

March 2016

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### Repository Citation

Andrew J. Weisberg and Frank E. Vandervort, *A Liberal Dilemma: Respecting Autonomy While Also Protecting Inchoate Children from Prenatal Substance Abuse*, 24 Wm. & Mary Bill Rts. J. 659 (2016), <https://scholarship.law.wm.edu/wmborj/vol24/iss3/6>

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**A LIBERAL DILEMMA: RESPECTING AUTONOMY WHILE  
ALSO PROTECTING INCHOATE CHILDREN FROM  
PRENATAL SUBSTANCE ABUSE**

Andrew J. Weisberg\* and Frank E. Vandervort\*\*

Substance abuse is a significant social problem in America.<sup>1</sup> It is estimated that some eighteen million Americans have an alcohol abuse problem and that almost five million have a drug abuse problem.<sup>2</sup> According to the National Institute on Drug Abuse, substance abuse costs some \$700 billion per year.<sup>3</sup>

Substance abuse is a major contributor to child maltreatment.<sup>4</sup> It is estimated that between one- and two-thirds of cases in which children enter foster care are linked to parental substance abuse.<sup>5</sup> Unfortunately, this may be an underestimate as

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<sup>1</sup> See Frank E. Vandervort, *Legal Rights of Fetuses and Young Children*, in *PRINCIPLES OF ADDICTIONS AND THE LAW: APPLICATIONS IN FORENSIC, MENTAL HEALTH, AND MEDICAL PRACTICE* 229, 229 (Norman S. Miller ed., 2010); see also Seetha Shankaran et al., *Impact of Maternal Substance Use During Pregnancy on Childhood Outcome*, 12 *SEMINARS FETAL & NEONATAL MED.* 143, 143 (2007) (noting that some of the impacts of substance abuse include crime, increased healthcare costs, and reduced productivity).

<sup>2</sup> See SCHNEIDER INST. FOR HEALTH POL'Y, *SUBSTANCE ABUSE: THE NATION'S NUMBER ONE HEALTH PROBLEM* 75, 104 (2001).

<sup>3</sup> *Trends & Statistics: Costs of Substance Abuse*, NAT'L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/related-topics/trends-statistics> [<http://perma.cc/S68V-5TE4>] (last updated Aug. 2015).

<sup>4</sup> See Judy Fenster, *Substance Abuse Issues in the Family*, in *CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS* 335 (Gerald P. Mallon & Peg McCartt Hess eds., 2005) (noting that alcohol and other drug abuse accounts for seven in ten cases of child maltreatment); NANCY K. YOUNG & SIDNEY L. GARDNER, U.S. DEP'T OF HEALTH & HUMAN SERVS., *NAVIGATING THE PATHWAYS: LESSONS AND PROMISING PRACTICES IN LINKING ALCOHOL AND DRUG SERVICES WITH CHILD WELFARE* 3 (2002), <http://www.cffutures.org/files/publications/Navigating%20the%20Pathways-Tap%2027.pdf> [<http://perma.cc/Y3SS-89BT>] (noting that “[s]ubstance use is generally believed to be associated with the abuse and neglect of children”).

<sup>5</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., *BLENDING PERSPECTIVES AND BUILDING COMMON GROUND: A REPORT TO CONGRESS ON SUBSTANCE ABUSE AND CHILD PROTECTION* 41 (1999) [hereinafter *BLENDING PERSPECTIVES*] (“[A]t least 50 percent of substantiated child abuse and neglect reports involve parental abuse of alcohol or other drugs, and fully 80 percent of States reported that substance abuse and poverty are the top two issues contributing to abuse and neglect in their States.” (citation omitted)).

recent research suggests that many cases, particularly cases in which children have been exposed to alcohol *in utero*, are missed or improperly diagnosed.<sup>6</sup> Of particular concern is substance abuse by pregnant women.<sup>7</sup> Each instance of substance abuse increases the risk of inflicting serious and lasting harm on the future child.<sup>8</sup>

Three parties' interests are at issue when determining how to address substance use or abuse by pregnant women: the pregnant woman's interest, the inchoate child's interest, and the State's interest.<sup>9</sup> Before the intersection of these interests can be properly explored, however, a few definitions must be established.

These parties' interests in the debate over prenatal substance abuse are often loosely referred to as "rights."<sup>10</sup> This Article avoids confusion by employing that term in a limited, specific manner. As Wesley Newcomb Hohfeld noted in his now classic formulation, simply because one has an interest in doing something does not mean that one has a "right" to do it.<sup>11</sup> Using this approach, "rights" only exist when the law places a duty on others not to interfere with the exercise of an interest.<sup>12</sup> That duty, in turn, gives the right-bearer a corresponding legally enforceable claim against such interference.<sup>13</sup> When the law accommodates a person's interest but does not create a corresponding duty that others not interfere, that interest is merely a "privilege."<sup>14</sup> A "privilege" is best thought of as a "liberty"<sup>15</sup> or a physical or personal freedom.<sup>16</sup>

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<sup>6</sup> See Ira J. Chasnoff et al., *Misdiagnosis and Missed Diagnoses in Foster and Adopted Children with Prenatal Alcohol Exposure*, 135 PEDIATRICS 264, 264–67 (2015) (finding that in a sample of 547 children who were in the child welfare system, 156 children met the diagnostic criteria for fetal alcohol spectrum and that 125 of those children had never previously been diagnosed); Jim Henry et al., *Neurobiology and Neurodevelopmental Impact of Childhood Traumatic Stress and Prenatal Alcohol Exposure*, 38 LANGUAGE SPEECH & HEARING SERVICES SCHOOLS 99, 100 (2007) (discussing the difficulty in assessing prenatal exposure to alcohol).

<sup>7</sup> See YOUNG & GARDNER, *supra* note 4, at 3; see also Shankaran et al., *supra* note 1, at 143–44 (noting numerous impacts of substance use and abuse by pregnant woman).

<sup>8</sup> See Vandervort, *supra* note 1, at 230–31.

<sup>9</sup> See generally ROBERT H. MNOOKIN & D. KELLY WEISBERG, *CHILD, FAMILY, AND STATE: PROBLEMS AND MATERIALS ON CHILDREN AND THE LAW* (7th ed. 2014).

<sup>10</sup> See, e.g., *About NAPW*, NAT'L ADVOCATES FOR PREGNANT WOMEN, [http://www.advocatesforpregnantwomen.org/main/about\\_us/about\\_us.php](http://www.advocatesforpregnantwomen.org/main/about_us/about_us.php) [<http://perma.cc/LH2P-M5DZ>] (referring to the "right of self-determination" and the "right to bodily integrity").

<sup>11</sup> Wesley Newcomb Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16, 28–29 (1913–1914).

<sup>12</sup> *Id.* at 32 ("A duty or a legal obligation is that which one ought or ought not to do. 'Duty' and 'right' are correlative terms. When a right is invaded, a duty is violated." (footnote omitted)).

<sup>13</sup> *Id.* at 30–31 (noting that "claim" is an appropriate synonym for the term "right").

<sup>14</sup> See *id.* at 55 ("A right is one's affirmative claim against another, and a privilege is one's freedom from the right or claim of another.").

<sup>15</sup> *Id.* at 36 ("A 'liberty' considered as a legal relation (or 'right' in the loose and generic sense of that term) must mean, if it have [sic] any definite content at all, precisely the same thing as *privilege* . . . ." (footnote omitted)).

<sup>16</sup> *Id.* at 42–43.

Additionally, this Article uses the term “inchoate child” instead of “person” or “fetus” to avoid inadvertently advocating for or against abortion. This Article avoids use of the term “person” in deference to those who express valid concerns that current legislation aimed at criminally punishing women who use or abuse substances during pregnancy is intended to establish “fetal personhood” and undermine the Supreme Court’s holding in *Roe v. Wade*.<sup>17</sup> This Article explicitly rejects such an endeavor. Because the term “fetus,” at least when the fetus is pre-viable, refers to a biological entity that lacks legal interests,<sup>18</sup> that term will only be used to describe that entity of pre-viability. Instead, this Article adopts the term “inchoate child” to describe the entity that exists once the woman has decided to bring her pregnancy to term—or after the point of viability<sup>19</sup>—that has unique, recognized rights and imposes corresponding duties on others, specifically the pregnant woman.

With these terms defined, the dilemma becomes clear: a pregnant woman has a recognized right to privacy over her body that, until the point of fetal viability, entitles her to elect to have an abortion.<sup>20</sup> At the same time, the inchoate child has a right to “begin life with a sound mind and body.”<sup>21</sup> The state has a long-recognized interest in protecting pregnant women,<sup>22</sup> protecting the inchoate child,<sup>23</sup> and minimizing state expenditures for remedying preventable harms.<sup>24</sup>

Law inherently “entails substantive choices about the type and scope of property rights that a free and democratic society can recognize without violating its deepest values.”<sup>25</sup> While “traditional liberals tend to make relatively individualist arguments

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<sup>17</sup> 410 U.S. 113 (1973); see also *About NAPW*, *supra* note 10.

<sup>18</sup> See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (“It must be stated at the outset and with clarity that *Roe*’s essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State’s interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman’s effective right to elect the procedure.”).

<sup>19</sup> See *id.*

<sup>20</sup> *Id.*; *Roe*, 410 U.S. at 152–53 (recognizing abortion as an extension of the right to privacy under the Constitution).

<sup>21</sup> *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980) (citation omitted) (holding that substance abuse during pregnancy may constitute neglect sufficient for the court to assert jurisdiction over a newborn child).

<sup>22</sup> See *Casey*, 505 U.S. at 846 (“[T]he State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.”).

<sup>23</sup> *Id.*

<sup>24</sup> *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 609 (1982) (“[A] State’s interests in the health and well-being of its residents extend beyond mere physical interests to economic and commercial interests . . .”).

<sup>25</sup> Joseph William Singer, *Property as the Law of Democracy*, 63 DUKE L.J. 1287, 1304 (2014) (discussing the political and social import of recognized property rights).

in certain areas such as . . . reproduction,”<sup>26</sup> they tend to also favor government programs like the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) that are intended to help newborns and other children lead healthy lives.<sup>27</sup> In order to properly address the issue of substance abuse during pregnancy, this Article argues that liberals must advocate for a continuum of well-funded drug treatment programs that address the needs of pregnant addicts. We must also recognize, however, that inchoate children are entitled to state intervention when necessary to protect them from harm caused by addicted mothers—mothers who will not, or cannot, protect them.<sup>28</sup>

This Article first discusses the interests at play for each of the three parties, identifying which are legally recognized “rights” and which are mere “privileges.”<sup>29</sup> Second, this Article summarizes the current state of medical knowledge regarding the harms posed by substance abuse during pregnancy.<sup>30</sup> In general, medical research, although imperfect, is sufficiently advanced to conclude that each episode of substance abuse by a pregnant woman creates an unreasonable risk of severe harm to the inchoate child.<sup>31</sup> This Article then addresses the three approaches that have been employed to address substance abuse by pregnant women—public health, criminalization, and civil commitment.<sup>32</sup> Finally, this Article reviews the constitutional requirements for civil commitment, demonstrating that the states’ civil commitment approach is constitutionally permitted.<sup>33</sup> The Conclusion provides a policy framework for addressing substance abuse by pregnant women that appropriately balances each party’s competing interests.<sup>34</sup> We argue for a continuum of treatment options to ensure pregnant women receive the needed level of treatment, but one that also includes sufficient enforcement mechanisms to ensure inchoate children are ultimately protected.<sup>35</sup>

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<sup>26</sup> J.M. Balkin, *The Hohfeldian Approach to Law and Semiotics*, 44 U. MIAMI L. REV. 1119, 1138 (1990).

<sup>27</sup> See Ned Resnikoff, *As Shutdown Drags On, America’s Vulnerable Suffer*, MSNBC (Oct. 4, 2013, 10:34 AM), <http://www.msnbc.com/all/shutdown-drags-vulnerable-suffer> [<http://perma.cc/9PST-TZV8>] (supporting continued funding for WIC programs).

<sup>28</sup> See *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980); see also Jenifer McKim & Michael Bottari, *Cases of Newborns with Addictions Soaring*, BOS. GLOBE (Mar. 30, 2014), <https://www.bostonglobe.com/metro/2014/03/29/explosion-drug-exposed-infants-reveals-weakness-massachusetts-child-protection/0ZhSZUhIBbn0jVEIOBgIsJ/story.html> [<http://perma.cc/R3FE-WSSV>] (describing one case in which an infant who was born drug exposed and sent home with her parents died as a result of exposure to drugs and discussing broader issues involving drug exposed infants).

<sup>29</sup> See *infra* Part I.

<sup>30</sup> See *infra* Part II.

<sup>31</sup> See *supra* notes 6–8 and accompanying text.

<sup>32</sup> See *infra* Part III.

<sup>33</sup> See *infra* Part IV.

<sup>34</sup> See *infra* Conclusion.

<sup>35</sup> See *infra* Conclusion.

## I. A TRIANGLE OF RIGHTS

A comprehensive legal approach to substance abuse by pregnant women requires considering all parties involved, determining each one's rights and privileges, and then determining how those rights and privileges interact. This Part begins by analyzing the rights and privileges of the pregnant woman and the state. It concludes by analyzing the inchoate child's rights and privileges, which are frequently overlooked in academic legal discourse but are crucial to the discussion about proper legal responses to substance abuse during pregnancy.

*A. The Pregnant Woman*

## 1. Rights

The right to privacy is a pregnant woman's most salient right at issue.<sup>36</sup> Although not explicit in the Constitution, the Supreme Court has long found such a right to exist, implicitly rooted in various constitutional provisions.<sup>37</sup> A right to bodily privacy is one of the "areas or zones of privacy" covered by this general privacy right.<sup>38</sup> This right protects against certain physical invasions of one's body,<sup>39</sup> as well as against particular legal regulations of the body such as the right to choose an abortion.<sup>40</sup>

The pregnant woman's right to bodily privacy, however, is not absolute.<sup>41</sup> At the point of fetal viability, a pregnant woman can be legally restricted from having an abortion.<sup>42</sup> At viability, a pregnant woman's privacy becomes secondary to the state's interest in protecting both her health and the inchoate child's right to be born healthy.<sup>43</sup>

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<sup>36</sup> See *supra* note 20 and accompanying text.

<sup>37</sup> See *Roe v. Wade*, 410 U.S. 113, 152 (1973) (the right has been located in "the First Amendment, . . . the Fourth and Fifth Amendments, . . . the penumbras of the Bill of Rights, . . . in the Ninth Amendment, . . . [and] in the concept of liberty guaranteed by the first section of the Fourteenth Amendment" (citations omitted)).

<sup>38</sup> *Id.*

<sup>39</sup> See, e.g., *Kennedy v. L.A. Police Dep't*, 901 F.2d 702, 711–16 (9th Cir. 1989) (finding the city's blanket policy of subjecting all felony arrestees to a visual body-cavity search unconstitutional), *abrogated on other grounds by* *Hunter v. Bryant*, 502 U.S. 224 (1991).

<sup>40</sup> See *Roe*, 410 U.S. at 153.

<sup>41</sup> See *id.* ("[A]ppellant and some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.").

<sup>42</sup> See *id.* at 163–64; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992).

<sup>43</sup> See *Roe*, 410 U.S. at 163–64.

## 2. Privileges

Our nation's current patchwork of alcohol, tobacco, and marijuana regulations demonstrate that people's interest in ingesting these substances is a "privilege," not a "right," and may be curtailed if the government demonstrates a rational basis for doing so.<sup>44</sup> Thus, whether alcohol can be sold is left to the discretion of states or local political subdivisions.<sup>45</sup> States also establish the legal age to consume alcohol, and challenges to these regulations are subject to rational basis review.<sup>46</sup> When alcohol consumption is permitted, regulations regarding use are left to the states' discretion and need no compelling justification.<sup>47</sup>

Like alcohol, tobacco is heavily regulated.<sup>48</sup> The federal government regulates tobacco sales through the Food and Drug Administration under the Family Smoking Prevention and Tobacco Control Act.<sup>49</sup> Under the Act, the Secretary of Health and Human Services may regulate the sale and distribution of tobacco as "would be appropriate for the protection of the public health."<sup>50</sup> The only limit on this power is that the minimum age to buy tobacco products cannot be raised above eighteen.<sup>51</sup>

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<sup>44</sup> See, e.g., *Gallagher v. City of Clayton*, 699 F.3d 1013, 1017–20 (8th Cir. 2012) (upholding a city ordinance that banned smoking in certain places under a rational basis standard of review).

<sup>45</sup> *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 110 (1980) (noting that the Twenty-First Amendment gives each state "virtually complete control over whether to permit importation or sale of liquor and how to structure the liquor distribution system"). A number of counties are "dry," that is, the possession of alcohol is illegal. See Hunter Schwarz, *Where in the United States You Can't Purchase Alcohol*, WASH. POST: GOVBEAT (Sept. 2, 2014), <https://www.washingtonpost.com/blogs/govbeat/wp/2014/09/02/where-in-the-united-states-you-cant-purchase-alcohol/> [<http://perma.cc/W7SP-MGXX>].

<sup>46</sup> *South Dakota v. Dole*, 483 U.S. 203, 211–12 (1987) (noting that offering states a 5% increase in federal highway funds if they raised their drinking age to twenty-one was a particularly successful way of achieving Congress's objective).

<sup>47</sup> For example, drinking on public streets and in parks is banned outright by most states and political subdivisions. See Joe Satran, *The Secret History of the War on Public Drinking*, HUFFINGTON POST, [http://www.huffingtonpost.com/2013/12/14/public-drinking-laws\\_n\\_4312523.html](http://www.huffingtonpost.com/2013/12/14/public-drinking-laws_n_4312523.html) [<http://perma.cc/NS2K-QKXQ>] (last updated June 26, 2015). New Orleans is a notable, limited exception to this general rule. See NEW ORLEANS, LA., CRIM. CODE § 54-404(a) (2016), [https://www.municode.com/library/la/new\\_orleans/codes/code\\_of\\_ordinances](https://www.municode.com/library/la/new_orleans/codes/code_of_ordinances) [<http://perma.cc/XX42-6MKT>].

<sup>48</sup> See *supra* note 44 and accompanying text; see also TOBACCO CONTROL LEGAL CONSORTIUM, FEDERAL REGULATION OF TOBACCO: A SUMMARY 1–4 (2009), <http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-fda-summary.pdf> [<http://perma.cc/9TAG-BDGG>].

<sup>49</sup> 21 U.S.C. § 387a (2012).

<sup>50</sup> *Id.* § 387f(d)(1).

<sup>51</sup> *Id.* § 387f(d)(3)(A)(ii).

Tobacco is also regulated by the states, with regulation varying considerably across jurisdictions.<sup>52</sup> These regulations need only to be justified by a rational basis.<sup>53</sup>

The law relating to marijuana is rapidly evolving.<sup>54</sup> In states where its use is legal, either medically or recreationally, an individual possesses a “privilege” analogous to that for alcohol and tobacco.<sup>55</sup> The Supreme Court has held that laws restricting marijuana consumption are subject to rational basis review.<sup>56</sup>

Pregnant women have a “right” to privacy and a “privilege” to consume alcohol, tobacco, and marijuana under certain circumstances.<sup>57</sup> Pregnant women—like all Americans—lack a legally cognizable interest in consuming illegal drugs, including marijuana where illegal or prescription drugs except as provided by law.<sup>58</sup>

## B. The State

### 1. Rights

States have few “rights” in the Hohfeldian sense of legally enforceable interests.<sup>59</sup> The Tenth Amendment guarantees states the power to legislate on all topics that are not delegated to the federal government or explicitly prohibited from state action under the Constitution.<sup>60</sup> State laws addressing substance abuse during pregnancy represent an

<sup>52</sup> See AM. NONSMOKERS’ RIGHTS FOUND., U.S. 100% SMOKEFREE LAWS IN NON-HOSPITALITY WORKPLACES AND RESTAURANTS AND BARS (2016), <http://www.no-smoke.org/pdf/WRBLawsMap.pdf>.

<sup>53</sup> See *NYC C.L.A.S.H., Inc. v. City of New York*, 315 F. Supp. 2d 461, 491 (S.D.N.Y. 2004) (upholding smoking bans and noting that “in the final analysis, the test is not whether the scientific materials the legislators relied upon was medically sound or empirically correct, but whether the enactments find some rational basis on some ‘conceivable state of facts’” (citations omitted)).

<sup>54</sup> See *State Medical Marijuana Laws*, NAT’L CONF. ST. LEGISLATURES (Jan. 25, 2016), <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> [<http://perma.cc/M47Q-ZB8U>].

<sup>55</sup> See, e.g., MICH. COMP. LAWS ANN. § 333.26424(a) (West 2013) (providing for the use of medical marijuana); see also *Sladek v. Town of Palmer Lake*, No. 13-cv-02165-PAB-MEH, 2014 WL 789080, at \*4 (D. Colo. Feb. 27, 2014) (dismissing, on governmental immunity and mootness grounds, plaintiff’s complaint against town ordinance prohibiting the operation of recreational marijuana shops).

<sup>56</sup> See *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 493 (2001).

<sup>57</sup> See *supra* notes 20, 37, 54–55 and accompanying text.

<sup>58</sup> See *Commonwealth v. Leis*, 243 N.E.2d 898, 903 (Mass. 1969) (“The right to smoke marihuana is not ‘fundamental to the American scheme of justice . . . .’ It is not within a ‘zone of privacy’ formed by ‘penumbras’ of the First, Third, Fourth and Fifth Amendments and the Ninth Amendment of the Constitution of the United States. . . . The defendants have no right, fundamental or otherwise, to become intoxicated by means of the smoking of marihuana.” (citations omitted)); see also *Ravin v. State*, 537 P.2d 494, 502 (Alaska 1975); *Laird v. State*, 342 So. 2d 962, 965 (Fla. 1977).

<sup>59</sup> See, e.g., *supra* notes 25–26, 44–47, 53, 56 and accompanying text.

<sup>60</sup> U.S. CONST. amend. X.



exercise of this authority.<sup>61</sup> States also derive a Hohfeldian “right” under the Eleventh Amendment, which implicitly recognizes states’ sovereign immunity by prohibiting, in certain circumstances, states from being sued in federal court.<sup>62</sup>

## 2. State Interests

States have two main interests in relation to curbing substance abuse by pregnant women: protecting the inchoate child and protecting the public fisc from unnecessary expenditures.<sup>63</sup> State interests in protecting the inchoate child are rooted in the greater interest of protecting public health.<sup>64</sup> State interests in protecting public health have been deemed “compelling.”<sup>65</sup> More specifically, the state has an “urgent” interest in protecting children from maltreatment.<sup>66</sup> The Supreme Court has also recognized that the state has at least some public health interest in fetuses from the moment of conception,<sup>67</sup> specifically a “legitimate interest” in the inchoate child’s health.<sup>68</sup> At the point of viability, these interests override a pregnant woman’s right to have an abortion.<sup>69</sup>

The government also has a legitimate interest in protecting the public fisc, including both federal and state treasuries.<sup>70</sup> Although this interest would not justify curtailing an individual’s fundamental rights, it is a sufficient rationale for legislation restricting “privileges.”<sup>71</sup>

<sup>61</sup> See *infra* Part III.

<sup>62</sup> U.S. CONST. amend. XI.

<sup>63</sup> See *infra* note 70 and accompanying text; *supra* note 21 and accompanying text.

<sup>64</sup> See, e.g., *Emp’t Div., Dep’t of Human Res. of Or. v. Smith*, 494 U.S. 872, 905–07 (1990) (O’Connor, J., concurring) (recognizing a compelling state interest in uniformly applying drug laws, without religious exclusions, because of the state’s “overriding interest in preventing the physical harm caused by the use of a Schedule I controlled substance”).

<sup>65</sup> See, e.g., *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 310 (1978); *Buchwald v. Univ. of N.M. Sch. of Med.*, 159 F.3d 487, 498 (10th Cir. 1998) (explaining that “public health is a compelling government interest” (citation omitted)).

<sup>66</sup> See *Lassiter v. Dep’t of Soc. Servs. of Durham Cty.*, 452 U.S. 18, 27–28 (1981); *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) (recognizing the right of the state to intervene in family life to protect the welfare of children).

<sup>67</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (“[T]he State has legitimate interests from the *outset of the pregnancy* in protecting the health of the woman and the life of the fetus that may become a child.” (emphasis added)).

<sup>68</sup> *Id.*

<sup>69</sup> *Id.* (confirming “the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman’s life or health”).

<sup>70</sup> *Brock v. Pierce Cty.*, 476 U.S. 253, 262 (1986) (“[T]he protection of the public fisc is a matter that is of interest to every citizen . . . .”); see also *Midlantic Nat’l Bank v. N.J. Dep’t of Env’tl. Prot.*, 474 U.S. 494, 516 (1986) (Rehnquist, J., dissenting) (“[The government’s] interest in these cases lies not just in protecting public health and safety but also in protecting the public fisc.”).

<sup>71</sup> *Walker v. Bain*, 257 F.3d 660, 669 (6th Cir. 2001) (recognizing “the government’s legitimate interest in protecting state and federal treasuries”).

### C. *The Inchoate Child*

#### 1. Rights

Although children nominally have many of the same constitutional rights as adults, minors' ability to exercise these rights is limited in many respects.<sup>72</sup> First, minors are not always entitled to the same procedural due process that adults are.<sup>73</sup> Second, the Supreme Court has recognized that minors' "inability . . . to make mature choices"<sup>74</sup> allows the state to restrict some of their rights.<sup>75</sup> Lastly, in order to "protect[] its youth from . . . their own immaturity,"<sup>76</sup> the state can restrict minors' ability by requiring parental notification or consent for important decisions including marriage and abortion.<sup>77</sup> Because the law gives parents so much discretion over how to raise their children,<sup>78</sup> children do not appear to have any unique legal "privileges."

The law recognizes even fewer rights for inchoate children than for living ones. Because *Roe* and *Casey* frame restrictions on a pregnant woman's right to an abortion in terms of the state's interests,<sup>79</sup> they do not recognize a right of inchoate children to be born. The only right the law recognizes for inchoate children is a general right, if they are born at all, to be born healthy.<sup>80</sup> The law recognizes this right in two ways: (1) straightforward affirmations of the right in findings that substance abuse during pregnancy may constitute child maltreatment; and (2) the idea

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<sup>72</sup> *Bellotti v. Baird*, 443 U.S. 622, 635 (1979) ("Viewed together, our cases show that although children generally are protected by the same constitutional guarantees against governmental deprivations as are adults, the State is entitled to adjust its legal system to account for children's vulnerability and their needs for 'concern, . . . sympathy, and . . . paternal attention.'" (quoting *McKeiver v. Pennsylvania*, 403 U.S. 528, 550 (1971))).

<sup>73</sup> *Id.* (citing *In re Gault*, 387 U.S. 1, 30 (1967)).

<sup>74</sup> *Id.* at 636.

<sup>75</sup> *See, e.g.*, *Ginsberg v. New York*, 390 U.S. 629, 638 (1968) (upholding criminal conviction for selling sexually oriented materials to a minor and noting that "even where there is an invasion of protected freedoms 'the power of the state to control the conduct of children reaches beyond the scope of its authority over adults . . .'" (quoting *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944))).

<sup>76</sup> *Bellotti*, 443 U.S. at 637.

<sup>77</sup> *See, e.g.*, MASS. GEN. LAWS ANN. ch. 207, §§ 24, 25 (West 2015) (requiring parental consent for marriage of persons under 18); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 947–48 (1992).

<sup>78</sup> *Bellotti*, 443 U.S. at 638 (noting that the process of raising children, "in large part, is beyond the competence of impersonal political institutions," because "[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include *preparation for obligations the state can neither supply nor hinder*" (alteration in original) (quoting *Prince*, 321 U.S. at 166)).

<sup>79</sup> *Casey*, 505 U.S. at 846; *Roe v. Wade*, 410 U.S. 113, 149–50 (1973).

<sup>80</sup> *In re Baby X*, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980).

that the child, once born, can recover damages for injuries that their parents or third parties inflict *in utero*.<sup>81</sup>

Courts that deem prenatal substance abuse sufficient for proving maltreatment frequently begin with the premise that a “child has a legal right to begin life with a sound mind and body.”<sup>82</sup> When a woman’s substance abuse during pregnancy infringes on that right, that substance abuse justifies a finding of maltreatment immediately upon birth.<sup>83</sup> Even when this right is not explicitly referenced, it remains implicit in courts’ findings.<sup>84</sup> In finding that substance abuse during pregnancy is sufficient to prove maltreatment, courts equate injuries sustained *in utero* with those sustained after birth, when the child has a clear right not to be injured.<sup>85</sup>

Other courts recognize the right to be born healthy by sustaining children’s damages actions for injuries inflicted during the gestational period.<sup>86</sup> As discussed earlier, in Hohfeld’s analysis, only right-bearers can obtain judicial remedies when other parties infringe on their interests.<sup>87</sup> Many courts allow children to sue their mothers for prenatally inflicted injuries, suggesting that such recovery is possible when the mother’s prenatal substance abuse injures the child because she infringed upon the right not to be exposed to harmful substances *in utero*.<sup>88</sup> Liability is available for injuries inflicted at any time after conception, not just after the point of viability.<sup>89</sup>

<sup>81</sup> *See id.*

<sup>82</sup> *Id.*; *see also In re Paul*, No. 321991, 2014 WL 7157652, at \*1 (Mich. Ct. App. 2014).

<sup>83</sup> *In re Paul*, 2014 WL 7157652, at \*1.

<sup>84</sup> *In re Troy D.*, 215 Cal. App. 3d 889, 897–98 (1989).

<sup>85</sup> *Id.* at 897 (“The fact that Troy was diagnosed as being born under the influence of a dangerous drug is legally sufficient for the juvenile court to exercise jurisdiction.”).

<sup>86</sup> *In re Shakyra C.*, No. H14CP05008118A, 2006 WL 1828561, at \*7–8 (Conn. Super. Ct. 2006) (finding in favor of the child when she had been exposed to cocaine *in utero*). *But see* N.J. Dep’t of Children & Families v. A.L., 59 A.3d 576, 580, 586 (N.J. 2013) (suggesting that courts are hesitant to remove children from their parents when no actual harm occurred, because “[t]he law’s ‘paramount concern’ is the ‘safety of the children,’ . . . and ‘not the culpability of parental conduct’” (citations omitted)).

<sup>87</sup> Hohfeld, *supra* note 11, at 30.

<sup>88</sup> RESTATEMENT (SECOND) OF TORTS § 869(1) (AM. LAW INST.1977) (“One who tortiously causes harm to an unborn child is subject to liability to the child for the harm if the child is born alive.”); *see also* Nat’l Cas. Co. v. N. Tr. Bank, 807 So. 2d 86 (Fla. Dist. Ct. App. 2001) (holding that a child has a cause of action against its mother for any prenatal auto accident injuries that the child suffered as a result of its mother’s negligence); *Grodin v. Grodin*, 301 N.W. 2d 869, 869 (Mich. Ct. App. 1980) (where son and father sued mother and doctor for damages to son’s teeth allegedly resulting from use of medication during pregnancy, and the court held that a “[c]hild’s mother bears same liability for injurious, negligent conduct, resulting in prenatal injuries, as would a third person”); *Bonte v. Bonte*, 616 A.2d 464 (N.H. 1992) (where a child born alive has a cause of action against his or her mother for the mother’s negligence for an auto accident that caused an injury to the child when *in utero*).

<sup>89</sup> RESTATEMENT (SECOND) OF TORTS § 869(1) cmt. d (“The rule . . . is not limited to unborn children who are ‘viable’ at the time of the original injury . . . . If the tortious conduct

## II. THE IMPACT OF PRENATAL SUBSTANCE EXPOSURE

The use and abuse of substances by pregnant women is prevalent in the United States.<sup>90</sup> At least one in every ten neonates is exposed to illicit drugs or alcohol *in utero*, and more than two in every ten are exposed to tobacco.<sup>91</sup> Medical researchers' knowledge about the harm caused by prenatal exposure is imperfect.<sup>92</sup> Even when the impact of substance abuse during pregnancy can be determined in the aggregate, the harm it will do a particular child is difficult to predict.<sup>93</sup> Additionally, many pregnant substance abusers abuse multiple substances.<sup>94</sup> Ecological factors like income, nutrition, and age can mitigate or aggravate ingested substances' impact on development.<sup>95</sup>

At some point, child welfare law must enforce the rules that society feels best protect its most vulnerable members. Although research should inform child welfare policy, policy-making cannot be postponed while research knowledge develops. If the research is incomplete concerning prenatal exposure to cocaine, for example, pregnant women cannot be allowed to ingest cocaine until researchers determine its harmful effects to a scientific certainty. By drawing on published medical analysis, this Part provides an overview of the risks posed by the six most commonly abused substances: alcohol, tobacco, marijuana, cocaine, methamphetamines, and opiates including those legally prescribed (e.g., oxycodone and methadone) and those that are illegal (e.g., heroin).

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and the legal causation of the harm can be satisfactorily established, there may be recovery for any injury occurring at any time after conception.”).

<sup>90</sup> NAT'L INST. ON DRUG ABUSE, PRENATAL EXPOSURE TO DRUGS OF ABUSE—MAY 2011 (2011) [hereinafter PRENATAL EXPOSURE], <http://www.drugabuse.gov/sites/default/files/prenatal.pdf> [<http://perma.cc/V5S5-RXTY>].

<sup>91</sup> *See id.*

<sup>92</sup> *Id.*

<sup>93</sup> *See* William M.K. Trochim, *Two Research Fallacies*, RES. METHODS KNOWLEDGE BASE (2006), <http://www.socialresearchmethods.net/kb/fallacy.php> [<http://perma.cc/ZED7-R5UP>] (discussing the “ecological fallacy,” wherein conclusions are made about individuals based only on analyses of group data).

<sup>94</sup> NAT'L ABANDONED INFANTS ASSISTANCE RES. CTR., LITERATURE REVIEW: EFFECTS OF PRENATAL SUBSTANCE EXPOSURE ON INFANT AND EARLY CHILDHOOD OUTCOMES 2 (2006) [hereinafter LITERATURE REVIEW], [http://aia.berkeley.edu/media/pdf/prenatal\\_substance\\_exposure\\_review.pdf](http://aia.berkeley.edu/media/pdf/prenatal_substance_exposure_review.pdf) [<http://perma.cc/L99N-VZ5F>] (“[M]others who gave birth to infants prenatally exposed to illegal substances were also found to have used greater amounts of alcohol and tobacco while pregnant compared to mothers whose children were not exposed . . . .”); *see also* Philip A. May & J. Phillip Gossage, *Maternal Risk Factors for Fetal Alcohol Spectrum Disorders: Not as Simple as It Might Seem*, 34 ALCOHOL RES. & HEALTH 15, 23 (2011) (noting that smoking is much more common among mothers of children with fetal alcohol spectrum disorders).

<sup>95</sup> May & Gossage, *supra* note 94, at 20–21 (describing the increased risk of a child getting FASD based on the mother's age, body size, nutrition, and socioeconomic status); *see also* LITERATURE REVIEW, *supra* note 94, at 2 (“How and by whom the child exposed to substances in-utero is raised can have profound effects on growth and development.”).

Overall, and acknowledging the limitations of our knowledge, the research to date makes plain that substance use or abuse during pregnancy likely harms children, sometimes severely and permanently.<sup>96</sup> Because this risk is more than *de minimis*, every episode of prenatal substance abuse inflicts avoidable risk and sometimes devastating harm. Even in a world of imperfect information, a pregnant mother who uses alcohol, tobacco, or illegal drugs is properly considered to be endangering her inchoate child.

#### A. Alcohol

“Alcohol is a teratogen that has raised concerns about birth outcomes for years.”<sup>97</sup> Its effects on developing children have been studied since at least 1899.<sup>98</sup> Of all the substances commonly abused during pregnancy, the risks posed by alcohol are the most thoroughly documented.<sup>99</sup> Between 10 and 15% percent of women report consuming alcohol at some point while pregnant.<sup>100</sup> Of pregnant women who consume alcohol, 3.9% report engaging in binge drinking, and 0.7% report heavy alcohol use.<sup>101</sup>

Prenatal alcohol exposure harms the fetus in specific ways, which were termed Fetal Alcohol Syndrome (FAS) in 1973.<sup>102</sup> Today, the effects of prenatal alcohol exposure are classified on a four-part continuum called Fetal Alcohol Spectrum Disorder (FASD).<sup>103</sup> FAS stands at the severe end of the FASD continuum and refers to a characteristic pattern of facial dysmorphism, delayed physical development, and specific mental and behavioral deficits.<sup>104</sup> All three domains must be impacted for a diagnosis of FAS.<sup>105</sup>

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<sup>96</sup> It is worth noting that most state child protection laws authorize state authorities to intervene in family life where there is either harm or threatened harm to a child. *See, e.g.*, ALA. CODE § 26-14-1 (2015); MICH. COMP. LAWS ANN. § 722.622(f) (West 2015).

<sup>97</sup> Philip A. May et al., *The Epidemiology of Fetal Alcohol Syndrome and Partial FAS in a South African Community*, 88 DRUG & ALCOHOL DEPENDENCE 259, 259 (2007).

<sup>98</sup> *See, e.g.*, W.C.A. Sullivan, *A Note on the Influence of Maternal Inebriety on the Offspring*, 45 J. MENTAL SCI. 489 (1899), *reprinted in* 40 INT’L J. EPIDEMIOLOGY 278 (2011).

<sup>99</sup> *See, e.g.*, Judy Fenster, *Substance Abuse Issues in the Family*, in CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 335, 337 (Gerald P. Mallon & Peg McCartt Hess eds., 2005).

<sup>100</sup> *See* PRENATAL EXPOSURE, *supra* note 90.

<sup>101</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2005 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 30 (2006) [hereinafter 2005 NATIONAL SURVEY], <http://www.dpft.org/resources/NSDUHresults2005.pdf> [<http://perma.cc/8MKR-PEPV>].

<sup>102</sup> Kenneth L. Jones & David W. Smith, *Recognition of the Fetal Alcohol Syndrome in Early Infancy*, 302 LANCET 999 (1973) (coining the phrase “fetal alcohol syndrome”).

<sup>103</sup> May et al., *supra* note 97, at 260.

<sup>104</sup> *See id.*

<sup>105</sup> *Id.*

Children with only some of the three FAS characteristics are assigned the next most severe diagnosis on the spectrum, Partial Fetal Alcohol Syndrome (PFAS).<sup>106</sup> PFAS children have at least some of the facial dysmorphia associated with FAS and have either the growth deficiencies or neurological abnormalities as well.<sup>107</sup> Children prenatally exposed to alcohol who exhibit the neurodevelopmental delays and/or behavioral problems associated with FAS but no physical dysmorphology are classified separately on the FASD spectrum as having Alcohol-Related Neurodevelopmental Deficits (ARND).<sup>108</sup> Those with the typical dysmorphology of FAS but minimal behavioral or neurodevelopmental problems are classified as suffering Alcohol-Related Birth Defects (ARBD).<sup>109</sup>

FASDs cause diverse harms to children, including effects on physical, neurological, and behavioral development.<sup>110</sup> Typical physical indicators include short eye openings, a thin border between the upper lip and the facial skin, an underdeveloped midface, and droopy eyelids.<sup>111</sup> Prenatal alcohol exposure also diminishes brain function because it detrimentally impacts the formation of the hippocampus, frontal lobe, and corpus collosum.<sup>112</sup> Children whose mothers drank during pregnancy also have increased instances of behavioral problems<sup>113</sup> and lower IQ scores<sup>114</sup> than children whose mothers did not drink during pregnancy.

There is no minimum blood alcohol content (BAC) that, once exceeded, will guarantee that FASDs occur.<sup>115</sup> For this reason, the Centers for Disease Control and Prevention advocates abstaining from alcohol during pregnancy as the only way to reliably prevent FASDs.<sup>116</sup> Most scientific studies conclude that the likelihood of suffering FASDs and the severity of the FASDs are unique to each individual

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<sup>106</sup> *Id.* at 261.

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* at 260.

<sup>109</sup> *Id.*

<sup>110</sup> Jennifer D. Thomas et al., *Fetal Alcohol Spectrum Disorders: From Research to Policy*, 33 ALCOHOL RES. & HEALTH 118, 118 (2010).

<sup>111</sup> May & Gossage, *supra* note 94, at 20.

<sup>112</sup> *Id.* The hippocampus is a brain structure the function of which is to encode and store memory. FRANCES E. JENSEN & AMY ELLIS NUTT, *THE TEENAGE BRAIN: A NEUROSCIENTIST'S SURVIVAL GUIDE TO RAISING ADOLESCENTS AND YOUNG ADULTS* 44 (2015). The frontal lobe, which makes up about 40% of the human brain is responsible for executive functioning, reasoning, abstract thought, and planning. *Id.* at 35–36. The corpus callosum is the structure which connects the two hemispheres of the brain and allows them to communicate with one another. *Id.* at 136.

<sup>113</sup> May et al., *supra* note 97, at 265.

<sup>114</sup> May & Gossage, *supra* note 94, at 17.

<sup>115</sup> *Id.* at 16.

<sup>116</sup> *Fetal Alcohol Spectrum Disorders (FASDs)*, CENTERS FOR DISEASE CONTROL & PREVENTION [hereinafter *Fetal Alcohol Spectrum Disorders*], <http://www.cdc.gov/ncbddd/fasd/index.html> [<http://perma.cc/P8XB-VLCH>].

case.<sup>117</sup> Some studies, however, draw a line between FASD likelihood and a pregnant woman consuming a certain number of drinks per week.<sup>118</sup> From this perspective, the likelihood and severity of FASDs in a particular pregnancy is determined by multiple interrelated factors including the quantity of drinking, frequency of drinking, the time of drinking, and ecological factors.<sup>119</sup>

### 1. The Quantity and Frequency of Drinking

Quantity and frequency of alcohol consumption have the largest impact on the susceptibility to FASDs.<sup>120</sup> Quantity of alcohol consumed is key because binge drinking produces the highest BAC in the mother's system, which in turn has the most damaging impact.<sup>121</sup> Over 5% of pregnant women in the United States report engaging in binge drinking,<sup>122</sup> which the National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines as "a pattern of drinking that brings BAC to 0.08 gram percent or above."<sup>123</sup> For an average adult woman, this means consuming four or more drinks within a two-hour period.<sup>124</sup> Even infrequent binge drinking, when coupled with frequent light-to-moderate alcohol ingestion during pregnancy, has been shown to increase the risk of FASD.<sup>125</sup>

Frequency of drinking is also key because an isolated instance of binge drinking is not likely to result in a diagnosable FASD.<sup>126</sup> Frequent binge drinking, which some researchers consider to be an average of at least one binge per week, is far

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<sup>117</sup> See, e.g., May & Gossage, *supra* note 94, at 16 ("[E]vidence gathered to date suggests that the most substantial contributor to the variability in dysmorphology and other developmental deficits arises from differences in the extent of alcohol exposure, drinking pattern, and other maternal risk factors.").

<sup>118</sup> Asher Ornoy & Zivanit Ergaz, *Alcohol Abuse in Pregnant Women: Effects on the Fetus and Newborn, Mode of Action and Maternal Treatment*, 7 INT'L J. ENVTL. RES. & PUB. HEALTH 364, 367 (2010).

<sup>119</sup> *Id.*

<sup>120</sup> See May & Gossage, *supra* note 94, at 17–18.

<sup>121</sup> *Id.* at 17.

<sup>122</sup> See U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 26 (2014), <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf> [<http://perma.cc/8JJG-WBYR>] (where findings were based on pregnant women ages fifteen to forty-four for data from 2012–2013).

<sup>123</sup> May & Gossage, *supra* note 94, at 17 (citing the National Institute on Alcohol Abuse and Alcoholism). The National Institute on Alcohol Abuse and Alcoholism Council approved the definition of binge drinking. DEP'T OF HEALTH & HUMAN SERVS., NIAAA NEWSLETTER (2004), [http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter\\_Number3.pdf](http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf) [<http://perma.cc/5J7Y-PXG9>].

<sup>124</sup> May & Gossage, *supra* note 94, at 17.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

more likely to cause a FASD.<sup>127</sup> In a 1991 study of Native Americans living in the Southwest, for instance, tribes whose customs led pregnant women to drink heavily and frequently had the highest ratio of FAS to Fetal Alcohol Effects (FAEs) in children, with 4.4 cases of FAS for every case of FAE.<sup>128</sup> Tribes whose customs resulted in infrequent bingeing, in contrast, had a ratio of only 1.4 cases of FAS for every case of FAE.<sup>129</sup>

In general, “[p]opulations in which alcohol is consumed in a more moderate pattern, with lower amounts consumed over an extended period of time, generally will have fewer cases of FASD overall.”<sup>130</sup> As Professor Ernest L. Abel explains:

[A]lthough consumption of an ounce of alcohol a day is technically heavier than consumption of an ounce a week, the term heavy drinking implies something different, and “alcohol abuse” involves something different still—drinking at a level that has definite implications for the health of the drinker and her unborn child. The more frequent the episodes of heavy drinking, . . . the greater the potential abnormalities for the unborn child. While effects have been attributed to the kinds of low levels of exposure described as moderate, . . . the evidence . . . clearly indicates this inference is unwarranted.<sup>131</sup>

## 2. The Timing of Drinking

“The timing of maternal drinking is critical as to which anatomical features are affected.”<sup>132</sup> Although there is no time during fetal development when alcohol exposure cannot cause harm,<sup>133</sup> it is generally agreed that the most severe harm occurs during the first trimester of pregnancy.<sup>134</sup> The first few weeks of pregnancy is “the period when body plans are laid out, and the precursors of what will become organ systems are determined.”<sup>135</sup>

By the end of the third week of pregnancy, for instance, facial features, heart cells, eye tissues, and the neural plate have begun to form and differentiate.<sup>136</sup> Alcohol

<sup>127</sup> *See id.*

<sup>128</sup> *Id.* at 19.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* at 17.

<sup>131</sup> ERNEST L. ABEL, *FETAL ALCOHOL ABUSE SYNDROME* 18 (1998).

<sup>132</sup> May & Gossage, *supra* note 94, at 20.

<sup>133</sup> Erica O’Neil, *Developmental Timeline of Alcohol-Induced Birth Defects*, EMBRYO PROJECT ENCYCLOPEDIA, <http://embryo.asu.edu/pages/developmental-timeline-alcohol-induced-birth-defects> [<http://perma.cc/MXJ7-8TMP>] (last updated Sept. 25, 2013).

<sup>134</sup> *Id.* (“[T]he occurrence of the more severe birth defects correlates with exposure to alcohol in the embryonic stage [(the first eight weeks of development after fertilization)] rather than the fetal stage [(the remaining weeks of development)].”).

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*



exposure at this time can cause “minor midline facial abnormalities characteristic of FAS,” atrial and ventricular abnormalities in the heart, problems with heart valve formation, a reduction in white matter in the brain, impaired signaling pathways to create brain cells, and retinal damage.<sup>137</sup>

Heart cells continue to differentiate during the fourth week of pregnancy, meaning that alcohol exposure during this time can also cause atrial and ventricular abnormalities and impair heart valve formation.<sup>138</sup> Alcohol consumption during the fifth week of pregnancy can impede eye development, causing microphthalmia (abnormally small eyeballs) and optic nerve hypoplasia (underdeveloped eye nerves).<sup>139</sup> Maternal alcohol consumption during the sixth, seventh, and eighth weeks of pregnancy can harm the developing central nervous system, resulting in an underdeveloped—or nonexistent—corpus collosum and cerebellum.<sup>140</sup>

### 3. Other Maternal Risk Factors

In addition to the quantity, frequency, and timing of maternal alcohol consumption, recent research reveals that ecological factors and behaviors play important roles as well.<sup>141</sup> In some cases, maternal age, the number of previous pregnancies (“gravidity”), the number of previous successful births (“parity”), body size, nutrition, and socioeconomic status can impact whether and where a child may fall on the FASD spectrum.<sup>142</sup>

As age, gravidity, and parity increase, so does the chance that prenatal alcohol exposure will cause a child to be on the more severe end of the FASD continuum.<sup>143</sup> Simply put, “the older the drinking pregnant woman is and the more pregnancies and children she has had, the greater the average likelihood that she will have a more severely affected child compared with other women drinking in a similar manner and at similar levels.”<sup>144</sup> Body size impacts the likelihood of FASD because smaller mothers have less body mass to reduce each drink’s impact on BAC, thereby increasing the risk to the fetus by increasing BAC much like binge drinking does.<sup>145</sup> Although the impact of proper nutrition is unclear aside from its tendency to increase body mass index (BMI), preliminary studies suggest that mothers of children with FASD tend to have a significantly lower intake of key nutrients.<sup>146</sup> Additional research

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<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> May & Gossage, *supra* note 94, at 20–22.

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* at 20.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.* at 21.

<sup>146</sup> *Id.* (noting that mothers of FASD children have significantly lower consumption of riboflavin, calcium, certain omega-3 fatty acids, zinc, B-vitamins, and copper).

is exploring the possibility that certain nutrients might reduce the damage caused by prenatal alcohol exposure.<sup>147</sup>

Mothers of any socioeconomic level can have children on the fetal alcohol spectrum, but children with the most severe forms of FASD, FAS and PFAS are frequently born to poor women.<sup>148</sup> Although socioeconomic status is related to other risk factors like gravidity, parity, or poor nutrition, some researchers attribute FASD's socioeconomic disparity to a concept called "weathering."<sup>149</sup> Weathering describes the cumulative effect of conditions commonly found amongst poor women—e.g., substandard living conditions, inadequate nutrition, and high levels of stress—on degrading the ability of a mother's body to protect the fetus from the effects of alcohol.<sup>150</sup> Findings that American women of lower socioeconomic strata begin regular drinking at an earlier age may also help explain weathering's impact on FASD prevalence, as a longer history of alcohol exposure might accelerate the weathering process by decreasing her liver's ability to metabolize alcohol, changing the electrolyte balance in the digestion system, and exposing the ovum to alcohol's teratogenic effects prior to any conception.<sup>151</sup>

#### 4. Fiscal Concerns

FASD is a major fiscal concern for every level of government.<sup>152</sup> FASD is preventable, as abstaining from alcohol consumption during pregnancy avoids any chance of a child being born with FASD.<sup>153</sup> "The United States has the highest incidence of FAS in the world."<sup>154</sup> FASD causes 10% of mental retardation in the United States, making FASD the most common known cause of mental retardation.<sup>155</sup>

Each child with FAS, on average, costs society over two million dollars during his or her lifetime.<sup>156</sup> These costs cover health care, residential and support services, and productivity losses.<sup>157</sup> According to the most recent estimate from the National Institute on Alcohol Abuse and Alcoholism, the United States spent more than \$4 billion on health care and other services to care for individuals with FAS in 1998.<sup>158</sup>

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<sup>147</sup> *Id.*

<sup>148</sup> *Id.*; see, e.g., Nesrin Bingol et al., *The Influence of Socioeconomic Factors on the Occurrence of Fetal Alcohol Syndrome*, 6 CHILD. ALCOHOLICS 105 (1987) (finding that, even with comparable drinking levels, the risk of bearing a child with FAS was 15.8 times higher for women at lower socioeconomic levels than for women in higher ones).

<sup>149</sup> May & Gossage, *supra* note 94, at 22.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> Cf. Chuck Lupton et al., *Cost of Fetal Alcohol Spectrum Disorders*, 127c AM. J. MED. GENETICS 42, 45–46 (2004) (showing the cost of care for individuals with FAS).

<sup>153</sup> See *Fetal Alcohol Spectrum Disorders*, *supra* note 116.

<sup>154</sup> Fenster, *supra* note 99, at 337.

<sup>155</sup> *Id.*

<sup>156</sup> Lupton et al., *supra* note 152, at 49.

<sup>157</sup> *Id.* at 43.

<sup>158</sup> *Id.* at 49 (referencing NIAAA's 1998 estimate).

It is estimated that reducing the incidence of FAS by just 1% would save the United States \$8 billion over the next generation.<sup>159</sup> The substantial cost that FAS—let alone the other FASD diagnoses—imposes in lives harmed and dollars spent gives all levels of government a strong social and fiscal imperative to take reasonable measures to reduce the incidence of FASD.<sup>160</sup>

### B. Tobacco

Pregnant women's use of tobacco products also poses serious risks to the developing fetus.<sup>161</sup> Although the adverse effects of prenatal cigarette smoking are well-documented, the underlying scientific mechanisms are not fully understood.<sup>162</sup> Prenatal cigarette use is prevalent<sup>163</sup> and has remained similar over time. This suggests that cigarette smoking during pregnancy is likely to remain a problem.<sup>164</sup>

Maternal cigarette use deprives the developing fetus of nutrients and oxygen and exposes it to harmful compounds.<sup>165</sup> Carbon monoxide and nicotine from tobacco

<sup>159</sup> Patricia R. Congdon, *Prenatal Prosecution: Taking a Stand for the State and the Well-Being of Its Soon-To-Be Citizens*, 5 CHARLESTON L. REV. 621, 628 (2011).

<sup>160</sup> *Id.* at 652–53.

<sup>161</sup> *Reproductive Health: Tobacco Use and Pregnancy*, CENTERS FOR DISEASE CONTROL & PREVENTION [hereinafter *Tobacco Use and Pregnancy*], <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm> [<http://perma.cc/S53C-JHCE>] (last updated Sept. 9, 2015).

<sup>162</sup> Lucinda J. England et al., *Effects of Maternal Smokeless Tobacco Use on Selected Pregnancy Outcomes in Alaska Native Women: A Case-Control Study*, 92 ACTA OBSTETRICIA ET GYNECOLOGICA 648, 652 (2013). Because cigarettes were, on average, 84.5% of the tobacco products used in the United States between 2001 and 2002, this Part focuses on cigarette use amongst pregnant women because that represents the great majority of prenatal tobacco use. See U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 43 (2012) [hereinafter 2011 NATIONAL SURVEY], <http://archive.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf> [<http://perma.cc/66CQ-JM6U>]. It is worth noting that there is some evidence that nicotine harms the fetus regardless of how it is delivered—meaning that smokeless tobacco products and nicotine replacement therapy may also harm fetal health. See England et al., *supra*, at 648 (concluding that “[p]renatal smokeless tobacco use does not appear to reduce risk of pregnancy-associated hypertension or to substantially increase risk of abortion” in the studied population); Denise Mann, *Study Shows Smokeless Tobacco Increases Risk That Newborns Will Have Breathing Pauses in Sleep*, WEBMD (Aug. 29, 2011), <http://www.webmd.com/baby/news/20110826/snuff-use-during-pregnancy-harmful-to-newborns> [<http://perma.cc/AUC9-3UNZ>] (“It’s the nicotine, not the way it is delivered, that may increase health risks in newborns . . .”).

<sup>163</sup> See 2011 NATIONAL SURVEY, *supra* note 162, at 47 (finding that, based on data from pregnant women ages 15–44 for 2010–2011, approximately 17.6% of pregnant women in the United States smoke while pregnant).

<sup>164</sup> See *id.* at 47 (illustrating that 18% of pregnant women used cigarettes in 2002, compared to 17.6% in the 2011 study).

<sup>165</sup> NAT'L INST. ON DRUG ABUSE, RESEARCH REPORT SERIES: TOBACCO/NICOTINE 6–7

interfere with the oxygen supply to the fetus.<sup>166</sup> Smoking also exposes the fetus to lead, arsenic, and numerous other poisonous substances.<sup>167</sup> These substances may impact the fetus more than the mother.<sup>168</sup> Nicotine, for example, accumulates once it crosses the placenta, resulting in concentrations in the fetus that are as much as 15% higher than in the mother.<sup>169</sup> Smoking also damages the placenta, the baby's source of nutrition during pregnancy, and sometimes causes the placenta to prematurely separate from the womb ("placental abruption").<sup>170</sup>

Smoking while pregnant can severely impact the fetus in lasting ways.<sup>171</sup> *In utero* tobacco exposure significantly increases the risk of low birth weight and premature delivery.<sup>172</sup> It also increases neonatal hyperactivity<sup>173</sup> and raises the risk of spontaneous abortion by 30–100%.<sup>174</sup> Children exposed to tobacco *in utero* also have an increased risk of craniosynostosis, a birth defect where part of the developing skull prematurely hardens into bone and results in a misshapen head.<sup>175</sup> Smoking during pregnancy has also been linked to decreased pulmonary function,<sup>176</sup> sudden infant death syndrome,<sup>177</sup> and harm to the child's mental and emotional functioning.<sup>178</sup>

(2016) [hereinafter TOBACCO/NICOTINE], [https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/tobaccorr\\_1\\_2016.pdf](https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/tobaccorr_1_2016.pdf) [<http://perma.cc/4MKV-W368>].

<sup>166</sup> *Id.*

<sup>167</sup> *Diseases & Conditions: How Smoking Affects You and Your Baby During Pregnancy*, CLEV. CLINIC, [https://my.clevelandclinic.org/health/diseases\\_conditions/hic\\_Am\\_I\\_Pregnant/hic\\_Coping\\_with\\_the\\_Physical\\_Changes\\_and\\_Discomforts\\_of\\_Pregnancy/hic\\_How\\_Smoking\\_Affects\\_You\\_and\\_Your\\_Baby\\_During\\_Pregnancy](https://my.clevelandclinic.org/health/diseases_conditions/hic_Am_I_Pregnant/hic_Coping_with_the_Physical_Changes_and_Discomforts_of_Pregnancy/hic_How_Smoking_Affects_You_and_Your_Baby_During_Pregnancy) [<http://perma.cc/VR7S-7B42>].

<sup>168</sup> *See id.*

<sup>169</sup> TOBACCO/NICOTINE, *supra* note 165.

<sup>170</sup> *See Tobacco Use and Pregnancy*, *supra* note 161.

<sup>171</sup> *Cf. id.* (citing premature birth, birth defects, and infant death as side effects of smoking during pregnancy).

<sup>172</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., HOW TOBACCO SMOKE CAUSES DISEASE: THE BIOLOGY AND BEHAVIORAL BASIS FOR SMOKING-ATTRIBUTABLE DISEASE 536, 538 (2010) [hereinafter HOW TOBACCO SMOKE CAUSES DISEASE], [http://www.ncbi.nlm.nih.gov/books/NBK53017/pdf/Bookshelf\\_NBK53017.pdf](http://www.ncbi.nlm.nih.gov/books/NBK53017/pdf/Bookshelf_NBK53017.pdf) [<http://perma.cc/9NDA-LYUU>].

<sup>173</sup> Joseph R. DiFranza et al., *Prenatal and Postnatal Environmental Tobacco Smoke Exposure and Children's Health*, 113 PEDIATRICS 1007, 1009 (2004).

<sup>174</sup> HOW TOBACCO SMOKE CAUSES DISEASE, *supra* note 172, at 530.

<sup>175</sup> Beth W. Alderman et al., *Increased Risk of Craniosynostosis with Maternal Cigarette Smoking During Pregnancy*, 50 TERATOLOGY 13, 13–14, 17 (1994) (finding that smoking up to one pack per day during pregnancy is linked to a 70% increase in the likelihood of craniosynostosis, and smoking more than a pack per day increases the risk by 250%).

<sup>176</sup> DiFranza et al., *supra* note 173, at 1010.

<sup>177</sup> Tushar Shah et al., *Sudden Infant Death Syndrome and Reported Maternal Smoking During Pregnancy*, 96 AM. J. PUB. HEALTH 1757, 1759 (2006) (noting that 21% of all SIDS cases are attributable to smoking and 61% of SIDS cases amongst smokers are attributable to prenatal smoking).

<sup>178</sup> *See, e.g.*, DiFranza et al., *supra* note 173, at 1009 (citing many studies finding that children whose mothers smoked while pregnant had increased rates of behavior problems, like

### C. Marijuana

It is estimated that 5–10% of pregnant women in the United States use illegal drugs.<sup>179</sup> They use marijuana far more than other illegal drugs,<sup>180</sup> accounting for up to 75% of total illegal drug use by pregnant women.<sup>181</sup> Despite this, limited research data are available.<sup>182</sup> The research that has been done suggests that its use is cause for concern.<sup>183</sup>

When marijuana is consumed, its active compound tetrahydrocannabinol (THC) binds to receptors in the brain.<sup>184</sup> THC crosses the placenta, so maternal consumption of marijuana also exposes the developing fetus to the drug.<sup>185</sup> Although the precise chemical mechanics of THC's impact on the developing fetus are under study, researchers have determined that THC binds to at least one receptor in the developing nervous system.<sup>186</sup>

THC can cause considerable damage when it binds to receptors in the developing nervous system.<sup>187</sup> Maternal cannabis smoking has been shown to reduce mRNA expression in the fetal hippocampus,<sup>188</sup> which has been linked to difficulties with both short- and long-term memory.<sup>189</sup> THC in the developing nervous system also blocks the formation of synapses and axons, the connections between nerve cells

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attention-deficit/hyperactivity disorder, with the studies even accounting for potential confounding variables).

<sup>179</sup> 2011 NATIONAL SURVEY, *supra* note 162, at 23; *see also* Rachel Barclay, *Cannabis During Pregnancy Impairs Baby's Brain Development*, HEALTHLINE NEWS (Jan. 28, 2014), <http://www.healthline.com/health-news/children-cannabis-impairs-fetal-brain-development-012814#1> [<http://perma.cc/73T3-2C7S>] (noting that over 10% of unborn children in the United States and Europe have been prenatally exposed to marijuana).

<sup>180</sup> Fenster, *supra* note 99, at 337.

<sup>181</sup> Chaya G. Bhuvaneshwar et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 59 (2008) (finding that of the 2.8% of pregnant women studied in the United States who use illegal drugs, approximately 75% use marijuana and 10% use cocaine).

<sup>182</sup> *Learn About Marijuana: Marijuana, Reproduction, and Pregnancy*, U. WASH. ALCOHOL & DRUG ABUSE INST. [hereinafter *Learn About Marijuana*], <http://learnaboutmarijuana.wa.org/factsheets/reproduction.htm> [<http://perma.cc/9KP7-D6YS>].

<sup>183</sup> *Id.*

<sup>184</sup> Giuseppe Tortoriello et al., *Miswiring the Brain: Δ<sup>9</sup>-Tetrahydrocannabinol Disrupts Cortical Development by Inducing an SCG10/Stathmin-2 Degradation Pathway*, 33 EMBO J. 668, 668 (2014).

<sup>185</sup> Barclay, *supra* note 179.

<sup>186</sup> *See* Tortoriello et al., *supra* note 184, at 676.

<sup>187</sup> *See id.* at 668.

<sup>188</sup> *Id.* at 672.

<sup>189</sup> Fabiola Trevizol et al., *Cross-Generational Trans Fat Intake Modifies BDNF mRNA in the Hippocampus: Impact on Memory Loss in a Mania Animal Model*, 25 HIPPOCAMPUS 556 (2015).

in the cerebral cortex that allow the brain to perform higher thinking skills and form memories.<sup>190</sup>

Because THC chemically interferes with the central nervous system's development, "even low concentrations of THC . . . could have profound and long-lasting consequences for both brain and behavior of offspring."<sup>191</sup> This is particularly worrisome, given that the marijuana Americans consume has an increasingly higher average of THC content.<sup>192</sup> Even though not all children who have been prenatally exposed to cannabis suffer immediate and obvious effects, even relatively subtle damage can increase the risk of neuropsychiatric diseases.<sup>193</sup>

THC's detrimental impact on nervous system development makes it unsurprising that some babies born to women who used marijuana during pregnancy have traits indicative of neurodevelopmental problems, including altered responses to visual stimuli, increased tremulousness, and a high-pitched cry.<sup>194</sup> The impacts of prenatal marijuana exposure do not disappear with age.<sup>195</sup> Three-year-old children with prenatal marijuana exposure have more trouble sleeping—including nocturnal waking, more time awake after sleep onset, and lower sleep efficiency—than comparable children that were not exposed.<sup>196</sup> At older ages, children prenatally exposed to marijuana are more likely to fall below their non-exposed peers in problem-solving skills, memory, and the ability to remain attentive.<sup>197</sup> Marijuana use during pregnancy has also been linked to numerous physical problems.<sup>198</sup>

#### D. Cocaine

Available studies provide disparate estimates of the prevalence of cocaine use by pregnant women.<sup>199</sup> The National Pregnancy and Health Survey, conducted in

<sup>190</sup> Karolinska Institute, *Cannabis During Pregnancy Endangers Fetal Brain Development*, SCI.DAILY (Jan. 27, 2014), <https://www.sciencedaily.com/releases/2014/01/140127093140.htm> [<http://perma.cc/9J3X-X892>]; Tanya Lewis, *Marijuana Use During Pregnancy Affects Baby's Brain*, LIVESCIENCE (Jan. 27, 2014, 6:46 AM), <http://www.livescience.com/42853-marijuana-during-pregnancy-baby-brain.html> [<http://perma.cc/QET8-48J5>].

<sup>191</sup> NAT'L INST. ON DRUG ABUSE, RESEARCH REPORT SERIES: MARIJUANA 11–12 (2015) [hereinafter MARIJUANA], [https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/mjrrs\\_9\\_15.pdf](https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/mjrrs_9_15.pdf) [<http://perma.cc/95VG-DP2L>].

<sup>192</sup> Caleb Hellerman, *Is Super Weed, Super Bad?*, CNN, <http://www.cnn.com/2013/08/09/health/weed-potency-levels/> [<http://perma.cc/6QK2-ZPSX>] (last updated Aug. 9, 2013, 6:53 PM) (noting that marijuana's average THC content has increased from less than 1% in the 1970s to nearly 13% today).

<sup>193</sup> Barclay, *supra* note 179.

<sup>194</sup> MARIJUANA, *supra* note 191.

<sup>195</sup> See, e.g., Ronald E. Dahl et al., *A Longitudinal Study of Prenatal Marijuana Use: Effects on Sleep and Arousal at Age 3 Years*, 149 ARCHIVES PEDIATRICS & ADOLESCENT MED. 145 (1995).

<sup>196</sup> *Id.*

<sup>197</sup> MARIJUANA, *supra* note 191.

<sup>198</sup> *Learn About Marijuana*, *supra* note 182.

<sup>199</sup> Bhuvaneshwar et al., *supra* note 181, at 59.

1992, is considered to still provide the most recent national data available.<sup>200</sup> Of the four million women who gave birth during the survey period, approximately 45,000 (1.1%) reported using cocaine while pregnant.<sup>201</sup> Other studies at the same time, however, found prenatal cocaine exposure to be as high as 30% in more targeted populations.<sup>202</sup> Rough estimates about the current prevalence of prenatal cocaine use are between 1% and 5%.<sup>203</sup>

When a pregnant woman ingests cocaine, she enjoys approximately a two hour “high” that peaks during the first hour.<sup>204</sup> She then suffers a corresponding “crash” from catecholamine depletion that leads to irritability, discomfort, and depression.<sup>205</sup> This crash, in turn, triggers a craving for the next dose.<sup>206</sup> Cocaine constricts blood vessels when it enters the mother’s system, increasing the mother’s blood pressure and decreasing the amount of oxygen supplied to the fetus.<sup>207</sup> Because of cocaine’s low molecular weight, it crosses the placenta and has additional direct effects on fetal circulation.<sup>208</sup> This is a particularly severe concern when crack cocaine is ingested, because one dose of crack cocaine delivers at least ten times the amount of cocaine present in a standard “line” of powdered cocaine.<sup>209</sup>

Cocaine consumption harms the fetus.<sup>210</sup> The constriction of blood vessels in the placenta, and the resultant decrease in oxygen supplied to the fetus, increases the risk of numerous obstetric complications such as spontaneous abortion, uterine rupture, and premature labor or delivery.<sup>211</sup> *In utero*, it can also lead to placental abruption, oxygen deficiency in the fetal tissues (“fetal hypoxia”), intracranial hemorrhage, and still-birth.<sup>212</sup> Once cocaine passes the placenta and restricts fetal circulation, it can have

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<sup>200</sup> *FAS Frequently Asked Questions*, EMORY MATERNAL SUBSTANCE ABUSE & CHILD DEV., <http://www.psychiatry.emory.edu/PROGRAMS/GADrug/faqL.htm> [<http://perma.cc/YB5F-9PWC>].

<sup>201</sup> *See id.*

<sup>202</sup> Enrique M. Ostrea, Jr. et al., *Drug Screening of Newborns by Meconium Analysis: A Large-Scale, Prospective, Epidemiologic Study*, 89 *PEDIATRICS* 107, 108 (1992) (focusing on a cohort of 3,010 pregnant women living in the Detroit area).

<sup>203</sup> Claire D. Coles, *Frequently Asked Questions About Cocaine in Pregnancy*, EMORY MATERNAL SUBSTANCE ABUSE & CHILD DEV., <http://www.psychiatry.emory.edu/PROGRAMS/GADrug/faqO.htm> [<http://perma.cc/B9L4-MCQA>] (estimating that between 1% and 5% of pregnant women use cocaine and that “[i]n some [urban] areas, . . . it’s probably higher, in some rural areas, lower.”).

<sup>204</sup> Bhuvanewar et al., *supra* note 181, at 61.

<sup>205</sup> *Id.*

<sup>206</sup> *Id.*

<sup>207</sup> Chanapa Tantibanchachai & Mark Zhang, *Cocaine as a Teratogen*, EMBRYO PROJECT ENCYCLOPEDIA, <http://embryo.asu.edu/pages/cocaine-teratogen> [<http://perma.cc/93FT-ZZS9>] (last updated Feb. 9, 2015, 6:08 PM).

<sup>208</sup> *Id.*

<sup>209</sup> Bhuvanewar et al., *supra* note 181, at 61.

<sup>210</sup> Tantibanchachai & Zhang, *supra* note 207.

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

a variety of teratogenic effects, including killing parts of the fetal brain and intestines due to insufficient blood supply, swelling of the kidneys due to urine backup (“hydronephrosis”), a variety of cephalic and cardiac disorders, cleft palate, cleft lip, possessing an abnormal number of digits (“polydactyly”), down syndrome (“Trisomy 21”), and causing a fetus’s intestines to stick out of his or her body (“gastroschisis”).<sup>213</sup>

Although many children prenatally exposed to cocaine appear physically normal, according to the National Institute on Drug Abuse, this “should not be overinterpreted to indicate that there is no cause for concern.”<sup>214</sup> Scientists are increasingly finding that prenatal cocaine exposure can lead to “subtle, yet significant” deficits in some aspects of cognitive performance, information processing, and attention to tasks.<sup>215</sup> Cocaine use during pregnancy can lead to severe neurological deficits because early exposure to cocaine interferes with neurotransmitters, the chemicals involved in attention and control.<sup>216</sup> Consequently, prenatal cocaine exposure has been shown to cause children to suffer from a lack of attention span and the loss of visual memories.<sup>217</sup> Research available on the long-term effects of prenatal cocaine exposure, though limited, links fetal exposure to cocaine and inattentiveness in fully developed children.<sup>218</sup> Children prenatally exposed to cocaine also score lower on intelligence tests.<sup>219</sup>

An additional concern is that prenatal cocaine use reduces the efficacy of the fetal blood-brain barrier, which in turn increases fetal exposure to other harmful substances.<sup>220</sup> This is particularly detrimental to fetal health because many pregnant women who use cocaine also abuse other substances.<sup>221</sup> These harms are compounded by the fact that cocaine often has synergetic effects when combined with other teratogenic substances.<sup>222</sup> For example, studies have shown that alcohol or benzodiazepines, both of which are frequently taken to mediate the “crash” following cocaine use, may further amplify the fetal risks posed by the cocaine itself.<sup>223</sup> Simply using benzodiazepines when pregnant is known to cause cleft palates,<sup>224</sup> and alcohol directly harms the fetus’s development.<sup>225</sup> Animal studies have shown that

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<sup>213</sup> *Id.*

<sup>214</sup> NAT’L INST. ON DRUG ABUSE, RESEARCH REPORT SERIES: COCAINE 6 (2010), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/cocainerrs.pdf> [<http://perma.cc/SY68-E7WH>].

<sup>215</sup> *Id.*

<sup>216</sup> Tantibanchachai & Zhang, *supra* note 207.

<sup>217</sup> *Id.*

<sup>218</sup> *Id.*

<sup>219</sup> *Id.*

<sup>220</sup> Bhuvanewar et al., *supra* note 181, at 61.

<sup>221</sup> *Id.* (calling polydrug use “a clinically significant problem since cocaine is rarely used alone by those with addictions”).

<sup>222</sup> *Id.*

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

<sup>225</sup> *See supra* notes 132–40 and accompanying text.



using benzodiazepines in combination with cocaine, however, additionally harms the fetus by increasing the likelihood of malformed kidneys (“hydronephrosis”), missing testicles (“cryptorchidism”), and incomplete ossification of the skeleton.<sup>226</sup>

### *E. Methamphetamine*

Although American use of methamphetamine appears to have decreased in recent years,<sup>227</sup> it is still a substantial problem. In some Western and Midwestern states, methamphetamine is the most frequently abused drug after alcohol and marijuana.<sup>228</sup> It is difficult to obtain targeted data on methamphetamine abuse during pregnancy because 80% of pregnant women who use methamphetamine also use at least one other harmful substance like tobacco or alcohol.<sup>229</sup> Although the precise proportion of pregnant women who use methamphetamine is not readily available, it is clearly significant.<sup>230</sup> In 2006, 24% of pregnant women admitted for federally funded substance abuse treatment were using methamphetamine.<sup>231</sup>

“Methamphetamine can be smoked, snorted, injected, or ingested orally . . . .”<sup>232</sup> Once in the mother’s system, methamphetamine causes a massive release of dopamine in the brain.<sup>233</sup> This dopamine release causes the mother to experience a “high” accompanied by feelings of euphoria, increased alertness, and a sense of confidence in others.<sup>234</sup> While this “high” is occurring, the methamphetamine also causes the mother’s blood vessels to constrict, raising her blood pressure.<sup>235</sup> Methamphetamine has also been found to damage the mother’s placenta, causing placental abruption.<sup>236</sup> Although

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<sup>226</sup> Bhuvanewar et al., *supra* note 181, at 61.

<sup>227</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 1 (2013), <http://samhsa.gov/data/sites/default/files/NSDUHresults2012/NSDUHresults2012.pdf> [<http://perma.cc/92KL-787N>] (noting that the number of past month methamphetamine users decreased between 2006 and 2012, from 731,000 to 440,000).

<sup>228</sup> THE AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS, METHAMPHETAMINE ABUSE IN WOMEN OF REPRODUCTIVE AGE (2011) [hereinafter METHAMPHETAMINE ABUSE], <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co479.pdf> [<http://perma.cc/7JY3-46JM>].

<sup>229</sup> Lynne Smith et al., *Effects of Prenatal Methamphetamine Exposure on Fetal Growth and Drug Withdrawal Symptoms in Infants Born at Term*, 24 DEVELOPMENTAL & BEHAV. PEDIATRICS 17, 17 (2003).

<sup>230</sup> METHAMPHETAMINE ABUSE, *supra* note 228, at 1.

<sup>231</sup> *Id.*

<sup>232</sup> *Id.*

<sup>233</sup> Smith et al., *supra* note 229, at 17.

<sup>234</sup> *Id.*

<sup>235</sup> *Id.* at 21.

<sup>236</sup> Anne Harding, *Meth Use in Pregnancy Endangers Mom and Baby*, REUTERS (July 29, 2010, 4:20 PM), <http://www.reuters.com/article/2010/07/29/us-meth-pregnancy-idUSTRE66S5M720100729> [<http://perma.cc/CBF2-RA6H>].

placental abruption normally occurs in less than 1% of births in the United States, it can occur at a rate up to ten times that amongst pregnant methamphetamine users.<sup>237</sup>

The increased maternal blood pressure associated with methamphetamine consumption reduces the amount of oxygen that the fetus receives, sometimes to the point of depriving the fetus of an adequate oxygen supply (“hypoxia”).<sup>238</sup> Increased blood pressure and damage to the placenta may deprive the fetus of sufficient nutrients.<sup>239</sup> These effects can alter fetal growth and development,<sup>240</sup> leading to premature birth, low birth weight, and other fetal growth restrictions including decreased body weight, length, and head circumference.<sup>241</sup> Isolated cases of cardiac defects, cleft palates, and improper openings for bile ducts in the liver (“biliary atresia”) have also been reported in infants exposed to methamphetamine *in utero*.<sup>242</sup>

The fact that children prenatally exposed to methamphetamine experience stunted growth is more than an aesthetic issue, as it can lead to significant long-term health and neurodevelopmental problems.<sup>243</sup> “Low birth weight infants have an increased risk of mortality and childhood morbidity”<sup>244</sup> as well as developing type 2 diabetes later in life.<sup>245</sup> Although many low birth weight infants experience accelerated growth after they are born, this growth itself can be harmful because it “stresses the limited cell mass in the growth-restricted pancreas.”<sup>246</sup> Children with poor prenatal and postnatal head circumference often have neurological abnormalities that restrict mental development.<sup>247</sup> Children born with small head circumference who experience good post-natal head growth fare less well developmentally than do control children.<sup>248</sup>

Children prenatally exposed to methamphetamine also exhibit troubling cognitive and behavioral deficiencies, including aggressive behavior,<sup>249</sup> delays in mathematics and language skill acquisition, and difficulty with physical activities.<sup>250</sup> Additionally, methamphetamine-exposed newborns display poor visual recognition

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<sup>237</sup> *Id.* (noting that in contrast with a 1% occurrence in the population generally, 10% of the study’s pregnant methamphetamine users suffered placental abruption).

<sup>238</sup> Smith et al., *supra* note 229, at 21.

<sup>239</sup> *Id.*

<sup>240</sup> *See id.* at 20, tbl. 2.

<sup>241</sup> Bertis B. Little et al., *Methamphetamine Abuse During Pregnancy: Outcome and Fetal Effects*, 72 *OBSTETRICS & GYNECOLOGY* 541, 542 (1988).

<sup>242</sup> Smith et al., *supra* note 229, at 17.

<sup>243</sup> Lynne M. Smith et al., *The Infant Development, Environment, and Lifestyle Study: Effects of Prenatal Methamphetamine Exposure, Polydrug Exposure, and Poverty on Intra-uterine Growth*, 118 *PEDIATRICS* 1149, 1154–55 (2006).

<sup>244</sup> *Id.* at 1155.

<sup>245</sup> *Id.*

<sup>246</sup> *Id.*

<sup>247</sup> *Id.*

<sup>248</sup> *Id.*

<sup>249</sup> Smith et al., *supra* note 229, at 22.

<sup>250</sup> *Id.*

memory, a measure associated with intelligence.<sup>251</sup> The prevalence of these deficits may be understated, as researchers are concerned that current tests—which were designed to measure the effects of prenatal heroin exposure—may fail to identify deficits in the more withdrawn, quiet infants that tend to be characteristic of methamphetamine-using mothers.<sup>252</sup>

*F. Opioids: Heroin, Methadone, and Painkillers*

Heroin and methadone are the most commonly used forms of opioids amongst pregnant women.<sup>253</sup> Heroin use has increased over the past decade,<sup>254</sup> in large part because regulators have stiffened their oversight of prescription drugs.<sup>255</sup> Studying heroin's effects on the developing fetus is difficult because pregnant women who use heroin tend to use other substances like tobacco, alcohol, or cocaine as well.<sup>256</sup> It is estimated that approximately 7,000 opiate-exposed births occur annually.<sup>257</sup>

After a pregnant woman consumes opioids, she experiences a “high” lasting several hours.<sup>258</sup> Opioids' transplacental passage takes less than an hour, meaning that opioids enter the fetus's system soon after they enter the mother's system.<sup>259</sup> Withdrawal, for both the mother and the fetus, likely begins between six and forty-eight hours after the mother's last opioid usage.<sup>260</sup> Maternal opioid withdrawal is characterized by flu-like symptoms as well as anorexia, which can impair fetal growth.<sup>261</sup> The maternal stress accompanying withdrawal can also negatively impact the fetus, as some studies show increased levels of epinephrine in the mothers' amniotic fluid during opiate withdrawal.<sup>262</sup>

Many opioid-exposed inchoate children and neonates suffer from Neonatal Abstinence Syndrome (NAS) before or after birth.<sup>263</sup> The number of babies born in the United States with signs of opiate drug withdrawal tripled between 2000 and

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<sup>251</sup> *Id.*

<sup>252</sup> *See id.*

<sup>253</sup> Bhuvaneshwar et al., *supra* note 181, at 62.

<sup>254</sup> *Id.*

<sup>255</sup> *See* Sanjay Gupta, *Unintended Consequences: Why Painkiller Addicts Turn to Heroin*, CNN, <http://www.cnn.com/2014/08/29/health/gupta-unintended-consequences/> [<http://perma.cc/J3KQ-L9NP>] (last updated Jan. 3, 2015, 12:13 PM).

<sup>256</sup> Bertis B. Little et al., *Maternal and Fetal Effects of Heroin Addiction During Pregnancy*, 35 J. REPROD. MED. 159 (1990).

<sup>257</sup> Bhuvaneshwar et al., *supra* note 181, at 62.

<sup>258</sup> *Id.* at 61.

<sup>259</sup> *Id.* at 62.

<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Id.*

<sup>263</sup> *Id.*

2009.<sup>264</sup> It is generally worse to experience NAS during pregnancy than after birth.<sup>265</sup> Infants suffering from NAS display wakefulness, irritability, tremulousness, and temperature dysregulation, and a general failure to thrive.<sup>266</sup> NAS lasts up to ten weeks after birth and requires management in a neonatal intensive care unit.<sup>267</sup>

Aside from NAS, the most consistent impact of prenatal opioid exposure is to impair fetal growth.<sup>268</sup> Opioid use during pregnancy often results in low birth weight, which poses numerous risks for the child.<sup>269</sup> Up to 14% of children prenatally exposed to heroin have a head circumference below the third percentile.<sup>270</sup> The primary two factors determining the likelihood of restricted fetal growth are the type of opioid consumed and the quality of prenatal care received.<sup>271</sup> Low birth weight infants are more commonly born to heroin-using pregnant women than to methadone-using pregnant women, and opioid-free pregnant women have the lowest overall rate of occurrence.<sup>272</sup> Overall, the likelihood of having a low birth weight infant is 41–45% for pregnant women who use heroin, 24–26% for those who use methadone, and 12–19% for drug-free controls.<sup>273</sup> Children who were prenatally exposed to opioids frequently have behavioral issues as well as difficulty with perception and learning.<sup>274</sup>

Although methadone is also an opioid and impacts a developing fetus similarly to heroin, opioid-addicted pregnant women should still be encouraged to stop using other drugs and get methadone treatment because the benefits of getting proper prenatal care likely outweigh the harms that methadone causes. Unfortunately, 50–90% of patients receiving methadone treatment continue to use other drugs at the same time.<sup>275</sup> When a pregnant woman joins a methadone program, stops using other drugs, and gets proper care, she reduces the newborn's chances of suffering NAS and is more likely to have a healthy birth outcome.<sup>276</sup> Methadone treatment, when

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<sup>264</sup> See Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000–2009*, 307 JAMA 1934, 1937 (2012).

<sup>265</sup> Bhuvaneshwar et al., *supra* note 181, at 62.

<sup>266</sup> *Id.*

<sup>267</sup> *Id.*

<sup>268</sup> J. Christopher Glantz & James R. Woods, Jr., *Cocaine, Heroin, and Phencyclidine: Obstetric Perspectives*, 36 CLINICAL OBSTETRICS & GYNECOLOGY 279, 289 (1993).

<sup>269</sup> Bhuvaneshwar et al., *supra* note 181, at 61.

<sup>270</sup> Geraldine S. Wilson et al., *The Development of Preschool Children of Heroin-Addicted Mothers: A Controlled Study*, 63 PEDIATRICS 135, 139 (1979).

<sup>271</sup> See Glantz & Woods, *supra* note 268, at 290 (discussing different opiates' impact on birth outcomes, and prenatal care's mitigating potential).

<sup>272</sup> *Id.*

<sup>273</sup> See *id.*

<sup>274</sup> Wilson et al., *supra* note 270, at 140. These difficulties appear to be linked to low birthweight. Bhuvaneshwar et al., *supra* note 181, at 61.

<sup>275</sup> Glantz & Woods, *supra* note 268, at 288.

<sup>276</sup> See Nat'l Consensus Dev. Panel, *Effective Medical Treatment of Opiate Addiction*, 280

coupled with proper prenatal care, provides therapeutic benefits that remediate many of the drug's ill effects on the developing child.<sup>277</sup> For this reason, pregnant women that receive methadone along with good prenatal care have low-birth-weight babies at rates comparable to drug-free pregnant women.<sup>278</sup>

The best benefit of enrolling in a methadone treatment program, however, is the fact that the treatment program can put the pregnant woman in touch with other services that she might need. Not only does enrollment in a methadone program demonstrate to Child Protective Services (CPS) that the mother is invested in taking care of her inchoate child, the treatment program can help the woman create a better framework for a more organized life.<sup>279</sup> Once infants are born, they are far more likely to be discharged to the mother if she is enrolled in a methadone program.<sup>280</sup> This may simply reflect CPS's desire to encourage enrollment in such programs, but it may reflect CPS's recognition that these women have demonstrated a capacity to utilize resources for the benefit of both themselves and their children.

More recently, Subaxone is being used to treat addicted pregnant women.<sup>281</sup> Like Methadone, Subaxone is, in part, an opioid and, in part, a narcotic drug designed to reverse the effects of other narcotics.<sup>282</sup> Early research suggests that it is safer for inchoate children than methadone.<sup>283</sup> Subaxone has a better impact than methadone and it is also prescribed for women addicted to prescription medications.<sup>284</sup> It is more highly controlled than methadone and requires that the patient come to a healthcare facility to obtain a dose of the drug.<sup>285</sup>

### III. STATE RESPONSES TO PRENATAL SUBSTANCE ABUSE

The medical information discussed above demonstrates that substance abuse by pregnant women has a detrimental impact on children, as well as a corresponding fiscal impact on the state. Federal and state governments have responded to these harms in a variety of ways. The federal government has not adopted a particular

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JAMA 1936, 1939 (1998) (recommending methadone maintenance for opioid addicted pregnant women).

<sup>277</sup> Stephen R. Kandall et al., *The Narcotic-Dependent Mother: Fetal and Neonatal Consequences*, 1 EARLY HUMAN DEV. 159, 159 (1977).

<sup>278</sup> See Glantz & Woods, *supra* note 268, at 290.

<sup>279</sup> See Geraldine S. Wilson et al., *Follow-Up of Methadone-Treated and Untreated Narcotic-Dependent Women and Their Infants: Health, Developmental, and Social Implications*, 98 J. PEDIATRICS 716, 720 (1981).

<sup>280</sup> See Kandall et al., *supra* note 277, at 159.

<sup>281</sup> Subaxone is a medication made from Buprenorphine and naloxone. Interview with Caren Stalburg, M.D., University of Michigan Medical School, in Ann Arbor, Mich. (May 3, 2015).

<sup>282</sup> *Id.*

<sup>283</sup> *Id.*

<sup>284</sup> *Id.*

<sup>285</sup> *Id.*

approach and instead provides financial assistance to support states' efforts as long as they meet certain minimum requirements.<sup>286</sup> Under the Child Abuse Prevention and Treatment Act (CAPTA), the Department of Health and Human Services provides federal grants to support each state's child protection system.<sup>287</sup> In order to be eligible for a CAPTA grant, a state's governor must certify that the state either enforces a state law, or operates a statewide program, that requires healthcare providers to notify CPS when newborns are identified as being affected by "illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder."<sup>288</sup> As of April 2015, fourteen states and the District of Columbia included prenatal substance exposure in their definitions of child abuse or neglect.<sup>289</sup> Nineteen states and the District of Columbia had reporting procedures for newborns that showed evidence of prenatal exposure to drugs, alcohol, or other controlled substances.<sup>290</sup>

CAPTA does not require that states prosecute substance abuse by pregnant women or deem such exposure to be "child abuse" or "neglect."<sup>291</sup> However, it allows states to take either action on their own initiative.<sup>292</sup> Although states differ in how they approach substance abuse by pregnant women, they all recognize its harmful impact on children and the immense cost it imposes on society.<sup>293</sup> Each state seeks to minimize these impacts with some combination of remedies generally falling into one of three categories: (1) informational; (2) paternal; or (3) criminal.<sup>294</sup> By examining how selected states address the problem, this Part provides an overview of current state efforts to minimize the harms caused by prenatal exposure to alcohol and other drugs.

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<sup>286</sup> See 42 U.S.C. § 5106a(b)(1)(A)–(2)(B)(ii) (2012).

<sup>287</sup> *Id.* § 5106a(a)(1)(A).

<sup>288</sup> *Id.* § 5016a(b)(2)(B)(ii).

<sup>289</sup> CHILD WELFARE INFO. GATEWAY, PARENTAL DRUG ABUSE AS CHILD ABUSE 2 n.3 (2015), <https://www.childwelfare.gov/pubPDFs/drugexposed.pdf> [<http://perma.cc/X7GY-QPVF>] (noting that, as of April 2015, "Arizona, Arkansas, Colorado, Florida, Illinois, Indiana, Louisiana, Minnesota, North Dakota, South Carolina, South Dakota, Texas, Virginia, and Wisconsin include[d] exposure of infants to drugs in their definitions of child abuse or neglect.").

<sup>290</sup> *Id.* (noting that, as of April 2015, "Alaska, Arizona, Arkansas, California, Illinois, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, Oklahoma, Pennsylvania, Utah, and Virginia ha[d] enacted specific reporting procedures for drug-exposed infants").

<sup>291</sup> 42 U.S.C. § 5016a(b)(2)(B)(ii)(I)–(II).

<sup>292</sup> See *id.* § 5016c(a)(3).

<sup>293</sup> See, e.g., OR. REV. STAT. § 430.905(1) (West 2015) ("Because the growing numbers of pregnant substance users and drug- and alcohol-affected infants place a heavy financial burden on Oregon's taxpayers and those who pay for health care, it is the policy of this state to take effective action that will minimize these costs.").

<sup>294</sup> See, e.g., *id.* § 430.905(3)(a)–(d).

*A. The “Public Health Approach”—Education and Voluntary Treatment*

Many states attempt to minimize the harms of prenatal substance abuse through non-coercive measures, which are collectively referred to as the “public health approach.”<sup>295</sup> Oregon, for example, combats substance abuse by pregnant women exclusively through voluntary treatment programs.<sup>296</sup> This approach is premised on the belief that substance-abusing women avoid obtaining prenatal care out of fear that the state will take away their child once their substance abuse is discovered.<sup>297</sup> States that follow this approach explicitly prohibit any legal repercussions for the pregnant substance abuser.<sup>298</sup> Under Oregon law, once a healthcare professional determines that a pregnant patient is abusing drugs or alcohol, that professional must “tell the patient about the potential health effects of continued substance abuse and recommend counseling by a trained drug or alcohol abuse counselor.”<sup>299</sup> This is not done to build a case against the expectant mother but in the explicit hope that the mother will stop her behavior and CPS will not have to take custody once the child is born.<sup>300</sup> Similarly, in Washington State, pregnant substance abusers cannot be prosecuted for child mistreatment because its criminal law does not recognize fetuses as “children.”<sup>301</sup>

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<sup>295</sup> See Jean Reith Schroedel & Pamela Fiber, *Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women*, 1 YALE J. HEALTH POL’Y L. & ETHICS 217, 224 (2001) (noting that thirty-three states have “adopted laws that utilize a public health approach”).

<sup>296</sup> *Id.* at 223 (although Oregon does not seek to institutionalize the pregnant addict or to prosecute her, the state may utilize protective proceedings once the inchoate child is born.).

<sup>297</sup> See, e.g., CTR. FOR REPROD. RIGHTS, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN’S HEALTH AND CHILDREN’S INTERESTS 6 (2000) [hereinafter PUNISHING WOMEN], [http://reproductiverights.org/sites/default/files/documents/pub\\_bp\\_punishingwomen.pdf](http://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf) [<http://perma.cc/VAG7-Y6VS>] (“[F]ear of being reported to the authorities discourages women from communicating honestly about their addiction problems to health care professionals who need that information to provide appropriate medical care to both the woman and her newborn.”).

<sup>298</sup> See Schroedel & Fiber, *supra* note 295, at 224.

<sup>299</sup> OR. REV. STAT. § 430.920(1).

<sup>300</sup> *Id.* § 430.915 (“[I]t is the policy of this state that the provider encourage and facilitate counseling, drug therapy and other assistance to the patient in order to avoid having the child, when born, become subject to protective services.”).

<sup>301</sup> *State v. Dunn*, 916 P.2d 952, 955 (Wash. Ct. App. 1996) (affirming dismissal of child endangerment charges when newborn tested positive for cocaine because “[n]o Washington *criminal* case has ever included ‘unborn child’ or fetus in its definition of person. When the Legislature intends to include the fetus in a class of criminal victims, it specifically writes that language into the statute”); see WASH. REV. CODE ANN. § 9A.42.030 (West 2015) (stating that the parent or caretaker of a child is guilty of criminal mistreatment in the second degree if he recklessly “creates an imminent and substantial risk of death or great bodily harm”); see also *id.* § 9A.42.010(3) (defining “child” as “a person under eighteen years of age”). The child abuse or neglect statutes similarly define a “child” as “any person under the age of eighteen years of age.” *id.* § 26.44.020 (1)–(2).

Non-coercive policies often find favor in the medical community because they reinforce the larger medical approach of treating substance abusers as addicts whose actions are beyond their control.<sup>302</sup> As the National Association for Perinatal Addiction Research and Education points out, prenatal substance abusers are “addicts who become pregnant, not pregnant women who decide to use drugs.”<sup>303</sup> For pregnant addicts, therefore, prenatal substance abuse is considered the result of a complex disease and “not simply the product of a failure of individual willpower.”<sup>304</sup>

The question remains, however, whether entirely voluntary programs like Oregon’s and Washington’s are the best way to protect the inchoate child’s right to be born healthy. Even though these programs are often helpful for those who enroll, their voluntary nature endangers the inchoate child whose mother fails to complete treatment. Washington’s limited-enrollment “Safe Babies Safe Moms” program (SBSM), for example, showed positive results.<sup>305</sup> The incidence of low birth weight infants born to mothers in the program was 66% lower than the state average, and mothers who enrolled in the program while pregnant had a 35% lower rate of CPS referrals than mothers who enrolled in the program after giving birth.<sup>306</sup> But not all programs in Washington were similarly effective.<sup>307</sup> One-quarter of women enrolled in the state’s Parent Child Assistance Program (PCAP) failed to complete substance abuse treatment.<sup>308</sup>

Even if programs like SBSM and PCAP were fully funded and scaled to need, because they are voluntary, women who do not enter or complete them place their inchoate child at risk. As noted earlier, each instance of substance abuse during pregnancy increases the risk of harm to the inchoate child. Given that at least 30% of participants quit rehab at the most prominent substance abuse treatment centers in the country,<sup>309</sup> and the National Institute on Drug Abuse reports that about 40–60%

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<sup>302</sup> See, e.g., Kathryn T. Jones, Note, *Prenatal Substance Abuse: Oregon’s Progressive Approach to Treatment and Child Protection Can Support Children, Women, and Families*, 35 WILLAMETTE L. REV. 797, 798–99 (1999) (“[I]n order to provide safe, permanent families that will enable afflicted children to succeed, state policies must recognize that the substance-abusing mother is often a victim herself: she is controlled by her addiction.”).

<sup>303</sup> See PUNISHING WOMEN, *supra* note 297, at 7.

<sup>304</sup> Board of Trustees, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2667 (1990).

<sup>305</sup> ASS’N. OF STATE & TERRITORIAL HEALTH OFFICIALS, REDUCING ALCOHOL AND DRUG-EXPOSED INFANTS CASE STUDY 1–3 (2013), <http://www.astho.org/Washington-State-Guidelines-Reduce-Alcohol-and-Drug-Exposed-Babies/> [<http://perma.cc/W8FM-PCBV>].

<sup>306</sup> *Id.*

<sup>307</sup> See *id.* (the PCAP was aimed at maintaining the family unit, but only half the mothers managed to abstain from drug or alcohol for a year during the PCAP).

<sup>308</sup> *Id.*

<sup>309</sup> Liz Neporent, *When Rehab Is a Revolving Door*, EVERYDAY HEALTH (Feb. 13, 2012), <http://www.everydayhealth.com/addiction/0213/when-rehab-is-a-revolving-door.aspx>



of drug addicts that complete rehab will relapse,<sup>310</sup> a substantial number of pregnant women will likely continue to engage in substance abuse. Purely voluntary treatment programs, therefore, fall short because they inherently accept a significant amount of risk to the inchoate child. By foregoing potential coercive measures, programs like Oregon's and Washington's entrust the ultimate well-being of the inchoate child to decisions made by an addict—someone who, by definition, is controlled by something that cannot be checked by her willpower alone.

According to voluntary treatment advocates like the Center for Reproductive Rights and the American Congress of Gynecologists and Obstetricians, fetal health is still maximized—despite the fact that some preventable substance abuse will occur—when pregnant women have no fear of state action against them.<sup>311</sup> This is primarily because they believe: (1) that women will avoid prenatal care when they fear state recourse;<sup>312</sup> and (2) prenatal care “greatly reduces the negative effects of substance abuse during pregnancy.”<sup>313</sup> When women forego prenatal care because they are afraid of becoming the target of legal action, they argue, healthy birth outcomes are reduced in the aggregate.<sup>314</sup>

The arguments in favor of purely voluntary solutions are well-intentioned, but they overlook the possibility that non-voluntary remedies could further reduce the impact of substance abuse during pregnancy. Indeed, some of the studies relied on to justify voluntary public-health approaches accept that coercive measures might

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[<http://perma.cc/Z5A8-WES6>] (noting that Promises Treatment Centers in Malibu, CA, which costs \$55,000 per month, has a recovery rate of only 70%).

<sup>310</sup> See A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1693 (2000).

<sup>311</sup> PUNISHING WOMEN, *supra* note 297, at 1; see THE AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS, SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST 1–2 (2011) [hereinafter SUBSTANCE ABUSE REPORTING AND PREGNANCY], <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf> [<http://perma.cc/VNU7-TZMU>] (“Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.”).

<sup>312</sup> SUBSTANCE ABUSE REPORTING AND PREGNANCY, *supra* note 311.

<sup>313</sup> *Id.*; see also Erik Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. TIMES (Oct. 24, 2013), <https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html?r=0> (“The women are scared to come in if they have dependency problems . . . . When you allow them to be honest you get better outcomes in their pregnancies.”).

<sup>314</sup> Emily Figdor & Lisa Kaeser, *Concerns Mount over Punitive Approaches to Substance Abuse Among Pregnant Women*, 1 GUTTMACHER REP. ON PUB. POL’Y 3 (1998) (“Critics . . . argue that, in practice, punitive measures of this type are counterproductive to protecting infant health. They warn that such policies . . . only create obstacles to drug treatment and prenatal care. As a result, the rights of the woman are compromised, largely at the expense of both her health *and* the health of her fetus.”).

be beneficial.<sup>315</sup> Additionally, they overlook the fact that some studies have found that other factors, like the belief that getting prenatal care means submitting to “embarrassing tests,” dissuade pregnant women from getting prenatal care even more than the fear of being reported to CPS.<sup>316</sup> By respecting individual autonomy at all costs, voluntary approaches inherently accept a level of harm to inchoate children that can be avoided under some of the more coercive state approaches discussed later. Even though these coercive approaches have drawbacks, the less drastic of them avoid the shortcomings of the voluntary programs while striking a fairer balance among the interests of all three parties.

### *B. The Criminalization Approach—Deterring Prenatal Substance Abuse*

On the opposite end of the continuum, a few states criminally prosecute pregnant women who use illegal drugs and other substances.<sup>317</sup> Some states prosecute under child welfare statutes, while at least one more brings assault charges for harm the inchoate child suffers from substance abuse.<sup>318</sup>

South Carolina and Alabama prosecute substance abuse during pregnancy under child welfare statutes.<sup>319</sup> Appellate courts in both states have interpreted the word “child,” as used in state child endangerment statutes, to include an inchoate child.<sup>320</sup> The South Carolina Supreme Court made this determination in *Whitner v. State*, which denied a mother’s request for post-conviction relief after she pled guilty to criminal child neglect for ingesting crack cocaine during the third trimester of her pregnancy.<sup>321</sup> Noting that it had previously interpreted the word “person” to include a viable fetus in civil and criminal statutes, the South Carolina Supreme Court concluded “it would be absurd to recognize the viable fetus as a person for purposes of homicide laws and wrongful death statutes but not for purposes of statutes proscribing

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<sup>315</sup> See, e.g., Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 *DRUG & ALCOHOL DEPENDENCE* 199, 203 (1993).

<sup>316</sup> Ashley H. Schempf & Donna M. Strobino, *Drug Use and Limited Prenatal Care: An Examination of Responsible Barriers*, 200 *AM. J. OBSTETRICS & GYNECOLOGY* 412e1, 412e3, 412e7 (2009).

<sup>317</sup> See Vandervort, *supra* note 1, at 240–45. During the 1990s, a number of prosecutors brought criminal charges under general statutes, such as those prohibiting the delivery of illegal drugs or child abuse, against pregnant substance abusers. *Id.* Most courts rejected the application of these general statutes in this context. *Id.* More recently, as will be discussed *infra*, a few states have enacted statutes aimed more specifically at prosecuting substance abuse by pregnant women.

<sup>318</sup> See Vandervort, *supra* note 1, at 234; see also *infra* notes 321–22, 326 and accompanying text.

<sup>319</sup> *Ankrom v. State*, 152 So. 3d 373, 376 (Ala. Crim. App. 2011); *Whitner v. State*, 492 S.E.2d 777, 779 (S.C. 1997), *cert. denied*, 523 U.S. 1145 (1998).

<sup>320</sup> *Ankrom*, 152 So. 3d at 379–80; *Whitner*, 492 S.E.2d at 779–81.

<sup>321</sup> 492 S.E.2d at 777.

child abuse.”<sup>322</sup> Citing *Whitner*, the Supreme Court of Alabama recently adopted a similar interpretation of its own child welfare laws in *Ex Parte Ankrom*.<sup>323</sup> In that 2013 opinion, which addressed appeals from two separate cases, the court upheld the convictions and prison sentences of two women for “chemical endangerment of a child” for using cocaine while pregnant.<sup>324</sup>

At least one state prosecutes abuse of illegal drugs as assault.<sup>325</sup> In April 2014, a Tennessee law took effect amending the state’s assault statutes to explicitly include a fetus “at any stage of gestation in utero” as a potential assault victim.<sup>326</sup> This law allows prosecutors to charge pregnant women with a crime up to “aggravated assault”—which carries a possible prison sentence of up to fifteen years—if their use of illegal drugs during pregnancy harms their newborn.<sup>327</sup> To encourage expectant mothers to get treatment, the law provides a “safe harbor” affirmative defense that applies when a woman was “actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.”<sup>328</sup> If these conditions are met, this defense prevents punishment under the law.<sup>329</sup>

Tennessee’s criminal prosecution of prenatal substance abuse differs from South Carolina’s and Alabama’s in a few important respects. Although South Carolina and Alabama can only prosecute prenatal substance abuse that harms viable fetuses,<sup>330</sup> Tennessee’s statutory language includes fetus pre-viability.<sup>331</sup> Additionally, prenatal

<sup>322</sup> *Id.* at 780 (citing *Fowler v. Woodward*, 138 S.E.2d 42 (S.C. 1964)) (allowing wrongful death action for a viable fetus injured while still in the womb); see *State v. Horne*, 319 S.E.2d 703, 705 (S.C. 1984) (upholding voluntary manslaughter conviction for man who stabbed his pregnant wife in abdomen, resulting in fetus’s death).

<sup>323</sup> 152 So. 3d 397, 407 (Ala. 2013) (“[I]n the present case, we do not see any reason to hold that a viable fetus is not included in the term ‘child,’ as that term is used in § 26-15-3.2, Ala.Code (1975). Not only have the courts of this State interpreted the term ‘child’ to include a viable fetus in other contexts, the dictionary definition of the term ‘child’ explicitly includes an unborn person or a fetus. In everyday usage, there is nothing extraordinary about using the term ‘child’ to include a viable fetus. . . . Unless the legislature specifically states otherwise, the term ‘child’ is simply a more general term that encompasses the more specific term ‘viable fetus.’”).

<sup>324</sup> *Id.* at 397–402.

<sup>325</sup> See TENN. CODE ANN. § 39-13-107(c)(2) (West 2015).

<sup>326</sup> *Id.* § 39-13-107(a).

<sup>327</sup> See generally Sanya Dosani, *Should Pregnant Women Addicted to Drugs Face Criminal Charges?*, AL JAZEERA AM., <http://america.aljazeera.com/watch/shows/america-tonight/articles/2014/9/4/should-pregnant-womenaddictedtodrugsfacecriminalcharges.html> [http://perma.cc/UXU9-8F2N] (last updated Mar. 31, 2015, 4:00 PM) (discussing the law).

<sup>328</sup> TENN. CODE ANN. § 39-13-107(c)(3).

<sup>329</sup> *Id.*

<sup>330</sup> See *Ankrom v. State*, 152 So. 3d 373, 379–80 (Ala. Crim. App. 2011); see also *id.* at 380 (discussing South Carolina’s approach).

<sup>331</sup> See TENN. CODE ANN. § 39-13-107(a).

exposure to alcohol or tobacco might trigger child endangerment proceedings in South Carolina or Alabama,<sup>332</sup> but it cannot lead to an assault prosecution in Tennessee because Tennessee's law proscribes prosecuting "any lawful act or lawful omission" by an expectant mother.<sup>333</sup> This provision essentially limits Tennessee's fetal assault prosecutions to instances where an expectant mother uses illegal drugs.<sup>334</sup>

The criminalization approach embodied in the laws of South Carolina, Alabama, and Tennessee has encountered considerable criticism.<sup>335</sup> One of the most frequent criticisms of criminalization is that its underlying logic ignores medical knowledge about addiction.<sup>336</sup> When introducing Tennessee's legislation on the House floor, for instance, the bill's chief sponsor Representative Terri Weaver referred to pregnant addicts as "the worst of the worst" and said that she hoped the threat of jail time would scare them into treatment.<sup>337</sup> This attitude directly contradicts the medical understanding, discussed above, that addiction is a disease.<sup>338</sup> Opponents argue that, because of the true nature of addiction, criminal prosecution "ma[kes] it a crime to carry a pregnancy to term if you struggle with addiction or substance abuse."<sup>339</sup> Even if pregnant substance abusers were "the worst of the worst," critics point out that there is no medical basis for Tennessee's exemption for pregnant women who use alcohol and tobacco because these substances are at least as harmful as illegal drugs.<sup>340</sup>

Critics also argue that threatening criminal prosecution will not encourage women to enroll in treatment programs.<sup>341</sup> Instead, they argue that the threat of prosecution likely increases the danger to fetal health by driving vulnerable women away from substance abuse treatment because they fear detection.<sup>342</sup> Even if the

<sup>332</sup> See *Ankrom*, 152 So. 3d at 384; Vandervort, *supra* note 1, at 237–38.

<sup>333</sup> TENN. CODE ANN. § 39-13-107(c)(1)(a).

<sup>334</sup> *Id.* § 39-13-107(c)(2); Cathleen R. Smith, *Tennessee Handbook Series: Criminal Offenses and Defenses in Tennessee* § A290 (2014–2015 ed.).

<sup>335</sup> See PUNISHING WOMEN, *supra* note 297, at 4 (South Carolina); see also *infra* note 339 and accompanying text.

<sup>336</sup> See Schroedel & Fiber, *supra* note 295, at 220.

<sup>337</sup> Dosani, *supra* note 327.

<sup>338</sup> See Schroedel & Fiber, *supra* note 295, at 224.

<sup>339</sup> Tara Culp-Ressler, *Tennessee Will Now Criminally Charge Pregnant Women Who Use Drugs*, THINKPROGRESS (Apr. 29, 2014, 5:06 PM), <http://thinkprogress.org/health/2014/04/29/3432433/tennessee-criminalize-pregnant-women/> [<http://perma.cc/MBJ8-QDE2>].

<sup>340</sup> See Nina Martin, *A Stillborn Child, a Charge of Murder and the Disputed Case Law on 'Fetal Harm,'* PROPUBLICA (Mar. 18, 2014, 11:00 AM), <http://www.propublica.org/article/stillborn-child-charge-of-murder-and-disputed-case-law-on-fetal-harm> [<http://perma.cc/T9MH-TKVJ>] ("There is no convincing evidence that prenatal cocaine exposure is more strongly associated with fetal harm or developmental deficits than exposure to legal substances, like tobacco and alcohol, or many other factors.").

<sup>341</sup> See Tony Gonzalez, *Tennessee Will Criminalize Moms Who Use Drugs While Pregnant*, TENNESSEAN (Apr. 30, 2014, 11:34 AM), <http://www.tennessean.com/story/news/politics/2014/04/29/tn-will-criminalize-moms-using-drugs-pregnant/8473333/> [<http://perma.cc/ZP78-FGLB>].

<sup>342</sup> *Id.*; see PUNISHING WOMEN, *supra* note 297, at 6 ("[W]omen are reluctant to seek treatment if there is a possibility of [civil or criminal] punishment . . .").

threat of criminal prosecution did encourage women to seek out drug treatment, critics point out that these women likely would be unable to enroll and would not receive any benefit for trying.<sup>343</sup> Tennessee's "safe harbor" provision, for instance, does not reward women who try but fail to enroll in a treatment program.<sup>344</sup> At the same time, the state's drug treatment facilities do not have enough beds to meet demand, and most do not accept pregnant women.<sup>345</sup> Even if a treatment center will accept pregnant women, many will only accept women who are drug-free at the time of admission.<sup>346</sup> Because they do not realistically provide opportunities for women to get treatment, prenatal care, or to work to manage their addiction, these criminalization laws can have very limited impact on fetal harm.

Other opponents challenge these states' criminal prosecution regimes as a Trojan horse for less popular political beliefs.<sup>347</sup> According to Lynn Paltrow, the Executive Director of the National Advocates for Pregnant Women (NAPW), the South Carolina criminalization law upheld in *Whitner* "goes to the heart of today's abortion debate, lending support to the anti-abortion position that fetuses are persons and that pregnant women's health and freedom may be subordinated to those rights."<sup>348</sup> NAPW also challenges the criminalization statutes as applied, arguing that real-world decisions to arrest and charge women often involve political and moral overtones.<sup>349</sup> According to a 2013 NAPW report, the vast majority of criminal prosecutions involve illegal drug use rather than alcohol or tobacco.<sup>350</sup> The women charged are also disproportionately young, poor, and African American.<sup>351</sup>

Given states' actions over the last twenty-five years, NAPW's criticisms are valid. In the late 1980s and early 1990s, largely in response to concerns about pregnant women using crack cocaine, many states—including South Carolina—prosecuted drug-addicted pregnant women for delivering a controlled substance to a minor.<sup>352</sup> Although the law at issue had been created to punish drug dealers,<sup>353</sup> prosecutors argued

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<sup>343</sup> Dosani, *supra* note 327.

<sup>344</sup> *See id.*

<sup>345</sup> *See id.*

<sup>346</sup> *See id.*

<sup>347</sup> *See* Annaick Miller, *Using the "War on Drugs" to Arrest Pregnant Women*, POL. RES. ASSOCIATES (Sept. 17, 2015), <http://www.politicalresearch.org/2015/09/17/using-the-war-on-drugs-to-arrest-pregnant-women/> [<http://perma.cc/QX35-2U2Y>] ("Lynn Paltrow, executive director of the National Advocates for Pregnant Women, has consistently highlighted how Tennessee's prenatal drug use law is a continuation of the anti-abortion 'personhood' campaign.").

<sup>348</sup> Lynn Paltrow, *Our Common Struggle*, NAT'L ADVOCATES FOR PREGNANT WOMEN, <http://www.advocatesforpregnantwomen.org/articles/common.htm> [<http://perma.cc/Z8FA-RHJB>].

<sup>349</sup> Dosani, *supra* note 327.

<sup>350</sup> *See* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 310 (2013).

<sup>351</sup> *See id.*

<sup>352</sup> Vandervort, *supra* note 1, at 240–45.

<sup>353</sup> *See* Tamar Lewin, *Drug Use in Pregnancy: New Issues for the Courts*, N.Y. TIMES

that the drug-addicted pregnant women had delivered controlled substances to their newborn through the umbilical cord in the seconds after the child was born.<sup>354</sup> Although these prosecutions were largely unsuccessful,<sup>355</sup> the same opinions that found in favor of the defendants often encouraged state legislatures to directly address the problem of prenatal substance abuse.<sup>356</sup> For example, in the last sentence of its opinion in *State v. Johnson*, the Florida Supreme Court stated that “[i]f that is the intent of the Legislature, then this statute should be redrafted to clearly address the basic problem of passing illegal substances from mother to child *in utero*, not just in the birthing process.”<sup>357</sup>

These exhortations by courts, and the fact that many prosecutors brought “delivery” charges because of a “fetal personhood” worldview,<sup>358</sup> make it plausible that today’s criminalization laws have an anti-abortion lineage as well as a child welfare one. Additionally, given that the “delivery” prosecutions that lead to today’s criminalization laws occurred during the racially tinged “crack baby” scare in the late 1980s,<sup>359</sup> it is similarly likely that current criminalization laws would suffer from the same enforcement biases.<sup>360</sup>

Criminal prosecution presumably has good intentions, but it does not appear to sufficiently minimize the harms caused by prenatal exposure. Its greatest shortcoming is that it fails to solve the underlying addiction that drives the substance abuse, and

(Feb. 5, 1990), <http://nytimes.com/1990/02/05/us/drug-use-in-pregnancy-new-issue-for-the-courts.html>.

<sup>354</sup> *Id.*; see *Johnson v. State*, 602 So. 2d 1288, 1290 (Fla. 1992) (reversing conviction of “a mother, who ingested a controlled substance [(cocaine)] prior to giving birth, for delivery of a controlled substance to the infant during the thirty to ninety seconds following the infant’s birth, but before the umbilical cord is severed”).

<sup>355</sup> Vandervort, *supra* note 1, at 240–45; see, e.g., *Johnson*, 602 So. 2d at 1296 (reversing conviction because the state’s “delivery” statute “does not encompass ‘delivery’ of an illegal drug derivative from womb to placenta to umbilical cord to newborn after a child’s birth”).

<sup>356</sup> See Hayley Fox, *Pregnant Drug Users Face Criminal Prosecution, but Doctors Say That’s a Mistake*, TAKEPART (Apr. 1, 2015), <http://www.takepart.com/article/2015/04/01/pregnant-jail-time-drug> [<http://perma.cc/7DFS-VCL4>].

<sup>357</sup> 602 So. 2d at 1296.

<sup>358</sup> Lewin, *supra* note 353 (quoting Greenville, S.C. prosecutor Joseph Watson) (“[A] viable fetus has the same legal rights as a baby. So I believe the child-neglect laws can apply.”).

<sup>359</sup> See Danielle Cadet, ‘Crack Babies’ Comparison to Neonatal Drug Withdrawal Ignores Racist Rhetoric of 1980s, *Experts Argue*, HUFFINGTON POST: BLACK VOWS (Sept. 4, 2012, 8:18 AM), [http://www.huffingtonpost.com/2012/08/31/crack-babies-neonatal-drug-withdrawal\\_n\\_1847712.html](http://www.huffingtonpost.com/2012/08/31/crack-babies-neonatal-drug-withdrawal_n_1847712.html) [<http://perma.cc/K8YB-XVKU>] (“The ‘crack baby’ is a black baby . . . . The mainstream media’s approach to black women with substance abuse problems was completely punitive and vilifying, and it was as if these women weren’t even human beings.”).

<sup>360</sup> See *id.* (“The whole response to the so-called crack baby epidemic was completely punitive . . . . The response was all about punishment—punishing [black mothers] for their transgressions, rather than trying to get them help or trying to solve the problem.” (alteration in original) (quoting Enid Logan, Associate Professor of Sociology at the University of Minnesota)).

fails to protect the inchoate child because, by the time the state brings criminal charges, the neonate has already been harmed. Additionally, incarcerating mothers might create unintended consequences, including denying her family its sole wage earner or putting her current children at risk to enter the foster care system.

Although voluntary treatment programs like those in Oregon and Washington state connect pregnant women with medical professionals who can help them manage their addiction in order to reduce the effects that substance abuse will have on the inchoate child,<sup>361</sup> South Carolina, Alabama, and Tennessee's criminalization approaches have no analogous benefits. Criminal prosecution's only benefit is if, as Representative Weaver argues,<sup>362</sup> it successfully deters substance abuse before it happens. But in order for this to happen, drug addicts would need to be rational actors. As discussed previously, pregnant addicts are not using the type of rational cost-benefit analysis that threats of jail time can influence. By punishing these women for actions that they often cannot fully control and providing no help for their inchoate children before they are harmed, criminal prosecution is likely the least effective method of minimizing harm.

### C. *The Paternal Solution—Involuntary Commitment*

Three states, Minnesota, South Dakota, and Wisconsin, allow judges to civilly commit substance-abusing pregnant women.<sup>363</sup> None of these states apply civil commitment as a punitive remedy.<sup>364</sup> All require court proceedings and constitutionally sufficient due process before civil commitment can occur.<sup>365</sup>

#### 1. Constitutional Requirements for Civil Commitment

Civil commitment is a weighty imposition on individual liberty.<sup>366</sup> Freedom from physical restraint “has always been at the core of the liberty protected by the Due Process Clause.”<sup>367</sup> However, “that liberty interest is not absolute”<sup>368</sup> and can be constrained outside of a criminal setting.<sup>369</sup> When mentally ill individuals pose a

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<sup>361</sup> See Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense*, 29 J. ADDICTIVE DISEASES 231, 237–38 (2010).

<sup>362</sup> *Id.* at 234.

<sup>363</sup> MINN. STAT. ANN. § 253B.065 (West 2015); S.D. CODIFIED LAWS § 34-20A-70 (West 2015); WIS. STAT. ANN. § 48.193 (West 2015).

<sup>364</sup> See MINN. STAT. ANN. § 253B.065; S.D. CODIFIED LAWS § 34-20A-70; WIS. STAT. ANN. § 48.193.

<sup>365</sup> See *infra* Part III.C.2.a.

<sup>366</sup> See *Addington v. Texas*, 441 U.S. 418, 425 (1979) (“This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty . . .”).

<sup>367</sup> *Kansas v. Hendricks*, 521 U.S. 346, 356 (1997) (citations omitted).

<sup>368</sup> *Id.*

<sup>369</sup> *Id.* at 357 (noting that states have, “in certain narrow circumstances,” provided for people’s forcible civil detainment).

danger to themselves or others,<sup>370</sup> states' *parens patriae* and police powers empower them to civilly commit those people.<sup>371</sup>

The Fourteenth Amendment's Due Process Clause places baseline requirements on a state's civil commitment power.<sup>372</sup> As the Supreme Court outlined in *Addington v. Texas*, due process requires that the state present "clear and convincing" evidence before civil commitment can occur.<sup>373</sup> In *Jones v. United States*, the Court held that due process requires that the nature and duration of commitment bear "some reasonable relation to the purpose for which the individual is committed."<sup>374</sup> This means that the individual must be confined for the purpose of treatment and must be released once she is no longer a danger to herself or others.<sup>375</sup>

## 2. Civil Commitment Laws Comply with Constitutional Requirements

Although the specifics of each state's statute differ, all three statutes comply with the Constitution's due process requirements discussed above. Each enumerates a clear standard that must be met before a court can order civil commitment.<sup>376</sup> Additionally, each statute mandates that commitment be to a suitable treatment facility and directly links the duration of civil commitment to the pregnant woman's recovery from addiction.<sup>377</sup>

### *a. Standards for Civil Commitment*

Each of the three state statutes contains a specific standard for when a pregnant substance abuser may be civilly committed.<sup>378</sup> The Minnesota and South Dakota statutes comply with *Addington* by explicitly requiring that this standard be proven

<sup>370</sup> *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will . . . there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.").

<sup>371</sup> *Addington*, 441 U.S. at 426.

<sup>372</sup> *Id.* at 418.

<sup>373</sup> *See id.* at 427.

<sup>374</sup> 463 U.S. 354, 368 (1983) (quoting *Jackson v. Indiana*, 406 U.S. 715, 732 (1972)).

<sup>375</sup> *O'Connor*, 422 U.S. 574–75; *see Jones*, 463 U.S. at 368 ("The purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness. The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous.").

<sup>376</sup> MINN. STAT. ANN. § 253B.065(5)(c) (West 2015); S.D. CODIFIED LAWS § 34-20A-77 (West 2015); WIS. STAT. ANN. § 48.193(1)(c) (West 2015).

<sup>377</sup> MINN. STAT. ANN. §§ 253B.22(4), 253B.066(10) (West 2015); S.D. CODIFIED LAWS §§ 34-20A-77, 34-20A-81 (West 2015); WIS. STAT. ANN. §§ 48.207(1m)(a)–(c), 48.205 (West 2015).

<sup>378</sup> MINN. STAT. ANN. § 253B.065(5)(c); S.D. CODIFIED LAWS § 34-20A-77; WIS. STAT. ANN. § 48.193(1)(c).



by “clear and convincing” evidence.<sup>379</sup> While Wisconsin’s statute does not explicitly require “clear and convincing evidence,” it is likely also constitutional.<sup>380</sup>

Minnesota allows for the civil commitment of pregnant women as an “early intervention treatment.”<sup>381</sup> To order early intervention treatment, a Minnesota judge must find “by clear and convincing evidence that a pregnant woman is a chemically dependent person.”<sup>382</sup> An expectant mother is considered “chemically dependent” when she has, during pregnancy, “engaged in excessive use, for a nonmedical purpose, of controlled substances or their derivatives, alcohol, or inhalants that will pose a substantial risk of damage to the brain or physical development of the fetus.”<sup>383</sup> Courts can order “a variety of treatment alternatives including, but not limited to, day treatment, medication compliance monitoring, assertive community treatment, crisis assessment and stabilization, partial hospitalization, and short-term hospitalization.”<sup>384</sup>

South Dakota law authorizes “involuntary commitment” when an expectant mother is abusing drugs or alcohol.<sup>385</sup> Involuntary commitment is appropriate when the expectant mother “is an alcoholic or drug abuser who habitually lacks self-control as to the use of alcoholic beverages or other drugs” and “[i]s pregnant and abusing alcohol or drugs.”<sup>386</sup> These allegations must be proven by clear and convincing evidence.<sup>387</sup>

In Wisconsin, ordering civil commitment for substance abuse during pregnancy is a two-step process.<sup>388</sup> A judge must first find it necessary to take jurisdiction over the expectant mother and the unborn child,<sup>389</sup> and the judge must then decide to order that the expectant mother be taken into custody.<sup>390</sup> Civil commitment is appropriate when there is

a showing satisfactory to the judge that . . . the adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not

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<sup>379</sup> MINN. STAT. ANN. § 253B.065(5)(c); S.D. CODIFIED LAWS § 34-20A-77.

<sup>380</sup> See *infra* notes 392–96 and accompanying text.

<sup>381</sup> MINN. STAT. ANN. § 253B.065(5)(c).

<sup>382</sup> *Id.*

<sup>383</sup> *Id.*

<sup>384</sup> *Id.* § 253B.066(1).

<sup>385</sup> See S.D. CODIFIED LAWS § 34-20A-70 (West 2015).

<sup>386</sup> *Id.*

<sup>387</sup> *Id.* § 34-20A-77.

<sup>388</sup> See WIS. STAT. ANN. § 48.133 (West 2015).

<sup>389</sup> See *id.* (stating that jurisdiction over the expectant mother and unborn child is appropriate when the expectant mother “habitually lacks self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the expectant mother receives prompt and adequate treatment for that habitual lack of self-control”).

<sup>390</sup> *Id.* § 48.193(1)(c).

made a good faith effort to participate in any alcohol or other drug abuse services offered to her.<sup>391</sup>

Notably, the Wisconsin statute simply requires a “showing satisfactory to the judge”<sup>392</sup> before civil commitment can be ordered, but not “clear and convincing evidence.”<sup>393</sup> The statute does not further define “[satisfactory] showing.”<sup>394</sup> Although other provisions in the Wisconsin Children’s Code also refer to a “showing satisfactory to the judge,” they do not define “satisfactory” either.<sup>395</sup> It is therefore possible that a Wisconsin judge could find a satisfactory showing on the basis of less than “clear and convincing” evidence and unconstitutionally order a civil commitment. However, a satisfactory showing does not necessarily require less than “clear and convincing” evidence. Under the canon of constitutional avoidance, therefore, Wisconsin’s statute would likely be properly interpreted as requiring “clear and convincing” evidence before a satisfactory showing could be found for ordering civil commitment.<sup>396</sup>

*b. Nature of Civil Commitment*

Under each state’s laws, civilly committed expectant mothers must be placed in an appropriate treatment facility.<sup>397</sup> Minnesota requires that each treatment facility be supervised by a special review board, which audits the facility every six months and may “examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement.”<sup>398</sup> Minnesota also requires that each patient be given written notice of their right to appear before the review board during each visit.<sup>399</sup> Under South Dakota law, a court “may not order commitment of a person unless it determines that the proposed facility is able to provide adequate and appropriate treatment for him and

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<sup>391</sup> *Id.*

<sup>392</sup> *Id.*

<sup>393</sup> *See id.*

<sup>394</sup> *See id.*

<sup>395</sup> *See, e.g., id.* § 48.19(c) (allowing a child to be taken into custody under “[a]n order of the judge if made upon a showing satisfactory to the judge that the welfare of the child demands that the child be immediately removed from his or her present custody”); *id.* § 48.19(cm).

<sup>396</sup> *See Clark v. Martinez*, 543 U.S. 371, 380–81 (2005) (“[W]hen deciding which of two plausible statutory constructions to adopt, a court must consider the necessary consequences of its choice. If one of them would raise a multitude of constitutional problems, the other should prevail—whether or not those constitutional problems pertain to the particular litigant before the Court.”).

<sup>397</sup> MINN. STAT. ANN. § 253B.22(4) (West 2015); S.D. CODIFIED LAWS § 34-20A-77 (West 2015); WIS. STAT. ANN. § 48.207(1M)(a)-(c).

<sup>398</sup> MINN. STAT. ANN. § 253B.22(4).

<sup>399</sup> *Id.* § 253B.22(3).

the treatment is likely to be beneficial.”<sup>400</sup> In Wisconsin, an expectant mother who is ordered into custody can be held under supervision in the home of an adult relative or friend, a “licensed community-based residential facility,” or a hospital.<sup>401</sup>

*c. Duration of Civil Commitment*

All three state statutes comply with *Jones* because they condition the duration of the pregnant woman’s civil commitment on her recovery from substance abuse. Minnesota limits “early intervention” treatment commitments to ninety days.<sup>402</sup> Early release can be obtained when a committed expectant mother, or a person acting on her behalf, petitions the committing court for an order “that the [committed individual] is not in need of continued care and treatment or for an order that [the committed individual] is no longer a person who is . . . chemically dependent” and provides sufficient evidence to support such a finding.<sup>403</sup>

Under South Dakota law, an “involuntary commitment” can last up to ninety days.<sup>404</sup> If it is determined at any point during treatment that the reasons for the commitment no longer exist, further treatment will not be likely to significantly improve her condition, or that treatment is no longer appropriate, the committed pregnant woman can be released before the end of the ninety-day period.<sup>405</sup> When the ninety-day period concludes, she will be automatically discharged from treatment unless an order for recommitment is obtained.<sup>406</sup> If necessary, the court may issue up to two additional ninety-day recommitment orders—allowing up to nine months of civil commitment—applying the same standards for commitment and release applicable to the initial commitment order.<sup>407</sup>

Although there is no apparent time limit on how long an expectant mother can be civilly committed under the Wisconsin statute, she will be released from the treatment facility once her intake worker determines that she can be safely released.<sup>408</sup> In order to permit release, the intake worker must determine that there is no longer probable cause to believe that (1) the expectant mother is within the jurisdiction of the court; (2) releasing the mother creates a “substantial risk” that the unborn child’s physical health will be seriously affected or endangered by the expectant mother’s substance abuse “to a severe degree”; and (3) the expectant mother either refuses

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<sup>400</sup> S.D. CODIFIED LAWS § 34-20A-77.

<sup>401</sup> WIS. STAT. ANN. § 48.207(1m)(a)–(c); *id.* § 48.207(2)(b) (discussing the need for supervisory services for in-home detentions).

<sup>402</sup> MINN. STAT. ANN. § 253B.066(3).

<sup>403</sup> *Id.* § 253B.17(1).

<sup>404</sup> S.D. CODIFIED LAWS § 34-20A-81.

<sup>405</sup> *See id.* § 34-20A-80.

<sup>406</sup> *See id.* § 34-20A-81.

<sup>407</sup> *See id.* §§ 34-30A-81–83.

<sup>408</sup> *See* WIS. STAT. ANN. § 48.205 (West 2015).

treatment or has not made a “good faith effort” to participate in treatment services offered to her.<sup>409</sup>

*d. Criticisms of the Civil Commitment Approach*

Opponents of civil commitment characterize it as inherently “punitive”<sup>410</sup> and argue that “confinement [is] a penalty for non-compliance” with doctors’ orders to stop abusing substances and seek treatment.<sup>411</sup> However, this argument lacks a clearly established legal basis. In *Kansas v. Hendricks*, the Supreme Court explicitly held that when civil commitment is imposed on those “who suffer from a volitional impairment rendering them dangerous beyond their control,” such confinement is inherently non-punitive.<sup>412</sup> Additionally, “the mere fact that a person is detained does not inexorably lead to the conclusion that the government has imposed punishment.”<sup>413</sup>

Furthermore, civilly committing substance-abusing expectant mothers furthers neither of the primary rationales for criminal punishment—retribution and deterrence.<sup>414</sup> Civil commitment proceedings for the mentally ill are not retributive because they “do[] not affix culpability for prior . . . conduct.”<sup>415</sup> Instead, these proceedings only use prior conduct to demonstrate that someone is mentally ill or to support a finding that she is dangerous to herself or others.<sup>416</sup> Similarly, civil commitment has little deterrence value because the people confined “are, by definition, suffering from a mental abnormality . . . that prevents them from exercising adequate control over their behavior” and “are therefore unlikely to be deterred by the threat of confinement.”<sup>417</sup>

Critics also argue that civil commitment for substance-abusing expectant mothers is inherently punitive if no meaningful treatment is provided.<sup>418</sup> There is little question that the provision of treatment (or lack thereof) is a serious concern. At least one pregnant woman who was committed under the Minnesota statute, for instance, was apparently confined to a ward for people with eating disorders and received “no treatment for her drug addiction.”<sup>419</sup> According to the Center for Reproductive Rights, at least some women who are committed actually end up in jail.<sup>420</sup> These

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<sup>409</sup> *Id.* § 48.205(1m).

<sup>410</sup> PUNISHING WOMEN, *supra* note 297, at 5–6.

<sup>411</sup> April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 170 (2007).

<sup>412</sup> 521 U.S. 346, 358 (1997).

<sup>413</sup> *Id.* at 363 (quoting *United States v. Salerno*, 481 U.S. 739, 746 (1987)).

<sup>414</sup> *See id.* at 362.

<sup>415</sup> *See id.*

<sup>416</sup> *See id.*

<sup>417</sup> *See id.* at 362–63.

<sup>418</sup> *See* PUNISHING WOMEN, *supra* note 297, at 1.

<sup>419</sup> Cherry, *supra* note 411, at 170.

<sup>420</sup> PUNISHING WOMEN, *supra* note 297, at 8.

lapses show key areas for improvement, as discussed in the Conclusion, but they have little legal impact on civil commitment's non-punitive nature. The Supreme Court is clear that the provision of even "meager" treatment, especially as part of a newly created civil commitment program, does not transform that program into a punitive one.<sup>421</sup>

#### IV. AN IDEAL SOLUTION

As the preceding Parts demonstrate, substance abuse, including the use of legal substances, by pregnant women is a serious social problem. Unfortunately, as discussed in Part III, states' solutions too often fail to treat substance abuse during pregnancy as the complex problem that it is.<sup>422</sup>

In this Part, we outline a framework for a pragmatic, comprehensive, and politically feasible approach to minimizing substance abuse during pregnancy.<sup>423</sup> Our framework operates on two levels. Initially, the state invests resources to create a robust voluntary drug-treatment program in which pregnant substance abusers can participate without fear of legal sanction. However, when pregnant substance abusers refuse voluntary treatment, civil commitment should be utilized and should empower the courts to order her committed to a drug treatment facility. This framework is premised on four key understandings: (1) substance abuse during pregnancy poses serious, unacceptable risks of inflicting long-lasting harms on the inchoate child; (2) the large majority of pregnant women who abuse substances do so because of addiction, not a morally reprehensible disregard for the inchoate child's well-being; (3) it is in the state's financial interest to provide effective treatment for pregnant substance abusers; and (4) when a pregnant woman refuses to enroll and participate in voluntary treatment programs, civil commitment is warranted to protect the inchoate child's right to be born healthy and the state's interest in protecting and preserving the public fisc.

##### *A. Substance Abuse During Pregnancy Poses an Unacceptable Risk to the Inchoate Child's Well-Being*

As discussed in Part II, research demonstrates that substance abuse during pregnancy can cause severe, irremediable harm to the inchoate child.<sup>424</sup> The harms from abusing legal substances, like alcohol or tobacco products, are well-documented and point to a clear connection between pregnant women ingesting these substances and injury to the inchoate child.<sup>425</sup> Even though use of illegal drugs during pregnancy is

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<sup>421</sup> *Hendricks*, 521 U.S. at 367–68.

<sup>422</sup> *See supra* Part III.

<sup>423</sup> The framework suggested here does not address primary or even tertiary prevention efforts, which we believe are crucial. We address only the tact that should be taken when a woman who is pregnant is engaging in the use of harmful substances.

<sup>424</sup> *See supra* Part II.

<sup>425</sup> *See, e.g.*, Shah et al., *supra* note 177, at 278; England et al., *supra* note 162, 648–49.

less well-studied, and has been overstated and manipulated in the past as part of a larger “War on Drugs” narrative, the available research makes it clear that consumption of drugs, whether illegal or legal drugs used illegally, during pregnancy may also be harmful.<sup>426</sup> Even though each instance of prenatal exposure does not guarantee that the inchoate child will be harmed,<sup>427</sup> it is properly deemed “reckless behavior” because each use imposes an entirely avoidable, unnecessary, and unacceptable risk of grievous injury on the inchoate child.<sup>428</sup> Although not all children whose mothers abuse substances during pregnancy are injured, those children who are injured impose substantial costs on the state and society in general.<sup>429</sup>

*B. The Large Majority of Pregnant Substance Abusers Are Addicts First, and Need to Be Treated Accordingly*

As discussed in Part III, many pregnant women who abuse substances do so because they are addicted.<sup>430</sup> In fact, many of these women became pregnant after they were already addicted.<sup>431</sup> Calling pregnant substance abusers “the worst of the worst”<sup>432</sup> is stigmatizing and counterproductive because it mischaracterizes the real nature of the problem and results in the misdirection of efforts to address the problem.

Because most pregnant women who use drugs were addicts before they became pregnant,<sup>433</sup> the best policy is to squarely address their addiction. States that employ the public health approach, like Oregon,<sup>434</sup> are the best example of how to do this

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<sup>426</sup> See, e.g., Tortoriello et al., *supra* note 184, at 668; Trevizol et al., *supra* note 189; MARIJUANA, *supra* note 191.

<sup>427</sup> See MARIJUANA, *supra* note 191.

<sup>428</sup> See MODEL PENAL CODE § 2.02(2)(c) (2015) (“A person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor’s conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor’s situation.”).

<sup>429</sup> See Lupton et al., *supra* note 152 (noting that each child with FAS costs society an average of \$2 million during his or her lifetime).

<sup>430</sup> See Jones, *supra* note 302, at 797.

<sup>431</sup> See PUNISHING WOMEN, *supra* note 297, at 7 (arguing that most prenatal substance abusers are “addicts who become pregnant, not pregnant women who decide to use drugs”).

<sup>432</sup> See Dosani, *supra* note 327 (quoting Tennessee State Representative Terri Weaver).

<sup>433</sup> See, e.g., Jones, *supra* note 302, at 797, 799.

<sup>434</sup> See, e.g., OR. REV. STAT. ANN. § 430.905(1) (West 2015) (“Because the growing numbers of pregnant substance users and drug- and alcohol-affected infants place a heavy financial burden on Oregon’s taxpayers and those who pay for health care, it is the policy of this state to take effective action that will minimize these costs.”); *id.* § 430.915 (“[I]t is the policy of this state that the provider encourage and facilitate counseling, drug therapy and other assistance to the patient in order to avoid having the child, when born, become subject to protective services.”).

successfully, assuming they are adequately funded. They encourage participation by guaranteeing that disclosing an addiction will lead to help and avoid unpleasant consequences. Still, the state must have, and not hesitate to use, more coercive approaches when pregnant addicts will not voluntarily enter and remain in treatment.

*C. Providing Sufficient Drug Treatment Programs Is in the Government's Financial Interest*

Plans for combating drug addiction have traditionally broken down along partisan lines, with liberals supporting more funding for drug-treatment programs and conservatives emphasizing increased anti-drug enforcement.<sup>435</sup> However, there appears to be growing support among conservatives for increased spending on treating, rather than punishing, addicts.<sup>436</sup>

Increased drug treatment furthers many of the state's interests discussed in Part I. These include having a healthy populace by treating addiction as an illness,<sup>437</sup> protecting inchoate children's health because prenatal substance abusers who participate in drug treatment have more successful birth outcomes than those who do not,<sup>438</sup> and protecting the public fisc.<sup>439</sup>

Building, staffing, and maintaining sufficient treatment facilities unquestionably costs a lot of money. A pragmatic view of how expensive treatment programs really are, however, looks at inherent savings as well as cost expenditures. Drug treatment programs' savings come from two sources: decreased care costs as fewer people have birth defects caused by prenatal exposure and increased economic output as addicted women are provided the treatment they need.<sup>440</sup>

<sup>435</sup> See, e.g., Steve Mistler, *Impassioned Gov. LePage Calls for Drug Battle Reinforcements*, PORTLAND PRESS HERALD, <http://www.pressherald.com/2015/03/31/lepage-makes-second-attempt-to-expand-drug-enforcement/> [<http://perma.cc/6WBT-934R>] (last updated Mar. 31, 2015) (discussing Democrat state legislators' refusal to approve increased spending for anti-drug agents, judges, and prosecutors unless funds were similarly allocated for drug treatment programs).

<sup>436</sup> For example, Countering fellow Republicans' assertion that such programs were "another government handout for the poor," Ohio Governor John Kasich recently stated:

"Maybe you think we should put them in prison" . . . "I don't. I don't think that's a conservative position. Because the reality is, if you don't treat the drug addicted and the mentally ill and the working poor, you're gonna have them and they're gonna be a big cost to society. I think rehabbing them, getting them on their feet, training them and getting them jobs, is a conservative position."

Daniel J. McGraw, *Who Is the GOP's Strongest Candidate?*, POLITICO MAG. (Apr. 15, 2015), <http://www.politico.com/magazine/story/2015/04/john-kasich-is-the-gop-only-hope-for-president-116855?0=1> [<http://perma.cc/D2RY-4KKA>].

<sup>437</sup> See Jones, *supra* note 302, at 799.

<sup>438</sup> See, e.g., METHAMPHETAMINE ABUSE, *supra* note 228.

<sup>439</sup> See, e.g., McGraw, *supra* note 436; Lupton et al., *supra* note 152, at 42.

<sup>440</sup> There are other associated savings like reduced crime.

The savings from decreased care costs can provide a great deal of money for the cost of running a robust treatment program for pregnant substance abusers, many of whom may not require inpatient treatment. As discussed in Part II, it is estimated that each incidence of FAS costs society over \$2 million during that individual's lifetime,<sup>441</sup> and a 1% decrease in FAS would save society more than \$8 billion over the next generation.<sup>442</sup> Similarly, treating a single case of neonatal abstinence syndrome costs an additional \$53,400 in the immediate post-birth timeframe.<sup>443</sup> Given that prenatal exposure causes far more problems than just FAS, decreasing the overall incidence of prenatal substance exposure would result in even larger savings.

Even if the predicted 40–60% of pregnant women relapse after completing treatment,<sup>444</sup> simply keeping them “in the system” increases the likelihood of a healthy birth outcome<sup>445</sup>—which, when it happens, saves the state more than enough money to pay for multiple rounds of drug treatment.<sup>446</sup>

Pregnant substance abusers cost the state more than just increased care costs once their child is born. Because these women are addicted, it is more likely that they will not be working.<sup>447</sup> Treatment programs offer pregnant women more than just a chance to get clean. They can be the first step to building a more productive, successful life.<sup>448</sup>

#### *D. When Pregnant Substance Abusers Refuse to Enter Drug Treatment Programs, Civil Commitment Is Warranted*

Although a robust drug treatment program like the one discussed above will help many women who struggle with prenatal substance abuse, inevitably some women will refuse to enroll in a voluntary program and continue their substance abuse. It

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<sup>441</sup> Lupton et al., *supra* note 152, at 49.

<sup>442</sup> See Congdon, *supra* note 159, at 628.

<sup>443</sup> See Partick et al., *supra* note 264, at 1936 (also noting that “[n]ewborns with NAS were also more likely to be covered by Medicaid . . . and [to] reside in zip codes within the lowest income quartile”).

<sup>444</sup> NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 12 (2012) [hereinafter PRINCIPLES OF DRUG ADDICTION TREATMENT], [http://www.drugabuse.gov/sites/default/files/podat\\_1.pdf](http://www.drugabuse.gov/sites/default/files/podat_1.pdf) [<http://perma.cc/7N9N-97KG>] (noting that 40–60% of drug rehab patients relapse).

<sup>445</sup> See METHAMPHETAMINE ABUSE, *supra* note 228.

<sup>446</sup> PRINCIPLES OF DRUG ADDICTION TREATMENT, *supra* note 444, at 13 (noting that a full year of methadone treatment only costs approximately \$4,700 per patient).

<sup>447</sup> See Annalyn Kurtz, *1 in 6 Unemployed Are Substance Abusers*, CNN MONEY (Nov. 26, 2013, 8:12 AM), <http://money.cnn.com/2013/11/26/news/economy/drugs-unemployed/> [<http://perma.cc/BZ4K-Z98K>].

<sup>448</sup> See McGraw, *supra* note 436 (quoting Ohio Governor John Kasich).



should be emphasized that a pregnant woman's refusal to enroll does not make her morally blameworthy and should not result in punishment, because it may simply be a symptom of an addiction that she cannot control.<sup>449</sup> The problem with pure public health approaches, like Oregon's program,<sup>450</sup> is that there is no legal recourse for the inchoate child or state when this happens. Although the number of women who refuse voluntary treatment will hopefully be low, even one pregnant woman who abuses substances is too many because her abuse violates her inchoate child's right to be born with a sound mind and body. Just as the state intervenes to protect minors from abusive parents, it should intervene to protect the inchoate child's mind and body from its mother's reckless actions.

Tennessee's "safe harbor" provision, discussed previously,<sup>451</sup> provides a good example of how an ideal response to this scenario would operate. Although Tennessee law holds pregnant substance abusers criminally liable, it absolves these women of liability if they enroll in drug treatment.<sup>452</sup> This provision provides little help in practice because Tennessee has very few treatment opportunities available,<sup>453</sup> but if coupled with a robust treatment program like the one previously discussed, "safe harbor" would provide a meaningful choice. A better system would incorporate a rule like Wisconsin's and mandate civil commitment for treatment when there is a satisfactory showing that an expectant mother has refused treatment.<sup>454</sup> Because refusal to participate in treatment might be an involuntary symptom of addiction rather than a fully considered choice, criminal liability is not appropriate for a pregnant substance abuser who refuses voluntary treatment. Additionally, criminal sanction does little to protect the inchoate child's right to be born healthy. Drugs are likely more readily attainable in prison than inside a dedicated drug treatment facility,<sup>455</sup> and a prison is unlikely to provide the services needed to break the pregnant woman's addiction. Although not all women subjected to civil commitment are currently sent to an appropriate treatment facility, and building and operating sufficient in-patient treatment facilities will likely be expensive, the costs of doing so will be more than outweighed by the immense savings from getting addicted women clean and increasing the likelihood of healthy birth outcomes.

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<sup>449</sup> Board of Trustees, *supra* note 304, at 2667 (noting that prenatal substance abuse is "not simply the product of a failure of individual willpower").

<sup>450</sup> See *supra* Part III.A; see also Jones, *supra* note 302, at 798–800.

<sup>451</sup> See *supra* notes 325–39 and accompanying text.

<sup>452</sup> TENN. CODE ANN. § 39-13-107(c)(3) (West 2015).

<sup>453</sup> See Dosani, *supra* note 327.

<sup>454</sup> See WIS. STAT. ANN. § 48.193(1)(c) (West 2015).

<sup>455</sup> PUNISHING WOMEN, *supra* note 297, at 8 ("Putting [pregnant] women in jail—where drugs may be available but treatment and prenatal care are not—jeopardizes the health of pregnant women and their future children and does little to solve the underlying problem of addiction." (footnotes omitted)).

## CONCLUSION

Conservatives often argue that drug use and abuse is a choice, a personal moral failing.<sup>456</sup> But our fellow liberals are too quick to discount personal responsibility entirely, arguing that addiction should be treated only as a disease and that addicts should be offered only voluntary treatment.<sup>457</sup> These long-standing positions have given us the so-called war on drugs and criminal laws of the sort recently enacted in Alabama, Tennessee, and long-enforced in South Carolina.<sup>458</sup> But the liberal insistence on individual liberty and unwillingness to support paternalistic policies beget laws of the entirely voluntary sort that Oregon and Washington have enacted.<sup>459</sup>

Both of these approaches leave the rights and the needs of inchoate children out of the mix. The authors believe that children—both inchoate and living—are the most vulnerable, least politically powerful group in society and that they warrant our liberal compassion. In this circumstance, liberal compassion should support greater state intervention to protect these members of our community who cannot protect themselves.

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<sup>456</sup> See generally Nicholas Kristof, Opinion, *It's Not Just About Bad Choices*, N. Y. TIMES (June 13, 2015), <http://www.nytimes.com/2015/06/14/opinion/sunday/nicholas-kristof-its-not-just-about-bad-choices.html> (arguing that many social maladies such as homelessness and substance abuse are the result of a combination of poor individual choices and structural economic disadvantage).

<sup>457</sup> See *supra* Part III.A.

<sup>458</sup> See *supra* Part III.B.

<sup>459</sup> See *supra* Part III.A.

