTECTING AMERICA'S VULNERABLE CHILDREN AND FAMILIES (2009)).

255. Aron Shlonsky & Eileen Gambrill, *Risk Assessment*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 253, 260 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

256. Marianne Berry & Sara McLean, *Family Preservation*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 270, 280 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014).

257. Kemp et al., *supra* note 157, at 62–63.

258. Patricia Moran & Deborah Ghate, *The Effectiveness of Parenting Support*, 19 CHILD. & SOC'Y 329, 331 (2005) (internal citations omitted).

This problem is best evidenced by Klevens and Whittaker's review of 140 publications spanning three decades of research on 188 primary prevention programs for child maltreatment, which found two major gaps: lack of rigorous evaluation and a lack of focus on neglect.[259] First, only about a quarter of the studies (23.4%) involved a controlled trial and a majority (51.1%) had no evaluation at all.[260] In addition, a majority of programs that did evaluate effects did not measure the effect on child maltreatment directly (57.9%), instead measuring hypothesized "risk factors" for child maltreatment. "Although it is important to measure those mediators, it is equally important to measure final outcomes such as child maltreatment and other related health outcomes until the link between risk factors and outcomes is known with greater certainty."[261] Second, "only three programs [1.6%] specifically targeted neglect, the most common form of child maltreatment . . . Even among programs that purported to address physical abuse and neglect, the elements that specifically addressed neglect were unclear."[262]

b. The Current Services Available Through the Family Regulation System are Not Designed to Address the Toxic, Intractable Problems That Families Face

In addition to these deep methodological deficiencies, it is also generally accepted that family regulation system services have difficulties solving toxic, intractable problems shown above in Section I.C.2. As Kemp and her colleagues summarize:

> Although the gold standard for efficacy in child welfare services focuses on key child welfare outcomes—safety, stability, permanency—it can be challenging to produce changes in these domains with family support interventions, particularly where families are experiencing multiple personal, social, and economic challenges. Indeed, reviews of supportive interventions suggest that in general their ability to prevent new or repeat maltreatment is limited . . . [R]ealistically, gains from . . . remedial supports now available are likely to be fragile, particularly given the rapidly compounding social and economic risks currently facing vulnerable families and children.[263]

Almost too obvious to point out, these toxic structural environments that many families targeted by the family regulation system live in are "clearly not the

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259. Joanne Klevens & Daniel J. Whitaker, *Primary Prevention of Child Physical Abuse and Neglect: Gaps and Promising Directions*, 12 CHILD MALTREATMENT 364, 370 (2007).

260. *Id.* at 366 Table 1."Thus, the effectiveness of a majority of primary prevention programs for child maltreatment is still unknown."*Id.* at 370.

261. *Id*.

262. *Id.* (internal citations omitted).

263. Kemp et al., *supra* note 157, at 62–63 (internal citations omitted).

optimal one for learning."[264] "[C]onsiderable evidence has shown that outside stressors hamper learning and implementing the lessons from parent training programs."[265] One review of the literature stated that "[p]roblems of low socioeconomic status, comorbid psychiatric conditions, and lack of family and social supports are among the most important predictors of poor adherence during addiction treatment and of relapse following treatment."[266] For example, the most popular methods of short-term services of eight weeks or six months are only "very effective when the problems are of an acute nature and center on parenting practices or interactions between family members." [267] However, "most of the families served by the family regulation system for child maltreatment are also besieged by more intractable problems, including poverty, unemployment, low education, mental illness, and substance abuse. These conditions are not easily solved by learning new behavior patterns within eight weeks—or even six months."[268]

Requiring parents to complete these ineffective services amounts to "wishful thinking,"[269] increasing "risk to children by losing opportunities to alter factors related to child maltreatment."[270] Ultimately,

> Given the proven ineffectiveness of family preservation models with parental drug addiction and homelessness, it is necessary to rethink the approach to these families when maltreatment is the presenting issue. Short-term solutions have not been shown to be effective, regardless of the intensity. Problems of addiction, mental illness, and poverty are chronic conditions, not maladaptive behavior patterns easily overcome by learning new behavior responses to stress. The child welfare system continues to be challenged to develop new responses to these problems that will not result in the wholesale removal of children . . .[271]

3. Reality: There is No Clear Evidence that Compulsory Treatment or Family Regulation System Services Can Resolve Substance Use Challenges

The default court-ordered requirement for parents accused of substance use is substance misuse treatment programs (hereinafter referred to as "treatment").

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264. Richard P. Barth, *Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities*, 19 FUTURE CHILD. 95, 112 (2009).

265. *Id.*

266. *Drug Dependence*, *supra* note 227, at 1693.

267. Berry & McLean, *supra* note 256, at 281.

268. *Id.*

269. Shlonsky & Gambrill, *supra* note 255, at 260 ("Providing services without carefully evaluating their impact opens the door to 'wishful thinking' that services will be successful when indeed there may be no progress or effects are in fact harmful, ultimately increasing rather than decreasing risk.").

270. *Id.*

271. Berry & McLean, *supra* note 256, at 284.

However, there is no clear evidence that compelled treatment reduces substance use. In brief, "much of the research on compulsory treatment programs is of such methodologically poor quality as to make inferences about the . . . efficacy of coerced treatment problematic."[272]

There is increasing acceptance that successful treatment outcomes are influenced by factors such as the objective aspects of who or what is compelling the participant to get treatment, the subjective perceptions of the participant about their treatment, and the level of engagement, retention, and follow-up.[273] Of 71 different studies reviewed by Wild, Roberts, and Cooper, the only two which attempted to account for these factors showed that while "legal coercion . . . may facilitate retention, it may undermine client involvement in the process of behavior change."[274]

This finding has been affirmed by more recent literature reviews showing that a "majority of studies (78%) evaluating compulsory treatment" of any type, from inpatient abstinence-based therapy to outpatient group therapy, "failed to detect any significant positive impacts on drug use or criminal recidivism over other [voluntary] approaches, with two studies detecting negative impacts (22%)."[275] One of the offered reasons for the suboptimal treatment outcomes is that "ongoing interactions with law enforcement and the threat of detainment within compulsory drug detention centers may cause drug-dependent individuals to avoid harm reduction services or engage in risky drug-using behaviors out of a fear of being targeted by police."[276]

But it is not only that substance abuse programs may not help parents—these coercive, court-ordered programs may actively harm families. There is also evidence demonstrating that parents receiving substance abuse treatment have a higher likelihood of being reported for child maltreatment and a decreased quality of child developmental well-being.[277] The research suggests this could be due to the inability of services to meet client needs or the addition of mandated reporters (the substance abuse treatment provider) in parents' lives. However, there is also the issue that participating in substance abuse treatment demands immense resources from families who are often resource-poor. It takes time and money to

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272. T. Cameron Wild, *Compulsory Substance-User Treatment and Harm Reduction: A Critical Analysis*, 34 SUBSTANCE USE & MISUSE 83, 92 (1999); T. Cameron Wild et al., *Compulsory Substance Abuse Treatment: An Overview of Recent Findings and Issues*, 8 EUR. ADDICTION RES. 84, 90 (2002) [hereinafter *Compulsory Substance Abuse Treatment*].

273. J. H. Littell, *Client Participation and Outcomes of Intensive Family Preservation Services*, 25 SOC. WORK RSCH. 103, 111–12 (2001) (finding that outcomes of family preservation services (FPS) varied by the level of client participation such that even when treatment is mandated, active participants are likely to be different from passive or resistant recipients).

274. *Compulsory Substance Abuse Treatment*, *supra* note 272, at 90.

275. D. Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 INT'L J. DRUG POL' Y 1, 7 (2016).

276. *Id.*

277. Shenyang Guo et al., *Propensity Score Matching Strategies for Evaluating Substance Abuse Services for Child Welfare Clients*, 28 CHILD. & YOUTH SERV. REV. 357, 379 (2006).

commute to the treatment center or drug testing, and energy to coordinate care for the child or children, all potentially conflicting with work and school schedules that provide the fragile resources for the family to maintain its standard of living.[278]

4. Reality: To Strengthen Families and Protect Children, Parents Need Material Support

"At the core of successful family reunification practice is a belief in the essential bonds of the family, in the family's ability to make change, and in the importance of focusing on a family's strengths to achieve (and maintain) reunification and the commitment to providing the services and supports each family and child needs."[279] In the service of this purported goal, family regulation systems have three main options:

> One, provide [financial] assistance to the parents that would allow the children to remain with their families. Two, remove the children and place them into more expensive substitute care, either by alleging specific harm to the children or by attributing the lack of resources to the failings of the parents. Three, do nothing and allow children to suffer harm such as malnutrition and homelessness.[280]

The family regulation system cannot do nothing. But rather than provide financial assistance to families, the family regulation system decides that they ought to remove children resulting in "the unnecessary and prolonged out-of-home care of . . . children for 'reasons of poverty.'"[281] This section shows that common sense is confirmed by overwhelming scientific research: material support (also known as "concrete" support) which addresses problems of poverty through assistance with finances, childcare, education, housing, and employment,[282] should be the first and highest prioritized support for families–even those with alleged substance abuse issues. For too long, minority and low-income children have been "poorly served by the child welfare system" —the "economic

278. Elizabeth Flock & Ashley Remkus, *How Court-Ordered Drug Testing Poses Impossible Choices*, PBS NEWSHOUR (Dec. 8, 2020), https://www.pbs.org/newshour/nation/how-court-ordered-drug-testing-poses-impossible-choices.

279. Barbara A. Pine et al., *Reunification*, *in* CHILD WELFARE FOR THE TWENTY-FIRST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 339, 352 (Gerald P. Mallon & Peg McCartt Hess eds., 2d ed. 2014) (quoting J. Zamosky et al., *Believing in families*, *in* TOGETHER AGAIN: FAMILY REUNIFICATION IN FOSTER CARE 155, 174 (Barbara A. Pine, Robin Warsh, & Anthony N. Maluccio eds., 1993)) (internal quotations omitted).

280. Mary Keegan Eamon & Sandra Kopels, *'For Reasons of Poverty': Court Challenges to Child Welfare Practices and Mandated Programs*, 26 CHILD. & YOUTH SERV. REV. 821, 834 (2004) (summarizing Daan Braveman & Sarah Ramsey, *When Welfare Ends: Removing Children from the Home for Poverty Alone*, 70 TEMP. L. REV. 447, 469 (1997)).

281. *Id.* ("Child welfare advocates, lawyers, policy makers, and researchers must identify and advocate for cost-effective, humane methods to provide parents with the financial assistance.").

282. Jones, *supra* note 222, at 321–22.

dimension" can no longer be "considered beyond the purview of child protective services."[283]

a. The Federal Government Identifies Material Support as Critical for Families Involved in the Family Regulation System

Material support has been identified by the U.S. Department of Health and Human Services (HHS) as one of the key five areas of focus for families to be healthy, safe, and loving alongside nurturing and attachment, knowledge of parenting and of child and youth development, parental resilience, and social connections.[284] As HHS explains, "[c]aregivers with access to financial, housing, and other [material] resources and services that help them meet their basic needs can better attend to their role as parents."[285] HHS explains further that:

> Many factors affect a family's ability to care for their children. Families who can meet their own basic needs for food, clothing, housing, and transportation—and who know how to access essential services such as child care, health care, and mental health services to address family-specific needs—are better able to ensure their children's safety and well-being . . . . When parents do not have steady financial resources, lack health insurance, or suffer a family crisis such as a natural disaster or the incarceration of a parent, their ability to care for their children may be at risk. Financial insecurity is associated with greater rates of child abuse and neglect, and families living in poverty often benefit from specific concrete supports, such as help with housing, food, transportation, child care, clothing, furniture, and utilities . . . . Offering concrete supports may also help prevent the unintended neglect that sometimes occurs when parents are unable to provide for their children.[286]

As HHS explains, material support is not only a standalone need, but underlies the other four areas of nurturing and attachment, knowledge of parenting, parental resilience, and social connections.[287] For example, material support often determines the ability of a parent to be resilient, to cope "with the stresses of everyday life, as well as an occasional crisis . . . [and] have the flexibility and inner strength necessary to bounce back when things are not going well."[288]

283. *Id.*

284. U.S. DEP'T HEALTH & HUM. SERVS.' CHILDREN'S BUREAU, OFF. ON CHILD ABUSE AND NEGLECT, *Strengthening Families and Communities: 2011 Resource Guide*, 20 (2011) (report refers to "concrete" support which is identical to "material" support for the purposes of this Article).

285. *Id.*

286. *Id.* at 34.

287. *Id.* at 28.

288. *Id.*

However, "life stressors, such as a family history of abuse[,] . . . physical and mental health problems, marital conflict, substance abuse, and domestic or community violence—and financial stressors[,]. . . homelessness—may reduce a parent's capacity to cope . . . with the typical day-to-day stresses of raising children."[289]

Most of the methods that HHS highlights for building resilience are actually methods of identifying and utilizing material supports. HHS states that parents should (1) learn "[h]ow to handle major stressors, including accessing resources and supports from family, friends, faith communities, and other community resources;"[290] (2) identify and access "[p]rograms that offer family-to-family help or mentoring for personalized, intensive, sustained services or support, especially in times of crisis;"[291] and (3) utilize "mental health and counseling services, substance abuse treatment, domestic violence programs, and self-help support groups."[292] But what is the cause and solution to most family's stressors and crises? How does a family receive personalized, intensive, and sustained services for mental health and counseling, substance abuse treatment, or domestic violence? One word: money.

b. Material Support is a Precondition for Improving Family Safety, Permanency, and Well-Being

That money is the key problem for families is not a novel conclusion as research has repeatedly shown that material support is best understood as a precondition for parental engagement in services. "Parental engagement in services is a key proximal outcome in child welfare practice, a necessary element in efforts to better integrate evidence-based practices from child mental health and other areas into child welfare services, and a fundamental contributor to all three child welfare goals—safety, permanency, and well-being."[293] But before one can get to the parent engagement where services attempt to teach parents strategies, conferences with parents, and complete case work, certain preconditions must be met, including financial stressors and poverty-related stress.[294] Material support meets these preconditions because they address "basic needs."[295] "[U]ntil basic survival needs are addressed, parents may be unable to engage effectively with services targeted to other family issues."[296] "A major consensus of the reported findings is

289. *Id.*; *see also* Felitti et al., *supra* note 179; MacKenzie et al., *supra* note 158.

290. U.S. DEP'T HEALTH & HUM. SERVS.' CHILDREN'S BUREAU, OFF. ON CHILD ABUSE AND NEGLECT, *supra* note 284, at 30.

291. *Id.*

292. *Id.*

293. Susan P. Kemp et al., *Engaging Parents in Child Welfare Services: Bridging Family Needs and Child Welfare Mandates*, 88 CHILD WELFARE 101, 120 (2009) [hereinafter *Engaging Parents*].

294. *Id.* at 110 (finding that other preconditions include addressing separation and loss, addictions/mental health, social isolation, status (including stigma and marginality), cultural barriers, and negative service experiences).

295. Kemp et al., *supra* note 157, at 62–63.

296. *Id.* at 63.

that social and family factors have important implications for children and families in need of services . . . If ecological factors are major correlates of abuse [(and they are)], fewer parenting classes would be needed, and more material support would be appropriate." [297] As summarized by Kemp and her colleagues:

> Responding to parents' immediate, practical needs is central to successful engagement. In a study of therapeutic foster care, parents reported that their participation would have been enhanced by assistance with transportation and appointment scheduling that was more responsive to their life circumstances. [Other researchers] likewise found that the participation of African American families in family protective services (FPS) was enhanced by the provision of a wide array of concrete services. Prompt, reliable attention to practical needs is important not only on its own terms but also as a gateway to engagement with workers and other services, since parents who receive help with immediate and worrying needs are likely to be more hopeful and less distrustful.[298]

More specifically, material support has been shown to reduce incidents of maltreatment. A study of Illinois families with inadequate food, clothing, or shelter, compared those families receiving cash assistance against those receiving no cash assistance. First, they found that those who received cash assistance were less likely to have a child placed in substitute care within the 15-month period (26.7% vs. 39.2%).[299] Second, among those children placed into substitute care who received a "return home" permanency goal, 60% of the children from families receiving cash assistance returned home within the 15-month period as compared to only 23% of the children from families not receiving cash assistance.[300] Third, children whose families received cash assistance spent less time on average in substitute care (306 days vs. 403 days).[301] In sum, "families who receive . . . cash services enter substitute care less often, and also stay for shorter durations once in care."[302] This resulted in significant cost savings estimated at approximately $1,798 per family.[303]

Similarly, a statewide study of 1,601 moderate and high-risk families in Oklahoma with no initial involvement in child protective services showed that for these families, the "simple provision of basic concrete needs [(i.e., material support)] seemed to perform as well, or better than, many of the more involved and typical [family perseveration and family support] parenting approaches, including

297. Jones, *supra* note 222, at 321–22.

298. *Engaging Parents*, *supra* note 293, at 112 (internal citations omitted).

299. Kristen Shook & Mark Testa, Cost-Savings Evaluation of the Norman Program: Final Report to the Department of Children and Family Services 2 (1997).

300. *Id.* at 3.

301. *Id.* at 6.

302. *Id.* at 5.

303. *Id.* at 6.

in-home services" in preventing maltreatment.[304] In the study, material supports included arranging for daycare, assistance in finding housing or transportation, and assistance in acquiring food or childcare supplies.[305] Pairing up similar families with similar risks and needs across types of support showed that material support resulted in significantly fewer incidents of maltreatment than services such as parent education and nurturing classes, or in-home services such as family preservation or Healthy Families America.[306] Specifically, families receiving material support continuously had the lowest likelihood of maltreatment at every interval from day one through the end of the three-year study. [307] At the end of the three-year study, after comparing similar families while adjusting for the service type and initial family risk, only 8% of families receiving material support had a maltreatment incident (the most successful service in the study), as compared to 16% of families receiving parenting education, 18% for nurturing classes, 20% for Healthy Families America, and 22% for family preservation.[308] "It was noteworthy that neither the more intensive service models (e.g., family preservation) nor services based upon nationally standardized models (e.g., [Healthy Families America]) were very effective with the high-risk or even moderate-risk groups. In fact, both approaches were among the highest in failure rates for these risk strata."[309]

The mechanism for the effectiveness of material support, while indirect, is nonetheless as simple as it is powerful: poverty puts stress on families and exposes them to the family regulation system. Providing material support can reduce and eliminate those stressors, allowing parents to successfully address any other challenges they have such as substance abuse or parenting issues, ultimately preventing maltreatment, out-of-home placement, and termination of parental rights.[310] In sum:

> The presence of material hardship is so pervasive in child abuse and neglect cases that any strategy aimed at greatly reducing the incidence of child abuse and neglect must centrally address this bedrock context in which severe harm to children thrives. The most effective way to

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304. Mark Chaffin et al., *Family Preservation and Family Support Programs: Child Maltreatment Outcomes Across Client Risk Levels and Program Types*, 25 CHILD ABUSE & NEGLECT 1269, 1284 (2001) (where material supports were referred to as "basic [] needs" services).

305. *Id.* at 1275.

306. *Id.* at 1282.

307. *Id.* at 1283 (interpreting Figure 4).

308. *Id.* (interpreting Figure 4).

309. *Id.* at 1285.

310. Kemp et al., *supra* note 157, at 63 ("[the] outcomes shown to be positively correlated with [material support] interventions include (1) relief of immediate material and practical needs; (2) increased access to information and referrals; (3) increased satisfaction with services and workers; (4) enhanced engagement in services (both buy-in and use); (5) increased personal, interpersonal, and community support and/or reduced social isolation; (6) reduced stress; and, (7) increased self-efficacy and self-confidence.") (internal citations omitted).

> reduce child abuse and neglect is to reduce poverty and its attendant material hardships. . . . [W]ithout a key focus on material hardship, other additionally desirable approaches will not succeed in significantly reducing the incidence and severity of child abuse and neglect within our nation.[311]

c. Material Support is Especially Valuable for Families With Substance Use Challenges

The value of material support has been shown to assist substance-abusing parents in particular. For parents with substance use disorder, researchers "continue to find that the nature and severity of the psychiatric, family, employment, medical, and legal problems of substance-abuse patients are major predictors of posttreatment outcome from substance-abuse treatment. This is not new; results of many studies during the past decade support this conclusion."[312] For example, in a study of 130 adults who were medically determined to be dependent upon alcohol, drugs, or both, the adults receiving material support from case managers, who coordinated and expedited medical screenings, and provided housing assistance, parenting classes, and employment services, had significantly fewer physical and mental health problems, better social functioning, and less substance use six months after treatment than those without specific material support.[313]

In interviews with eighty-six predominantly Black women in substance abuse programs, the interviewer found these women emphasized the value of material support:

> Many forms of tangible help, including child care, a "place" to live, and money emerged as concrete support that impacted the experience of recovery from addiction. For example, women reported that network members taking care of their children supported their recovery: "she baby-sits when I go to AA meetings," "keeps my child when I get stressed," "given my kids food, going to buy them shoes and winter coats," "she takes care of my kid, keeps them well and gives me information on how they are doing." Shelter, or a place to live, was also reported as important to the process of recovery: "let me stay with her and got me off the street," "put me in a hotel until I could get a place here," "she provides me with a place to live" and "grateful that she didn't put me out, if it weren't for her I would be using today." Each of these data elements reveals that women often were in need of housing while battling addiction and co-morbid mental illnesses. Money was

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311. Leroy H. Pelton, *The Continuing Role of Material Factors in Child Maltreatment and Placement*, 41 CHILD ABUSE & NEGLECT 30, 31 (2015).

312. A. Thomas McLellan, *Problem-Service "Matching" in Addiction Treatment: A Prospective Study in 4 Programs*, 54 ARCH. GEN. PSYCHIATRY 730, 734 (1997).

313. *Id* at 731, 733.

> also reported as critical to recovery. Money to help with recovery was utilized in many ways: "giving me money to pay rent," "took me to dollar store and bought me personal items," "helps me pay my bills, helps buy things for baby like diapers," "buys stuff for the baby," "pays for babysitting," and "*bus fare*." Finally, women reported that help finding employment was important to their recovery: "*tries to get me jobs*" and "*job search*."[314]

When studies focus on parents involved in the child welfare system who have substance use disorders, they repeatedly show that material support is foundational. Chambers and Porter showed that families with high levels of substance abuse often had a high need for transportation and a moderate need for housing and employment, and families with a combination of economic distress and personal challenges needed help addressing their basic needs, mental health, and domestic violence before they could address alleged parenting issues.[315] In a study of 148 substance-abusing women involved in child protection, parents reported needs going far beyond mere substance use: 70% needed medical care, 62% needed job training and counseling, 56% needed housing assistance, 54% needed family counseling, 46% needed child care, 45% needed assistance with public benefits, 32% needed domestic violence counseling, and 33% needed legal help.[316] A separate study showed that women's drug use was significantly reduced when they received material support including transportation, health care, legal services, housing services, childcare in addition to other social services.[317] Women "receiving more health and social services reported better outcomes, both in substance use and in satisfaction with services."[318] When services "were matched to needs, matched counseling services were associated with reports of less substance use, and matched ancillary services (legal help, housing, job training) were associated with client satisfaction."[319] In summary, the study suggested that "[w]omen are more likely to have positive outcomes from substance abuse treatment when (1) the program provides services that improve access to treatment, specifically transportation, outreach and child care services and (2) they are engaged in treatment with health and social services."[320]

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314. Elizabeth M. Tracy et al., *Social Support: A Mixed Blessing for Women in Substance Abuse Treatment*, 10 J. SOC. WORK PRACT. ADDICTION 257, 267 (2010) (emphasis added).

315. Ruth M. Chambers & Cathryn C. Potter, *Family Needs in Child Neglect Cases: A Cluster Analysis*, 90 FAM. SOC. J. CONTEMP. SOC. SERV. 18, 22 (2009).

316. Brenda D. Smith & Jeanne C. Marsh, *Client-Service Matching in Substance Abuse Treatment for Women With Children*, 22 J. SUBST. ABUSE TREAT. 161, 165 (2002).

317. Jeanne C. Marsh et al., *Increasing Access and Providing Social Services to Improve Drug Abuse Treatment for Women With Children*, 95 ADDICTION 1237, 1244 (2000) (showing in Table 2 that use of the "enhanced program" statistically reduced drug use, $p < 0.01$).

318. Smith & Marsh, *supra* note 316, at 167.

319. *Id.*

320. Marsh et al., *supra* note 317, at 1246.

E. Myth: Testing Pregnant Mothers and Their Infants for Law Enforcement is a Fairly Used and Necessary Method of Ensuring the Welfare of the Child

One of the most invasive and terrorizing results of the merger of the family regulation system with the war on drugs is the drug testing (screening) of pregnant moms and their infants. This merger became a question of Constitutional significance in the Supreme Court case *Ferguson v. City of Charleston* when the programmatic drug testing of pregnant women for law enforcement purposes was held to violate the Fourth Amendment right against warrantless search and seizure.[321] However, before and after the *Ferguson* decision, testing remains prevalent across the United States.[322] Similarly, both before and after *Ferguson*, national medical organizations had been publishing statements criticizing this merger.[323] But despite the Supreme Court decision, the widespread advocacy, opposition from medical experts, and the lack of any federal requirement for drug testing pregnant women and their infants,[324] the enthusiasm for surveilling, testing, and criminalizing mothers is ever-present.

1. Reality: Fetal Substance Exposure is Only One Factor Influencing a Child's Development and Does Not Automatically Indicate Developmental Harm

The short-term and long-term effects of fetal substance exposure are more complicated than they may first seem and are simply one factor in a child's development. "The effects of prenatal exposure to drugs on brain development are complex and are modulated by the timing, dose, and route of drug exposure."[325] According to the American Academy of Pediatrics, "[a]ny single factor, such as prenatal substance exposure, may be less salient to the overall developmental outcome of these children than the cumulative effects of exposure in the context of multiple home environmental and circumstance risks"[326] including "financial

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321. 532 U.S. 67, 76 (2001).

322. *See, e.g.*, The Editorial Board, *Slandering the Unborn*, N.Y. TIMES (Dec. 28, 2018), https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html; SANGOI, *supra* note 1; LAPIDUS ET AL., *supra* note 14; BIRTH RIGHTS: A RESOURCE FOR EVERYDAY PEOPLE TO DEFEND HUMAN RIGHTS DURING LABOR AND BIRTH, *supra* note 14; CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA, *supra* note 14; Nina Martin, *How Some Alabama Hospitals Quietly Drug Test New Mothers — Without Their Consent*, PROPUBLICA (Sept. 30, 2015), https://www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent; Hayley Fox, *Weed and Pregnancy: How Cannabis Laws Are Hurting Mothers*, ROLLING STONE (Nov. 17, 2018), https://www.rollingstone.com/culture/culture-features/weed-pregnancy-mother-family-marijuana-cannabis-755697/; Oren Yaniv, *WEED OUT: More than a Dozen City Maternity Wards Regularly Test New Moms for Marijuana and Other Drugs*, N.Y. DAILY NEWS (Dec. 29, 2012), https://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292.

323. Stephen W. Patrick et al., *A Public Health Response to Opioid Use in Pregnancy*, 139 PEDIATRICS 1, 3 (2017) (collecting statements).

324. Ryan & Huang, *supra* note 54, at 303.

325. Barbara L. Thompson et al., *Prenatal Exposure to Drugs: Effects on Brain Development and Implications for Policy and Education*, 10 NAT. REV. NEUROSCI. 303, 303 (2009) [hereinafter *Prenatal Exposure to Drugs*].

326. *Families Affected by Parental Substance Use*, *supra* 182, at e3.

instability, food and housing insecurity, a chaotic living environment, inconsistent employment, domestic violence, social stigma or isolation, incarceration, and stress."[327] Due to these complicated factors, "it is difficult to justify categorizing such exposure as a form of child abuse and neglect in its own right."[328]

Critically, the legality of a substance has no effect on how fetal substance exposure affects children. Many "mistakenly assume that the legal or illegal status of a drug correlates with its biological impact on fetal brain development and long-term clinical outcomes. . . . [M]any legal drugs such as nicotine and alcohol can produce more severe deficits on brain development than some illicit drugs, such as cocaine."[329] This reality is evidenced by summaries from the American Academy of Pediatrics (AAP) on the short- and long-term effects of fetal substance exposure which were strong for alcohol, some effect for nicotine and cocaine, mixed to no effect for opiates and marijuana, and were largely unknown for methamphetamine.[330] Ultimately, as summarized by Hayley R. Price, Abby C. Collier, and Tricia E. Wright:

> [O]ur lack of pharmacological knowledge has been compounded by a general misunderstanding of addiction and substance use/misuse within the medical profession that is further complicated with respect to pregnant women and children. Misunderstanding is based on a lack of addiction knowledge in primary healthcare providers as well as a lack of evidence-based knowledge of drugs in pregnancy and the neonate. Moreover, local, state and federal policies tend to focus on the (generally unproven) risks of illicit drugs, while ignoring the real need for medication and medical care for pregnant women, such as for medical pain at the end of pregnancy due to physiological stress. And then, in a punitive legal atmosphere; drug use and misuse cannot be treated as a medical issue and becomes increasingly politicized, legalized and stigmatized in these pregnant women and for their children.[331]

Focusing again on marijuana specifically, medical and scientific evidence does not suggest that marijuana exposure alone is associated with adverse neonatal outcomes or long-term cognitive functioning impairments. In 2017, the American College of Obstetricians and Gynecologists (ACOG) explained that the "[a]vailable evidence does not consistently suggest that marijuana causes

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327. *Id.*

328. Testa & Smith, *supra* note 213, at 161.

329. *Prenatal Exposure to Drugs, supra* note 325.

330. *Families Affected by Parental Substance Use, supra* 182 at e3. Marylou Behnke et al., *Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus*, 131 PEDIATRICS e1009, 1016 (2013).

331. Hayley R. Price et al., *Screening Pregnant Women and Their Neonates for Illicit Drug Use: Consideration of the Integrated Technical, Medical, Ethical, Legal, and Social Issues*, 9 FRONTIERS PHARMACOLOGY 1, 8 (2018).

structural anatomic defects in humans. . .[,] does not suggest an association between marijuana use in pregnancy and perinatal mortality. . .[, and] do[es] not show an association between marijuana use and preterm birth."[332] According to the AAP, Conner and colleagues wrote the leading systematic review attempting to "determine the independent effect of marijuana use during pregnancy on both maternal and early neonatal outcomes" by accounting for other drug use like tobacco.[333] This systematic review examined studies from 1982 to 2015 and concluded that the increased risk for adverse neonatal outcomes reported in women using marijuana in pregnancy is likely the result of coexisting use of tobacco and other confounding factors and not attributable to marijuana use itself.[334] Attention should be focused on aiding pregnant women with cessation of substances known to have adverse effects on the pregnancy such as tobacco.[335]

Major studies since 2015, provide similar results. A 2016 study of 396 women found "no association between marijuana use and healthcare utilization or birth outcomes."[336] There were no significant differences in prevalence of low birth weight, mean gestational age at delivery, preterm delivery rates, NICU admissions, or birth weight.[337] Even though there was an increased prevalence of very low birth weight infants (less than 1500 g), it was not significant after adjusting for age, race, education, and cigarette smoking.[338] A 2018 study of 9,013 women showed no significant difference in the prevalence of low-birth-weight infant, preterm infant, term low birth weight infant, and attendance at one-week infant check-up between prenatal marijuana users as compared to non-users.[339] A

332. *Marijuana Use During Pregancy and Lactation*, *supra* note 288, at 206–07.

333. Sheryl A. Ryan, Seth D. Ammerman, & Mary E. O'Connor, *Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes*, 142 PEDIATRICS 1, 3–4 (2018) (citing Shayna N. Conner et al., *Maternal Marijuana Use and Adverse Neonatal Outcomes: A Systematic Review and Meta-analysis*, 128 OBSTETRICS GYNECOLOGY 713 (2016)).

334. *See* Ryan, Ammerman, & O'Connor, *supra* note 333.

335. *See id.*

336. Katrina Mark et al., *Marijuana Use and Pregnancy: Prevalence, Associated Characteristics, and Birth Outcomes*, 19 ARCH. WOMEN'S MENT. HEALTH 105, 113 (2015).

337. *Id.* ("We found few differences in birth outcomes by marijuana use. Low birth weight (LBW) infants (those less than 2500 g) were equally distributed across the marijuana exposure groups (14.0% vs 13.8%, p =1.000) . . . There was no difference in mean gestational age at delivery by marijuana status (38 weeks 2 days versus 38 weeks 6 days, p =0.139) nor were there any differences in preterm delivery rates, NICU admissions, or birth weight (3026 g vs 3089 g, p = 0.555).").

338. *Id.* ("[V]ery low birth weight (VLBW) infants (less than 1500 g), although rare, were more common in marijuana-exposed pregnancies (10.0% vs 1.8%, p = 0.032). . . . After adjusting for known confounders (age, race, education, cigarette smoking), VLBW was no longer associated with marijuana use and LBW remained unassociated. However, age and a lesser high school education were associated with LBW.").

339. Ko et al., *supra* note 203, at 74 ("Marijuana users during pregnancy also reported a higher number of stressors in the year before birth (≥3 stressors) and significantly higher prevalence of smoking cigarettes during the last 3 months of pregnancy (43.0% vs. 12.4%), binge drinking during the last 3 months of pregnancy (2.9% vs. 1.0%), drinking alcohol but not binging during the last 3 months of pregnancy (14.2% vs. 6.8%), and physical abuse only before pregnancy (8.1% vs. 1.3%), only during pregnancy (3.2% vs. 0.7%) and both before and during pregnancy (9.6% vs. 1.5%) compared to nonusers. There was no significant difference in prevalence of low birthweight infant (5.9% vs. 5.3%),

2020 systematic critical review of 1,001 statistical comparisons of longitudinal studies for the impact of in-utero marijuana exposure on cognitive function for individuals aged zero to twenty-two found that "[t]he current evidence does not suggest that prenatal cannabis exposure alone is associated with clinically significant cognitive functioning impairments."[340]

Ultimately, even the ACOG and the AAP only go as far as a moratorium perspective that while there is a lack of quality evidence that marijuana affects children, medical professionals should still discourage the use of marijuana for those trying to get pregnant, during pregnancy, and while they are breastfeeding.[341] Although more recent recommendations suggest that even though it is discouraged during breastfeeding, "it is not currently recommended to withdraw lactation support if women are unable to abstain."[342]

2. Reality: Infant Drug Testing with Legal Penalties and Referrals to Child Welfare Services are Opposed by Medical Professionals as They Do Not Ensure Proper Care or Improved Outcomes for the Mother or the Child

Even though states are increasingly targeting and punishing pregnant women who use substances, the consensus of medical and public health communities could not be clearer: punishing women for the use of illicit substances during pregnancy is ineffective and harmful to the mother and the child. More than twenty national organizations have published statements against such prosecution and punishment including the American Medical Association (AMA), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians, American Public Health Association, American Nurses Association, American Psychiatric Association, American Society of Addiction Medicine, March of Dimes, National Perinatal Association, and the Association of Women's Health, Obstetric and Neonatal Nurses.[343] Many also state that any drug testing of a pregnant woman requires her informed consent.[344]

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preterm infant (7.2% vs. 7.1%), term low birth weight infant (2.5% vs. 2.0%), and attendance at 1-week infant check-up compared to nonusers (91.4% vs. 93.7%) among women who reported marijuana use during pregnancy and nonusers (p's > 0.05)."). Infants born to prenatal marijuana users did show a statistically significant lower average birthweight than non-users of 2.3 ounces but the association did not remain significant after accounting for tobacco cigarette smoking. Also note that, in general, for each kilogram (2 lbs) of weight gained by mom in 1st/2nd trimester predicts 26-31g (0.9-1.1 oz) increase in birth weight – reflects less than 4 lbs of weight gain of mom.

340. Ciara A. Torres et al., *Totality of the Evidence Suggests Prenatal Cannabis Exposure Does Not Lead to Cognitive Impairments: A Systematic and Critical Review*, 11 FRONTIERS PSYCHOLOGY 816, 816 (2020).

341. *Marijuana Use During Pregnancy and Lactation*, *supra* note 228, at 205; Ryan, Ammerman, & O'Connor, *supra* note 333, at 10–11.

342. Thompson et al., *supra* note 123, at 15–16.

343. Patrick et al., *supra* 323 at 3 (collecting statements) (internal citations omitted).

344. *See e.g.*, *id.* at 4 ("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"); ACOG, Opposition TO CRIMINALIZATION OF

Despite this troubling but unsurprising division between politicians and medical experts, the following summarizes some of the key arguments from the AMA, AAP, and ACOG. In 1990, the AMA's Board of Trustees recommended adoption of recommendations regarding legal penalties of pregnant women including: (1) "[p]regnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs" and (2) "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate."[345] Similarly, in 1990, the AAP stated that "punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health . . . [T]he public must be assured of nonpunitive access to comprehensive care that meets the needs of the substance-abusing pregnant woman and her infant."[346] In their 2017 statement reaffirming that position, the AAP stated that "[t]he treatment of pregnant women with substance use disorder requires a coordinated, evidence-based, public health approach . . . [P]unitive approaches to substance use in pregnancy are ineffective and may have detrimental effects on both maternal and child health."[347] As the ACOG explained in 2011, and reaffirmed in 2022, the legal actions and policies criminalizing substance abuse during pregnancy are "disturbing":

> Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician–gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient. . . .[P]renatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity . . . Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.[348]

Individuals During Pregnancy and the Postpartum Period (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period ("Before performing any test on the pregnant individual or neonate, including screening for the presence of illicit substances, informed consent should be obtained from the pregnant person or parent. This consent should include the medical indication for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and discussion of the possible outcome of positive test results").

345. David Orentlicher & Kristen Halkola, *Law and Medicine/Board of Trustees Report: Legal Interventions During Pregnancy. Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J. Am. Med. Assoc. 2663, 2670 (1990).

346. Committee on Substance Abuse, *Drug-exposed infants [policy statement]*, 86 Pediatrics 639, 641 (1990).

347. Patrick et al., *supra* note 323, at 4.

348. Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist, 1 (2014); *see also* ACOG, *supra* note 344 ("The American College of Obstetricians and Gynecologists (ACOG) opposes any policies or practices that seek to criminalize individuals for conduct alleged to be harmful to their pregnancy").

The following sections summarize how laws punishing pregnant women for substance use reduce the quality of medical care for them and their children, and encourage health providers to become de facto law enforcement, causing pregnant women to distrust and avoid health providers.

a. Laws Punishing Pregnant Women for Substance Use Reduce the Quality of Medical Care for Them and Their Children

Recent studies have started to statistically show that these punitive laws reduce the quality of care provided to mothers and their children. In a cross-sectional study of eight American states and nearly 4.6 million births, states with "policies that criminalized substance use during pregnancy, considered it grounds for civil commitment, or considered it child abuse or neglect were associated with significantly greater rates of NAS [(neonatal abstinence syndrome caused by prenatal opioid use)] in the first full year . . . and more than one full year after enactment."[349] A separate study examined the use of medication-assisted treatment (MAT), which is the standard of care for pregnant women with opioid use disorders, known to improve the outcomes for both the mother and the infant.[350] In a study of 8,292 treatment episodes for pregnant women with opioid use disorders, researchers showed that in the eighteen states that permit child abuse charges for illicit drug use during pregnancy, MAT was used 33% of the time, as compared with 51% of the time in states without a law.[351] In sum, prenatal child abuse laws may impede access to the accepted medical standard of care for pregnant women.[352]

For those who believe they are acting in the best interests of the child (despite contrary evidence throughout this entire Article and their medical associations), studies have also shown that substance-exposed children reported to criminal or family regulation systems are actually less likely to receive the services that they need, and significantly more likely to experience punitive outcomes such as out-of-home placement, foster care, or adoption. A study of healthy cocaine-exposed newborns with similar medical and social risk factors compared newborns who received a negative test and went home with their mother with those who received a positive test and were referred to child welfare services.[353] Despite their near identical health risks, newborns referred to child welfare services not only failed

349. Laura J. Faherty et al., *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome*, 2 J. AM. MED. ASSOC. e1914078, e1914078 (2019).

350. 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).

351. *Id.* at 598.

352. *Id.* at 600.

353. *See generally* Robert S. Byrd et al., *Why Screen Newborns for Cocaine: Service Patterns and Social Outcomes at Age One Year*, 23 CHILD ABUSE & NEGLECT 523 (1999).

to receive significantly enhanced clinical or support services, but were also more likely to experience punitive outcomes, likely because of the increased invasive surveillance of the family. Specifically, the newborns referred to child welfare services as opposed to going home with their family were more likely to be placed out of home (50% vs. 22%), in foster care (45% vs. 11%), or adopted (14% vs. 0%); and, at age year one were less likely to be at home with their mother (45% vs. 83%), more likely to be in foster care (27% vs. 6%), and more likely to be adopted (9% vs. 0%).[354] In other words, the decision to involve child welfare services for substance-exposed children is, in practice, not a decision to protect the child as much as it is a decision to tear the child away from their family.

b. Laws Punishing Pregnant Women Encourages Health Providers to Become de facto Law Enforcement, Causing Pregnant Women to Distrust and Avoid Health Providers

These punitive policies are also known to give license to health providers to become de facto law enforcement officers in the criminal punishment system even though they are clearly in violation of the principles laid out by every major association. Paltrow and Flavin examined 413 criminal cases from 1973 to 2005 where a woman's pregnancy was a key factor.[355] As they explained: "Although it is often presumed that medical information is confidential and rigorously protected by constitutional and statutory privacy protections [and] . . . medical ethics, cases we have identified challenge that assumption. [D]isclosures, including bedside interrogations by . . . state authorities, likely contradict most medical patients' expectations of privacy . . ." [356] Of the 276 cases where the authors could identify how the case came to the attention of the police, prosecutors, and courts, leading to arrest, detention, or forced intervention, a plurality (112 or 41%) were disclosures from health care workers such as doctors, nurses, etc.

> Far from being a bulwark against outside intrusion and protecting patient privacy and confidentiality, we find that health care and other 'helping' professionals are sometimes the people gathering information from pregnant women and new mothers and disclosing it to police, prosecutors, and court officials . . . . [I]n some cases making a report to child welfare authorities was no different than making a report directly to law enforcement officials.[357]

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354. With the initial placement out of home and foster care being statistically significant and the age year 1 being statistically significant. *Id.* at 528.

355. *See generally* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y L. 299 (2013).

356. *Id.* at 326.

357. *Id.* at 327.

Women, particularly low-income women of color, are acutely aware of their criminalization and surveillance from interactions with healthcare providers. Parents know they will be punished whether it is legal or not, whether it is supported by medical associations or not. As Paltrow and Flavin showed, "[o]verwhelmingly, the deprivations of liberty [of pregnant women for substance use] occurred in spite of a lack of legislative authority, in defiance of numerous and significant appellate court decisions dismissing or overturning such actions."[358] These women know they cannot trust that their healthcare providers will treat them confidentially and with dignity.[359]

For pregnant women who do go to their healthcare provider knowing the risk of law enforcement, they go because they are seriously concerned with the consequences of their substance use. They are not numb. They know the feelings of guilt and shame. As Ethel, a 29-year-old Latina, explained, "I was using, and the baby was suffering and I was using. And he had—I mean, he's like this little, little thing. It's like, 'How could you do that to him?"[360] But when they arrive, some healthcare providers stigmatize them instead of providing a nurturing place that encourages them to return. As Phoebe, a 20-year-old Black woman described, "They look at you foul and they tell me [sarcastic voice], 'Oh, you're a crack user.' And I say, 'Bitch, you lucky I came to the doctor.' And then they want to look at your record, and then this nurse look at it. . .They talking all loud, everybody around."[361] The ridicule, on top of the legal vulnerability, causes women to disengage from the traditional healthcare provider system. Jessie, a 33-year-old Black woman explains:

> I know a lot of mothers say that they don't get prenatal care 'cause they feel like as soon as they walk through the door, they will be judged. "Oh you're a crack head. Why. . . did you get pregnant anyway?" So they don't get prenatal care . . . they are thinking how they gonna be looked at when they walk in the hospital door, like they not good enough to be pregnant.[362]

As a result, affected women have increasingly focused on creating "parallel care systems" which have the possibility of harming themselves or their children such as births at home, non-traditional birthing methods, delayed registration of birth, delayed immunizations, and delayed health care follow-up, all to avoid the possibility of surveillance and punishment.[363] But given the alternatives of

358. *Id.* at 320.

359. *See, e.g.*, Carter, *supra* note 93, at 169; SANGOI, *supra* note 1; Kuo et al., *supra* note 65.

360. Katherine Irwin, *Ideology, Pregnancy and Drugs: Differences Between Crack-Cocaine, Heroin and Methamphetamine Users*, 22 CONTEMP. DRUG PROB. 611, 619 (1995).

361. *Id.* at 617.

362. *Id.* at 618.

363. Carter, *supra* note 93, at 169; Branigin, *supra* note 127.

criminalization and punishment, society has already forced them to make these decisions for the survival of their family.

3. Reality: Drug Testing of Pregnant Women and Their Infants Disproportionately Target Women of Color and Poor Women in Ways that Persist Even When Standardized or Universal Protocols are Used

Bias and discrimination pervade the entire family regulation system.[364] To the family regulation system, the only thing worse than a substance-using parent is a substance-using parent who is pregnant, poor, or a woman of color.[365] Even the ACOG agrees that "[i]mplicit bias regarding race and class often influence the decision to utilize coercive tactics or judicial intervention. Coercive tactics, including court orders, are more commonly applied to individuals with low incomes, young people, people of color, and people who are immigrants."[366] Whether one believes this is common knowledge or not, it must be articulated so that we continue to understand the depths of the discrimination and punishment. Study after study shows that women of color and poor women are more likely to be tested (or screened), more likely to be reported to government services, and more likely to face criminal punishment. Physicians and other service providers are even more likely to attribute an injury to abuse in poor families but attribute the same injury to an accident in higher-income families.[367] Moreover, because of the structural discrimination in our society, when standardized or universal protocols are used, discrimination persists because the so-called "objective" precursors are also infused with disparities.

a. Despite Women of Color Being No More Likely to Maltreat Their Children or Use Substances, They are More Likely to be Drug Tested, Reported to Law Enforcement, and Charged With Crimes or Maltreatment of Their Children

To appreciate the racial and class disparities in how pregnant women are drug tested and reported, one must first understand two realities. First, families of color are no more likely to mistreat their children than non-families of color. The federally conducted National Incidence Studies in 1980, 1986, and 1993 "found child maltreatment to be unrelated to race/ethnicity [such that a]fter controlling for these risk factors, African American families were found to have less risk of child

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364. ROBERTS, *supra* note 7.

365. Even further, "SEI reports are correlated with mental illness, domestic violence, poverty, homelessness, and other disadvantages that may be more directly associated with child maltreatment." Testa & Smith, *supra* note 213, at 161.

366. ACOG, *supra* note 344; *See also* Testa & Smith, *supra* note 213, at 161.

367. Richard O'Toole et al., *Theories, Professional Knowledge, and Diagnosis of Child Abuse*, *in* THE DARK SIDE OF FAMILIES: CURRENT FAMILY VIOLENCE RESEARCH 349, 353 (David Finkelhor et al. eds., 1983) (in a serious injury vignette, 70% of the physicians studied judged child abuse when the parent was of low socioeconomic status as compared to 51% when the parent's socioeconomic status was high; and in a low injury case, 43% of physicians judged child abuse when the parent was black as compared to 23% when the parent was white); *see generally* Eli H. Newberger et al., *Pediatric Social Illness: Toward an Etiologic Classification*, 60 PEDIATRICS 178 (1977).

maltreatment than White families."[368] Second, women, regardless of race, use substances during pregnancy at similar rates overall, though some differences do occur with respect to substance and pattern of use. For example, a national survey of over 180,000 women from 2002 to 2006 examined women's alcohol use, binge alcohol use, cigarette use, daily cigarette use, marijuana use, use of marijuana on six or more days, psychotherapeutic use, and cocaine use.[369] The results showed that non-Hispanic white women reported higher rates of alcohol, cigarette, marijuana, and psychotherapeutic use than Hispanic and Black women; and the same rate of use for crack and cocaine.[370] A more recent meta-analysis found that both white and Black women use drugs during pregnancy, and while there are differences with respect to substance and pattern of use, white and Black women have similar rates of any use during the prenatal period.[371]

Despite overall similar use between races, pregnant women of color, especially Black and Native American women, are significantly more likely to be drug tested (or screened) and reported to government services.[372] "The major inadequacy with existing hospital surveillance practices is that screening is done selectively in such a way that puts African American infants at disproportionate risk of CPS detection and involvement."[373] A study of 2,121 mothers giving birth in a Rochester, New York, hospital in 2005–2006 showed that infants born to Black mothers were statistically significantly more likely to be drug tested than white mothers whether they met the established testing criteria (35.1% vs 12.9%) or not (5.3% vs 1.2%).[374] The mother's race remained independently associated with testing even when the authors controlled for screening criteria, income, insurance status, and maternal education.[375] A separate study of 8,976 women delivering at an urban hospital in Bronx, New York, found that Black women were 1.7 times more likely to be tested than non-Black women; unemployed women were 2.1 times as likely to be tested as employed women; and those from the poorest quartile neighborhoods were 2.1 times more likely to be tested than

368. Kathy Lemon Osterling et al., *Understanding and Addressing Racial/Ethnic Disproportionately in the Front End of the Child Welfare System, in* EVIDENCE FOR CHILD WELFARE PRACTICE 9, 14 (2010) (citing Andrea Sedlak & Dana Schultz, *Race Differences in Risk of Maltreatment in the General Child Population*, *in* RACE MATTERS IN CHILD WELFARE: THE OVERREPRESENTATION OF AFRICAN AMERICAN CHILDREN IN THE SYSTEM 47 (Dennette Derezotes, John Poertner, & Mark F. Testa eds., 2005)).

369. Pradip K. Muhuri & Joseph C. Gfroerer, *Substance Use Among Women: Associations with Pregnancy, Parenting, and Race/Ethnicity*, 13 MATERNAL & CHILD HEALTH J. 376, 381 (2009).

370. *Id.*

371. Sarah C. M. Roberts & Amani Nuru-Jeter, *Universal Alcohol/Drug Screening in Prenatal Care: A Strategy for Reducing Racial Disparities? Questioning the Assumptions*, 15 MATERNAL & CHILD HEALTH J. 1127, 1129 (2011). (internal citations omitted).

372. *See, e.g.*, Carter, *supra* note 93 at 167.

373. Testa & Smith, *supra* note 213, at 161.

374. M. A. Ellsworth et al., *Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns*, 125 PEDIATRICS e1379, e1382 (2010).

375. *Id.*

those in the wealthiest quartile neighborhoods.[376] This is despite the fact that Black women were less likely (0.9 times) to have a positive illicit drug test, unemployed women were only 1.1 times as likely to test positive as employed women, and women from the poorest quartile neighborhoods were only 1.1 times more likely to test positive than those in the wealthiest quartile neighborhoods.[377] Lastly, in a study of majority white women, physicians at a Connecticut hospital serving low-income patients tested Black women at delivery for cocaine use 1.9 times more than they tested white women.[378]

Given the racial disparities in testing, it is no surprise that there are similar racial disparities in reporting to government services. As background, the national proportion of admissions for substance abuse treatment was approximately 59% non-Hispanic white, 22% Black, and 14% Hispanic—a majority of whom were either not in the labor force (40%) or unemployed (32%).[379] Despite this, "studies have shown increased rates of referral, investigation, substantiation, and placement for children of color, even after controlling for other explanatory variables such as poverty."[380] "[C]hildren of color are referred, investigated, substantiated, and placed in care at a higher rate than white children . . . . [The] existence of racial/ethnic disproportionality in child welfare is clear."[381] The following provides a summary of some of the most referenced studies showing these disparities.

Testa and Smith studied the reports of substance-exposed infants from hospitals in Illinois from 1985 to 2007 and found that substance-exposed infant (SEI) reports were disproportionately distributed among ethnic groups.[382] For example, in 1995, 59% of Illinois infants were non-Hispanic white while 20% were Black. In that same year, SEI reports were 12% non-Hispanic white and 83% Black. This is a "disproportionality ratio" of 20 SEI reports on Black infants for every one report on a non-Hispanic white infant.[383] The disproportionality ratio was the same when Black infants were compared with Hispanic infants. The interesting part is that by 2002, the disproportionality ratio had fallen to seven SEI reports on Black infants for every one report on a non-Hispanic white infant. The entire

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376. Hillary Veda Kunins et al., *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in The Peripartum Setting*, 16 J. WOMEN'S HEALTH 245, 249 (2007).

377. *Id.* at 251 Table 3.

378. Bonnie D. Kerker et al., *Patients' Characteristics and Providers' Attitudes: Predictors of Screening Pregnant Women for Illicit Substance Use*, 28 CHILD ABUSE & NEGLECT 209, 217–18 (2004).

379. TREATMENT EPISODE DATA SET (TEDS) 1995-2005: NATIONAL ADMISSIONS TO SUBSTANCE ABUSE TREATMENT SERVICES, 28–29 (2007).

380. Osterling et al., *supra* note 368, at 14 (internal citations omitted).

381. *Id.* at 8, 17.

382. Testa & Smith, *supra* note 213, at 159.

383. Disproportionality ratio is calculated by (1) dividing the percentage of reports for group 1 by group 1's percent of infants, then (2) dividing that amount by the percentage of reports for group 2 by group 2's percent of infants. Here, the Black infants have SEI reports 4.15 times their share of the infant population: 83% divided by 20%. White infants have SEI reports only 0.2 times their share of the infant population: 12% divided by 59%. The total disproportionality ratio for Black infants as compared to non-Hispanic white infants is therefore 20.4.

decline was explained by the 64% reduction in SEI rates for Black infants. Hispanic infants also experienced a 61% decline but non-Hispanic white infants only rose slightly by 8%. The authors explain that this data validates "concerns . . . that publicly funded, inner-city hospitals were using protocols that resulted in more drug testing than the protocols used by privately insured, suburban hospitals, thus bringing African American infants disproportionately to the attention of CPS."[384] The related "decline among Hispanics but not among majority whites suggests that changes in drug surveillance practices, particularly in the inner city, may have also figured in the SEI decline." [385] In other words, a report for a substance-exposed infant is determined by the hospital surveillance, not by the underlying question of whether the infant is actually substance exposed.

These racial disparities have been found everywhere from Florida and California to Washington state. In a 1990 Florida study where 715 women were screened at birth for substances, Black women were reported at approximately 9.6 times the rate of white women, and poor women (family income less than $12,000) were more likely to be reported than others.[386] This is despite the similar rates of positive results among white and Black women (15.4% and 14.1%, respectively).[387] In California, a study of SEI reports by maternal race among the 2006 birth cohort found that both Black and Hispanic infants were statistically significantly more likely to be reported to CPS than white infants with 1.15 and 1.13 SEI reports, respectively, for every white infant SEI report.[388] In a Washington state study of 760,863 births from 2006 to 2013 which does not have universal testing, there were 1.5 SEI reports for Black infants for every one white infant report and 4.3 SEI reports for Native American infants for every one white infant report.[389] Interestingly, the study also showed a statistically significant effect of insurance type on whether SEI was reported: despite having approximately equal amounts of births with public and private insurance (44% and 49%, respectively), over 79% of the PSE reports were for births using public insurance—suggesting a relationship to income and wealth.[390]

The same disparities occur in cases where pregnant women were arrested and charged with crimes. Paltrow and Flavin's study of criminal cases against pregnant women found deep race and class disparities: of the 368 women where they could discern their race, 52% were Black and an additional 7% were other women of color.[391] With respect to class, they found that "[o]verwhelmingly, and

384. Testa & Smith, *supra* note 213, at 159.

385. *Id.*

386. Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 N. ENGL. J. MED. 1202, 1204 (1990).

387. *Id.*

388. Putnam-Hornstein et al., *supra* note 26, at 4.

389. Rebecca Rebbe et al., *Child Protection Reports and Removals of Infants Diagnosed with Prenatal Substance Exposure*, 88 CHILD ABUSE & NEGLECT 28, 31 Table 1 (2019).

390. *Id.*

391. Paltrow & Flavin, *supra* note 355, at 311.

regardless of race, women in our study were economically disadvantaged" with over 71% qualifying for indigent counsel.[392] In addition, healthcare providers appeared to disproportionately disclose information when the patients were women of color as nearly half of Black women (48%) were reported by healthcare providers as compared to only 27% of white women.[393]

The race and class disparities were also an undercurrent in the lives of the plaintiff women in *Ferguson*. Although the question was about a warrantless search, there was a stark racial component. The records of the hospital at issue "indicate[d] that among its pregnant patients[,] equal percentages of white and African American women consumed illegal drugs. However, of the 30 women arrested under the [unconstitutional] interagency drug-testing policy, 29 were African American."[394] The results of the policy were horrifying:

> One woman spent the last three weeks of her pregnancy in jail. During this time[,] she received prenatal care in handcuffs and shackles. Authorities arrested another woman soon after she gave birth; still bleeding and dressed in only a hospital gown, she was handcuffed and taken to the city jail.[395]

As Paltrow and Flavin point out, *Ferguson*'s holding, which supposedly prohibits collaboration between police and healthcare providers to identify and arrest pregnant women, seems to have no effect on the ground.[396] It is still the case for too many women that healthcare professionals and child welfare authorities are just law enforcement in different uniforms.

b. Proposed Standardized Protocols or Universal Drug Testing Have Not Been Shown to Reduce the Racial Disparities

Given these race and class issues, some researchers have hypothesized that the disparities are a result of too much discretion among healthcare providers and therefore, proposed standardized protocols or universal testing.[397] Research clearly shows that neither proposal will reduce disparities because the biases are deeper than that. To the question of standardized protocols, researchers studied over 45,000 births at multiple California hospitals from 2009 to 2013.[398] They

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392. *Id.*

393. *Id.* at 327.

394. AMERICAN CIVIL LIBERTIES UNION, *Ferguson v. City of Charleston: Social and Legal Contexts*, https://www.aclu.org/other/ferguson-v-city-charleston-social-and-legal-contexts (last visited Jan. 11, 2023) (internal citations omitted).

395. *Id.* (internal citations omitted).

396. Paltrow & Flavin, *supra* note 355, at 327.

397. *See e.g.*, Ira J. Chasnoff et al., *Screening for Substance Use in Pregnancy: A Practical Approach for the Primary Care Physician*, 184 AM. J. OBSTET. GYNECOL. 752, 755–56 (2001).

398. S. C. M. Roberts et al., *Does Adopting a Prenatal Substance Use Protocol Reduce Racial Disparities in CPS Reporting Related to Maternal Drug Use? A California Case Study*, 35 J. PERINATOL. 146, 148 (2015).

found that adopting a standardized protocol for ordering urine toxicology testing for mothers and infants did not reduce disparities in reports to child welfare services in general nor in reports specifically addressing maternal substance use—in fact, adopting the standardized protocol increased disparities.[399] In the hospital that adopted the standardized protocol, there was no significant effect on the disparity: Black infants were five times more likely to be to be reported than a non-Hispanic white infant before and after implementation.[400] At the same time, in the control hospitals where there was no standard protocol, Black infants were four times more likely to be reported than a non-Hispanic white infant at the beginning of the study but only two times more likely to be reported at the end. Paradoxically adopting the protocol at one hospital maintained the racial disparity over time while similar hospitals without the protocol reduced the racial disparity over time. The authors explain that standardized protocols like this may have "institutionalized the process of identifying more Black [women] than white women" because the "risk factors" are merely factors that are known to have higher rates among Black women (i.e., poor birth outcomes, limited prenatal care, and children out of care). This leads to more drug testing, more identified drug use, and more children out of care, resulting in a continuation of the racial disparities.[401]

In short, the disparities are not just found in testing and reporting, but in the supposedly "objective" precursors that health providers rely on in determining who to test, including the documentation of prior substance use, the reliance on health service provider suspicion, and the use of the mother's insurance status. A study of medical charts of 1,083 women delivering at a Connecticut hospital found that providers were significantly more likely to document Black and Hispanic women using cocaine, alcohol, and other drugs than white women.[402] A study of 49 Chicago-area hospitals with nurse administrators found that the most frequently cited criteria for determining which women to test included the health provider's suspicion of drug use, and some hospitals relied on the woman's insurance status (i.e., whether public insurance or self-pay).[403] A study of provider beliefs, comprising 96% white nurses, sought to examine the prevalence of alcohol and drug abuse by race among adolescent pregnant women in their providers' care. The study found a large variation among estimates, but in general, the study concluded that providers underestimated marijuana and other drug use among white women and alcohol use among Black women.[404]

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399. *Id.* at 149.

400. *Id.*

401. *Id.* at 149 (internal citations omitted).

402. Bonnie D. Kerker et al., *Racial and Ethnic Disparities in Medical History Taking: Detecting Substance Use Among Low-Income Pregnant Women*, 16 ETHNICITY & DISEASE 28, 30 (2006).

403. *See generally* Marilyn Birchfield et al., *Perinatal Screening for Illicit Drugs: Policies in Hospitals in a Large Metropolitan Area*, 15 J. PERINATOL. 208 (1995).

404. Sarah E. Teagle & Claire D. Brindis, *Substance Use Among Pregnant Adolescents: A Comparison of Self-Reported Use and Provider Perception*, 22 J. ADOLESC. HEALTH 229, 234–35 (1998).

The ubiquity of disparities, or institutional biases,[405] throughout the process also undermines the proposals for universal testing, the toxicology testing of all newborns. Universal screenings are unlikely to work given the "possibility that providers and CPS may respond differently to positive urine toxicology tests among white versus black newborns or respond differently to different substances."[406] For example, in a 1993 study of 99 women with cocaine-exposed infants (49% Black and 40% Hispanic),[407] an infant was significantly more likely to be placed outside the family when the mother had prior child welfare records and was Black.[408] Additionally, the denial of custody to the mother was significantly more likely when the mother had prior child welfare records, was Black, or did not live in her own home.[409]

IV. Conclusion

This Article has provided tactical information for parents, family defenders, and advocates to use when they are arguing in court against the family regulation system. However, we must recognize that harm and trauma start the moment the family regulation system comes to a family's door or bedside. Once a charge has been brought against a family, they are forced to face a system founded on the war on drugs, supercharged by carceral science and technology, and reliant upon pseudoscientific myths to oppress Black, indigenous, immigrant, poor, and other marginalized communities. At that point, it is already too late to achieve the full measure of justice. Only if we reject these myths, abolish the family regulation system, and embrace the science of substance use and family welfare, can we imagine and build a more humane and democratic society that no longer relies on the removal of children and prevention of reunification to solve social problems.

The family regulation system terrorizes parents, families, and communities. It has combined the carceral myths about substance use with the punitive beliefs about the war on drugs to justify its use of substance use-related allegations to tear apart families. To be clear, yes, there are families which warrant some degree of safety intervention. Yes, some parents cannot safely parent their children because of the nature of their substance abuse. However, this Article's review of decades of studies and interviews makes clear that the family regulation system

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405. Roberts et al., *supra* note 398, at 149 ("It is also worth considering other potential causes of disparities, such as institutional bias—whether institutions serving larger proportions of lower-income women have different approaches than institutions serving lower proportions of lower-income women; racial disparities in receipt and effectiveness of substance abuse treatment during pregnancy; racial disparities in levels and types of drugs used; racial disparities in co-existing risk factors for CPS reporting (for example, inadequate prenatal care, unstable housing, incarceration and violent partners) among pregnant women using drugs; and disparities in documentation of prior alcohol and drug use in prenatal charts.") (internal citations omitted).

406. *Id.* (internal citations omitted).

407. Daniel R. Neuspiel et al., *Custody of Cocaine-Exposed Newboms: Determinants of Discharge Decisions*, 83 Am. J. Pub. Health 1726, 1726 (1993).

408. *Id.*

409. *Id.*

has no evidence that its specific procedures and punishments serve to help families. Therefore, any successful intervention is a random and rare outcome against a vast ocean of harm. The family regulation system must be abolished because the current system refuses to do the things that we know help families. For those who need intervention and for those who do not, we need a system built upon an honest accounting of how gender, poverty, stress, substance use, and other factors all interact.

This analysis reveals a truth that must be more widely remembered by those fighting against any carceral system: pseudoscience may be their weapon, but science is ours. Our current family regulation system based on pseudoscience must be abolished, but we should only construct a new one if we commit to basing it on science. The science provides an outline of how we can imagine and build a more humane and democratic society that no longer relies on punishing people to meet human needs and solve social problems.[410] Such a society would forbid laws that allow charges to be filed against a parent or terminate their parental rights solely because (a) the parent exposes their child to controlled substances, (b) the child is present during the use or manufacture of controlled substances, (c) the parent, child, birth mother, or infant tests positive for controlled substances, (d) the parent does not accept, fully participate, or successfully complete recommended drug treatment, or (e) the parent has a history of using controlled substances or refusing or completing recommended drug treatment. Such a society would understand the historically racist and classist roots of the family regulation system and design a system of support that accounts for the differing needs of different genders. Such a society would base its understanding of substance use on science like the DSM-5 and won't assume that substance use automatically impairs parenting quality. Such a society would provide material financial support to families in need, addressing problems of poverty through help with finances, childcare, education, housing, and employment. Such a society would understand that substance use is only a small part of a parent's complex social, behavioral, and economic challenges. Such a society would not always require compulsory treatment and abstinence because substance use disorders are chronic illnesses, often co-occurring with mental disorders, where no cure exists, and relapse is common. Such a society would not test pregnant people or their infants without their consent or mandate reporting merely for the use of illicit substances during pregnancy. Such a society can exist, but only if we bring it kicking and screaming into reality.

In 1990, Robert Halper saw the "dangers [of] overpromising what services can accomplish, especially in the absence of other supports for children and

410. For additional recommendations and paths forward, *see generally*, *e.g.*, SANGOI, *supra* note 1; ROBERTS, *supra* note 7; Dorothy Roberts, *Collateral Consequences, Genetic Surveillance, and the New Biopolitics of Race*, 54 HOW. L.J. 567 (2011); LAPIDUS ET AL., *supra* note 14; BIRTH RIGHTS: A RESOURCE FOR EVERYDAY PEOPLE TO DEFEND HUMAN RIGHTS DURING LABOR AND BIRTH, *supra* note 14; SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., *supra* note 96; Anna Arons, *An Unintended Abolition: Family Regulation during the COVID-19 Crisis*, 11 COLUMB. J. RACE L. (2021); Trivedi, *supra* note 10, at 571–78; Gossett, *supra* note 58, at 821–24; Albert et al., *supra* note 8.

families."[411] He argued that "there is something wrong in our collective life" that explains our reluctance to make a true commitment to children and families at risk.[412] He then asked questions we are still asking over three decades later:

> The idea that a set of services finally exists that can improve outcomes for our highest-risk children is appealing. Yet in a context of increasing social and economic polarization and the disengagement of a growing proportion of young inner-city families from mainstream expectations, it also raises a number of questions. What burden of social problem solving should discrete helping services be expected to carry? What can be expected of services for families that have experienced two or three generations of internally and socially generated damage? What can services provide to those children for whom there is no longer any tight link between effort and outcome; or to those adults whose communities no longer provide the social resources needed to implement strategies of social mobility? Should we base expectations for services on the best possible services or on average-expectable services? . . .[413]
>
> Services cannot alter the social conditions that produce or exacerbate, and ultimately reproduce, individual and family problems. Services cannot bridge the huge social and racial divisions that persist in American society, nor can they be the catalyst that causes self-sufficient Americans to see that they share common needs and a common world with vulnerable and dependent Americans. [We must address our] continuing reluctance to alter basic social arrangements and priorities that cause damage to so many children and families . . . .[414]

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411. Robert Halpern, *Fragile Families, Fragile Solutions: An Essay Review*, 64 SOC. SERV. REV. 637, 637 (1990).

412. *Id.* at 638.

413. *Id.* at 638–39.

414. *Id.* at 647.