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CRIMINALIZING PREGNANCY^{a1}

The state of Tennessee arrested a woman two days after she gave birth and charged her with assault of her newborn child based on her use of narcotics during her pregnancy. Tennessee's 2014 assault statute was the first to explicitly criminalize the use of drugs by a pregnant woman. But this law, along with others like it being considered by legislatures across the country, is only the most recent manifestation of a long history of using criminal law to punish poor mothers and mothers of color for their behavior while pregnant. The purported motivation for such laws is the harm to the child from prenatal exposure to illegal drugs. But recent scientific studies undermine the harm narrative.

This Article is the first to take a close look at the science behind these laws. Recent longitudinal studies confirm that the use of illegal drugs while pregnant, in and of itself, rarely results in long-term adverse consequences to the fetus and subsequent child. Meanwhile, the negative consequences of ingesting licit substances such as tobacco, alcohol, and other lawfully prescribed medications, often are much greater than the potential undesirable effects of drug use. Poverty, domestic violence, and a father's behavior prior to conception also have been shown to have significant harmful impacts on fetal development. Although the criminalization of drug use by pregnant women does not prevent impairment of the fetus and subsequent child, it often leads to additional detrimental consequences. The state regularly steps in and removes children born to women using illicit drugs while pregnant, even when there is no evidence of harm to the child and despite the documented harms to newborns from placement in the foster care system. Additionally, as every major medical organization has publicly indicated, pregnant women are less likely to seek prenatal care if they fear arrest for using drugs, creating damaging effects greater than any potential harms from the drug use.

*Legislatures' unwillingness to acknowledge the empirical evidence contradicting the rationales for this latest batch of criminal laws might cause one to wonder whether the harm to the child is truly the motivating impetus behind these laws. The existing statutes have a disproportionate impact on poor mothers and mothers of *948 color. In fact, class- and race-based constructions of motherhood go a significant distance toward explaining the presence of these laws. This Article analyzes how our current approach to the use of drugs by pregnant women relies on these troubling economic- and race-based social constructions, rather than on any scientific or empirical evidence. By challenging the erroneous presumptions motivating these laws, this Article hopes to move legislatures toward effectively addressing the more substantial risks to developing fetuses.*

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INTRODUCTION

In July 2014, Jamillah Washington, a thirty-year-old African American woman, was arrested under a new Tennessee law allowing prosecution of a woman for assault for using illegal narcotic drugs while pregnant.¹ Ms. Washington gave birth to a *949 daughter who “tested positive” for marijuana and heroin.² She sought treatment for her opioid addiction on three occasions during the course of her pregnancy but was turned away each time due to her pregnancy.³ Police reported that she admitted using heroin two days before the birth.⁴ That same month, Mallory Loyola, a white woman age twenty-six, was arrested under the same law after giving birth to a baby girl who tested positive for amphetamine.⁵ Although amphetamine is not a narcotic, Ms. Loyola pled guilty a month later “to avoid jail time.”⁶ At least one of the women qualified for a public defender, and as a consequence of their arrests, the Department of Children's Services began investigations of both mothers.⁷ At least ninety-five other women were prosecuted under this law prior to its sunset in June 2016.⁸

Although Tennessee's statute was the first to explicitly criminalize the use of drugs by a pregnant woman, the law is only the most recent incarnation in a long history of states using criminal laws to punish primarily poor, often minority mothers for their behavior while pregnant. Four additional states have contemplated similar legislation since Tennessee's law went into effect. Prior to the statute's enactment, numerous states relied on generally applicable criminal statutes--criminal neglect, delivery of drugs to a minor, chemical endangerment of a child, involuntary manslaughter, and other similar statutes-- to pursue prosecutions of women for using drugs during pregnancy.⁹ In the federal system, judges rely on sentencing enhancements to accomplish a similar end. For example, one federal judge recently enhanced *950 a woman's sentence under the federal sentencing guidelines, doubling her sentence from six to twelve years, based on her use of drugs while pregnant.¹⁰ The judge granted the enhancement based on the prosecution's argument that a substantial risk of harm arose when “this defendant [gave] birth to a drug addicted baby.”¹¹

The articulated motivation for pursuing these prosecutions is the risk of harm to the fetus, with the focus being on the short-term harms to the fetus and the long-term harms to the future child. Preventing a mother from hurting either her fetus or her child is a compelling and intuitive desire. And most of us probably feel fairly confident in our assumption that a pregnant woman's use of illegal drugs *will* cause damage, certainly to the developing fetus but likely to the child once born as well. As a result, few question the judgment of punishing a woman who engages in such behavior. After all, fetuses and newborn children are among the most vulnerable of our population. A clear message of “accountability” and moral condemnation must be sent. Although a father's preconception behavior also plays an important role in fetal health and development,¹² that role remains unexamined. Most assume that because a woman carries a child in utero for nine months, her behavior during that time will have a substantial effect on the development of the child and fetus, whereas a father's limited interaction in the creation of the fetus minimizes the extent to which his preconception risk-taking behavior impacts fetal development.

Over the past thirty years, several prominent legal scholars have suggested, based on preliminary data, that the science might not support our intuitions and assumptions.¹³ However, until recently, scientists did not have the strong long-term data to support the scholars' assertions. The results of national longitudinal studies were not yet available. Of the available studies, most focused on certain drugs present in the public dialogue at the time, such as cocaine, and did not evaluate drugs, like heroin, *951 that were largely ignored by society. Other drugs were not yet in regular use, either because they had not yet been approved by the FDA, such as buprenorphine, or because they simply were not used much at the time, like methamphetamine. Scientists also lacked much of the current knowledge about the role of genetics and epigenetics in fetal development.

As a result, the legal scholarship has not considered in depth the scientific evidence regarding the fetal and postnatal consequences of substance use by a woman during pregnancy. This Article is the first to examine the scientific literature and explore the legal implications of this data. Counter to most of our intuitions, the science challenges the purported ill effects offered to justify the use of the criminal law to punish a pregnant woman who uses, and often is addicted to, illegal drugs. The data undermines the prominent and common narratives about the damage a pregnant woman inevitably causes to her child if she consumes alcohol or drugs while pregnant.

In the vast majority of cases, exposure to drugs in utero does not result in the negative long-term effects legislators, and most of us, presume.¹⁴ Despite recent increases in methamphetamine and heroin use, cocaine remains the drug used most by pregnant women who come to the attention of authorities.¹⁵ Yet a recent longitudinal study concluded that children exposed to cocaine in their mother's womb did not exhibit long-term developmental consequences, even in adulthood.¹⁶ Other similar studies on the effects of marijuana and opiate exposure in utero produced substantially similar results.¹⁷

***952** In fact, many behaviors in which pregnant women engage have been documented and shown to be far more damaging to a developing fetus than using illegal drugs. For example, the lawful behaviors of smoking cigarettes, taking certain prescription drugs under the supervision of a physician, and in some women, drinking alcohol, each have an equal or greater negative effect on a developing fetus than illegal drugs. Likewise, environmental factors such as household violence have a more significant impact than any drug, legal or illegal, on the health and development of a fetus and child.¹⁸

The collateral consequences attributable to criminalizing a mother's use of illegal drugs are substantial. The prosecution of a woman for her behavior while pregnant tends to result in greater harm to the child, rather than less. If a pregnant woman using illegal drugs comes to the attention of law enforcement and prosecutorial authorities, odds are great that immediately after birth, her child will be taken away from her, in the name of the safety and protection of the child. Ample scientific and social science studies indicate that this removal of the child, without any evidence of actual harm, consistently results in poorer outcomes for that child, tending to cause greater long-term damage. To the extent a newborn experiences short-term withdrawal symptoms, taking her from her mother only cements the potential harmful effects of the drug.

In light of criminalization's ineffectiveness in addressing the potential harms from in utero maternal drug use, one has to question why states that use criminal statutes to prosecute pregnant women continue to pursue this course of action. At first blush, one might conclude that legislators, prosecutors, and courts are simply misguided. Perhaps they are unaware of the science and the potential negative impacts of prosecuting pregnant women and new mothers, despite the repeated entreaties of prominent doctors and medical organizations against this path. Certainly medical professionals have given the public reason to distrust their assessment of the benefits and harms to pregnant women on previous occasions.¹⁹

***953** This Article takes the position that more than simple lack of information and overreliance on intuition is at issue. Having reviewed the science, the demographics of pregnant drug, alcohol, and tobacco users, and the history of these prosecutions, this author concludes prosecutions of women for using drugs while pregnant are really about socioeconomic status, gender, and fundamentally, race. Only when one includes and explores these factors does the narrative make sense. For example, if our society were truly concerned about harms caused by a woman's activities while pregnant, we would expect to see middle- and upper-class white women charged with child endangerment for lawfully taking prescription drugs, drinking alcohol, or smoking cigarettes while pregnant. Yet such prosecutions are rare to nonexistent. When anyone is prosecuted for their activities while pregnant, they are primarily, if not only, poor and African American women.²⁰

This Article seeks to challenge the purported negative outcomes caused by in utero exposure to drugs and to elucidate other underexplored consequences stemming from our current punitive approach to this group of women. Part I examines the current scientific literature regarding the ingestion of illegal drugs by pregnant women. This Part then compares these studies with those examining the effects of exposure to alcohol and cigarettes in utero. After challenging the prevailing beliefs about the danger posed by these various factors, the Article turns in Part II to an exploration of the concrete effects resulting from an approach that views drug use by expectant women as a crime. Ultimately, in Part III, this Article concludes that our failure to accurately perceive and address the harms implicated by the criminalization of in utero exposure to drugs is yet another manifestation of deeply held misconceptions of poor women of color. The result is another example of the state's overreaching in an attempt to control poor and African American women's bodies in the name of the public good.

I. THE FETAL HARM FALLACY

Almost twenty-five years ago, in the wake of the crack cocaine epidemic, troubling stories circulated about babies born “addicted to crack.” Reports alleged “so-called crack babies ... had small heads and were easily agitated and prone to tremors and bad muscle tone.”²¹ Others claimed the babies were “aloof and avoided eye contact.”²² “Crack babies” became the prototypical symbol of bad mothering.²³ A billboard in Los Angeles in 1991 depicted a tiny African American baby, lying in a *954 hospital incubator with tubes coming from his nostrils, limbs, and head. The caption read: “He couldn't take the hit ... If you're pregnant, don't take drugs.”²⁴

The fears of a generation of troubled children--children born with learning, emotional, and behavioral deficits who would overwhelm the school system and jails, be unable to hold a job, or form meaningful relationships--turned out to be unfounded. In fact, scientists and physicians have long suspected that the effects of cocaine use by pregnant mothers on their children are relatively small and short-term, and certainly not the “catastrophic effects” predicted.²⁵ A recent large-scale longitudinal study confirmed early scientific findings. Additionally, prominent physicians and medical advocacy groups have been outspoken in asserting that babies born with these illegal drugs in their system do not tend to have lasting problems.²⁶

Despite this generally accepted professional understanding, legislatures have continued to endorse and propagate a flawed myth of maternal harm, largely based on race- and class-based ideas of motherhood, leading to laws that have little to no anchoring in medical realities. This Part begins with a brief introduction to how the law has treated pregnant women who use drugs over the past forty years. It then turns to a discussion of the validity of judicial and legislative assertions about the harms prenatal drug use cause to the developing fetus and subsequent child. In order to understand how little the law reflects the scientifically accepted understandings of the effects of both illegal and legal drugs, alcohol, and tobacco on fetuses and, subsequently, children, a review of current scientific and medical literature will follow.

*955 A. *A Brief History of the Law's Treatment of Drug-Using Pregnant Women*

Although Tennessee's 2014 statute was the first in the nation to explicitly criminalize the use of illegal drugs by a pregnant woman, Tennessee is certainly not the first state to prosecute a woman for this behavior.²⁷ As of April 1992, approximately 167 women had been arrested on criminal charges because they used illegal drugs while pregnant.²⁸ These women came from twenty-four states, although a disproportionate number of them came from four particular counties in Florida and South Carolina.²⁹ None of the twenty-four states had criminal statutes aimed at punishing drug-using pregnant women; rather, prosecutors extended generally applicable criminal statutes to this group of women.³⁰ Prosecutors relied on a wide range of preexisting statutes, including criminal child support laws, contributing to the delinquency of a minor, child endangerment, delivery of drugs to a minor, assault with a deadly weapon, manslaughter, and homicide.³¹ In the cases where the race of the woman could be identified, approximately 70% involved women of color.³² Poor women were more likely to be prosecuted than those with financial means.³³

A more recent study, analyzing data from 1973 until 2005, was published in 2011.³⁴ Lynn Paltrow and Jeanne Flavin reviewed data from legal, medical, news, and other periodical databases and obtained additional information through their own involvement with cases as well as through conversations with lawyers, judges, and health care providers.³⁵ Paltrow and Flavin identified 413 women against whom state action had been taken due to their behavior during pregnancy.³⁶ Not all of these cases involved allegations of drug use, but the majority did--approximately 84%.³⁷ These cases took place in every state except six, as well as at the federal level.³⁸ More than two-thirds of the cases came from ten states, again led by South Carolina and then Florida.³⁹ Approximately 71% of the women were economically disadvantaged, and approximately 59% were women of color.⁴⁰ African American women constituted 52% of those subject to state intervention in their pregnancies, whereas they constitute approximately 6-7% of the general population.⁴¹

*956 Strikingly, in the majority of cases, no evidence of harm to the fetus or newborn was present.⁴² Rather, in many cases, the criminal charges relied on a positive drug test or an identified “risk of harm.”⁴³ Often, that “risk of harm” never evolved into an actual harm.⁴⁴ Even in cases where harm was alleged, the causal link between the pregnant woman's action or inaction and the identified harm often could not be established.⁴⁵

The legal landscape changed in 1997, when the South Carolina Supreme Court found that a statute's prohibition on child abuse and endangerment applied to viable fetuses.⁴⁶ The state prosecuted Cornelia Whitner on a charge of criminal child neglect after her baby was born with cocaine in its system.⁴⁷ On appeal, Ms. Whitner argued that her lawyer was ineffective for failing to advise her that the statute under which she was convicted might not apply prenatally.⁴⁸ Finding that “South Carolina law has long recognized that viable fetuses are persons holding certain legal rights and privileges,”⁴⁹ the court held there was no “rational basis for finding a viable fetus is not a ‘person’ in the present context” and affirmed Ms. Whitner's conviction.⁵⁰

In addition to the fetal personhood argument, the court also looked to the underlying policy rationales for allowing a fetus to be a person in this particular context. The court first confirmed the general proposition that “[t]he abuse or neglect of a child at any time during childhood can exact a profound toll on the child herself as well as on society as a whole.”⁵¹ The court then continued, declaring “the consequences of abuse or neglect which takes [sic] place after birth often pale in comparison to those resulting from abuse suffered by the viable fetus before birth.”⁵² Although the court admitted that “the precise effects of maternal crack use during pregnancy are somewhat unclear,” because Ms. Whitner's child was born “with cocaine in its system,” and because “it is well documented and within the realm of public knowledge that such use can cause serious harm to the viable unborn child,” the court found there to be no doubt that Ms. Whitner “endangered the life, health, and comfort of her child.”⁵³ It concluded, “the State's interest in protecting the life and health of the viable fetus ... is compelling.”⁵⁴

The South Carolina Supreme Court stood alone in its finding, despite numerous attempts by prosecutors in other states to persuade courts to follow it.⁵⁵ In 2013, *957 Alabama became the only other state to join its ranks.⁵⁶ In a case with parallel facts to *Whitner*, one of the petitioners in *Ex parte Ankrom*, Hope Ankrom, was prosecuted after her child tested positive for cocaine at birth.⁵⁷ The Alabama Supreme Court combined Ms. Ankrom's case with Amanda Kimbrough's on appeal. Ms. Kimbrough's child tested positive for methamphetamine at birth.⁵⁸ However, Timmy Kimbrough also suffered other complications at his birth, only some of which may have been attributable to the methamphetamine, and he passed away shortly thereafter.⁵⁹ Prosecutors charged both women with chemical endangerment of a child.⁶⁰ Relying on the language in *Whitner*, the Alabama Supreme Court found the plain meaning of the word “child” in the context of the chemical endangerment statute includes “unborn children.”⁶¹ Similarly, it found the state had a legitimate interest in providing unborn children “protection from the use of a controlled substance by their mothers.”⁶² The Alabama Supreme Court reaffirmed its holding a year later.⁶³

Tennessee's bill brought a new dimension to the legal landscape. Both South Carolina and Alabama's prosecution of women depended on an interpretation of the statutory term “person” or “human being” by the highest court.⁶⁴ Tennessee's legislature avoided wading into the territory of whether a fetus constitutes a human being, *958 and instead, explicitly criminalized the use of drugs by a pregnant woman.⁶⁵ Tennessee's law permitted, “prosecution of a woman for assault ... for the illegal use of a narcotic drug ... while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.”⁶⁶ The statute did not define “harm,” and it disregarded the medical definition of “addiction.” Contrary to what the law presumes, babies are not born “addicted” to illegal drugs because “[a]ddiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. In fact, babies cannot be born ‘addicted’ to anything regardless of drug test results or indicia of physical dependence.”⁶⁷ The law allowed for an affirmative defense if “the woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.”⁶⁸ Although other states had tried to pass similar statutes over the past several decades, those statutes never made it through the legislative process, or they morphed into other, noncriminal laws.⁶⁹

Prosecutors spearheaded the legislative effort in Tennessee, telling legislators “they needed stronger penalties to control addicted women's behavior.”⁷⁰ One district attorney told a House committee the goal was to balance “deterrence with accountability

and with treatment.”⁷¹ “I’m not out just to simply punish mothers, but I know human nature,” he continued. “Sometimes the incentive to get in a program might be the fact that we can charge these mothers [with a crime].”⁷² Another prosecutor in favor of the bill asserted that if the legislature passed the bill, it would hopefully “save the state money because these women, if they get cured of that addiction, are not going to be breaking into cars to feed that habit and then have to be housed out at the penal farm or at the Tennessee Department of Corrections or whatever the situation might warrant.”⁷³

*959 Similarly, the bill’s legislative sponsor, State Representative Terri Lynn Weaver, expressed an interest in holding addicts “accountable” for their use of drugs while pregnant. According to Representative Weaver, her bill was needed in order to reach “ladies ... who would [not] consider prenatal care. These are ladies who are strung out on heroin and cocaine, and their only next decision is how to get their next fix. ... What they’re thinking about ... is just money for the next high.”⁷⁴ Despite no evidence to support her perception of pregnant addicts, she went on to depict these women as cornered by the police with “a syringe up their arm” and “life in their belly,”⁷⁵ and repeatedly asserted her view that drug-using pregnant women were “the worst of the worst.”⁷⁶ Asserting that the bill was not punitive, Representative Weaver compared pregnant women who suffer from addiction to a five-year-old child, commenting that “they test you and they test you and then you have to spank ‘em, and you’ve got some accountability there because you’re trying to train them.”⁷⁷

Some prosecutors and legislators expressed a desire to help pregnant women seek drug treatment. As one prosecutor declared, the goal is “to hold a ‘velvet hammer’ over the heads of pregnant drug addicts to make them get treatment.”⁷⁸ Or, in the words of another, “We’re not looking to lock them up, we’re looking to get them help.”⁷⁹ Representative Weaver also asserted that her bill was designed to ensure pregnant women “get help.”⁸⁰ This was a surprising argument, given that a year before, Tennessee passed a law that gave drug-using pregnant women priority spots in drug treatment programs and provided other protections intended to encourage drug treatment without penalizing the woman for her drug use.⁸¹ However, many felt the *960 Safe Harbor law did not go far enough, despite limited data on which to judge the law’s success, and pushed for criminalization a year later.⁸²

Fundamentally, both prosecutors and legislators repeatedly expressed concern about harm to the fetus and subsequent child. As the interim executive director of the state prosecutors’ conference explained, “the district attorneys feel we have innocent children who are being harmed, in some cases to the point of death, and someone needs to be there for these children.”⁸³ His predecessor also noted, “We don’t have any problem with these mothers trying to get treatment and trying to get help, but if we have a child that’s damaged because of this drug injection, or stillborn, we need the ability to prosecute these ladies.”⁸⁴ Representative Weaver made a similar remark: “We have made a window for women who are pregnant to be above the law,” she asserted, and her legislation’s goal was to “sav[e] babies,” to “answer for those who do not have a voice.”⁸⁵ She continued, “any society that puts value on life would agree that these defenseless children deserve some protection.”⁸⁶

One might assume that the high rates of drug use in the state played a role in the proposal and passage of Tennessee’s law. As of 2013, Tennessee led the nation in methamphetamine use⁸⁷ and had the second highest rate of *prescription* opiate consumption.⁸⁸ The legislators seemed particularly concerned with the effects of neonatal abstinence syndrome (NAS), a condition that only arises in the context of opiate use, including both prescription opiates as well as “street” drugs like heroin. NAS is a group of treatable side effects that include excessive and high-pitched crying, irritability, and poor sucking reflexes, among other symptoms.⁸⁹ A study of pregnant women found 33.6% of Medicaid-eligible pregnant women in Tennessee filled a lawful prescription for opioids at some point during their pregnancy.⁹⁰ Notably, 60% *961 of the babies born in Tennessee with NAS were born to mothers who had a lawful prescription for their medication.⁹¹

Yet it was not the high rates of lawful prescription opiate use, or even methamphetamine use, that motivated legislators to pass this law.⁹² Legislators repeatedly referred to the scourges of cocaine and heroin as the target drugs.⁹³ As a result, Tennessee’s law only criminalized the use of *narcotics* by pregnant women—cocaine and opioids fell under this definition,⁹⁴ methamphetamine did not.⁹⁵ Additionally, the conduct of women who were prescribed opioids lawfully did not appear to be prohibited by the statute, regardless of any potential negative effects of the drug on the developing fetus or subsequent child.⁹⁶

Despite assertions that the lives of children were on the line, a search of Tennessee and U.S. databases revealed no deaths from NAS withdrawal since the condition was first diagnosed.⁹⁷

Tennessee's bill passed convincingly in the state Senate and House with bipartisan support⁹⁸ and backing from both white and Black lawmakers, despite a range of *962 objections from conservatives and liberals alike.⁹⁹ The law that passed in 2014 included a sunset provision to allow for legislators to review how the statute was working after a two-year period. However, the racial dynamics underlying the bill became apparent when the House bill came up for a vote. Representative Weaver, who is white, made a comment on the House floor about addicted women in Memphis having eight or nine babies addicted to drugs, drawing a sharp rebuke from one of her African American colleagues:

I don't know if you know ... but that [comment] was very offensive. And so I just wanted to share that with you. Because all over the state of Tennessee, women are having babies because [sic] they're on drugs, not just in West Tennessee, and the implication [was that this is just occurring] in urban areas Actually, [women who are on drugs are having babies] also in rural areas.¹⁰⁰

The underlying racial and gender dynamics surrounding the statute again became apparent during the House Committee hearings to renew the bill. In response to questions and apparent opposition to the bill by an African American, female representative out of Memphis, the white, male chair of the House Committee on Criminal Justice (a former prosecutor who supported allowing the law to remain in force) responded, "What we're saying is if *you* don't get the help that *you* need and then *your* child is born at full term and the day before or a couple days beforehand, *you* used one of these harmful substances and endangered *your* child--*you* used cocaine the night before--then we're going to hold ... that parent accountable."¹⁰¹ Prior to this exchange, committee members only referred to the abstract "woman" or "women" when discussing the targets of the bill.

After several days of hearings in March 2016, the House Subcommittee on Criminal Justice voted, in a three-three tie, to let the law expire.¹⁰² The three members *963 rejecting the law--the one Black Committee member, joined by two lawyer colleagues--expressed concern about the "unintended consequences" of the statute, primarily that the law discouraged women from seeking drug treatment early in their pregnancies.¹⁰³ One dissenting member highlighted evidence that the brunt of the developmental damage from opioids occurs in the first trimester, in addition to evidence that if a woman using an opioid tried to stop using drugs after learning she was pregnant, the harm to both her and her fetus would be more significant.¹⁰⁴ The law was allowed to sunset on June 30, 2016.

Because Tennessee's law is the only one to have explicitly criminalized the use of drugs by pregnant women, it remained under close scrutiny throughout the two years it was in force. The number of infants born with NAS remained about the same over the two years the law was in effect--approximately 1000 infants annually were born with NAS at the time the law went into force as well as two years later.¹⁰⁵ No evidence suggested that the law itself, or the threat of being arrested under the law, prevented opioid use by pregnant women.¹⁰⁶ Notably, even after the bill's passage, approximately 80% of newborns experiencing withdrawal from NAS in Tennessee were exposed to lawfully prescribed drugs, not heroin or other illegal substances.¹⁰⁷ The statute did not contemplate ingestion of lawfully obtained prescriptions by a pregnant woman.

Statistics on the number of prosecutions under Tennessee's law during its two years in force are difficult to obtain, as lawmakers did not require any agency to track them.¹⁰⁸ As of the fall of 2015, at least ninety-seven women had been prosecuted under Tennessee's statute, and likely more.¹⁰⁹ However, approximately 16,000 *964 substance-exposed babies were born in Tennessee during that same time period.¹¹⁰ The most recent, publicly available demographic information documented background on arrests of only nine women, approximately 10% of the known arrests.¹¹¹ Five were Black, four white, all of them poor.¹¹² Eight of the nine qualified for a public defender.¹¹³

Since Tennessee passed its 2014 bill into law, four other states contemplated similar legislation. North Carolina's 2015 proposal mirrored Tennessee's almost exactly.¹¹⁴ Oklahoma's legislation, proffered that same year, also closely resembled Tennessee's, although rather than allow evidence of drug treatment as an affirmative defense, Oklahoma's bill only permitted such evidence

to be introduced in mitigation at sentencing.¹¹⁵ Louisiana's 2015 proposed law redefined battery to allow for the prosecution of a woman who illegally uses any controlled dangerous substance while pregnant “if the child is born addicted to, or otherwise harmed by, the substance used while pregnant.”¹¹⁶

Most recently, a Missouri legislator introduced a bill before the House, inspired by Tennessee's law but with a much broader reach.¹¹⁷ Unlike the four states mentioned above, which each expanded (or proposed expanding) an existing criminal statute to allow its scope to cover fetuses, Missouri's proposal created a new crime of “abuse of an unborn child.”¹¹⁸ A woman can be convicted of this crime if she “knowingly ingests, injects, consumes, inhales, or otherwise uses a narcotic drug or controlled substance without a prescription” while she is pregnant *or* “knows or reasonably should have known” she was pregnant.¹¹⁹ The child need not be born “addicted to or harmed by” the drug for the woman's actions to be criminal.¹²⁰ Rather, if the child shows evidence of harm, the charge moves up from a misdemeanor class B offense to a misdemeanor class A offense.¹²¹ If the child dies, the offense becomes a class D felony.¹²² As with Tennessee's bill, the legislator sponsoring Missouri's proposed legislation indicated his goal was to “get women into treatment before they give birth.”¹²³ “I want to make sure these ladies get the help they need,” he said.¹²⁴ As a result, a woman who commits any of these offenses may be referred to a drug treatment program, if permitted by the court.¹²⁵ As of this writing, none of these bills has been passed into law.

Despite the lack of success with reducing NAS and opioid use by pregnant women under Tennessee's statute, other states appear ready to continue what Tennessee started. Thus it remains important to look closely at the motivations and justifications offered in support of this type of prosecution.

B. The Effects of Illicit Drug Use In Utero

Underlying the actions of the state courts, legislators, and prosecutors in their decisions to allow the pursuit of criminal charges against women for using drugs while pregnant is the intuitive belief that such drug use causes harm, or at the very least, a serious risk of harm, to both the developing fetus and the child subsequently born. This next Part explores the scientific evidence in order to determine whether our intuitions are actually supported by the science.

Typically, maternal prenatal substance abuse has been defined in relation to three types of addictive substances: alcohol, tobacco, and illegal drugs.¹²⁶ According to a recent national study, approximately 5.4% of pregnant women nationwide use illicit drugs, 9.4% consume alcohol, and 15.4% smoke tobacco cigarettes.¹²⁷ These rates have remained fairly consistent over the past decade.¹²⁸ However, substantial overlap exists. “Approximately 32% of women who use illicit drugs during pregnancy also use alcohol and cigarettes.”¹²⁹

Recent longitudinal studies have begun to explore pregnant women's use of legally authorized prescription drugs. Yet medications vary in their prenatal effects and scientists are only beginning to look comprehensively and comparatively at the effects of various prescriptions on fetal and childhood development. As a result, most conversations about prenatal substance abuse focus on the three substances listed in the preceding paragraph, despite increasing evidence of prescription drug use and abuse by pregnant women.

Illicit drugs constitute the smallest percentage of addictive substances pregnant women ingest. Yet, over a thirty-two-year period between 1973 and 2005, pregnant women were arrested or subjected to restrictions on physical liberty at least 348 times due to an allegation that they had used an illegal drug.¹³⁰ Between 2005 and December 2014, another 380 cases arose,¹³¹ marking a rapid acceleration in the criminalization of drug use by pregnant mothers.

Arrests and prosecutions disproportionately affect poor women and women of color,¹³² even though wealthier women and white women are as likely to use substances—including alcohol and tobacco—and far more likely than others to voluntarily report substance use during pregnancy.¹³³ White pregnant women are “less likely to be screened for substance abuse compared to Black women” and are less likely to have substance use documented in their charts than both Black and Latina women.¹³⁴ Women who seek care in public clinics and hospitals, usually women of lower socioeconomic status, also are much more likely to be screened than those of greater means who tend to visit private doctors' offices or hospitals.¹³⁵

Despite illicit drug use being relatively rare among pregnant women, criminal laws focus on this behavior, overlooking other maternal, paternal, and external factors that play a greater role in a fetus and child's development. Rather than rely on scientific research, our laws assess harm based on the social meaning of different drugs.¹³⁶ As several notable scientists observed, “Illicit drugs are the most often targeted drugs in the fight against maternal substance abuse, because they are perceived to produce the most harmful side effects in both the mothers and the children.”¹³⁷ These perceptions do not always match up with reality, however.

This next Part looks in more detail at the accepted medical knowledge regarding the consumption of illegal drugs by pregnant women.

1. Cocaine

Cocaine was the first major illegal drug to inspire the expansive and aggressive use of criminal laws to punish pregnant women for its use.¹³⁸ Cocaine remains the drug most used by women subject to arrest or court intervention.¹³⁹ Eighty-one percent of pregnant women involved in cases where authorities intervened to curtail her liberty involved an allegation of cocaine use.¹⁴⁰ Although initial studies suggested that children exposed to cocaine in utero were “irreparably doomed and damaged,”¹⁴¹ *968 numerous subsequent studies, including a national large-scale, longitudinal study,¹⁴² debunked those findings.

Now, scientists generally acknowledge that their initial suppositions and studies were incorrect.¹⁴³ Children exposed in utero to cocaine do not end up with developmental or behavioral differences markedly distinct from similarly situated children who did not receive such exposure. Rather, studies have documented that prenatal exposure to cocaine does not have a negative effect on a child's weight, length, or head circumference,¹⁴⁴ has little impact on “children's scores on nationally normed assessments of cognitive development,”¹⁴⁵ has not shown consistent negative effects on cognitive or psychomotor development,¹⁴⁶ inhibitory control,¹⁴⁷ memory,¹⁴⁸ or receptive language,¹⁴⁹ revealed no association with a reduction in receptive or expressive language skills,¹⁵⁰ and has shown no effect on motor development.¹⁵¹ Cocaine exposure in utero has not been shown to affect toddler play or problem-solving abilities, or to cause behavioral disturbances,¹⁵² although there is some evidence that prenatal exposure to cocaine may contribute to difficulties with sustained attention and behavioral self-regulation starting during adolescence.¹⁵³ However, gestational cocaine exposure does not appear to have an effect on teenage pregnancy rates, school failure rates, drug use, or court adjudication.¹⁵⁴

Home environments and violence, by contrast, did affect these outcomes.¹⁵⁵ In fact, one of the important findings to come out of the studies of prenatal cocaine exposure is the critical observation that “early cognitively stimulating experiences in *969 the home environment are critical for later learning.”¹⁵⁶ Caretaker involvement is “significantly associated” with decreases in any potential behavioral issues.¹⁵⁷ Cocaine-exposed children with high resilience, many friends, and family resources experienced fewer attention and behavioral problems.¹⁵⁸ As children get older, childhood experience likely plays a more significant role in later cognitive functioning than what occurred in utero.¹⁵⁹

At least one state court has acknowledged that “cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.”¹⁶⁰ Yet that court is in the minority. Legislators, courts, and prosecutors all continue to rely on the narrative of dangerous crack-addicted mothers who are birthing damaged, ineducable children who are on an inevitable path toward criminality and prison, ignoring the reality that few, if any, statistically significant differences exist in the long-term health and life outcomes between those babies exposed to cocaine in utero and those not exposed.¹⁶¹

2. Amphetamines

The second most commonly used drug by pregnant women who have come into contact with the justice system is methamphetamine/amphetamines.¹⁶² The number of pregnant women using methamphetamine while pregnant tripled between 1994 and 2006,¹⁶³ although several studies indicate that fewer than one percent of women use methamphetamine while pregnant.¹⁶⁴ The prenatal effects of methamphetamine are only beginning to be studied, and are complicated by the fact that women who use methamphetamine frequently use tobacco, alcohol, and other drugs as well, skewing the outcomes of the studies.¹⁶⁵

Previous studies suggested the possibility of results somewhat similar to cocaine. For example, they indicated the risk of disrupting the development of the fetus was unlikely.¹⁶⁶ In a review of current studies, the American College of Obstetricians and *970 Gynecologists (ACOG) summarized its findings on the possible long-term effects of methamphetamine in utero: children ages three to sixteen were similar in motor skills, nonverbal intelligence, and short-term spatial memory, but showed potential issues with attention span, verbal memory, visual/motor integration, and long-term spatial memory, behavioral problems, poorer psychosocial well-being, and lower academic achievement.¹⁶⁷

The National Institute of Drug Abuse is currently in the midst of a population-based longitudinal study to evaluate developmental outcomes in mothers who used amphetamines while pregnant.¹⁶⁸ Early results suggest findings slightly more troubling than those found with prenatal exposure to cocaine. Although the multicenter longitudinal study indicates no cognitive differences in children exposed to methamphetamine in utero, it has revealed increased emotional reactivity, anxiety, and depression in children ages three and five.¹⁶⁹ At age five, attention problems also began to manifest.¹⁷⁰ By age seven-and-a-half, some of the children exhibited more aggressive, rule-breaking behavior.¹⁷¹

However, several other indications make it less clear that methamphetamine is the source of these deficits. The study found that children prenatally exposed to methamphetamines faced other significant adversity in their early years, such as extreme poverty or a change in caregiver before the age of three, which were “strong determinants of adverse behavioral outcomes in methamphetamine exposed children” and associated with behavioral and emotional control issues.¹⁷² Additionally, many of the women who gave birth to children with these deficits also drank alcohol and smoked cigarettes, making the specific effects of methamphetamine less certain.¹⁷³ ACOG has clarified there “is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine.”¹⁷⁴ Because these *971 studies are in the early phase, the possibility remains that, as with cocaine, the scientific findings will not end up supporting the initial indications of methamphetamine's negative effects.

3. Opioids¹⁷⁵

Opioids come in both legal and illegal forms. They include morphine, codeine, Vicodin, Demerol, oxycodone, heroin, and methadone. Only a very small number of women nationally use opioids while pregnant, and more women abuse prescription pain relievers than illegal opiates.¹⁷⁶ According to a 2008 study, 0.1% of pregnant women were estimated to have used heroin in the past thirty days, and 1% reported “nonmedical use of opioid-containing pain medication.”¹⁷⁷ Another study suggests the numbers are slightly higher.¹⁷⁸

One of the primary conditions associated with the use of opioids by pregnant women is Neonatal Abstinence Syndrome (NAS).¹⁷⁹ Some babies exposed to opioids in utero are born with NAS, a group of treatable side effects of prenatal exposure to prescription medications and heroin.¹⁸⁰ Some of the most prominent side effects include excessive and high-pitched crying, irritability, and poor sucking reflexes, among other symptoms.¹⁸¹ The condition itself has not been associated with any long-term adverse effects.¹⁸²

Conversely, reducing a pregnant woman's opiate intake, or forcing/encouraging her to cease the use of opioids altogether while pregnant, is much more dangerous to the fetus. In the first trimester, withdrawal can cause miscarriage.¹⁸³ In the third trimester, premature labor or stillbirth may result.¹⁸⁴ As a result, for many years, the *972 preferred method of addressing a pregnant woman's opioid use has been maintenance of opioid intake, preferably through the use of methadone as opposed to other

opioids.¹⁸⁵ According to ACOG, methadone maintenance during pregnancy is “part of a comprehensive package of prenatal care.”¹⁸⁶ Buprenorphine, another opioid, is increasingly recommended and used in a manner similar to methadone.¹⁸⁷

Studies have not found significant differences in cognitive development between children up to five years of age exposed to methadone and those who are not, controlling for age, race, and socioeconomic status.¹⁸⁸ In fact, children exposed to heroin or methadone in utero function in the normal range of mental and motor development through ages five to six.¹⁸⁹ Most opioids do not carry an increased risk of birth defects, with the exception of codeine, and even those risks are fairly small.¹⁹⁰ Limited data are available on long-term outcomes of infants exposed to opioids in utero.¹⁹¹

More women today abuse prescription pain relievers than illegal opioids.¹⁹² Although most laws either explicitly or implicitly prohibit the prosecution of women using opioids under the care of a physician, a national study of over a million women from 2000 to 2007 revealed that an average of 21.6% filled a prescription for an opioid during pregnancy.¹⁹³ Codeine and hydrocodone accounted for the majority of prescriptions filled.¹⁹⁴ Prescriptions for methadone and buprenorphine were rarely filled.¹⁹⁵

4. Marijuana

Although tobacco and alcohol are the most common addictive substances pregnant women ingest, marijuana is the leading illegal¹⁹⁶ drug. A recent study found that 3.7% of pregnant women use marijuana.¹⁹⁷

The evidence from numerous well-controlled studies concludes there are *973 “minimal to no effects” of prenatal exposure.¹⁹⁸ Some evidence suggests this is because the placenta acts as a barrier, limiting exposure to THC, although the evidence is not conclusive.¹⁹⁹ In utero marijuana exposure is not associated with any major fetal growth or physical abnormalities.²⁰⁰ Numerous studies have shown no association with low birth weight, gestational age, or preterm birth.²⁰¹ Likewise, school-aged children exposed to marijuana in utero did not show any lower IQs, although some showed deficits in problem solving, memory, and attention up to the age of sixteen.²⁰² This may be due to the fact that smoking marijuana produces five times the amount of carbon monoxide as tobacco smoking.²⁰³ Additionally, as with amphetamines, scientists often have trouble discerning what may be the effects of marijuana and what is attributable to the concurrent use of alcohol, tobacco, or other illegal drugs, as well as the effects of poverty, malnutrition, lack of prenatal care, and intimate partner violence, with which there is often overlap.²⁰⁴

C. The Effects of Alcohol In Utero

In contrast to findings indicating relatively few harmful effects to a fetus from most illegal drugs, the negative effects of excessive alcohol consumption during pregnancy are well documented and established, yet not criminalized. Medical experts continue to assert that both alcohol and tobacco are the most dangerous addictive drugs to a developing fetus.²⁰⁵ Fetal Alcohol Syndrome (FAS) has been recognized in medical literature since 1968, and it contributes to slow growth, damage to the nervous system, facial abnormalities, and developmental delays.²⁰⁶ Although *974 “high levels” of alcohol consumption are the undisputed cause of FAS, what constitutes a “high level” is unclear.²⁰⁷ Fetal Alcohol Spectrum Disorder (FASD), which is much more prevalent than FAS, “encompasses all patients displaying some of the clinical features of fetal alcohol exposure.”²⁰⁸ The syndromes falling under the FASD umbrella include cognitive deficits, growth retardation, memory deficits, poor motor skills, facial abnormalities, and behavioral problems.²⁰⁹

Despite the well-documented effects and presence of FAS and FASD, only 5-10% of women who drink during pregnancy give birth to children manifesting these syndromes.²¹⁰ Numerous factors contribute to the presence or absence of FAS/FASD, including poor nutrition and health, the quantity of alcohol consumed over the course of the pregnancy, frequency and duration of alcohol exposure, and the developmental stage of the fetus at the time of consumption.²¹¹ Additionally, recent genetic studies

have revealed that certain genes are more susceptible to the negative effects of alcohol than others.²¹² Both a mother's genetic background and *975 environmental or "epigenetic"²¹³ factors contribute significantly to the likelihood that a fetus will be affected by maternal alcohol intake.²¹⁴ Although scientists only recently have begun to figure out which genes play a role and which do not, numerous studies conducted over the past forty years leave the findings firmly established.²¹⁵

Notwithstanding the commonly known and identifiable effects of FAS and FASD, to this author's knowledge, no state has prosecuted a woman for consuming alcohol while pregnant,²¹⁶ nor has any legislature criminalized the intake of alcohol by pregnant women.²¹⁷ In forty-one of 348, or about 11%, of identifiable cases of arrest or forced legal intervention between 1973 and 2005, alcohol consumption was mentioned, but only in addition to other illegal drug use.²¹⁸

D. The Effects of Cigarettes In Utero

Of the three categories of addictive substances outlined above, tobacco use is the most prevalent among pregnant women,²¹⁹ and, research would suggest, the most dangerous. Tobacco is one of the more harmful addictive substances on the fetus. As one expert noted, "[I]f substances were ranked in terms of the severity of their devastating consequences to fetal and maternal health, the two legal substances of alcohol and tobacco would likely decidedly trump the negative consequences associated with illicit substances such as cocaine, heroin, and marijuana."²²⁰

Cigarette smoke contains approximately 4000 chemical compounds, including *976 carbon monoxide, approximately thirty of which are dangerous to the fetus.²²¹ Cigarette smoke reduces uterine blood flow by up to 38%, results in low birth weight, and interferes with normal placental function and fetal development, particularly the developing nervous system and brain.²²² Some studies have linked prenatal nicotine exposure to sudden infant death syndrome (SIDS) as well as short- and longer-term behavioral and cognitive problems and effects on IQ and attention deficits.²²³

Despite its known dangers, tobacco use is not illegal for pregnant women, and, as with alcohol, neither legislators nor prosecutors have sought to criminalize or prosecute women for using tobacco while pregnant. In a review of cases involving forced legal intervention of pregnant women, the fact that a woman smoked cigarettes was mentioned in only 3% of cases.²²⁴

E. Prescription and Over-the-Counter Drugs

Historically, the medical and legal communities only contemplated the effects of illicit drugs, alcohol, and tobacco on fetal and childhood development. Little attention was paid to prescription or over-the-counter drugs. As a result, "there is insufficient information on the risks and safety for the vast majority of medications, whether they are obtained by a prescription or over the counter."²²⁵ Given the exponentially increasing use of prescription and over-the-counter drugs by pregnant women²²⁶ --both under the care of a physician and outside the care of a physician--the medical community has begun to place greater focus on this line of inquiry. To date, only one study, based on data from the Centers for Disease Control and the Slone Epidemiology Center, has evaluated prescription medication use during pregnancy over a significant period of time.²²⁷ We are still awaiting studies on over-the-counter medications.²²⁸

According to the longitudinal study of prescription medicine use by pregnant women, over the past thirty years, pregnant women have increased their use of prescription drugs by more than 68%.²²⁹ By 2008, nine out of every ten women took *977 medication while pregnant, and about seven out of ten took medication requiring the prescription of a physician.²³⁰

Many researchers suspect that prescription medications may cause damage to developing fetuses and children. For example, recent research indicated that a particular type of epilepsy drug can cause neurological problems, including autism spectrum disorder.²³¹ More extensive research needs to be done in order to determine the potential consequences of taking common medications.

At this point, however, so long as a pregnant woman is using prescription drugs with a valid prescription, legislators seem to not be particularly concerned about the potential harmfulness of those drugs. In fact, four of the five states to enact or propose legislation criminalizing drug use by pregnant women have carved out an explicit exception for lawful acts by a pregnant woman or medication prescribed by a physician.²³² Over-the-counter medications similarly are not contemplated by statutes or legislators. Only drugs deemed illegal or illegally used without a doctor's supervision are worthy of criminalization.

This differential legal treatment of a medication solely based on whether a woman has a lawful prescription suggests that harm to the fetus and subsequent child are not the primary concern of legislators, but that harm, perhaps, is a pretext for some other motivation behind these laws. A closer look at the demographics of the primary users of each type of drug provides a clearer picture as to what the underlying motivations might be.

***978 F. Demographics of Substance Use by Pregnant Women**

Most of the women arrested for consuming illegal drugs while pregnant are of financially limited means, and historically, women of color, with Black women overrepresented.²³³ In many ways, this result is unsurprising, given the fears and prejudices stemming from the crack cocaine epidemic of the 1980s and early 1990s. As mentioned previously, most women who came into contact with the criminal justice system for using drugs while pregnant between 1973 and 2005 were cocaine users.²³⁴ Not incidentally, the majority of those women were indigent (71%) or women of color (59%).²³⁵ Studies from the early 1990s confirm that pregnant Black women of lesser economic means appear to have used cocaine at a higher rate than pregnant women of other races.²³⁶ Yet the existence of such a correlation is only the beginning of the story.

The association between the rates of cocaine use and prosecutions for such behavior begins to reveal how class and race have influenced, and continue to influence, what behaviors are criminalized. In the context of criminal laws, particularly drug laws relating to poor women of childbearing age, states use class and race as proxies for deviant behavior.²³⁷ Whatever illegal drug appears to be in most regular use by poor women seems to spur on a new series of laws, or interpretations of existing laws, aimed at controlling poor women's reproductive capacities. Harkening back to the stories of “crack babies” from an earlier time, about ten years ago, news articles began discussing “meth babies,” who purportedly “ma[d]e the crack baby look like a walk in the nursery,” and more recently, “oxytots,” describing children born dependent to prescription opioids.²³⁸

Economic status appears to be an increasingly important factor in predicting which women will be subject to arrest for their drug use while pregnant. Authoritative data on the use of other substances by pregnant women confirm that the link between poor women's behavior and criminalization is causal, rather than merely correlated. Pregnant methamphetamine users tend to be white, young, unmarried, of lower socioeconomic status, and with less than a high school education.²³⁹ Likewise, women who ingest marijuana while pregnant tend to be younger, white, with a lower level of education, and higher rates of unemployment and low pay.²⁴⁰

Opioids are a bit more complicated, in part because some of them can be obtained and ingested legally, and in part because of the increasingly white, middle-class ***979** nature of heroin use in this country.²⁴¹ The use of illegal opioids by pregnant women disproportionately occurs in rural and suburban settings.²⁴² Pregnant opioid-using women from rural areas tend to be white and young, but they are also more likely to be employed than similarly situated urban opioid users.²⁴³ Pregnant rural users are more likely to use prescription opioids illegally, whereas pregnant urban users, who are often Black, are more likely to use heroin.²⁴⁴

Nevertheless, heroin increasingly is considered a “white person's scourge.”²⁴⁵ Although it once primarily affected inner-city, minority communities, heroin is now being used with regularity by younger, middle-class white people outside urban areas.²⁴⁶ With the shift in demographics, legislators, the public, and even the previous President of the United States²⁴⁷ increasingly have called for a public health approach, rather than the punitive approach for which they advocated when lower-class Black communities were suffering from heroin's effects.²⁴⁸ White middle-class heroin users often have “parents who are empowered They know how to call a legislator, they know how to get angry with their insurance company, they know how to advocate. They have been so instrumental in changing the conversation.”²⁴⁹

The more compassionate approach legislators, the executive branch, and the public are taking with regard to the average white heroin user, however, shows no signs of affecting pregnant women. Poor white, and Black, pregnant women who do not have resources are still regularly arrested for using heroin while pregnant.²⁵⁰

By contrast, when we look at the demographics of pregnant women who drink alcohol, ingest tobacco, and use lawfully obtained prescription drugs--often *980 prescription drugs that are opioids--they tend to be white women with a higher education and socioeconomic status. In other words, as with illegal drugs, race and class dynamics undoubtedly have an impact on the law's treatment of pregnant women who drink, smoke cigarettes, and take pain pills-- but in a very different way.

Newborns with white mothers have the greatest risk of alcohol exposure in utero.²⁵¹ The greatest percentage of pregnant women who consume alcohol are college-educated, employed white women ages thirty-five to forty-four.²⁵² In fact, Black women are 41% less likely to drink while pregnant than white women, and Latina women are 58% less likely to do so.²⁵³

The statistics on prenatal lawful prescription use largely mirror that of alcohol. An average of 21.6% of women in a nationwide study filled a prescription for an opioid during pregnancy.²⁵⁴ Twenty-nine percent of those women were white, 19% Black, and 13.4% Latina.²⁵⁵ Consistent with alcohol use, educated white women took prescription medications at a higher rate during pregnancy than those with less education.²⁵⁶ These medications include Xanax, Oxycontin, Demerol, Ritalin, and Tylenol with codeine. Prescription medication use was lowest among pregnant Latinas, with "intermediate" use among pregnant Black women.²⁵⁷

Cigarette smoking is the one anomaly. Unlike those who drink while pregnant, cigarette smokers tend to be less educated and have a lower income than nonsmokers.²⁵⁸ Pregnant women ages twenty to twenty-four are more likely to smoke than pregnant women of other ages.²⁵⁹ Native American women report the highest rates of smoking during pregnancy,²⁶⁰ followed by white women.²⁶¹ By contrast, pregnant Black and Latina women smoke cigarettes at low rates.²⁶² In fact, Black pregnant women are 71% less likely to smoke during pregnancy than white women, *981 and Latina women 76% less likely.²⁶³ In other words, those who smoke cigarettes while pregnant largely mirror those who use methamphetamines, marijuana, and unlawful opioids. One might surmise that perhaps the strong presence of the tobacco lobby plays a role in the hesitation to criminalize tobacco use,²⁶⁴ although it does not explain the failure to creatively use general criminal statutes to prosecute women who smoke tobacco while pregnant if, in fact, legislators are truly concerned about harm to fetuses and subsequent children.

Rather, it seems to come down to the perception that our society sees drugs classified as illegal as morally reprehensible in some way, whereas tobacco, although more dangerous, is legal and therefore accepted. As several prominent scientists have noted, "When prenatal cocaine and tobacco exposure are compared dispassionately, it becomes clear how sociopolitical forces shape discrepant interpretations of similar scientific data."²⁶⁵

II. THE HARMS OF CRIMINALIZATION

The prevailing belief about the damage inherent in using illegal drugs while pregnant turns out to be largely unfounded. Yet legislators and the general public rely on these flawed assumptions about the danger to our children from illegal drug use to justify the arrest and prosecution of certain women for their behaviors while pregnant. At the same time, they ignore the well-established negative consequences that attend to criminalizing the prenatal use of drugs.

This next Part turns its focus to the harmful outcomes a newborn child experiences as a result of the state's intervention upon discovery of her mother's illegal drug use. In addition to the potential consequences of certain lawful addictive substances,²⁶⁶ the state's remedial measures often create additional problems for the child. In most instances, the deleterious implications from discouraging prenatal treatment and removing the child from the home outweigh the potential negative consequences to a child from in utero exposure to illegal drugs.

A. The Harms of Removal

Although many associate the removal of a newborn child with the pain and emotion the parent experiences, the child herself often suffers significant difficulties as a result of the removal.²⁶⁷ In fact, one of the most significant negative effects resulting from the criminalization of drug use by a pregnant woman is the removal of her ***982** newborn.²⁶⁸ Most states are quite aggressive about removing newborns from the custody of mothers who use drugs while pregnant.²⁶⁹ Often this results in the child's placement with a relative or foster family for anywhere from months to years to an indefinite period of time.²⁷⁰

1. Harms to the Child

According to most legislatures, the goal of removal is to protect children from “unsafe settings and mothers too impaired and unstable to provide proper care” by temporarily removing them from those environments.²⁷¹ The goal of this temporary removal is to rehabilitate the parents and reunify them with their children.²⁷² In practice, child welfare authorities usually open a case when an infant tests positive for an illegal substance either because the infant has been harmed by the exposure, or because they believe in utero exposure to the illegal substance is an indicator of future maltreatment.²⁷³ Yet both of these bases for potential removal are problematic. If a child tests positive for an illegal drug, removal generally occurs for reasons other than whether the child suffers any harm from that prenatal exposure.²⁷⁴ As one journalist observed, “[a] woman can be charged ... even if her baby is born perfectly healthy, [and] even if her goal was to protect her baby from greater harm.”²⁷⁵ Additionally, studies have shown that families of substance-exposed children are no more likely to engage in maltreatment of their children than families without children who are substance-exposed.²⁷⁶ In other words, the focus of removal process is not on the ***983** well-being of the child, as legally required,²⁷⁷ but on a judgment about society's fears of the possible harm from drug use.

Eighteen states' child abuse and neglect statutes allow for the removal of a child from a woman who use drugs during pregnancy.²⁷⁸ In fact, some states define a “neglected minor” to include infants born with controlled substances in their system.²⁷⁹ Other states go even further. In Minnesota, for example, although a doctor is not required to test every child born, if a doctor suspects a mother used drugs “for ... nonmedical purpose[s]” during her pregnancy, the doctor is required to test the child.²⁸⁰ If the child has drugs in her system, the doctor must report the child as neglected.²⁸¹ These statutes disproportionately impact poor Black mothers.²⁸²

In part because of these statutes, the number of children entering foster care under the age of one has remained relatively high over the past thirty years.²⁸³ The foster ***984** care population increased exponentially from the mid-1980s through the early 1990s as a result of the crack cocaine epidemic.²⁸⁴ The increase in identifiable parental substance abuse led to a significant increase in the number of very young infants entering foster care.²⁸⁵ As of 1994, 23% of children entering the foster care system were under a year of age.²⁸⁶ That percentage has subsequently decreased somewhat, and as of September 2014, 17% of children entering the foster care system had not reached a year of age.²⁸⁷ However, at 17%, this percentage remains much higher than that of any other age group entering the foster care system.²⁸⁸

Medical personnel, often in conjunction with law enforcement and social service providers, are the primary institutional players referring infants to the child protection system.²⁸⁹ Drug use is more likely to be detected in those less financially privileged because their private lives already tend to be more subject to governmental intrusion.²⁹⁰ Those with less financial means are more likely to seek medical treatment at public clinics and hospitals.²⁹¹ One scholar noted, “because poor families are more public and interact so frequently with governmental agencies, their problems are more visible to the child protection authorities.”²⁹² By contrast, wealthier women generally visit private doctors' offices and hospitals.²⁹³ Private doctors generally do not test their patients for drug use and would be disinclined to report them to the police.²⁹⁴ As Professor Dorothy Roberts observed, “These doctors have a financial stake in securing their patients' business and referrals.”²⁹⁵ If a pregnant woman with private insurance encounters resistance from her medical provider, she can seek out another medical provider, an option not available to women obtaining health care from a public hospital or clinic.²⁹⁶

***985** Most hospitals do not have formal screening procedures.²⁹⁷ Rather, medical professionals determine whether to test a newborn based on their perceptions of the expectant mother's behavior.²⁹⁸ A majority of women alleged in court to have used illegal drugs while pregnant were low income, often African American, and reported by hospital staff.²⁹⁹ Black women are drug tested during delivery more often than white women, and when their drug use is found, it is reported to child welfare authorities at a much higher rate than with their white peers.³⁰⁰ Troublingly, hospital staff appear to disclose information to police and prosecutors regularly, despite rules protecting patient confidentiality, and without legal authority authorizing them to do so.³⁰¹

Because state statutes permit the removal of a child in the event of a positive drug test, removal occurs early on for some children, generally to the detriment of their short- and long-term health and development. Recent scientific studies highlight some of the known benefits of early mother and child contact. Skin-to-skin contact between mother and child, also known as "kangaroo care," immediately after birth and for a period of time between fifteen and sixty minutes has been shown to benefit newborns in numerous ways, both short and long term.³⁰² A year after birth, children who were permitted this contact exhibited less irritability and dysfunction than infants separated from their mothers in the delivery room.³⁰³ Kangaroo care specifically has been shown to help with NAS as well.³⁰⁴ If the newborn is permitted to maintain skin-to-skin contact with her mother for three hours or more, the severity of the NAS symptoms diminish.³⁰⁵ In fact, kangaroo care counteracts frequent ***986** features of NAS such as irritability, poor sleep, poor state regulation, and stress.³⁰⁶ Newborns with NAS permitted to engage in kangaroo care were able to sleep calmly, in stark contrast to other babies with NAS.³⁰⁷

Breastfeeding also has been shown to benefit not only babies in general, but specifically those with NAS. Numerous studies have shown that human breast milk is "the quintessential source of protective nutrients for newborn infants."³⁰⁸ Other studies suggest that breastfeeding improves cognitive development, as measured by IQ and academic ratings.³⁰⁹ In the context of NAS, the amount of the opiate transferred during breastfeeding is generally very slight, but it has been shown to reduce the symptoms of NAS.³¹⁰

As indicated previously, according to most federal and state laws, removal should be a temporary solution, with the long-term goal being reunification of the child with their parent. Yet, as we see, the reality is quite different than what the law contemplates. Race and socioeconomics play a role in determining whether a child enters the child welfare system. As Professor Roberts observes, "It's a political decision to treat the needs of Black children through a coercive means of taking them from their parents and putting them in the custody of ... the government, represented by the custody of others, whether it's foster parents or group homes or other kinds of institutions."³¹¹

Race and socioeconomics also affect how long the child stays in the system.³¹² Children of color make up a disproportionate fraction of the children in foster care.³¹³ Twenty-two percent of children entering the foster care system are Black and 21% are Latino.³¹⁴ These percentages are much higher than the percentage of Blacks and ***987** Latinos in the general population.³¹⁵ Native American children also have high rates of representation in the foster care system.³¹⁶ Likewise, minority children receive differential treatment in the foster care system. They stay in the foster care system longer than other children, receive fewer services, receive fewer service plans, and see their parents less often.³¹⁷ As of 2012, the average length of stay for an African American child in the foster care system was 29 months, down from 40.6 months in 2002.³¹⁸ The average length of stay for a Latino child in 2012 was 23.2 months, a Native American child 21.2 months, and a white child 18.3 months.³¹⁹ As of the most recent data, on any given day, 24% of children in the foster care system are Black, 22% Latino.³²⁰

Children in the foster care system face a multitude of problems. They run a high risk of "emotional, behavioral, developmental, and physical health problems."³²¹ They tend to have higher rates of mental health issues and lag behind in educational achievement.³²² The rates of emotional, behavioral, and developmental problems are three to six times greater than the prevalence of such issues among children not in foster care.³²³ Studies have shown that many foster parents have unrealistic developmental expectations of their foster children, inadequate empathy for the children, or a lack of "parent-child role clarity."³²⁴ Undoubtedly these factors contribute to the risks facing children in foster care placements.

Infants who test positive at birth for illegal drugs are more likely to be placed in foster care than other possible out-of-home placements.³²⁵ Unfortunately, when foster parents know their foster child experienced prenatal drug exposure, they choose to return the baby more often than if the baby is not exposed to drugs in utero, and more often than if they do not know the child previously was exposed to drugs.³²⁶ This may be because many caregivers believe they are not equipped to care for drug-exposed infants, and they fear they will not be able to manage their care.³²⁷

***988 2. Harms to the Mother**

At the same time, removal amounts to punishment of the mother for her use of drugs. This punishment comes in several forms. Removal itself is a form of punishment.³²⁸ Many mothers who have their children removed at birth due to their own drug use during pregnancy do not want their child removed. As one scholar has noted, “[W]omen do not abuse drugs in a vacuum. There are a variety of societal factors, such as poverty, domestic violence, lack of social support and education, related to drug use.”³²⁹

The birth of a child gives many women both hope and a window of opportunity where they feel change is possible.³³⁰ For these women, the concern for their baby's health and well-being can be a motivating factor to cut down or quit drug use.³³¹ In fact, studies have shown that women who keep custody of their children “complete substance abuse treatment at a higher rate.”³³² As social scientists have observed, certain women perceive pregnancy as giving them a “chance at motherhood--possibly one of the only conventional, socially sanctioned identities available to the women in our study”; other women, who already have children, perceive it as a chance to be a “good mother.”³³³

To then lose the child at birth results in a “double loss” for these women--not only does the mother lose the child, she also loses the image of herself as a competent mother.³³⁴ In other words, she may feel as though “to fail at motherhood is to fail at what is considered a woman's most fundamental social role.”³³⁵ Numerous studies have confirmed that when women are denied the opportunity to raise their own children due to removal of the child or incarceration, they are “stigmatized by society through social ostracism” and judgment.³³⁶

In many instances, not only is the child removed from the mother as a result of the mother's drug use, but the mother is charged with a crime³³⁷ and detained, an ***989** additional punishment for using drugs.³³⁸ The number of Black children with an incarcerated mother has doubled over the past thirty years.³³⁹ If the child's birth mother is incarcerated, the harms of removal are exacerbated. Often, a child who is separated from her mother due to the mother's incarceration grieves the parental absence as a death.³⁴⁰ The long-term impact on the child is equally significant, often leading to withdrawal, or even verbal or physical aggression.³⁴¹

A majority of states have a law permitting termination of parental rights if a parent is incarcerated.³⁴² Additionally, under federal law, states are required to initiate termination of parental rights procedures if a child has been in foster care for fifteen of the past twenty-two months.³⁴³ The most recent data from the Bureau of Justice Statistics indicates that the average state drug possession sentence is thirty-seven months; most people will serve an estimated sixteen months of that time.³⁴⁴ As a result, many incarcerated mothers will lose permanent custody of their child if they are incarcerated for using drugs while pregnant. Even if a woman's sentence is shorter than fifteen months, reunification is almost impossible due to the numerous time-consuming conditions required for a mother to regain custody of her child.³⁴⁵ These conditions include participating in drug treatment--without the child present--and securing employment and housing,³⁴⁶ difficult tasks after serving time in a jail or prison.

By contrast to the fairly discouraging odds for prenatally exposed children in the foster care system, many infants do much better in their own home environments. ***990** Although many mothers may only have used drugs once or a few times throughout their pregnancy--and evidence suggests that child protective authorities target women with less severe addiction problems³⁴⁷--even women who use drugs more regularly are not the inherently bad mothers many assume. In fact, numerous studies have shown that women who use illegal drugs are able to be competent, concerned mothers.³⁴⁸ Drug-using mothers share the same values as non-drug-using mothers, engage in similar childrearing practices and methods of discipline, and have the same expectations

for their children.³⁴⁹ Mothering tends to be of as central importance for drug-using mothers as it is to those who do not use drugs.³⁵⁰ Parent-child interactions also do not tend to suffer due to a mother's drug use.³⁵¹ As a result, numerous experts have concluded that keeping the family intact should be the primary goal, not removing the child solely because maternal drug use is discovered.³⁵²

The importance of a stable early home environment cannot be overemphasized,³⁵³ as effective interventions within a child's home environment are more likely to lead to positive outcomes than removal from the home.³⁵⁴ A child's environment and caregiver play a far greater role in cognitive development than any prenatal exposure to illegal drugs.³⁵⁵ Studies show that drug-exposed infants who remain with their biological mothers demonstrate better cognitive development than those placed in the care of relatives or foster care.³⁵⁶ Meanwhile, a high stress, unpredictable neonatal environment, such as one that results after removing a child from her mother's care, can increase the severity of potential harms from drug and alcohol use while pregnant.³⁵⁷ Children who are removed from their mothers and placed in an institutional setting after birth tend to suffer from neurological deficits in the areas of the brain involved in higher cognition, emotion, and emotion regulation.³⁵⁸ These deficiencies *991 eventually go on to negatively affect intellectual, linguistic, emotional, and social development.³⁵⁹

As a result, social scientists highlight the critical importance of a child's psychological identification with, and emotional connection to, her caregiver.³⁶⁰ In fact, environmental factors can substantially minimize any potential negative impacts of prenatal exposure to illegal drugs, such as NAS, on early childhood physical and developmental growth.³⁶¹ A stable, enriched environment can ameliorate the potential harms from such exposure.³⁶² This security lays the foundation for later developmental stages, as well as the child's fundamental feelings of self-worth and competence.³⁶³ Although some children can make up for these impairments if they are transitioned into a "highly nurturing environment" early in their lives, most children suffer irreparable harm that continues to expand the longer the child goes without permanence in a stable, supportive home.³⁶⁴ Programs recognizing that vulnerable infants can develop normally, and even excel, in the care of their mothers have been quite successful.³⁶⁵

B. Lack of Prenatal Care

Although removal is probably the biggest source of harm to both the child and the mother, the lack of prenatal care a drug-using woman receives is also a significant source of harm to the developing fetus. As a result, every major medical organization in this country has vocally opposed criminalizing drug use by pregnant women. The organizations are concerned that an already vulnerable pregnant woman will not seek prenatal care if she fears, or knows, she will be arrested upon discovery of her drug use. Ostensibly, Tennessee's law, as well as some of the other proposed bills, encouraged women to seek drug treatment by permitting an affirmative defense if the woman "actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug."³⁶⁶ However, the dearth of available drug treatment programs with bed space and treatment options for pregnant women challenges this apparent encouragement. Of the states proposing similar legislation, North Carolina is the only one to include a provision allowing drug treatment to prohibit a conviction.³⁶⁷

*992 According to a 1990 report issued by the American Medical Association's (AMA) Board of Trustees, "Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment."³⁶⁸ As a result, the AMA passed a resolution opposing any legislation that criminalizes "maternal drug addiction."³⁶⁹ The American Public Health Association made a similar recommendation a year later.³⁷⁰ Since that time, every major medical, psychiatric, psychological, and public health organization has made similar proclamations.³⁷¹

*993 Each of those organizations has reached a similar conclusion--the punishment of pregnant women for using drugs is likely to send an "unintended message about the dangers of prenatal care. Ultimately, fear surrounding prenatal care would likely undermine, rather than enhance, maternal and child health."³⁷² Both scientific studies³⁷³ and anecdotal evidence support this conclusion. Several doctors in Tennessee, for example, learned that pregnant drug users avoided going to the doctor to get

prenatal care, going out of state to deliver or simply disappearing altogether.³⁷⁴ In fact, the need for prenatal care is greater for women who are using drugs, as most will need specialized, comprehensive medical and obstetric care, in addition to addiction counseling.³⁷⁵

The harm to the fetus and subsequent child from not receiving prenatal care can be substantial. Not only can the harms include low birth rate and early detection and treatment for long-term conditions, but the lack of prenatal care increases the risk of neonatal death by forty to fifty percent.³⁷⁶ Black mothers are more than three times more likely not to receive prenatal care than white mothers,³⁷⁷ and whether or not they receive prenatal care, they face infant mortality rates double that of any other racial group in the United States.³⁷⁸ Prenatal care is particularly important in high-risk populations, such as those who use drugs and those of lower socioeconomic status.³⁷⁹

The scientific evidence, expert recommendations, and qualitative evidence have fallen on deaf ears. In Tennessee, for example, prosecutors led the push for the legislative change permitting the explicit prosecution of pregnant women for using narcotic drugs while pregnant. As the Executive Director of the Tennessee District Attorneys General Conference explained to reporters, “We don’t have any problem with these mothers trying to get treatment and trying to get help, but if we have a child that’s damaged because of this drug injection, or stillborn, we need the ability to prosecute these ladies.”³⁸⁰

Although a stated motivation for Tennessee’s bill was to assist pregnant women in getting drug treatment, most states (including Tennessee) have few, if any, treatment options for those expecting a child. As of 2013, only 17%, or 2362, of all mental health and substance abuse facilities nationwide had programs specifically designed for pregnant and postpartum women.³⁸¹ Of those, approximately 87% are private facilities, almost 40% of which are for-profit organizations.³⁸² This number continues to diminish when looking at whether childcare is available. Only 7%, or 1004, of all mental health and substance abuse facilities provide childcare for participants in the program, and only 3.6%, or 509, had residential beds for clients’ children.³⁸³ Although the data does not indicate how many programs provide both, undoubtedly, the facilities that have programs for pregnant and postpartum women *and* provide childcare are few and far between.

“[C]hildcare is a necessary component for the majority of women seeking [drug] treatment.”³⁸⁴ Compared to their male counterparts, women who seek drug treatment tend to be younger, less educated, unemployed, suffering from anxiety, depression, or suicidal thoughts, and have dependent children.³⁸⁵ For many women, a treatment facility that lacks childcare poses a significant barrier to treatment.³⁸⁶ Significantly, evidence suggests that postpartum women whose infants lived with them during inpatient drug treatment had higher completion rates and longer average stays in treatment.³⁸⁷ Conversely, those who were not permitted to bring their children with them seemed “unable to concentrate fully on their own recovery” and left treatment early.³⁸⁸

Access to treatment was recognized as a major problem when the Tennessee House Criminal Justice Subcommittee began to consider whether to allow Tennessee’s prenatal assault law to continue beyond the initial two-year period. The committee heard testimony that only eleven facilities in Tennessee would accept a pregnant woman into their drug treatment program, and of those, approximately half had waiting lists.³⁸⁹ Additionally, three facilities would not take insurance to cover the costs of treatment; they only accepted out-of-pocket money.³⁹⁰ Admission to some facilities required women to see a high-risk OB-GYN, which were often hard to find.³⁹¹ As a result, after the law’s passage in 2014, the number of pregnant women in publicly funded treatment programs declined over the next two years.³⁹²

When the bill was first passed, prosecutors, and apparently legislators, were not concerned about the limited treatment options. As one Tennessee prosecutor noted, “I wouldn’t want one detail to get in the way of what this bill would do.”³⁹³ The lack of treatment as a true viable option belies the assertion that the ability to prosecute “these ladies” was the impetus behind Tennessee’s law, or any of the other laws that have been used to prosecute women for using drugs while pregnant. The deeper motivation, as articulated by a Davidson County prosecutor, is the fundamental belief that “[d]rug users are not good parents.”³⁹⁴ Based on this belief, several Nashville-area prosecutors tried getting the courts to order women to take birth control

as a condition of probation and encouraging the jails to hand out long-acting contraception.³⁹⁵ Likewise, the push to terminate parental rights is rooted in this view. Many feel criminal penalties are needed “to control addicted women's behavior.”³⁹⁶

III. CONSTRUCTIONS OF MOTHERHOOD

Extensive evidence documents the harmful effects of in utero exposure to tobacco and, in some instances, alcohol, as well as the negative consequences of removing a child from her parent and the lack of prenatal care. Although most assume the ill effects of illegal drug use are far worse than any of these, the scientific evidence rejects this conclusion. Our laws, however, continue to rely on misplaced assumptions about harm. States criminalize, either directly or indirectly, the use of illegal drugs by pregnant women, but no state has contemplated criminalizing the use of tobacco while pregnant or the failure to obtain prenatal care.³⁹⁷ Likewise, legislators continue to disregard the significant role that poverty, domestic and neighborhood violence, epigenetic factors, and the father's own behavior play in harms experienced by a developing fetus and child.

The critical question is, why? Why, if we have significant, reliable, longitudinal evidence documenting the relatively few adverse consequences from illegal drugs, and similar studies documenting the greater damage caused by tobacco, alcohol, the lack of prenatal care, and removal from the home, why are we choosing to make illegal drug use while pregnant a separate crime?

Our society's perceptions of gender, class, and race provide the answer. As Professor Reva Siegel long ago noted, “the reality of this harm does not necessarily explain the ways this society chooses to regulate women's conduct.”³⁹⁸ She *996 continued, posing the question, “Would this society so readily contemplate criminal prosecution, ‘protective’ incarceration, or custody-deprivation as responses to maternal addiction if the policies were to be applied to privileged women rather than the poor?”³⁹⁹ A similar question can, and should, be framed regarding the intersectionality of race and socioeconomic status: would we continue to pursue these criminal laws if the policies were applied to privileged white women rather than poor Black women?⁴⁰⁰ A closer look at how laws criminalizing a pregnant woman's conduct are implemented provides a resounding “no” to these questions. As Siegel concluded back in 1992, “today as in the past, judgments about motherhood in this society are delineated by class and race, as well as by sex.”⁴⁰¹ Now, almost twenty-five years later, strikingly little has changed.

A. The Usual Justifications for Punishment Do Not Apply

The state legislators creating laws specifically criminalizing the use of drugs by pregnant women, the prosecutors who rely on these and other generally applicable criminal laws to punish women for this same behavior, and the judges who sanction punishment based on these justifications all vocally rely on the harm to the fetus and subsequent child as motivation for their actions. Yet, with the harm fallacy debunked, it becomes apparent that something else must be the true motivation for these actions. Typically, criminal law relies on five primary theories to justify punishing someone: utilitarianism, retribution, deterrence, rehabilitation, and incapacitation. Perhaps, with the harm theory nullified, the justification is one of these pillars.

A closer look reveals that none of the usual justifications for punishment step in to do that work. As indicated previously,⁴⁰² rehabilitation is one ostensible motivation for Tennessee's law and North Carolina's proposed bill. Both include provisions encouraging pregnant women to seek drug treatment. But the lack of available treatment options and the apparent unconcern for this “detail” in the law belie the assertion that rehabilitation truly is the concern.⁴⁰³ Additionally, ample evidence shows pregnant women are more likely to seek drug treatment if they do not fear prosecution when they go to get prenatal treatment. If rehabilitation is the goal, increasing funding and available drug treatment options for pregnant women and removing the threat of a criminal conviction and jail time are far more likely to encourage this result.

The debunked harm fallacy likewise tends to undermine utilitarianism as a justification for punishing illegal drug use by pregnant women. Utilitarianism punishes only if the overall benefit to society of such punishment outweighs the overall harm. In her pitch to renew Tennessee's law, Representative Weaver articulated a utilitarian *997 theory, telling the Subcommittee on Criminal Justice, “We need all hands on deck to defeat the darkness of drug addiction unleashed on our most vulnerable. Our newborn babies are tormented by drugs and that's just got to stop.”⁴⁰⁴ She noted the “devastation” drugs have on “everyone and everything”: “Drugs are destroying our lives. Babies are leaving our hospitals ... [and] going right back into a dangerous drug-infested home.”⁴⁰⁵ A utilitarian theory supports criminalization if, despite the harms such an approach creates, it reduces

the negative consequences of drug addiction generally, and more specifically, the negative consequences of maternal drug use to the fetus and subsequent child.

The evidence does not support a utilitarian theory, however. As Part II documents, the deleterious effects of criminalizing drug use by pregnant women are expansive, affecting the children born to these women, the women themselves, and broader attempts to eliminate drug use by women of childbearing age and curtail the potential harms from this behavior. Pregnant women do not seek prenatal care and often forego an opportunity to cease their use of drugs when laws like this are in place.⁴⁰⁶ More societal harms seem to be created by implementing this type of law than reduced. The children born to mothers who used drugs while pregnant, overall, do not appear to be better served by this type of law, nor does society. Illegal drug use is much less of a danger than many other deleterious behaviors that are not criminalized. The damaging outcomes from society's treatment of pregnant women who may be struggling with drug abuse, poverty, physical abuse, or any other number of unseen battles outweigh any potential benefits of making such behavior a crime.

Deterrence is another primary goal of criminal law--both the deterrence of women from using drugs, and the deterrence of others from engaging in similar behavior. Tennessee's law, as well as the bills introduced in other states, openly acknowledged deterrence as a motivation. As one prosecutor noted during legislative hearings in Tennessee, "The whole intent of this bill ... balances deterrent [sic] with accountability and with treatment."⁴⁰⁷

Yet the data does not support criminalizing maternal drug use under this theory either.⁴⁰⁸ For example, over the period of time Tennessee's law was in effect, the number of infants exposed to heroin or born with NAS remained the same as prior to the law's passage.⁴⁰⁹ There was no evidence indicating the law decreased the percentage of drug-exposed babies.⁴¹⁰ Testimony from former addicts before the House Subcommittee confirmed the law did not deter their use. Instead, women did not seek drug treatment or prenatal care prior to giving birth because they feared arrest.⁴¹¹ Additionally, 80% of infants going through withdrawal in Tennessee were exposed *998 to legally prescribed drugs.⁴¹² The law as written in Tennessee, and proposed in other states, which excludes the prosecution of women using lawfully prescribed substances, would have no impact on this group of children. In this context, deterrence fundamentally fails as a proposed justification. Rather than being deterred from using drugs, pregnant drug users are deterred from seeking prenatal care and other services that might lead them to limit their drug use.

Some states have cited incapacitation as a motivation for their approaches to these laws. Two arguments could be made for incapacitation. The first involves the illegal behavior by the mother. As Representative Weaver noted in response to a colleague who expressed concerns about putting an addicted mother in jail, "[T]he lady is already dealing and breaking the law-- she is dealing with illegal narcotics, so that's already a crime."⁴¹³ In other words, incarceration is a legitimate punishment for someone who "is dealing with illegal narcotics," regardless of whether she is pregnant or has recently given birth. A second reason to incapacitate a mother is to prevent her from hurting her fetus with her continued illicit activity.

In response to the first contention, the general illegality of "dealing with" prohibited drugs does not justify the incapacitation of pregnant or recently postpartum women. Certainly incapacitation removes someone who uses drugs from society and punishes them for engaging in an illegal activity--the possession of illegal drugs. However, laws such as Tennessee's do not authorize prosecuting pregnant women for *possessing* drugs, but for using them, alleging the *use* to be an assault on the fetus/child. Supreme Court case law prohibits criminalizing drug addiction and, inferentially, the use of drugs.⁴¹⁴ If drug use is not illegal, it cannot be the justification for incapacitating someone.

Likewise, incapacitation does little to address the concerns regarding the conduct of the women targeted by these laws, the issue raised by the second argument. Those who argue in favor of incapacitation as a justification for criminalizing prenatal drug use rely on the flawed assumption that prenatal drug use causes certain negative outcomes to the fetus and subsequent child. If, in reality, prenatal drug use causes few-to-no harmful effects, as discussed in Part I, incapacitation cannot be used as a valid justification for this type of law.

We finally turn to retribution, the most significant tool in most modern legislators' and prosecutors' arsenals. Retribution requires the punishment to fit the crime, and it is often summed up by the Old Testament idea of "an eye for an eye." In the language of prosecutors and legislators, "these ladies" need to be held "accountable."⁴¹⁵ *999 But the harm for which the woman needs to be held accountable, for which she needs to atone, is the harm to the fetus. The "victim" of the crime here is the fetus.⁴¹⁶ Under this theory, the woman must be punished appropriately for the harm she caused her child. But if the harm to the fetus

and subsequent child is minimal to nonexistent, the justification for retribution becomes moot. Under a retributivist approach, someone cannot be punished more harshly than her actions deserve. If there is little to no harm, there is little to no basis for which to criminalize a person's actions.

Underlying each of these standard criminal law justifications is a thread of moral blameworthiness, however. Criminal law is aimed at punishing conduct deemed morally threatening to society.⁴¹⁷ Moral condemnation alone appears to be the only justification for criminalizing prenatal drug use. As one Tennessee prosecutor noted, he believes “[d]rug users are not good parents.”⁴¹⁸ In other words, in his view, this moral judgment justifies the criminalization of prenatal drug use and the requirement that women be made to pay for their moral transgression by giving up their children and being subject to criminal punishment.⁴¹⁹ Likewise, Representative Weaver declared that this law brings “redemption and hope to many Tennesseans.”⁴²⁰ Although other legislators and judges might not be quite so explicit in their condemnation, a closer look at how these statutes play out on the ground reveals moral judgment about what does and does not constitute good motherhood to be the motivating factor behind these laws.

B. Race-, Gender-, and Class-Based Moral Judgments

Moral blameworthiness is at the heart of the punishments many women are now facing. For many, the use of drugs is seen as a moral failure. Drug users are seen as people who are unworthy to procreate and undeserving to be mothers. They are “quickly branded ... as immoral and unfit mothers.”⁴²¹ This moral judgment is visible in statements such as “drug users are not good parents” or these mothers are “the worst of the worst.” When someone makes this type of declaration, she usually has an image of who that “drug user” or bad parent is. Often, she envisions the drug-using bad parent as a poor woman, many times a Black poor woman.⁴²² They envision her with a “syringe in her arm” and a “baby in her belly,” hanging out on a street corner.⁴²³ In 1997, Professor Roberts wrote that the criminalization of drug use by *1000 pregnant women “belongs to the continuing legacy of the degradation of Black motherhood. ... The prosecutions are better understood as a way of punishing Black women for having babies rather than a way of protecting Black fetuses.”⁴²⁴ The word “Black” must be supplemented with, and increasingly can be replaced by, the word “poor.”

Historically, laws punishing drug-using pregnant women were applied almost exclusively to Black women of a lower socioeconomic class, but in their most recent manifestation, these laws are applied more broadly to all women of a lower socioeconomic class. No empirical or anecdotal evidence appears to exist documenting the prosecution of any middle- to upper-class women for these crimes. However, decades of evidence support the conclusion that only those of lesser financial means are ending up in the criminal justice system for their behavior while pregnant.⁴²⁵ The available data from Tennessee's prosecution of drug-using women, albeit quite limited, is a case in point. Approximately half of the women prosecuted were white, the other half Black; almost all were poor.⁴²⁶ As Professor Michele Goodwin observed, at this point, “class matters as much as race” in the application of these laws.⁴²⁷

This observation, however, does not tell the full story. The heightened attention paid to class distinctions does not answer the question of whether white women or women of other races are collateral damage of policies that remain aimed at Black women, or whether poorer non-Black women are now being treated similarly to how Black women historically have been treated. Interactions like the one between the representatives during both the Tennessee House Subcommittee on Criminal Justice hearing and floor debate,⁴²⁸ as well as the statistics on how few women are prosecuted relative to the widespread evidence of maternal drug use in utero, suggest that perhaps these laws do remain aimed at Black women, and that white women and women of others races are collateral damage.⁴²⁹ Other indications suggest that class distinctions are increasingly racialized, and that perhaps, non-Black women are now being subject to the same punitive viewpoints as Black women have been for at least a century.

Over the past fifty years, social scientists have observed that class distinctions have come to play as important a role in determining one's sociopolitical status as race itself.⁴³⁰ As class distinctions have become more polarized, they also have *1001 become increasingly racialized.⁴³¹ The racialization of class attributes has led to the identification of those who are underprivileged to be conceptualized as a member of a racially disempowered group.⁴³² As one scholar noted, “Race has left

a heavy footprint on class.”⁴³³ In fact, racial categories take on renewed force against the backdrop of class, reinforcing these racialized categories rather than erasing them.⁴³⁴

In many ways, class is as much about culture and morality as it is about economics.⁴³⁵ Our society associates wealth, advantage, and presumptions of innocence with whiteness, the presumptive norm.⁴³⁶ Conversely, deviance, lack of wealth, disadvantage, and presumptions of guilt are associated with Blackness.⁴³⁷ In certain limited circumstances, Blacks with money are permitted to become “operatively *1002 white.”⁴³⁸ Likewise, for whites without money, the opposite also can be true. Whites without wealth and advantage can become “operatively Black.” In other words, someone white can be “implicitly raced.”⁴³⁹

The criminal justice system provides a stark example of this trend, evidence of which is apparent in the context of making drug use by pregnant women a crime. Overwhelmingly, statistics show that most women caught using illegal drugs while pregnant are poor.⁴⁴⁰ Although many are still Black, increasingly the women arrested for using drugs while pregnant are white.⁴⁴¹ In the eyes of the criminal justice system, however, poor white drug-using pregnant women have become “operatively Black.” Poor white women who use drugs while expecting are now subject to a similar moral condemnation and criminal punishment as their Black peers have been for approximately forty years.⁴⁴² The fact of their phenotypic whiteness does not prevent them from being implicitly racialized as Black.⁴⁴³ Society's recent forgiving treatment of middle- and upper-class white heroin users supports the conclusion that class reinforces racialized categories rather than eliminating them.

The prosecution of drug-using women who have just given birth adds another level of degradation onto a person society views as undeserving to be a mother in the first place.⁴⁴⁴ These prosecutions are a form of punishment for the woman's failure to comply with society's expectations for a soon-to-be mother. As Professor Goodwin observed, “[S]tate interventions in women's pregnancies seem far more related to evaluating women's compliance and obedience.”⁴⁴⁵ If not kept in check, drug-using women are always at risk for more pregnancies, an indication of their “reproductive unruliness” and the “intractability of [their] procreative facilities.”⁴⁴⁶ By daring to become pregnant, these women invoke “connotations of danger, moral failure, pathology, and instability.”⁴⁴⁷ Even without the drug use, they are morally culpable for being poor and pregnant; their level of deviance and culpability only increases with the presence of drug use or addiction.⁴⁴⁸ Poor, pregnant women are the “other” by which middle-class women define their middle-class selves as women *1003 of moderation and restraint, women who are sexually responsible, educated, and healthy.⁴⁴⁹ In essence, the law imposes severe penalties on the poor, pregnant drug user—a criminal conviction and removal of her child—for the audaciousness of her defiant choice to continue her pregnancy to completion despite her lack of financial resources, and her lack of moderation and restraint, as evidenced by her use of drugs during the prenatal period.⁴⁵⁰

Gender also augments the confluence of class and race in the context of maternal drug laws, yet again ignoring what scientists know about fetal and child development. Large-scale genetic and epigenetic studies have found that the biological father's use of drugs, alcohol, and tobacco, diet, and other factors can have short- and long-term implications for a developing fetus and child, sometimes for generations.⁴⁵¹ However, no legislator or prosecutor is talking about prosecuting men for using drugs in the days, weeks, or years prior to conception. The legal burden is placed entirely on the mother.⁴⁵²

Inherent in statutes that criminalize the use of drugs by pregnant women, as well as in general criminal laws interpreted to accomplish the same end, is the idea that when a pregnant woman does not act as society expects her to, she is deserving of punishment.⁴⁵³ She is being prosecuted primarily because of her pregnancy, not just her drug use alone.⁴⁵⁴ As Professor Deborah Tuerkheimer explains, “The paradigmatic pregnant woman is selfless, sacrificing, willing and able to put the interests of her unborn child ahead of her own needs and desires, and fully committed to—and capable of—providing a uterine environment that is nothing short of perfection. Deviation from this archetype threatens social norms”⁴⁵⁵ A pregnant woman who uses illegal drugs violates these expectations and our social norms and is “viewed as self-indulgent, placing her desire to get ‘high’ ahead of the need of her offspring to be born healthy.”⁴⁵⁶

*1004 The act of punishing and confining a woman for this behavior, for being a “bad or unacceptable mother,” imposes what amounts to a “state legitimized form of motherhood” onto the woman.⁴⁵⁷ Because a pregnant woman who is using drugs

is behaving as a “bad parent,” the state may intervene and punish her for violating our societal expectations of motherhood. Rather than help her get prenatal care and treatment in a real and meaningful way, allowing her to fulfill her role as a mother to her child, the government punishes her, thereby “refus[ing] to affirm [her] human dignity by helping [her] overcome obstacles to good mothering.”⁴⁵⁸ Pregnancy becomes a tool, an opportunity for state supervision, management, and regulation of poor women.⁴⁵⁹

As a result, pregnant women of lower socioeconomic backgrounds continue to be arrested and punished for using drugs while pregnant, while little is being done to increase the availability of treatment. With the shift in the government's focus toward methamphetamine and opioids, one wonders whether the more compassionate approach to drug use may ultimately prevail, particularly given that the public face attached to the pregnant methamphetamine or opioid user is white and middle class, rather than Black and poor, as it was during the crack cocaine epidemic.

CONCLUSION

Statutes that explicitly criminalize the use of illegal drugs by pregnant women, although perhaps well intended, are based on faulty assumptions about the negative consequences caused by such drug use and a downplaying of the harms. The harms of criminalization can be avoided by ceasing the practice of using criminal law as a mechanism to try and address the health-related harms of drug use. Removing criminal sanctions would encourage women to get prenatal care, thereby increasing the likelihood of a healthy baby and the odds that the mother will receive drug treatment. This could also discourage the close connection between the medical community and law enforcement, at the expense of the doctor-patient relationship.

Likewise, a child should not be removed from her mother solely because the mother has used an illegal drug while pregnant. Some showing of serious harm should be required, and the harm should be serious enough that coercive state intervention will do more good than harm. If women are encouraged to seek prenatal care, correspondingly, they are also more likely to take advantage of wrap-around services to help with the continuation of services and drug treatment once they are new mothers.⁴⁶⁰

***1005** To be clear, this Article is not advocating for the use or abuse of illegal drugs. This Article is advocating for a more holistic, empirically based, health and welfare approach to the use of drugs by a high risk population. The answer does not lie in criminal courts. Although drug use and abuse will not go away any time soon, we can more effectively protect fetuses and the subsequent children by being thoughtful and conscientious about our approach to both their health and the health of their mothers.

Footnotes

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¹ TENN. CODE ANN. § 39-13-107 (2014), amended by TENN. CODE ANN. § 39-13-107 (Supp. 2016); George Brown & Molly Smith, *Mother of Addicted Infant To Get Treatment*, WREG.COM (Memphis) (Aug. 4, 2014, 9:46 AM), <http://wreg.com/2014/08/04/mother-of-addicted-infant-to-get-treatment/> [https://perma.cc/7GG8-AKLG];

Tom Humphrey, *Memphis Woman Becomes 2nd Charged Under Drug-Abusing Mother Law*, KNOXBLOGS.COM: TOM HUMPHREY'S HUMPHREY ON THE HILL (July 29, 2014), <http://knoxblogs.com/humphreyhill/2014/07/29/memphis-woman-becomes-2nd-charged-drug-abusing-mother-law/> [<https://perma.cc/T5G5-XKUS>]. The author notes that although the possession of drugs is a crime, the use of drugs is not, in and of itself, a crime. See *Robinson v. California*, 370 U.S. 660 (1962).

- 2 Humphrey, *supra* note 1.
- 3 Rosa Goldensohn & Rachael Levy, *The State Where Giving Birth Can Be Criminal*, NATION (Dec. 10, 2014), <http://www.thenation.com/article/state-where-giving-birth-can-be-criminal/> [<https://perma.cc/2VL6-HFQE>].
- 4 Brown & Smith, *supra* note 1; Humphrey, *supra* note 1.
- 5 Aaron Wright, *Mom Charged Under Drug-Addicted Baby Law Going to Rehab*, WBIR.COM (Knoxville) (Aug. 5, 2014, 6:45 PM), www.wbir.com/story/news/local/mcminn-monroe/2014/08/05/woman-charged-under-drug-addicted-baby-law-to-appear-in-court/13614755 [<https://perma.cc/67HG-EC4Q>]; cf. Katie McDonough, *First Woman Arrested Under Tennessee Law That Criminalizes Pregnancy Outcomes*, SALON (July 11, 2014, 4:28 PM), www.salon.com/2014/07/11/first_woman_arrested_under_tennessee_law_that_criminalizes_pregnancy_outcomes/ [<https://perma.cc/N6AF-CWHL>].
- 6 Wright, *supra* note 5. Ms. Loyola successfully completed a drug treatment program, resulting in the charges against her being dismissed, as required by the new law. § 39-13-107; *Mom's Charge in Prenatal Drug Case Dropped After She Completes Program*, WBIR.COM (Knoxville) (Feb. 6, 2015, 7:24 PM), <http://legacy.wbir.com/story/news/2015/02/06/moms-charge-in-newborn-drug-case-dropped-after-she-completes-program/23002693/> [<https://perma.cc/YFL4-N6AK>].
- 7 See Brown & Smith, *supra* note 1; Goldensohn & Levy, *supra* note 3; Stephen Hatchett, LINKEDIN, <https://www.linkedin.com/in/stephen-hatchett-723a802a> (indicating that Loyola's lawyer, Stephen Hatchett, was employed as an Assistant Public Defender in Madisonville, Tennessee on August 5, 2014, the date he represented Ms. Loyola in court); McDonough, *supra* note 5.
- 8 Sheila Burke, *Doctors Applaud End of Tennessee's Fetal Assault Law*, AP: BIG STORY, <http://bigstory.ap.org/article/08ce8448799148bf852babadc33d1aef/doctors-applaud-end-tennessees-fetal-assault-law> [<https://perma.cc/537N-ZA88>].
- 9 See, e.g., *Ex parte Ankrom*, 152 So. 3d 397 (Ala. 2013); Doretta Massardo McGinnis, Comment, *Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory*, 139 U. PA. L. REV. 505, 505 (1990); Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene> [<https://perma.cc/Y4GG-882G>]. This approach permits an end-run around clearly established Supreme Court precedent prohibiting the criminalization of addiction. *Robinson v. California*, 370 U.S. 660 (1962) (finding statute that makes drug addiction a criminal offense unconstitutional). Many states also utilize civil commitment statutes to detain a woman until she gives birth to prevent her from ingesting drugs or alcohol while pregnant. See *infra* note 216.
- 10 Brief of the Appellant at 5-18, *United States v. Weld*, 619 Fed. App'x 512 (6th Cir. 2015) (No. 14-5894), *cert. denied*, 136 S. Ct. 1688 (2016) (relying on U.S. SENTENCING GUIDELINES MANUAL § 2D1.1(b)(13) (U.S. SENTENCING COMM'N 2015)); see also *Weld*, 619 Fed. App'x at 513.

- 11 Brief of the Appellant, *supra* note 10, at 25 n.9. See *infra* text accompanying note 67 regarding the inaccurate use of the term “addicted” to describe a newborn. See also *Weld*, 619 Fed. App’x at 513 (“Weld gave birth to a son who showed signs of opiate and amphetamine exposure, as well as drug-withdrawal symptoms.”).
- 12 See *infra* text accompanying note 451.
- 13 See, e.g., April L. Cherry, *Shifting Our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 J.L. & HEALTH 6 (2015); Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 CALIF. L. REV. 781, 805 n.121, 809-11 (2014); Lynn M. Paltrow, *Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs*, 8 DEPAUL J. HEALTH CARE L. 461 (2005); Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 938 (1997).
- 14 See, e.g., Lindsay Beyerstein, *Bad Medicine in Tennessee for Pregnant and Drug-Addicted Women*, AL JAZEERA AMERICA (Sept. 30, 2014, 5:00 AM), <http://america.aljazeera.com/articles/2014/9/30/tennessee-new-laws1391.html> [<https://perma.cc/NGF7-8FXL>] (quoting Dr. Robert Newman, president emeritus at New York’s Beth Israel Medical Center); Robert G. Newman et al., Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women (Mar. 11, 2013) <http://advocatesforpregnantwomen.org/Opioid%20Open%C20Letter%20-%20March%202013%20-%20FINAL.pdf> [<https://perma.cc/UY72-F258>]; see also, e.g., AM. NURSES ASS’N, OPPOSITION TO CRIMINAL PROSECUTION OF WOMEN FOR USE OF DRUGS WHILE PREGNANT AND SUPPORT FOR TREATMENT SERVICES FOR ALCOHOL DEPENDENT WOMEN OF CHILDBEARING AGE (1991); COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST 1 (2011) (noting that prenatal care greatly reduces the negative effects of substance abuse during pregnancy); NAT’L PERINATAL ASS’N, POSITION PAPER: SUBSTANCE ABUSE AMONG PREGNANT WOMEN 2 (2011) (“Using the criminal justice system is a misguided attempt to protect the fetus, [and] undermines maternal and fetal wellbeing”).
- 15 See 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, 315-16 (2013).
- 16 Katie McDonough, *Long-Term Study Debunks Myth of the “Crack Baby,”* SALON (July 23, 2013, 1:16 PM), http://www.salon.com/2013/07/23/longterm_study_debunks_myth_of_the_crack_baby/ [<https://perma.cc/V242-9JD7>]; see also Paltrow & Flavin, *supra* note 15, at 333-34.
- 17 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN & AM. SOC’Y ADDICTIVE MED., COMMITTEE OPINION: OPIOID ABUSE, DEPENDENCE, AND ADDICTION IN PREGNANCY 5 (2012; reaffirmed 2016); Karol Kaltenbach & Hendrée Jones, *Maternal and Neonatal Complications of Alcohol and Other Drugs*, in LOWINSON AND RUIZ’S SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 648 (Pedro Ruiz & Eric C. Strain eds., 5th ed. 2011); see also *infra* text accompanying note 198. But see *infra* text accompanying notes 165-68.
- 18 See, e.g., Henrietta S. Bada, Carla M. Bann, Toni M. Whitaker, Charles R. Bauer, Seetha Shankaran, Linda LaGasse, Barry M. Lester, Jane Hammond & Rosemary Higgins, *Protective Factors Can Mitigate Behavior Problems After Prenatal Cocaine and Other Drug Exposures*, 130 J. PEDIATRICS e1479, e1480, e1482, e1483 tbl.2 (2012); cf. *About Behavioral Risk Factor Surveillance System ACE Data*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 1, 2016), http://www.cdc.gov/violenceprevention/acestudy/ace_brfs.html [<https://perma.cc/7MMV-C4AA>].
- 19 See, e.g., DOROTHY ROBERTS, KILLING THE BLACK BODY 104-201 (1997) (discussing the racially charged policies from the 1990s and on that degrade the reproductive decisions of Black women by, among other methods, promoting controversial birth control methods and criminalizing drug use during pregnancy); Michele Goodwin,

Prosecuting the Womb, 76 GEO. WASH. L. REV. 1657, 1689-90 (2008) (discussing how reproductive policies “specifically target and disenfranchise specific racial groups,” leading to “arbitrary enforcement, attenuated adjudication, and inconsistent punishment,” particularly in a Charleston, South Carolina hospital in the late 1990s); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 283-84 (1992) (explaining that doctors originally opposed abortion as a way to establish themselves as professionals and to distinguish themselves from midwives).

20 Paltrow & Flavin, *supra* note 15, at 311; Roberts, *supra* note 13, at 938.

21 Susan FitzGerald, “Crack Baby” Study Ends with Unexpected but Clear Result, PHILLY.COM (July 22, 2013), http://web.archive.org/web/20161016031431/http://articles.philly.com/2013-07-22/news/40709969_1_hallam-hurt-so-called-crack-babies-funded-study [<https://perma.cc/46D3-X878>].

22 *Id.*

23 *Id.*

24 LAURA E. GÓMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 1 (1997).

25 *See, e.g.*, Deborah A. Frank, Marilyn Augustyn, Wanda Grant Knight, Tripler Pell & Barry Zuckerman, *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613, 1614 (2001).

26 Beyerstein, *supra* note 14; Libby Copeland, *Oxytots*, SLATE: DOUBLE X (Dec. 7, 2014, 7:52 PM) http://www.slate.com/articles/double_x/doublex/2014/12/oxytots_and_meth_babies_are_the_new_crack_babies_bad_science_and_the_rush.html [<https://perma.cc/9G5M-5T6S>]; Newman et al., *supra* note 14; *see also* AM. NURSES ASS'N, *supra* note 14 (“[The American Nurses Association] recognizes alcohol and other drug problems as treatable illnesses. The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems.”); COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, *supra* note 14 (noting that prenatal care greatly reduces the negative effects of substance abuse during pregnancy); COUNCIL ON ADDICTION PSYCHIATRY, AM. PSYCHIATRIC ASS'N, POSITION STATEMENT: ASSURING THE APPROPRIATE CARE OF PREGNANT AND NEWLY-DELIVERED WOMEN WITH SUBSTANCE ABUSE DISORDERS (2016) (“The use of the legal system to address perinatal alcohol, tobacco, or other substance use disorders is inappropriate. APA opposes the criminal prosecution and incarceration of pregnant and/or newly delivered women on child abuse charges based on the use of substances during pregnancy.”); NAT'L PERINATAL ASS'N, *supra* note 14 (“Using the criminal justice system is a misguided attempt to protect the fetus, [and] undermines maternal and fetal wellbeing”); Helene M. Cole, Am. Med. Ass'n Bd. of Trs., *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663 (1990) (analyzing the negative implications of using legal interventions to address drug use by pregnant women).

27 *See, e.g.*, LYNN M. PALTROW, AM. CIVIL LIBERTIES UNION FOUND., CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN: NATIONAL UPDATE AND OVERVIEW (1992).

28 *Id.* at 3. As of that time, two women had been arrested for drinking while pregnant. *Id.* at 5. One had her charges dropped because the state could not prove harm to the fetus. *Id.*

29 *Id.* at 3.

30 *Id.*

31 *Id.* at 4.

32 *Id.* at 6.

33 *Id.*

34 Paltrow & Flavin, *supra* note 15.

35 *Id.* at 301-02.

36 *Id.* at 309.

37 *Id.* at 315.

38 *Id.* at 309 (Delaware, Maine, Minnesota, Rhode Island, Vermont, and West Virginia marked the exceptions.).

39 *Id.*

40 *Id.* at 311.

41 *Id.* As of the latest census data from 2015, Black individuals made up 13.3% of the national population, and women make up 50.8%. *QuickFacts: United States*, U.S. CENSUS BUREAU (last updated July 1, 2015), <http://www.census.gov/quickfacts/table/PST045215/00> [<https://perma.cc/QN4E-SAXU>].

42 Paltrow & Flavin, *supra* note 15, at 317-18.

43 *Id.* at 318.

44 *Id.*

45 *Id.*

46 *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997).

47 *Id.* at 778-79.

48 *Id.* at 779.

49 *Id.*

50 *Id.* at 780.

51 *Id.* (emphasis in original).

52 *Id.*

53 *Id.* at 782.

54 *Id.* at 785.

55 *See, e.g.,* Reinesto v. Superior Court, 894 P.2d 733, 735-37 (Ariz. Ct. App. 1995); Reyes v. Superior Court, 141 Cal Rptr. 912, 912-15 (Cal. Ct. App. 1977); Johnson v. State, 602 So. 2d 1288, 1292-95, 1296 (Fla. 1992); State v. Luster, 419 S.E.2d 32, 33-35 (Ga. Ct. App. 1992); State v. Aiwohi, 123 P.3d 1210, 1213-24 (Haw. 2005); Herron v. State, 729 N.E.2d 1008, 1010-11 (Ind. Ct. App. 2000); Commonwealth v. Welch, 864 S.W.2d 280, 281-85 (Ky. 1993); Kilmon v. State, 905 A.2d 306, 313-14 (Md. 2006); People v. Hardy, 469 N.W.2d 50, 52-53 (Mich. Ct. App. 1991); State v. Wade, 232 S.W.3d 663, 664-65 (Mo. 2007); State v. Martinez, 137 P.3d 1195, 1195-97 (N.M. Ct. App. 2006); State v. Geiser, 763 N.W.2d 469, 470-74 (N.D. 2009); State v. Gray, 584 N.E.2d 710, 711-13 (Ohio 1992); *In re* Unborn Child of Starks, 18 P.3d 342, 345-48 (Okla. 2001); *Ex parte* Perales, 215 S.W.3d 418, 419-20 (Tex. Crim. App. 2007); State v. Dunn, 916 P.2d 952, 955-56 (Wash. Ct. App. 1996); State *ex rel.* Angela M.W. v. Kruzicki, 561 N.W.2d 729, 733-40 (Wis. 1997); *cf. In re* A.C., 573 A.2d 1235, 1242-47, 1252 (D.C. 1990) (en banc); *In re* Fetus Brown, 689 N.E.2d 397, 403-05 (Ill. App. Ct. 1997).

56 *Ex parte* Ankrom, 152 So. 3d 397 (Ala. 2013).

57 *Id.* at 401-02.

58 *Id.* at 402.

59 *Id.* at 403.

60 *Id.* at 401.

61 *Id.* at 411, 419.

62 *Id.* at 418. The court did go on to clarify that although it agreed with *Whitner* on the issue of whether an “unborn child” is a person, it did not support *Whitner*’s distinction between an unborn child “before and after viability [In this context,] the viability distinction has no place in the laws of this State.” *Id.* at 419.

63 *Ex parte* Hicks, 153 So. 3d 53, 57 (Ala. 2014). Recently, the Alabama legislature passed a bill to exempt pregnant women who use a controlled substance as directed by a medical provider, or with the “good faith belief” that their prescription was lawful, from the state’s chemical endangerment law. Nina Martin, *Alabama Lawmakers Limit Drug Prosecutions in Pregnancy*, PROPUBLICA (May 4, 2016, 2:02 PM), <https://www.propublica.org/article/alabama-lawmakers-limit-drug-prosecutions-in-pregnancy> [<https://perma.cc/ZSP4-UFRP>]. Alabama Governor Robert Bentley signed the bill into law in May 2016. *Id.*

- 64 Likewise, some states have enacted laws in recent years that expand the scope of homicide statutes to extend to fetuses as well. *E.g.*, Goodwin, *supra* note 13, at 788.
- 65 TENN. CODE ANN. § 39-13-107 (2014), amended by TENN. CODE ANN. § 39-13-107 (Supp. 2016).
- 66 *Id.* § 39-13-107(c)(2).
- 67 Newman et al., *supra* note 14; see also KASIA MALINOWSKA-SEMPRUCH & OLGA RYCHKOVA, OPEN SOC'Y FOUNDS., THE IMPACT OF DRUG POLICY ON WOMEN 11 (2015) (observing how “erroneous ideas about neonatal ‘addiction’ circulate and gain a foothold in the popular mind, even to the point of calling into question decades of research and World Health Organization (WHO)” research).
- 68 § 39-13-107(c)(3).
- 69 Paltrow, *supra* note 13, at 462-65, 462 n.9, 463 nn.10-12.
- 70 Goldensohn & Levy, *supra* note 3.
- 71 *Hearing on S.B. 1391 Before S. Judiciary Comm.*, 108th Gen. Assemb. (Tenn. 2014) [hereinafter Mar. 18, 2014, S.B. 1391 Hearing] (statement of Barry Staubus, District Attorney for Sullivan County, at 2:12:49) <http://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB1391&ga=108> (click “Video,” then click third “video” link next to Mar. 18, 2014 hearing date, then click on the link for S.B. 1391 on the left side of the screen).
- 72 *Id.* at 2:13:30. Previous prosecutorial efforts to encourage judges to order birth control as a condition of probation or get correctional facilities to give out long-acting contraception in the jails were unavailing. Goldensohn & Levy, *supra* note 3.
- 73 *Hearing on H.B. 1295 Before the H. Criminal Justice Comm.*, 108th Gen. Assemb. (Tenn. 2013) (statement of Amy Weirich, District Attorney for Shelby County, at 30:40), <http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=HB1295&GA=108> (click “Video,” then click second “video” link next to Apr. 9, 2013, hearing date, then click on the link for H.B. 1295 on the left side of the screen).
- 74 *Debate on H.B. 1295*, 108th Gen. Assemb. (Tenn. 2014) (statement of Rep. Terri Lynn Weaver, at 5:12:48, 5:14:39), <http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=HB1295&GA=108> [hereinafter Apr. 9, 2014, Debate on H.B. 1295] (click “Video,” then click second “video” link next to Apr. 9, 2014, hearing date, then click on the link for H.B. 1295 on the left side of the screen).
- 75 *Id.* at 5:32:00.
- 76 *Id.* at 5:14:31, 5:40:57.
- 77 *Hearing on H.B. 1660 Before the H. Subcomm. on Criminal Justice*, 109th Gen. Assemb. (Tenn. 2016) (statement of Rep. Terri Weaver, at 2:30:03), <http://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=HB1660&ga=109> [hereinafter Mar. 15, 2016, H.B. 1660 Hearing] (click “Video,” then click second “video” link next to Mar. 15, 2016, hearing date, then click on the link for H.B. 1660 on the left side of the screen).

- 78 Beyerstein, *supra* note 14. There are considerable issues that pregnant women face in getting treatment, not the least of which is the lack of available treatment options. *Id.*
- 79 Goldensohn & Levy, *supra* note 3.
- 80 Abby Ohlheiser, *Tennessee Passes Legislation To Criminally Prosecute Drug-Addicted Pregnant Women*, ATLANTIC (Apr. 9, 2014), <http://www.theatlantic.com/politics/archive/2014/04/tennessee-passes-legislation-to-criminally-prosecute-drug-addicted-pregnant-women/360424/> [<https://perma.cc/8BWT-E6RA>].
- 81 TENN. CODE. ANN. § 33-10-104(e), (f) (2015) (“[A] pregnant woman referred for drug abuse or drug dependence treatment at any treatment resource that receives public funding shall be a priority user of available treatment.”); *see also* Ohlheiser, *supra* note 80.
- 82 Goldensohn & Levy, *supra* note 3.
- 83 Tony Gonzalez & Dave Boucher, *Tennessee Targets Meth Abuse During Pregnancy*, WBIR.COM (Knoxville) (Apr. 8, 2015, 2:39 PM) <http://legacy.wbir.com/story/news/crime/2015/04/08/tennessee-targets-meth-abuse-during-pregnancy/25474383/> [<https://perma.cc/E6TB-E5YW>].
- 84 Tony Gonzalez, *Remedies Differ on Dealing with Addicted Babies*, TENNESSEAN, Mar. 11, 2013, at A6, 2013 WLNR 6286732.
- 85 Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74 (statement of Rep. Terri Lynn Weaver, at 5:32:21, 5:41:24, 5:32:15).
- 86 *Id.* at 5:10:38.
- 87 *Tennessee Now Leads the Nation in Meth Use, TBI Says*, WSMV.COM (Nashville) (May 6, 2013, 5:25 PM), <http://www.wsmv.com/story/22045724/tennessee-now-leads-the-nation-in-meth-use-tbi-reports> [<https://web.archive.org/web/20161210030209/http://www.wsmv.com/story/22045724/tennessee-now-leads-the-nation-in-meth-use-tbi-reports>].
- 88 Beyerstein, *supra* note 14. Dr. Stephen Patrick, a neonatologist at Vanderbilt University School of Medicine, testified before the Criminal Justice Subcommittee in a 2016 hearing. According to Dr. Patrick, as the opioid epidemic took off between 2000 and 2012, the presence of opioids increased five-fold nationwide, with Tennessee, Alabama, Michigan, and Kentucky each reflecting a rate of three times the national average. Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (statement of Dr. Stephen Patrick, at 1:33:45, 1:34:36-1:35:37).
- 89 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 17, at 5.
- 90 Rishi J. Desai, Sonia Hernandez-Diaz, Brian T. Bateman & Krista F. Huybrechts, *Increase in Prescription Opioid Use During Pregnancy Among Medicaid-Enrolled Women*, 123 OBSTETRICS & GYNECOLOGY 997, 999 (2014).
- 91 Lauren Rankin, *Proposed Tennessee Law Would Allow Drug-Addicted Pregnant Women To Be Prosecuted*, COSMOPOLITAN (Apr. 10, 2014), <http://www.cosmopolitan.com/health-fitness/advice/a6337/drug-addicted-pregnant-women-tennessee-law/?src=rss> [<https://perma.cc/L8VW-NTZ3>].

- 92 See Melissa Jeltsen, *Please, Stop Locking Up Pregnant Women for Using Drugs*, HUFFINGTON POST (Jan. 11, 2016), http://www.huffingtonpost.com/entry/pregnant-drugs-crime_us_5692ea9ee4b0cad15e653dd0 [<https://perma.cc/TH9L-9JMB>].
- 93 Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74 (statement of Rep. Terri Lynn Weaver, at 5:11:23, 5:23:09, 5:32:00).
- 94 Although cocaine is typically classified as a “narcotic” drug for federal and state drug law purposes, pharmacologically, cocaine is not actually a narcotic. See Carl B. Schultz, Note, *Statutory Classification of Cocaine as a Narcotic: An Illogical Anachronism*, 9 AM. J.L. & MED. 225, 225 (1983).
- 95 DRUG ENFT ADMIN., U.S. DEPT OF JUSTICE, DRUGS OF ABUSE, 2015 EDITION: A DEA RESOURCE GUIDE 36 (2015) (“[N]arcotic” refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is ‘opioid.’ Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin [], Vicodin[], codeine, morphine, methadone, and fentanyl.”). This appears to have been an oversight that legislators unsuccessfully “scrambled” to try and fix a year later. Gonzalez & Boucher, *supra* note 83. See S.B. 586, 109th Gen. Assemb., 1st Reg. Sess. (Tenn. 2015). The bill failed to pass the Senate Judiciary Committee.
- 96 The statute explicitly states that it does not apply to “any lawful act or lawful omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant, or to any lawful medical or surgical procedure to which a pregnant woman consents.” TENN. CODE ANN. § 39-13-107(c)(2) (2014), amended by TENN. CODE ANN. § 39-13-107 (Supp. 2016).
- 97 Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (statement of Mary Linden Salter, Executive Director of Tennessee Association of Alcohol, Drug, and Other Addiction Substances, at 2:12:35, 2:12:56).
- 98 See HB 1295, TENN. GEN. ASSEMBLY, <http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=HB1295&GA=108> (click on “Votes” link on right side of screen) (listing all representatives voting “aye” and “no” on the bill). The bill’s co-sponsors were Representative Weaver, a white Republican who represents a somewhat rural district outside Nashville, and Senator Reginald Tate, a Black Democrat who represents a more urban constituency in Memphis. See *id.* (sponsorship noted on left side of screen). The votes in both chambers were not strictly on party lines. See *id.*
- 99 *Id.* Objections ranged from concerns that the bill encouraged pregnant drug users to obtain abortions to the lack of available drug treatment facilities, from the question of funding to indications that the law would discourage pregnant women from getting prenatal care. See, e.g., Mar. 18, 2014, S.B. 1391 Hearing, *supra* note 71 (statement of Sen. Doug Overby, at 2:14:29, 2:15:52); *id.* at 2:29:48 (statement of Mary Nell Bryan, Pres. of Children’s Hospital Alliance of Tennessee, and employee of March of Dimes); *id.* at 2:54:27 (statement of Nathan Ridley, Tennessee Association of Alcohol, Drugs, and Other Addiction Services); Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74, at 5:11:37 (statement of Rep. Sherry Jones); *id.* at 5:26:30 (statement of Rep. Bill Dunn). Those objections would surface again in the spring of 2016, when the law came up for renewal.
- 100 Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74 (statement of Rep. Brenda Gilmore, at 5:36:50). Representative Weaver apologized, *id.* at 5:37:36, but one of her white male colleagues from a primarily white, affluent Memphis suburb came to her defense, confirming that the “conversation about a lady having nine babies addicted to drugs is a true story,” *id.* at 5:43:02 (statement of Rep. Mark White).
- 101 *Id.* at 3:13:28 (statement of Rep. William Lamberth) (emphasis added).

- 102 Joel Ebert, *Tennessee Law that Punishes Mothers of Drug-Dependent Babies To End*, TENNESSEAN (Mar. 23, 2016, 7:52 PM), <http://www.tennessean.com/story/news/politics/2016/03/22/tennessee-law-punishes-mothers-drug-dependent-babies-end/82141832> [https://perma.cc/U275-B5LY].
- 103 *Hearing on H.B. 1660 Before the H. Subcomm. on Criminal Justice*, 109th Gen. Assemb. (Tenn. 2016) (statement of Rep. Mike Stewart at 3:18:05), <http://wapp.capitol.tn.gov/apps/videowrapper/default.aspx?CommID=870000> (click “Video,” then click second “video” link next to Mar. 22, 2016, hearing date, then click on the link for H.B. 1660 on the left side of the screen); *see also id.* at 3:18:45 (statement of Rep. Andrew Farmer) (observing that there is a “messaging” problem because both women who testified before the Committee previously were afraid to get help due to the existence of the law). Representative Andrew Farmer also expressed concern that the bill would encourage pregnant drug-using women to have an abortion. *Id.* at 3:10:50.
- 104 *Id.* at 3:20:27 (statement of Rep. Andrew Farmer).
- 105 Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (statement of Dr. Stephen Patrick at 1:37:35).
- 106 *Id.*
- 107 *Id.* at 1:39:30. In fact, Dr. Patrick knew of only three cases in Tennessee where a newborn exposed to heroin in utero experienced drug withdrawal. *Id.* at 1:39:18. Dr. Patrick reported no spike in heroin-exposed infants in Tennessee during the time the law was in force. *Id.*
- 108 Gonzalez & Boucher, *supra* note 83.
- 109 Burke, *supra* note 8; Jeltsen, *supra* note 92 (noting that twenty-two women were prosecuted in Shelby County); Kylie McGivern, *Update on Law that Allows for Prosecution of Women who Give Birth to Drug-Dependent Babies*, WATE.COM (Knoxville) (Mar. 24, 2015, 9:18 PM), <http://wate.com/2015/03/24/update-on-law-that-allows-for-prosecution-of-women-who-give-birth-to-drug-dependent-babies/> [https://perma.cc/N8YX-65MS] (noting ten prosecutions in a judicial circuit covering four counties and eight in Sullivan County). Only two-thirds of Tennessee’s district attorneys offices responded to a survey sent out by the Tennessee Department of Safety and Homeland Security. Burke, *supra* note 8. Prosecutions are most common in Sullivan County, in the far northeastern part of the state, and Shelby County, the county in which Memphis sits. Documentation from December 2014 indicated that two-thirds of the arrests under this new law occurred in Memphis, Goldensohn & Levy, *supra* note 3, despite Memphis prosecutors indicating that they “invoked the law very selectively, only pursuing cases when the babies tested positive and the mothers refused treatment,” Burke, *supra* note 8.
- 110 Mar. 15, 2016, Hearing on H.B. 1660, *supra* note 77 (statement of Dr. Stephen Patrick, M.D., neonatologist, at 1:37:50). According to the presiding judge in Sevier and Grainger County Circuit Court, O. Duane Slone, between 2012 and 2013, 28.1% of babies born in Tennessee with NAS were in his district, followed by Knox County with 11.6% and Shelby County with 2.1%. *Id.* at 1:58:03 (statement of Hon. O. Duane Slone).
- 111 Goldensohn & Levy, *supra* note 3.
- 112 *Id.*
- 113 *Id.*

- 114 S.B. 297, 2015 Gen. Assemb., Reg. Sess. (N.C. 2015). North Carolina's bill was referred to the Committee on Rules and Operations of the Senate. *Senate Bill 297*, N.C. GEN. ASSEMBLY, <http://www.ncleg.net/gascripts/BillLookup/BillLookup.pl?Session=2015&BillID=S297> [https://perma.cc/3HNV-62ME].
- 115 S.B. 559, 55th Leg., 1st Sess. (Okla. 2015) (as introduced). Oklahoma's proposed legislation was referred to the Criminal Justice and Corrections Committee. *Bill Information for SB 559*, OKLA. ST. LEGISLATURE, <http://www.oklegislature.gov/BillInfo.aspx?Bill=SB559&Session=1500> [https://perma.cc/7P6P-KG2Z].
- 116 S.B. 8, 2015 Reg. Sess. (La. 2015). An additional provision amended the homicide law to allow for the prosecution of a woman who used drugs while pregnant “if the child dies as a result of the use of the substance while pregnant.” *Id.* Louisiana's bill was referred to the Senate Judiciary Committee. *SB8*, LA. ST. LEGISLATURE, <https://legis.la.gov/Legis/BillInfo.aspx?s=15RS&b=SB8&sbi=y> [https://perma.cc/QZM6-M7DN].
- 117 H.B. 1903, 98th Gen. Assemb., 2d Reg. Sess. (Mo. 2016). The legislator proposing the bill proposed an identical bill last year. That bill was referred to the Select Committee on State and Local Governments. *H.B. 1284*, MO. HOUSE REPRESENTATIVES (2015) <http://www.house.mo.gov/BillActions.aspx?bill=HB1284&year=2015&code=R> [https://perma.cc/7YB2-5E3N]. Earlier this month, the House referred the current bill to the Committee on Children and Families. *H.B. 1903*, MO. HOUSE REPRESENTATIVES (2016) <http://www.house.mo.gov/BillActions.aspx?bill=HB1903&year=2016&code=R> [https://perma.cc/5FYL-EYC2].
- 118 H.B. 1903.
- 119 *Id.*
- 120 *Id.*
- 121 *Id.*
- 122 *Id.*
- 123 *Missouri Looks at Criminalizing Using Drugs While Pregnant*, CBS ST. LOUIS (Jan. 4, 2016, 7:54 PM), <http://stlouis.cbslocal.com/2016/01/04/missouri-looks-at-criminalizing-using-drugs-while-pregnant/> [https://perma.cc/8RGK-DYXP].
- 124 Jon Swedien, *Nixa Lawmaker Wants To Add Criminal Penalties for Drug Use During Pregnancy*, SPRINGFIELD NEWS-LEADER (Jan. 2, 2016, 5:58 PM), <http://www.news-leader.com/story/news/politics/2016/01/02/nixa-lawmaker-wants-add-criminal-penalties-pregnant-drug-use/78133798/> [https://perma.cc/FG8R-55UU].
- 125 H.B. 1903.
- 126 Barry M. Lester, Lynne Andreozzi & Lindsey Appiah, *Substance Use During Pregnancy: Time for Policy To Catch Up with Research*, HARM REDUCTION J., Apr. 20, 2004, at 1. Absent from that conceptualization are prescription drugs that are technically legal, but still potentially addictive. However, this Article will contemplate the abuse of prescription drugs as well.
- 127 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL

FINDINGS 26, 37, 51 (2014). The definition of “illicit drugs” for purposes of the survey includes “marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used nonmedically.” *Id.* at 1.

128 *Id.*

129 Lester et al., *supra* note 126, at 4.

130 Paltrow & Flavin, *supra* note 15, at 301, 304, 315.

131 Copeland, *supra* note 26.

132 Paltrow & Flavin, *supra* note 15, at 311; *see also* LENORA LAPIDUS, NAMITA LUTHRA, ANJULI VERMA, DEBORAH SMALL, PATRICIA ALLARD & KIRSTEN LEVINGSTON, CAUGHT IN THE NET: THE IMPACT OF DRUG POLICIES ON WOMEN AND FAMILIES 15 (2005); Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13; Martin, *supra* note 9; *cf.* GÓMEZ, *supra* note 24, at 94-95 (explaining that jurisdictions with increasing proportions of racial minorities were more likely to prosecute women for using drugs while pregnant). In large part, poor women are more likely to be prosecuted because public hospitals, where those with lower incomes tend to receive medical care, are more likely than private hospitals to test pregnant women for drugs and more likely to report women whose tests show drug use. *See* Kolata, *supra*; *infra* Part II.A.

133 Ira J. Chasnoff, Harvey J Landress & Mark E. Barrett, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1202 (1990); Jennifer R. Havens, Leigh Ann Simmons, Lisa M. Shannon & Wendy F. Hansen, *Factors Associated with Substance Use During Pregnancy: Results from a National Sample*, 99 DRUG & ALCOHOL DEPENDENCE 89, 93 (2009).

134 Havens et al., *supra* note 133, at 93; *see also* Bonnie D. Kerker, John M. Leventhal, Mark Schlesinger & Sarah M. Horwitz, *Racial and Ethnic Disparities in Medical History Taking: Detecting Substance Use Among Low-Income Pregnant Women*, 16 ETHNICITY & DISEASE 28, 30-31 (2006); Bonnie D. Kerker, Sarah M. Horwitz & John M. Leventhal, *Patients' Characteristics and Providers' Attitudes: Predictors of Screening Pregnant Women for Illicit Substance Use*, 28 CHILD ABUSE & NEGLECT 209, 209 (2004).

135 ROBERTS, *supra* note 19, at 173-74.

136 Copeland, *supra* note 26 (citing Dr. Deborah Frank).

137 Lester et al., *supra* note 126, at 7.

138 Twenty-five years before Mallory Loyola's arrest in Tennessee, Jennifer Clarise Johnson, a twenty-three-year-old crack addict, was the first woman in the United States to be convicted for exposing her baby to drugs while pregnant. *Johnson v. State*, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991), *overruled by* 602 So.2d 1288 (Fla. 1992); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420 (1991). Ms. Johnson, who lived in Florida, told an investigator she smoked marijuana and ingested crack cocaine three to four times every other day during her pregnancy. *Johnson*, 602 So.2d at 1291. She suffered a crack overdose a month before her daughter was born and used crack cocaine the morning she gave birth. *Id.* Ms. Johnson was convicted of two counts of delivering a controlled substance to a minor. *Id.* at 1290.

- 139 Paltrow & Flavin, *supra* note 15, at 315-16.
- 140 *Id.* at 315.
- 141 Lester et al., *supra* note 126, at 7.
- 142 Laura M. Betancourt, Wei Yang, Nancy L. Brodsky, Paul R. Gallagher, Elsa K. Malmud, Joan M. Giannetta, Martha J. Farah & Hallam Hurt, *Adolescents with and Without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language*, 33 NEUROTOXICOLOGY & TERATOLOGY 36 (2011).
- 143 Dr. Ira Chasnoff, whose work first suggested the negative implications of cocaine on a fetus, later recanted his initial findings and published numerous other studies with contrary results. *E.g.*, CAROL MASON, KILLING FOR LIFE: THE APOCALYPTIC NARRATIVE OF PRO-LIFE POLITICS 92-93 (2002).
- 144 Frank et al., *supra* note 25, at 1615.
- 145 *Id.*
- 146 *Id.* at 1616.
- 147 Betancourt et al., *supra* note 142, at 41.
- 148 *Id.*
- 149 *Id.*
- 150 Frank et al., *supra* note 25, at 1616.
- 151 *Id.*
- 152 *Id.* at 1617.
- 153 John P. Ackerman, Tracy Riggins & Maureen M. Black, *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 J. PEDIATRICS 554, 563 (2010) *see also* Bada et al., *supra* note 18, at e1479, e1482, e1484 (2012). However, most of the studies reaching this conclusion involved children exposed to multiple substances in utero, including cocaine, tobacco, marijuana, and alcohol, Ackerman et al., *supra*, at 555, 563; Bada et al., *supra* note 18, at e1480-82, making it difficult to ascertain with certainty that cocaine exposure was the cause of these attention and behavior deficiencies.
- 154 Betancourt et al., *supra* note 142, at 43.
- 155 *Id.*; Bada et al., *supra* note 18, at e1482, e1485.

- 156 Betancourt et al., *supra* note 142, at 41.
- 157 Bada et al., *supra* note 18, at e1482.
- 158 *Id.*
- 159 Betancourt et al., *supra* note 142, at 44.
- 160 *McKnight v. State*, 661 S.E.2d 354, 358 n.2 (S.C. 2008).
- 161 McDonough, *supra* note 16.
- 162 Paltrow & Flavin, *supra* note 15, at 315.
- 163 Nwando Eze, Lynne M. Smith, Linda L. LaGrasse, Chris Derauf, Elana Newman, Amelia Arria, Marilyn A. Huestis, Sheri A. Della Grotta, Lynne M. Dansereau, Charles Neal & Barry M. Lester, *School-Aged Outcomes Following Prenatal Methamphetamine Exposure: 7.5-Year Follow-Up from the Infant Development, Environment, and Lifestyle Study*, 170 J. PEDIATRICS 34, 34 (2016).
- 164 Sheri Della Grotta, Linda L. LaGasse, Amelia M. Arria, Chris Derauf, Penny Grant, Lynne M. Smith, Rizwan Shah, Marilyn Huestis, Jing Liu & Barry M. Lester, *Patterns of Methamphetamine Use During Pregnancy: Results from the Infant Development, Environment, and Lifestyle (IDEAL) Study*, 14 MATERNAL & CHILD HEALTH J. 519, 520 (2010).
- 165 *Id.*; see also Loretta P. Finnegan & Stephen R. Kandall, *Maternal and Neonatal Effects of Alcohol and Drugs*, in SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 805 (Joyce H. Lowinson et al. eds., 4th ed. 2005).
- 166 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTHCARE FOR UNDERSERVED WOMEN, METHAMPHETAMINE ABUSE IN WOMEN OF REPRODUCTIVE AGE 2 (2011); See also R.J. Felix, C.D. Chambers, L.M. Dick, K.A. Johnson & K.L. Jones, *Prospective Pregnancy Outcome in Women Exposed to Amphetamines*, 61 TERATOLOGY 441, 441 (2000); Bertis B. Little, Laura M. Snell & Larry C. Gilstrap III, *Methamphetamine Abuse During Pregnancy: Outcome and Fetal Effects*, 72 OBSTETRICS & GYNECOLOGY 541, 543 (1988); James J. Nora, Dan G. McNamara & F. Clarke Fraser, *Dexamphetamine Sulphate and Human Malformations*, 289 LANCET 570, 571 (1967).
- 167 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 166, at 2; Eze et al., *supra* note 163, at 34.
- 168 *What Are the Risks of Methamphetamine Abuse During Pregnancy?*, NAT'L INST. ON DRUG ABUSE (2013), <http://www.drugabuse.gov/publications/research-reports/methamphetamine/what-are-risks-methamphetamine-abuse-during-pregnancy> [<https://perma.cc/V59S-57A3>].
- 169 Eze et al., *supra* note 163, at 34-35.
- 170 *Id.* at 35.

- 171 *Id.* at 36.
- 172 *Id.* at 36-37.
- 173 *See infra* Parts I.C-D for information about the effects of alcohol and cigarettes on fetal and childhood development; *see also* Eze et al., *supra* note 163, at 36.
- 174 Amicus Curiae Brief of Medical & Public Health, Reproductive Justice, & Criminal Justice System Reform Experts & Organizations in Support of the Appellant & Urging Resentencing at 7 n.10, [United States v. Weld](#), 619 Fed. App'x 512 (6th Cir. 2015) (No. 14-5894) (quoting an ACOG report about methamphetamine use during pregnancy).
- 175 *See supra* note 95 for how “opioid” is defined.
- 176 *See* Sonia Minnes, Adelaide Lang & Lynn Singer, *Prenatal Tobacco, Marijuana, Stimulant, and Opiate Exposure: Outcomes and Practice Implications*, 6 ADDICTION SCI. & CLINICAL PRAC. 57, 65 (2011).
- 177 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 17 (citing Ali Azadi & Gary A. Dildy III, *Universal Screening for Substance Abuse at the Time of Parturition*, 198 AM. J. OBSTETRICS & GYNECOLOGY e30-2 (2008)).
- 178 *Id.*
- 179 Babies born with NAS are often referred to as “addicted.” However, this term is not applicable to newborns. *See supra* text accompanying note 67.
- 180 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 17, at 5. However, “not all infants born to drug-dependent mothers show withdrawal symptomatology.” Finnegan & Kandall, *supra* note 165, at 814.
- 181 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 17, at 5.
- 182 *See* Beyerstein, *supra* note 14 (noting that NAS is a “transient condition” and quoting Dr. Newman, president emeritus at New York’s Beth Israel Medical Center, as saying “[t]here has never been any evidence suggesting that [NAS] leads to lasting problems.”); Walter K. Kraft & John N. van den Anker, *Pharmacological Management of the Opioid Neonatal Abstinence Syndrome*, 59 PEDIATRIC CLINICS OF N. AM. 1147 (2012) (“[I]mportan[tly], there is no evidence of long-term adverse outcomes in children treated with pharmacological agents in comparison with infants who do not require treatment for NAS”).
- 183 Martin, *supra* note 9.
- 184 *Id.*
- 185 *Id.*; *see also* AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 17, at 3; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., METHADONE TREATMENT FOR PREGNANT WOMEN (rev. ed. 2014).
- 186 AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 17, at 3

- 187 *Id.* at 3-4.
- 188 *Id.* at 5.
- 189 Finnegan & Kandall, *supra* note 165, at 822. However, chronic untreated heroin use during pregnancy “is associated with” the potential for restricted fetal growth and an increased risk of other significant difficulties during pregnancy. AM. COLL. OF OBSTETRICS AND GYNECOLOGISTS, *supra* note 17, at 2.
- 190 AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 17, at 2. Multiple studies reveal a small increased risk of congenital heart defects with the use of codeine. *Id.*
- 191 *Id.* at 5.
- 192 Minnes et al., *supra* note 176, at 61.
- 193 Desai et al., *supra* note 90, at 998.
- 194 *Id.* at 999.
- 195 *Id.*
- 196 Although marijuana has been decriminalized and even legalized in some states, at the time of the cited study data, 2002-2003, *see* Havens et al., *supra* note 133, at 92, no state had yet legalized marijuana.
- 197 *Id.* at 91.
- 198 Kaltenbach & Jones, *supra* note 17, at 657; *See also* Marleen M.H.J. van Gelder, Jennita Reefhuis, Alissa R. Caton, Martha M. Werler, Charlotte M. Druschel & Nel Roeleveld, *Characteristics of Pregnant Illicit Drug Users and Associations Between Cannabis Use and Perinatal Outcome in Population-Based Study*, 109 DRUG & ALCOHOL DEPENDENCE 243, 244 (2010); Minnes et al., *supra* note 176, at 61. *But see* Mohammad R. Hayatbakhsh, Vicki J. Flenady, Kristen S. Gibbons, Ann M. Kingsbury, Elizabeth Hurron, Abdullah A. Mamun & Jake M. Najman, *Birth Outcomes Associated with Cannabis Use Before and During Pregnancy*, 71 PEDIATRIC RES. 215, 217 (2012).
- 199 Marylou Behnke & Vincent C. Smith, *Prenatal Substance Abuse: Short-and Long-term Effects on the Exposed Fetus*, 131 J. PEDIATRICS e1009, e1012 (2013). This is distinct from other drugs, for which the placenta does not have this effect. *Id.* *But see* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON OBSTETRIC PRACTICE, MARIJUANA USE DURING PREGNANCY AND LACTATION 2 (2015) (noting that in animal models, THC crossed the placenta but resulted in fetal exposure levels that were 10% of maternal exposure levels).
- 200 Minnes et al., *supra* note 176, at 61.
- 201 van Gelder et al., *supra* note 198, at 244.
- 202 Minnes et al., *supra* note 176, at 61.

- 203 Behnke et al., *supra* note 199, at e1012; *see also* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 199, at 2.
- 204 AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 199, at 2.
- 205 Havens et al., *supra* note 133, at 93; *see also* Krzysztof M. Kuczkowski, *The Effects of Drug Abuse on Pregnancy*, 19 CURRENT OPINIONS OBSTETRICS & GYNECOLOGY 578 (2007); Melanie A. Manning & H. Eugene Hoyme, *Fetal Alcohol Spectrum Disorders: A Practical Clinical Approach to Diagnosis*, 31 NEUROSCIENCE & BIOBEHAVIORAL REVS. 230 (2007).
- 206 Lester et al., *supra* note 126, at 5.
- 207 *Id.* at 6.
- 208 Amy C. Lossie, William M. Muir, Chiao-Ling Lo, Floyd Timm, Yunlong Liu, Whitney Gray & Feng C. Zhou, *Implications of Genomic Signatures in the Differential Vulnerability to Fetal Alcohol Exposure in C57BL/6 and DBA/2 Mice*, FRONTIERS GENETICS, June 2014, at 1.
- 209 *Id.*
- 210 *Id.*; *cf.* COMM. TO STUDY FETAL ALCOHOL SYNDROME, INST. OF MED., FETAL ALCOHOL SYNDROME: DIAGNOSIS, EPIDEMIOLOGY, PREVENTION, AND TREATMENT 10 (Kathleen Stratton et al. eds., 1996); Ernest L. Abel, *An Update on Incidence of FAS: FAS is Not an Equal Opportunity Birth Defect*, 17 NEUROTOXICOLOGY & TERATOLOGY 437, 437-39 (1995); Claire D. Coles, *Impact of Prenatal Alcohol Exposure on the Newborn and the Child*, 36 CLINICAL OBSTETRICS & GYNECOLOGY 255, 255 (1993) (noting that only 5-10% of women who drink while pregnant do so at high enough levels to pose a risk to their fetuses).
- 211 Abel, *supra* note 210, at 441; Coles, *supra* note 210, at 263-64; Lossie et al., *supra* note 208, at 1; Susan E. Maier & James R. West, *Drinking Patterns and Alcohol-Related Birth Defects*, 25 ALCOHOL RES. & HEALTH 168, 168 (2001); Philip A. May, Jason Blankenship, Anna-Susan Marais, J. Phillip Gossage, Wendy O. Kalberg, Belinda Joubert, Marise Cloete, Ronel Barnard, Marlene De Vries, Julie Haskin, Luther K. Robinson, Colleen M. Adnams, David Buckley, Melanie Manning, Charles D.H. Parry, H. Eugene Hoyme, Barbara Tabachnick & Soraya Seedat, *Maternal Alcohol Consumption Producing Fetal Alcohol Spectrum Disorders (FASD): Quantity, Frequency, and Timing of Drinking*, 133 DRUG & ALCOHOL DEPENDENCE 502, 510 (2013).
- 212 David Gilliam, *Embryo Transfers Between C57BL/6J and DBA/2J Mice: Examination of a Maternal Effect On Ethanol Teratogenesis*, FRONTIERS IN GENETICS, December 2014, at 5; Dan Goldowitz, Alexandre A. Lussier, Julia K. Boyle, Kaelan Wong, Scott L. Lattimer, Candis Dubose, Lu Lu, Michael S. Kobor & Kristin M. Hamre, *Molecular Pathways Underpinning Ethanol-Induced Neurodegeneration*, FRONTIERS IN GENETICS, July 2014, at 4-11; Morgan L. Kleiber, Eric J. Diehl, Benjamin I. Laufer, Katarzyna Mantha, Aniruddho Chokroborty-Hoque, Bonnie Alberry & Shiva M. Singh, *Long-Term Genomic and Epigenomic Dysregulation as a Consequence of Prenatal Alcohol Exposure: A Model for Fetal Alcohol Spectrum Disorders*, FRONTIERS IN GENETICS, June 2014, at 5-7, 9-10; Michael S. Kobor & Joanne Weinberg, *Focus On: Epigenetics and Fetal Alcohol Spectrum Disorders*, 34 ALCOHOL RES. & HEALTH 29 (2011); Lossie et al., *supra* note 208; Edward A. Mead & Dipak K. Sarkar, *Fetal Alcohol Spectrum Disorders and Their Transmission Through Genetic and Epigenetic Mechanisms*, FRONTIERS IN GENETICS, June 2014, at 6-7.
- 213 “Epigenetic” is defined as relating to or arising from nongenetic influences on gene expression. *See, e.g.*, Siddhartha Mukherjee, *Same but Different: How Epigenetics Can Blur the Line Between Nature and Nurture*, NEW

YORKER (May 2, 2016), <http://www.newyorker.com/magazine/2016/05/02/breakthroughs-in-epigenetics> [<https://perma.cc/7C74-VGSK>].

- 214 Abel, *supra* note 210, at 441; Gilliam, *supra* note 212, at 2, 5; Goldowitz et al., *supra* note 212, at 2; Kleiber et al., *supra* note 212, at 1-2, 5-10; Kobor & Weinberg, *supra* note 212; Lossie et al., *supra* note 208, at 2; Mead & Sarkar, *supra* note 212, at 1, 3-7.
- 215 See, e.g., Katherine K. Christoffel & Ira Salafsky, *Fetal Alcohol Syndrome in Dizygotic Twins*, 87 J. PEDIATRICS 963 (1975); Goldowitz et al., *supra* note 212, at 1; Raili S. Riikonen, *Difference in Susceptibility of Teratogenic Effects of Alcohol in Discordant Twins Exposed to Alcohol During the Second Half of Gestation*, 11 PEDIATRIC NEUROLOGY 332 (1994); Ann P. Streissguth & Philippe Dehaene, *Fetal Alcohol Syndrome in Twins of Alcoholic Mothers: Concordance of Diagnosis and IQ*, 47 AM. J. MED. GENETICS 857 (1993).
- 216 However, several states allow for the detention or civil commitment of women for drinking alcohol while pregnant. See MINN. STAT. ANN. § 253B.02, subd. 2 (West 2014) (authorizing civil commitment of persons who are “chemically dependent,” defined to include a “pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose” of drugs or alcohol); S.D. CODIFIED LAWS § 34-20A-63 (2011) (authorizing civil commitment of women who are “pregnant and abusing alcohol or drugs”); WIS. STAT. ANN. § 48.193 (West 2011) (permitting state authorities to take a woman into custody if they believe she is pregnant and demonstrates “habitual lack of self-control” in the use of alcoholic beverages or controlled substances).
- 217 But see *supra* note 216.
- 218 Paltrow & Flavin, *supra* note 15, at 316.
- 219 See, e.g., Havens et al., *supra* note 133, at 91.
- 220 Kaltenbach & Jones, *supra* note 17, at 648.
- 221 Behnke, *supra* note 199, at e1011; Lester, *supra* note 126, at 6.
- 222 Lester, *supra* note 126, at 6; see also Behnke, *supra* note 199, at e1011-12; Havens et al., *supra* note 133, at 89.
- 223 Lester, *supra* note 126, at 6; see also Minnes et al., *supra* note 176, at 59-60.
- 224 Paltrow & Flavin, *supra* note 15, at 316.
- 225 Allen A. Mitchell, Suzanne M. Gilboa, Martha M. Werler, Katherine E. Kelley, Carol Louik & Sonia Hernández-Díaz, *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976-2008*, 205 AM. J. OBSTETRICS & GYNECOLOGY 51.e1, 51.e1 (2011).
- 226 See *infra* notes 229-30 and accompanying text.
- 227 Mitchell et al., *supra* note 225.

- 228 In large part, this is due to the difficulty in obtaining data on over-the-counter drug use by pregnant women. Scientists can obtain clearer data on prescription drugs from electronic medical records and insurance claims, but those sources do not systematically capture data on over-the-counter drug use. *Id.* at 51.e6. There is also a dearth of data on whether written prescriptions are filled or filled but not taken, as well as on prescriptions shared among family members or friends. *Id.* at 51.e6-e7.
- 229 *Id.* at 51.e3.
- 230 *Id.* at 51.e3-4. Interestingly, which prescription medications pregnant women use has evolved over time. Pregnant women used some medications, such as progesterone and amoxicillin, consistently over the thirty-three-year period of the study. *Id.* at 51.e5. Amoxicillin is the most-used common prescription medication, used by almost 4% of women between 1997 and 2003, followed by other antibiotics and progesterone, each used between 2% and 3% of pregnant women. *Id.* at 51.e7 tbl.2. Over that same period, use of antinausea medication and antidepressants have increased dramatically, with 7.5% of pregnant women using antidepressants in recent years, whereas other drugs were removed from the market or made over-the-counter, obviously decreasing their use or scientists' ability to track their use. *Id.* at 51.e5-e6.
- 231 Press Release, Brown Univ., Tadpole Model Links Drug Exposure to Autism-Like Effects (Feb. 17, 2015), <http://news.brown.edu/articles/2015/02/tadpoles> [<https://perma.cc/8J3B-YFJ2>].
- 232 TENN. CODE ANN. § 39-13-107(c)(1) (2014) (“Nothing in [this statute] shall apply to any lawful act or lawful omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant”), *amended by* TENN. CODE ANN. § 39-13-107 (Supp. 2016); H.B. 1903, 98th Gen. Assemb., 2d Reg. Sess. (Mo. 2016) (“A person commits the offense of abuse of an unborn child ... if such person knowingly ingests, injects, consumes, inhales, or otherwise uses a narcotic drug or a controlled substance without a prescription while such person is pregnant”); S.B. 297, 2015 Gen. Assemb., Reg. Sess. (N.C. 2015) (“This section shall not apply to any lawful act or lawful omission by a pregnant woman with respect to an unborn child with which she is pregnant”); S.B. 559, 55th Leg., 1st Sess. (Okla. 2015) (as introduced) (“This section shall not apply to any lawful act or omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant”); *cf.* S.B. 8, 2015 Reg. Sess. (La. 2015) (marking no exception for women acting lawfully or under the care of a physician, but criminalizing women who use drugs “illegally” while pregnant).
- 233 *See supra* Part I.A.
- 234 *See supra* Part I.B.1.
- 235 *See* Paltrow & Flavin, *supra* note 15, at 311.
- 236 Chasnoff et al., *supra* note 133, at 1204; Finnegan & Kendall, *supra* note 165, at 822. This author has been unable to locate any more recent national data.
- 237 *See infra* Part III.B.
- 238 Copeland, *supra* note 26.
- 239 AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 166, at 3; Eze et al., *supra* note 163, at 36; Grotta et al., *supra* note 164.

- 240 Gelder et al., *supra* note 198, at 244-45; *see also* Caitlin E. Martin, Nyaradzo Longinaker, Katrina Mark, Margaret S. Chisolm & Mishka Terplan, *Recent Trends in Treatment Admissions for Marijuana Use During Pregnancy*, 9 J.ADDICTIVE MED. 99, 100 (2015).
- 241 Andrew Cohen, *When Heroin Hits the White Suburbs*, MARSHALL PROJECT (Aug. 12, 2015, 6:00 AM), <https://www.themarshallproject.org/2015/08/12/when-heroin-hits-the-white-suburbs> [<https://perma.cc/LG3Q-5AUG>].
- 242 Sarah H. Heil, Stacey C. Sigmon, Hendree E. Jones & Michael Wagner, *Comparison of Characteristics of Opioid-Using Pregnant Women in Rural and Urban Settings*, 34 AM. J. DRUG & ALCOHOL ABUSE 463, 463-64, 467-68 (2008).
- 243 *Id.* at 467-69.
- 244 *Id.* Evidence does indicate that approximately 75% of those who now use heroin were introduced to opioids by using prescriptions drugs nonmedically. Theodore J. Cicero, Matthew S. Ellis, Hilary L. Surratt & Steven P. Kurtz, *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 823 (2014).
- 245 Cohen, *supra* note 241.
- 246 *Id.*; Sonia Saraiya, *Eric Holder Gets Real About Heroin and Race: It's a Crisis Because White People Are Hooked*, SALON (Feb. 24, 2016, 10:10 AM), http://www.salon.com/2016/02/24/eric_holder_gets_real_about_heroin_and_race_its_a_crisis_because_white_people_are_hooked/ [<https://perma.cc/M2ZD-LH5R>].
- 247 Harrison Jacobs, *Obama Gave a Huge Signal that the Old War on Drugs Is Over*, BUS. INSIDER (Mar. 30, 2016, 3:01 PM), <http://businessinsider.com/obamas-latest-plan-to-fight-heroin-abuse-is-a-big-step-2016-3> [<https://perma.cc/4X3A-58SP>].
- 248 Cohen, *supra* note 241; Saraiya, *supra* note 246; Ekow N. Yankah, Opinion, *When Addiction Has a White Face*, N.Y. TIMES (Feb. 9, 2016), <https://www.nytimes.com/2016/02/09/opinion/when-addiction-has-a-white-face.html> [<https://perma.cc/YYD9-9WLU>].
- 249 Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, N.Y. TIMES (Oct. 30, 2015), <https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html> [<https://perma.cc/ZA4G-7HJB>].
- 250 *See* Humphrey, *supra* note 2; *supra* Part I.A.
- 251 Krista M. Perreira & Kalena E. Cortes, *Race/Ethnicity and Nativity Differences in Alcohol and Tobacco Use During Pregnancy*, 96 AM. J. PUB. HEALTH 1629, 1631 (2006).
- 252 *Id.* at 1631, 1633; *Fetal Alcohol Spectrum Disorders (FASDs)*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 17, 2015), <http://www.cdc.gov/ncbddd/fasd/data.html> [<https://perma.cc/WMB3-5DAY>].
- 253 Perreira & Cortes, *supra* note 251, at 1632.

- 254 Desai et al., *supra* note 90, at 997.
- 255 *Id.* at 998.
- 256 Mitchell et al., *supra* note 225, at 51.e5.
- 257 *Id.*
- 258 *Burden of Tobacco Use in the U.S.*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 2, 2017), <http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html> [https://perma.cc/V7VN-84Q8]; *see also* Kaltenbach & Jones, *supra* note 17, at 658.
- 259 CHILDTRENDS DATA BANK, MOTHERS WHO SMOKE WHILE PREGNANT: INDICATORS ON CHILDREN AND YOUTH 5 (2015).
- 260 Data on Native American women is relatively scarce, *see* LAPIDUS ET AL., *supra* note 132, at 17, but there is some evidence that Native women, generally, experience high rates of arrest and incarceration. *See, e.g.*, Kimberlé W. Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race, and Social Control*, 59 UCLA L. REV. 1418, 1436 (2012).
- 261 CHILDTRENDS DATA BANK, *supra* note 259, at 4; *see also* Perreira & Cortes, *supra* note 251, at 1632.
- 262 About 7% of pregnant Black women smoke, and only 2% of Latina women who are pregnant smoke. CHILDTRENDS DATA BANK, *supra* note 259, at 4.
- 263 Perreira & Cortes, *supra* note 251, at 1632.
- 264 According to the Center for Responsive Politics, the tobacco industry spent more than \$19.8 million on lobbyists to represent the industry to Congress in 2016. CTR. FOR RESPONSIVE POLITICS, *Tobacco: Industry Profile: Summary*, OPENSECRETS.ORG, <https://www.opensecrets.org/lobby/indusclient.php?id=A02> [https://perma.cc/5VHK-QZ8B] (last updated Jan. 25, 2017).
- 265 Frank et al., *supra* note 25, at 1620; *see also* MALINOWSKA-SEMPRUCH & RYCHKOVAA, *supra* note 67, at 10-11.
- 266 *See supra* Part I.
- 267 *See, e.g.*, DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 17-18 (2002).
- 268 To be clear, the removal of the child takes place in separate, civil child neglect or abuse proceedings, but those proceedings can be triggered by both civil and criminal investigations of prenatal drug abuse, just as criminal proceedings can be triggered by civil neglect and abuse investigations. *See, e.g.*, GOMEZ, *supra* note 24, at 76.
- 269 *See, e.g.*, Josh Gupta-Kagan, *Towards a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897, 959 (2014); Molly McNulty, Note, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant*

Women for Harm to Their Fetuses, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 285-86 (1987-88); Martin, *supra* note 9 (discussing Alabama's forceful approach).

270 Martin, *supra* note 9.

271 *Id.*

272 See, e.g., 42 U.S.C.A. § 671(a)(15) (West 2011 & Supp. 2016) (requiring states to make “reasonable efforts” to avoid the need to remove a child from parental custody and, when removal is necessary, to seek reunification of the parent and child).

273 Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 CHILD ABUSE & NEGLECT 97, 109 (2002).

274 *Id.* at 109-10; see also Michael Wald, *State Intervention on Behalf of “Neglected” Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985, 1002 (1975).

275 Martin, *supra* note 9; see, e.g., SHEIGLA MURPHY & MARSHA ROSENBAUM, PREGNANT WOMEN ON DRUGS: COMBATING STEREOTYPES AND STIGMA 56, 58-64 (1999) (discussing how pregnant drug users weigh the potential harms from keeping the baby versus making a decision to terminate the pregnancy).

276 Smith & Testa, *supra* note 273, at 110; Mark F. Testa & Brenda Smith, *Prevention and Drug Treatment*, FUTURE OF CHILD., Fall 2009, at 147, 162. The possible exception is additional exposure to substance abuse by parents who continue to use after birth. Smith & Testa, *supra* note 273, at 110.

277 In determining custody, courts generally are required to consider the “best interests of the child.” See, e.g., *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978) (acknowledging “best interests of the child” standard as consistent with constitutional due process requirements).

278 See Leticia Miranda, Vince Dixon & Cecilia Reyes, *How States Handle Drug Use During Pregnancy*, PROPUBLICA (Sept. 30, 2015), <https://projects.propublica.org/graphics/maternity-drug-policies-by-state> [<https://perma.cc/DYC4-HGZU>]; see also ROBERTS, *supra* note 267, at 155.

279 See, e.g., 705 ILL. COMP. STAT. ANN. 405/§§ 2-3(1)(c) (West 2007 & Supp. 2015) (“Those who are neglected include ... any newborn infant whose blood, urine, or meconium contains any amount of a controlled substance ... or a metabolite of a controlled substance” unless “the presence of [the substance] in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.”); MINN. STAT. ANN. § 626.5562 (West 2009) (requiring that, if newborn infant tests positive for controlled substance, doctor must report the child as neglected); MO. REV. STAT. § 211.447(5) (West 2013 & Supp. 2014); NEV. REV. STAT. ANN. § 432B.330(4) (LexisNexis 2015) (“A child may be in need of protection if the child is identified as being affected by prenatal illegal substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure.”); OKLA. STAT. ANN. tit. 10A, § 1-1-105(20) (West 2009 & Supp. 2015) (“‘Deprived child’ means a child ... who is ... in need of special care and treatment ... [because the child] at birth tests positive for alcohol or a controlled dangerous substance”); see also IND. CODE § 31-34-1-10 (2016) (establishing that a child is in need of services if born with any amount of a controlled substance in the child's body, and the child needs treatment that the parent is unlikely to provide without the coercive intervention of the court).

280 § 626.5562(2).

281 *Id.*

282 ROBERTS, *supra* note 267, at 155; Testa & Smith, *supra* note 276, at 159. Studies estimate that between six and nine million children “live in households in which a caregiver abuses alcohol or drugs,” yet far fewer children ever enter the foster care system, for *any* reason. Testa & Smith, *supra* note 276, at 150. Only a third of the approximately 900,000 children with substantiated maltreatment allegations were placed in foster care. *Id.* “Even if all of these substantiated cases with children in the home involved parental substance abuse, the number would conservatively reflect only about 10 percent of the estimated number of children living with a parent who abuses substances.” *Id.*

283 ADMIN. ON CHILDREN, YOUTH, & FAMILIES, CHILDREN'S BUREAU, U.S. DEPT' OF HEALTH & HUMAN SERVS., THE AFCARS REPORT 2 (2015), <http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf> [<https://perma.cc/46K5-MXGF>]; KATHY BARBELL & MADELYN FREUNDLICH, CASEY FAMILY PROGRAMS, FOSTER CARE TODAY 4 (2001); *cf.* Testa & Smith, *supra* note 276, at 162 (“[T]he average age of children born substance-exposed who are removed from parental custody is less than three”). Although only a small percentage of infants are reported as substance-exposed, approximately 50% of those infants are removed from the home. *Id.* at 159.

284 Eugene M. Lewit, *Children in Foster Care*, FUTURE OF CHILD., Winter 1993, at 192, 196-97.

285 *Id.* at 196.

286 BARBELL & FREUNDLICH, *supra* note 283, at 4.

287 ADMIN. ON CHILDREN, YOUTH, & FAMILIES, CHILDREN'S BUREAU, *supra* note 283, at 2.

288 *Id.*

289 BARBELL & FREUNDLICH, *supra* note 283, at 1; Goodwin, *supra* note 19, at 1715, 1743; Paltrow & Flavin, *supra* note 15, at 326-27.

290 *See, e.g.*, ROBERTS, *supra* note 19, at 173; Annette R. Appell, *Protecting Children or Punishing Mothers: Gender, Race, and Class in the Child Protection System*, 48 S.C. L. REV. 577, 584-85 (1997); *see* Khiara M. Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113 (2011).

291 ROBERTS, *supra* note 19, at 173; Appell, *supra* note 290, at 584.

292 Appell, *supra* note 290, at 585.

293 ROBERTS, *supra* note 19, at 173.

294 *Id.*; *see* GÓMEZ, *supra* note 24, at 77 (“[M]ost public hospitals have procedures for identifying and reporting pregnant drug users, but most private hospitals do not.” (emphasis in original)).

295 ROBERTS, *supra* note 19, at 173; *see also* GÓMEZ, *supra* note 24, at 77; Roberts, *supra* note 138, at 1433.

296 Bridges, *supra* note 290, at 127.

- 297 ROBERTS, *supra* note 19, at 174.
- 298 ROBERTS, *supra* note 19, at 174; Goodwin, *supra* note 13, at 796; Goldensohn & Levy, *supra* note 3 (“According to numerous interviews with hospital staff and patients, some hospitals drug-test mothers before birth and others do not. Some test all mothers; others test based on appearance and behavior. Some hospitals in poor neighborhoods test everyone; in rich neighborhoods, not so much.”).
- 299 Paltrow & Flavin, *supra* note 15, at 333.
- 300 SUSAN C. BOYD, MOTHERS AND ILLICIT DRUGS: TRANSCENDING THE MYTHS 10-11 (1999); ROBERTS, *supra* note 19, at 174-75; Appell, *supra* note 290, at 588-89; Chasnoff et al., *supra* note 133, at 1204; Michelle Oberman, *Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs*, 43 HASTINGS L.J. 505, 510 (1992); Paltrow & Flavin, *supra* note 15, at 310-11, 322, 327.
- 301 Paltrow & Flavin, *supra* note 15, at 329.
- 302 See Sheau-Huey Chiu, Gene Cranston Anderson & Maria D. Burkhammer, *Newborn Temperature During Skin-to-Skin Breastfeeding in Couples Having Breastfeeding Difficulties*, 32 BIRTH 115, 115-16 (2005); Sari Goldstein Ferber & Imad R. Makhoul, *The Effect of Skin-to-Skin Contact (Kangaroo Care) Shortly After Birth on the Neurobehavioral Responses of the Term Newborn: A Randomized, Controlled Trial*, 113 J. PEDIATRICS 858, 858-59 (2004).
- 303 Ksenia Bystrova, Valentina Ivanova, Maigun Edhborg, Ann-Sofi Matthiesen, Anna-Berit Ransjö-Arvidson, Rifkat Mukhamedrakhimov, Kerstin Uvnäs-Moberg & Ann-Marie Wildström, *Early Contact Versus Separation: Effects on Mother-Infant Interaction One Year Later*, 36 BIRTH 97, 106 (2009).
- 304 Susan M. Ludington-Hoe & Amel M. Abouelfettoh, *Can Kangaroo Care Help Newborns with Neonatal Abstinence Syndrome? Case Report*, 3 CLINICAL NURSING STUD., no. 4, 2015, at 44.
- 305 *Id.* at 50.
- 306 *Id.*
- 307 *Id.*
- 308 Allan Walker, *Breast Milk as the Gold Standard for Protective Nutrients*, 156 J. PEDIATRICS (SUPPLEMENT) S3, S6 (2010).
- 309 Michael S. Kramer, Frances Aboud, Elena Mironova, Irina Vanilovich, Robert W. Platt, Lidia Matush, Sergei Igumnov, Eric Fombonne, Natalia Bogdanovich, Thierry Ducruet, Beverley Chalmers, Ellen Hodnett, Sergei Davidovsky, Oleg Skugarevsky, Oleg Trofimovich, Ludmila Kozlova & Stanley Shapiro, *Breastfeeding and Child Cognitive Development*, 65 ARCHIVES GEN. PSYCHIATRY 578, 581 (2008). *But see* Anjali Jain, John Concato & John M. Leventhal, *How Good Is the Evidence Linking Breastfeeding and Intelligence?*, 109 J. PEDIATRICS 1044 (2002).
- 310 Ludington-Hoe & Abouelfettoh, *supra* note 304, at 50-51. Generally, newborns with NAS are treated for withdrawal, meaning they are given opiates in increasingly smaller doses to wean them off the drug. *See, e.g.*, Finnegan & Kandall, *supra* note 165, at 817.

- 311 Dorothy Roberts, Weyrauch Lecture at the University of Florida Levin College of Law: Prisons, Foster Care, & the Systemic Punishment of Black Mothers and Their Children, at 20:34 (Mar. 16, 2016), <https://mediasite.video.ufl.edu/Mediasite/Play/46c2afb30eb143f4b77fe161a35ad1531d>.
- 312 LAPIDUS ET AL., *supra* note 132, at 50; ROBERTS, *supra* note 267, at 7-10, 16-20. Notably, most foster parents are white, married, and have completed a higher than average education level. *See, e.g.*, Kathleen M. Kirby, *Foster Parent Demographics: A Research Note*, J. SOC. & SOC. WELFARE, June 1997, at 135, 135.
- 313 BARBELL & FREUNDLICH, *supra* note 283, at 5.
- 314 ADMIN. ON CHILDREN, YOUTH & FAMILIES, CHILDREN'S BUREAU, *supra* note 283, at 2.
- 315 As of the latest census data from 2015, Black individuals made up 13.3% of the national population, and Latinos made up 17.6%. *QuickFacts: United States*, *supra* note 41.
- 316 OFFICE OF DATA, ANALYSIS, RESEARCH & EVALUATION, U.S. DEPT OF HEALTH & HUMAN SERVS., DATA BRIEF 2013-1: RECENT DEMOGRAPHIC TRENDS IN FOSTER CARE 2 (2013), http://www.acf.hhs.gov/sites/default/files/cb/data_brief_foster_care_trends1.pdf [<https://perma.cc/E5QP-TCJ7>].
- 317 BARBELL & FREUNDLICH, *supra* note 283, at 5.
- 318 OFFICE OF DATA, ANALYSIS, RESEARCH & EVALUATION, *supra* note 316, at 4.
- 319 *Id.*
- 320 ADMIN. ON CHILDREN, YOUTH & FAMILIES, *supra* note 283, at 2.
- 321 BARBELL & FREUNDLICH, *supra* note 283, at 6.
- 322 *Id.*
- 323 *Id.*
- 324 John G. Orme, Cheryl Buehler, Michael McSurdy, Kathryn W. Rhodes, Mary Ellen Cox & David A. Patterson, *Parental and Familial Characteristics of Family Foster Care Applicants*, 26 CHILD. & YOUTH SERVS. REV. 307, 321 (2004).
- 325 Lester et al., *supra* note 126, at 18.
- 326 *Id.*
- 327 *Id.*
- 328 ROBERTS, *supra* note 19, at 159.

- 329 Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, 26 WIS. J.L. GENDER & SOC'Y 241, 253 (2011); *see also* MURPHY & ROSENBAUM, *supra* note 275, at 50-52; Oberman, *supra* note 300, at 512-13.
- 330 MURPHY & ROSENBAUM, *supra* note 275, at 58 ("These women viewed their pregnancies as opportunities to change their life-styles, almost as if the pregnancy was a special gift to provide them with new hope and resolve."); *see also* BOYD, *supra* note 300, at 60.
- 331 *See, e.g.*, MURPHY & ROSENBAUM, *supra* note 275, at 66.
- 332 COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, MATERNAL DECISION MAKING, ETHICS, AND THE LAW 8 (2005) (replaced by Committee Opinion No. 664, June 2016); Gupta-Kagan, *supra* note 269, at 959-60.
- 333 MURPHY & ROSENBAUM, *supra* note 275, at 65; *cf.* BOYD, *supra* note 300, at 63.
- 334 MURPHY & ROSENBAUM, *supra* note 275, at 65 (citing Valerie D. Raskin, *Maternal Bereavement in the Perinatal Substance Abuser*, 9 J. SUBSTANCE ABUSE TREATMENT 149, 149 (1992)).
- 335 *Id.* at 66.
- 336 BOYD, *supra* note 300, at 59-60.
- 337 Criminal charges carry with them numerous additional consequences, beyond just the fact of the charges, as well. *See, e.g.*, Michael Pinard, *Criminal Records, Race and Redemption*, 16 N.Y.U. J. LEGIS. & PUB. POL'Y 963, 968-69 (2013) (discussing collateral consequences of an arrest, with and without a conviction attached).
- 338 Although the Supreme Court does not view pretrial detention as punishment, *see United States v. Salerno*, 481 U.S. 739, 752 (1987), this Author tends to take a different view, *see* Cortney E. Lollar, *What Is Criminal Restitution?*, 100 IOWA L. REV. 93, 105-22 (2014) (defining punishment in a manner that includes pretrial detention).
- 339 Roberts, *supra* note 311, at 18:10.
- 340 LAPIDUS ET AL., *supra* note 132, at 50.
- 341 Stephanie Bush-Baskette, *The War on Drugs and the Incarceration of Mothers*, 30 J. DRUG ISSUES 919, 923 (2000).
- 342 The statutes of twenty-four states explicitly connect the termination of parental rights to a parent's incarceration. MARGARET COLGATE LOVE, JENNY ROBERTS & CECILIA KLINGELE, COLLATERAL CONSEQUENCES OF CRIMINAL CONVICTION: LAW, POLICY AND PRACTICE § 2.27 (2016 ed.). An additional five states have statutory provisions that include parental incarceration as a factor in termination of parental rights proceedings. *Id.*
- 343 42 U.S.C.A. § 675(5)(E) (West 2011 & Supp. 2016).
- 344 BUREAU OF JUSTICE STATISTICS, OFFICE OF JUSTICE PROGRAMS, STATE COURT SENTENCING OF CONVICTED FELONS: 2004 STATISTICAL TABLES, <http://www.bjs.gov/content/pub/html/scscf04/tables/>

scs04105tab.cfm [https://perma.cc/GQW4-RDVW] (last revised Feb. 9, 2017). The median prison sentence for women is sixty months, according to a study by the Government Accounting Office. U.S. GEN. ACCOUNTING OFFICE, GAO/GGD-00-22, WOMEN IN PRISON: ISSUES AND CHALLENGES CONFRONTING U.S. CORRECTIONAL SYSTEMS 30 (1999).

345 LAPIDUS ET AL., *supra* note 132, at 56.

346 See, e.g., Ronnie Halperin & Jennifer L. Harris, *Parental Rights of Incarcerated Mothers with Children in Foster Care: A Policy Vacuum*, 30 FEMINIST STUD. 339, 340-41 (2004) (discussing requirements to avoid termination of parental rights); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1484 (2012).

347 See Gupta-Kagan, *supra* note 269, at 961.

348 BOYD, *supra* note 300, at 14.

349 *Id.* at 15.

350 *Id.*

351 *Id.* at 16.

352 *Id.* Financially, keeping children with their birth parents is also sound policy; it costs the government “eleven times as much per child to provide foster care as to provide public aid to families.” ROBERTS, *supra* note 267, at 191 (emphasis omitted).

353 See, e.g., John P. Ackerman, Tracy Riggins & Maureen M. Black, *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 J. PEDIATRICS 554, 563-54 (2010).

354 Gupta-Kagan, *supra* note 269, at 960; *cf.* Roberts, *supra* note 311, at 21:02 (discussing how, prior to the 1960s, when most child welfare money went to white families, money went to supporting children in their homes; when more Black children began to enter the child welfare system, during the 1970s-90s, policy and financial shift toward removing children from their families and placing them in foster care).

355 See Ackerman et al., *supra* note 353, at 563; Betancourt et al., *supra* note 142, at 44; Frank et al., *supra* note 25, at 1616.

356 Minnes et al., *supra* note 176, at 66-67.

357 See, e.g., Kleiber et al., *supra* note 214, at 9; Minnes et al., *supra* note 176, at 66-67.

358 James G. Dwyer, *The Child Protection Pretense: States' Continued Consignment of Newborn Babies to Unfit Parents*, 93 MINN. L. REV. 407, 417 (2008) (citing Charles H. Zeanah, Charles A. Nelson, Nathan A. Fox, Anna T. Smyke, Peter Marshall, Susan W. Parker & Sebastian Koga, *Designing Research To Study the Effects of Institutionalization on Brain and Behavioral Development: The Bucharest Early Intervention Project*, 15 DEV. & PSYCHOPATHOLOGY 885, 888 (2003)).

- 359 *Id.*
- 360 *Id.*
- 361 GÓMEZ, *supra* note 24, at 24.
- 362 *See, e.g.,* Kleiber et al., *supra* note 214, at 9; Minnes et al., *supra* note 176, at 66.
- 363 Dwyer, *supra* note 358, at 418, 419.
- 364 *Id.* at 423.
- 365 *See, e.g.,* Lester et al., *supra* note 126, at 29-30 (discussing Vulnerable Infants Program of Rhode Island).
- 366 TENN. CODE ANN. § 39-13-107(c)(3) (2014), amended by TENN. CODE ANN. § 39-13-107 (Supp. 2016)
- 367 S.B. 297, 2015 Gen. Assemb., Reg. Sess. (N.C. 2015). However, Missouri's bill does allow for the possibility of a drug court program referral. H.B. 1903, 98th Gen. Assemb., 2d Reg. Sess. (Mo. 2016). Oklahoma's proposal only permits evidence of a person's continued involvement in a drug treatment program to be considered as mitigation in sentencing. S.B. 559, 55th Leg., 1st Sess. (Okla. 2015) (as introduced). The other two states' proposals-- North Carolina's and Louisiana's--have no mention of drug treatment.
- 368 Cole, *supra* note 26, at 2667.
- 369 AM. MED. ASS'N, H-420.970 TREATMENT VERSUS CRIMINALIZATION: PHYSICIAN ROLE IN DRUG ADDICTION DURING PREGNANCY, RES. 131, A-90 (1990) (reaffirmed 2010) ("It is the policy of the AMA ... to oppose legislation which criminalizes maternal drug addiction"), <https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMADoc%2FHOD.xml-0-3713.xml> [<https://perma.cc/83HH-RC4Q>].
- 370 Am. Pub. Health Ass'n, *Policy Statement No. 9020: Illicit Drug Use by Pregnant Women*, 81AM. J. PUB. HEALTH 253 (1991).
- 371 *E.g.,* AM. NURSES ASS'N, *supra* note 14 ("[The American Nurses Association] recognizes alcohol and other drug problems as treatable illnesses. The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems."); AM. PSYCHOLOGICAL ASS'N, RESOLUTION ON SUBSTANCE ABUSE BY PREGNANT WOMEN 59-60 (1991) (affirming "that alcohol and drug abuse by pregnant women is a public health problem and that laws, regulations and policies that treat chemical dependency primarily as a criminal justice matter requiring punitive sanctions are inappropriate," and encouraging "the use of health care strategies to foster the welfare of chemically dependent women and their children by expanding access to prenatal care and to reproductive health care generally"); AM. SOC'Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON CHEMICALLY DEPENDENT WOMEN AND PREGNANCY 1 (1989) ("Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing harm to children and to society as a whole."); COMM. ON ETHICS, *supra* note 332, at 9 ("Pregnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses."); COUNCIL ON ADDICTION PSYCHIATRY, *supra* note 14 ("[P]olicies of prosecuting pregnant and/or postpartum women who have used either alcohol or illegal substances during pregnancy on grounds of 'prenatal

child abuse' [and their] subsequent incarceration in jails, prisons or in locked psychiatric unit deprives the mother of her liberty and disrupts the incipient or nascent maternal-infant bond."); NAT'L PERINATAL ASS'N, *supra* note 14 ("NPA opposes punitive measures that deter women from seeking appropriate care during the course of their pregnancies Using the criminal justice system is a misguided attempt to protect the fetus, undermines maternal and fetal wellbeing, and discourages the development of programs that address the needs of these women and their children [P]rosecution does not stop pregnant women from abusing drugs [Rather,] the threat of criminal punishment fosters fear and mistrust between healthcare providers and patients, imperiling the health of women and their children."); Comm. on Substance Abuse, Am. Acad. of Pediatrics, *Drug-Exposed Infants*, 86 J. PEDIATRICS 639, 641 (1990) ("The [Academy] is concerned that [arresting drug-addicted women who become pregnant] may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment.").

372 COMM. ON ETHICS, *supra* note 332, at 8.

373 Renee Milligan, Barbara K. Wingrove, Leslie Richards, Margaret Rodan, Lillie Monroe-Lord, Velishie Jackson, Barbara Hatcher, Cynthia Harris, Cassandra Henderson & Allan A. Johnson, *Perceptions About Prenatal Care: Views of Urban Vulnerable Groups*, BMC PUB. HEALTH, no. 2, 2002, at 1.

374 Goldensohn & Levy, *supra* note 3.

375 Finnegan & Kandall, *supra* note 165, at 832.

376 J. Rosenberg, *Neonatal Death Risk: Effect of Prenatal Care Is Most Evident After Term Birth*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 270 (2002), <https://www.guttmacher.org/pubs/journals/3427002.html> [<https://perma.cc/FV7Z-EWQQ>].

377 *Id.*

378 Milligan et al., *supra* note 373, at 2.

379 *Id.*

380 Gonzalez, *supra* note 84.

381 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEPT OF HEALTH & HUMAN SERVS., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2013, at 54 tbl.4.11 (2014), http://www.samhsa.gov/data/sites/default/files/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf [<https://perma.cc/LV4E-JRRN>] (reporting that 2362 out of 14,148 total treatment facilities offer services specifically geared to pregnant or postpartum women). Tennessee has twenty-four facilities, or 11% of its facilities, that treat pregnant or postpartum women. *Id.* at 108 tbl.6.12b.

382 *Id.* at 54 tbl.4.11 (using numbers on the left side of the table).

383 *Id.* at 51 tbl.4.8.

384 Janet W. Steverson & Traci Rieckmann, *Legislating for the Provision of Comprehensive Substance Abuse Treatment Programs for Pregnant and Mothering Women*, 16 DUKE J. GENDER L. & POL'Y 315, 324 (2009).

- 385 MALINOWSKA-SEMPRUCH & RYCHKOVA, *supra* note 67, at 11.
- 386 *Id.*
- 387 H. Westley Clark, *Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children: Treatment and Policy Implications*, 80 CHILD WELFARE 179, 189 (2001).
- 388 *Id.*
- 389 Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (statement of Mary Linden Salter, Executive Director of Tennessee Association of Alcohol, Drug, and Other Addiction Substances, at 2:16:00).
- 390 *Id.*
- 391 *Id.*
- 392 *Id.* at 2:15:38.
- 393 Goldensohn & Levy, *supra* note 3 (quoting Sullivan County prosecutor Barry Staubus).
- 394 *Id.* (quoting Davidson County prosecutor Brian Holmgren).
- 395 *Id.*
- 396 *Id.*
- 397 This Article does not advocate the creation of such laws.
- 398 Siegel, *supra* note 19, at 339.
- 399 *Id.* at 344.
- 400 *See, e.g.*, Roberts, *supra* note 138, at 1445-50.
- 401 Siegel, *supra* note 19, at 344.
- 402 *See supra* Part II.B.
- 403 Additionally, Tennessee passed a civil version of its assault bill the year before, *see* TENN. CODE. ANN. § 33-10-104(e), (f) (2015), which also encouraged treatment, but without the criminal stigma and punishment attached. If rehabilitation were the true motivation, the legislature would have had no need to pass a criminal law a year later, without waiting to see whether the initial civil provision was successful.

- 404 Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (statement of Rep. Terri Lynn Weaver, at 1:19:58).
- 405 *Id.* at 1:21:15, 1:21:54.
- 406 *See supra* Parts II.A.2, II.B.
- 407 Mar. 18, 2014, S.B. 1391 Hearing, *supra* note 71 (statement of Barry Staubus, District Attorney for Sullivan County, at 2:12:48).
- 408 Mar. 15, 2016, Hearing on H.B. 1660, *supra* note 77 (statement of Dr. Stephen Patrick, at 1:37:35).
- 409 *Id.*
- 410 *Id.*
- 411 *Id.* (statements of Latony Lester, at 1:16:09 and Brittany Hudson, at 2:10:09).
- 412 *Id.* (statement of Dr. Stephen Patrick, at 1:39:29).
- 413 Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74 (statement of Rep. Terri Lynn Weaver, at 5:25:48). Representative Weaver's assessment was not entirely accurate, however. Long established Supreme Court precedent prohibits the criminalization of the mere use of drugs. [Robinson v. California](#), 370 U.S. 660, 666 (1962) (finding statute that makes drug addiction a criminal offense unconstitutional). Only the possession and distribution of drugs are illegal.
- 414 [Robinson](#), 370 U.S. at 666.
- 415 *See, e.g.*, Mar. 18, 2014, S.B. 1391 Hearing, *supra* note 71, at 2:12:48 (statement of Barry Staubus, District Attorney for Sullivan County); Apr. 9, 2014, Debate on H.B. 1295, *supra* note 74, at 5:12:48 (statement of Rep. Terri Lynn Weaver); Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77, at 2:30:03 (statement of Rep. Terri Lynn Weaver).
- 416 *See Cherry*, *supra* note 13, at 38-39 (discussing how recent statutes “grant rights to the fetus, create an adversarial relationship between the fetus and the pregnant woman, and criminalize the behavior of the pregnant woman”); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 696-97 (2006).
- 417 Cortney E. Lollar, *Child Pornography and the Restitution Revolution*, 103 J. CRIM. L. & CRIMINOLOGY 343, 388 (2013).
- 418 Goldensohn & Levy, *supra* note 3.
- 419 *Cf.* Cortney E. Lollar, *Punitive Compensation*, 51 TULSA L. REV. 99, 108 (2015) (discussing criminal law's attempts to remedy moral harms through punishment).
- 420 Mar. 15, 2016, H.B. 1660 Hearing, *supra* note 77 (Statement of Rep. Terri Lynn Weaver, at 1:20:55).

- 421 MALINOWSKA-SEMPRUCH & RYCHKOVA, *supra* note 67, at 12.
- 422 Goodwin, *supra* note 13, at 853-54.
- 423 *See supra* text accompanying notes 75-76.
- 424 ROBERTS, *supra* note 19, at 154; *see id.* at 180.
- 425 *See, e.g.,* PALTROW, *supra* note 27, at 6; Roberts, *supra* note 138, at 1432-36; Libby Copeland, *Wisconsin Is Throwing Pregnant Women in Jail To Protect “Unborn Children,”* SLATE (Dec. 16, 2014, 11:47 AM), http://www.slate.com/blogs/xx_factor/2014/12/16/tamara_loertscher_wisconsin_mother_is_thrown_in_jail_for_refusing_drug_treatment.html [https://perma.cc/7DAK-TT2Q]; Martin, *supra* note 9; Goodwin, *supra* note 13, at 786.
- 426 Goldensohn & Levy, *supra* note 3.
- 427 Goodwin, *supra* note 13, at 786.
- 428 *See supra* text accompanying note 101.
- 429 *See supra* notes 109 & 110 and accompanying text.
- 430 *See, e.g.,* William Julius Wilson, *The Declining Significance of Race: Revisited & Revised*, 140 DÆDALUS 55, 57 (2011). To be clear, enormous disparities in wealth remain between Black and white families in the United States, due to generations of policies that have limited the ability of African Americans to attain and maintain wealth. *See, e.g.,* MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (rev. ed. 2012); Goldburn P. Maynard Jr., *Addressing Wealth Disparities: Reimagining Wealth Taxation as a Tool for Building Wealth*, 92 DENV. U.L. REV. 145, 151-54 (2014); Paul Kiel, *Debt and the Racial Wealth Gap*, N.Y. TIMES (Dec. 31, 2015), http://www.nytimes.com/2016/01/03/opinion/debt-and-the-racial-wealth-gap.html?_r=0 [https://perma.cc/TMM6-NMBL].
- 431 *See, e.g.,* ROBERTS, *supra* note 19, at 110; *cf.* john a. powell, *The Race and Class Nexus: An Intersectional Perspective*, 25 LAW & INEQ. 355, 424 (2007) (“[C]lass identity in the United State[s] is already a racial identity.”).
- 432 KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* 173 (2011).
- 433 powell, *supra* note 431, at 397.
- 434 BRIDGES, *supra* note 432, at 173.
- 435 powell, *supra* note 431, at 389. Another recent series of laws revealing the enhanced role that class plays in punishing those who are poor involves the drug testing of welfare applicants, despite repeated evidence that few applicants ever test positive. Bryce Covert, *Tennessee Drug Tests Welfare Applicants, Discovers Less Than One Percent Use Drugs*, THINKPROGRESS (Aug. 7, 2014), <http://thinkprogress.org/economy/2014/08/07/3468610/tennessee-welfare-drug-test-positive/> [https://perma.cc/US5P-JTEF]; Alan Pyke, *Welfare Drug Tests in Tennessee Are Coming Up Pretty Close to Empty*, THINKPROGRESS (Feb. 9, 2016), <http://thinkprogress.org/economy/2016/02/09/3747642/>

tennessee-drug-tests-update/ [https://perma.cc/RRG6-AQB7]. Only one person, of 87,000 people tested in Arizona, had a positive drug test. Editorial, *Drug Testing Welfare Applicants Nets Little*, USA TODAY (Mar. 18, 2012, 7:30 PM), <http://usatoday30.usatoday.com/news/opinion/editorials/story/2012-03-18/drug-testing-welfare-applicants/53620604/1> [https://perma.cc/LBK5-DNCP]. In Utah, only twelve of 4730 applicants tested positive, or fewer than 0.3%. Michelle L. Price, *Only 12 Test Positive in Utah Welfare Drug Screening*, KSL.COM (Aug. 23, 2013, 3:42 PM), http://www.ksl.com/?sid=26559995&nid=148&title=only-12-test-positive-in-utah-welfare-drug-screening&fm=home_page&s_cid=queue-11 [https://perma.cc/JX6Q-C5M8]. In Florida, a slightly higher percentage, but still fewer than 3% of applicants, had positive drug tests. Lizette Alvarez, *No Savings Are Found from Welfare Drug Tests*, N.Y. TIMES, Apr. 18, 2012, at A14. Florida has had to pay out settlements based on court rulings that the testing was unconstitutional. Dara Kam, *Failed Drug-Test Requirement Costs Florida Taxpayers \$1.5 Million in Legal Fees*, MIAMI HERALD (June 21, 2015, 2:47 PM), <http://www.miamiherald.com/news/state/florida/article25114639.html> [https://perma.cc/5JXG-CT7Q]. Evidence actually suggests that the rate of positive drug tests for welfare applicants is lower than that of the general population. Darlena Cunha, *Why Drug Testing Welfare Recipients Is a Waste of Taxpayer Money*, TIME (Aug. 15, 2014), <http://time.com/3117361/welfare-recipients-drug-testing/> [https://perma.cc/S24T-NW3U].

436 Audrey G. McFarlane, *Operatively White?: Exploring the Significance of Race and Class Through the Paradox of Black Middle-Classness*, 72 LAW & CONTEMP. PROBS. 163, 165 (2009).

437 *Id.*; powell, *supra* note 431, at 420-21.

438 McFarlane, *supra* note 436, at 165.

439 BRIDGES, *supra* note 432, at 221; *cf. id.* at 229-30.

440 *See supra* Parts I.A. & I.F.

441 *See supra* Parts I.A., I.B. & I.F.

442 *See supra* Parts I.A. & I.F.

443 Cheryl I. Harris, *Whitewashing Race: Scapegoating Culture*, 94 CALIF. L. REV. 907, 916-17 (2006) (reviewing MICHAEL K. BROWN, MARTIN CARNOY, ELLIOT CURRIE, TROY DUSTER, DAVID B. OPPENHEIMER, MARJORIE M. SCHULTZ & DAVID WELLMAN, *WHITEWASHING RACE: THE MYTH OF A COLOR-BLIND SOCIETY* (2003)) (discussing the binary constructions of Blackness and Whiteness and the “Black/not Black” paradigm); *see also* BRIDGES, *supra* note 432, at 228-30 (acknowledging the Black/White paradigm, as well as Lani Guinier and Gerald Torres’s “Black/non-Black” paradigm, and proposing a white/nonwhite paradigm instead).

444 Roberts, *supra* note 138, at 1435-36; *cf.* BRIDGES, *supra* note 432, at 213-14 (discussing how women on welfare are viewed as failing to contribute to society, and therefore, more deserving of moral condemnation and less deserving of the mantle of motherhood).

445 Goodwin, *supra* note 13, at 798.

446 BRIDGES, *supra* note 432, at 158-59.

447 *Id.* at 165.

448 *Id.* at 172.

449 *Id.* at 166.

450 ROBERTS, *supra* note 19, at 180-81; *cf.* BRIDGES, *supra* note 432, at 158-159 (discussing the tension between the pathologization of poor pregnant women and the “intractability of [the body’s] procreative facilities” and “reproductive unruliness”).

451 James P. Curley, Rahia Mashoodh & Frances A. Champagne, *Epigenetics and the Origins of Paternal Effects*, 59 HORMONES & BEHAV. 306, 307-08 (2011); *see also, e.g.*, Matthew D. Anway, Andrea S. Cupp, Mehmet Uzumcu & Michael K. Skinner, *Epigenetic Transgenerational Actions of Endocrine Disruptors and Male Fertility*, 308 SCIENCE 1466 (2005); Tod Fullston, E. Maria C. Ohlsson Teague, Nicole O. Palmer, Miles J. DeBlasio, Megan Mitchell, Mark Corbett, Cristin G. Print, Julie A. Owens & Michelle Lane, *Paternal Obesity Initiates Metabolic Disturbances in Two Generations of Mice With Incomplete Penetrance to the F2 Generation and Alters the Transcriptional Profile of Testis and Sperm MicroRNA Content*, 27 FASEB J. 4226 (2016); Emma L. Marczylo, Akwasi A. Amoako, Justin C. Konje, Timothy W. Gant & Timothy H. Marczylo, *Smoking Induces Differential MiRNA Expression in Human Spermatozoa: A Potential Transgenerational Epigenetic Concern?*, 7 EPIGENETICS 432 (2012).

452 Obviously, this may have the potential to raise equal protection concerns. *See, e.g.*, Goodwin, *supra* note 13, at 858-59.

453 Cherry, *supra* note 13, at 47.

454 Roberts, *supra* note 138, at 1445.

455 Tuerkheimer, *supra* note 416, at 693.

456 April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 153 (2007) (quoting JEAN REITH SCHROEDEL, *IS THE FETUS A PERSON? A COMPARISON OF POLICIES ACROSS THE FIFTY STATES* 103 (2000)).

457 Cherry, *supra* note 456, at 195. Khiara Bridges has argued that “the interjection of the state into the woman’s decision-making process regarding parenting and future childbearing is a violation of the woman’s individual right to make these decisions without state interference and coercion.” Bridges, *supra* note 290, at 158.

458 Roberts, *supra* note 138, at 1476.

459 BRIDGES, *supra* note 432, at 43, 66, 70-71.

460 *See* Lester et al., *supra* note 126, at 26, 36; Minnes et al., *supra* note 176, at 65-67.

92 INLJ 947