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PROSECUTORIAL IMMUNITY: THE RESPONSE TO PRENATAL DRUG USE

Margaret P. Spencer*

I. INTRODUCTION

DRUG abuse by pregnant women has increased dramatically in the last ten years.1 As many as fifteen percent of all pregnant women ingest illegal drugs during their pregnancies.2 As a result, the number of drug-exposed infants has reached epidemic proportions. In 1989, the National Association on Perinatal Addiction Research and Education conservatively estimated that 375,000 drug-exposed infants are born each year—at least one out of every ten births in the United States.3

The escalation of prenatal drug use was, in large part, driven by the emergence of inexpensive, highly addictive crack cocaine. Since the

* Associate Professor of Law, Marshall-Wythe School of Law, College of William and Mary. B.A., 1969, Howard University; J.D. 1972, University of Virginia. The author would like to thank Paul Marcus, Rodney Smolla, and Richard Williamson for their helpful comments on earlier drafts of this article.

1. As used in this article, the term “drugs” designates those controlled substances, with the exception of marijuana, listed in the Controlled Substances Act, 21 U.S.C.A. §§ 801-812 (West 1981 & Supp. 1992). Marijuana is excluded because hospitals rarely screen or report prenatal exposure to marijuana, and because insufficient information exists on the effects of marijuana exposure on infants. See Bonnie I. Robin-Vergeer, Note, The Problem of the Drug Exposed Newborn: A Return to Principled Intervention, 42 Stan. L. Rev. 745, 753 n.25 (1990). Prenatal exposure to tobacco and alcohol are also not addressed. The use of these substances is lawful, and the resultant harm to the fetus, while substantial, is neither as substantial nor as well documented as the harm from drug use. Moreover, states rarely seek punitive sanctions against “pregnant alcoholics.” Jan Hoffman, Pregnant, Addicted—And Guilty?, N.Y. Times, Aug. 19, 1990, § 6 (Magazine), at 34, 35.


mid-1980s, crack cocaine has increased in availability and popularity, particularly among women of childbearing age. It is estimated that by the year 2000, the annual number of cocaine-exposed infants may be anywhere from 500,000 to 4,000,000.

These statistics and concomitant media attention have generated legal, social, and medical debate about the appropriate response to the prenatal drug use problem. Not surprisingly, many states have viewed prenatal drug use as just another part of our nation’s growing “drug crisis.” Their approach to the problem has been similar to the federal government’s response to the “drug crisis”—aggressive enforcement of existing criminal statutes and proposals for new legislation.

Approximately 180 women have been arrested in the United States for offenses related to their prenatal drug use. The charges against most of these women were based on novel interpretations of existing drug-trafficking or child-abuse statutes. These women have been charged with drug possession, drug distribution, delivery of drugs to minors, and criminal child abuse or neglect.


8. In Florida, Georgia, Illinois, Michigan, Massachusetts, North Carolina, and South Carolina, women were charged with drug distribution or delivery. In Connecticut, Florida, Idaho, Indiana, Kentucky, and Texas, women were charged with drug possession. In Nevada and South Dakota, women were charged with drug use or drug ingestion. In Ohio, South Carolina, and Virginia, women were charged with child neglect or abuse. See Lynn Paltrow & Suzanne Shende, ACLU Reproductive Freedom Project Memorandum, State by State Case Summary of Criminal Prosecutions Against Pregnant Women (May 21, 1991) (on file with author). An Illinois grand jury refused to indict a mother for manslaughter after her cocaine-exposed newborn died from brain damage. Isabel Wilkerson, Jury in Illinois Refuses to Charge Mother in Drug Death of
Prosecutions based on criminal child abuse statutes have had infrequent success. Courts have repeatedly held that a fetus is not a "child" within the meaning of statutes prohibiting acts endangering the welfare of children. Thus, prenatal drug use which affects a fetus is not prohibited by these statutes.

Prosecutions under drug distribution and delivery statutes have also failed. These cases were based on the mother’s postpartum transfer of drugs through the umbilical cord to her newborn child. Defendants challenged these prosecutions on several grounds. They claimed due process violations based on inadequate notice that drug use is equivalent to drug distribution, and lack of legislative intent to include the involuntary passage of drugs through the umbilical cord within the definition of drug delivery to minors. Defendants have also challenged these prosecutions as violations of the Equal Protection Clause and the right to privacy under the U.S. Constitution. To date, trial and appellate courts have dismissed these criminal cases.

Because prosecutions under existing criminal statutes have not been successful, many states have considered new legislation, and several have enacted such laws. Newborn, N.Y. Times, May 27, 1989, at A10.


11. On July 23, 1992, the Supreme Court of Florida reversed the only conviction against a prenatal drug user for delivery of drugs to her newborn baby. The court held that Florida’s statute prohibiting delivery of drugs to minors did “not encompass ‘delivery’ of an illegal drug derivative from womb to placenta to umbilical cord to newborn after a child’s birth.” Id. at 1296, rev’g 578 So. 2d 419 (Fla. Dist. Ct. App. 1991). In its opinion the court cited a number of other cases that had been dismissed by trial courts. Id. at 1294. The court further noted that in most of these cases, judges found that interpreting drug-trafficking statutes to prohibit distribution of drugs to a newborn infant was contrary to legislative history. Id. See, e.g., People v. Hardy, 469 N.W.2d 50, 52-53 (Mich. Ct. App. 1991).

Civil protective-custody cases have been more successful. See Sherman, supra note 7, at 10. Beginning in 1980, some courts have held that prenatal drug use resulting in the birth of drug-exposed infants establishes civil child neglect. See, e.g., In re Baby X, 293 N.W.2d 736 (Mich. Ct. App. 1980). For a description of civil child-neglect cases and cases involving the termination of parental rights, see Christina V. Burdette, Note, Fetal Protection—An Overview of Recent State Legislative Response to Crack Cocaine Abuse by Pregnant Women, 22 MEM. ST. U L REV 119, 125-26 (1991).
eral states have recently enacted statutes designed to protect the un­
born child from prenatal harm. Proposed legislation in at least four
states would make the act of giving birth to a drug-exposed infant a
felony.

Several members of Congress have supported such new legisla­
tion.14 A bill was introduced in the Senate authorizing federal prenatal
health care money only to states with a statute prohibiting prenatal
drug use. The bill provided that the state statute must make the act of
giving birth to a drug-exposed infant a felony punishable by at least
three years imprisonment.15

Although public support for criminal sanctions existed, neither
the Senate bill nor any of the state bills were enacted. Moreover, medi­
cal and legal scholars strongly criticized the use of any criminal sanc­
tion to address the problem of prenatal drug use. Many claimed the
prosecutions were ineffective and counter-productive. Drug-using preg­
nant women were deterred from seeking prenatal care and were being
punished, some argued, not for their drug use, but for having babies.17

12. Sherman, supra note 7, at 10; Catherine A. Kyres, Note, A "Cracked" Image of My
Mother/Myself? The Need for a Legislative Directive Proscribing Maternal Drug Abuse, 25 NEW
13. See Nancy K. Schiff, Note, Legislation Punishing Drug Use During Pregnancy: Attack on
introduced in Georgia, Louisiana, Ohio, and Colorado would make it a felony to give birth to
a drug-addicted child. Id. at 206-08. The bill proposed in Ohio would impose severe penalties,
including mandatory birth control implants. Id. at 207. A proposed bill in Colorado would expand
the definition of criminal child abuse to include the abuse of a controlled substance during preg­
nancy. Id. at 208. Legislatures in at least nine states have tried to amend the definition of child
abuse in civil statutes to include prenatal substance abuse. Sherman, supra note 7, at 10.
14. Dave Fratello, Prosecution of Pregnant Addicts Won't Prevent Crack Babies, N.Y. TIMES,
15. The proposed "Child Abuse During Pregnancy Prevention Act of 1989" stated that grants
would be awarded to "[s]tates to develop, implement, and operate five pilot projects for . . .
providing outreach, education, and treatment services concerning substance abuse to pregnant fe­
males, postpartum females and their infants." S. 1444, 101st Cong., 1st Sess. § 3(b) (1989). "To
be eligible to receive a grant . . . , a State shall submit . . . a certification that[] it is a crime in
such State to abuse a child, and that such abuse includes giving birth to an infant who is addicted
or otherwise injured or impaired by the substance abuse of its mother during pregnancy; . . . the
female so convicted shall be sentenced to a period of 3 years of mandatory rehabilitation in a
custodial setting. . . ." S. 1444, § 3(c)(4), (5).
16. A 1990 survey of 15 states by the Atlanta Constitution found that 71% of 1500 people
poll ed supported criminal penalties for pregnant women whose drug use injured their infants. The
survey also found that more women than men favored criminalization. Mark Curriden, Holding
17. See, e.g., Dorothy E. Roberts, Punishing Drug Addicts Who Have Babies: Women of
Color, Equality, and the Right of Privacy, 104 H A R V. L. REV. 1419, 1462 (1991); AMA Bd. of
Trustees, supra note 4, at 2663, 2667; Kary Moss, Substance Abuse During Pregnancy, 13 HARV.
Several critics viewed the problem as a conflict between fetal rights and maternal rights and argued that the effect of criminal intervention was to elevate the fetus to the status of a "person." \textsuperscript{18}

Opponents and proponents of criminalization agree, however, that the most effective solution to the problem of prenatal drug use is drug treatment and rehabilitation. \textsuperscript{19} They also recognize that either the pregnant drug user lacks the motivation to seek drug treatment or treatment programs are unavailable or unaffordable. \textsuperscript{20} For the pregnant drug user, then, the "just say no" command is a pitiless and inane response.

This Article argues that governmental intervention is appropriate to address both the motivation to seek treatment and the availability of treatment programs. This intervention should involve the criminal jus-

\textsuperscript{18} See, e.g., Kristen Barrett, \textit{Prosecuting Pregnant Addicts for Dealing to the Unborn}, 33 \textit{ARIZ. L. REV.} 221, 227-34 (1991); Robert Holland, Note, \textit{Criminal Sanctions For Drug Abuse During Pregnancy: The Antithesis of Fetal Health}, 8 \textit{N.Y.L. SCH. J. HUM. RTS.} 415 (1991); Doretta M. McGinnis, Comment, \textit{Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory}, 139 \textit{U. PA. L. REV.} 505 (1990); \textsuperscript{19} See, e.g., Maternal Rights and Fetal Wrongs, \textsuperscript{supra} note \textsuperscript{18}, at \textit{995} ("[E]ducating women and funding adequate prenatal care are better approaches to the problem . . . "); Lisa J. Keyes, Comment, \textit{Rethinking the Aim of the 'War on Drugs': States' Roles in Preventing Substance Abuse by Pregnant Women}, 1992 \textit{Wis. L. REV.} 197, 230-32; \textsuperscript{20} See Keyes, \textit{supra} note \textsuperscript{19}, at \textit{232} (arguing that pregnant women use drugs because they lack either incentives or resources to stop using drugs).
tice system and the social services system. The criminal justice system, which is currently a "disincentive" to prenatal care and drug treatment, could become an "incentive" for the drug user to seek care and treatment. This transformation is possible through the use of prosecutorial immunity. Such immunity should be granted to prenatal drug users for all offenses based on the evidence of a drug-affected infant who participate in treatment programs. The social services system should provide the user the "means" by which to obtain this immunity, by expanding and establishing prenatal and postpartum drug treatment facilities. Part II of this Article describes the effects of prenatal drug use, including the harm to the infant and the economic cost to society. Part III outlines a proposed solution which provides the pregnant drug user with both the resources and the incentive to stop using drugs. This solution includes criminal sanctions, under existing drug use statutes, as a "last resort" for mothers who refuse to participate in available treatment programs. Part IV evaluates the constitutionality of these criminal sanctions.

II. EFFECTS OF PRENATAL DRUG USE

Although disagreement exists on the most appropriate means to resolve the problem, the devastating effects of prenatal drug use on infants and society are beyond dispute. An understanding of these effects is essential to the development of an effective solution to prenatal drug use. This section describes the consequences to both the infant and society.

Drug exposure has seriously harmful physiological effects on the

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21. Prosecutorial immunity is a promise of nonprosecution. This immunity would prohibit the state from using the mother’s prenatal drug use, or the infant’s positive drug screen, as evidence in a subsequent prosecution. The scope of this nonstatutory immunity would be determined by the state. Use and derivative-use immunity would preclude prosecution based on prenatal drug evidence and any other evidence directly or indirectly derived from the prenatal drug use. Transactional immunity would bar prosecution for any transaction or matter relating to the prenatal drug use. Together, these immunities would sufficiently insure that a mother’s prenatal drug use would not "lead to the infliction of criminal penalties." Kastigar v. United States, 406 U.S. 441, 453 (1972). Because prosecutorial immunity would be provided through an agreement, rather than a formal court order, the state may be able to tailor the scope of the immunity to the case. See WAYNE R. LaFAVE & JEROLD H. ISRAEL, CRIMINAL PROCEDURE § 8.11, at 393-97 (1984).

Immunity has been suggested, but not explored, by at least one other commentator. See James Denison, Note, The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse, 64 S. CAL. L. REV. 1104, 1139 (1991) ("One alternative means of motivating addict mothers to take positive steps to protect their unborn children, at least where illicit substances are concerned, would be to offer . . . the promise of immunity from drug prosecution upon submitting to voluntary prenatal care.").
newborn infant. When ingested by pregnant women, drugs enter a fetus’ body through the mother’s bloodstream. The drugs may cause fetal high blood pressure, premature birth, low birth weight, and birth defects. Prenatal cocaine exposure can also cause neurological impairment.22 Some drug-affected infants are born with missing or shrunken limbs due to poor blood circulation.23 Many drug-exposed infants are also infected with HIV, the virus that causes AIDS, because their mothers contracted the disease through intravenous drug use.24

Cocaine is especially dangerous to the fetus if it is used during the first three months of pregnancy, when the brain and other organs are developing.25 Cocaine constricts the mother’s blood vessels and reduces the blood flow to the fetus through the placenta. By reducing the supply of blood to the fetus, cocaine depletes the fetus of oxygen.26


23. Christy Scatterella, Forced Birth Control?-Drug Baby Boom Sparks Call to Control Female Addicts, SEATTLE TIMES, June 24, 1991, at A1. Pregnant women who take drugs can also cause their babies to have strokes in the uterus. Romney, supra note 18, at 328. For a list of medical and obstetrical complications that occur when pregnant women take drugs, see Loretta P. Finnegan & Ronald J. Wapner, Drug Abuse in Pregnancy, MED. TIMES, Oct. 1983, at 4FM, 6FM-7FM; Judith Larsen et al., Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure, 18 PEPP. L. REV. 279 (1991).

24. Some infants are not drug exposed, but are infected with AIDS or the HIV virus. In most cases, however, infants with AIDS are also drug-exposed. James R. Cooper, Methadone Treatment and Acquired Immunodeficiency Syndrome, 262 JAMA 1664, 1667 (1989); Vincent P. Dole, Methadone Treatment and the Acquired Immunodeficiency Syndrome Epidemic, 262 JAMA 1681 (1989) (editorial). Unfortunately, the physical suffering for these infants begins at birth and ends at death. In 1988, the March of Dimes declared AIDS the nation’s fastest-growing birth defect and campaigned to encourage women who may be infected to get tested for AIDS before they become pregnant. The campaign slogan was “A baby with AIDS is born dying.” Peg Byron, AIDS Babies; Your Health: Treating the Youngest and Fastest Growing Group of AIDS Sufferers, UPI, Feb. 27, 1988, available in LEXIS, Nexis Library, UPI File; see also Rex Greene, M.D., Towards a Policy of Mercy: Addiction in the 1990s, 1991 STAN. L. & POL’Y REV. 227, 231 (outlining data that suggest the spread of neonatal AIDS through intravenous drug use).

25. For studies detailing the effects of cocaine on the developing fetus, see Ira J. Chasnoff, Drug Use in Pregnancy: Parameters of Risk, 35 PEDIATRIC CLINICS OF N. AM. 1403, 1406-07 (1988); Ira J. Chasnoff et al., Temporal Patterns of Cocaine Use in Early Pregnancy: Perinatal Outcome, 261 JAMA 1741 (1989); Gilberto F. Chavez, Maternal Cocaine Use in Early Pregnancy as a Risk Factor for Congenital Urogenital Abnormalities, 262 JAMA 795 (1989); Katherine Kaye et al., Birth Outcomes for Infants of Drug Abusing Mothers, 89 N.Y. ST. J. MED. 256 (1989); Louis G. Keith et al., Substance Abuse in Pregnant Women: Recent Experience at the Perinatal Center for Chemical Dependence of Northwestern Memorial Hospital, 73 OBSTETRICS & GYNECOLOGY 715 (1989).

26. See Ira J. Chasnoff et al., Cocaine Use in Pregnancy, 313 NEW ENGL. J. MED. 666, 668
consequences of decreased fetal oxygenation include prenatal strokes, premature births, growth retardation, injury to the central nervous system, and congenital malformations.27

Drug-exposed infants often have serious behavioral or emotional problems. Many become hyperactive, causing frustration for their parents. The added stress of caring for the drug-exposed child may cause the parents to physically abuse or simply neglect the child.28 Even if the child is not abused or physically harmed, prenatal drug use increases the risk of a poor maternal-infant relationship. A drug-abusing mother may be unable to care for a normal child. The relationship may be so detrimental to the child that it is difficult to determine whether the child’s unusual behavior results from the biological effects of prenatal drug exposure or poor parenting.29

Many drug-exposed infants are born into troubled families with histories of abuse and neglect. An estimated 675,000 children, a figure which includes children who managed to escape prenatal exposure, are abused or neglected each year due to drugs.30 According to one study, the correlation between substance abuse and child abuse or neglect by the substance abuser may be as high as eighty-three percent.31 Moreover, the cycle frequently continues with neglected or abused children eventually becoming drug-using and child-abusing parents.32

(1985); Zuckerman et al., Fetal Growth, supra note 22, at 766.

27. See Chasnoff, supra note 26, at 668-69. Minor neurological abnormalities may cause serious learning and behavior disabilities. Even newborns without birth defects or neurological abnormalities may experience withdrawal symptoms like seizures, eating difficulties, trembling, or lethargy. Larsen et al., supra note 23, at 291-96; AMA Bd. of Trustees, supra note 4, at 2666.

28. Rhode Island medical examiners determined that continued cocaine use by the parents of a seven-week-old child led to the child’s death from malnutrition and dehydration. William Q. Sturner et al., Cocaine Babies: The Scourge of the ’90’s, 36 J. FORENSIC Sci. 35, 36-37 (1991).

29. The addicted mother typically leads a disorganized, chaotic life which is not conducive to providing predictable and positive experiences that newborns require to develop normally. See Douglas J. Besharov, Whose Life Is It, Anyway? Pregnant Crack Users Act as Child Abusers, NAT’L L.J., Mar. 4, 1991, at 15. Moreover, drug use impairs a mother’s judgment and may cause her to physically abuse her children. A Ramsey County, Minnesota, Department of Human Services study found that parents who use cocaine are “extremely volatile with episodes of ‘normal’ behavior interspersed with episodes of unpredictable, dangerous and even violent behavior.” Id. at 16. In 1989, 70% of the child-abuse fatalities that occurred in families serviced by New York City’s child protective agency were drug related. Id.


32. Haldane, supra note 3, at B1. Pregnant drug users are frequently involved in abusive
The economic costs associated with drug-exposed infants provide a benchmark for the money that could be saved by preventing prenatal drug use. Caring for these infants is expensive. Moreover, the expenses fall not only on public and private health care systems, but also on foster care programs, social service systems and public school systems. The public costs of caring for these infants could soon reach $50 million to $100 million a year.33

The most expensive medical costs are for neonatal intensive care. Twenty-five percent of drug-exposed newborns need intensive care for several months. Such care can cost between $24,750 and $100,000 per infant.34 Cocaine-exposed infants have more physiological problems, and their medical care is more expensive than the care needed by other drug-exposed infants. Cocaine-exposed babies are fifty percent more likely to require intensive care and twice as likely to have very low birth weights, costing the country more than $500 million a year in hospital and delivery care alone.35 The additional cost for delivery and care of crack-exposed babies is over $11,000 per infant.36 The medical expenses for these children, which begin at birth and continue to age eighteen, may be as much as $750,000. Because these children are often uninsured, the government is forced to pay most of these medical relationships, and their “vulnerability to physical abuse may stem from a history of being abused as children.” Amin N. Daghestani, Psychosocial Characteristics of Pregnant Women Addicts in Treatment, in DRUGS, ALCOHOL, PREGNANCY AND PARENTING, 7, 11 (Ira J. Chasnoff ed., 1988). Between 74% and 90% of female drug users have been victims of sexual abuse, rape, or incest. See Renee M. Popovits, Criminalization of Pregnant Substance Abusers: A Health Care Perspective, 24 J. HEALTH & HOSP. L., June 1991, at 169, 172 (discussing studies on drug-dependent women and reports from the few drug abuse programs that treat pregnant women).


34. Fern S. Chapman, We’ll Pay Now or We’ll Pay Later, USA TODAY, Jan. 9, 1990, at A6; Retha Hill, Mothers and Babies Doing Well at Md. Center for Drug Abusers, WASH. POST, Feb. 10, 1992, at D3.

35. The American Medical Association estimates the hospital expenses for babies born to cocaine-addicted mothers is $504 million a year more than the hospital expenses for healthy babies. Associated Press, Care of Babies, N.Y. TIMES, Sept. 9, 1991, at B4. This figure does not include subsequent health and social services costs required to help cocaine-exposed children “cope with the damage sustained before birth.” The Cost of Not Preventing Crack Babies, N.Y TIMES, Oct. 10, 1991, at A26 (editorial).

bills.37

III. DRUG TREATMENT AND PROSECUTORIAL IMMUNITY

The alarming predictions of a “prenatal drug epidemic” have generated a number of proposed governmental responses. Many are humane and rehabilitative.38 Others are shockingly inhumane and punitive.39

The problem with many of these responses is that they fail to consider the reasons why pregnant women use drugs and avoid prenatal care and available drug treatment. Although there is no simple explanation for prenatal drug use, it exists in large part because the expectant mother has neither the ability nor the motivation to stop using drugs. An appropriate and effective response, therefore, must address this lack of “ability” and “motivation.” The harmful consequences of punitive sanctions40 could be avoided if the pregnant drug user had an opportunity to participate in prenatal care and drug treatment programs, and a realistic motivational “carrot”—the assurance of immunity from prosecution upon successful completion of the drug treatment program.

The trend toward legislation with only criminal sanctions indicates the need for a balanced, reasoned response to the problem of drug-exposed infants. State intervention should be designed to protect drug-affected children from immediate physiological harm and any potential post-hospitalization harm, and to protect society from the mother’s ille-

37. Another study estimates the medical costs per child, for the first four years of raising a drug addicted baby, are over $40,000. Dillin, supra note 36, at 8. A recent study by the U.S. Census Bureau also disclosed that “one American in four lacks continuous health-insurance coverage” and “hispanics, blacks, the young and city dwellers were more likely to spend at least a month without health insurance” during the 28-month period studied by the Census Bureau. More than half of those without insurance had no health insurance for more than 12 months of the 28-month study. Associated Press, One in Four Lacks Health Insurance, RICHMOND TIMES-DISPATCH, June 25, 1992, at A13.


39. “I know it sounds harsh, . . . but I think we should offer these mothers a week’s supply of free drugs if they would let us take out their uterus [sic]” was the recommendation of a neonatal intensive care nurse at a Detroit Hospital. Tom Hundley, Infants: A Growing Casualty of the Drug Epidemic, CHI. TRIB., Oct. 16, 1989, at 1.

gal drug use and its economic consequences. This response should be independent of and immaterial to the legal status of the fetus. The government should recognize that the problem of prenatal drug use is both a public health problem and a criminal drug use problem. Thus, the solution to such a problem must broadly address the medical, social, and legal issues associated with drug dependence and prenatal drug exposure. As part of such a solution, states must find the resources needed for prenatal services and drug treatment programs that meet the specific needs of the pregnant drug user.

Intensive drug abuse education and treatment programs must not only be made available and accessible, but must also be utilized by pregnant drug users. While accepting the view that prenatal treatment programs are the best solution, several experts doubt that pregnant addicts would voluntarily enroll in such programs. These experts believe that addicts, and some drug-using non-addicts, cannot act responsibly and will not voluntarily seek treatment.

An effective response must, therefore, include governmental coercion. The expectant mother should have a strong incentive to participate in drug treatment: prosecutorial immunity. She must be encouraged to select treatment and participate in available programs, or else risk prosecution for her prenatal ingestion of illegal drugs.

Punitive solutions to the prenatal drug use problem should be avoided, if possible, and pregnant drug users should not be punished merely because they give birth to drug-affected infants. However, drug users who refuse to participate in available treatment programs should not be immune from prosecution for their criminal conduct. These drug users have possessed and used drugs, in violation of existing

41. The former director of the National Center on Child Abuse and Neglect stated, “Cases like these [children battered by drug addicted parents] lead to proposals to expand treatment services for crack-addicted mothers. But at least for now, such services would probably make little difference. Crack addicts typically show little or no interest in prenatal care and are unlikely to seek it until very late in their pregnancy, if ever... [A]n expansion of drug-treatment services for women is long overdue but unlikely to produce quick or substantial results.” Douglas J. Besharov, Crack Babies: The Worst Threat Is Mom Herself, Wash. Post, Aug. 6, 1989, at B1.

42. Prenatal drug users may refuse to participate in available substance abuse treatment programs simply because they fail to see the need for treatment or because penal sanctions are too speculative. Ira J. Chasnoff, President of the National Association of Perinatal Addiction Research and Education, believes “drug-using individuals are not reality-based and have strong denial mechanisms. They tell themselves they will never be caught.” Punishing Pregnant Addicts: Debate, Dismay, No Solution, N.Y. Times, Sept. 10, 1989, at D5.

43. For discussions of the policy arguments against prosecuting mothers of drug addicted infants, see, e.g., McGinnis, supra note 18; Maternal Rights and Fetal Wrongs, supra note 18; Wilkins, supra note 17; Wright, supra note 18.
drug-possession and drug-use statutes. Prosecutors should only charge those offenders who refuse to participate in available drug abuse treatment programs. All other offenders should be granted immunity.

To encourage participation in prenatal and drug treatment programs, (1) the availability and accessibility of programs must increase; (2) all disclosures by pregnant drug users to medical personnel should be covered by the physician-patient confidentiality privilege; and (3) drug users who have not been granted immunity must be prosecuted.

A. Availability of Drug Treatment Programs for Pregnant Drug Users

Regardless of the incentive, or concern about the unborn child, pregnant drug addicts can rarely resist the urge to use drugs. Without treatment, “addicted women of reproductive age will continue to use drugs and will continue to bear children.” Prenatal care and drug treatment programs are therefore an essential component of an effective solution to the problem. Currently, drug treatment programs for pregnant drug users are almost non-existent. States need to expand

44. Drug users should not be charged with child abuse solely because they give birth to drug affected infants. Evidence of an infant’s positive toxicology screen should be followed by further assessment to determine whether the infant is at risk of abuse or neglect. A positive toxicology screen, however, is sufficient to establish a reasonable suspicion of drug possession and use. See, e.g., Children of Substance Abusers: Hearings Before the Senate Subcomm. on Children, Families, Drugs, and Alcoholism, Comm. on Labor and Human Resources, 101st Cong., 2d Sess. 63, 64 (1990) (statement of Kary L. Moss, staff attorney, ACLU) (toxicology screens reveal drugs ingested within 72 hours prior to the screen); see also People v. Hardy, 469 N.W.2d 50, 54 (Mich. Ct. App. 1991) (Reilly, J., concurring) (“The defendant may properly have been charged with possession of cocaine . . . . However, the use of controlled substances by a pregnant woman, without more, does not support the additional charge of delivery to another . . . .”).

45. See Shona B. Glink, Note, The Prosecution of Maternal Fetal Abuse: Is This the Answer?, 2 U. ILL. L. REV. 533, 577-78 (1991) (stating that pregnant drug users should be prosecuted only if rehabilitation programs are inadequate or unavailable; women who are “turned away” should not be prosecuted).

46. “I knew every time I picked up that drug that I was taking a risk of harming my baby. But the need for that drug was so great.” Michael Massing, The Two William Bennetts, N.Y. REV. OF BOOKS, Mar. 1, 1990, at 29 (statement of a drug user forced to give up her child due to her addiction). See Wendy K. Mariner et al., Pregnancy, Drugs and Perils of Prosecution, 9 CRIM. JUST. ETHICS 30, 36 (1990); AMA Bd. of Trustees, supra note 4, at 2667 (“Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance dependent have impaired competence in making decisions about the use of that substance.”).


48. Over one million drug addicts are seeking drug abuse treatment in the United States, but facilities are simply unavailable. Andrew H. Malcolm, In Making Drug Strategy, No Accord on
existing residential and non-residential substance abuse facilities and open new facilities.\textsuperscript{49} More importantly, every licensed substance abuse treatment facility should be required to give priority admissions to pregnant drug users.

Additional funding is needed from private and public sources to expand existing treatment programs and create additional programs.\textsuperscript{50} The obvious governmental response to this request is that additional public funding is simply unavailable.\textsuperscript{51} However, funds currently allocated for law enforcement and funds obtained from drug forfeitures could be diverted to programs for pregnant drug users.\textsuperscript{52}

\textit{Treatment}, N.Y. TIMES, Nov. 19, 1989, §1, at 1. A 1989 New York study found that of 78 programs in the city, 87% excluded pregnant crack addicts on Medicaid, 67% excluded pregnant women on Medicaid, and 54% denied admission to all pregnant women. Sherman, supra note 2, at 1; see also Sherman, supra note 7, at 3. Moreover, even if programs did admit pregnant women, access may be “limited by an addict’s financial status and also by less predictable variables such as luck and perseverance.” Oberman, supra note 47, at 517.

49. The New York State Division of Substance Abuse Services estimated that in 1990 there were more than 500,000 drug abusers in New York City. Treatment was available for only 42,000. Moreover, “[t]hings are even worse for pregnant drug abusers, who traditionally have been turned away from treatment.” Felicia R. Lee, \textit{Pregnant Drug Abusers Find Hope in Program}, N.Y. TIMES, Dec. 17, 1990, at B3.

50. Unfortunately, most of the prenatal drug users must depend on public facilities for prenatal care and drug treatment. Two-thirds of the women of childbearing age have no health insurance, and one-fourth lack health insurance for maternity care. Oberman, supra note 47, at 544.


52. Treatment programs could also be supported by “tax proceeds” from a “tax” on illegal drug sales. State legislation taxing drug sales was one of five recommendations addressing the penalties imposed for drug trafficking in a report to the states published by the Office of National Drug Control Policy in November 1990. OFFICE OF NATIONAL DRUG CONTROL POLICY, WHITE PAPER, STATE DRUG CONTROL STATUS REPORT (Nov. 1990) This legislation would “speed the progress and ensure the success of America’s anti-drug efforts.” Id. at 1. At least 28 states have statutes which authorize the collection of “taxes” from defendants who sell or possess controlled substances. (Alabama, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, Rhode Island, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming tax drug sales. Id. at app. See, e.g., KAN. STAT. ANN. § 79-5201 (1989)). Minnesota collected almost $1.5 million in four years from its drug sales tax. OFFICE OF NATIONAL DRUG CONTROL POLICY, supra, at 12.

A tax statute does not legalize drug sales or possession, but in theory requires drug possessors to purchase tax stamps to place on the drugs. The state may collect the tax from those with unstamped drugs or charge the defendant with tax evasion in addition to the illegal drug charge. The tax may average from $200 to $300 per gram of cocaine or heroin. Id.

States with no drug “tax” should consider “taxing” drug sales and allocating the “tax proceeds” for treatment programs for pregnant users.

States should also consider mandatory cash penalties for drug offenders. New Jersey collects
The forfeiture laws create a pool of funds to assist in the costs of drug enforcement. It makes sense to use that same pool of funds for drug treatment, which is an essential component of the "demand side" of the drug enforcement efforts. Indeed, money spent for drug treatment may be more cost effective than money spent in the investigation or prosecution of drug offenses. A 1990 congressional report cited a study suggesting that each dollar invested in drug treatment saves society five dollars in reduced crime and welfare costs.\footnote{See supra note 111.}

Moreover, the success and cost effectiveness of treatment has been documented in the few existing prenatal drug treatment programs. A Baltimore, Maryland prenatal residential center found that few drug-exposed infants born at the center required intensive care and that the intensive care costs at the center were $8640 per child, while the same costs at other medical facilities were $24,750 per child.\footnote{See supra note 114.} At the Chicago Northwestern Memorial Hospital, seventy percent of the participants in the prenatal substance abuse program delivered drug-free infants.\footnote{See supra note 114.} In New York City, two programs treated approximately fifteen hundred pregnant addicts and new mothers of cocaine-exposed babies in 1991. In seventy-five percent of these cases, "the children of these women would, absent the treatment, have been referred for foster care."\footnote{See supra note 116.} The city realized a one-year foster care savings of $22.7 million for the two programs, and a cumulative four-year savings of more than $250 million.\footnote{See supra note 117.} Because these prenatal treatment centers can be

\begin{itemize}
  \item a mandatory cash penalty, which has averaged $9 million a year, from charged drug offenders who want pretrial diversion and from convicted drug offenders. For convicted offenders, the penalty is imposed at sentencing, in addition to any other fine. \textit{Id.}; N.J. STAT. ANN. § 2C:35-15 (West Supp. 1992). The range of the cash penalty begins at $500 for drug possession and extends to $3000 for more serious drug offenses. This money is specifically earmarked for public-awareness initiatives and prevention and education programs established to decrease the demand side of the drug crisis. \textit{Id.}; OFFICE OF NATIONAL DRUG CONTROL POLICY, supra, at 12; see also State v. Bulu, 560 A.2d 1250, 1254 (N.J. 1989) (holding that the New Jersey penalty, which serves a "general rehabilitative or preventative function," may be constitutionally imposed on pretrial detainees).
  \item The Center for Addiction and Pregnancy in Baltimore, a 16-bed residential treatment center, cost $2.5 million. The state contributed $800,000 in start-up money and added $250,000 in early 1992. Within the first ten months, 43 of 48 babies born at the center went home without neonatal intensive care. Nationally, 25% of babies born to drug-using mothers remain hospitalized for neonatal care. Hill, \textit{supra} note 34, at D3.
  \item Wilkins, \textit{supra} note 17, at 1440.
  \item \textit{Id.}
\end{itemize}
relatively inexpensive to operate, and because treatment works, state and federal governments must increase the availability of treatment programs for pregnant drug users.

B. Confidentiality of Disclosures about Prenatal Drug Use

Prenatal care is essential to a healthy pregnancy and a healthy child. Prenatal care will reduce not only the risk of fetal injuries but also the health care expenses of drug-exposed infants and their mothers. The health care costs for the pregnant cocaine user who does not receive prenatal care and her cocaine-affected newborn average $31,000. The health care costs for a cocaine user who receives prenatal care and her newborn are approximately $7000.

Pregnant drug users, who have a more acute need for medical attention, rarely receive prenatal care. These women may be reported to government authorities if they seek medical services or drug counseling from public health practitioners. If one purpose of the government’s response is to “motivate” the drug user to seek help, the expectant mother should not be afraid to seek medical care. In fact, drug users may be more inclined to seek drug treatment during their pregnancies. The government should take advantage of this opportunity by maintaining the confidentiality of the physician-patient relationship throughout the pregnancy.

Public and private health care practitioners should screen pregnant women for substance abuse. Moreover, health care practitioners must specifically question pregnant women about drug use. To encourage honest responses, and prenatal care generally, women must be given written and verbal confirmation assuring the confidentiality of their re-

58. The Los Angeles Baby Step Inn, a 12-bed residential center for female drug addicts who are either pregnant or raising children, asks residents to pay a monthly fee of $350. Women who cannot pay the fee are not turned away. In addition to income from the residents, the facility receives a $150,000 grant from the state. Haldane, supra note 3, at B1.

59. Inadequate prenatal care is the major cause of high infant mortality rates. Infants born to women who received inadequate prenatal care are three times more likely to die prior to reaching their first birthday than infants whose mothers received adequate prenatal care. See Dana Hughes et al., The Health of America’s Mothers and Children: Trends in Access to Care, 20 CLEARINGHOUSE REV. 472, 473 (1986).


61. Id.

sponses. If practitioners identify a need for treatment and services, they should advise the patient of available substance abuse programs. Patients should also be advised that prosecutorial immunity is granted prenatal drug users who complete drug treatment programs.

Public and private hospitals should have protocols for discharging mothers of drug-exposed infants. These mothers and their infants must be referred to appropriate professionals for postpartum treatment services. They must receive priority attention from the appropriate health and social services agencies, and their care must be monitored throughout the treatment process.

C. Prosecuting Mothers Who Refuse to Participate in Available Drug Treatment Programs

My proposal requires the mother of a drug-exposed infant or fetus to either participate in an available treatment and rehabilitation program or agree to participate in a program when one becomes available, to avoid criminal prosecution. Opponents of state intervention might argue that the state should not require anyone, even persons suspected of criminal activity, to enter a drug treatment program. However, the scope of the prenatal drug use problem requires state intervention. The extent of harm to the fetus is undetected until the birth of the infant. Until that time state involvement is not justified. When drug exposure is documented after the birth of the infant, however, the "harm" to society and the infant exists, and the state has a compelling interest in "coercing" the mother to take needed action to help herself and any future children.

63. In addition to medical services, mothers of drug exposed infants may need housing, child care, transportation, or other services. See AMA Bd. of Trustees, supra note 4, at 2668 ("Important methods for preventing or minimizing fetal harm due to substance abuse by pregnant women include identification of women who are at high risk for being substance abusers, . . . and access to programs that address the full range of social and health care needs associated with substance abuse.").

64. Participation alone is sufficient, rather than successful completion of program. Successful completion is not required because it may not occur during the nine-month pregnancy period. However, some level of participation, which includes "substantial" attendance, is necessary to receive immunity. The goal of this proposal is to rehabilitate drug-using mothers and to protect the health of the potential child. The program administrators should be able to determine whether a participant has been meaningfully involved in the treatment process. Critics may claim that the majority of risks to the fetus occur within the first few months of pregnancy and, therefore, treatment after this period is not essential to protecting the health of the fetus. However, the "fetal brain develops rapidly in the last two months of pregnancy, and a pregnant woman's . . . drug abuse is especially harmful to the fetus at this time." Margery W. Shaw, Conditional Prospective Rights of the Fetus, 5 J. LEGAL MED. 63, 88-89 (1984).
Given the existing burdens on the criminal justice system, an initial inquiry suggested by this proposal is why any mother should be prosecuted. The obvious answer is that a criminal offense has been committed. The government may rightfully punish the mother who used drugs, not because she had a child but because she engaged in criminal conduct. The legal rationale for these prosecutions should be the illegality of drug use alone, i.e., the same rationale for punishing drug-using men and women who have not given birth to drug-affected infants. The government can use any admissible evidence against these drug users, and should also use any admissible evidence against drug-using mothers of drug-exposed infants.

My proposal also requires mandatory reporting of all drug-exposed newborn infants. Several states have passed legislation that requires hospitals to perform toxicology screens on all newborns and report positive results to child welfare authorities. Many hospitals also interpret state child abuse reporting laws to require reports of positive results.

Positive test results could lead to "drug use" charges against mothers who have not been granted immunity because of their failure

65. Of equal import, however, is the danger that a lack of punitive sanctions may lead to additional offenses, such as child abuse or neglect. Moreover, a woman is far more likely to have two or more drug-exposed children. Scattarella, supra note 23, at A1; Hugo Martin, Program Weans Mothers, Unborn Babies From Drugs, L.A. Times, Jan. 20, 1991, at B1.

66. See, e.g., OKLA. STAT. ANN. tit. 21, § 846(A)(2) (West Supp. 1992) ("Every physician or surgeon . . . attending the birth of a child who appears to be a child born in a condition of dependence on a controlled dangerous substance shall promptly report the matter to the county office of the Department of Human Services . . . ."); see also MASS. GEN. LAWS ANN. ch. 119, § 51A (West Supp. 1992); MINN. STAT. ANN. § 626.5562 (West Supp. 1992); UTAH CODE ANN. § 62A-4-504 (1989). Prenatal drug use, as evidenced by positive toxicology screens, is subject to mandatory child abuse reporting statutes in at least eight states. See Holland, supra note 18, at 437; Sherman, supra note 7, at 10.


For a discussion of the constitutional and ethical issues raised by the screening of newborns, see Moss, supra note 17, at 292-96. Moss argues that drug screening disproportionately affects poor women and women of color, violates a woman's right to privacy, interferes with the physician-patient relationship, frightens expectant mothers from drug treatment and prenatal care programs, and "may not be in the best interests of the child given the current state of foster care in the United States." Id. at 294-96; see also Kary L. Moss, Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings, 23 CLEARINGHOUSE REV 1406, 1409-13 (1990).

These arguments are misplaced when used in the context of newborn screening because only the newborn's results are reported. Moreover, there is no reporting of prenatal screens or the mother's postpartum screen, screens would be required at both private and public hospitals, and the compelling state interest in obtaining the results would outweigh any privacy interest of the mother. See infra text accompanying notes 102-20.
to participate in drug treatment programs. Immunity should be
granted to mothers who sought help, but were unable to receive treat­
ment because programs were unavailable or inaccessible. However,
mothers who were not granted immunity and who refuse to participate
in an available postpartum program should be prosecuted for their un­
lawful drug use, based on the positive toxicology screen.

IV. CONSTITUTIONAL ISSUES

The scholarship on prenatal drug use raises several constitutional
objections to any punitive response. Commentators claim that
"criminalization" of prenatal drug use violates the Equal Protection
Clause, the right to privacy, and the Eighth Amendment's prohibition
against cruel and unusual punishment. These arguments address pros­
ecutions based on existing drug trafficking statutes and proposed legis­
lation establishing the separate crime of prenatal drug use. The argu­
ments do not focus on the constitutionality of prosecutions under
existing drug use or drug possession statutes. Opponents of "criminal­
ization" nonetheless conclude that any use of prenatal drug ingestion
evidence against female defendants would be unconstitutional. These

68. Several states have criminalized the ingestion as well as the possession of illegal drugs. For
example, Michigan's statute provides: "A person shall not use a controlled substance unless the
substance was obtained directly from, or pursuant to, a valid prescription or order of a practitioner
while acting in the course of the practitioner's professional practice." MICH. COMP. LAWS ANN.
§ 333.7404(1) (West 1978). In Nevada, it is "unlawful for any person knowingly to use" a "con­
trolled substance except in accordance with a prescription [or] ... except when administered ...
at a rehabilitation clinic ... or a hospital ...." NEV. REV. STAT. ANN. § 453.411 (Michie 1991). The applicable penalties in Michigan and Nevada are based on the classification of the
drug as either a Schedule I, II, III, or IV substance. See also DEL. CODE ANN. tit. 16, § 4754
(Supp. 1992); IDAHO CODE § 37-2732 (Supp. 1992); OKLA. STAT. ANN. tit. 63,

Evidence of the mother's refusal to participate in a program is not relevant to the elements of
the offense and would be inadmissible in subsequent criminal proceedings. If convicted, the
mother could be subjected to the range of penalties designated by the state for the "drug use"
offense.

69. In many cases, the elements of the "use" offense and the location of the offense (venue)
can be established by direct evidence, e.g., witnesses, mother's statements. In other cases, the
offense and venue will be established by circumstantial evidence. For example, the positive toxicol­
ogy screen will indicate the amount of drugs ingested by the mother and the approximate time of
the ingestion. Investigation may reveal the mother's residence or whereabouts during that time
period. In addition, witnesses may be available who saw the mother with drug paraphernalia or
under the influence of drugs during her pregnancy, or the age of needle marks or scarring may be
useful in determining the location of the offense.

70. Maternal Rights and Fetal Wrongs, supra note 18, at 997; Martha Field, Controlling the
Woman to Protect the Fetus, 17 L. MED. & HEALTH CARE 114, 123-24 (1989); Holland supra
note 18, at 440-42; Romney, supra note 18, at 339-40.
opponents, however, do not adequately address the issue of how courts should respond to these constitutional challenges. This section discusses the constitutionality of my proposal and concludes that it would be upheld under all of the constitutional provisions mentioned above.

A. Equal Protection

Several scholars have assumed that prosecutions based on prenatal drug use are gender based and violate the Equal Protection Clause. Because evidence of a newborn's positive toxicology screen is used only in cases against women, these scholars claim that women are punished because of their drug use and their ability to get pregnant. It is doubtful, however, that use of this evidence constitutes a gender-based classification. Moreover, even if it does, state action based on a gender-based classification will be upheld if it serves "important governmental objectives" and is "substantially related to achievement of those objectives." In Geduldig v. Aiello, the Supreme Court held that a pregnancy-based classification was not a gender-based classification. At issue in Geduldig was the constitutionality of a state disability insurance program that did not cover pregnancy-related disabilities. Female employees who had been denied benefits for pregnancy-related disabilities ar-

71. See, e.g., Schiff, supra note 13, at 218-20. See generally Denison, supra note 21.
72. See Roberts, supra note 17, at 1445. There is no conclusive evidence linking the positive screen to paternal drug use, even though several studies indicate that children of male cocaine users may have chromosome damage and abnormal development. See Ricardo A. Yazigi et al., Demonstration of Specific Binding of Cocaine to Human Spermatozoa, 266 JAMA 1956 (1991); Tim Friend, Sperm May Carry Cocaine to Egg, USA TODAY, Oct. 9, 1991, at A1.
73. See infra text accompanying notes 74-80.
74. Craig v. Boren, 429 U.S. 190, 197 (1976). "To withstand constitutional challenge, previous cases establish that classifications by gender must serve important governmental objectives and must be substantially related to achievement of those objectives." Id.

The Supreme Court has applied different levels of scrutiny in determining violations of the Fourteenth Amendment's Equal Protection Clause. Gender-based classifications receive an intermediate level of scrutiny and are reviewed under the "substantial relationship" test. Id. Under this standard, the Supreme Court has invalidated statutes based on sexual stereotypes, but upheld statutes without sexual stereotypes which reasonably advance significant governmental interests. See Rostker v. Goldberg, 453 U.S. 57 (1981) (upholding military selective service act, which exempts women from the draft); Orr v. Orr, 440 U.S. 268 (1979) (invalidating law which allowed alimony payments only to wives from husbands).

Constitutional challenges based on the right to privacy, which has been deemed a fundamental right, are reviewed under the "strict scrutiny" standard, the highest level of review. See, e.g., Zablocki v. Redhai, 434 U.S. 374 (1978). See also infra notes 97-99 and accompanying text (discussion of Roe v. Wade).
gued that the program constituted invidious gender discrimination. The Court noted that men and women had received benefits under the program, and women had therefore benefitted from the state action. The Court then concluded that the state only discriminated against pregnant women, rather than all women. Because there was no evidence that the selection of risks covered by the disability program harmed all women—a definable group—the Court held there was no equal protection violation. 76

Several scholars criticized the Geduldig Court for failing to recognize the obvious: discrimination based on pregnancy affects all women in the same "sex-specific way." 77 By using "the male norm" to define "what constitutes sex-based inequality," the Court ignored the fact that non-pregnant women and men are not "similarly situated in their non-pregnant status." 78 However, the Court's reasoning was based solely on the realities of the biological process. Pregnancy is a unique physical condition. Although the Court failed to acknowledge that society's treatment of pregnancy affects gender equality, the Court's analysis indicates that biologically based claims are less problematic than nonbiological restrictions on women. 79 This reasoning also supports the constitutionality of prosecutorial immunity for prenatal drug users, which has a disparate effect on male drug users. 80

76. Geduldig, 417 U.S. at 496 n.20 ("While it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification . . . "); see also Massachusetts v. Feeney, 442 U.S. 256 (1979) (holding that the State, in granting absolute lifetime preference to veterans applying for civil service positions, did not discriminate against women in violation of the Equal Protection Clause).


78. Ruth Colker, The Female Body and the Law: On Truth and Lies, 99 YALE L.J. 1159, 1173-74 (1990) (reviewing ZILLAH R. EISENSTEIN, THE FEMALE BODY AND THE LAW (1988)). Nearly all nonpregnant women have the capacity to become pregnant and are therefore affected by the action. Men are not directly affected by the policy, and childbirth decisions are probably not as significant in their lives as they are in the lives of women.

79. Speculating on how the Supreme Court would currently interpret pregnancy-based restrictions leads to the conclusion that the Geduldig reasoning is consistent with the current theme in privacy cases, which acknowledges that such restrictions are "burdensome" but not "unduly burdensome." See Planned Parenthood v. Casey, 112 S. Ct. 2791, 2819 (1992); see also infra text accompanying notes 105-10.

80. Prosecutorial immunity serves the state's interest in protecting the health of the potential
Applying the *Geduldig* reasoning to the state's use of prenatal drug exposure evidence, a court would find that "pregnancy discrimination" is not invidious discrimination in violation of the equal protection clause. First, while the drug exposure evidence may be used against mothers of drug-affected babies, the criminal drug use statute proscribes drug use by all men and women. Therefore, pregnant women suspected of drug use are not singled out for "special treatment" because they are pregnant. They are prosecuted because the state has reason to believe they use drugs. If medical technology subsequently determines that a newborn's positive toxicology screen indicates drug use by the father, such evidence could be used against fathers of drug-affected babies.

Secondly, if pregnant drug users are singled out for special treatment, the state action does not single out all women for special treatment. Use of the positive toxicology screen against a female defendant only impacts women who give birth to drug-affected children, not all women. It has no impact on non-pregnant women who use drugs. Thus, under *Geduldig*, a gender-based classification cannot be established.81

More importantly, even if a gender-based classification could be established, legislation that is not facially discriminatory does not violate the Equal Protection Clause unless enacted with a discriminatory motive.82 Women who are prosecuted are charged with drug use, a crime unrelated to their pregnancy or gender. Thus, the state action is not facially discriminatory. Without objective proof that a governmen-

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82. The Supreme Court held in Massachusetts v. Feeney, 442 U.S. 256 (1979), that purposeful discrimination must be established by proving that the legislature acted "with discriminatory purpose" to harm women or that a gender-neutral action created a disparate impact on the basis of sex that can be categorized as per se intentional. *Id.* at 276.
tal approach adopted to curb this drug problem was intended to single out women, as a class, for discriminatory treatment, a court should not find the requisite discriminatory motive.

Moreover, even a gender-based action with a discriminatory motive may pass the Court's current test for gender discrimination. Such actions trigger only intermediate scrutiny and, "[t]o withstand constitutional challenge, . . . must serve important governmental objectives and must be substantially related to achievement of those objectives."83 Thus, if the state action serves an important state interest, it will be upheld even if it clearly singles out women for special treatment.84

In Michael M. v. Supreme Court,85 the Court validated the use of a gender-based classification upholding a statutory rape law that prohibited conduct by men only. The male defendant claimed the law violated the Equal Protection Clause. The Court recognized that teenage pregnancies had increased and that they have "particularly severe" social, medical, and economic consequences for the mother, her child, and the state.86 The Court also noted that legislative intent supporting the statutory rape statute was the desire to prevent illegitimate teenage pregnancies.87 The Court then found that the state's interest in preventing teenage pregnancies was sufficiently important to outweigh the discriminatory impact of the statute.88

The Court's decision in Michael M, like the Court's decision in Geduldig, generated a great deal of scholarly comment, including criti-

84. Mississippi Univ. for Women v. Hogan, 458 U.S. 718, 724 (1982). However, if the "means" the state uses to reach its objectives are inconsistent with the state interest, the Court may find that the state action was based on the "mechanical application of traditional, often inaccurate, assumptions about the proper roles of men and women." Id. at 725-26.
85. 450 U.S. 464 (1981). Michael M was decided by a sharply divided Court. Justice Rehnquist wrote the plurality opinion, Justices Blackmun and Stewart wrote concurring opinions, and Justice Brennan wrote a dissenting opinion.
86. Id. at 470-72.
87. Id. at 470.
88. Only four Justices of the five-member majority found that the legislature intended to prevent illegitimate teenage pregnancies. Id. Justice Blackmun's short concurrence criticized the Court's decisions restricting abortions and noted that although Michael M.'s rape victim "appears not to have been an unwilling participant in at least the initial stages of the intricacies that took place," she probably did not consent to sexual intercourse. Id. at 481-87. The four-member plurality rejected the claim that the legislature intended to preserve female chastity, rather than prevent teenage pregnancies. However, the plurality opinion noted that even if "the preservation of female chastity were one of the motives of the statute, and even if that motive be impermissible, petitioner's argument must fail because '[i]t is a familiar practice of constitutional law that this court [sic] will not strike down an otherwise constitutional statute on the basis of an alleged illicit legislative motive.'" Id. at 472 n.7 (quoting United States v. O'Brien, 391 U.S. 367, 383 (1968).
cism from several feminist scholars.89 Scholars argued that in upholding a statutory rape law which only punished males, the Court sanctioned the paternalistic restriction of female sexual freedom and perpetuated the discriminatory stereotype of females as passive victims of sexual activity.90 Although the Court emphasized the biological distinction between the sexes, and the consequences of that distinction, the Court's error was in characterizing these consequences as biological, rather than social.

Women do suffer "disproportionately the profound physical, emotional and psychological consequences of sexual activity."91 Unfortunately, culture and society force women to bear most of the nonphysical "consequences of sexual activity."92 The fact that these consequences are imposed by society and not by nature or biology, however, does not negate their existence.93 Moreover, although the effect of Michael M. may be to reinforce the social stereotype, the holding itself is basically sound: "Because virtually all of the significant[ly] harmful and inescapably identifiable consequences of teenage pregnancy fall on the young female," a legislature may elect to punish only the male, who "suffers few of the consequences of his conduct."94

In Michael M., as in Geduldig, the Court was faced with a basic biological difference between men and women—women can become pregnant and men cannot. This same biological difference will confront the Court when it is asked to decide the constitutionality of punitive sanctions involving prenatal drug use. Courts should recognize the similarities between the "particularly severe" social consequences of teenage pregnancies and the "particularly severe" social consequences of prenatal drug use.95 These consequences warrant a finding that the state's interests in stopping all drug use, including prenatal drug use, is at least as important an interest as preventing teenage pregnancies. Moreover, to the extent criminal penalties for statutory rape furthered the goal of preventing teenage pregnancies, immunity plus criminal penalties for drug use, based on evidence of a newborn's positive toxi-

89. See, e.g., Law, supra note 77, at 998-1001; Frances Olsen, Statutory Rape: A Feminist Critique of Rights Analysis, 63 Tex. L. Rev. 387, 413-29 (1984); Wildman, supra note 77; Andre-Clark, supra note 77.
90. See, e.g., Olsen, supra note 89, at 421-29.
91. Michael M., 450 U.S. at 471.
92. Id.
93. Id. at 473.
94. Id.
95. Id. at 472.
ology screen, further the goal of deterring prenatal drug use. 96

Thus, my proposal, which includes realistic treatment and rehabilitation alternatives, would be substantially related to legitimate state objectives. As such it would be upheld under the substantial relationship test currently applied to gender-based classifications. For this reason, a successful challenge to criminalization simply cannot be based on the Equal Protection Clause. 97

Finally, the proposal suggested in this Article would be upheld even if subjected to the strict scrutiny standard of review, the highest level of scrutiny applied to equal protection cases. 98 Under this standard, a court will not accept every permissible government purpose as sufficient to support a classification, but will instead require the government to show that it is pursuing a "compelling" end, the value of which is so great that it justifies a limitation of fundamental constitutional rights. 99 The classification must also meet the "least restrictive alternative" component of this test, i.e., "even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved." 100

This proposal serves a compelling interest that cannot be achieved through less discriminatory means. The state has a vital interest in

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96. The state could articulate a number of other objectives for its actions: (1) the state's interest in protecting the fetus' right to potential life; (2) the state's interest in protecting the baby's right to be born healthy; (3) the state's interest in protecting maternal health; (4) the state's interest in reducing the economic costs of caring for drug-affected children; and (5) the state's interest in deterring child abuse. While these objectives might pass the strict scrutiny test, they would be sufficient to pass the substantial relationship test.

97. The Supreme Court's decision in International Union, UAW v. Johnson Controls, 111 S. Ct. 1196 (1991), does not suggest that the use of prenatal drug use evidence would be unconstitutional. In Johnson Controls, an employer's regulation prohibited pregnant employees from working in areas where lead exceeded certain levels because of health risks. The Court found that the regulation violated Title VII of the Civil Rights Act of 1964, which includes pregnancy-based discrimination in its proscription of sex-based discrimination. 42 U.S.C. § 2000e(k) (1988). The Court held that decisions about the welfare of future children must be made by parents, rather than the employers who hire those parents.

This analysis was based on a statute which specifically prohibited pregnancy-based discrimination by employers and was therefore broader than the equal protection guarantees at issue here. Moreover, Johnson Controls involved neither criminal conduct nor state action. The conflict was between an employer and a parent, not the State and a parent. Thus, the Johnson Controls analysis is not applicable to an equal protection analysis of prenatal drug use, which involves a parent's illegal conduct and the harmful effects of that conduct.

98. See supra notes 76-81 and accompanying text.


“protecting the potentiality of human life,”101 i.e., in ensuring the health of babies and pregnant women. This compelling interest was identified in Roe v. Wade102 and, assuming applicability of the strict scrutiny level of review, the Supreme Court would probably identify the same interest in analyzing a constitutional challenge to the prosecutions based on evidence of prenatal drug use. The state also has a vital interest in protecting the public from social and economic costs of drug-exposed children.103

Moreover, there is no less restrictive alternative that would deter prenatal drug use. The only effective solution to the problem of drug-exposed infants is the provision of prenatal care and drug treatment programs for drug-using pregnant women.104 Without the realistic fear of prosecution, however, there would be no incentive to seek treatment and no need to obtain prosecutorial immunity. Combining the threat of prosecution with the possibility of immunity would further the objective of healthier babies because it would provide the incentive for the pregnant drug user to seek treatment. “While it is preferable to encourage voluntary compliance with treatment and social services, the state must be able to compel treatment before all hope of help for the fetus is lost.”105

This proposal includes the only response that could effectively address the prenatal drug use problem. Therefore, it would withstand an equal protection challenge under the highest level of constitutional scrutiny.

102. See Roe, 410 U.S. at 151, 162 (holding that the state has an “important and legitimate interest in protecting the potentiality of human life”). See also Planned Parenthood v. Casey, 112 S. Ct. 2791, 2817 (1992) (“Yet it must be remembered that Roe v. Wade speaks with clarity in establishing not only the woman’s liberty but also the state’s ‘important and legitimate interest in potential life.’ . . . That portion of the decision in Roe has been given too little acknowledgement and implementation by the Court in its subsequent cases.”).
103. See supra text accompanying notes 22-37.
104. See Michael A. Hammer, Comment, The Constitutional, Judicial and Social Pitfalls Attendant to the Criminalization of Prenatal Maternal Substance Abuse: A Plea for Governmental Uniformity and Mercy, 22 SETON HALL L. REV. 1456, 1502-04 (1992) (advocating the replacement of criminalization with state-imposed maternal education and rehabilitation programs); Terres, supra note 18, at 85-86 (“Direct governmental intervention is necessary to compel pregnant women to face their responsibility to their unborn children. . . . [I]t is not the only solution, however. Efforts to educate women and to improve health care must always remain a priority in order to prevent harm to our nation’s children.”).
B. **Right To Privacy**

The U.S. Constitution embodies a right to privacy that protects individual autonomy in matters relating to procreation, childbearing, and childrearing.\(^{106}\) The privacy decisions of the Supreme Court that bear most directly upon this proposal are the Court's abortion decisions, beginning with *Roe v. Wade*\(^ {107}\) and culminating most recently with *Planned Parenthood v. Casey*.\(^ {108}\)

In *Roe*, the Court held that a statute prohibiting abortions unnecessarily infringed on a woman's "fundamental" right to privacy. Any limitations on this right would only be upheld if they furthered a compelling state interest. The Court then found that two state interests would support such limitations: the interest in the health of the mother, which became compelling after the first trimester of the pregnancy, and the interest in the potential life of the fetus, which became compelling upon viability.\(^ {109}\)

In *Planned Parenthood v. Casey*, the Court reaffirmed what it described as the "essential holding of *Roe*."\(^ {110}\) A woman has the right to terminate a pregnancy before viability without undue interference from the state, but the state can restrict abortions after fetal viability because it has a legitimate interest in protecting the health of the woman and the life of the potential child. The Court, however, modified the practical application of *Roe* by imposing a more relaxed "undue burden" standard of judicial review on state actions affecting the right to privacy.\(^ {111}\)

The "undue burden" standard requires a finding that the state action at issue has "the purpose or effect of placing a substantial obstacle
in the path of a woman seeking an abortion of a nonviable fetus."112 State action with this purpose is invalid because the state has chosen a "means . . . to further the interest in potential life," which hinders "the woman's free choice."113 State action having a valid purpose, but with the "effect of placing a substantial obstacle in the path of a woman's choice," is unconstitutional because it "cannot be considered a permissible means of serving its legitimate ends."114

Opponents of criminalization claim that a prenatal drug user's reproductive autonomy is compromised in that she must either stop using drugs or have an abortion.115 Because addicted women lack the desire and the ability to stop using drugs, or because drug treatment is not available to them, the threat of prosecution "coerces" pregnant drug users to have abortions. However, although a woman has the right to choose to terminate or continue her pregnancy, this right is not absolute.

"[I]t is a constitutional liberty of the woman to have some freedom to terminate her pregnancy. . . . The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted . . . ."116

These state interests, therefore, may arguably support the punishment of women based solely on evidence of their prenatal drug use.117

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112. Id. at 2820.

113. Id.

114. Id. Under the undue burden standard, the Court invalidated Pennsylvania's spousal notification requirement: "The spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle." Id. at 2831.

A five-member majority invalidated this provision of the statute. Justice Blackmun, a member of this majority, applied the strict scrutiny standard of review. Id. at 2845-46 (Blackmun, J., concurring in part and dissenting in part). The other four dissenting justices would apply the least restrictive standard—the rational basis test—and uphold the provision. Id. at 2855-60 (Rehnquist, C.J., dissenting).

115. See Roberts, supra note 17, at 1460-71; Margaret Phillips, Comment, Umbilical Cords: The New Drug Connection, 40 BUFF. L. REV. 525, 552 (1992); Denison, supra note 21, at 1134-40; Dawn Johnsen, From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster, 138 U. PA. L. REV. 179, 191-95 (1989); Barrett, supra note 18, at 232-34.


117. John E.B. Myers, Abuse and Neglect of the Unborn: Can the State Intervene?, 23 DUQ. L. REV. 1, 18 (1984). However, some scholars argue that the "least burdensome means" compo-
Prosecutions based on evidence of prenatal drug use do, in fact, involve procreative and reproductive decisions. However, the right to obtain an abortion is the right to terminate a pregnancy. The pregnant drug user who gives birth to a drug-exposed infant did not choose to terminate her pregnancy. She elected to continue her pregnancy, engage in criminal conduct which risks the health of the potential child, and deliver the child. The issue then is whether the right to procreate or the right to an abortion should also include the right to make all three reproductive decisions listed above.

The discussion must focus on the second decision. The pregnant drug user has "some freedom to terminate her pregnancy" and the right to procreate, which includes the right to make childbearing decisions. She has the right to continue her pregnancy and deliver her baby. Should she also have the constitutional right to ingest drugs that will substantially harm her future child? The answer, of course, is no—for two reasons. First, there is no right to abuse a potential life inherent in the right to make childbearing decisions. Second, the woman who uses drugs during pregnancy is engaging in criminal conduct.

The woman who gives birth to a drug-exposed infant has chosen to continue her pregnancy. She has not decided to terminate her pregnancy, but to bear and deliver her child. Once she makes the decision to bring the child to term, then she must not abuse the future child. Clearly, the right to abort and the right to procreate cannot be equated with the right to abuse a potential life. "A woman who chooses to carry her pregnancy to term has a moral responsibility to make reasonable efforts toward preserving fetal health." The right to make childbearing decisions, therefore, should not include the right to abuse a potential life. The decision to subject a future child to the risk of birth defects, or death, is simply not a valid childbearing decision.

Women also have the right to make childrearing decisions. This right, however, does not include the right to abuse a child. Child abuse cannot be justified—on moral, legal, or ethical grounds. Therefore, no one questions the claim that a woman who abuses her child has not made a valid childrearing decision. Because there is no right to abuse a

118. Casey, 112 S. Ct. at 2816.
120. AMA Bd. of Trustees, supra note 4, at 2663.
"life" inherent in the right to make childbearing decisions, there should be no right to abuse a "potential life" inherent in the right to make childbearing decisions. 121

Regardless of the legal status of a fetus, or the arguments about the "life" (or lack thereof) of a fetus, it is a "potential life." Conduct abusing a potential life which is then carried to term, like conduct abusing a child, also cannot be justified or condoned on moral, legal, or ethical grounds. 122

Finally, the prenatal drug user is committing a crime by ingesting drugs. There is no constitutional right to use drugs. 123 The reproductive decision at issue here is not the decision to procreate or the decision to abort, but the decision to use drugs after deciding to bear a child. The prenatal drug user has elected to engage in criminal conduct during her pregnancy. She does not have the right to commit a crime. Moreover, to the extent the right to abort is not absolute, the state intervention here is limited to the pregnant woman's conduct in ingesting drugs. It does not affect the rights of pregnant women engaging in lawful conduct. The state can justifiably intervene to prevent the mother from engaging in criminal conduct. 124

Thus the right to privacy cases are distinguishable. These cases only involved the decision to lawfully bear a child or lawfully rear a child. They did not address the decision to commit a crime after exercising the right to bear a child. In sum, arguments based on the right to privacy, or the right to an abortion contained therein, are without

121. See id. at 2664 ("[T]he responsibility of a pregnant woman to her fetus is stronger than that of one individual to another. The duty of a pregnant woman to her fetus is more akin to the obligations of a parent to his or her child.").

122. A woman has a "moral duty to bring the child into the world as healthy as is reasonably possible." John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 Va. L. Rev. 405, 438 (1983). A woman also has a legal duty to refrain from illegal conduct, regardless of the effect of this conduct.


124. Pregnant abusers of legal substances need prenatal care and drug treatment, and we must be concerned about the health of the future children of these abusers. However, pregnant abusers of legal substances are not deterred from seeking drug treatment or prenatal care because of the fear of criminal sanctions. Thus, they do not need the "incentive" of prosecutorial immunity. Tobacco smoking and alcoholism are also "less expensive to cure" than drug use. In addition, the long-term consequences of prenatal alcohol and tobacco use are not as severe as those associated with prenatal drug use. The economic costs to society caused by these activities are not as substantial, and alcoholism and tobacco smoking have not generated the range of "non-drug" criminal activity caused by drug addiction. Therefore, there is no compelling need to prevent the harm to potential life caused by the prenatal abuse of legal substances.
merit.

Nevertheless, the threat of prosecution may, in fact, cause some women to seek an abortion. To this extent, prosecuting mothers would affect the right to choose whether to terminate a pregnancy. However, assuming applicability of the Supreme Court's privacy decisions, the criminal prosecutions of women who refuse to participate in treatment programs for their prenatal drug use should be upheld under the undue burden standard discussed in Casey.128A mere "effect" is simply not enough under this standard. The issue is whether prosecutions would "impose a substantial obstacle" to the exercise of the right to self-determination in matters involving the pregnancy. There is no "substantial obstacle" here. At best, prosecutions based on prenatal drug use evidence pose "an unacceptable danger of deterring the exercise" of the right to an abortion.127 The "mere possibility that some women will . . . likely to choose to have an abortion by virtue of" the criminal sanction does not unduly burden pregnant women. Therefore, based on the Supreme Court's current test in right to privacy cases, prenatal drug-use prosecutions under this proposal would be constitutional.129

C. Cruel and Unusual Punishment

The Eighth Amendment's Cruel and Unusual Punishment Clause not only limits the penalties for crimes, but also the conduct that may be defined as criminal. In Robinson v. California,130 the Court recognized that drug addiction is an illness and held that a criminal statute prohibiting drug addiction establishes a "status" crime in violation of the Eighth Amendment's prohibition of cruel and unusual punishment.131 Thus, the crime of being in a personal condition, without the

125. See supra text accompanying notes 112-14.
128. Id. at 829 (O'Connor, J., dissenting).
129. For a critique of the argument that prosecuting mothers for prenatal drug use violates the right to bodily autonomy and integrity because it is analogous to forced medical procedures on pregnant women, see Roberts, supra note 17, at 1457. Roberts argues that the mother's interests are weaker in the prenatal drug use context because the mother is not required to take any action to benefit the fetus, no direct physical intrusion is involved, and prenatal drug use not only harms the fetus but has no "social justification." Therefore, governmental intervention in the prenatal drug use context does not affect the woman's constitutionally protected right to protect her body from physical intrusion.
131. Id. at 665-67. "'No person shall use, or be under the influence of, or be addicted to the use of narcotics, excepting when administered by or under the direction of a person licensed by the State to prescribe and administer narcotics.' " Id. at 660 n.1 (quoting CAL. HEALTH AND SAFETY CODE § 11721 (repealed 1972)).
commission of some act, is unconstitutional. The prosecution of prenatal drug users, based solely on their status as drug addicts, would violate the Eighth Amendment. Opponents of criminalization claim that punishing a mother for prenatal drug use would also violate the Eighth Amendment. They argue that a mother would be punished "for her combined status as a pregnant woman and a drug addict. . . . Holding such addicts criminally liable for the happenstance of their having become pregnant, is to criminalize them for their continuing condition of addiction, not for any discrete actus reus that can be perceived as voluntary."¹³² Several commentators claim drug use by addicts is an involuntary act and argue that any punishment for prenatal drug use would be unconstitutional.¹³³

However, neither Robinson nor the Eighth Amendment applies to prosecuting mothers who give birth to drug-addicted babies for drug use.¹³⁴ Drug use is the criminal conduct usually caused by drug addiction. Six years after Robinson, the Supreme Court held that the Eighth Amendment only prohibits punishment for the addiction. It does not preclude punishment for criminal conduct that results from the addiction. In Powell v. Texas,¹³⁵ the Court upheld a conviction based on a statute prohibiting public intoxication. The Court determined that the proscribed criminal act was the defendant's act of public intoxication, rather than his "involuntary" alcoholic status.¹³⁶

The Powell dissenters argued that the Eighth Amendment, as interpreted in Robinson, precluded punishment for conduct by anyone who was "utterly powerless to avoid criminal guilt."¹³⁷ They noted that the crime in Powell differed from that in Robinson because it covered


¹³³. See Batey & Garcia, supra note 133, at 100-13. Robinson stands for the proposition that the eighth amendment prohibits the punishment of persons who, whatever their "bare desire[s]" and "propensitics," have committed no proscribed wrongful act. 370 U.S. at 679 (Harlan, J., concurring).

¹³⁴. The proscribed conduct in my suggested response is the use of drugs, as evidenced by the birth of a drug-exposed infant. While many pregnant women who use drugs may be addicts, the drug user who is not an addict could also be prosecuted. See People v. Barry, 504 N.E.2d 1381, 1383 (Ill. App. Ct. 1981) (finding "mere use does not make a person an addict").


¹³⁶. Id. at 532-36.

¹³⁷. Id. at 567-68.
(1) the status of intoxication; and (2) being in public. However, "the essential constitutional defect here is the same. . . . [T]he particular defendant was . . . in a condition which he had no capacity to change or avoid. . . . [He] was powerless to avoid drinking; . . . and . . . once intoxicated, he could not prevent himself from appearing in public places." 138

However, the Powell plurality specifically rejected expansion of Robinson to conduct resulting from the involuntary ingestion of drugs or alcohol, or any other "compulsive" conduct. The Court stated, "It is suggested in dissent that Robinson stands for the 'simple' but 'subtle' principle that '[c]riminal penalties may not be inflicted upon a person for being in a condition he is powerless to change.' " 139 The Court then interpreted Robinson to hold that "criminal penalties may be inflicted only if the accused has committed some act . . . which society has an interest in preventing . . . ." 140

The thrust of Robinson’s interpretation of the Cruel and Unusual Punishment Clause was that criminal penalties may be inflicted only if the accused has engaged in some criminal conduct or behavior. Robinson does not address the issue of whether certain conduct cannot constitutionally be punished because it is, in some sense, "involuntary" or "occasioned by a compulsion." 141 The Powell plurality noted that such an application would undermine the "constitutional doctrine of criminal responsibility" and make the Supreme Court "the ultimate arbiter of the standards of criminal responsibility, in diverse areas of the criminal law, throughout the country." 142 The Court was apparently concerned that addiction or alcoholism would justify the commission of not only offenses that are part of the syndrome of the disease, but also offenses committed to receive the money necessary to obtain the alcohol or drugs, e.g., burglary, larceny, prostitution, or drug distribution. 143 It found that conduct that is the inevitable consequence of the "status" is not prohibited from punishment by the Eighth Amendment. 144
If the Eighth Amendment does not apply to criminal conduct by an alcoholic, i.e., involuntary public intoxication caused by the involuntary condition of chronic alcoholism, then it does not apply to criminal acts by a drug addict, i.e., the possession and use of drugs caused by the addiction. Nor would it apply to prosecutions based on evidence of prenatal drug use. The drug use statute proscribes only the use of drugs, not the addiction. Therefore, punishment for voluntary or involuntary drug use after the drug user gives birth to a drug-exposed infant does not violate the Cruel and Unusual Punishment Clause of the Eighth Amendment.

This conclusion makes sense. Criminal acts resulting from some degree of socially developed compulsion should not be beyond society's control. Drug addiction may be an easily acquired disease. Addiction is also a treatable and curable (admittedly, with effort) disease. Moreover, addiction involves more than the self-administration of drugs. Addiction necessitates the unlawful purchase, possession, and use of drugs and involves not only harm to the user but harmful social byproducts as well. Because addiction has a potentially destructive impact upon society, public safety would be seriously threatened if society had no control over an addict's unlawful acts.

A psychological-involuntariness defense would seriously threaten the administration and enforcement of all criminal laws. If the possession and use of drugs are protected, as necessary incidents of the addictive condition, then the manufacture or distribution of drugs to the addict could be defended as a humane act which harms only the drug addict. Moreover, as the Powell plurality noted, the compulsion for drugs leads to other "non-drug" crimes, such as larceny, robbery, or burglary, necessitated by the addict's need to purchase drugs. Finally, if psychological reasons could deprive defendants of free choice,

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145. Since Powell, lower courts have consistently held that chronic alcoholism is not a defense to a charge of public drunkenness, and drug addiction is not a defense to a charge of use or possession of drugs. United States v. Moore, 486 F.2d 1139 (D.C. Cir. 1973); State v. Herro, 587 P.2d 1181 (Ariz. 1978); Vick v. State, 453 P.2d 342 (Alaska 1969); People v. Hoy, 158 N.W.2d 436 (Mich. 1968). See Phillip E. Hassman, Annotation, Drug Addiction or Related Mental State as Defense to Criminal Charge, 73 A.L.R. 3d 16 (1976). But see Anthony A. Cuomo, Mens Rea and Status Criminality, 40 S. Cal. L. Rev. 463, 506-12 (1967) (claiming that it is unconstitutional for addicts to be punished for possession or use of drugs).

146. See Robinson v. California, 370 U.S. 660, 667 n.9. (1962) ("Not only may addiction innocently result from the use of medically prescribed narcotics, but a person may even be a narcotics addict from the moment of his birth.").

147. Powell, 392 U.S. at 534.
defendants whose actions are caused by necessity (e.g., poverty) or duress could argue that their criminal conduct was involuntary because they had neither the chance nor the capacity to choose a lawful alternative.

The addictive status of a defendant, as a matter of law, does not excuse criminal conduct. More importantly, the addictive status of a defendant, including a prenatal drug user, as a matter of policy should not preclude prosecuting the defendant for her criminal conduct.

V. CONCLUSION

Prenatal drug use, like the general drug problem, is a serious socioeconomic problem and a complex legal problem. The criminal justice system, however, must do more than punish prenatal drug users. Criminal sanctions that only stigmatize the prenatal drug user are an ineffective and counterproductive solution. The threat of incarceration does not deter prenatal drug use, and incarceration itself does nothing to educate the prenatal drug user or improve life for her children. While punishing prenatal drug users is only a “finger in the dam” solution, to simply tell the user to “seek treatment” is worse. The tragic effects of prenatal drug use can only be prevented with a long-term investment. The appropriate solution, therefore, is to rehabilitate the user by “forcing” her to obtain treatment.

The phrase “just say no” is meaningless to prenatal drug users who want treatment but use drugs to escape their environment. A drug-addicted pregnant woman, like a drug addicted man or non-pregnant woman, is simply unable to “just say no.” The pregnant addict must have something to say “yes” to. Prenatal and postpartum drug treatment, with the promise of prosecutorial immunity, is the solution. It is not a total solution, but it would do more to help the addict and her future children than random criminal prosecutions or wishful thinking about drug treatment.