

Prosecuting Poverty, Criminalizing Care

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PROSECUTING POVERTY, CRIMINALIZING CARE

WENDY A. BACH*

ABSTRACT

In 2013, state legislators sitting at the heart of America's opiate epidemic created the crime of fetal assault. Although they offered a fairly standard series of criminologic rationales to justify the legislation, they also posited that the creation of this crime was a precondition to secure treatment (or care) resources for women addicted to opiates. This extraordinary supposition—that criminalizing conduct creates a road to care—is an outgrowth of three inter-linked socio-legal trends: the building of the carceral state, the criminalization of poverty, and the rapid growth, since the late 1980s, of a new generation of problem-solving courts. Framed in this

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historical context, this legislative rationale seems less extraordinary and more a predictable outgrowth of these disturbing trends. As such, the legislative rationale also provides a unique window into what actually happens to those who are the target of this form of criminalized care and a basis from which to evaluate the wisdom of these trends.

An empirical study of the fetal assault law reveals two phenomena—what this Article terms prosecuting poverty and criminalizing care. The fetal assault legislation prosecutes poverty in the sense that this form of punitive care was reserved almost exclusively for low-income women. Although addiction crosses class, this form of “care” is targeted at the poor. And when legislation criminalizes care, it distorts any real meaning of care. The criminal court case files reveal that, for the forty-one low-income women who are the focus of this Article, any notion that care was central to their prosecutions was either entirely illusory or profoundly debased. In the healthcare system, there was no confidentiality. Every prosecution in the study relied heavily on information obtained by healthcare providers and provided to police and prosecutors in order to establish the elements of the crime. For the majority of women in the criminal system, there is no evidence in their court files that they were even offered or received care. Instead, the case files document what so many poor, low-level offenders face: jail, bail, fines, probation, and the ever-present threat of more punishment. For the few women whose files indicate that care was offered, that care came at a high punitive price. Failure to comply with treatment came at a still higher price. Ultimately, this story suggests, and this Article argues, that we must turn away from these historical trends. Rather than continuing to prosecute poverty and criminalize care, we must reconceptualize the problem far more broadly and turn to programs that heal both families and communities.

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INTRODUCTION

Sullivan County is the second oldest county in Tennessee.¹ It is nestled in the mountains and is the home of several small, once-thriving industrial cities.² It is also at the center of the Appalachian opiate epidemic.³ When you talk to people in Sullivan County about opiates, talk quickly turns biblical. Opiates are devastating, they are flooding the county. Pills are cheap, and are everywhere and easy to get. People in this region are desperate to do anything they can to stem the tide. Opiates and pregnancy are part of this flood.⁴

For that reason, in the spring of 2014, Barry Staubus, the elected District Attorney in Sullivan County, Tennessee, testified before the state's General Assembly.⁵ He was there to support a law that would create a new crime: the crime of fetal assault.⁶ Under the proposed law, a woman was guilty of assault if (1) she took a narcotic, (2) she did not have a prescription for that narcotic, and (3) her infant was harmed as a result.⁷ After all, when women take opiates during pregnancy, it can affect their infants in the short term.⁸ The primary diagnosis for these babies is Neonatal Abstinence Syndrome, or NAS.⁹ Although there are significant questions about

1. Richard S. Venable, *Living in Sullivan County*, SULLIVAN COUNTY TENN., <http://sullivancountyttn.gov/node/20> [<https://perma.cc/3PEV-2ZWK>].

2. *See About Us: NETWORKS Sullivan Partnership*, NETWORKS SULLIVAN PARTNERSHIP, <http://www.networkstn.com/about/sullivan-networks-partnership> [<https://perma.cc/W9Y2-BH9L>].

3. *See* Becky Campbell, *NE Tennessee Prosecutors to Sue Drug Manufacturers over Opioid Epidemic*, JOHNSON CITY PRESS (June 13, 2017, 4:09 PM), <https://www.johnsoncitypress.com/Health-Care/2017/06/13/Live> [<https://perma.cc/23F9-36Z6>].

4. *See infra* notes 13-14 and accompanying text.

5. *See Hearing on S.B. 1391 Before the S. Judiciary Comm.*, 108th Gen. Assemb., 59th Sess. 2:04:00 (Tenn. Mar. 18, 2014) [hereinafter *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*], http://tnga.granicus.com/MediaPlayer.php?view_id=269&clip_id=9050# [<https://perma.cc/86M6-KQDV>] (testimony of Barry Staubus, District Attorney of Sullivan County).

6. *See id.*

7. 2014 Tenn. Pub. Acts Ch. 820 (amending TENN. CODE ANN. § 39-13-107(c)) (effective Apr. 29, 2014) (expired July 1, 2016).

8. *See infra* notes 144-49 and accompanying text.

9. ANGELA M. MILLER ET AL., TENN. DEP'T. OF HEALTH, NEONATAL ABSTINENCE SYNDROME SURVEILLANCE ANNUAL REPORT 2016 1-2 (2016), https://www.tn.gov/content/dam/tn/health/documents/nas/NAS_Annual_report_2016_FINAL.pdf [<https://perma.cc/CX5V-F2LV>].

what particular circumstances lead to NAS,¹⁰ there is no question that some infants suffering from NAS shake and cry in the first weeks of their life.¹¹ Those with more serious symptoms can also spend some time in neonatal intensive care.¹² In 2013, the year before the Sullivan County District Attorney testified, eighty-six babies born in Sullivan County were diagnosed with NAS.¹³ For a county with a population of 156,000 and only three birthing hospitals, this felt like a serious part of the flood.¹⁴

When Staubus testified, he said everything one might expect. He talked about the problem of NAS, the harm, and the overwhelming crisis.¹⁵ He talked about infants suffering, punishing women, and protecting innocent lives.¹⁶ But he also said something that was surprising. Staubus said that the crime of fetal assault would actually benefit the same mothers the law targeted:

I think when we see this statute ... we are going to be able to bring lots and lots of women into a program we're creating specifically for drug addicted mothers and so I think that with this statute, what we'll see is that there will be a vacuum for that and we'll see a lot of programs and we'll see a lot of judges and we'll see a lot of prosecutors wanting to do this and recommending this and the judges I think will find the resources to do it.¹⁷

The law subsequently passed, making Tennessee the only state in the nation to explicitly criminalize in-utero transmission of

10. See *infra* note 142 and accompanying text.

11. See Emmalee S. Bandstra et al., *Prenatal Drug Exposure: Infant and Toddler Outcomes*, 29 J. ADDICTIVE DISEASES 245, 247, 249 (2010).

12. See *infra* note 149 and accompanying text.

13. ANGELA M. MILLER & MICHAEL D. WARREN, TENN. DEP'T OF HEALTH, NEONATAL ABSTINENCE SYNDROME SURVEILLANCE ANNUAL REPORT 2013 25 (2013), https://www.tn.gov/content/dam/tn/health/documents/nas/NAS_Annual_report_2013_FINAL.pdf [<https://perma.cc/K6PC-J8SF>].

14. See Venable, *supra* note 1; TENN. JUSTICE CTR., COUNTING THE COST: HOW THE GAP IN HEALTH CARE COVERAGE IMPACTS ALL TENNESSEANS 10 (2015), <https://tnjustice.org/wp-content/uploads/2015/10/2015-11-17-Counting-the-Cost-Report.pdf> [<https://perma.cc/7HSC-M67G>].

15. See *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5, at 2:13:00.

16. See *id.*

17. See *id.* at 2:15:09.

illegally obtained opiates to a fetus.¹⁸ During that period, at least 124 women were prosecuted for this offense.¹⁹ Although legislators and other supporters offered a variety of justifications for the law, including incapacitation, retribution, and deterrence,²⁰ this Article focuses on a fourth, and quite unique justification offered in support of the statute: that the creation of the crime would generate opportunities for the creation and distribution of social welfare support (in the form of addiction treatment) to the women who were prosecuted.

The extraordinary idea, that a state might create a crime not to punish or to exact retribution but to provide care to the defendants prosecuted for the offense, is not quite as dissonant as it might first sound. It in fact arises from a very particular history. As has been thoroughly documented by a variety of historians, sociologists, and legal scholars, since the 1970s social welfare resources targeted at poor families envisioned and created during the New Deal and the Great Society have been largely deconstructed.²¹ To the extent that these social welfare resources have been left in place or reconstructed, they are now found deeply intertwined with the punitive agencies of the state.²² In the world of courts, this intertwining is most evident in the extraordinary growth, since the late 1980s, of a new generation of problem-solving courts.²³ Both the broad trend of criminalizing social welfare support, and the more narrow trend of manifesting this collapse by locating resources to solve social welfare problems within courts, have been widely critiqued.²⁴ Central among these critiques is the fear that when the law merges care and punishment, it both draws more individuals into punitive institutions (what scholars have called “net-widening”)²⁵ and compromises the quality of the care overall.²⁶

Tennessee’s implementation of the fetal assault law provides a unique window into both on-the-ground results of this history and

18. *See infra* note 213.

19. *See infra* note 260 and accompanying text.

20. *See infra* Part III.

21. *See infra* notes 77-93 and accompanying text.

22. *See infra* notes 92-94 and accompanying text.

23. *See infra* Part I.B.

24. *See infra* notes 54-59 and accompanying text.

25. *See infra* notes 112-15 and accompanying text.

26. *See infra* notes 119-26 and accompanying text.

the implications of those trends. This Article is the first in a series of publications arising from an empirical study of the implementation of this law. Other parts of the study, and subsequent publications, will focus on other crucial questions, such as the effectiveness of the prosecutions in targeting women whose infants were diagnosed with NAS, the significance of the fact that it appears that the large majority of defendants were white women, and the reality of what has happened to care resources in poor communities. This initial Article, however, focuses on the reality of care as it has played out in the Eastern Appalachian region of Tennessee where the majority of prosecutions took place, and what this evidence might tell us about the idea that creating a crime creates care.

Specifically, this Article asks, and begins to answer, two central questions. First, if the fetal assault law was justified as using the mechanisms of the criminal system to provide care, was this care plan for everyone or just for some? The study data reveals what the Article terms prosecuting poverty: the prosecutions targeted almost exclusively poor women. So the first thing the data reveals is that if this were a road to access care, it was a road used not for everyone, but only for the poor.

Second, if the law was justified as a road to care, was the provision of care a priority? More precisely, what happened in the hospital setting and what happened in the criminal setting that promoted or undermined access to care? The answers provided here are three-fold. First, the prosecutions were supported by extensive medical evidence gathered in the hospital setting and shared with child welfare, police, and prosecutors.²⁷ The sheer breadth of this data collection and data sharing raises serious questions about how linking healthcare to prosecution undermines the confidentiality necessary for high-quality care.²⁸ Second, in the criminal system itself, the files reveal that for the majority of the low-income women prosecuted for this crime there is no indication that the provision of care was central to the prosecution.²⁹ What we learn instead is that the criminal system did not prioritize care. Instead the women faced what most people face when they are prosecuted: bail, jail, fees,

27. *See infra* Part IV.A.1.

28. *See infra* Part IV.A.1.

29. *See infra* Part III.D.

tremendous pressure to plead guilty, then monitoring and, often, more jail and more fines.³⁰ Although the law was described by its supporters as a “velvet hammer” leading to care, the focus of the prosecution was, to put it bluntly, just a hammer.³¹ Admittedly, that characterization does not describe every case. The court files that are at the center of this Article indicate that, for a minority of the women, the case did involve some offer of treatment.³² These offers of treatment, however, came with extraordinary risk. Treatment was often offered along with incarceration and exorbitant criminal justice fees, and the failure to comply resulted in even more harsh punishment.³³ Thus, to the extent prosecution provided a road to care, it was a road lined with tremendous risk of punishment. Importantly, these findings raise serious questions about the reality of what it means to link care to punishment, questions that have broad implications for both the health care and legal fields, lending more credence to the argument that linking care to punishment ultimately debases care.

To tell this socio-legal story, this Article proceeds in four parts. Part I draws the lens back, situating this Tennessee story in a long history of the links between punishment and care in poor communities in America, concluding with a focus on the existence of today’s version of problem-solving courts and the role of jails as care providers of last resort. Part I also focuses on the critiques waged, by a variety of scholars, against contemporary systems that link punishment and care, both in the court systems and beyond. Part II contextualizes the Tennessee story within the dramatic rise in opiate use and abuse over the last decade, provides data on the rising numbers of infants affected by opiate abuse, and frames what we know about the problem that Tennessee legislators were seeking to address. Part III turns to Tennessee. It describes the legislation at issue and argues, based on a detailed review of the legislative history, that the law was justified in large part as a means to provide care to women using opiates. Having laid that context, Part III turns to data from two sources. First, relying on data from Tennessee birth records and criminal court files, it demonstrates

30. *See infra* notes 312-16 and accompanying text.

31. *See infra* Part III.D.

32. *See infra* Part III.D.

33. *See infra* Part II.D.3-4.

that the law was targeted almost exclusively at poor women. Second, relying on detailed analysis of the court files of the cases of forty-one women who were prosecuted in the Eastern Appalachian region of the state, Part III lays out the treatment and punishment trajectories of the cases as they were recorded in those files. In the end, the files reveal that, while the law was justified in part as a road to care, for the poor women who were prosecuted, any notion that their receipt of care was a priority in their cases was either entirely illusory or profoundly debased. Part IV concludes the Article by relinking this story to the larger historical trends described in Part I. The concluding Part draws on some qualitative research data as well as some data from the fields of social work, psychology, and pediatrics, and argues that, rather than continuing to collapse care into punitive systems, we must reverse course by separating care from punishment and building systems that support both families and communities.

I. HYPERINCARCERATION AND THE CRIMINALIZATION OF POVERTY

For the last several years, there has been significant scholarly attention on the structures and historical groundings of hyperincarceration³⁴ and what many refer to as the carceral state.³⁵ Thanks to the work of scholars such as Michelle Alexander³⁶ and James Forman,³⁷ among many others,³⁸ what used to be known only

34. The prefix “hyper” as opposed to the prefix “mass” is used to connote the targeted nature of these socio-legal phenomena. See Wendy A. Bach, *The Hyperregulatory State: Women, Race, Poverty, and Support*, 25 YALE J.L. & FEMINISM 317, 336 (2014) (citing Frank Rudy Cooper, *Hyper-Incarceration as a Multidimensional Attack: Replying to Angela Harris Through The Wire*, 37 WASH. U. J.L. & POLY 67, 68-69 (2011)). Hyperincarceration targets particular communities by race, class, gender, and place. *Id.* For a more extensive discussion of the use of this term and its grounding in the work of Loïc Wacquant, see *id.* at 334-38.

35. The term “carceral state” describes “the sprawling, dynamic network of policies, institutions, personnel, and apparatuses through which federal, state, local, and tribal governments exercise power to police, prosecute, and punish.” Janet Moore, *Isonomy, Austerity, and the Right to Choose Counsel*, 51 IND. L. REV. 167, 177 (2018) (citing MARIE GOTTSCHALK, *CAUGHT: THE PRISON STATE AND THE LOCKDOWN OF AMERICAN POLITICS* (2015)).

36. See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010).

37. See generally JAMES FORMAN JR., *LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA* (2017).

38. See, e.g., NICOLE GONZALEZ VAN CLEVE, *CROOK COUNTY: RACISM AND INJUSTICE IN AMERICA’S LARGEST CRIMINAL COURT* (2016); GOTTSCHALK, *supra* note 35.

by those touched by or working in the criminal legal system, has become more common knowledge. The U.S. incarcerates a far higher percentage of its population than any other nation.³⁹ We not only incarcerate, but we impose punitive consequences far beyond the prison walls. Post-release conditions severely limit those subject to them,⁴⁰ and the presence of a conviction often severely restricts employment and housing opportunities, as well as voting rights.⁴¹ We ensnare poor people in a web of fines and fees from which escape is extremely difficult, resulting in a host of tangible harms.⁴² The burdens of this larger carceral state are born disproportionately by poor African American people, and the geographic concentration of these effects harms whole families and communities.⁴³

At the same time that scholars have been developing this rich literature on the carceral state, another group of scholars has focused on the criminalization of poverty in the social welfare field. It has long been true that the receipt of poverty-based support is both deeply stigmatized⁴⁴ and deeply implicated in structural racism.⁴⁵ Over the last several decades we have increasingly turned our attention to the way in which the mechanisms and modalities of criminal law agencies have moved over to the social welfare state. Two notable works in this area, Kaaryn Gustafson's *Cheating Welfare*⁴⁶ and Khiara Bridges' *The Poverty of Privacy Rights*⁴⁷ paint this picture. In *Cheating Welfare*, Gustafson argues persuasively that, since 1996, the government has increasingly imported the mechanisms and modalities of criminal law into the welfare system.⁴⁸

39. See ALEXANDER, *supra* note 36, at 6.

40. See GOTTSCHALK, *supra* note 35, at 241-57.

41. For an extensive discussion of the many consequences of a criminal conviction see generally Joy Radice, *The Reintegrative State*, 66 EMORY L.J. 1315 (2017).

42. For an extensive recent discussion of this problem, see PETER EDELMAN, NOT A CRIME TO BE POOR 8-15, 26 (2017).

43. See ALEXANDER, *supra* note 36, at 121-24.

44. See LINDA GORDON, PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE 1890-1935 5 (1994); MICHAEL B. KATZ, IN THE SHADOW OF THE POORHOUSE: A SOCIAL HISTORY OF WELFARE IN AMERICA 238-39 (1986).

45. See, e.g., JILL QUADAGNO, THE COLOR OF WELFARE: HOW RACISM UNDERMINED THE WAR ON POVERTY 4-5 (1994).

46. KAARYN S. GUSTAFSON, CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY (2011).

47. KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017).

48. See generally GUSTAFSON, *supra* note 46.

Recipients are finger-imaged, stings are run within welfare offices, and recipients are being made to feel that the very act of applying for and receiving benefits is a crime.⁴⁹ Drawing another piece of the picture, Bridges demonstrates that, in the area of public benefits and beyond, while privacy rights exist for those with economic privilege, poor mothers simply do not hold these rights.⁵⁰ For poor women, “state intervention, coercion, and regulation” are the norm.⁵¹

But these two systems, the carceral state on the one hand and the social welfare system on the other, do not work entirely independently. They are in fact, quite intertwined.⁵² For example, in *Prison, Foster Care, and the Systemic Punishment of Black Women*, Dorothy Roberts describes the way that prisons and foster care agencies work in tandem to heighten the punishment of black women and their children.⁵³ Similarly Victor Rios’s *Punished* paints a vivid picture of the way that social welfare institutions in highly policed areas are deeply intertwined with police and probation staff to stigmatize and criminalize young black and Latino men.⁵⁴

Building on Roberts’ focus on system intersections, I argued in *The Hyperregulatory State* that, for poor women, and disproportionately for poor African American women, social welfare support is closely tethered to punitive arms of the state.⁵⁵ These harms are often accomplished through a phenomenon I termed *regulatory intersectionality*: the means by which social welfare systems collect and transmit evidence of purportedly deviant conduct from social welfare systems to child welfare and criminal systems, resulting in escalating risk of harm and escalating harms for poor women who seek support.⁵⁶ I described the administrative underpinnings of these regulatory intersections and escalating harms in two contexts:

49. *See id.* at 56-57.

50. *See generally* BRIDGES, *supra* note 47.

51. *See id.* at 205.

52. *See generally* Bach, *supra* note 34.

53. Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1476 (2012).

54. VICTOR M. RIOS, *PUNISHED: POLICING THE LIVES OF BLACK AND LATINO BOYS* 38, 91-93 (2011).

55. *See* Bach, *supra* note 34, at 318.

56. *See id.* at 319.

welfare drug testing and earlier cases of the criminalization of in-utero drug transmission.⁵⁷

In another striking example of these intersections, in *The New Racially Restrictive Covenant: Race, Welfare, and the Policing of Black Women in Subsidized Housing*, Priscilla Ocen described the targeting of African American Section 8 voucher holders by an astounding and devastating set of collaborations between social welfare, juvenile, and criminal system actors in three California cities, including two suburban communities outside of Los Angeles.⁵⁸

These trends have been noted not only by legal scholars but also by historians and political scientists. For example, in 2017, noted political scientists Joe Soss and Vesla Weaver published a piece in the *Annual Review of Political Science* pointing out that the field of political science's focus on the devastation of democratic participation in what they term "race-class subjugated communities" has left political scientists unable to adequately respond to the building up of policing in those communities.⁵⁹ Central among their observations is that:

In [race-class subjugated] communities today, police, courts, and welfare agencies work alongside one another as interconnected authorities and instruments of governance. The densely woven fabric of social control encompasses a host of "collaborative practices and shared information systems between welfare offices and various branches of the criminal justice system." Core functions of social provision—such as housing, employment, physical and mental health, and education—are carried out on a large scale by agencies of the carceral state; in fact, prisons are now the largest public providers of mental health services in the United States. In agencies such as Child Protective Services, the pursuit of child welfare goals blends seamlessly into the policing and prosecution of criminal negligence and abuse. In traditional means-tested welfare programs, officials employ criminal logics

57. *See id.*

58. Priscilla A. Ocen, *The New Racially Restrictive Covenant: Race, Welfare, and the Policing of Black Women in Subsidized Housing*, 59 *UCLA L. REV.* 1540, 1543-45, 1576-77 (2012).

59. Joe Soss & Vesla Weaver, *Police Are Our Government: Politics, Political Science, and the Policing of Race-Class Subjugated Communities*, 20 *ANN. REV. POL. SCI.* 565, 565-68 (2017).

of “penalty for violation” to discipline clients and aggressively investigate and prosecute cases of welfare fraud as felonies.⁶⁰

A. *Historical Roots*

As discussed in more detail below, the Tennessee fetal assault law was justified, in large part, as a mechanism to connect women struggling with addiction to treatment.⁶¹ Although it would turn out that the vast majority of women who were prosecuted did not go to drug courts, the law was linked, during the hearings, to Tennessee’s drug courts, a set of courts that arise from the modern problem-solving court movement.⁶² These courts are designed to rehabilitate offenders.⁶³ As one legislator articulated it, the prosecutions were “offering [the] mothers the help they so desperately need but cannot obtain on their own.”⁶⁴

The idea that courts are a locus of care for poor communities is hardly a new one. In U.S. history these ideas can be traced to the 1920s and the Progressive Era.⁶⁵ Michael Willrich’s *City of Courts* provides a stunning window into this history as it was born and played out in Progressive Era Chicago.⁶⁶ In the 1920s, Chicago was at the forefront of progressive politics.⁶⁷ In that era, “[a] progressive understanding of the criminal implied a *social* conception of crime and criminal responsibility: a recognition that much of the human behavior that society called ‘crime’ was in fact caused by forces of biological destiny or socioeconomic circumstance beyond the individual’s control.”⁶⁸ This fundamental shift in assumptions about the roots of crime gave rise to a set of courts that “aimed not merely to punish offenders but to assist and discipline entire urban populations Urban court systems grew more powerful than ever during

60. *Id.* at 577 (citations omitted) (quoting GUSTAFSON, *supra* note 46).

61. *See infra* notes 225-28 and accompanying text.

62. *See infra* Part III.D.3.

63. *See* Eric J. Miller, *Drugs, Courts, and the New Penology*, 20 STAN. L. & POL’Y REV. 417, 441 (2009).

64. *See Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5.

65. *See* MICHAEL WILLRICH, *CITY OF COURTS: SOCIALIZING JUSTICE IN PROGRESSIVE ERA CHICAGO*, at xxi, xxxviii-xxxix (2003).

66. *See generally id.*

67. *Id.* at xxi, xxvi.

68. *Id.* at xxi.

these years, partly by incorporating the therapeutic disciplinary techniques of psychiatry, medicine, and social work into everyday judicial practice.”⁶⁹ The result was a series of courts targeting particular populations and issues.⁷⁰ In Progressive Era Chicago, there were domestic relations courts, targeting poor husbands who were failing to provide for their families; moral courts, targeting primarily prostitution; and juvenile and boys courts, targeting youth crime.⁷¹ There was, too, a “Psychopathic Laboratory,” deeply intertwined with eugenicist ideas and practices, that purported to examine and propose interventions for defendants, often to devastating effect.⁷² These courts aimed not just to hold individuals accountable for criminal actions, but to bring a multidisciplinary approach to reforming the individuals and, by extension, their communities.⁷³

Ultimately Willrich concludes that “[w]ithout discounting the meaningfulness and ethical claim of the progressives’ expansive social conception of crime ... we can now see that, in those local institutions where the progressives put their ideas into practice, the result was often an intensified scrutiny and control of individual offenders and their families.”⁷⁴ In other words, to the extent that the courts offered help, it was help at a cost. As to cause, Willrich states that

[m]uch of this outcome surely had to do with the fact that, in the absence of a more developed welfare state, progressives tried to enact so much of their social reform agenda through the machinery of criminal courts, where the lines between criminality and dependency, welfare and policing, vanished perhaps *too* easily.⁷⁵

For the purposes of this Article, that observation—that the absence of independent social welfare resources perhaps led to the outcomes Willrich described—is prescient. Although we do not find ourselves

69. *Id.* at xxviii-xxix.

70. *See id.* at xxix.

71. *Id.* at 132-33, 174, 210.

72. *Id.* at 242-45.

73. *Id.* at 241, 277.

74. *Id.* at 320.

75. *Id.* at 320-21.

in the exact same position today, it appears that current manifestations of the linking of social welfare provision to scrutiny, punishment, policing, and courts—described by scholars such as Roberts, Bridges, Ocen, Soss, Weaver, and myself—never quite went away and in fact began building up significantly in the mid-1960s.⁷⁶

For that history, we have to fast-forward from the Progressive Era, through the New Deal, to the early 1960s and the War on Poverty. The New Deal brought us several key poverty-focused support programs, including Old Age Insurance (colloquially social security), public housing, and Aid to Families with Dependent Children (colloquially welfare).⁷⁷ The War on Poverty significantly expanded the scope of support programs for low-income families.⁷⁸ In terms of social welfare state development, that era gave rise to significant federally funded support programs including Medicare, Medicaid, and Food Stamps.⁷⁹ It also saw a dramatic growth in Aid to Families With Dependent Children, a program that began during the New Deal as a fairly small program for white widows but would grow, during the 1960s, to support a far larger and more racially diverse population.⁸⁰ In this way, the social welfare state that Willrich stated did not exist during the Progressive Era came into existence during the 1930s and grew substantially in the 1960s.⁸¹ Despite this significant growth, the United States has never provided support in poor communities on the scale of other democracies.⁸² Key supports, such as universal healthcare, high-quality schools, and comprehensive mental health services, to name just a few, have never existed on the scale necessary to provide significant support.⁸³ In addition,

76. See generally *supra* notes 44-60 and accompanying text.

77. See WILLRICH, *supra* note 65, at 313; Lawrence M. Friedman, *Public Housing and the Poor: An Overview*, 54 CALIF. L. REV. 642, 642 (1966).

78. See GUSTAFSON, *supra* note 46, at 23-24.

79. See *id.*

80. Joel F. Handler, *The Transformation of Aid to Families with Dependent Children: The Family Support Act in Historical Context*, 16 N.Y.U. REV. L. & SOC. CHANGE 457, 460, 480-83 (1987).

81. See KATZ, *supra* note 44, at 246-47, 254; Bach, *supra* note 34, at 330-31.

82. See *Social Spending Stays at Historically High Levels in Many OECD Countries*, ORG. FOR ECON. CO-OPERATION & DEV. (October 2016), <http://www.oecd.org/els/soc/OECD2016-Social-Expenditure-Update.pdf> [<https://perma.cc/V49B-TNZT>].

83. See Bach, *supra* note 34, at 318-19.

the link between social support, punishment, policing, and courts continued apace.⁸⁴

Elizabeth Hinton's *From the War on Poverty to the War on Crime* traces the roots of these institutional intersections.⁸⁵ Hinton demonstrates that, with the exception of a brief period during the early 1960s during which the Johnson administration invested heavily in community programs delinked from local government, the War on Crime began nearly simultaneously with the War on Poverty and led to a series of structural links between those two systems that remain with us today.⁸⁶ Beginning in the late 1960s, federal policymakers began to not only radically disinvest in community-based support, but they began integrating the policing and surveillance of urban African American youth into the very fabric of U.S. urban social welfare programs.⁸⁷ Ever focused on "potentially delinquent" black youth, 1960s Youth-Service Bureaus integrated law enforcement into recreational, education, and employment programs.⁸⁸ "By the mid-1970s, federal disinvestment from the public sector and the remnants of the War on Poverty programs meant social welfare agencies in urban centers had little choice but to incorporate crime control measures in their basic programming in order to receive funding."⁸⁹

Over time, basic and vital social supports, such as public housing and schools, became sites for surveillance, policing, and criminalization.⁹⁰ Take, for example, the Carter-era Urban Initiatives Anti-Crime Program, which "establish[ed] stronger partnerships between social and law enforcement institutions and devot[ed] the majority of funds to surveillance and security needs."⁹¹ In so doing, the

84. *See id.*

85. ELIZABETH HINTON, *FROM THE WAR ON POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA* (2016).

86. *See id.* at 61-62. For a more detailed history of Community Action and the mandate that Community Action programs be designed and run with the "maximum feasible participation" of the poor and the political contest over community control, see generally Wendy A. Bach, *Mobilization and Poverty Law: Searching for Participatory Democracy Amid the Ashes of the War on Poverty*, 20 VA. J. SOC. POL'Y & L. 96 (2012) and the sources cited therein.

87. HINTON, *supra* note 85, at 61-62.

88. *Id.* at 119.

89. *Id.* at 236.

90. *See id.*

91. *Id.* at 288.

Program “vastly enhanced the scope and power of punitive authorities in the most deteriorated and segregated public housing sites in the country.”⁹² By that time, “law enforcement and criminal justice institutions could involve themselves in virtually any community-based effort.”⁹³

This history has many implications, two of which are important to contextualizing the Tennessee story. The first is the rise of today’s problem-solving courts, and the second is the reality and effect today of the placing of care resources into punitive arms of the state.

B. Today’s Problem-Solving Courts

In the late 1980s, as the War on Crime continued to escalate, the prison population grew exponentially.⁹⁴ At the same time, the social safety net remained profoundly inadequate to meet the needs of those struggling in poor communities and resources for mental health deteriorated.⁹⁵ As a result, judges saw before them an increasingly devastated and systemically failed population.⁹⁶ In what in retrospect seems an inevitable development, the modern version of the problem-solving court movement was born.⁹⁷ Since the founding of the Miami Drug Court in 1989, this movement, posited as a direct response to the War on Drugs and the presence, in courts, of individuals with enormous need, has exploded.⁹⁸ Rather than focusing efforts on shrinking the feeder systems that led to the criminalization of wide swaths of poor communities or the devastation of social welfare resources in what Soss and Weaver call “race-class subjugated communities,”⁹⁹ the problem-solving court movement took this criminalization as a given.¹⁰⁰ In the face of this, they

92. *Id.*

93. *Id.* at 293.

94. *Id.* at 314.

95. *See id.* at 314-16.

96. *See* Jane M. Spinak, *Romancing the Court*, 46 FAM. CT. REV. 258, 270 (2008).

97. While the modern problem-solving court movement can be traced to the founding of the Miami Drug Court in 1989, the idea of courts as problem solvers finds older roots in the history of juvenile and family courts. *See* Spinak, *supra* note 96, at 259-60; *see also* Miller, *supra* note 63, at 420.

98. *See generally* Miller, *supra* note 63.

99. *See* Soss & Weaver, *supra* note 59, at 567.

100. *See* Miller, *supra* note 63, at 432.

sought a way to respond for those individuals who found themselves subject to prosecution and potential incarceration.¹⁰¹ Today there are over 3000 problem-solving courts found throughout every state in the nation.¹⁰² They include not only the traditional drug courts, but a wide range of specialized courts, including domestic violence courts, mental health courts, veterans courts, and community courts, just to name a few.¹⁰³ They are supported by significant federal, state, and local funding streams, a series of well-funded national organizations, and a robust research agenda evaluating their effectiveness along several metrics.¹⁰⁴

Echoing their progressive precursors, problem-solving courts embrace rather than reject the central role of courts and judges in solving social problems. As described in 2007 by the Center for Court Innovation (CCI), a leader in the field: “At their core was the idea that it was no longer enough just to arrest, process, and adjudicate an offender, but law enforcement officers, prosecutors, judges, and probation officers also needed to try to reduce recidivism, improve public confidence in justice, and prevent crime down the road.”¹⁰⁵ To accomplish these objectives, problem-solving courts incorporate a rehabilitative model within the court system, with the judge at the helm.¹⁰⁶

Problem-solving courts purport to accomplish this objective by “customizing punishment ... thereby reducing the likelihood of repeat offending and increasing the likelihood that the offender can become a productive member of society.”¹⁰⁷ There is broad consensus

101. *See id.* at 436-37.

102. *About NADCP*, NAT'L ASSOC'N DRUG CT. PROFS., www.nadcp.org/about [<https://perma.cc/EDM5-8NBF>].

103. *See* ROBERT V. WOLF, CTR. FOR CT. INNOVATION, PRINCIPLES OF PROBLEM-SOLVING JUSTICE 1 (2007), <https://www.courtinnovation.org/sites/default/files/Principles.pdf> [<https://perma.cc/2VE7-959D>].

104. *See* Suzanne M. Strong et al., *Census of Problem-Solving Courts, 2012*, BUREAU JUST. STATS. (Oct. 12, 2016), <https://www.bjs.gov/content/pub/pdf/cpsc12.pdf> [<https://perma.cc/3GCS-9ZEU>]; *Statewide Coordination of Problem-Solving Courts: A Snapshot of Five States*, CTR. FOR CT. INNOVATION, https://www.bja.gov/Publications/CCI_ProblemSolvingCoord.pdf [<https://perma.cc/MMU2-5WM7>].

105. WOLF, *supra* note 103, at 1.

106. *See* Mitchell B. MacKinem & Paul Higgins, *Introduction to PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?*, at vii (Paul Higgins & Mitchell B. MacKinem eds., 2009).

107. WOLF, *supra* note 103, at 7.

among those who support and promote this movement that courts and judges are “at the hub of a complex system.”¹⁰⁸ They bring a wide range of services together under one roof.¹⁰⁹ For example the Red Hook Community Justice Center, highlighted by CCI, brings in “local non-profits and government agencies that have agreed to place staff on-site to provide health care, youth counseling, job training, and other needed services.”¹¹⁰ Access to these services for noncriminally involved community members is sometimes present in the courts, but it appears as an afterthought. For example, in CCI’s highlighting of the Seattle Community Court, another court that offers extensive colocation of services, “[s]ervices are geared primarily to mandated offenders but are also available on a voluntary basis to walk-ins from the community.”¹¹¹

These courts have been subject to significant critiques, three of which are central for understanding the Tennessee case study. First, these courts have been critiqued for what scholars call “net-widening.”¹¹² This critique argues that, because of the nature of the court processes, individuals who might have otherwise either been diverted out of the system entirely or would have received very minimal punishment, are instead brought within far more invasive and long-term monitoring by the courts.¹¹³ This is true both in drug courts and in community courts—those courts established specifically to use community-based adjudication to solve intractable

108. *Id.* at 5.

109. *See id.*

110. *Id.* at 6.

111. *Id.* at 7.

112. Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1551-61 (2004).

113. *Id.*; see also Richard C. Boldt, *A Circumspect Look at Problem-Solving Courts*, in PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?, *supra* note 106, at 13, 17 (“[D]rug treatment courts and many other problem-solving courts serve to extend the reach of the criminal system, by retaining in the system defendants who otherwise might not be subject to criminal justice control and by failing to divert a significant number of other offenders—often those facing more serious changes—into alternative treatment-based dispositions. Drug treatment courts thus may produce a ‘net widening’ effect by channeling into the system defendants who would otherwise have avoided a criminal justice system disposition.”); Jane M. Spinak, *A Conversation About Problem-Solving Courts: Take 2*, 10 U. MD. L.J. RACE RELIG. GENDER & CLASS 113, 118 (2010) (“[T]he creation of problem-solving courts may result in more families being drawn into the court system—often referred to as ‘net widening’—because the lack of community resources leaves the court as the only place to secure help.” (footnotes omitted)).

problems in poor communities.¹¹⁴ For example, the first community court, established in New York City, was part and parcel of the broken windows theory of policing and was “designed to handle a wide range of low-level misdemeanor offenses that generally were not prosecuted at all prior to ... the establishment of these new courts.”¹¹⁵

Second, critics worry that problem-solving courts inevitably draw social welfare resources out of communities and voluntary settings and into inevitably coercive courts.¹¹⁶ For example, Anthony Thompson argued in 2002 that linking the provision of social services to the existence of community courts provides low-income communities with what might be a less than ideal option.¹¹⁷ As he framed it, “[i]n the absence of other alternatives, [community residents] embrace the notion of community courts because these courts bring with them a wide range of services. Given the choice, however, communities may prefer to access the services without the court structure.”¹¹⁸

There is some evidence that Thompson’s early fears are proving prescient. In a recent symposium on community courts, Robin Steinberg and Skylar Albertson explained that, “most community courts follow a postdisposition model for the provision of social services, meaning that the courts require admission of guilt before they will grant individuals access to court-sponsored resources.”¹¹⁹ Similarly, critics have argued that the need for mental health courts, another prominent form of problem-solving courts, is

a direct response to the problem of large numbers of persons with mental disabilities coming into the criminal justice system as a consequence of a history of deinstitutionalization and the failure of the community mental health system. Some experts have observed that these problem-solving courts, while essential in dealing with this influx in the short term, absorb resources

114. Miller, *supra* note 112, at 1551-61; Anthony C. Thompson, *Courting Disorder: Some Thoughts on Community Courts*, 10 WASH. U. J.L. & POL’Y 63, 63 (2002).

115. Boldt, *supra* note 113, at 18.

116. *See id.* at 19.

117. Thompson, *supra* note 114, at 91-92.

118. *Id.* at 92.

119. Robin Steinberg & Skylar Albertson, *Broken Windows Policing and Community Courts: An Unholy Alliance*, 37 CARODOZO L. REV. 995, 1016 (2016); *see also* Spinak, *supra* note 96, at 267 (“[M]ost treatment courts require a guilty plea, admission to child maltreatment, or waiver of other due process rights as conditions of participating in the court.”).

that could be directed toward ameliorating the problems more systemically.¹²⁰

Finally, critics argue that, even in the face of sincere dedication to centering rehabilitation, punishment almost inevitably prevails.¹²¹ As Jane Spinak explains, “you can hold out the promise of cure in a court system only if you have the means to enforce that cure. Failure to seek or submit to a cure or even failure to succeed in that cure inevitably leads to escalating punishment.”¹²² Often that punishment is far more severe than the person would have received had they not participated in the drug court.¹²³

In 2009, the National Association of Criminal Defense Lawyers issued a report on problem-solving courts.¹²⁴ They highlighted the elevated punishments associated with failure in drug court in comparison to the punishments defendants would have received had they simply pled guilty to the offense.¹²⁵

For example, a simple crack possession case will usually net a 10- to 20- day jail sentence in Manhattan. A defendant may wait 20 to 30 days for placement in a [drug court] program. If defendants enter a treatment program and fail, they may be sentenced to six months in jail.¹²⁶

So while problem-solving courts may at times provide some assistance, these successes come at the cost of bringing more individuals into the system, elevating the risk and severity of punishment for those who participate, increasingly linking the provision of care to the mechanisms of punishment, and depriving communities of social welfare resources that might otherwise be there to assist those who might voluntarily seek support.

120. Boldt, *supra* note 113, at 19.

121. See Spinak, *supra* note 96, at 265.

122. *Id.*

123. See *id.* at 267.

124. NAT'L ASS'N OF CRIM. DEF. LAW., AMERICA'S PROBLEM-SOLVING COURTS: THE CRIMINAL COSTS OF TREATMENT AND THE CASE FOR REFORM (2009), <https://www.nacdl.org/drugcourts/> [<https://perma.cc/MZ9L-YYQU>].

125. *Id.* at 8, 29.

126. *Id.* at 29 (footnotes omitted).

C. Jail as the New Safety Net

Another perhaps inevitable result of lack of investment in community-based social welfare services and the linking of social welfare resources to punitive institutions is the unique role that jails have come to play in providing social support to those in poverty. Carolyn Sufrin's *Jailcare: Finding the Safety Net Behind Bars* provides a window into this reality.¹²⁷ Sufrin is a physician and anthropologist who worked for many years in a women's jail in San Francisco.¹²⁸ Starting with the strange fact that the incarcerated are the only population in the United States with a constitutional right to healthcare,¹²⁹ Sufrin provides a rich and nuanced description of how care is provided in that setting.¹³⁰ She argues, starkly, that, "[j]ail is the new safety net."¹³¹ Throughout her narrative, we meet women who choose to be incarcerated in order to receive care and who come to count on jail as a place where they can receive that care.¹³² Sufrin provides not only a nuanced look into these realities, but a sharp and clear indictment of the structures that lead to women viewing jail as a respite and a source of care.¹³³ As she frames it,

[j]ailcare is a symptom of social failure, of abandonment of a group of people that includes poor, predominantly black women, whose reproduction has been vilified in policies and broader cultural narratives. Jailcare illustrates how mass incarceration and the frayed safety net are matters of reproductive justice, for they impair women's abilities to parent their children in stable and safe environments. The safety net's shortcomings are not simply a matter of quantity or funding, although shortages of public mental health care, housing, and addiction treatment absolutely play a role. Safety net inadequacies also emerge from the ways services are delivered, from ... the nature of the interpersonal relationships and how people are made to feel when accessing services Jailcare reflects the failure of society

127. See CAROLYN SUFRIN, *JAILCARE: FINDING THE SAFETY NET FOR WOMEN BEHIND BARS* (2017).

128. *Id.* at ix-xi.

129. See *id.* at 7 (citing *Estelle v. Gamble*, 429 U.S. 97 (1976)).

130. See *id.* at 6-7.

131. *Id.* at 5.

132. See *id.* at 208-26.

133. See *id.* at 215-17.

to provide an adequate safety net and the failure of our social imagination to consider that these women have contributions to make to society.¹³⁴

In the historical context and current reality laid out above, the idea that creating a crime might be a good way to get care to women struggling with substance abuse seems perhaps slightly less dissonant. Given the state of community-based social welfare resources and the increasingly central role that courts and jails purport to play in providing care, it makes a certain amount of sense that legislators thought that this might provide a road to care. Tennessee is, after all, facing a profound health crisis.¹³⁵ It is to that crisis, and the Tennessee response, that the following Part turns.

II. OPIATES AND NEONATAL ABSTINENCE SYNDROME

Tennessee's fetal assault legislation was framed as a response to what prosecutors and judges across the state considered a crisis facing infants in Tennessee.¹³⁶ Proponents of the bill shared video footage of images of infants suffering from Neonatal Abstinence Syndrome, the primary medical diagnosis of infants who are exposed to opiates prenatally and exhibit a defined set of symptoms in the weeks after birth.¹³⁷ These images are powerful, showing neonatal intensive care units filled with infants shaking and crying, seemingly uncontrollably.¹³⁸ These images drove the legislation.¹³⁹ Barry Staubus, the head District Attorney for Sullivan County, testified in favor of the bill in the Spring of 2014 and characterized the crisis in dramatic terms: "We are drowning in east Tennessee ... with these babies and we feel powerless."¹⁴⁰

Neonatal Abstinence Syndrome, or NAS, is a diagnosis associated with infants exposed in-utero to opiates, as well as to some other prescription medications.¹⁴¹ Not all infants who are exposed develop

134. *Id.* at 236.

135. *See* MILLER ET AL., *supra* note 9, at 2.

136. *See* *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5.

137. *Id.* at 2:09:00-2:12:15.

138. *See id.*

139. *See id.*

140. *Id.* at 2:14:05.

141. While NAS is predominantly associated with opiate exposure, it can also arise from

symptoms of NAS.¹⁴² Those who do exhibit withdrawal symptoms “ranging from feeding difficulties to seizures.”¹⁴³ There is no question that there are significant short-term effects of NAS.¹⁴⁴ Infants diagnosed with NAS can have increased rates of perinatal mortality, exhibit “[s]ignificant disruption [of] sleep patterns” and are at an increased “risk of SIDS and SUDI (sudden unexpected death in infancy).”¹⁴⁵ They are “more likely to have respiratory diagnoses ... to have low birthweight ... have feeding difficulties ... and have seizures.”¹⁴⁶ NAS cases range dramatically in the severity of symptoms and the necessary interventions, and there is significant debate in the medical literature about the appropriate care of infants diagnosed with NAS.¹⁴⁷ Many infants require only monitoring and do well through interventions such as “rooming-in,” in which mothers and infants stay together in the same room, and breastfeeding.¹⁴⁸ Others require more serious short-term interventions including medication and stays in the neonatal intensive care unit.¹⁴⁹

While some short-term effects of NAS are well documented, and the medical community is making substantial progress in the treatment of NAS in infants,¹⁵⁰ there is no conclusive evidence that

exposure to other substances. See CE Witt et al., *Neonatal Abstinence Syndrome and Early Childhood Morbidity and Mortality in Washington State: A Retrospective Cohort Study*, 37 J. PERINATOLOGY 1124, 1124 (2017).

142. The question of what kinds of exposure and what level of exposure will lead to NAS is not well understood. See Stephen W. Patrick et al., *Prescription Opioid Epidemic and Infant Outcomes*, 135 PEDIATRICS 842, 843 (2015) (citing Mark L. Hudak et al., *Neonatal Drug Withdrawal*, 129 PEDIATRICS 540, 542 (2012)).

143. *Id.*

144. Rod W. Hunt et al., *Adverse Neurodevelopmental Outcome of Infants Exposed to Opiate In-Utero*, 84 EARLY HUM. DEV. 29, 29, 32 (2008).

145. *Id.* at 32.

146. Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009*, 307 JAMA 1934, 1936 (2012).

147. See generally Matthew R. Grossman et al., *Neonatal Abstinence Syndrome: Time for a Reappraisal*, 7 HOSP. PEDIATRICS 115, 115-16 (2017) (alleging that reliance on the traditional method of diagnosis and treatment of NAS could be outdated and hindering healthcare providers' ability to assess the effectiveness of nonpharmacological interventions recommended by the American Academy of Pediatrics); Kathryn Dee L. MacMillan & Alison Volpe Holmes, *Neonatal Abstinence Syndrome and the Pediatric Hospitalist: 5 Years Later*, 8 HOSP. PEDIATRICS 51, 51 (2018) (noting the “significant variability in NAS care practices across U.S. hospitals”).

148. See Grossman et al., *supra* note 147, at 116; Macmillan & Holmes, *supra* note 147, at 52.

149. See Patrick et al., *supra* note 146, at 1939.

150. See *supra* notes 147-49 and accompanying text.

NAS has any long-term effects.¹⁵¹ While some studies seem to indicate that in-utero opiate exposure may correlate with longer-term developmental effects,¹⁵² other studies have been inconclusive or have reached the opposite conclusion.¹⁵³ In studies that have indicated correlations with various conditions, researchers found “no significant differences” when they took other factors such as “maternal education, [socioeconomic status], home environment, maternal/caregiver IQ, and maternal psychological symptoms” into consideration.¹⁵⁴

The rising number of NAS diagnoses over the last two decades has been driven by dramatic increases in the use and abuse of opiates in the region, as well as perhaps due to an increase in mechanisms to track the cases.¹⁵⁵ Although it has long been true that rates of illegal drug use and abuse are fairly consistent across class and race,¹⁵⁶ the rise of opiates in the early decades of the twenty-first century represent a significant set of demographic and geographic shifts.¹⁵⁷ The problem stems, to a large degree, from dramatic increases in opioid prescriptions.¹⁵⁸ “From 1991 to 2011, there was a near tripling of opioid prescriptions dispensed by U.S. pharmacies: from 76 million to 219 million prescriptions.”¹⁵⁹ Nationally, rates of prescription opiates rose steadily from 2006 to

151. See Bandstra et al., *supra* note 11, at 247-48.

152. *Id.* at 248.

153. See *id.* at 247-48; Hendrée E. Jones et al., *The Complexity of Examining Developmental Outcomes of Children Prenatally Exposed to Opiates. A Response to the Hunt et al. Adverse Neurodevelopmental Outcome of Infants Exposed to Opiates In-Utero*, 85 EARLY HUM. DEV. 29 (2009).

154. Jones et al., *supra* note 153, at 271.

155. See Grossman et al., *supra* note 147, at 115.

156. See U.S. DEP'T OF HEALTH & HUMAN SERVS.: SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 26 (Sept. 2014), <https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf> [https://perma.cc/YD7N-BFVR] (“There were no statistically significant differences in the rates of current illicit drug use between 2012 and 2013 for any of the racial/ethnic groups.”).

157. *U.S. Prescribing Rate Maps*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 31, 2017), <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> [https://perma.cc/6WZG-YYX6].

158. *Increased Drug Availability Is Associated with Increased Use and Overdose*, NAT'L INST. ON DRUG ABUSE (Jan. 2018), <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-abuse-heroin-use/increased-drug-availability-associated-increased-use-overdose> [https://perma.cc/C8WP-KMJD].

159. *Id.*

2012, and then began falling.¹⁶⁰ At the height of prescription rates in 2012, there were over 255 million opiate prescriptions written.¹⁶¹ This meant that for every 100 people, doctors wrote 81.3 prescriptions.¹⁶² Although national rates began to fall after 2012 to just under 215 million prescriptions, or a rate of 66.5 prescriptions per 100 people in 2016, these falling national figures hide significant regional and state variations.¹⁶³ Rates remain tremendously high in several regions, including Appalachia, the South, and several states in the Midwest and Great Lakes Region.¹⁶⁴ In 2016, in Tennessee, Arkansas, and Alabama, there were over 107 opiate prescriptions written for every 100 people.¹⁶⁵ In Louisiana, Mississippi, South Carolina, Oklahoma, Kentucky, West Virginia, Indiana, and Michigan, rates fell between 83 and 107 prescriptions per 100 people.¹⁶⁶

Not only are these prescription rates concentrated in particular regions, but they are evident at disproportionate rates among those with lower incomes.¹⁶⁷ “[T]he Medicaid patient population is more likely to receive prescriptions for opioid pain medications and to have opioids prescribed at higher doses and for longer periods of time than the non-Medicaid patient population.”¹⁶⁸ In addition, “[r]acial-ethnic disparities in opioid prescription have been documented nationally, with minorities being less likely to receive opioids.”¹⁶⁹ White women are in fact significantly more likely than African American women to use and abuse opiates and to die of an

160. *Id.*

161. *U.S. Prescribing Rate Maps*, *supra* note 157.

162. *Id.*

163. *Id.*

164. See *U.S. State Prescribing Rates, 2016*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 31, 2017), <https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> [<https://perma.cc/B9FX-G8Z3>].

165. *Id.*

166. *Id.*

167. See U.S. DEPT OF HEALTH & HUMAN SERVS., PUB NO. (SMA) 16-4978, A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS 6 (2016), https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf [<https://perma.cc/YM5V-2557>].

168. *Id.*

169. Astha Singhal et al., *Racial-Ethnic Disparities in Opioid Prescriptions at Emergency Department Visits for Conditions Commonly Associated with Prescription Drug Abuse*, 11 PLOS ONE 1, 2 (2016) (citing M. J. Pletcher et al., *Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in U.S. Emergency Departments*, 299 JAMA 70 (2008)).

opiate overdose.¹⁷⁰ This confluence of factors leads to a concentration of addiction in several white, poor, rural and geographically concentrated regions in the states.¹⁷¹

Along with these rises in the rates of opiate prescriptions is a dramatic increase in the number of overdose deaths due to opiates.¹⁷² As reported by the Centers for Disease Control, “[o]pioids were involved in 42,249 deaths in 2016, and opioid overdose deaths were five times higher in 2016 than 1999.”¹⁷³ Again, these deaths are geographically concentrated with the highest rates occurring in West Virginia, New Hampshire, Kentucky, Ohio, and Pennsylvania.¹⁷⁴

Neither women as a whole nor pregnant women are exempt from these statistics.¹⁷⁵ Between 1999 and 2010, “yearly prescription opioid overdose deaths among women increased from 1287 to 6631. These numbers represent a 400 percent increase over 10 years.”¹⁷⁶ Like the overall trends, these trends manifest disproportionately among low-income women.¹⁷⁷ One study, “using data from Medicaid-enrolled pregnant women from 47 states in the United States reported that 21.6 percent of the women filled at least one opioid prescription during their pregnancy.”¹⁷⁸ In Tennessee, “[f]rom 1995-2009, pregnancy-related use of opioid analgesics nearly doubled among [Medicaid] participants.”¹⁷⁹ Although rates are higher among

170. See Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CALIF. L. REV. 781, 793-94 (2014) (citing COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 538: NONMEDICAL USE OF PRESCRIPTION DRUGS 2 (2012), <https://www.ncbi.nlm.nih.gov/pubmed/22996128>); Allen A. Mitchell et al., *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976-2008*, 205 AM. J. OBSTETRICS & GYNECOLOGY 51.e1, 51.e5 (2011); Leonard J. Paulozzi et al., *Vital Signs: Overdoses of Prescription Opioid Pain Relievers: United States, 1999-2009*, 60 MORBIDITY & MORTALITY WKLY. REP. 1487, 1488 (2011), <https://www.cdc.gov/mmwr/pdf/wk/mm6043.pdf> [<https://perma.cc/SZM7-5YG2>] (reporting that non-Hispanic white women have a higher drug overdose death rate than women of other races).

171. Paulozzi et al., *supra* note 170, at 1487-88.

172. *Drug Overdose Death Data*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 19, 2017), <https://www.cdc.gov/drugoverdose/data/statedeaths.html> [<https://perma.cc/227Q-9J9X>].

173. *Id.*

174. *Id.*

175. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 156, at 1, 3.

176. *Id.* at 3 (citations omitted).

177. See Mahsa M. Yazdy et al., *Prescription Opioids in Pregnancy and Birth Outcomes: A Review of the Literature*, 4 J. PEDIATRIC GENETICS 56, 57 (2015).

178. *Id.*

179. Peter R. Martin & A. J. Reid Finlayson, *Opioid Use Disorder During Pregnancy in*

poor women, women who use commercial health plans and are therefore less likely to be low income “also showed high rates (14.4%) of prescription opioid dispensing between 2005 and 2011.”¹⁸⁰

These trends lead to a concentration of cases among infants and their mothers both nationally and in Tennessee.¹⁸¹

Between 2006 and 2012, the rate of infant and maternal hospitalizations related to substance use increased substantially, from 5.1 to 8.7 per 1,000 infant hospitalizations and from 13.4 to 17.9 per 1,000 maternal hospitalizations In 2012, among the neonatal stays with a substance-related condition, approximately 60% were related to neonatal drug withdrawal or NAS. Among maternal stays related to substance abuse, almost one-fourth involved opioids.¹⁸²

These trends are also notable in Tennessee.¹⁸³ “From 2009-2011, the rate of NAS among infants in [Tennessee Medicaid] increased from 6.0-10.7 per 1000 births and to 11.6 in 2013—representing a 16-fold increase since 2000.”¹⁸⁴ As the Tennessee Department of Health noted in becoming the first state in the nation to require data reporting on NAS from providers, “[s]ince the early 2000s, the incidence of NAS in Tennessee has increased by 10-fold, far exceeding the national increase (3-fold over the same time period).”¹⁸⁵

To understand the NAS trends, one has to understand a little more about opiate use by pregnant women. The first thing to know is that a large proportion of NAS cases develop as an expected result of the treatment of pregnant women for opiate addiction.¹⁸⁶ Although there are some small and early studies that seem to suggest that women can detox during pregnancy, and therefore limit the exposure of the fetus to opiates,¹⁸⁷ that research has been

Tennessee: Expediency vs. Science, 41 AM. J. DRUG & ALCOHOL ABUSE 367, 367 (2015).

180. Yazdy et al., *supra* note 177, at 57.

181. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 156, at 6.

182. *Id.* (citations omitted).

183. See Martin & Finlayson, *supra* note 179, at 367.

184. *Id.* (citations omitted).

185. MILLER ET AL., *supra* note 9, at 2.

186. Robert D. Stewart et al., *The Obstetrical and Neonatal Impact of Maternal Opioid Detoxification in Pregnancy*, 209 AM. J. OBSTETRICS & GYNECOLOGY 267, 267 (2013).

187. See, e.g., *id.* at 267; Jennifer Bell et al., *Detoxification from Opiate Drugs During Pregnancy*, 215 AM. J. OBSTETRICS & GYNECOLOGY 374, 374 (2016).

subject to challenge,¹⁸⁸ and the long-standing medical consensus is that pregnant women who are addicted to opiates should be treated throughout their pregnancies with medication-assisted therapy, or MAT.¹⁸⁹ This means that pregnant women who suffer from addiction are regularly prescribed opiates during their pregnancies.¹⁹⁰ The majority of infants who are born with NAS manifest these symptoms because of in-utero exposure to MAT.¹⁹¹ In addition, while it is true that some infants develop NAS as a result of exposure to illicit substances, comparatively few NAS cases arise from exposure to only illicit substances.¹⁹² The Tennessee Department of Health, relying on mandated reporting data,¹⁹³ breaks exposure down into three major categories: prescription only, illicit only, and both prescription and illicit use.¹⁹⁴ According to this data, the majority of NAS cases (52.5 percent in 2016) result from prescription use of opiates, predominantly the use of MAT.¹⁹⁵ Less than 20 percent (19.4 percent in 2016) result from purely illicit exposure, and finally the remaining cases (27.2 percent) result from a combination of illicit and legal exposure.¹⁹⁶ In Tennessee in particular, illegal (as

188. See John J. McCarthy & Mishka Terplan, *Detoxification from Opiates During Pregnancy: Stressing the Fetal Brain*, 215 AM. J. OBSTETRICS & GYNECOLOGY 670, 670 (2016). But see Craig V. Towers & Mark D. Hennessy, *Reply*, 215 AM. J. OBSTETRICS & GYNECOLOGY 670, 671 (2016).

189. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. ON OBSTETRIC PRAC., ACOG COMMITTEE OPINION NO. 711: OPIOID USE AND OPIOID USE DISORDER IN PREGNANCY 6 (2017), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>. [<https://perma.cc/MY9V-MPH3>] [hereinafter ACOG COMMITTEE OPINION].

190. See *id.*

191. See *id.*

192. See MILLER ET AL., *supra* note 9, at 8.

193. In 2013, in an effort to understand the scope and nature of the problem, the Tennessee Department of Health began requiring hospitals to report the numbers of infants diagnosed with NAS. Michael D. Warren et al., *Implementation of a Statewide Surveillance System for Neonatal Abstinence Syndrome—Tennessee, 2013*, 64 MORBIDITY & MORTALITY WKLY. RPT. 125, 125 (2015), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6405a4.htm> [<https://perma.cc/4VQ2-L5H4>].

194. See *id.* at 126.

195. MILLER ET AL., *supra* note 9, at 1, 5, 8. Of the cases of prescription exposure resulting in NAS in Tennessee, “[a]mong the 561 cases exposed to only prescription medications, 86.1% (n=483) were exposed to medication assisted treatment for the mother’s substance use disorder.” *Id.* at 6.

196. See *id.* at 8. There is also a very small number of cases where the source of exposure is unknown. See *id.*

opposed to legal but diverted) opiates play a very small role.¹⁹⁷ For example, in 2016 only 3.8 percent of the NAS cases in Tennessee resulted in whole or in part from the use of heroin.¹⁹⁸

A. A Crisis and No Treatment Resources to Meet It

These overlapping crises of over-prescription, diversion of lawfully prescribed substances, addiction overall and during pregnancy, and NAS resulted in a serious public health emergency.¹⁹⁹ The ability to mitigate this crisis is significantly hampered by a serious lack of treatment facilities.²⁰⁰ The Substance Abuse and Mental Health Services Administration, or SAMSHA, hosts a national listing of available treatment resources.²⁰¹ A recent search of facilities that provide substance abuse treatment of any form in Tennessee that accept Medicaid resulted in eighty-five programs in the state.²⁰² When that search was narrowed to facilities that are willing to treat pregnant women and post-partum women only twenty-three facilities were on the list.²⁰³ In 2014, a similar search was run and journalists from *America Tonight* followed up with the listed facilities seeking to gain information about whether there were any open treatment beds.²⁰⁴ From the listing at that time, only “[f]ive clinics confirmed that they allow pregnant women to enroll in their residential treatment program and accept Medicaid. With two of the programs completely full, there [were] fewer than 50 beds in Tennessee available to pregnant drug users.”²⁰⁵

197. *See id.*, at 6 tbl.1.

198. *Id.* at 6.

199. *See* ACOG COMMITTEE OPINION, *supra* note 189, at 2.

200. *See* Sanya Dosani, *Should Pregnant Women Addicted to Drugs Face Criminal Charges?*, AL JAZEERA AM. (Mar. 31, 2015, 4:00 PM), <http://america.aljazeera.com/watch/shows/america-tonight/articles/2014/9/4/should-pregnant-womenaddictedtodrugsfacecriminalcharges.html> [<https://perma.cc/4EVR-RCT9>].

201. *Behavioral Health Treatment Services Locator*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <https://www.findtreatment.samhsa.gov> [<https://perma.cc/48ZM-UYA2>].

202. *Locator Map*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <https://www.findtreatment.samhsa.gov/locator?sAddr=Tennessee%2C%2%200USA&submit=Go> [<https://perma.cc/VDL8-SEAQ>] (enter “Tennessee” in search box and refine search by clicking the relevant criteria).

203. *See id.* (narrowing the search to treatment of pregnant women and post-partum women).

204. *See* Dosani, *supra* note 200.

205. *Id.*

In Tennessee, as in the nation as a whole, there are concerted, if significantly underfunded, efforts to address the opiate epidemic in all its forms.²⁰⁶ In the particular area of use and abuse by pregnant women, difficult research questions, from the appropriate treatment of addicted pregnant women²⁰⁷ to the appropriate treatment of infants with NAS,²⁰⁸ are at the heart of current scientific work and merit substantial attention and resources.²⁰⁹ In addition, in light of what we now understand to be a significant and unwarranted hyperbole predicting the long-term futures of cocaine-exposed infants,²¹⁰ caution is clearly called for. Two things, however, are clear. First, throughout the regions hit hardest by the epidemic, there are far too few treatment resources.²¹¹ Second, as made clear by the studies of infants born exposed to crack, ensuring healthy outcomes for poor children requires far more than just assuring that pregnant women not ingest narcotics.²¹²

III. TENNESSEE RESPONDS: PROSECUTING POVERTY AND CRIMINALIZING CARE

This Part turns directly to the rationales offered for criminalization of this conduct and, relying on the criminal court files and birth and census data, to the demographics, trajectories, and outcomes for women prosecuted in Tennessee. This Part pays particular attention to the role and effect on healthcare provision and on evaluating whether or not the prosecutions were in fact a road to care.

206. See ACOG COMMITTEE OPINION, *supra* note 189, at 2; Dosani, *supra* note 200.

207. See ACOG COMMITTEE OPINION, *supra* note 189, at 6-8.

208. See Mark L. Hudak & Rosemarie C. Tan, *Neonatal Drug Withdrawal*, 129 PEDIATRICS 540, 547-49 (2012).

209. See ACOG COMMITTEE OPINION, *supra* note 189, at 2-3; Hudak & Tan, *supra* note 208, at 547-49.

210. See Grace Elizabeth Howard, *The Criminalization of Pregnancy: Rights, Discretion, and the Law 29-32* (Oct. 2017) (unpublished Ph.D. dissertation, Rutgers University) (on file with author).

211. See Dosani, *supra* note 200.

212. See Martin & Finlayson, *supra* note 179, at 367-68.

A. *Creating Crime to Create Care*

The legislation criminalizing fetal assault in Tennessee was originally proposed in the Spring of 2013 and was passed, with a sunset date of June 30, 2016, in the Spring of 2014.²¹³ The

213. 2014 Tenn. Pub. Acts 820 (expired July 1, 2016). Tennessee's statute criminalizing in-utero drug transmission was the first, and is, to date, the only statute enacted in the United States explicitly criminalizing the transmission of drugs to a fetus during pregnancy. Cara Angelotta et al., *A Moral or Medical Problem? The Relationship Between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women*, 26 *WOMEN'S HEALTH ISSUES* 595, 596 (2016). The Tennessee statute was in effect for just over two years, from April 28, 2014 to June 30, 2016. 2014 Tenn. Pub. Acts 820. As of the date of this writing, while similar legislation has been proposed or is under consideration, no other state has passed legislation authorizing these prosecutions. 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, 320-21 (2013). Despite the lack of statutory authorization, prosecutors across the nation have brought these cases by charging women with violating statutes originally intended to target crimes against living persons, not fetuses. See *id.* at 321-22. For example, between 1973 and 2005 the majority of prosecutions proceeded under the theory that the conduct constituted child abuse or child endangerment. *Id.* at 321. Similarly, between 2006 and 2015, at least 479 women were prosecuted in Alabama for "chemical endangerment," a crime originally created to target the harm to children who were living in houses where methamphetamine was being produced. See Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, *PROPUBLICA* (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene> [<https://perma.cc/PB7W-5WRH>]. In only two states, Alabama and South Carolina, have the courts approved these prosecutions after they were challenged. Howard, *supra* note 210, at 49-52. All other courts examining the issue have concluded that these prosecutions were unlawful, generally because the legislature that wrote the crimes in question were not thinking of crimes against a fetus when they wrote the statute. See Paltrow & Flavin, *supra* note 213, at 320-22.

This does not, however, mean that the Tennessee prosecutions were the first to be brought, nor does it mean that these prosecutions no longer take place. See *id.* at 321-22. These prosecutions were traced back to as early as 1973. See *id.* at 321. Through a variety of empirical methods, Paltrow and Flavin identified 413 cases of forced interventions of pregnant women in these circumstances between 1973 and 2005. *Id.* at 304. Three hundred and fifty-four of the cases involved criminal prosecution while the remaining involved primarily civil legal interventions. See *id.* at 321-22. Prosecutions have taken place in virtually every state in the nation. See *id.* at 309. Paltrow and Flavin documented prosecutions and/or other forced interventions against pregnant women in forty-four states. See *id.* at 300. The only exceptions were Delaware, Maine, Minnesota, Rhode Island, Vermont, and West Virginia. *Id.* at 309. Since that time over 1000 women have been prosecuted for transmitting drugs to their fetus. I arrive at this number by pulling data from a variety of sources. First, Paltrow and Flavin document 413 cases of forced intervention. *Id.* One hundred and ninety-seven of those cases take place in regions other than the South. See *id.* at 309-10. As to prosecutions that took place in the South, I am including data gathered in this study documenting 124 prosecutions for fetal assault in Tennessee, see *infra* notes 259-60 and accompanying text, and prosecutions documented by Grace Howard in two additional Southern states (182 in South Carolina and 501 in Alabama). Howard, *supra* note 210, at 63. This number could be an overcount in one

way but is likely a significant undercount in many others. It could be an overcount because the 413 forced interventions documented by Paltrow and Flavin include fifty-nine cases of civil forced interventions, so some percentage of what I have termed “non-Southern cases” may involve civil interventions. *See* Paltrow & Flavin, *supra*, at 311 tbl.1, 321. The number is likely a substantial undercount, however, because not all Southern states are included in the analysis and, far more importantly, every researcher who has attempted to gather this data has noted the significant difficulties in finding complete data due in large part to the ways criminal court records are kept. *See infra* notes 259-60 and accompanying text.

One can trace prosecutions back to the 1970s and the prosecution of women for giving birth to, what was then termed, “heroin babies.” *See* Paltrow & Flavin, *supra*, at 309, 312 fig.1. While these early prosecutions mark the start of this phenomena, the majority of prosecutions have come in two large waves. *See* Howard, *supra* note 210, at 28. The first began in earnest in 1989, and targeted poor, disproportionately African American women, predominantly in the South, who were accused of ingesting crack cocaine while pregnant. *See* Paltrow & Flavin, *supra*, at 309-12. The second, in more recent years, was against both white and black poor women, also predominantly in the South, for using methamphetamine, opiates, as well as other drugs. *See* Howard, *supra* note 210, at 28, 32-38; Paltrow & Flavin, *supra*, at 309-12. The first wave of prosecutions spiked between 1989 and 1991 and continued at a steady pace through the mid-2000s. *See* Paltrow & Flavin, *supra*, at 312 fig.1. In terms of the rates of intervention, the study identifies a handful of forced intervention cases before 1989 (generally between one and six cases per year). *See id.* The numbers of cases spike between 1989 and 1991. *See id.* In 1989-1991 they document between thirty-six and forty-three cases per year and then the numbers fall again and remain fairly steady between fifteen to twenty-five documented interventions per year through the end of the study period. *See id.* Although the study identifies 354 prosecutions during this period, the authors compellingly argue that, given the extraordinary difficulty of identifying existing cases, particularly those that result from the bringing of a charge and a subsequent guilty plea, this number represents a substantial undercount. *See id.* at 304.

The prosecutions were strongly associated with the crack cocaine epidemic and were targeted, both as a matter of empirical fact and as a matter of rhetoric, at poor African American women giving birth to what were then termed, “crack babies.” *See* Howard, *supra* note 210, at 28-30; Paltrow & Flavin, *supra*, at 333. Dorothy Roberts brought early and important attention to these prosecutions. *See* Roberts, *supra* note 53, at 1480. At this point there is no question that the cultural hysteria over “crack babies” was both deeply embedded in racial stereotyping and was largely overblown by the popular press. *See* Howard, *supra* note 210, at 29-32. Although babies born having been exposed to cocaine in-utero do manifest some small deficits, the long-term harm appears to be minor and far less serious than the long-term effects of in-utero exposure to alcohol and tobacco. *See* Paltrow & Flavin, *supra*, at 334.

The second wave began in the mid-2000s with the rise of methamphetamine and opiates. *See* Howard, *supra* note 210, at 28. In this second wave the prosecutions shifted, again both empirically and as a matter of rhetoric, to poor white women, “meth babies,” and “oxy-tots.” *See id.* at 28, 32-38. The racial shifts in prosecutions of women for in-utero drug transmission has been documented by a variety of scholars. For the period from 1973, when the Supreme Court decided *Roe v. Wade*, to 2005, Lynn Paltrow and Jean Flavin issued a report documenting “state actions taken against 413 women in forty-four states, the District of Columbia, and some federal jurisdictions between 1973 and 2005.” Paltrow & Flavin, *supra*, at 309. Paltrow and Flavin’s data reveal that, “[t]he largest percentage of cases originated in the South (56 percent), followed by the Midwest (22 percent), the Pacific and West (15

law that was in effect from 2014 to 2016 was, in its final form, fairly simple. It was structured to link to Tennessee's assault statute, which is typical of assault statutes in that it criminalizes as a Class A misdemeanor "[i]ntentionally, knowingly or recklessly caus[ing] bodily injury to another; [or] [i]ntentionally or knowingly caus[ing] another to reasonably fear imminent bodily injury."²¹⁴ Instead of risking legal challenges by bringing prosecutions under this statute without resolving the question of whether the statutory definition of "another" includes a fetus, the statute at issue here made this point clear, stating that:

[N]othing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug ... while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.²¹⁵

The statute allowed a woman to raise a complete defense to prosecution if she "actively enrolled in an addiction recovery program before the child [was] born, remained in the program after delivery, and successfully completed the program, regardless of

percent), and the Northeast (7 percent)." *Id.* These prosecutions focused almost entirely on poor women and, among these poor women, focused disproportionately on African American women. *See id.* at 300-01. In addition, whereas there were a few prosecutions in this period involving drugs other than cocaine, the drug that was most frequently named in the cases was cocaine. *Id.* at 315-16.

During the second wave of prosecutions, beginning roughly in the early 2010s, prosecutions appear to have remained focused in the South and in poor communities, but the racial makeup of those prosecutions began to shift from black to white. *See* Howard, *supra* note 210, at 28. As Grace Howard has revealed in her study of prosecutions in South Carolina and Alabama, as the targeted substances shifted from cocaine to methamphetamine and opiates, the racial makeup of defendants shifted overall from black to white. *See id.* This result is confirmed both through the data underlying this study of the Tennessee prosecutions as well as the work of other scholars. *See, e.g., id.* at 91, 93. In Tennessee, for the forty-one cases under study for this Article, all but one concerned a white defendant. *See infra* notes 267-69 and accompanying text. Similarly, Grace Howard has found that in South Carolina, "[a]nnually, black defendants outnumber white defendants in South Carolina through 2003. After 2003 the demographic composition of women arrested for pregnancy-related crimes in the state shifted dramatically. In 2014, the ratio of white to black defendants was 16:1." Howard, *supra* note 210, at 91. Similarly, Howard finds that in "Alabama arrests predominantly involve[] white women, making up 375 cases (75.9%)." *Id.*

214. TENN. CODE ANN. § 39-13-101(a)(1)-(2) (2018).

215. TENN. CODE ANN. § 39-13-107(c)(2) (2014) (expired July 1, 2016).

whether the child was born addicted to or harmed by the narcotic drug.”²¹⁶ A prescription for the narcotics at issue was also clearly a defense.²¹⁷ Throughout the legislative record, proponents of the legislation shifted between two primary narratives justifying the bill.²¹⁸ The first, focused both on the infants in crisis and what was characterized as deep maternal irresponsibility.²¹⁹ For example, Terri Lynn Weaver, the original sponsor of the bill in the House, characterized it in 2013 as a response to a form of child abuse.²²⁰ She began by noting that 111 infants had been diagnosed with NAS that year.²²¹ Of the mothers she stated, “[t]hese women don’t want help; they don’t even recognize there’s life in there.... This is for cases of women, they don’t care.”²²² In the 2013 hearing, Weaver is clear about her intent: “Let’s just focus on the children.”²²³ For Weaver, the purpose of the bill was to separate the women from their infants, and to use punishment as a means to deter future pregnancies and save babies.²²⁴

Although the focus on the infants and NAS, as well as the derogation of women who give birth to these children is strong throughout the legislative record, another theme emerges over time. This theme focuses both on the needs of the mothers and the purported role of the prosecutions themselves in providing treatment for the mothers.²²⁵ For example, Representative Hardaway characterized the legislation as serving as a benevolent force in the mothers’ lives: “[while] drugs tend to take your right mind away ... [with the] discipline ... [of the] court system ... [the mothers can] go

216. *Id.* § 39-13-107(c)(3).

217. *Id.* § 39-13-107(c)(2) (“[N]othing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug.”).

218. See *Hearing on S.B. 1295 Before the H. Crim. Just. Sub-Comm.*, 108th Gen. Assemb., (Tenn. Mar. 13, 2013)[hereinafter *Hearing on 1295 Before the H. Crim Just. Subcomm. (I)*], http://tnga.granicus.com/MediaPlayer.php?view_id=269&clip_id=7499&meta_id=140901 [<https://perma.cc/A2C6-LS8A>].

219. See *id.*

220. See *id.*

221. See *id.*

222. *Id.*

223. *Id.*

224. See *id.*

225. See *Hearing on S.B. 1295 Before the H. Crim. Just. Sub-Comm.*, 108th Gen. Assemb., 0:48:43 (Tenn. Apr. 9, 2013)[hereinafter *Hearing on 1295 Before the H. Crim Just. Subcomm. (II)*], http://tnga.granicus.com/MediaPlayer.php?view_id=269&clip_id=7751 [<https://perma.cc/5BB6-XGNK>].

back to being the nurturing caring parents that they would want to be.”²²⁶ Similarly Amy Wyrick, the District Attorney for Shelby County, who at one point characterized the women she prosecuted under the statute as “the worst of the worst” also characterized the law as a “velvet hammer,” one that presumably used the threat of punishment to gently but firmly compel women to address their addictions.²²⁷ But Wyrick assured the representatives that, “[n]one of us care to lock up mothers who are addicted to drugs.”²²⁸

Characterizing criminal sanctions as incentivizing defendants to cease engaging in illegal behavior and choose more positive paths is not unusual. Nor is it at all unusual, in an era of problem-solving courts, to characterize courts as able to use their coercive authority to compel behavioral changes in criminal defendants as well as others subject to the jurisdiction of various courts.²²⁹ What is unusual in this legislative record is the way that prosecutors and representatives begin to frame the creation of the crime, not just as creating an incentive for women to seek treatment, but as the precondition to and provider of treatment itself.²³⁰ In the minds and words of the supporters, it is the creation of the crime and the ability to prosecute that makes treatment possible.²³¹ This rationale is largely centered around the close linkage between this particular legislation and the Memphis drug court, but the linkage goes beyond that. Over and over again, legislators and prosecutors characterize prosecution itself as that which will provide access to treatment that is not otherwise available to the women.²³²

This point bears emphasis. Whereas recent drug courts were born of the idea that, as a result of the war on drugs, criminal courts

226. *Id.*

227. *Id.*

228. *Id.*

229. See *supra* notes 105-11 and accompanying text.

230. See *Hearing on 1295 Before the H. Crim. Just. Subcomm. (I)*, *supra* note 218; *Hearing on 1295 Before the H. Crim. Just. Subcomm. (II)*, *supra* note 225.

231. See *id.*

232. See *Hearing on H.B. 1660 Before the H. Crim. Just. Subcomm.*, 109th Gen. Assemb. (Tenn. March 15, 2016), http://tnga.granicus.com/MediaPlayer.php?view_id=341&clip_id=12002# [<https://perma.cc/EE24-56F2>]; *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5; *Hearing on S.B. 1391 Before the S. Judiciary Comm.*, 108th Gen. Assemb. (Tenn. April 9, 2013) [hereinafter *Hearing on S.B. 1391 Before the S. Judiciary Comm. (II)*], http://tnga.granicus.com/MediaPlayer.php?view_id=262&clip_id=7746# [<https://perma.cc/8Q A6-R2CP>]; *Hearing on 1295 Before the H. Crim. Just. Subcomm. (II)*, *supra* note 225.

found themselves with courtrooms filled with individuals with extensive needs that led to their criminal conduct,²³³ here something radically different happened. In the rhetoric of the hearings justifying the passage of the statute, the “treatment” available only through the courts is contemplated as so beneficial that it justifies the criminalization of previously noncriminal conduct.²³⁴

The legislative record contains at least three interrelated narratives along these lines: first, without the statute there are no social service resources available to the women; second, criminalization itself will lead to the creation of treatment resources; and finally, the law is there to serve and enable the creation and support of drug courts.²³⁵

In both the 2013 hearings on initial enactment and in the 2016 hearings on reauthorization, there are multiple statements suggesting that the women who would be subject to prosecution could not access treatment without being prosecuted. Perhaps most poignant was the statement of Barry Staubus, the Sullivan County District Attorney who spoke of his community as “drowning” and “powerless” in the face of the prevalence of NAS.²³⁶ Staubus would go on to lead the state in number of prosecutions per capita.²³⁷ As quoted in the introduction to this Article, he hoped the statute would give rise to the creation of desperately needed treatment resources for his community.²³⁸

Similarly, in 2016 District Attorney General Amy Weirich spoke in favor of reauthorization: “What was happening before we had this legislation is that those babies were being taken from their mothers and their mothers were left helpless without any chance of getting the help they need.”²³⁹ This rhetorical framing, “before we had this

233. See *supra* notes 98-106 and accompanying text.

234. See *supra* notes 225-28.

235. See *supra* notes 225-34.

236. *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5 (statement of Barry Staubus, Dist. Attorney of Sullivan County).

237. Mallory Yu et al., *In Tennessee, Giving Birth to a Drug-Dependent Baby Can Be a Crime*, NAT'L PUB. RADIO (Nov. 18, 2015, 3:22 PM), <https://www.npr.org/sections/health-shots/2015/11/18/455924258/in-tennessee-giving-birth-to-a-drug-addicted-baby-can-be-a-crime> [<https://perma.cc/6T6Q-BGPM>] (stating that Barry Staubus prosecuted over twenty drug-using mothers in 2015 as the district attorney for Sullivan County).

238. See *supra* note 17 and accompanying text.

239. *Hearing on H.B. 1660 Before the H. Criminal Justice Sub-Comm.*, *supra* note 232 (statement Dist. Attorney Gen. Amy Weirich).

legislation,” clearly indicates that, in Weirich’s view, it was the creation of the crime that led to help.²⁴⁰ Similarly, Representative Lamberth stated in 2016 that “one hundred percent of the women that were seeking drug court assistance right ... now would not be aware of it.”²⁴¹ Nowhere among the statements of proponents of the legislation is there any suggestion that this state of affairs—the seemingly overwhelming lack of resources available to support pregnant women struggling with addiction—might call not for the creation of a new crime but instead for the augmentation of community-based social support.²⁴² Instead, in their statements, criminalization and treatment are inextricably intertwined.²⁴³

Quite explicitly in the view of these proponents, if the problem is the lack of resources for women needing help, the solution is the creation of the crime. Senator Kelsey, a senator from Nashville, Tennessee, described the law in 2015 as “offering their mothers the help they so desperately need but cannot obtain on their own.”²⁴⁴ He went on to say:

The other issue that this committee also needs to consider is that these women are usually not being sent to jail at all but in fact the beginning of the prosecution is what the court [is] able to do to send them to drug treatment. That’s another very important and positive aspect for the bill.²⁴⁵

Similarly, Senator Tate explained that “this bill what it does is gives the DA or a judge the right or authority if you will to send a mother of a child to a drug court.”²⁴⁶ This view is not restricted to legislators. Instead, for those women who desperately need treatment, it is descriptive of the reality in their communities.

In one of the most striking moments in the hearings, Latoni Lester, an African American woman from Memphis who was prosecuted under the statute, diverted to, and graduated from the

240. *See id.*

241. *Hearing on H.B. 1660 Before the H. Criminal Justice Sub-Comm., supra* note 232 (statement of Rep. William Lamberth, Chair, H. Crim. Just. Subcomm.).

242. *See id.*

243. *See id.*

244. *Hearing on S.B. 1391 Before the S. Judiciary Comm. (II), supra* note 232.

245. *Id.* (statement of Sen. Brian Kelsey, Chair, S. Judiciary Comm.).

246. *Id.* (statement of Sen. Reginald Tate).

Memphis Drug Court, testified in favor of reauthorization.²⁴⁷ During the hearing, Representative William Lamberth asked Ms. Lester if “[w]ithout a statute on the books ... would you have gotten the help that you are getting right now?”²⁴⁸ She responded, “No, I am very thankful for the program.”²⁴⁹ Clearly for Ms. Lester, no help was available to her before she was prosecuted.²⁵⁰

Finally, revealing what some imply was the real justification for the statute—namely filling the seats of drug courts throughout the state—Senator Finney, from Jackson, Tennessee, talked about the potential benefits to his district with the creation of this crime: “we have a great drug court in Jackson ... and I’m sure it would benefit from something like this.”²⁵¹ At this point, it should be clear that a central rationale for the creation of this crime was the ability to use prosecution as a mechanism to create and help women access treatment resources.

The Sections that follow now turn to data collected on the prosecutions of women for fetal assault in Tennessee.²⁵² This data reveals two important points. First, the prosecutions focused almost exclusively on poor women. In addition, in the vast majority of prosecutions that took place in rural, Appalachian, eastern Tennessee, the criminal court files reveal two related phenomena about the relationship between care and punishment. One, presumptions of confidentiality in health care settings were significantly compromised in these cases, raising serious questions about the effects of punishment on the quality of care in those settings.²⁵³ Turning to the criminal system setting, the case files reveal significant punishment with either no access to treatment (in the majority of cases) or access to treatment linked strongly to significant punishment

247. *Hearing on H.B. 1660 Before the H. Criminal Justice Sub-Comm.*, *supra* note 232 (statement of Latoni Lester).

248. *Id.*

249. *Id.*

250. *See id.*

251. *Hearing on S.B. 1391 Before the S. Judiciary Comm. (I)*, *supra* note 5 (statement of Sen. Lowe Finney).

252. [EDITOR'S NOTE: Due to privacy concerns and Institutional Review Board rules, Professor Bach was unable to share the court records, medical records, and interview transcripts referenced in the following Sections with the editors of the *William & Mary Law Review*. The editors were unable to independently verify the information contained in these sources. The records and transcripts of the interviews are on file with the author.]

253. *See infra* Part III.D.

with very little access to treatment.²⁵⁴ If the justification for the statute was using the mechanisms of prosecution to link women to care, this data raises serious questions about the success of those efforts. Further, as Part IV argues, to the extent that this case study is indicative of the implications of the collapse of boundaries between support systems and punitive systems, this data suggests that we must delink these systems and devote resources to autonomy-enhancing, community-based social welfare support.

B. Prosecuting Poverty: The Tennessee Cases

There is no question that those who sought passage of Tennessee's fetal assault law were seeking a way to address the high rates of NAS.²⁵⁵ Whether it be a "velvet hammer" to compel individual women to address their addiction,²⁵⁶ a means to take advantage of the resources of problem-solving courts,²⁵⁷ or a strong message designed to deter other women,²⁵⁸ the law was justified in large part as a way to address this public health problem. What actually happened in Appalachia, however, tells quite a different story.

Over the course of nearly two years, working with a team of research assistants, I gathered criminal court²⁵⁹ records documenting the cases of approximately 124 women who were prosecuted for this offense.²⁶⁰ In addition, I requested and received the birth

254. *See infra* Part III.D.

255. *See supra* notes 213-24 and accompanying text..

256. *See supra* note 227 and accompanying text.

257. *See supra* notes 229-34 and accompanying text.

258. *See supra* notes 223-24 and accompanying text.

259. I use the term "criminal court" generically here to refer to the courts in which the charges against these women were brought. As detailed below, in Tennessee misdemeanor prosecutions are generally initiated in lower courts, called General Sessions Courts, only proceeding to the Tennessee "criminal court" in certain circumstances. *See infra* notes 295-302 and accompanying text.

260. To gather this information, the research team on this project sent requests pursuant to the Tennessee Open Records Act to every prosecution office, police agency, and court in the State of Tennessee that would have records of any prosecution. TENN. CODE ANN. §§ 10-7-501-516 (2018). We followed up on those requests by letter and phone on multiple occasions. Ultimately, we gathered information documenting the existence of 124 women who were prosecuted for this crime between April 28, 2014 and June 30, 2016. As there is no central database recording prosecutions, this project was reliant on the compliance of individuals in those offices to have kept records and then provide them in response to our requests. There is no way to guarantee that this is an accurate count of the number of prosecutions. In fact,

records of every infant born and subsequently diagnosed with NAS during the time when the law was in effect. These two sets of data reveal significant information about what actually occurred during the period when this law was in effect.

After the initial round of data collection, it became clear that many prosecutors across the state, particularly in three of the four larger cities, chose not to prosecute this crime and many other districts in the western half of the state brought very few prosecutions. Prosecutions concentrated in one geographic region. To understand this information, one has to know just a little about Tennessee geography. Tennessee is long and thin, stretching from the eastern Appalachian region at the borders of North Carolina and Kentucky, through Nashville to just north of Alabama and all the way west to Memphis, which is north of Mississippi.²⁶¹ There are three major cities—Knoxville in the east, Nashville in the middle, and Memphis in the west.²⁶² Geographically, the eastern half of Tennessee is in the largely economically distressed regions of Appalachia.²⁶³ While

it is likely an undercount to some degree. *See, e.g.*, Paltrow & Flavin, *supra* note 213, at 304 (explaining why the authors believe their study of 413 cases constitutes an undercount). Nevertheless, this number of prosecutions closely matches the number of cases that District Attorneys reportedly brought against women for this crime. Data on file with author. These prosecutions focused in two geographic areas: rural Eastern Appalachia and Memphis, Tennessee. In the second phase of data gathering, we collected the full court records for women who were prosecuted in several specific judicial districts in the Eastern Appalachian region of the state through additional requests by email, letter, and phone, as much as possible. The data collection for the files in six judicial districts Eastern Tennessee is complete, and the data collection is still in progress for the additional eastern districts as well as the Memphis cases. *Id.* For this reason, and because of the significant differences between the criminal systems in Appalachia and Memphis, this Article focuses on only forty-one Appalachian cases for which we have full information. The relevant courts do not keep data in a centralized manner and, as a result, we do not have consistent data for each woman. Nevertheless, these court files draw a fairly clear picture of the trajectories of prosecution in the eastern districts that chose to bring these cases.

261. Sarah McCantess Howell et al., *Tennessee*, ENCYCLOPEDIA BRITANNICA ONLINE, <https://www.britannica.com/place/Tennessee#ref276556> [<https://perma.cc/B9P2-ACHY>].

262. *Id.*

263. Appalachia is defined, by the national legislation creating the Appalachian Regional Commission as, “a 205,000-square-mile region that follows the spine of the Appalachian Mountains from southern New York to northern Mississippi.” *The Appalachian Region*, APPALACHIAN REGIONAL COMMISSION, https://www.arc.gov/appalachian_region/TheAppalachianRegion.asp [<https://perma.cc/B4SJ-2A25>]. Appalachia “includes all of West Virginia and parts of 12 other states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. Forty-two percent of the Region’s population is rural, compared with 20 percent of the

the vast majority of those in the east are white,²⁶⁴ and the areas are predominantly rural, Memphis is a majority black city and is far more densely populated, along with Knoxville and Nashville.²⁶⁵ The majority of prosecutions took place in the Eastern, predominantly rural areas of Appalachia. Forty-one of these cases are the focus of this Part.²⁶⁶ These case files reveal a complex story about what

national population.” *Id.* While not all of Appalachia is economically distressed, the majority of counties in Appalachian Tennessee are classified as either economically “distressed” or economically “at risk.” APPALACHIAN REG’L COMM’N, COUNTY ECONOMIC STATUS AND NUMBER OF DISTRESSED AREAS IN APPALACHIAN TENNESSEE, FISCAL YEAR 2016 (2015) [hereinafter COUNTY ECONOMIC STATUS], http://www.arc.gov/images/appregion/economic_statusFY2016/CountyEconomicStatusandDistressAreasFY2016Tennessee.pdf [<https://perma.cc/66H7-YT-NH>]. To determine these classifications, the Commission averages, for each year and each county, the unemployment rate, per capita market income, and the poverty rate and then compares this to the national averages. *Source & Methodology: Distressed Designation and County Economic Status Classification System, FY 2007-FY 2018*, APPALACHIAN REGIONAL COMMISSION, <https://www.arc.gov/research/sourceandmethodologycountyeconomicstatusfy2007fy2018.asp> [<https://perma.cc/P8X6-Y4XY>]. Counties are classified as “distressed” when they fall into the bottom ten percent of counties by these measures. *Id.* Counties are classified as “at risk” if they fall between ten percent and 25 percent when compared to national averages and “transitional” if they fall between 25 percent and 75 percent of national averages. *Id.* The majority of Appalachian counties in Tennessee are classified as either distressed or at risk, but some are classified as transitional. COUNTY ECONOMIC STATUS, *supra*. The majority of at risk and transitional counties have census tracts within them that fall into the distressed classification. *Id.* Note that this Article pulled data from fiscal year 2016, the only full year during which the prosecutions took place.

264. For example, Sullivan County, Tennessee, the district in the far northeast of the state and in which 31 prosecutions took place, is 95.1 percent white in the 2016 census. *QuickFacts: Sullivan County, Tennessee; Shelby County, Tennessee; Tennessee*, U.S. CENSUS BUREAU (July 1, 2017) [hereinafter *QuickFacts: Sullivan County*], <https://www.census.gov/quickfacts/fact/table/sullivancountytennessee,shelbycountytennessee,tn/PST045217> [<https://perma.cc/9B3J-5KPV>]. Shelby County, Tennessee, in the far west of the state was 54.1 percent Black or African American. *Id.*

265. *QuickFacts: Memphis City, Tennessee; United States*, U.S. CENSUS BUREAU (July 1, 2017), <https://www.census.gov/quickfacts/fact/table/memphiscitytennessee,US/PST045217> [<https://perma.cc/X6FE-GZVY>]. Sullivan County has a population of 379.4 persons per square mile in contrast to Shelby County, which has a population of 1,215.5 persons per square mile. See *QuickFacts: Sullivan County, supra* note 264.

266. There is a numerical difference between the number of cases in this region for which we have files and the full number of relevant prosecutions. In the area under study for this Article, we documented sixty-eight individual prosecutions. Of the sixty-eight, twenty of the files were either missing or had been expunged. The courts, police agencies, and prosecutors affirmed that the prosecutions had taken place but could not provide any information about the identity of the women or the cases. For seven additional cases, we were given the names of the women prosecuted but no additional information or documentation. We received court files for the remaining forty-one women who are the focus of this Article.

actually happened, who was targeted, and what it meant to be targeted for this crime.

The first striking fact confirms larger national data, showing the shift in the overall racial makeup of these prosecutions.²⁶⁷ Of the forty-one women who are the focus of this Article and who were all prosecuted in judicial districts in the Appalachian regions of eastern Tennessee, all but one woman was white.²⁶⁸

The second striking fact is that all available evidence suggests that the vast majority of the women who were prosecuted were poor. To determine the economic characteristics of the women who were prosecuted, I relied on several indications in the court files as well as birth record data. A woman was classified as low income if one or more of three indicators appeared in the criminal court files: she was listed as unemployed; she was listed as homeless; or there was some indication that the court had determined her as indigent and therefore entitled to appointed counsel. A woman was also classified as low income if her infant's birth record data listed her household as having an income under \$25,000 per year or if more than 50 percent of those residing in her census tract lived below the poverty line. For nine of the forty-one cases, the woman did not live in a census tract with more than 50 percent of its residents below the poverty line and neither her child's birth record nor the criminal court files gave any indication of her income status. Despite this, given the overall demographics of these courts, these women too were likely indigent.

These data, and their implications, bear repeating. If this legislation was designed, as its proponents expressed, as a way to use the mechanisms of the criminal legal system to address the healthcare needs and behavior of women giving birth to infants with NAS, or, to draw from the legislative testimony, to address the flood of babies,²⁶⁹ this was a public health solution targeted not at all women but nearly exclusively at poor women. The next Part of this Article takes this premise as a given and begins to ask what

267. *See supra* notes 213-14 and accompanying text.

268. For one woman, race was marked as A, presumably indicating that the woman was Asian American. All others were marked W for white.

269. *See supra* Part III.A.

actually happened to the white, low-income women prosecuted for fetal assault in the Eastern Appalachian regions of Tennessee.²⁷⁰

To begin to paint this picture, the following Section turns to the basic legal and institutional frameworks of the various local systems involved in these cases and to what the criminal court files tell us about what happened to the low-income white women who were prosecuted for this offense.

C. Three Intersecting Legal Systems at Play

As a general rule, the information that would lead to prosecution for fetal assault flowed through three separate systems. In the vast majority of cases, the initial information was gathered by hospital staff (doctors, nurses, and social workers). A report was then made by someone at the hospital to the Department of Children's Services. Prosecution was then initiated, based on both the hospital records and reports as well as data gathered and provided by child welfare officials to police and prosecutors. Therefore, to understand the prosecutions one needs to understand components of and interactions between the healthcare system, the child welfare system, and the criminal system.²⁷¹

1. The Healthcare System

The healthcare system's role in these prosecutions comes into play predominantly when professionals within that system disclose information about their patients (both mothers and infants) to child welfare officials, police, and prosecutors. While these disclosures are legally authorized under limited circumstances, as a general rule, medical records are confidential.²⁷² These privacy protections are designed to encourage honest communication between care providers and their patients. The principal federal legal protection creating

270. The fact that these prosecutions targeted poor white women while earlier prosecutions for similar offenses in other jurisdictions targeted poor black women, *see* Howard, *supra* note 210, at 28-32, gives rise to a set of very important questions that will be explored in later work arising from this study.

271. For an extensive discussion of how these systems interact to impose harm disproportionately in poor, African American communities, *see* generally Bach, *supra* note 34.

272. *See infra* notes 273-82 and accompanying text.

this confidentiality is the federal Health Insurance Portability and Accountability Act (HIPAA).²⁷³ As a general rule, HIPAA protects the confidentiality of what it defines as “protected health information,” which includes, among other things, both medical records and statements made to medical personnel during the course of treatment.²⁷⁴

However, HIPAA, state, and federal law concerning child abuse significantly limit these protections for individuals suspected of child abuse.²⁷⁵ HIPAA authorizes the disclosure of protected health information in two circumstances relevant to these cases. Such information can be disclosed to “[a] public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.”²⁷⁶ In addition, providers can disclose to a government authority information about an individual that the healthcare provider “reasonably believes to be a victim of abuse, neglect, or domestic violence.”²⁷⁷ Moreover, like all states, Tennessee law requires health care providers to report suspected cases of abuse or neglect.²⁷⁸ This overall legislative schema carves out specific exemptions that allow healthcare providers to disclose both suspected cases of child abuse, and to share the medical information of potential victims of abuse.

Adding to these legal mechanisms permitting disclosure in these circumstances, the federal Child Abuse Prevention and Treatment Act (CAPTA), which provides a significant amount of funding to state child welfare programs, imposes specific requirements as a

273. Health Insurance Portability and Accountability Act of 1966, 42 U.S.C. § 1320d (2012).

274. HIPAA extends these protections to what it defines as “protected health information.” *Id.* The term “health information” is defined as

any information, including genetic information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

45 C.F.R. § 160.103 (2017). “Protected health information” is defined as “individually identifiable health information.” *Id.*

275. *See infra* notes 276-82 and accompanying text.

276. 45 C.F.R. § 164.512(b)(1)(ii).

277. *Id.* § 164.512(c)(1).

278. TENN. CODE ANN. § 37-1-403 (2018). Indeed, Tennessee’s law is unusually broad in that it requires “any person” to make sure to report. *Id.* (emphasis added).

condition of receiving federal funds.²⁷⁹ In order to receive CAPTA funds, each state must submit a plan for the administration of its CAPTA program that complies with a variety of federal requirements.²⁸⁰ Among other conditions, states must put in place

policies and procedures ... to address the needs of infants born with and identified as being affected by substance abuse ... including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants.²⁸¹

When taken together, these provisions allow hospital personnel to disclose to both DCS and police medical information about both mothers who they suspect took drugs while pregnant and about infants who are adversely effected by that exposure.²⁸² Thus, when women who have used narcotics during pregnancy enter the hospital to give birth, their privacy is already severely compromised.

2. *The Child Welfare System*

In Tennessee, the Tennessee Department of Children's Services, or DCS, administers the child welfare system.²⁸³ DCS has a variety of responsibilities when it comes to the protection of children who have been reported to the agency as potential victims of abuse or neglect.²⁸⁴ When a case is called in to the Tennessee child abuse hotline, it is classified into one of two categories: assessment or investigation.²⁸⁵ While the classification of a case as "assessment"

279. *Child Abuse Prevention and Treatment Act (CAPTA) State Grants*, CHILD. BUREAU, ADMIN. FOR CHILD. & FAMILIES (May 17, 2012), www.acf.hhs.gov/programs/cb/resource/capta-state-grants [https://perma.cc/2DZ2-MC9S].

280. 42 U.S.C. § 5106a(b)(1) (2018). This requirement was added to CAPTA as a result of the Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36, 117 Stat. 800, 800-31 (2003).

281. § 5106a(b)(2)(B)(ii).

282. See Bach, *supra* note 34, at 349.

283. *About Us*, TENN. DEP'T CHILD. SERV., <https://www.tn.gov/dcs/about-us.html> [https://perma.cc/4ACA-UX2N].

284. See *id.*

285. See *Tennessee Child Abuse Hotline FAQ*, TENN. DEP'T CHILD. SERV., <https://www.tn.gov/dcs/program-areas/child-safety/reporting/hotline-faq.html> [https://perma.cc/DP59-DUGV].

covers the vast majority of cases, the designation “investigation” is reserved for cases classified by the agency as “severe abuse.”²⁸⁶ Three categories of cases fall into this classification under the statute: sexual and trafficking abuse, abuse resulting in death/near-death, and exposing infants to environments where drugs are being manufactured. However, under agency policies, the presence of an NAS diagnosis leads to a classification of “severe abuse.”²⁸⁷

The classification of a case as “severe child abuse”²⁸⁸ has several related implications. First, the classification indicates that the abuse might lead not just to child welfare intervention by DCS but also to prosecution of the parent.²⁸⁹ Because the cases are considered more severe and because they might involve criminal investigation and prosecution, a severe abuse classification triggers the convening of what in Tennessee is called a Child Protective Investigative Team (CPIT), in which information is shared among the team participants.²⁹⁰ That team is made up both of DCS officials, prosecutors, police, and various other mandated participants.²⁹¹ After preliminary investigation, the team makes a variety of decisions concerning the child welfare case itself.²⁹² In this category falls, among many other issues, decisions as to whether the child will remain in the home or be removed, any services to be offered or

286. Interview with Travis Bishop, Supervisor, Tennessee Department of Children’s Services, Knox Region (May 30, 2018) (transcript on file with author). In Tennessee, the courts have made clear that prenatal substance abuse may constitute severe child abuse for the purpose of termination of parental rights. See *In re B.A.C.*, 317 S.W.3d 718, 725 (Tenn. Ct. App. 2009).

287. See TENN. CODE ANN. § 37-1-102(b)(27) (2018); interview with Travis Bishop, *supra* note 286.

288. TENN. CODE ANN. § 37-1-102(b)(27).

289. Interview with Travis Bishop, *supra* note 286. It is notable that a NAS diagnosis is still considered severe abuse even after the Tennessee statute explicitly criminalizing this conduct is no longer law. When asked about this Mr. Bishop explained that prosecutions are no longer recommended but that the police and DCS officials continue to collaborate, sharing, for example, evidence discovered by DCS of other drug crimes. *Id.*

290. See TENN. CODE ANN. § 37-1-607(b)(1).

291. *Id.* § 37-1-607(a)(3) (“It is the intent of the general assembly that the child protective investigations be conducted by the team members in a manner that not only protects the child but that also preserves any evidence for future criminal prosecutions. It is essential, therefore, that all phases of the child protective investigation be appropriately conducted and that further investigations, as appropriate, be properly conducted and coordinated.”); *Administrative Policies and Procedures 14.6*, TENN. DEP’T CHILD. SERV., <https://files.dcs.tn.gov/policies/chap14/14.6.pdf> [<https://perma.cc/BU4N-6YPP>].

292. See TENN. CODE ANN. § 37-1-607(b)(2).

required, whether the agency will plan for return of the child to the home, and what the parents or guardians must do to facilitate this return.²⁹³ In addition, the CPIT will make a recommendation to the Attorney General's office as to whether it should prosecute the parent.²⁹⁴ While other allegations of abuse could, in particular circumstances, lead DCS to involve police and prosecution in its cases, it is only in the CPIT context that this participation is mandated by DCS procedures.

3. *Police, Prosecution, and Courts*

Once the Attorney General's office determines that a woman should be prosecuted, the case proceeds into the criminal system.²⁹⁵ Every county in the state has a lower level court, called the General Sessions Court, in which misdemeanor prosecutions are generally initiated.²⁹⁶ The General Sessions Court is a court of limited jurisdiction that can conduct preliminary hearings, enter judgment after a plea agreement, and monitor those under sentence in the court.²⁹⁷ A defendant who wishes not to plead in General Sessions Court can either have a preliminary hearing to determine whether there is probable cause to proceed or can waive that hearing.²⁹⁸ If the court finds there is probable cause or if the defendant waives the hearing, the case is "bound over" to a higher court, either Criminal Court or Circuit Court, depending on the judicial district in which the Sessions Court is located.²⁹⁹ As is the case nationally, the vast

293. *See id.*

294. *See id.* § 37-1-607(b)(5); *see also Administrative Policies and Procedures 14.6, supra* note 291.

295. *See* TENN. R. CRIM. P. 4(a) ("If the affidavit of complaint and any supporting affidavits filed with it establish that there is probable cause to believe that an offense has been committed and that the defendant has committed it, the magistrate or clerk shall issue an arrest warrant to an officer authorized by law to execute it or shall issue a criminal summons for the appearance of the defendant.").

296. *See* TENN. CODE ANN. §§ 16-15-501(a)-(b).

297. *See id.* § 16-15-501(d)(1).

298. *See generally* TENN. R. CRIM. P. 5.1.

299. When probable cause is found, "the magistrate shall bind the defendant over to the grand jury and either release the defendant pursuant to applicable law or commit the defendant to jail by a written order." *Id.*; *see also* TENN. R. CRIM. P. 9(a) (stating that when the grand jury returns an indictment or presentment, a capias or criminal summons will issue).

majority of misdemeanor defendants plead guilty.³⁰⁰ In Tennessee, those pleas are generally entered in, and sentences are supervised by, General Sessions Court.³⁰¹ General Sessions Courts are authorized to, and often required to, charge a variety of fees and costs, and have the full power to impose lawful sentences on defendants who plead guilty in their courts or who are found guilty of violating some condition of sentencing.³⁰²

A common outcome for individuals charged with a misdemeanor is the imposition of a jail sentence “suspended” to a probationary term.³⁰³ Such a person is sentenced to a prison sentence, for example a maximum misdemeanor sentence of eleven months and twenty-nine days of incarceration, but that sentence is suspended for the person to complete probation in the community.³⁰⁴ Depending on the county, either county employees or private probation companies under contract with the court system supervise probation.³⁰⁵ A

300. In 2012, 97 percent of federal cases and 94 percent of state cases ended in plea bargains, with defendants pleading guilty in exchange for a lesser sentence. Erica Goode, *Stronger Hand for Judges in the ‘Bazaar’ of Plea Deals*, N.Y. TIMES (Mar. 22, 2012), <https://www.nytimes.com/2012/03/23/us/stronger-hand-for-judges-after-rulings-on-plea-deals.html> [<https://perma.cc/92YC-KXV5>]. This number has increased in most states since that time. In 2017, 98 percent of felony arrests in New York ended in plea bargains. Gaby Del Valle, *Most Criminal Cases End in Plea Bargains, Not Trials*, OUTLINE (Aug. 7, 2017) (citing Beth Schwartzapfel, *Defendants Kept in the Dark About Evidence, Until It’s Too Late*, N.Y. TIMES (Aug. 7, 2017), https://www.nytimes.com/2017/08/07/nyregion/defendants-kept-in-the-dark-about-evidence-until-its-too-late.html?_r=0 [<https://perma.cc/ER7J-LN9J>]), <https://theoutline.com/post/2066/most-criminal-cases-end-in-plea-bargains-not-trials?zd=1> [<https://perma.cc/9X45-TQZD>]).

301. “At the General Sessions level, a defendant charged with a misdemeanor has the option [to] plead guilty to the charges.” *Criminal Justice 101*, OFF. DISTRICT ATTY GEN. FOR KNOX COUNTY, TENN., <https://www.knoxcounty.org/dag/resources/index.php> [<https://perma.cc/VSV6-BHVQ>]. The judgment and sentence associated with a plea is determined when the plea is accepted. See TENN. R. CRIM. P. 11(c)(1)-(5) (outlining the possible actions of the court in accepting a plea deal).

302. See TENN. CODE ANN. §§ 8-21-401(f)-(g) (2018) (describing the various costs that can be taxed by a general sessions court); see also TENN. R. CRIM. P. 11(c)(1)-(5).

303. See TENN. CODE ANN. § 40-35-303(c)(1) (“If the court determines that a period of probation is appropriate, the court shall sentence the defendant to a specific sentence but shall suspend the execution of all or part of the sentence and place the defendant on supervised or unsupervised probation either immediately or after a period of confinement for a period of time no less than the minimum sentence allowed under the classification.”).

304. *Id.*

305. See *id.* § 40-35-303(k) (“The commissioner of correction, sheriff, warden, superintendent or other official having authority and responsibility for convicted defendants may contract with any appropriate public or private agency not under the commissioner’s, sheriff’s, warden’s, superintendent’s or other official’s control for custody, care, subsistence, education,

failure to comply with probationary terms, which often include the payment of costs and fines, can result in a charge of “violation of probation.”³⁰⁶

If the defendant is found guilty of a violation, he or she can have probation “revoke[d]” at which point he or she must often serve some or all of the previously imposed jail time.³⁰⁷ These charges of violation and the accompanying jail time arise from a failure to comply with a particular probationary requirement, for example making a payment, showing up for an appointment, or passing a drug test.³⁰⁸ In addition, because it is always a requirement of probation not to commit additional crimes, a violation of probation can be filed if there is a new allegation of criminal conduct during the probationary period.³⁰⁹ Put differently, once a person is on probation and engages in criminal conduct, he or she can receive not one but two charges—one for violation of probation and one for the new conduct. If convicted, the person then faces two jail sentences—the jail term of the original offense and jail time on the new offense.³¹⁰ For example, if a defendant is on probation for a misdemeanor and receives a suspended sentence of eleven months and twenty-nine days and then pleads guilty to (or is found guilty of)

treatment or training of the defendants. The cost of the contract services shall be paid by the appropriate state or local entity to the department or the local jail or workhouse.”)

306. *See id.* § 40-35-311(a)-(b) (“Whenever it comes to the attention of the trial judge that any defendant who has been released upon suspension of sentence has been guilty of any breach of the laws of this state or has violated the conditions of probation, the trial judge shall have the power to cause to be issued under the trial judge’s hand a warrant for the arrest of the defendant as in any other criminal case.”).

307. *See id.* § 40-35-311(e)(1)(A)-(B) (explaining the two alternatives a trial judge is statutorily bound to follow when a violation of probation is found).

308. *See id.* §§ 40-35-303(d)-(i).

309. *Id.* § 40-35-311(e)(1) (“If the trial judge finds that the defendant has violated the conditions of probation and suspension by a preponderance of the evidence, the trial judge shall have the right by order duly entered upon the minutes of the court to revoke the probation and suspension of sentence.”).

310. “If, while on probation, the defendant is given a jail sentence for a new case to run consecutively to the probated case, that sentence tolls the probationary period until he is released from parole expiration on the intervening sentence. Then his probation starts running again.” Chris Craft, *Alternative Sentencing: Probation, Community Corrections, Diversion, Modification and Revocation*, TENN. JUD. ACAD. (Aug. 21, 2014) (citing *State v. Malone*, 928 S.W.2d 41, 44 (Tenn. Crim. App. 1995)), http://www.tncourts.gov/sites/default/files/docs/what_every_judge_should_know_about_criminal_law-ppt_handouts.pdf [<https://perma.cc/8G2E-QAAY>].

another class A misdemeanor, the resulting sentence could be up to twenty-two months and fifty-eight days of jail time.³¹¹

For those readers not familiar with U.S. criminal systems, another important piece to understand is the use of jail and bail during the course of these cases. Courts often jail misdemeanor defendants at the initiation of the prosecution.³¹² Within fourteen days of that jailing, a court official generally makes one of three determinations.³¹³ First, the court official can release a person upon a promise to return to court.³¹⁴ Second, that official, who is sometimes, but not always, a judge, can impose bail allowing the defendant to deposit money with the court in order to be released.³¹⁵ Finally, the official can decide to hold the person without bail, in which case the defendant will remain in jail until the charges resolve.³¹⁶ If bail is set, the vast majority of defendants pay, if they can, through the use of a private bonding company.³¹⁷ The individual generally must deposit 10 percent of the bail amount and the company will guarantee the rest.³¹⁸

The significance of the bail system is difficult to overstate, particularly for poor defendants who are eligible to receive a probationary sentence. For those defendants, a plea agreement is, without question, the quickest way to get out of jail and back to the

311. The resulting sentence being a combination of the two eleven month, twenty-nine-day misdemeanor maximums.

312. See TENN. R. CRIM. P. 5.1(b).

313. See TENN. R. CRIM. P. 5(c)(1)(B) (“The magistrate shall schedule a preliminary hearing to be held within fourteen days if the defendant remains in custody.”); see also 8 TENNESSEE JURISPRUDENCE: CRIMINAL PROCEDURE. § 20 (2018).

314. See 8 TENNESSEE JURISPRUDENCE: CRIMINAL PROCEDURE § 20; see also David M. Reutter & Mel Motel, *Bail Bond Companies Profit While Poorest Defendants Remain in Jail*, JUST POL’Y INST.: JUST. POL’Y BLOG (Sept. 26, 2012), <http://blog.justicepolicy.org/2012/09/bail-bond-companies-profit-while.html> [<https://perma.cc/CN77-4F3S>] (“Most defendants were released through publicly-funded pretrial services that granted release on personal recognizance based on a promise to appear at future court dates.”).

315. 8 TENNESSEE JURISPRUDENCE: CRIMINAL PROCEDURE § 18 (“[I]f it appears that an offense has been committed and there is probable cause to believe the defendant guilty thereof, the accused must be committed to jail or admitted to bail to await the action of the grand jury.”).

316. *Id.* § 20.

317. See Reutter & Motel, *supra* note 314.

318. See *id.* (“[F]or every detainee released through a pretrial release program, that’s one less potential fee available to bondsmen, who usually collect 10 percent of the full bond amount from their paying customers.”).

community.³¹⁹ If you cannot make bail, and you refuse to plead in General Sessions Court, you will sit in jail for weeks or months while your case is bound over to a higher court, and if you then choose to litigate in that court, you can easily sit in jail for many more months before hearings and trial in your case.³²⁰ For defendants facing more serious charges, who may have no hope of a nonjail sentence, the bail system plays a different role, but for those who could receive probation, the pressure the bail system creates to plead is extraordinary.³²¹

D. Tracing the Cases

The cases of the low-income, white women prosecuted in Eastern Tennessee play out within these basic structures. For this Article, I examined the court files of forty-one women prosecuted in the Appalachian regions of East Tennessee, all of whom were prosecuted for this crime.³²² As noted above, all but one of these women are white, and all of the women for whom their court files or birth records indicated their income level were poor.³²³ In analyzing these case files, I was seeking to answer several questions concerning the role of care and its relationship to criminal prosecution. First, what was the role of healthcare providers in the prosecutions and how might that role have affected the care women received during their pregnancies? Second, what might we learn about the relationship between prosecution and care if we look at the cases through the lens of the articulated intention to use the law to provide treatment to women giving birth to infants with NAS?

As to the first question, the criminal court files reveal that the vast majority of prosecutions relied heavily on information gathered

319. *See id.* (“Defendants who can afford to pay a bonding company are released from jail, while poor defendants who cannot remain behind bars—sometimes for months or years while awaiting trial.”).

320. *See id.*

321. *See id.*; *see also Replacing Bail with an Algorithm*, *ECONOMIST* (Nov. 23, 2017), <https://www.economist.com/news/united-states/21731631-new-jersey-has-bold-experiment-reduce-number-people-jail-awaiting> [<https://perma.cc/HM3G-X38Q>] (detailing the ways in which the commercial bail industry has impacted defendants of various socioeconomic backgrounds and has rooted itself in the justice system).

322. Please note that throughout this Section of the Article women are referred to by pseudonyms assigned to each file during the research process.

323. *See supra* note 268 and accompanying text.

by hospital personnel in the hospital setting and that these disclosures, while arguably lawful, conflicted with fundamental tenets of confidentiality that underlie the relationship between patients and care providers.³²⁴ As to the second large question—what of the supposition that these prosecutions were a “velvet hammer” leading to care—one can break the evidence in the files down into three basic categories: (1) those in which there is evidence of an offer of or provision of treatment as part of the criminal case, (2) those that indicate that the woman accessed treatment outside the criminal case, and (3) those in which there is no such evidence.³²⁵ The majority fall into the last group and, in those files it is clear that the criminal cases were entirely about punishment, as that punishment plays out in the lower criminal courts all over the nation.³²⁶ For the minority who did receive some offers of care as part of their criminal case, these offers came at a very high punitive price.³²⁷

1. The Role of Hospitals and Hospital Personnel in Prosecutions

A central contention of those who opposed the passage of the fetal assault law was that prosecuting women for conduct that harmed their fetus would deter women from seeking both prenatal care and substance abuse treatment.³²⁸ The advocates certainly had history on their side in that fear. South Carolina is one of now only two states in which the state high court has held that a fetus is a person for the purposes of prosecutions against pregnant women for the ingestion of drugs while pregnant.³²⁹ The impact of that court decision on pregnant women’s utilization of drug treatment programs was clear. In the year following a decision by the South Carolina Supreme Court to treat a viable fetus as a “child” for the purposes of South Carolina’s child abuse and endangerment

324. See *infra* Part III.D.1.

325. See *infra* Part III.D.2.

326. See Part III.D.2.

327. See *infra* Part III.D.3.

328. See Alexa Kolbi-Molinas, *What's Next? Prosecuting a Pregnant Woman for Working Full Time?*, ACLU: SPEAK FREELY BLOG (Dec. 11, 2014), <https://www.aclu.org/blog/speakeasy/whats-next-prosecuting-pregnant-woman-working-full-time> [<https://perma.cc/5NFB-S58A>].

329. See Howard, *supra* note 210, at 46, 48-50.

statute,³³⁰ “drug treatment programs in the state experienced as much as an 80% decline in admissions of pregnant women.”³³¹ This history appears to have been repeated in a different form in Tennessee.

In the eastern part of the state, East Tennessee Children’s Hospital is a major care provider for infants with more serious forms of NAS, providing what many consider to be the highest standard of care.³³² That hospital tracked the number of admitted infants with NAS who had no prenatal care before and after the implementation of the fetal assault law.³³³ Their results, while based on very small numbers, are quite disturbing. In the quarter before the law passed, only one infant diagnosed with NAS had no prenatal care.³³⁴ Two quarters later, in the last three months of 2014, six infants with NAS had had no prenatal care.³³⁵ While the number went down to three in the first quarter of 2015 it rose again over the next several quarters, from seven, to seventeen and sixteen infants in the last two quarters of 2015.³³⁶ This provides some evidence that the fears of advocates were well-founded.

Examining the criminal case files sheds some light on why women might have feared that seeking care could lead not to care but to punishment. The forty-one women who are the focus of this Section almost without exception received medical care during or after the birth of their child at a local hospital. A few appear to have tried to avoid hospital care altogether. For example, Lacy Wilder, a low-income white woman, gave birth to her son in a toilet in her home. It was only after the birth of the child that she and her son were

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

331. Cynthia Dailard & Elizabeth Nash, *State Responses to Substance Abuse Among Pregnant Women*, GUTTMACHER REP. PUB. POL’Y (2000), <http://www.guttmacher.org/pubs/tgr/03/6/gr030603.html> [<https://perma.cc/KRD3-5G3E>].

332. *See Neonatal Intensive Care in East Tennessee*, E. TENN. CHILD. HOSP., <https://www.etch.com/Specialties/Neonatal-Intensive-Care.aspx> [<https://perma.cc/3ELJ-7LRB>].

333. *East Tennessee Children’s Hospital - NAS Babies with No Prenatal Care*, E. TENN. CHILD. HOSP., https://www.scribd.com/doc/303920415/East-Tennessee-Children-s-Hospital-No-Prenatal-Care-Chart#fullscreen&from_embed [<https://perma.cc/7472-A8ZL>].

334. *Id.*

335. *Id.*

336. *Id.*; see also Paul C. Erwin et al., *Neonatal Abstinence Syndrome in East Tennessee: Characteristics and Risk Factors Among Mothers and Infants in One Area of Appalachia*, 28 J. HEALTH CARE FOR POOR & UNDERSERVED 1393, 1404 (2017).

transported to a hospital for care. Several other women in the study gave birth to their infants in cars.

What is perhaps most striking about the court files and their relationship to care is the overwhelming presence of what might generally be assumed to be confidential medical information in the files. As noted above, the law provides extensive protections against the use of confidential medical information in the prosecution of a crime but carves out exceptions in cases of potential abuse.³³⁷ Each criminal case is initiated through a charging document that provides a factual basis for the prosecution.³³⁸ In order to bring charges, the state must allege conduct that, if proven, would allow for a conviction of the offense.³³⁹ In all forty-one cases, the facts alleged were collected, at least in part, in the hospital setting. The files contain references to drug test results of the mother, the umbilical cord, and the infant; statements made by women to doctors and nurses about drug use; and symptoms exhibited by the infants. The case of Dana Mitchell is typical. The Affidavit of Complaint underlying her charges alleges that:

[Dana Mitchell] gave birth to a baby girl ... [at X Medical Center]. Upon admission [Dana's] UDS (urine drug screen) tested positive for THC and Opiates. It is reported that during her prenatal care [Dana] tested positive for THC. Opiates and Benzodiazepines and counseled for her drug use by the OBGYN. Baby ... was born at 39 weeks with a weight of 6 lbs 9 oz. [the infant] was showing signs of withdrawal. The cord state of [the infant] came back positive for THC and Opiates (Hydrocodone and Oxycodone).

This particular affidavit then goes on to detail additional facts provided to the police by the DCS investigator assigned to the case.

Similarly, the Affidavit of Complaint in Vanessa Thomas's case states that:

On the above date [an infant] was born at [a hospital] with the defendant being the mother of the child. Upon admission to the hospital [Vanessa Thomas] told staff that she had been taking

337. See *supra* notes 272-78 and accompanying text.

338. See TENN. R. CRIM. P. 3.

339. See *id.*

suboxone that she did not have a prescription [stet]. She did test positive for suboxone ... The umbilical cord came back testing positive for suboxone. The child was transported to [another hospital] because of the high levels on its Finnegan score, and the child had neonatal abstinence syndrome. Some of the symptoms was excessive crying, swelling, sneezing, nasal stuffiness, milk tremors, sleeps less than one hour after feeds. On [x date the hospital] reported that the Finnegan score was up to 15.

While these disclosures are arguably legal under the various exceptions to HIPAA outlined above,³⁴⁰ the affidavits raise serious questions about how the confidentiality exceptions might be subtly or not-so-subtly affecting the relationships of trust between patients and providers that are so essential to the provision of care. The conversations that led to these disclosures were no doubt in large part essential to providing care to the women and their infants. Making sure, for example, that the treating professionals know that a pregnant woman ingested particular substances during pregnancy is no doubt important to the health of both mother and child. The general presumptions of confidentiality and trust encourage patients to disclose what can be embarrassing and potentially legally-compromising information to their caretakers.³⁴¹ But, one has to wonder whether the patients who were participating in these conversations presumed that the information was confidential. One has to wonder further how women reacted and how word spread once it became clear that their doctors and nurses were the main source of information leading to prosecution. The number of women who gave birth outside a hospital setting in the sample as well as the declining use of prenatal care suggests that this vulnerability to reporting may well have added to women's fears.

Going even further, it is not entirely clear whether the healthcare providers were viewing their role solely through the lens of medical care or whether, at certain crucial moments, they also viewed themselves and conducted themselves as an arm of the police. Take for example Vanessa Thomas's case described above. Ms. Thomas

340. See *supra* notes 272-78 and accompanying text.

341. *Confidentiality, Patient/Physician*, AM. ACAD. FAM. PHYSICIANS (Dec. 2017), <https://www.aafp.org/about/policies/all/patient-confidentiality.html> [<https://perma.cc/PK6V-RKMG>].

apparently disclosed to her care provider that she took Suboxone, a prescription medication, during her pregnancy and she did not have a prescription for that medication. Suboxone is the brand name for an opiate (buprenorphine alone or in combination with naloxone) prescribed to those suffering from addiction.³⁴² While The American College of Obstetricians and Gynecologists recommends methadone for treating pregnant women addicted to opiates, they also suggest that drugs such as buprenorphine can play the same role.³⁴³ While available by prescription, Suboxone is also often available from illegal sources.³⁴⁴

In the course of the conversation with her care provider, Ms. Thomas disclosed not only that she took Suboxone, but that she had no prescription for that medication. If this particular infant's symptoms had arisen solely from the ingestion of prescription narcotics, then there was no basis for prosecution,³⁴⁵ a fact at least potentially within the knowledge of this care provider. This leads inevitably to the question of why questions about the source of her Suboxone were asked. Did the provider have a medical basis for asking this clearly legally important question? Perhaps s/he asked it because s/he was required by CAPTA to disclose to child welfare officials infants, "born with and identified as being affected by substance abuse."³⁴⁶ Perhaps s/he had slipped roles from healthcare provider to investigator for child welfare, the police and prosecution?³⁴⁷ In these subtle and, perhaps, not so subtle ways, the role of

342. NAT'L CTR. SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., *supra* note 156, at 75.

343. *See* AM. OBSTETRICIANS & GYNECOLOGISTS, *supra* note 189, at 4.

344. *See* Kate King, *Lacking Treatment Options, Opioid Addicts Turn to Black Market*, WALL ST. J. (June 22, 2017, 8:00 AM), <https://www.wsj.com/articles/lacking-treatment-options-opioid-addicts-turn-to-black-market-1498132803> [<https://perma.cc/G34A-QLB5>].

345. *See* TENN. CODE ANN. § 39-13-107(c)(2) (2018) ("Nothing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the *illegal* use of a narcotic drug ... while pregnant." (emphasis added)).

346. 42 U.S.C. § 5106a(b)(2)(B)(ii) (2012) (emphasis added).

347. There is another plausible explanation for this line of inquiry. In 2013, Tennessee began requiring hospitals to report cases of NAS. Warren et al., *supra* note 193, at 125. As part of this reporting, the hospital must report the source of exposure, which includes reporting whether the exposure was as a result of legally prescribed or off-prescription use. TENN. DEP'T OF HEALTH, QUICK REFERENCE GUIDE TO THE NEONATAL ABSTINENCE SYNDROME (NAS) REPORTING SYSTEM (2012), https://www.tn.gov/content/dam/tn/health/documents/nas/NAS_ReportingQuickReferenceGuide.pdf [<https://perma.cc/3KGV-D63Y>]. That particular reporting requirement, however, is anonymous in the sense that no names or demographic information about the mothers or infants is provided to the Department. *See id.*

healthcare providers in these hospitals settings played a significant role in prosecutions and, at least arguably, undermined trust needed between patient and care provider that is so essential to high quality care.

2. The Relationship Between Prosecution and Care

As detailed above, a central justification for passage of the law was that it would provide an incentive for women to seek treatment and a set of mechanisms to ensure that it would be available to them. With respect to accessing treatment as part of their criminal cases, these women fall into four basic categories. The cases of six women were dismissed in court for a variety of reasons, including that there was no allegation and presumably no evidence that those women had actually consumed narcotics during their pregnancies or that they “did not meet the statute” for some other reason.³⁴⁸ The remaining thirty-five women pled guilty to the charge and received a variety of dispositions in their cases. As to accessing treatment, the files of two of the women indicate that they were mandated to complete some form of alcohol and drug assessment as part of their mandatory probation. These two court files tell us nothing about whether that assessment was done or what happened as a result of it. Twelve other women were in fact mandated to go to some level of treatment, such as Sarah Hunter, who was mandated to go to “90 meetings in 90 days,” and others who were clearly sent to inpatient facilities for some period of time as a part of their sentence. For the other twenty-one women, despite having pled guilty, there is no evidence in their files that treatment was offered or provided.

For the twelve women who were given some access to treatment in the course of their criminal case, the level of detail in the files varies significantly, from a simple notation that the defendant was to complete or was referred to a particular program, to extensive details cataloguing the various stages of her case. For the purposes of painting the picture of the interactions between criminal prosecution and treatment, I recount below, in a good deal of detail,

348. For example, the affidavits of complaint in two of the cases assert only that the women tested positive for THC, which is evidence of marijuana usage but not evidence of the usage of narcotics.

the facts that the General Sessions Court file reveals about five cases. The first two cases are those of Maria Walsh and Vanessa Thomas.

3. Accessing Treatment at a Cost: The Cases of Maria Walsh and Vanessa Thomas

Ms. Walsh, like the rest of the defendants, gave birth to an infant with various health problems associated with opiate exposure. The affidavit of complaint charging her with fetal assault details the problems associated with her labor, the symptoms of her infant, and the results of various drug tests performed in the hospital.

Ms. Walsh gave birth in March of 2015, and was charged with fetal assault and arrested four months later. Bail was set at \$10,000. She appears to have made bail because she was subsequently charged with another offense—the failure to appear at a court date. The court file, provided by the court for this research, contains no record of the scheduling of this court date nor any notification to her that there was in fact a court date. Nevertheless, by the time she pled guilty in late July, she pled to both charges and received two consecutive sentences of eleven months and twenty-nine days suspended to probation. The court imposed probation fees of \$100, presumably per month and court costs “as set.” She was required to pay \$50 per month toward these expenses. At that time, the judgment contemplated that she would be on probation four days short of two years, which, at a cost of \$100 per month, would result in the imposition of \$2,400 in probation fees, as well as other court costs. Clearly, all parties assumed that there was some chance that this indigent defendant would not be able to pay all these payments, because there is a notation on the judgment indicating that “[d]efendant agrees to extend probation [beyond the two years] until P.I.F.” This particular notation appears in the judgments for every defendant in that particular county. Upon inquiry, court staff informed me that P.I.F stands for “paid in full.”

Eight months later, Ms. Walsh was charged with a violation of probation issues for two offenses, the failure to “pay monetary obligations,” which, at that point, totaled \$618.50 and a failure to appear in court, “as required by the terms of [her] probation to explain any reasons for his/her failure to comply with other

probation requirements.” Her cost sheet indicates that, between the initiation of charges and the violation of probation, she had managed to pay only \$40.00.

On this violation, Ms. Walsh was ordered held without bond. After one month in jail, she pled guilty, her probation was revoked, and she was ordered to serve two years in prison. It was only at this point that there was any indication of an offer of treatment. The judgment on that day stated, “after serving 9 months in jail, the Court agrees to allow the defendant to enter and complete long-term rehab, as approved by the Court.” As to the issue of her costs, in a decision rare among the files, Ms. Walsh was also “declared indigent as to cost in this case.”

The case of Vanessa Thomas, the woman who told hospital personnel that she had obtained Suboxone illegally, is—like Ms. Walsh’s case—emblematic of several in the sample in which women were, in fact, given access to treatment, but that treatment came at a tremendously high risk of sanctions for the failure to comply and at a high monetary cost. At the time of her prosecution for fetal assault, Ms. Thomas was already on probation for simple possession of a controlled substance and child abuse. She had pled guilty to those charges the year prior to her pregnancy and was in the midst of serving two consecutive sentences of eleven months and twenty-nine days each on probation. Any violation of that probation could result in the reinstatement of her almost two-year jail term. In this sense, she was already known to the criminal system. And, because she was already on probation, a condition of that probation was not to commit additional crimes. In addition, in her original case, Ms. Thomas had been ordered to pay several hundred dollars in court costs, and she had not kept up with her payments. At the time of her child’s birth, Ms. Thomas was then facing sanction not only for fetal assault but for two separate instances of violation of probation—the failure to pay costs and the failure to desist from criminal activity. This set of circumstances would significantly impact the trajectory of her case and would make the consequences of any failure to comply with court orders very steep.

Ms. Thomas gave birth to her child on January 3, 2015. An arrest warrant was issued twelve days later, on January 15, and she was arrested and taken to jail on that day. No bail was set, so, presumably, Ms. Thomas remained in jail until her case was resolved. A

judge at that point made a determination that Ms. Thomas was indigent and appointed a public defender to represent her. Given that determination, it is not clear why the court expected her to be able to pay the various costs associated with her case, but nevertheless, these fees continued to accrue throughout her case.

Ms. Thomas's fetal assault case would not be resolved for nearly two more months, during which time she presumably sat in jail. Between the fetal assault charge and her ultimate plea on March 17, 2015, the state filed two separate allegations of violation of probation—one for a failure to pay and one for having committed the crime of fetal assault while on probation. Though her original court costs had originally been lower, by mid-March, they were up to \$1,701.75, and she had made little progress in paying them. She also found herself facing the potential of significant jail time. If her probation on the original charges was revoked, the judge could do a variety of things, including continuing probation, imposing some jail time followed by more probation, or imposing the original jail sentence of eleven months and twenty-nine days.³⁴⁹ In addition, a finding of guilty of the fetal assault charge could result in another eleven month and twenty-nine day sentence for that charge or a total of almost two years in prison.³⁵⁰ So, going into court on March 17, 2015, Ms. Thomas faced serious risks of incarceration.

On that day, Ms. Thomas did plead guilty, and she was sentenced to a year in prison—six months for the violation of probation and another six months for the fetal assault charge. Though the judge imposed this jail time, he suspended her jail sentence so that she could go to inpatient treatment. Ms. Thomas went to jail and waited for a treatment bed. It was not until June 16, three months later, that a bed became available. During that three-month period, Ms. Thomas had a constitutional right to receive healthcare,³⁵¹ but, given the paucity of funding and widespread allegations that care is

349. See TENN. CODE ANN. § 40-35-311(e)(1).

350. This potential sentence would be reduced by any days Ms. Thomas had already served, before various hearings and trials, in jail. For example, if she was sentenced to two eleven month and twenty-nine day consecutive sentences but had already been in jail before various court proceedings for twenty-two days, she would serve the full sentence minus twenty-two days.

351. See *Estelle v. Gamble*, 429 U.S. 97, 103-05 (1976).

not in fact provided, there is little reason to be confident that she received any addiction care in jail.

It is hard to tell what happened with the treatment bed, but, on October 2, 2015, there was a new violation of probation filed, alleging two violations—that she had failed to appear for her long-term treatment and that she had failed to make any progress on her court costs. She got arrested two months later, on December 21, 2015. On January 25, 2016, she was ordered to serve 180 days and then was again placed on probation, “until compliance.” Presumably, this order was focused on compliance with the order to pay costs. By 2016, Ms. Thomas’s costs on the fetal assault charge, as well as the various violations of probation, totaled \$4,478.25. Her cost bill, like all the cost bills in the sample, included a wide range of charges. For example, on one of the violations of probation, for which she owed a total of \$3,827.75, she owed sixteen different categories of fees:

Fee	Amount
State Criminal Fee	\$2.00
State Cic	\$26.50
Attorneys Reim Tax	\$2.75
Fingerprint Tax	\$1.00
Victim Notification Fund	\$3.00
Judicial Comm. Tax	\$2.00
Officers Cost—County	\$40.00
County Litigation Tax	\$37.50
Courthouse Building Fund	\$2.00
Library Fund	\$1.00
Data Entry Gen. Sess.	\$4.00
Clerk Fee Gen. Sess.	\$62.00
Jail Fees-Other	\$3,600.00
Data Entry Officer	\$2.00
Mis/Felony Tax	\$12.50
Litigation Tax	\$29.50
Total	\$3,827.75

Several items are of note in this cost sheet. First, note the number of parts of the system that are funded, at least in part, through the

imposition of small fees charged to criminal defendants. Everything from the prison library to the taking of fingerprints is paid for, at least in part, by the defendants themselves. A second thing to note is the \$3,600 charge for her jailing. The practice of charging defendants for costs associated with their jailing is quite widespread.

The data above was run and provided to me on December 29, 2016, nearly a year after the last event in Ms. Thomas's case. At that point, she had not made any payments. And unlike Ms. Walsh, who was lucky enough to have gotten a decision from the judge declaring her indigent and therefore waiving her costs, Ms. Thomas was not so lucky. The court had the authority to hold open her probation until she fully paid these costs as well as the costs associated with her other charges. Given Ms. Thomas's indigency, it seems likely that she, like so many around the country, embroiled in the cost and fee structures of lower criminal courts,³⁵² will remain under supervision and subject to potential sanction because of those costs.

These two cases are emblematic of those of several women in the study in the relationship between punishment and care. In Ms. Walsh's case, there was an indication that after nine months in jail as punishment for fetal assault, missing court dates, and failing to pay costs, she might get a treatment bed. For Ms. Thomas, she did eventually receive an offer of in-patient treatment. We do not know what happened, but there is at least an allegation that she did not take advantage of that resource. So in this sense, perhaps the legislation was working as it was designed to work; the prosecution, threats of jail, and imposition of high fees served as a "velvet hammer" that might have coerced these two women into getting the help they needed.³⁵³ But these cases also make clear that these offers of treatment—for this particular population of low-income white women giving birth to infants with NAS—came at a high risk, a high punitive price, and at the risk of potentially unending possibilities of punishment by the criminal system.

352. See EDELMAN, *supra* note 42, at 7.

353. See *supra* note 227 and accompanying text.

4. *Criminal Prosecution Despite Engagement in Treatment:
The Case of Lacy Wilder*

The case of Lacy Wilder represents a different set of circumstances regarding the relationship between prosecution and access to treatment. Ms. Wilder, like Ms. Thomas, is white and low-income. Also like Ms. Thomas, at the time she gave birth to her child Ms. Wilder was already on probation, subjecting her to potential punishment not just for the fetal assault, but also for violating her probation by committing a new crime. In 2012, approximately two years prior to the birth of her child, Ms. Wilder had pled guilty to promotion of methamphetamine manufacture, a Class D felony.³⁵⁴ At that time, the court imposed a three-year jail sentence, but suspended that sentence to supervised probation.

As was the case for Ms. Thomas, any violation could lead to revocation of probation and imposition of that three-year jail term. At the time Ms. Wilder pled guilty to that felony, she owed a balance of \$8,803.00 in fees. Two years later, in April of 2014, a violation of probation was filed in her case, alleging, among other things, that she failed a drug test. A warrant issued; bond was set at \$50,000, but she was not arrested at that time. It was not until January of 2015 that these charges were resolved. At that point, Ms. Wilder pled guilty to the violation of probation, her probation was reinstated, and the court extended supervision another six months.

Before that plea, though, in July of 2014, Ms. Wilder gave birth in a toilet in her home. Her court file revealed that she admitted to someone (it is not clear who) that she had used methamphetamines, opiates, and subutex during her pregnancy. The prosecution was clearly already aware that she had used drugs during her pregnancy because they had charged her, three months earlier, with violating probation by failing a drug test and had added six months to her sentence for that violation. Despite this, the prosecution engaged in the fairly common practice of adding any and all additional possible charges. So, in January of 2015, the state brought the new fetal assault charge. In December of 2014, she was arrested on the assault charge and, two months later, in March of 2015, she was again charged with violation of probation. This time,

354. See TENN. CODE ANN. § 37-17-433(f) (2018).

the allegation was that she had violated probation by engaging in criminal activity: the fetal assault itself.

Now, because of these two new charges, she was again facing a potential reinstatement of her now three-and-a-half year jail sentence as well as a jail sentence of up to eleven months and twenty-nine days for the fetal assault itself. In August of that year she again pled guilty, this time to an additional year of probation.

Although Ms. Wilder's story is similar to Ms. Thomas's in the trajectory of a woman already on probation in the system, her treatment story is quite different. Her court file revealed that within weeks of giving birth both Ms. Wilder and the father of the child voluntarily entered an outpatient treatment program. This apparently went well enough that the Department of Children's Services voluntarily returned the child to Ms. Wilder's home, an indication that the agency had concluded that Ms. Wilder was addressing her addiction issues and that her child was safe in her care. This set of decisions, by Ms. Wilder to enter treatment and by DCS to allow her to parent, did not end the prosecution. As described above, the state proceeded, leaving her on probation and subject both to continued supervision and, at that point, to nearly \$9,000 in costs and fees on her felony case and an additional \$415.50 in costs on her fetal assault case.

5. Criminal Prosecution Without Treatment: The Cases of Margaret Swann and Bailey Johnson

Although the cases of Ms. Walsh, Ms. Thomas, and Ms. Wilder tell a story of treatment associated to some degree with the criminal case, in twenty-one of the thirty-six cases in which women pled guilty, there is no indication in the files that treatment was offered or required during the case.³⁵⁵ These cases play out, to a large extent, in ways that mirror misdemeanor prosecutions in general, with the imposition of probation along with fees that must be paid

355. Before proceeding, it is important to note the limitations of this data. The fact that the criminal case files do not show an offer of or requirement of treatment does not mean that these women may not have been offered treatment by actors within either the child welfare or the criminal legal systems. It does, however, indicate that offering and/or requiring treatment was not central to the disposition of the case.

prior to the closure of the case and the end of probation.³⁵⁶ The cases of Margaret Swann and Bailey Johnson, both of whom are also low-income and white, are emblematic of these cases.

In June of 2015, Ms. Swann gave birth to a child who was, according to the file, born with withdrawal symptoms. A month and a half later, Ms. Swann was charged with fetal assault, a warrant issued for her arrest, and bail was set at \$10,000. She was arrested about two weeks later, stayed in jail until her court date and, on the day of court, pled guilty. She was sentenced to eleven months and twenty-nine days in jail suspended to probation and she was ordered to pay \$75.00 a month toward her costs and toward the fee for her probation. A month later, she paid her costs in full and nine months later, having not been accused of violating her probation, her case was closed. There was no indication in her file that she was offered or had access to treatment as a result of the prosecution.

Unlike Ms. Swann, Ms. Johnson was not quite as compliant with court requirements. She gave birth in June of 2015 and, like the vast majority of defendants in the study, her court file contained what would otherwise be protected medical information.³⁵⁷ Unlike many of the other court files, but similar to the cases in this particular jurisdiction, Ms. Johnson was charged with attempted fetal assault rather than with fetal assault itself. This charge carried half the maximum penalty or five months and twenty-nine days of incarceration.³⁵⁸ In late October 2016 she pled guilty to that offense, was fined \$25.00, and received the full sentence (five months and twenty-nine days) suspended to probation. On that day, she was given a cost statement totalling \$810.50 and was ordered

356. See *supra* Part III.C.3 (discussing misdemeanor prosecutions in Tennessee General Sessions Court).

357. One interesting aspect of Ms. Johnson's case, which is mirrored in prosecutions across the state, involves the drug she is charged with ingesting during pregnancy. Ms. Johnson's affidavit of complaint alleges that her infant tested positive for cocaine. As discussed above, the fetal assault law was framed as a response to NAS, which is a condition that results from neonatal exposure to opiates, not cocaine. See Witt et al., *supra* note 141, at 1124. Nevertheless, the statute contemplated exposure to "narcotics," which in Tennessee are defined by statute to include cocaine. See TENN. CODE ANN. § 39-17-402(17)(D).

358. In Tennessee, a criminal attempt is classified as "one ... classification lower than the most serious crime attempted." TENN. CODE ANN. § 39-12-107. In this case, fetal assault is classified as a class A misdemeanor, so the attempt was classified as a class B misdemeanor. See *supra* note 215 and accompanying text. The maximum penalty for a class B misdemeanor in Tennessee is five months and twenty-nine days. TENN. CODE ANN. § 40-35-111(e)(2).

to pay \$10.00 per month toward those costs. In a notation echoed in other files, this cost statement says that, “Per New Tennessee Law, if not paid in full within one year of plea, license will be revoked without notice.”

After sentencing, Ms. Johnson was assigned to serve her probation with the Correctional Counseling Institute, a local private probation company under contract with the court. Four months later, there was a report that she missed an appointment. A letter was sent scheduling an additional appointment and she did not appear. A bench warrant issued for Ms. Johnson’s arrest to “answer to the charge of FTR 14 days in jail.” Presumably, FTR was shorthand for failure to report, and, according to the court note on the warrant, she had to serve fourteen days in jail as a result of the allegation. She was arrested in early July and appeared in court eight days later. She was then ordered to serve thirty days in jail. By that time, her costs included not only the \$810.50 on the original charge, but an additional \$1,032 on the violation of probation, for a total of \$1,842.50. Unlike Ms. Swann, who somehow gathered the resources to buy her way out of supervision and punishment, Ms. Johnson would remain under supervision and the threat of additional incarceration until those, and any additional costs imposed as a result of continued supervision, were paid. For her, and for many others subject to those conditions, escape seemed nearly impossible.

IV. THE ROAD FORWARD

This Article began by centering the idea, deeply embedded in the justifications for passage of Tennessee’s fetal assault law, that it is appropriate not only to provide care to those who find themselves subject to the criminal legal system, but that this system of care is so valuable that it made sense to create an entirely new crime just to get those care resources to addicted women in Tennessee. This logic went beyond the original justifications offered for today’s version of problem-solving courts.³⁵⁹ The original justifications argued that, because defendants in court had care needs that were not being addressed elsewhere, the courts should transform.³⁶⁰ The state

359. *See supra* Part I.B.

360. *See supra* note 17 and accompanying text; *see also* Miller, *supra* note 63, at 420-23.

should reframe its mission and add care resources to its structures to address the needs of those who are already there.³⁶¹ But Tennessee's logic goes beyond this. Proponents argued, explicitly, that courts were so good at solving these problems that it made sense to create a crime just to create the possibility that women could receive care.³⁶²

As this Article has shown, however, at least for the women in East Tennessee, this promise was unfilled. For the majority of women, there is no evidence in the criminal court files that care was prioritized in their criminal case.³⁶³ For the minority to whom it was offered, that offer was accompanied by the risk of extraordinary punishment in the form of jail and fines.³⁶⁴ As scholars critical of problem-solving courts have long argued, when you collapse care into a system designed primarily to punish, punishment ultimately prevails.³⁶⁵ There are several lessons to be drawn from this data.

First, while not central to the questions of care at the heart of this Article, these cases provide a particularly poignant example of the profound absurdity and cruelty of funding criminal legal systems on the backs of poor defendants. Every woman discussed in this Article, and likely every woman who was prosecuted, was indigent. Despite their indigence, the fees piled up.³⁶⁶ Some, such as Ms. Swann, found a way to pay them, and one, Ms. Walsh, had her fees waived, but many did not.³⁶⁷ The seemingly prosaic notation in several court files that, “[d]efendant agrees to extend probation until P.I.F.,” and the preprinted notation on many of the plea agreements that, pursuant to Tennessee law, defendants who fail to pay fees will lose their drivers' licenses,³⁶⁸ are stark evidence of the enormous economic pressure placed on poor people finding themselves subject to these systems. As was the case for many of the poor women, escaping this system in the face of this pressure was almost impossible. And failing to comply leads inevitably to more fees and

361. See Miriam Steele et al., *Identifying Therapeutic Action in an Attachment-Centered Intervention with High Risk Families*, 38 CLINICAL SOC. WORK J. 61, 71 (2010).

362. See *Hearing on S.B. 1391 Before S. Judiciary Comm. (I)*, *supra* note 5.

363. See *supra* Part III.D.3.

364. See *supra* Part III.D.3.

365. See *supra* notes 121-26 and accompanying text.

366. See generally Paltrow & Flavin, *supra* note 213, at 310-11.

367. See *supra* Part III.D.

368. *But see* Thomas v. Haslam, 303 F. Supp. 3d 585, 598 (M.D. Tenn. 2018).

more jail time.³⁶⁹ National attention on this issue began in earnest with the publication of the Obama Administration's report on the policing, prosecution, and court systems in Ferguson, Missouri³⁷⁰ and has continued with the publications of Peter Edelman's book, *Not a Crime to Be Poor*.³⁷¹ It is essential that advocacy efforts to eliminate that funding system continue.

Second, and returning to the broader framework of this Article, this case study indicates that the trajectory of the criminalization of poverty and, more specifically, the collapse of notions of social support (or care) into punitive systems, continues apace. Though this is a specific example, others, such as the interlocked social welfare, child welfare, and criminal systems I described in *The Hyperregulatory State*,³⁷² the healthcare system described by Bridges,³⁷³ the targeting of Section 8 recipients by multiple state systems described by Ocen,³⁷⁴ and the intersections between child welfare and prison systems described by Roberts,³⁷⁵ are similar in the means by which criminal systems (and criminal system logic) has moved into the social welfare arena and distorted central notions of care that should be at the heart of our social welfare system.³⁷⁶

So perhaps instead of remaining locked in that historical trajectory, one can read this case study to suggest that we have traveled too far down that road. Instead we must think about ways to rebuild care systems in poor communities separate from the more punitive arms of the state. Moving in this direction involves a series of steps. First, the prosecutions described in this Article arose out

369. See *supra* Part III.D.3.

370. U.S. DEP'T JUST., C.R. DIVISION, INVESTIGATION OF THE FERGUSON POLICE DEPARTMENT, (Mar. 4, 2015), https://www.justice.gov/sites/default/files/opa/press-releases/attachments/2015/03/04/ferguson_police_department_report.pdf [<https://perma.cc/V8PL-58PJ>]; see also Conor Friedersdorf, *Ferguson's Conspiracy Against Black Citizens*, ATLANTIC (Mar. 5, 2015), <https://www.theatlantic.com/national/archive/2015/03/ferguson-as-a-criminal-conspiracy-against-its-black-residents-michael-brown-department-of-justice-report/386887/> [<https://perma.cc/2BKX-5AUV>] (drawing attention to the high use of fees for minor violations by state officials).

371. See EDELMAN, *supra* note 42.

372. See Bach, *supra* note 34.

373. See BRIDGES, *supra* note 47.

374. See Ocen, *supra* note 58.

375. See ROBERTS, *supra* note 53.

376. See *supra* Part I.

of systemic collaborations between healthcare, child welfare, and criminal legal system actors.³⁷⁷ But for those collaborations, the prosecutions could not have taken place. One place to start is to create more structural boundaries between these systems. One can think about this specifically, in terms of the systemic intersections highlighted in this case study, or more broadly, at a wide variety of other systemic intersections giving rise to other ways poverty is prosecuted and care is criminalized. Second, we must draw resources away from punitive agencies and into care systems that function separately from child welfare and criminal systems. These care systems have to function both at the individual and family level and at the community level. And crucially, these systems must be designed with the active participation of members of those communities.

A. Intervening in the Systems at the Heart of the Case Study

The case files reveal the deep collaboration and information sharing between actors in the healthcare, child welfare, and criminal systems that laid the groundwork for these prosecutions.³⁷⁸ One path to reform is to take a careful look at the rules and practices that gave rise to these collaborations.

1. The Healthcare System

As discussed in detail above, the prosecutions highlighted in this Article relied, to a remarkable extent, on information gathered in the healthcare setting.³⁷⁹ Blood test results, statements to care providers, clinical observations, and diagnoses, as well as extensive lab reports were all present in the court files. All this information, once presumed confidential, found its way into public records and into the hands of those who sought not to provide care, but to prosecute and punish. As detailed above, generally speaking, these disclosures were likely authorized by the various legal rules concerning child abuse reporting.³⁸⁰ The case study, however, raises

377. *See supra* Part III.D.1.

378. *See supra* Part III.D.1.

379. *See supra* Part III.C.

380. *See supra* Part III.C.

questions about whether we have struck the proper balance in these legal rules. As discussed above, CAPTA requires disclosure to child welfare officials upon evidence that an infant was “born with and ... affected by substance abuse.”³⁸¹ Moreover, this requirement is laid on top of preexisting state requirements to report suspected cases of abuse.³⁸² This requirement pressures healthcare providers to focus not on the provision of care, but on the gathering of evidence for child welfare and prosecution agencies. In light of the preexisting requirement to report abuse, perhaps CAPTA’s requirements go too far.³⁸³

In the context of existing CAPTA requirements, the data in this paper suggests that the healthcare field, and the legal systems that govern it, have a responsibility to define for themselves what constitutes an infant “affected by substance abuse.”³⁸⁴ Is the presence of drugs in the infant or mother’s system alone enough to require a report? States vary on how they answer this question and the information about these prosecutions might suggest a more conservative approach to reporting.³⁸⁵

However, this case study suggests that a larger reckoning by healthcare providers is in order. There is every reason to fear that this case study is emblematic of larger trends in healthcare for poor people in the U.S. The women’s data here was shared so easily and so extensively that it is hard believe that this is not common practice. Serious inquiry is in order about the ways in which interactions between medical personnel and child welfare and criminal system actors distort the provision of care and likely violate medical ethics principles.³⁸⁶

381. 42 U.S.C. § 5106a(b)(2)(B)(ii) (2012).

382. See TENN. CODE ANN. § 37-1-403(a)(1) (2018).

383. This CAPTA provision was added to the federal statute in 2003. See 42 U.S.C. § 5106a(b)(2)(B)(ii) (2012). Shortly thereafter, Ellen M. Weber argued that the burden placed on healthcare providers to discover and report illegal conduct would distort their care role. See Ellen Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Response*, 75 UMKC L. REV. 789, 839 (2007).

384. 42 U.S.C. § 5105a(b)(2)(B)(ii).

385. See Bach, *supra* note 34, at 349-51.

386. For important work along these lines, see, for example, George J. Barry & Diane L. Redleaf, *Medical Ethics Concerns in Physical Child Abuse Investigations: A Critical Perspective*, FAM. DEF. CTR. (Mar. 14, 2014), <https://www.familydefensecenter.net/wp-content/uploads/2016/04/Medical-Ethics-Concerns-in-Physical-Child-Abuse-Investigations-corrected-reposted.pdf> [<https://perma.cc/N4Z8-B89Q>].

2. *The Child Welfare System*

Just as this case study raises serious questions about how the criminalization of care distorted healthcare, so too does it raise serious questions about the wisdom of easy and automatic collaboration between child welfare and criminal system actors. One of the most striking pieces of policy at the center of these cases is the decision in Tennessee to classify drug exposure as “severe abuse” subject to procedures that draw police and prosecution into the case of every woman who gives birth to a drug-exposed infant.³⁸⁷ And it is important to note that, while the criminal law classifying this conduct as fetal assault is no longer in effect, the classification of drug-exposure as severe abuse remains.³⁸⁸ That decision is, in effect, a determination that women addicted to drugs while pregnant are analogous to those who commit sexual abuse and those whose actions result in the death or near-death of children.

The significant lack of data on the long-term harms of drug-exposure when contrasted with the enormous harms associated with sexual and severe physical abuse certainly calls this analogy into question.³⁸⁹ But beyond this, the designation raises questions about whether the asserted purpose of the child welfare system, like the healthcare system, is being distorted. Although one can certainly question whether the child welfare system is the appropriate entity to respond, it is clear that the child welfare system and the criminal system have different purposes.

Child welfare systems are in place primarily to protect children and are required, in all but a few circumstances, to make reasonable efforts to maintain a child in the home.³⁹⁰ In the vast majority of circumstances they must provide services to mothers to help them achieve reunification.³⁹¹ The goal is not punishment, but support. But when the system conceptualizes a case, from the very start, as one in which criminal intervention is appropriate, we are already talking about punishment. On the micro level, one way to address the harms described in this Article is to reform this state-level

387. See *supra* notes 286-94 and accompanying text.

388. See *In re B.A.C.*, 317 S.W.3d 718, 725 (Tenn. Ct. App. 2009); see also *supra* note 287.

389. See Bandstra et al., *supra* note 11, at 246.

390. See TENN. CODE ANN. § 37-1-166(a) (2018).

391. See *id.* § 37-1-166(c)(3).

policy. But on a broader level, we as a nation need to take a very careful look at collaborations between child welfare, police, and prosecutors. These collaborations are certainly appropriate in some cases, but they undermine the notions of support that should be at the heart of child welfare policy. As a result, they merit careful scrutiny.

3. The Criminal Legal System

As noted above, this case study demonstrates that, in its dominant form,³⁹² the criminal legal system is not tremendously good at providing care.³⁹³ This calls into question the true purpose of criminalizing in-utero drug transmission. Although this Article has focused on the care rationales behind the law, it has also strongly focused on punishment. For the women who are the focus of this study, the criminal legal system turned out to be very good at punishment.³⁹⁴ The first and most obvious lesson one can draw from this is that we need to be very honest about the rationales and functions of crime creation and prosecution. In their functioning, these cases may well have been about punishment, incapacitation, or deterrence, but they were not about the criminal legal system prioritizing access to care.

Even for those women whose files indicate that they were, at some point in their cases, offered an opportunity for care, it came at a very high cost.³⁹⁵ For women such as Maria Walsh and Vanessa Thomas, who were both indigent and who owed thousands of dollars and had spent months in jail at the end of their cases,³⁹⁶ it is not clear how anything that happened was designed to help them get the care they needed to turn their lives around. It may have been

392. One potential answer to the failures demonstrated in this case study, which focused on cases that went through traditional courts, is problem-solving courts and that, had the cases actually gone through them, the results would have been different. Statewide, early data collection in the study indicated that 17 of the 124 documented cases of women prosecuted for fetal assault in Tennessee had their cases processed through the Memphis Drug Court and that, while these women were offered treatment, many of them ultimately failed the program and received jail sentences. Although data collection is not complete, this is the only evidence to date of women accessing drug courts as a result of fetal assault prosecutions.

393. *See supra* Part III.D.

394. *See supra* Part III.D.

395. *See supra* Part III.D.3.

396. *See supra* Part III.D.3.

more politically palatable for some to frame this legislation as a benevolent force, but it turned out not to reflect reality. This case study suggests that, rather than continuing to conceptualize the criminal system as a place where defendants can get help, we should instead return that system to its role in punishment and deterrence, and turn to creating a better, community-based system of care. To do that, though, we have to significantly reframe the problem we are trying to address.

B. Reconceptualizing the Problem and Moving Towards Larger Solutions

Part II of this Article framed the problem that this legislation was responding to as stemming from the rise in rates of neonatal abstinence syndrome.³⁹⁷ It summarized data showing the variation in the severity of neonatal abstinence syndrome, the conflicting and limited evidence concerning the long-term effects of in-utero opiate exposure, and the difficulties of isolating these effects from other variables such as lack of prenatal care, poor nutrition, stress, violence, and postnatal parental drug use.³⁹⁸ In Tennessee, NAS was framed as an epidemic to which the legislature felt compelled to respond; the women were framed as the perpetrators of harm and the prosecutions were framed as a means to solve the problem.³⁹⁹ But in conclusion and to envision a more comprehensive care response, it is important begin by reframing the problem. We can start by revisiting the last time we as a society reacted institutionally to in-utero drug exposure.

The focus on NAS exists in the long shadow of what researchers now acknowledge as largely baseless cultural fears and stigma associated with infants exposed to crack cocaine.⁴⁰⁰ Those infants were strongly associated in the cultural imagination with poor African American women and were labeled “crack babies.”⁴⁰¹ This gave rise to the first significant wave of prosecutions of poor, disproportionately African American women for in-utero drug

397. See *supra* Part II.

398. See *supra* notes 142-49 and accompanying text.

399. See Dosani, *supra* note 200.

400. See Paltrow & Flavin, *supra* note 213, at 333.

401. See ALEXANDER, *supra* note 36, at 5, 51-52.

transmission.⁴⁰² Some social workers at the time predicted, “a lost generation—kids with a host of learning and emotional deficits who would overwhelm school systems and not be able to hold a job or form meaningful relationships.”⁴⁰³

Today our understanding of these children is far more nuanced. Although in-utero cocaine exposure has been shown to have some moderate effects on various developmental and behavioral outcomes⁴⁰⁴ and there are clear short-term effects in pregnancy,⁴⁰⁵ we now know that we were largely misframing the problem. The intellectual journey of Dr. Hallam Hurt, then chair of Neonatology at the Albert Einstein Medical Center, is emblematic of this story.⁴⁰⁶

Dr. Hurt and her team conducted a twenty-five-year longitudinal study comparing the development of infants exposed to crack cocaine to similarly situated infants who were not exposed.⁴⁰⁷ Dr. Hurt and her team followed 224 babies born between 1989 and 1992.⁴⁰⁸ Half had been exposed to cocaine in-utero and the other half had not.⁴⁰⁹ All the infants were born near or at full term and were from low-income, predominantly African American families.⁴¹⁰ At the initiation of this study, Philadelphia was experiencing a drug epidemic similar to the opiate epidemic of today and policymakers there were focusing, as we are today, on the effect of drug exposure on infants.⁴¹¹ “[N]early one in six newborns at city hospitals had mothers who tested positive for cocaine.”⁴¹²

What Hurt and her team found was that, as the infants aged, there were “no significant differences between the cocaine-exposed children and the controls.”⁴¹³ What they did find, however, was that

402. See Paltrow & Flavin, *supra* note 213, at 299-300, 310-11.

403. Susan FitzGerald, ‘Crack Baby’ Study Ends with Unexpected but Clear Result, PHILA. INQUIRER (June 21, 2017), http://www.philly.com/philly/health/20130721__Crack_baby__study_ends_with_unexpected_but_clear_result.html?arc404=true [https://perma.cc/98NN-BDQV].

404. See Barry M. Lester & Linda L. Lagasse, *Children of Addicted Women*, 29 J. ADDICTIVE DISEASES 259, 264 (2010).

405. See *supra* notes 146-50 and accompanying text.

406. See FitzGerald, *supra* note 403.

407. See *id.*

408. See *id.*

409. See *id.*

410. See *id.*

411. See *id.*

412. See *id.*

413. See *id.* For the research underlying these claims see, for example, Laura M.

both groups of poor children, those who had been exposed to cocaine and those who had not, “lagged on developmental and intellectual measures compared to the norm.”⁴¹⁴ Similar results have been echoed in other long-term and rigorous studies.⁴¹⁵ These consistent results throughout the many years of the study led Hurt and her team to look at other factors that might be harming the development of these children.⁴¹⁶

They looked at a variety of environmental factors and found that although “being raised in a nurturing home” led to better outcomes, significant proportions of the children, by age seven, had been exposed to significant violence including gunshots, witnessing a shooting, and seeing a dead body.⁴¹⁷ That exposure correlated with increased signs of depression and anxiety.⁴¹⁸ These findings echo similar research that has firmly established that exposure to what are termed “adverse childhood experiences” (or ACEs) has harmful long-term physical and mental effects on children.⁴¹⁹ At the end of the nearly quarter century study of these children, Hurt framed her conclusions succinctly: “Poverty is a more powerful influence on the

Betancourt et al., *Adolescents with and Without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language*, 33 *NEUROTOXICOLOGY & TERATOLOGY* 36 (2011) (finding no significant developmental differences between cocaine-exposed children and controls); Hallam Hurt et al., *Functional Magnetic Resonance Imaging and Working Memory in Adolescents with Gestational Cocaine Exposure*, 152 *J. PEDIATRICS* 371 (2008); Hallam Hurt et al., *A Prospective Evaluation of Early Language Development in Children with In-Utero Cocaine Exposure and in Control Subjects*, 130 *J. PEDIATRICS* 310 (1997); Hallam Hurt et al., *Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing*, 151 *ARCHIVES PEDIATRICS & ADOLESCENT MED.* 1237 (1997).

414. FitzGerald, *supra* note 403.

415. See, e.g., Josephine V. Brown et al., *Prenatal Cocaine Exposure: A Comparison of 2-Year-Old Children in Parental and Nonparental Care*, 75 *CHILD DEV.* 1282 (2004); Rina D. Eiden et al., *Externalizing Behavior Problems Among Polydrug Cocaine-Exposed Children: Indirect Pathways via Maternal Harshness and Self-Regulation in Early Childhood*, 28 *PSYCHOL. ADDICTIVE BEHAV.* 139 (2014); Deborah A. Frank et al., *Level of Prenatal Cocaine Exposure and Scores on the Bayley Scales of Infant Development: Modifying Effects of Caregiver, Early Intervention, and Birth Weight*, 110 *PEDIATRICS* 1143 (2002); Deborah A. Frank et al., *Problematic Substance Use in Urban Adolescents: Role of Intrauterine Exposures to Cocaine and Marijuana and Post-Natal Environment*, 142 *DRUG & ALCOHOL DEPENDENCE* 181 (2014).

416. See FitzGerald, *supra* note 403.

417. See *id.*

418. See *id.*

419. See Anthony Biglan et al., *Evolving a More Nurturing Society to Prevent Adverse Childhood Experiences*, 17 *ACAD. PEDIATRICS* 150 (2017).

outcome of inner-city children than gestational exposure to cocaine.⁴²⁰ Ultimately, Hurt and her team turned their focus to the effects of poverty on developmental growth and Hurt has since gone on to focus her research on these crucial and complex issues.⁴²¹

Perhaps this history, and some additional knowledge from healthcare research, can teach us a lesson about how to reframe both the problem and the solution. Rather than continuing to frame the problem individually and punitively, as mothers' potentially criminal, abusive, or neglectful conduct that harms children, we can instead frame it primarily in the context of the resources that struggling parents (who often have experienced severe trauma in their own lives) and struggling, under-resourced communities need in order to heal and raise healthy children.

To get a sense of what this looks like in the context of addiction and family-centered care, take, for example, a program in East Tennessee: the Great Starts Program. The Great Starts Program is a residential treatment program housing pregnant and parenting women and their children together.⁴²² The women in the Great Starts Program have experienced, on average, 5.6 ACEs. The concept of ACEs and their affect on health stems from a study, published in 1998, in the *American Journal of Preventative Medicine*.⁴²³ ACEs include: "psychological, physical, or sexual abuse; emotional or physical neglect; family dysfunctions including alcohol or drug abuse in the home; divorce or loss of biological parent; depression or mental illness in the home; the mother being treated violently; or a household member being in prison."⁴²⁴

The title of the ACEs study describes its dramatic findings: *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*.⁴²⁵ The study demonstrated a clear linkage between exposure to adverse experiences and later physical health problems.⁴²⁶ Experiencing ACEs

420. FitzGerald, *supra* note 403.

421. *See id.*

422. *Great Starts*, HELEN ROSS MCNABB CTR., <https://www.mcnabbcenter.org/service/great-starts> [<https://perma.cc/KU7M-4XAV>].

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

424. Biglan et al., *supra* note 419, at 150.

425. Felitti, *supra* note 423.

426. *See id.* at 250.

makes it significantly more likely that one will experience a wide range of negative outcomes, and the more ACEs you experience, the more likely this is.⁴²⁷ Negative outcomes can include things such as chronic depression, suicide attempts, and anxiety disorders, as well as “a significantly greater likelihood of premature death due to physical illness.”⁴²⁸ ACEs are scored on a scale from one to seven.⁴²⁹ The higher the score the higher the number of adverse experiences and the higher likelihood of harm.⁴³⁰ The average score at Great Starts of 5.6 gives one a sense of the enormity of the task before the women in achieving health. Their children are similarly “at risk of early adversities and toxic stress including NAS, developmental delays, abuse and neglect, and parental separation due to parental incarceration and placement in out-of-home care.” The women are also nearly all low-income,⁴³¹ which means that they likely come from vastly under-resourced communities lacking in safety and basic community resources such as parks, safe streets, daycares, and good schools.

The data coming from the ACE study is daunting. Even more daunting is the knowledge that experiencing trauma as a child can lead to intergenerational trauma. A child whose basic needs for healthy parenting are not met is more likely to become a mother who similarly cannot meet her child’s needs.⁴³² But the very good news is that this cycle can be interrupted. Important advances in mental health treatment, such as the development of Child-Parent Psychotherapy, have “been shown to be effective ... for families whose risk context includes maternal depression, poverty, domestic violence, mothers with trauma histories, and maltreated children known to preventive services.”⁴³³

427. See Biglan, *supra* note 419, at 150.

428. See *id.*

429. Felitti, *supra* note 423, at 248.

430. See *id.* at 248, 250.

431. Interview with Great Starts staff member (transcript on file with author). It is important to note that ACEs and their effects are not isolated to poor households. ACEs overall, and some ACEs in particular, do occur at higher rates at the lower end of the income spectrum, however, the damaging health effects ACEs occur throughout the income spectrum.

432. See Steele et al., *supra* note 361, at 62-63, 65-66.

433. *Id.* at 62; see also ALICIA F. LIEBERMAN & PATRICIA VAN HORN, PSYCHOTHERAPY WITH INFANTS AND YOUNG CHILDREN: REPAIRING THE EFFECTS OF STRESS AND TRAUMA ON EARLY ATTACHMENT 64-65 (2010).

Work like this, on the individual and family level, can provide the support that women need, and this is precisely what is going on at Great Starts. Great Starts offers what they call “a continuum of family-focused services.”⁴³⁴ As they frame it, “[t]he overarching goal is to prevent infants and small children from parental separation and strengthen the parent-child bond through comprehensive treatment services and specialized services for children.”⁴³⁵

And, as the larger research predicts, this is working at Great Starts on an individual and family level. Eighty-seven percent of children born while in the Great Starts program are not diagnosed with NAS.⁴³⁶ Eighty-one percent spend no time in the NICU and 83 percent are born full term and at a healthy weight.⁴³⁷ The mothers do well too. Eighty-seven percent are not using at exit; only 7 percent lack health insurance on exit; 85 percent achieve housing stability, and overall they demonstrate “improved well being as measured by depression and trauma assessments ... an increase in nurturing parenting skills and a decrease in parenting stress.”⁴³⁸ But in a region with astonishing rates of opiate abuse, this is the only addiction treatment program in East Tennessee that houses mothers with their children.⁴³⁹ They have spots for fourteen families at a time.⁴⁴⁰ And, unsurprisingly, they too are, inevitably, part of the criminalization of care. The vast majority of mothers in the program are already involved in—and are often referred by—child welfare and criminal justice agencies.⁴⁴¹ Clearly we need much, much more than a small model program, both in East Tennessee and in the many regions hardest hit by the opiate epidemic.

But even if we had enough beds in clinics such as Great Starts, we would only be focusing on the level of the individual family. For the women and children who get this care, the communities to which they return after being in the program often lack fundamental

434. Interview with Great Starts staff member, *supra* note 431.

435. *Id.*

436. *Id.*

437. *Id.*

438. Great Starts Program information and outcomes data on file with author.

439. Great Starts is in fact only one of two programs in the State of Tennessee that provides this model of care. The other, Renewal House, is located in the middle of the state, in Nashville. Interview with Great Starts staff member, *supra* note 431.

440. *Id.*

441. *Id.*

supportive resources. One staff member at Great Starts clearly framed this issue. For the 70 percent of women who complete the program,

they're happy, they're sober, they are parenting, they're bonding, they're reconnecting with family members that they haven't been with, they're working their case plans with their families, they're working towards getting their children back. We've had clients get their children back, and then unfortunately they go into a community that is harsh.... It's so sad when you see families that are capable of doing well, given the proper support. You know, you see them parenting beautifully, and living a happy life, and getting a job, and yeah. It's sad.⁴⁴²

This too is the focus of research. Although the original ACE studies focused on individual adverse experiences, we know that communities characterized by a lack of safety and supportive resources can also undermine family health.⁴⁴³ The exposure of young children to violence noted in Dr. Hurt's work is emblematic of these enormous community-based harms.⁴⁴⁴ In short, place matters. "Place-based research and analysis has shown that poorer neighborhoods are characterized by much less physical, economic, educational, and social capital than more affluent ones."⁴⁴⁵ As the field of pediatrics is coming to understand,

[t]he more distressed a neighborhood, the more the daily toll of seeking to get by and stay safe produces stress.... At some point, there must not only be a focus upon individually based services and supports for young children and their families, but for community-building activities to support and strengthen the community's overall capacity to support its children.⁴⁴⁶

So we need to invest in resources to make communities safer and more supportive. Investing in resources means, among many other

442. *Id.*

443. See Charles Bruner, *ACE, Place, Race, and Poverty: Building Hope for Children*, 17 *ACAD. PEDIATRICS* S123 (2017).

444. See FitzGerald, *supra* note 403.

445. Bruner, *supra* note 443, at 124.

446. *Id.* at 125.

things, parks, good schools, opportunities for interaction, and safe streets. Finally, it is clear that solutions cannot be imposed on communities from the outside. Instead, solutions that are generated from impacted communities themselves often offer the most hope.⁴⁴⁷

In 2013, the Tennessee legislature attempted to respond to astonishingly high rates of opiate addiction and the effect of that addiction epidemic on children. In 2016 attempts to make the law permanent failed, seemingly relegating this particular experiment to history. Sadly, however, just at this Article was going to press, Tennessee's fetal assault law was reintroduced in the state house and senate,⁴⁴⁸ leading to the distinct possibility that the harms described in this Article will be repeated in the years to come. Tennessee legislators were certainly right then, and they are right today, that there is a serious addiction crisis in the state. The epidemic is devastating families and communities both in Tennessee and well beyond. But we will never heal children by punishing their mothers. Instead we have to turn away from criminalization and recommit to a far more robust and respectful vision of care for children, families and communities.

447. See PREVENTION INST., ADVERSE COMMUNITY EXPERIENCES AND RESILIENCE: A FRAMEWORK FOR ADDRESSING AND PREVENTING COMMUNITY TRAUMA 17, 23-24 (2016). At the conclusion of the *From the War on Poverty to the War on Crime*, Elizabeth Hinton makes this precise point. See HINTON, *supra* note 85, at 336-37. She marks the mid-1960s decision to abandon the commitment to maximum feasible participation as the moment when we turned away from supporting grassroots participation in the administration of federally funded poverty programs and turned toward building the war on crime. *Id.*

448. H.B. 1168, 111th Gen. Assemb., Reg. Sess. (Tenn. 2019), <http://www.capitol.tn.gov/Bills/111/Bill/HB1168.pdf> [<https://perma.cc/ZJS9-MTE7>]; S.B. 659, 111th Gen. Assemb., Reg. Sess. (Tenn. 2019), <http://www.capitol.tn.gov/Bills/111/Bill/SB0659.pdf> [<https://perma.cc/9965-R9TK>].