
THE WAR ON DRUGS AND THE WAR ON ABORTION: SOME
INITIAL THOUGHTS ON THE CONNECTIONS,
INTERSECTIONS AND THE EFFECTS

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While many people view the war on abortion and the war on drugs as distinct, there are in fact many connections and overlaps between the two. Their history, the strategies used to control and punish some reproductive choices and those to control the use of certain drugs, the limitations that exist to access to reproductive health care and drug treatment, and the populations most harmed by those limitations are remarkably similar. These similarities are particularly apparent where the issues coalesce in the regulation and punishment of pregnant, drug-using women.¹

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1. See, e.g., Lynn Paltrow, *Pregnant Drug Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999 (1999); Lynn Paltrow, *Our Common Struggle*, HARM REDUCTION COMMUNICATION (Spring 1999); Lynn Paltrow, *Prosecution and Prejudice: Judging Drug Using Pregnant Women*, in MOTHER TROUBLES (Julia Hanigsberg & Sara Ruddick eds., 1999); Lynn Paltrow & Carol Tracy, *When the War on Drugs and War on Abortion Collide: The Prosecution of Pregnant Women*, Drug Policy Foundation, 12th Int'l Conference, 1999 Policy Manual.

Those who are concerned about fundamental issues of social justice may be losing ground, missing opportunities to build coalitions and strengthen arguments by failing to recognize the similarities among and relationships between the issues.

A comparison of the efforts to control reproduction and some (but significantly, not all) drug use reveals much about those who seek to control both and about their true agendas. If efforts to control reproduction and drugs are rooted in forms of bigotry and prejudice that are essentially the same, neither drug addiction nor pregnancy should be a basis for scapegoating some individuals or for dividing progressive coalitions. If efforts to control both reflect a common political agenda, and are used to draw attention away from real underlying issues-like poverty, race discrimination, and lack of a coherent national health-care policy then those who fight against each must recognize that they have a common cause and develop a more comprehensive strategy that addresses both as fundamental issues of social justice rather than as single, separate and special interest issues. Finally, if some people – African American women – are particularly harmed by these efforts to control reproduction and some drug use,² there is both an opportunity and a need to develop interventions that respond effectively and specifically to these harms and to the barriers they face.

Only by recognizing those shared aspects of measures to control reproduction and drug use can we have the opportunity to develop more effective responses to each. While some of the parallels that are drawn in this examination may be inapt, and more cogent ones might be added by people better versed than this author in drug control policy and the history of reproductive rights, the similarities discussed here are intended to stimulate further exploration and discussion.

2. Gina Kolata, *Racial Bias Seen on Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13; DOROTHY ROBERTS, *KILLING THE BLACK BODY* 172-76 (1997); Renee I. Solomon, *Future Fear: Prenatal Duties Imposed by Private Parties*, 17 AM. J.L. & MED. 411, 418 (1991) (noting that “70% of those arrested for drug-related fetal abuse have been African-American” because “[r]ace and poverty biases make it easy to blame the victim”); Loren Siegel, *The Pregnancy Police Fight the War on Drugs*, in *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE* 249 (Craig Reinerman & Harry G. Levine eds., 1997) (“During the late 1980s, as the specter of ‘crack babies’ haunted American political rhetoric, more than two hundred criminal prosecutions were initiated against women in almost twenty states.”); see also Lynn M. Paltrow et al., *Criminal Prosecutions Against Pregnant Women, Nat’l Update and Overview* (ACLU/Reprod. Freedom Project, New York, N.Y.) (1992) (documenting 167 arrests nationwide as of 1992); <<http://www.advocatesforpregnantwomen.org>>.

I. CONTROLLING REPRODUCTION, CONTROLLING DRUGS.

Throughout history, women have sought to control their reproduction regardless of cultural, religious or family proscriptions against contraception, abortion and child bearing.³ Similarly, people have always sought to alter their state of consciousness through a wide range of mind-altering experiences and drugs, some of them associated with religious rites.⁴ Thus, one obvious connection between the two subjects is that both relate to what people do and have always done, with or to their own bodies, even in the face of severe restrictions.

Both also reflect the extremes of the human experience. On the one hand, sex and drugs can give people mind expanding, life affirming, ecstatic experiences.⁵ Each, however, can be associated with violence, abuse, and despair. A woman's relationship to her sexuality and her ability to reproduce may be affected deeply and permanently by experiences of incest, molestation and rape, all far too common in the lives of American women.⁶ Similarly, for those who turn to drugs to numb

3. See, e.g., LINDA GORDON, *WOMAN'S BODY, WOMAN'S RIGHT: BIRTH CONTROL IN AMERICA* (1976); ANGELA Y. DAVIS, *WOMEN, RACE & CLASS* 7 (1981); CAROL JOFFE, *DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE* viii (1995) ("It is beyond dispute that many abortions took place in the United States while the procedure was illegal; some estimates put the number of abortions in the years leading up to Roe as high as 1.2 million. Many, probably a majority of these cases, were women's attempts at self-abortion. The others were performed by some combination of lay persons, nurses, midwives, and physicians.").

4. See, e.g., David A. J. Richards, *Drug Use and the Rights of the Person: A Moral Argument for Decriminalization of Certain Forms of Drug Use*, 33 RUTGERS L. REV. 607, 631 (1981) ("Drug use appears to be very ancient, sometimes appearing in forms that mix inextricably several or all of the therapeutic, religious, and recreational elements.").

5. CAROLE JOFFE, *THE REGULATION OF SEXUALITY: EXPERIENCES OF FAMILY PLANNING WORKERS* 84 (1986). Although, for a brief time in her career, Margaret Sanger made clear the connection between sexual pleasure and contraception, once stating, "Never be ashamed of passion. If you are strongly sexed, you are richly endowed," the provision of reproductive health services, including abortion and contraception tend to avoid acknowledgment of sexuality for their patients. As one family planning clinic worker explained: "We are never going to achieve credibility with our clients until we acknowledge that 'family planning' has something to do with making love. And people in our field have been unable to do that."

6. See, e.g., Patricia Tjaden & Nancy Thoennes, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*, U.S. Department of Justice, National Institute of Justice, Centers for Disease Control and Prevention (1998) <<http://www.ncjrs.org/txtfiles/172837.txt>> (concluding that "physical assault is widespread among American women" and reporting

the pain of such experiences,⁷ drug use frequently becomes chaotic, dangerous and out of control.⁸ Thus, efforts to address sexuality, reproduction and drug use all require responses that take into account an extremely broad range of experience and the disparate needs that emerge from that experience.

To state the obvious, both issues are marked by controversy, passion and politics. The temperament of that controversy however is surprisingly similar. What has been written about drug issues applies with equal descriptive accuracy to reproductive health issues: They are both "hopelessly intertwined with deeply ingrained notions of morality and sin, religious-style certitude, and righteous indignation . . ."⁹

II. PROHIBITION

such findings as "1 of 6 US women . . . experienced an attempted or completed rape as a child and/or adult").

7. *Women and Drug Abuse*, NIDA CAPSULES (June 1994) (Among drug using women, 70% report having been abused sexually before the age of 16; and more than 80% had at least one parent addicted to alcohol or one or more illicit drugs); Marsha Rosenbaum, *Women: Research and Policy*, in WILLIAMS & WILKINS, *SUBSTANCE ABUSE* 654-65 (1997) ("Researchers have consistently found high levels of past and present abuse in the lives of women drug users. Many have suggested that there is a relationship, if not absolutely causal, between violence experienced by women and drug use"); Jahn L. Forth-Finegan, *Sugar and Spice and Everything Nice: Gender Socialization and Women's Addiction - A Literature Review*, in FEMINISM AND ADDICTION 25 (Claudia Bepko ed., 1991) ("Difficult and physically abusive childhood experiences are reported to be frequent, and the incidence of sexual abuse among alcoholics has been shown to be very high, often as high as 75% of the women in treatment."); Patt Denning & Jeannie Little, *Harm Reduction in Mental Health*, HARM REDUCTION COMMUNICATION (Spring 2001) (One can also predict the likelihood of developing problems with drug use based on traumatic experiences: "up to 80% of people with a history of significant trauma will abuse substances.").

8. See NORMAN E. ZINBERG, M.D., *DRUG, SET AND SETTING: THE BASIS FOR CONTROLLED INTOXICANT USE* (1984) (demonstrating that illicit drugs may be used in controlled ways that do not inevitably result in addiction, depending on the context in which they are used); Edith Springer, A.C.S.W., *Taking Drug Users Seriously*, HARM REDUCTION PARTICIPANT'S WORKBOOK at 9 (depicting a range of drug use, including experimental, occasional, regular, heavy and chaotic/out of control); see also *Typical Drug User Not Poor, Jobless*, THE POST & COURIER, Sept. 9, 1991 (reporting on a Substance Abuse and Mental Health Service's Administration report finding that seven in ten people who used illegal drugs in 1997 had full-time jobs and quoting Barry McCaffrey, White House Drug Policy Director, "the typical drug user is not poor and unemployed").

9. Craig Horowitz, *Drugs Are Bad, Drugs Are Bad, Drugs Are Bad, Drugs Are Bad: The Drug War Is Worse*, NEW YORK MAGAZINE, Feb. 5, 1996, at 22-25 ("When the subject . . . comes up, otherwise open minded people stick to principle even when principle has little empirical support or practical value.").

Both abortion and certain drugs have been outlawed at various times in American history. Another similarity: Even when outlawed and enforced through draconian measures, the effect of efforts to prohibit both abortion and drug use have been notoriously and consistently unsuccessful.¹⁰ Not only do women continue to have abortions and people continue to use those drugs that have been outlawed, the criminalization of these activities results in flourishing illegal markets,¹¹ and a deeply ingrained cynicism toward the government authority that attempts to enforce the law.¹²

III. JUSTIFYING CONTROL AND PUNISHMENT

Reproduction and drug use share many commonalities when it comes to justifications for prohibition and regulation. In both cases, various forms of stigma and prejudice, including but not limited to those based on race, ethnicity, and gender, have been employed to justify such control. For example, abortion became illegal in the United States, in part

10. JOFFE, *supra* note 3, at 29 (“A study published by Frederick Taussig in 1936 estimated a half-million illegal abortions were taking place in the United States annually; the Kinsey Report in 1953 suggested that nine out of ten premarital pregnancies among its respondents were aborted, while over 20 percent of the married women in the sample reported having had an abortion while married. [E]stimates of illegal abortion in the 1950’s and in the years immediately leading up to *Roe* range as high as 1.2 million per year”). Horowitz, *supra* note 9, at 26 (“[D]rug use continues to rise. The National Institute on Drug Abuse, which is staunchly hawkish on the drug war, reports, alarmingly, that marijuana use among eighth-graders more than doubled between 1991 and 1994. Among adults, use of all drugs has consistently gone up, though most of this increase is attributable to the runaway popularity of marijuana.”); Ernest Drucker, Ph.D., *Drug Prohibition and Public Health, 25 Years of Evidence*, 114 PUB. HEALTH REP. 14 (Jan.-Feb. 1999) (“Drugs are cheaper, more powerful, and more available today than at any time in the past 25 years.”); MIKE GRAY, *DRUG CRAZY: HOW WE GOT INTO THIS MESS AND HOW WE CAN GET OUT* 188, 189 (2000) (describing widespread access to a range of illicit drugs in every part of the country and for every age group and noting that continued drug use in America cannot be attributed to the lack of resources: “In the attempt to make America drug-free, the taxpayers laid out over \$300 billion in the last fifteen years alone. To put that in perspective, we went to the moon for less than a third of that amount.”).

11. JOFFE, *supra* note 3, at 29 (“One well-known result of the ‘century of criminalization’ that resulted from the efforts of the AMA was a flourishing market in illegal abortion”); Horowitz, *supra* note 10, at 26 (“[I]t is hard to imagine that drugs could be much more available than they are right now. In fact, most of what is generally labeled as the ‘drug problem’ is actually the illegal-drug-trade problem –the pervasive, devastating collateral damage from a black market that now grosses nearly \$60 billion a year.”).

12. See, e.g., GRAY, *supra* note 10, at 189 (describing how “it’s hard to find an African-American family that has not had a direct, personal, unpleasant experience with law-enforcement – more often than not, something to do with the drug war”).

based on appeals to xenophobia and nativism.¹³ As Carole Joffe summarizes: "The drive to criminalize abortion, which started in mid-century and peaked by the early 1880's, when all the states had enacted antiabortion statutes, stemmed from a variety of motivations, including societal anxiety about the declining birth rates of Anglo-Saxon women in comparison to those of newly arriving immigrants."¹⁴ Similarly, efforts to sterilize certain populations have been justified by various forms of stigma and prejudice, including but not limited to those based on class and race.¹⁵

With respect to laws aimed at drug use, they too have been based on appeals to racist fears, in many instances unambiguously so:

Racism was called into play early on. Popular literature of the time shows that racist propaganda, which played on white men's insecurities about their own power, flourished at the end of the 19th century. Among other things, the notion that using cocaine would heighten the desire of black men to rape white women was widely proclaimed. The same was held to be true with regard to the use of opium by Chinese men. Fears of "hopped up Negroes" and "opium smoking Chinamen" fueled anti-drug sentiment, especially in the South and West. Despite the fact that, at the time, the majority of addicts were actually those white housewives hooked on patent medicines, the alleged threat to "our

13. See JAMES MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900* (1978).

14. JOFFE, *supra* note 3, at 28.

15. See ROSALIND POLLACK PETCHESKY, *ABORTION AND WOMAN'S CHOICE* 87, 180 (1984) (describing how the American eugenics movement of the early 20th century "resulted in the involuntary sterilization of over 45,000 persons in the United States in the years between 1907 and 1945, half of them mentally ill as opposed to mentally defective, and the great majority of them poor women" and how "[n]early all of the documented or court-adjudicated instances of sterilization abuse during the 1970's involved women who were poor and either black, Mexican-American, Puerto-Rican, or Native-American or women who were incarcerated or mentally incompetent); see also Iris Lopez, *Agency and Constraint: Sterilization and Reproductive Freedom Among Puerto Rican Women in New York City*, in *SITUATED LIVES: GENDER AND CULTURE IN EVERYDAY LIVES* (Louise Lamphere et al. eds., 1997)

<<http://www.hsph.harvard.edu/grhf/WoC/reproductive/lopez.html>>;

HELEN RODRIGUEZ-TRIAS, M.D., *STERILIZATION ABUSE IN BIOLOGICAL WOMAN – THE CONVENIENT MYTH* 147 (Ruth Hubbard, Mary Sue Henifin & Barbara Fried eds., 1982) (describing how U.S. policy, beginning in the 1940's, resulted in the sterilization of over one-third of all Puerto-Rican women, and sterilization abuse particularly in communities of color in the 1970's); BETSY HARTMANN, *REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL & CONTRACEPTIVE CHOICE* 227-249 (1987).

women," viewed as poor innocents, was used to heighten moral outrage over intoxication.¹⁶

More recently, enforcement and increased penalties for using certain drugs were seen during the Nixon administration as a way of controlling particular populations, specifically youth and black people.¹⁷

Today, the expansion of the war on drugs has been justified, at least in part by images of crack-using women, particularly pregnant African American women. By associating crack and its alleged harms with low-income African American women,¹⁸ people have been willing both to believe vast amounts of misinformation about cocaine's effects¹⁹ and to

16. Maia Szalavitz, *War on Drugs, War on Women*, ON THE ISSUES MAGAZINE, Winter 1999, at 43; see also GRAY, *supra* note 10, at 46-47, 76 (At the turn of the century the typical American addict was a middle-aged southern white woman strung out on laudanum (an opium-alcohol mix)).

17. DAN BAUM, SMOKE AND MIRRORS: THE WAR ON DRUGS AND THE POLITICS OF FAILURE 8 (1996) ("Richard Nixon and congressional Republicans benefited directly from this blurring of the distinction between marijuana and heroin. Broadly defined, drugs were common to the cultures of both urban blacks and college hippies, and Republicans were eager to link race rioters with campus protesters.").

18. See Drew Humphries, *Crack Mothers at 6: Prime Time News, Crack/Cocaine, and Women*, VIOLENCE AGAINST WOMEN, Feb. 1998, at 45 ("Socially constructed as Black and urban, the media demonized crack mothers as the threatening symbols for everything that was wrong with America"); Angela Y. Davis, *Masked Racism: Reflection on the Prison Industrial Complex*, COLORLINES, Fall 1998 ("images of black welfare mothers reproducing criminal children").

19. Research has found that crack-exposed children are not doomed to suffer permanent mental or physical impairment, and that whatever effects may result from the use of this drug are greatly overshadowed by poverty and its many concomitants – poorer nutrition, inadequate housing, health care and stimulation once the child is born. See Deborah A. Frank, M.D. et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613 (Mar. 28, 2001); Wendy Chavkin, M.D., M.P.H., *Cocaine and Pregnancy – Time to Look at the Evidence*, 285 JAMA 1626 (Mar. 28, 2001); Hallam Hurt, M.D., et al., *Problem-Solving Ability of Inner-City Children With and Without In Utero Cocaine Exposure*, 20 DEV. & BEH. PEDIATRICS 418 (Dec. 1999); see also Linda C. Mayes, M.D., et al., *The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 (1992). As yet other researchers explain:

The "crack baby" on which drug policy is increasingly based does not exist. Crack babies are like Max Headroom and reincarnations of Elvis – a media creation. Cocaine does not produce physical dependence, and babies exposed to it prenatally do not exhibit symptoms of drug withdrawal. Other symptoms of drug dependence – such as "craving" and "compulsion"—cannot be detected in babies. In fact, without knowing that cocaine was used by their mothers, clinicians could not distinguish so-called crack-addicted babies from babies born to comparable mothers who had never used cocaine or crack.

respond with a variety of proposals for punishing pregnant women and new mothers²⁰ rather than with calls for medical investigation, improved treatment and services including financial support for the women whose problems are significantly related to poverty.²¹

Whether addressing abortion or drugs, efforts to criminalize and punish also relied on the pretense that it was necessary to protect middle class white women and to reinforce their traditional place in society. The original efforts to outlaw abortion were led by physicians of the newly formed American Medical Association who wanted to establish their professional status by taking "control [of] the terms under which 'approved' abortions were performed."²² By taking abortion out of the control of women and away from the physicians' business competitors, – healers, homeopaths and midwives, – doctors could monopolize this area of medical practice. Among the arguments the doctors used to justify this campaign was that abortion represented a threat to male authority over women. As the authors of an 1871 AMA report asserted about women who had abortions:

She becomes unmindful of the course marked out for her by Providence, she overlooks the duties imposed on her by the marriage contract. She yields to the pleasures – but shrinks from the pains and responsibilities of maternity; and, destitute of all delicacy and refinement, resigns herself, body and soul, into the hands of unscrupulous and wicked men. Let not the husband of such a wife flatter himself that he possesses her affection. Nor can she in turn ever merit even the respect of a virtuous husband.

John P. Morgan & Lynn Zimmer, *The Social Pharmacology of Smokeable Cocaine Not All It's Cracked Up to Be*, in *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE* 131, 152 (Craig Reinerman & Harry G. Levine eds., 1997).

20. See generally LAURA E. GÓMEZ, *MISCONCEIVING MOTHERS* 26 (1997) (describing the California legislature's response to media portrayals of crack-using mothers including numerous proposals to punish pregnant women); ROBERTS, *supra* note 2; PALTROW, *supra* note 2, at 1002-1003, 1020-1021; Alexandra L. Cox, *Reproduction, Apprehension, Production: The Visual Politics of the Crack Baby Scare*, Yale University American Studies Senior Essay (2001) (on file with author).

21. See, e.g., NANCY D. CAMPBELL, *USING WOMEN: GENDER, DRUG POLICY, AND SOCIAL JUSTICE* 13 (2000) ("If addiction was attributed to women's lack of support for raising children alone, policy might veer toward strengthening women's political autonomy and economic security").

22. JOFFE, *supra* note 3, at 28; see also ELLEN CHESLER, *WOMAN OF VALOR: MARGARET SANGER AND THE BIRTH CONTROL MOVEMENT IN AMERICA* 64 (1992) (explaining that the American Medical Association, largely responsible for the laws criminalizing abortion, "launched a virulent and determined campaign against abortion...played upon class, race, and gender tensions developing as a consequence of the steady erosion of fertility among native white American women").

She sinks into old age like a withered tree, stripped of its foliage; with the stain of blood upon her soul, she dies without the hand of affection to smooth her pillow.²³

Carrying these views forward, doctors in the 1930's claimed that "if women know they can destroy the fetus very easily, they become lax in their sexual morals."²⁴

Similarly, "[d]rug policy was constructed by dominant groups" as a mechanism for preserving "white women's innocence."²⁵ Assertions that white women would be raped by men of color on drugs perpetuated racist views of men of color, mythologized the effect that certain drugs have, and simultaneously portrayed white women as vulnerable and in need of protection, thus ignoring their status as moral agents, and distracting attention from victimization they might be encountering at the hands of white men.

In addition, drug policy itself has been used to reinforce stereotypes about different groups of women. Nancy Campbell elucidates how at various times, "white women are represented as using drugs to remain functional, orderly, and clean, while women of color who use drugs are depicted as the nonproductive inhabitants of chaos, decay, and squalor."²⁶ Similarly Campbell notes that during the 1950's, "[a]ddicted white women were diagnosed with personality disorders; addicted women of color were 'sociopathically disturbed' and hence more 'deviant.'"²⁷

The control of both drug use and reproduction have thus been justified by resort to popular prejudices and particular fears about certain populations and in turn used to reinforce deeply embedded stereotypes about the particular populations.

IV. CONTROLLING SPEECH ABOUT DRUGS AND REPRODUCTION

Indirect methods of control, including restrictions on free speech concerning the beneficial uses of contraception, abortion and those drugs

23. JOFFEE, *supra* note 3, at 29 (citing Smith-Rosenberg, *The Abortion Movement and the AMA* 236-37 and noting "there are contemporary antiabortion statements that present the abortion-seeking woman in a similar light); see Connaught Marshner, *The New Traditional Woman* (Washington, D.C.: Free Congress Research and Educational Foundation 1982)."

24. RICKIE SOLINGER, *BEGGARS AND CHOOSERS: HOW THE POLITICS OF CHOICE SHAPES ADOPTION, ABORTION, AND WELFARE IN THE UNITED STATES* 47 (2001) (advanced copy on file with author).

25. CAMPBELL, *supra* note 21, at 69.

26. *Id.* at 3.

27. *Id.* at 152.

deemed illegal are also remarkably similar. In 1961, Justice William O. Douglas observed that "the right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion."²⁸ This, however, has been anything but obvious when it comes to state regulation of information about both reproductive health care and drugs. To the contrary: government leaders have sought vigorously to suppress the dissemination of information about drugs and devices known unequivocally to save lives and to improve health and well-being.

In 1873 the Comstock law labeled advice on contraception and abortion "obscene, lewd, lascivious, and filthy."²⁹ This law, among other things, made it a crime to transport by the public mail system material including:

Every obscene, lewd, or lascivious, and every filthy book, pamphlet, picture, paper, letter, writing, print, or other publication of an indecent character, and every article or thing designed, adapted, or intended for preventing conception or producing abortion, or for any indecent or immoral use; and every article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for preventing conception or producing abortion, or for any indecent or immoral purpose.³⁰

Until 1965 it was still illegal for Connecticut doctors, in the privacy of their offices, to advise married couples that contraception could prevent unwanted pregnancy and the health risks associated with it.³¹ Until 1977 restriction on the sale and advertisement of contraception were still on the

28. *Poe v. Ullman*, 367 U.S. 497, 513 (1961) (Douglas, J., dissenting).

29. CHESLER, *supra* note 22, at 68 (quoting in part the Comstock Act of 1873). One interesting point of comparison is the fact that in each case the criminalization of information about contraception and abortion and the criminalization of certain non-alcoholic drugs, were largely the result of efforts of two zealous, politically motivated men in unique and lengthy positions of power: Anthony Comstock, who was responsible for the passage and enforcement of laws punishing the dissemination of information about contraception and abortion, *see id.* at 66-73, and Harry Anslinger, who after the passage of initial narcotic control laws, oversaw America's campaign against drugs from 1930 to 1961 as head of the Federal Bureau of Narcotics; *see* GRAY, *supra* note 10, at 65-91.

30. CHESLER, *supra* note 29.

31. *Griswold v. Connecticut*, 381 U.S. 479 (1965) (successfully challenging Connecticut's 1879 criminal statute making the use and/or prescription of any form of birth control a crime for both woman and doctor); *see generally* DAVID GARROW, *LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF ROE v. WADE* (1994) (discussing the origins of the *Griswold* litigation and its relationship to *Roe v. Wade*).

books in New York State and elsewhere.³² Even today, US Supreme Court doctrine permits speech restrictions on the provision of reproductive health information – abortion – by doctors in certain government programs. As recently as 1991, the United State Supreme Court upheld "the gag rule" which, prohibits a project funded under Title X – the federal program that funds family planning programs across the country – from engaging in activities that encourage, promote or advocate abortion as a method of family planning.³³

Using a very similar strategy, the federal government, in response to passage of California's Proposition 215, "the Compassionate Use of Marijuana Act," threatened doctors with criminal prosecution, loss of Medicaid and Medicare payments and revocation of their federal prescription drug licenses if they advised their patients about medical benefits of marijuana.³⁴ This 1996 law provides, in part, that:

Seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.³⁵

32. *See generally* Carey v. Population Services Int'l, 431 U.S. 678 (1977) (successfully challenging a New York statute that placed severe restrictions on the sale and advertisement of contraceptives within the state).

33. *See generally* Rust v. Sullivan, 500 U.S. 173 (1991) (finding no violation of doctor's free speech rights, and no violation of women's due process rights to prohibit Title X programs from developing or disseminating materials advocating abortion as a method of family planning, paying dues to any group that advocates abortion as a method of family planning as a substantial part of its activities, and requiring projects funded by Title X to be organized so that they are physically and financially separate from prohibited abortion activities); *but cf.* Legal Services Corp. v. Velazquez, 531 U.S. 533 (2001) (striking down restrictions on publicly funded legal services attorneys and distinguishing Rust as a case in which the government uses private speakers to transmit information pertaining to its own program).

34. Conant v. McCaffrey, No. C97-00139, 2000 U.S. Dist. LEXIS 13024, (N.D. Cal. Sept. 7, 2001) (granting summary judgment on free speech grounds, thereby prohibiting federal officials from threatening or punishing physicians for recommending medical marijuana).

35. CAL. HEALTH & SAFETY CODE § 11362.5(a) (West 1997) (Under the Act, neither patients nor physicians may be punished or denied any right or privilege for conduct relating to medical use of marijuana.); *see also* CAL. HEALTH & SAFETY CODE §§ 11362.5(b)(1)(B), 11362.5(d) (Similar measures have passed in Alaska, Arizona, Hawaii, Maine, Nevada, Oregon and Washington State.); *see generally* Dan Baum, *California's Separate Peace*, ROLLING STONE, Oct. 30, 1997, at 43-52.

Despite extensive evidence of the beneficial effects of marijuana,³⁶ it remains classified as an illegal drug whose distribution sale and medical prescription are all illegal under federal law.³⁷ In May 2001, the United State Supreme Court rejected the argument that medical marijuana distributors could use a medical-necessity defense to the federal law criminalizing marijuana. While the court did not strike down California's compassionate use act, or address the availability of a medical necessity defense for the patients who somehow manage to get medical marijuana, the Court based its decision, in part, on the 1970 congressional finding that marijuana has "no currently accepted medical use."³⁸

Thus even when it is clear that certain drugs or contraceptive devices could improve people's health, the government has used control over medical practice as a mechanism for preventing dissemination of that knowledge and information.

V. ACCESS TO REPRODUCTIVE HEALTH CARE AND DRUG TREATMENT

In both arenas, the state not only restricts information about medically safe and useful procedures, it also restricts access to them. In the case of reproduction, access to abortion, contraception and other reproductive health care is deliberately blocked or limited. In the case of drug use, access to treatment and other approaches that can reduce the harmful effects of drug use are deliberately blocked or limited.

36. See, e.g., Jerome Kassirer, M.D., *Editorial: Federal Foolishness and Marijuana*, *NEW ENG. J. MED.*, Jan. 30, 1997, at 366 (Thousands of patients with cancer, AIDS, and other diseases report that they have obtained striking relieve from intractable nausea, vomiting and pain by smoking marijuana); LYNN ZIMMER & J.P. MORGAN, *MARIJUANA MYTHS, MARIJUANA FACTS: A REVIEW OF THE SCIENTIFIC EVIDENCE* (1997); *Institute of Medicine, Marijuana and Medicine: Assessing the Science Base*, <<http://www.nap.edu>> (The Institute of Medicine (IOM), a branch of the National Academy of Sciences, stating that smoked marijuana is effective in treating pain, chemotherapy induced nausea and vomiting, and the poor appetite and wasting caused by AIDS or advanced cancer, and declaring that marijuana was not particularly addictive and did not appear to be a "gateway" to the use of harder drugs such as heroin or cocaine).

37. *United States v. Oakland Cannabis Buyers' Coop.*, 121 S. Ct. 1711 (2001); see also *Federal Warning on Medical Marijuana Leaves Physicians Feeling Intimidated*, *THE WASHINGTON POST*, Jan. 1, 1997.

38. *Oakland Cannabis Buyers' Coop.*, 121 S. Ct. at 1714; see also Stuart Taylor, Jr., *Medical Marijuana and the Folly of the Drug War*, *NAT'L J.*, May 21, 2001.

For example, even though abortion is now legal, and has long been recognized as safe,³⁹ access is extremely limited as the result of a wide variety of restrictive laws. As Joffe explains:

Some 84 percent of all U.S. counties are without abortion facilities. The number of U.S. hospitals where abortions are performed decreased by 18 percent between 1988 and 1992, and less than one third of the nation's hospitals with the capability to perform abortions (defined as hospitals that offer obstetrical services) do so.⁴⁰ The majority of ob/gyns presently in practice do not perform abortions, and most residents in this specialty are not routinely being trained in abortion procedures.⁴¹

All sorts of restrictions exist in the abortion context for procedures that are safe and medically approved – from mandated counseling unrelated to the patient's needs, to unnecessary waiting periods, to notification requirements designed to delay and intimidate.⁴² Until September 28, 2000, RU486, a medication known to be both safe and effective in inducing early abortion was banned in America, despite years of favorable research results in the U.S. and experience in other countries.⁴³

39. JOFFE, *supra* note 3, at 4 (“The public health benefits of legal abortion have been amply documented. In contrast to the pre-*Roe* era, in which many thousands of women died or were injured from illegal abortions, legal abortion is among the safest procedures today performed in medicine...”); Lynn M. Paltrow, *Amicus Brief: Richard Thornburgh v. America College of Obstetricians and Gynecologists*, 9 WOMEN’S RTS. LAW REP. 3 (1986).

40. JOFFE, *supra* note 3, at 3 (citing Stanley Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1991 and 1992*, in 26 FAMILY PLANNING PERSP. 100-106, 112 (1994); ABORTION FACTBOOK 56-57 (New York: Alan Guttmacher Institute, 1992).

41. JOFFE, *supra* note 3, at 3.

42. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 840 (1992) (upholding, among other things a so called “informed consent provision” with a mandatory 24-hour waiting period as well as a parental consent requirement).

43. See, e.g., *Feminist Majority Foundation, The Fight to Make Mifepristone (RU486) Available to U.S. Women: A Brief Chronology*, <<http://www.feminist.org/>> (detailing U.S. clinical trials of the drug beginning in 1983, its availability in France in October 1988 after the French Minister of Health declared RU486 “the moral property of women,” and then more than a decade of activism seeking its approval for use in the United States); see also *Benten v. Kessler*, No. 92-3161, 1992 U.S. Dist. LEXIS 14747 (1992) (representing an unsuccessful challenge to the U.S. importation ban on RU486).

Similarly, access to safe and effective treatment for drug addiction is deliberately limited in America today.⁴⁴ "Methadone is the most effective treatment for heroin addiction, yet government regulations largely block its prescription by primary-care physicians and its sale by pharmacies, instead limiting methadone distribution to special clinics (which tend to be poorly staffed and inconveniently located)."⁴⁵ Methadone's benefits "have been established by hundreds of scientific studies,"⁴⁶ and yet:

. . . Methadone can be prescribed *exclusively* by "comprehensive treatment programmes," and not by physicians in their private offices, in hospital clinics, in community health centres, etc. Collectively, these programmes can accommodate less than 15% of those whom methadone treatment might help.⁴⁷

Likewise, abortion services are now largely limited to free standing clinics. Although this was not the result of specific federal legislation as in the case of methadone treatment,⁴⁸ the isolation of abortion services from mainstream medical care similarly leaves patients and staff without adequate access to abortion services and, in addition, permits patients and staff to be easily targeted for violence and harassment.⁴⁹ Particular harms of these systems are startlingly similar, including harrowing stories of

44. See MICHAEL MASSING, *THE FIX: UNDER THE NIXON ADMINISTRATION, AMERICA HAD AN EFFECTIVE DRUG POLICY, WE SHOULD RESTORE IT* (NIXON WAS RIGHT) (1998).

45. Peter Vanderkloot, *Methadone: Medicine, Harm Reduction or Social Control*, HARM REDUCTION COMMUNICATION 1,4 (Spring 2001) (As one long time methadone patient-advocate explains: "[t]he reality is . . . the system through which methadone is provided is a uniquely oppressive bureaucracy that greatly reduces the benefits of the medication and generates harm where none existed before"); *id.* at 6.

46. Holly Catania, *About Methadone*, The Lindesmith Center/Drug Policy Foundation (2001).

47. Robert G. Newman, M.D., *Addiction and Methadone: One American's View*, 2 *HEROIN ADDICTION & RELATED CLINICAL PROBLEMS* 19, 22 (2000) (emphasis in the original).

48. JOFFE, *supra* note 3, at 46-49 (Despite the Supreme Court's ruling in *Roe v. Wade*, the majority of U.S. hospitals failed to establish abortion services, private physicians continued to be reluctant to provide such services, and mainstream medical organizations distanced themselves from the issue, failing to encourage greater provision of services through such things as public statements, guidelines, or standards on abortion services.).

49. JOFFE, *supra* note 3, at 48-49 ("The situation after *Roe* was one in which the medical mainstream's reluctance to become involved in abortion led to an increasing dependence on the freestanding clinic as the major site for both abortion services and training. Though the freestanding clinic in many ways has been a very positive model of abortion services, . . .this heavy reliance on clinics has further isolated abortion from dominant medical institutions—a development with negative consequences."); *id.* at 51.

both methadone patients and abortion patients having to travel hundreds of miles to the "nearest clinic."⁵⁰

While communities across the country have been using zoning laws to keep abortion clinics from opening, similar laws have long been used to prevent the establishment of methadone programs.⁵¹ Moreover, efforts in

50. Vanderkloot, *supra* note 45, at 4. As one methadone patient-advocate explains:

The damage begins with the actual need to travel to the clinic. In many parts of the country, the nearest clinic is hundreds of miles away, but even in cities like New York, it is common for people to have to travel for an hour or more to their clinic—virtually every single day. Limited hours of operation make the situation worse still. Many clinics only allow patients to be medicated in a narrow window of opportunity, usually in the morning.

Another story reports the case of Linda Clark, who died in a traffic accident during one of the many car trips she had to take to obtain methadone treatment. Ms. Clark had to make a 400-mile drive to Springfield, Massachusetts several times a week because her home state, Vermont, outlawed methadone treatment. *See* correspondence from Holly Catania to Lynn Paltrow (March 29, 2000) (on file with author). Similarly, women seeking abortion services must also travel long distances—both because of provider shortages and because of restrictions on access like the Minnesota parental consent provision challenged in *Hodgson v. Minnesota*, 493 U.S. 962 (1989):

Minnesota is a large state. Many teenagers hitchhiked long distances from home under extreme weather conditions to undergo the judicial bypass procedure and obtain an abortion, coming to Duluth or the Twin Cities from the far corners of the state, northern Michigan, and Canada. Lacking other accommodations, it was not uncommon for them to spend the night in the clinic lobby or in a car in the hospital parking lot.

Brief for Petitioners at 9, *Hodgson v. Minnesota*, 493 U.S. 962 (1989). *See also* Planned Parenthood Dot Com Fact Sheet, *Abortion After the First Trimester* (visited May 15, 2001) <<http://www.plannedparenthood.org/library/facts/>> (A 1993 survey of U.S. abortion providers found that among women who have non-hospital abortions, approximately 16 percent travel 50 to 100 miles for services, and an additional eight percent travel more than 100 miles); *Bray v. Alexandria Women's Health Clinic*, 113 S. Ct. 753, 781-82 (Stevens, J., dissenting from majority opinion, holding, in part, that anti-abortion demonstrators incidental effect on women's right to interstate travel did not suffice to show a conspiracy to deprive those women of their protected interstate travel rights and describing extensive interstate travel by women needing abortion services).

51. *Compare* *Planned Parenthood of Minn. v. Citizens for Community Action*, 558 F.2d 861 (Minn. Ct. App. 1977) and *Deerfield Medical Center v. City of Deerfield Beach*, 661 F.2d 328 (Fla. Dist. Ct. App. 1981) (reversing the trial court's denial of a preliminary injunction where a zoning board denied an application to open an abortion facility based on board members' personal objections to abortion) *with* *Bay Area Addiction Research Treatment, Inc. v. City of Antioch*, 179 F.3d 725 (Cal. App. 4th 1991). *See also* *Planned Parenthood of Minn.*, 558 F.2d 861 (1977) (finding that a six-month moratorium on the construction of abortion clinics in the city which was adopted in response to "clamorous public opposition" to the abortion facility, preventing the establishment of the only abortion clinic in the city of St. Paul unconstitutionally deprives

both arenas, to give people greater access to health care through private physicians face serious hurdles. For example, although it was hoped that the availability of RU486 would enable significant numbers of women to get procedures from private physicians, abortion restrictions on the books may make the delivery of such services illegal,⁵² just as private physicians still cannot prescribe methadone.⁵³

Access has also been blocked to many "harm reduction" techniques that have proved effective both in terms of public health and cost savings.⁵⁴ Proponents of harm reduction recognize:

[O]vercoming drug addiction is usually a difficult and gradual process. [Harm reductionists] seek to turn public policy away from punitive criminal justice approaches and toward providing drug abusers with information and assistance that can help them reduce consumption and minimize the risks associated with their continuing drug use. Harm reductionists favor drug treatment over imprisonment and favor broadening drug treatment to include non-abstinence-based models.⁵⁵

As Ethan Nadelmann explains, "[h]arm-reduction innovations include efforts to stem the spread of HIV by making sterile syringes

women of abortion services "unique in cost, convenience and patient privacy," and that the zoning ordinance is not a legitimate land use regulation but "a disguised attempt to regulate medical practices," "discriminatory," and "enacted in bad faith").

52. *Interest in Abortion Pill Often Wanes as Doctors Learn About the Obstacles*, N.Y. TIMES, Sept. 30, 2000, at A1 ("In some states, the laws governing abortion services speak of 'abortions' without saying how they are performed," thus making it possible that state laws that regulate doctors who provide abortions, and that often go into extraordinary detail—concerning things like the size of the hallways in medical offices, the registration of abortion providers and the disposal of the fetal tissue will apply even to private physicians who prescribe RU-486 to their patients.).

53. See Ethan A. Nadelmann, *Commonsense Drug Policy*, 77 FOREIGN AFF. 111, 118, (Jan./Feb. 1998) ("Integrating methadone with mainstream medicine makes treatment more accessible, improves its quality, and allocates ancillary services more efficiently. It also helps reduce the stigma of methadone programs and community resistance to them.").

54. Drucker, *supra* note 10, at 16, 28 (noting that in the United States, "the very use of the term harm reduction is still banned from the federal policy lexicon and denied funding because it is seen as 'condoning drug use'").

55. See SHEIGLA MURPHY & MARSHA ROSENBAUM, PREGNANT WOMEN ON DRUGS: COMBATING STEREOTYPE AND STIGMA 100 (1999); see also The Harm Reduction Coalition, *Principles of Harm Reduction* <<http://www.harmreduction.org/prince.html>>; Andrew Tatarsky, *An Integrative Approach to Harm Reduction Psychotherapy: A Case of Problem Drinking Secondary to Depression*, in SESSION: PSYCHOTHERAPY IN PRACTICE 9, 9-24 (1998); PATT DENNING, PRACTICAL HARM REDUCTION PSYCHOTHERAPY: AN ALTERNATIVE APPROACH TO ADDICTION (2000).

readily available and collecting used syringes."⁵⁶ Making clean needles available to injection drug users through needle exchange programs⁵⁷ and permitting their sale at pharmacies⁵⁸ have proven highly effective in curtailing the transmission of HIV/AIDS and hepatitis.⁵⁹ This has also been shown to be an important first step in helping drug users obtain drug information, treatment, detoxification, social services and primary health care.⁶⁰ Moreover, numerous public health groups including the American Medical Association, the National Institutes of Health, the Centers for Disease Control and Prevention, and the Institute of Medicine, have endorsed needle exchange programs.⁶¹ Despite the fact that government sponsored research has shown that such programs do not lead to increased drug use and does have numerous positive health effects, the federal policy prohibits use of its funds for such life-and cost-saving measures.⁶²

56. Nadelmann, *supra* note 53, at 114 (Other harm reduction approaches include "allowing doctors to prescribe oral methadone for heroin addiction treatment, as well as heroin and other drugs for addicts who would otherwise buy them on the black market; establishing 'safe injection rooms' so addicts do not congregate in public places and dangerous 'shooting galleries'; employing drug analysis units at the large dance parties called raves to test the quality and potency of MDMA, known as Ecstasy, and other drugs that patrons buy and consume there; decriminalizing (but not legalizing) possession and retail sale of cannabis and, in some cases, possession of small amounts of 'hard' drugs; and integrating harm-reduction policies and principles into community policing strategies.").

57. Horowitz, *supra* note 9, at 24 (describing the Lower East Side Needle Exchange Program in New York City, though the harrowing effects of addiction (and poverty) are on vivid display, so is a rare enlightened attitude toward the afflicted. "This place gives me hope and it makes me feel loved," says Terri, who volunteers at the needle exchange. "This place keeps you from hurting yourself until you're able to make a choice to straighten yourself out.").

58. This activity is currently prohibited by most paraphernalia laws.

59. Most programs in the United States are funded by local government or private donors. See Sheryl Gay Stolberg, *Clinton Decides Not to Finance Needle Program*, N.Y. TIMES, April 21, 1998, at A1. While violence has come to be associated with abortion clinics, a recent arson attack on a needle exchange program raises concern about the isolation and vulnerability of people who need services to reduce the morbidity and mortality associated with illegal drug use; see also Henry K. Lee, *New Year's Eve Fruitvale Blaze Looks Like Arson*, S.F. CHRON., Jan. 3, 2001, at A15 (reporting that a New Year's Eve blaze that destroyed the offices of a needle exchange program in Oakland's Fruitvale district appears to be arson, causing an estimated \$250,000 in damage).

60. See The Lindesmith Center/Drug Policy Foundation, *Research Brief, Syringe Availability* (1997).

61. *Id.*; see also *AIDS Activists Say Needle Law Adds to Risks in New Jersey*, ASSOCIATED PRESS, Mar. 11, 2001.

62. Stolberg, *supra* note 59, at 2 (describing how President Clinton refused to lift an eight year funding ban on needle exchange despite promising to do so once government scientists certified that the programs reduced the spread of AIDS and did not encourage drug use); see also *Syringe Availability*, *supra* note 60.

The common governmental orientation toward control and punishment in both drug policy and reproductive health care policy is reflected in the funding priorities of each. The \$16 billion dollar budget for drug law enforcement, interdiction and supply reduction represents two thirds of the total federal budget addressing drug use in this country.⁶³ And while the government ignores the need for treatment, the lack of treatment for women is even more acute.⁶⁴

Similarly, the government refuses to fund abortion services for poor women,⁶⁵ while ensuring that funding *is* available for permanent sterilization services for the same population of women.⁶⁶ The government has failed to increase adequately funding for the Title X family planning program, and fails to require private insurers to provide adequate coverage of contraceptive services and supplies.⁶⁷

63. Drucker, *supra* note 10, at 15; PETER RYDELL & SUSAN S. EVERINGHAM, *CONTROLLING COCAINE: SUPPLY VERSUS DEMAND PROGRAMS* (1994) (A 1994 report by the Rand Corporation, looking specifically at efforts to control cocaine, found that treatment accounts for only a 7 % share of government expenditures with 73 % going to domestic law enforcement, 7% to source-country control and 13% to interdiction).

64. *See generally* DRUG STRATEGIES, KEEPING SCORE, WOMEN AND DRUGS: LOOKING AT THE FEDERAL DRUG CONTROL BUDGET 32 (1998) (“Although significant progress has been made in the past decade in understanding the health and socioeconomic impact of substance abuse among women, treatment is still scarce. Only a small fraction of the estimated nine million women with serious alcohol and other drug problems are able to get treatment, unless they can afford to pay”); *see also* Dorothy Roberts, *The Challenge of Substance Abuse for Family Preservation Policy*, 3 J. HEALTH CARE L. & POL’Y 72, 78, 1999 (“Government officials have largely ignored the burgeoning need for comprehensive, long-term treatment for women”).

65. *See generally* *Harris v. McRae*, 448 U.S. 297 (1980) (upholding the Hyde Amendment, which denies Medicaid coverage for abortion services to low-income women whose health care costs would otherwise be covered by government programs); *Maher v. Roe*, 432 U.S. 464 (1977) (rejecting an equal protection challenge to a regulation of the Connecticut Welfare Department that limited Medicaid funding for first trimester abortions to those that were medically necessary—thus permitting states as well as the federal government to deny coverage for the cost of abortion services).

66. Lopez, *supra* note 15, at 7 (“The refusal of the state to provide public funds for abortion services, except in narrowly defined therapeutic cases, while making sterilization readily available, suggests a definite predilection for sterilization over temporary methods of birth control and abortion.”).

67. *U.S. Policy Can Reduce Cost Barriers to Contraception*, ISSUES IN BRIEF (The Alan Guttmacher Institute) (1999) (Title X funding has not kept pace with program costs or inflation, hindering the program’s ability to serve all those seeking care.); *see also* Ellen Nakashima, *Cut in Birth Control Benefit of Federal Workers Sought*, WASH. POST, Apr. 12, 2001, at A12 (reporting that President Bush has proposed dropping a requirement that all health insurance programs for federal employees cover a broad range of birth control).

In stark contrast to the situation in other developed nations, where contraceptives are easily affordable under universal health insurance systems, contraceptive supplies and services are expensive in this country and American women must rely on a variety of fragmented systems and programs to help them cover these costs.⁶⁸

The federal government has also permitted the states to deny increased "welfare" payments to a woman who conceives and bears another child while she is on welfare,⁶⁹ and state funding for a range of women's reproductive health care – including screening and treatment for cervical cancer, sexually transmitted diseases, HIV prevention for women and obstetrical and gynecological care for low-income women – reflect a policy of extreme neglect.⁷⁰

VI. INTERFERING WITH MEDICAL PRACTICE AND THE MEDICAL PROFESSION'S RESPONSE

According to AMA ethical guidelines, a fundamental element of the Patient-Physician relationship includes the patient's "right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives."⁷¹ These guidelines also state that, "[p]atients should receive guidance from their physicians as to the optimal course of action" and that patients have a right to confidentiality.⁷²

68. Cynthia Dailard, *Sex Education: Politicians, Parents, Teachers and Teens*, The Guttmacher Report (Feb. 2001) ("Costs for *supplies alone* can run approximately \$360 per year for oral contraceptives, \$189 per year for the injectable, \$450 for the implant and \$240 for an IUD"); see also Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363 (1998).

69. Patricia Donovan & Lisa Kaeser, *Welfare Reform, Marriage and Sexual Behavior*, ISSUES IN BRIEF (The Alan Guttmacher Institute) (2000); Susan L. Thomas, *Race Gender and Welfare Reform, the Antinatalist Response*, 28 J. BLACK STUDIES 419, 435 (1998) (discussing coercive measures including welfare caps in a historical context); see also *C.K. v. New Jersey Dep't of Health & Human Services*, 92 F.3d 171 (3rd Cir. N.J. 1996) (rejecting constitutional challenges to New Jersey's "family cap" provision finding stated purposes of the program likely to further goals of AFDC).

70. Theresa M. McGovern, *Building Broader Women's Health/Reproductive Healthcare Coalitions in the States: A Look at Idaho, Texas, and Florida*, AN OPEN SOCIETY INSTITUTE INITIATIVE (2000) (documenting the terrible public health record for providing for women's health services in three states, and the grassroots efforts to advocate for change in those states).

71. Am. Med. Ass'n., *Current Opinions of the Council on Ethical and Judicial Affairs, E-Principles of Medical Ethics* at § 10.01. See <<http://www.ama-assn.org/ama/pub/category/2510.html>>.

72. *Id.* at § 10.02.

Many restrictions on both reproductive health care and certain drugs interfere with the physician's ability to follow these guidelines as well as their ability to prescribe treatment that may be most beneficial to the patient. For example, the "gag rule" on Title X providers would prevent doctors in these programs from mentioning abortion even if that was deemed to be the optimal medical course of action for a patient. Similarly, mandatory and scripted abortion consent laws force doctors to act as government spokespersons, in effect expressing the State's "preference for childbirth over abortion."⁷³ A doctor, for example, might have to inform a woman about state published materials describing the availability of child support from the father,⁷⁴ even if the pregnancy resulted from a rape or the woman had already spent years unsuccessfully attempting to collect child support for the children she already had.

Numerous states have passed what have been labeled "TRAP" regulations: Targeted Regulation of Abortion Providers.⁷⁵ "TRAP" laws regulate the medical practices or facilities of doctors who provide abortions by imposing burdensome and unnecessary requirements that are not mandated for comparable medical services.⁷⁶ Examples of these regulations are rules permitting state agencies to copy and remove patient records, jeopardizing patient confidentiality, or mandating unique structural or administrative specifications that are not medically warranted and that increase costs so significantly that doctors are dissuaded from providing abortion services.⁷⁷

73. *Planned Parenthood of Southeastern Penn. v. Casey*, 505 U.S. 833, 883 (1992).

74. *Id.* at 907.

75. Center for Reproductive Law and Policy, *Targeted Regulation of Abortion Providers (TRAP): Avoiding the TRAP* (visited May 23, 2001) <http://www.crlp.org/pub_fac_trap.html/>.

76. *Id.*

77. A District Court judge considering a challenge to South Carolina's thirty pages of new licensing regulations for doctors who provide more than five abortions a month said:

The regulations "would seem to appear reasonable at first blush, but fail upon closer examination." For instance, while the provision for tuberculin skin testing would appear very reasonable from a public health standpoint, he observed that the "DHEC has not required such testing of all health care personnel - choosing instead to impose the costly testing only upon clinics and physicians that perform abortions on a regular basis." Furthermore, he noted that some of the provisions "border on the absurd," specifically citing the requirements that the entire facility be kept free from unspecified odors and all outside areas be kept free of grass and weeds.

Greenville Women's Clinic v. Bryant, 66 F. Supp. 2d 691 (D.S.C. 1999), *rev'd*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 121 S. Ct. 1188 (2001).

Attempts by the federal government to silence California doctors and prevent them from recommending medical marijuana would also prevent doctors from discussing with their patients the "optimal course of action." Drug laws in the United States also interfere with doctors' ability to provide the care deemed most appropriate for a patient. In England, doctors have at times had "broad discretion to prescribe whatever drugs help addicted patients manage their lives and stay away from illegal drugs and their dealers."⁷⁸ This is not the case in the United States. And, according to Mike Gray, as a result of drug law enforcement, doctors are extremely limited in their ability to prescribe narcotic pain medication to patients who need it and have largely "abandoned" patients with chronic pain who need ongoing narcotic painkillers "just to get out of bed."⁷⁹

Despite these and other intrusions on medical practice in the name of abortion regulation and the war on drugs, the medical community has been relatively accepting of these measures. As discussed earlier, it was in fact the medical community that initially sought criminalization of abortion. And while leading medical groups did, nearly a century later, take positions supporting reform of such laws,⁸⁰ Carol Joffe argues, that today, "it is the medical community itself, and not [radical antiabortion groups like] Operation Rescue, that bears chief responsibility for the present marginalization of abortion provision."⁸¹

Similarly, Mike Gray argues that the medical profession made it easy for laws criminalizing certain drugs, originally disguised as tax regulations, to replace professional medical judgment:

It may seem strange that a guild as powerful as the American Medical Association would allow a bunch of Treasury men to wade into their profession and start telling them how to write prescriptions, but the fact is most doctors found the narcotics issue disgusting. Addiction wasn't studied in medical school, nobody seemed to know much about it, and the only experience for most physicians these days was the occasional junkie who showed up wild-eyed, unwashed, and desperate, terrorizing

78. Nadelmann, *supra* note 53, at 119 (describing policies and studies in Britain, Switzerland and the Netherlands that permit physicians to provide maintenance heroin and other drugs to help addicted patients lead healthier, more productive and non-criminal involved lives).

79. GRAY, *supra* note 10, at 183-85.

80. See *Roe v. Wade*, 410 U.S. 113, 141-46 (1973).

81. JOFFE, *supra* note 5, at 6; see also Sylvia A. Law, *Silent No More: Physician's Legal and Ethical Obligations to Patients Seeking Abortion*, 21 N.Y.U. REV. L. & SOC. CHANGE 279 (identifying mainstream medicine's failure to provide responsible medical referrals for pregnant women as a primary reason for limited availability of abortion services).

everybody in the waiting room. Every word from his mouth was likely to be a lie and if you turned your back he'd clean the place out. (The average physician would probably have been astounded to know that only a decade before, many of the wretched desperados had held down jobs, owned homes, and raised families.) The medical profession was more than happy to turn this ugly problem over to the Treasury Department.⁸²

Today, education in medical school about both abortion and addiction remains extremely limited. Only 12 percent of United States residency programs in obstetrics and gynecology require routine training in first trimester abortions.⁸³ Less than one percent of the curriculum in United States medical schools is devoted to drug abuse and addiction.⁸⁴

VII. "EPIDEMICS" OF DRUGS AND PREGNANCY

Very often, identical language is used to describe and define the terms of the public discussion about both drugs and reproduction. In the recent past, both the use of cocaine and pregnancy by teenagers have been reported and decried as "epidemics." Virtually everyone has heard about the crack "epidemic" of the 1980's. This term was used by policy-makers and media moguls to suggest that crack use was rampant across all strata of the U.S. population and as a justification for more punitive law enforcement measures. Government data and research into actual use patterns, however reveal that overall cocaine use was in fact down during this period and that "if the word 'epidemic' is used to mean a disease or disease-like condition that is 'widespread' or 'prevalent' then there has never been an epidemic of crack addiction (or even crack use) among the vast majority of Americans."⁸⁵ As authors Reinerman and Levine explain,

82. GRAY, *supra* note 10, at 60-61.

83. Melinda Voss, *Medical Students Battle for Pro-Choice Education* (visited May 21, 2001) <<http://www.womensnews.org/article>>; American Medical Women's Association, *Reproductive Health Initiative Fact Sheet* (visited May 21, 2001) <<http://www.amwa-doc.org>>.

84. Dispelling Myths about Addiction: Strategies to Increase Understanding and Strengthen Research (visited May 21, 2001) <<http://www.nationalacademies.org/news.nsf/>>.

85. Craig Reinerman & Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare*, in *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE* 18, 28, 33 (Craig Reinerman & Harry G. Levine eds., 1997); *see also* DREW HUMPHRIES, *CRACK MOTHERS: PREGNANCY DRUGS, AND THE MEDIA* 43-47 (1999) (identifying lack of survey evidence to support claims of a crack epidemic).

a more proper use of the word epidemic would be to describe the extensive use of alcohol and tobacco.⁸⁶

Significantly, during almost exactly the same period, the press and activists coined the term – an "epidemic of teen pregnancy." As Kristin Luker explains, "[b]y the early 1980's Americans had come to believe that teenagers were becoming pregnant in epidemic numbers."⁸⁷ "Ironically (in view of all [the] media attention,) births to teenagers actually *declined* in the 1970s and 1980s."⁸⁸ In fact in the 1980's "contrary to prevailing stereotypes – older women and white women were slowly replacing African Americans and teens as the largest groups within the population of unwed mothers."⁸⁹ Correctly applying the terminology required the conclusion that the "real 'epidemic' occurred when Dwight Eisenhower was in the White House and poodle skirts were the height of fashion."⁹⁰

While there actually was no epidemic of cocaine use or teenage pregnancy, the use of that language did serve political purposes. As Reniarman and Levine argue:

Crack was a godsend to the Right. They used it and the drug issue as an ideological fig leaf to place over the unsightly urban ills that had increased markedly under Reagan administration social and economic policies. "The drug problem" served conservative politicians as an all-purpose scapegoat. They could blame an array of problems on the deviant individuals and then expand the nets of social control to imprison people for causing the problems.⁹¹

86. *Id.* ("Although there was an increase in crack use, it occurred among a "distinct minority of teenagers and young adults from impoverished urban neighborhoods.").

87. KRISTIN LUKER, *DUBIOUS CONCEPTIONS: THE POLITICS OF TEENAGE PREGNANCY* 81 (1997).

88. *Id.*

89. *Id.* at 83.

90. *Id.* at 82 (It is true, however, that the types of behavior that led to pregnancy among those teens who did become unwed mothers "were traditionally much more common among African Americans than among whites, and more common among the poor than among the privileged.").

91. Reinerman & Levine, *supra* note 85, at 41 (The Right was not alone in adopting and promoting the rhetoric of a cocaine epidemic. Liberals and Democrats also found in crack and drugs a means of recapturing Democratic defectors by appearing more conservative. And they too found drugs to be a convenient scapegoat for the worsening conditions in the inner cities. All this happened at a historical moment when the Right successfully stigmatized the liberal's traditional solutions to the problems of the poor as ineffective and costly. Thus, in addition to the political capital to be gained by waging the war, the new chemical bogeyman afforded politicians across the ideological spectrum

Similarly, Kristin Luker observed that "pregnant teenagers made a convenient lightning rod for the anxieties and tensions in American's lives. Economic fortunes were unstable, a postindustrial economic order was evolving, and sexual and reproductive patterns were mutating. Representing such teenagers as the epitome of society's ills seemed on quick way of making sense of these enormous changes."⁹² More specifically, poverty could be blamed on the "sexual and reproductive decisions that poor [teenaged] women make."⁹³

Luker's research demonstrates that early childbearing was not a widespread phenomenon and that it would not impoverish women who were not already poor.⁹⁴ As she concluded: "Childbearing among teenagers has relatively little effect on the levels of poverty in the United States. But income disparities have become a pervasive fact of American life, and it is scarcely surprising that when experts . . . labeled 'teenage pregnancy' a fundamental cause of poverty, Americans were willing to listen."⁹⁵

Both drug and pregnancy epidemics are used to redirect attention to "*individual* deviance, immorality, or weakness"⁹⁶ and away from fundamental, pervasive problems like unemployment, poverty, racism and sexism that drastically reduce individuals' ability to exercise choice and maintain control over their lives.⁹⁷

VIII. JUST SAYING NO TO COMPREHENSIVE SEX AND DRUG EDUCATION PROGRAMS

Similarities also exist in government endorsement of and funding for prevention programs. Candid and comprehensive education programs

both an explanation for pressing public problems and an excuse for not proposing the unpopular taxing, spending, or redistributing needed to do something about them).

92. LUKER, *supra* note 87, at 106.

93. *Id.*

94. *Id.* at 108.

95. *Id.*

96. Reinerman & Levine, *supra* note 85, at 37 (emphasis in the original); *see also* LUKER, *supra* note 87, at 86 (teen pregnancy "appeared to explain a number of dismaying social phenomena, such as spreading signs of poverty, persistent racial inequalities, illegitimacy, freer sexual mores, and new family structures").

97. *See, e.g.*, CAMPBELL, *supra* note 21, at 67 (Drugs mark the discontent within the "civilizing process" to an extraordinary degree in U.S. political culture... Drug policy thus operates as "symbolic policy" to index social disorder. Like other symbolic policies, such as child abuse, drunk driving, or teen pregnancy, drug policy discourse uses claims about the scope of individual "deviance" to justify expanded governmental intervention.").

that distinguish between the use and abuse of drugs, and that accept the inevitability that some young people will experiment with drugs and engage in sexual activity, can help prevent unwanted pregnancies and harmful drug use.⁹⁸ Nevertheless, our government has chosen, in both arenas, to limit support exclusively to programs based on abstinence only, fear-based models that have proven to be at best ineffective – and possibly counterproductive.⁹⁹

In the late 1970's and early 1980's, the federal government began funding abstinence only drug education programs, instituting as official policy, former First Lady, Nancy Reagan's "just say no" slogan.¹⁰⁰ The DARE program is a prototype of this approach.¹⁰¹

Since 1990, DARE has received over \$8 million in direct federal funding plus millions more in state and local funds. Approximately 20,000 police officers have delivered drug education to an estimated 25 million youth as part of the DARE program. Evaluation after evaluation has shown "no long term effects resulting from DARE exposure."¹⁰²

Negative assessments of the program are by no means limited to particular interest groups. A recent report from the United States Surgeon General concluded that:

DARE is the most widely implemented youth drug prevention program in the United States. It receives substantial support from

98. See, e.g., Marsha Rosenbaum, *Kids, Drugs, and Drug Education, A Harm Reduction Approach*, POL'Y STATEMENT (The National Council on Crime and Delinquency) (Aug. 1996) (discussing alternative harm reduction models); see also ANDREW WEIL, M.D. & WINIFRED ROSEN, *FROM CHOCOLATE TO MORPHINE: EVERYTHING YOU NEED TO KNOW ABOUT MIND-ALTERING DRUGS* 7 (1993) (discussing the need to provide adolescents with reliable information concerning both drugs and sexuality).

99. As Marsha Rosenbaum has observed:

Unfortunately, drug education does not seem to have successfully achieved its goal of abstinence among teenagers. In the years directly following the state tactics and resistance campaigns, studies indicated an increase in drug-use among the targeted population. By the 1990's following the "just say no" campaign of the 1980's, the use of marijuana and psychedelic drugs had increased among teens.

Rosenbaum, *supra* note 98.

100. See MARSHA ROSENBAUM, *SAFETY FIRST: A REALITY-BASED APPROACH TO TEENS, DRUGS, AND DRUG EDUCATION* 3, 4 (1999).

101. Rosenbaum, *supra* note 98, at 8; *supra* note 100, at 2.

102. ROSENBAUM, *supra* note 100, at 8.

parents, teachers, police, and government funding agencies, and its popularity persists despite numerous well-designed evaluations and meta-analyses that consistently show little or no deterrent effects on substance use. Overall, evidence on the effects of the traditional DARE curriculum, which is implemented in grades 5 and 6, shows that children who participate are as likely to use drugs as those who do not participate.¹⁰³

Indeed, in light of the overwhelming evidence of lack of success, DARE program directors have finally acknowledged that their strategy "has not had sufficient impact and say they are developing a new approach to spreading their message."¹⁰⁴

Despite evidence that abstinence only models did not work in the drug arena, the federal government chose to support comparable abstinence only models in sex education.¹⁰⁵ The welfare laws of the 1990's committed:

nearly \$850 million in public funds over five years . . . to promote abstinence for anyone who is not married and to reward states that reduce out-of-wedlock births and abortions among *all* women in the state. Moreover, the law guarantees these large expenditures of public funds without any evidence that the strategies it embraces will have their intended effects and without any specific plans to evaluate their impact to determine whether any of the funded programs are worthy of continuation and replication.¹⁰⁶

Similarities between drug abstinence and sex abstinence programs are not accidental. As a leading proponent of sexual abstinence programs,

103. Youth Violence: A Report of the Surgeon General (Jan. 2001) <<http://www.surgeongeneral.gov/library/>>.

104. Kate Zernike, *U.S.: Antidrug Program Says it Will Adopt a New Strategy*, N.Y. TIMES, Feb. 15, 2001, at A1.

105. See Donovan, *supra* note 69; see also Jacqueline E. Darroch et al., *Changing Emphases in Sexuality Education in U.S. Public Secondary Schools, 1988-1999*, FAM. PLAN. PERSP. (Sept./Oct. 2000) (finding that public school sexuality education teachers report focus on abstinence-only instruction increased markedly during the 1990's and that instruction in all grades is much less likely to cover birth control, abortion, how to obtain contraceptive and STD services, and sexual orientation than it was in the late 1980's); Dailard, *supra* note 68 (reviewing recent studies finding a significant disparity between policymaker's emphasis on abstinence only education and the desires of students, parents and teachers who want more comprehensive information about how to avoid unintended pregnancy and STDs and about how to become sexually healthy adults).

106. Donovan, *supra* note 69, at 1.

Janet Parshall, of the Family Research Council, explicitly stated that: sex education programs should resemble the "Just Say No" anti-drug programs.¹⁰⁷ This is so despite the fact that:

The scant research conducted on abstinence-only education (all aimed at teenagers) suggests that such programs have little or no effect on initiation of sexual intercourse, but researchers say too few data exist to make a definitive judgment. What is clear from the research is that more comprehensive sexuality education programs that provide information about both abstinence and contraception, teach communications skills and provide access to family planning services do have some effect: They are more likely both to persuade adolescents to delay the initiation of sexual intercourse and to lead to greater contraceptive use among teenagers when they become sexually active.¹⁰⁸

The extent to which the *same* abstinence only philosophy underlies both drug and sex education programs is demonstrated in the government's Girl Power! Campaign. Originally conceived as an anti drug program, it was simply "repackaged" as a teen pregnancy prevention program in response to welfare reform laws that directed the secretary of DHHS to implement an abstinence based "strategy for preventing out-of-wedlock teenage pregnancies."¹⁰⁹

IX. THE MYTHOLOGY OF CHOICE: REPRODUCTION AND DRUG ADDICTION

The term "choice" is often applied to both reproductive decision-making and to drug use. Women have a right to "choose" to have an abortion and drug addicts make a "choice" to use drugs. In both areas, however, it is a term that obscures the lack of choice that many people have and the larger economic and institutional barriers that deny people, and disproportionately deny people of color, particularly low-income women of color, the ability to make consumer-like choices.

This particular similarity is best exemplified in cases in which efforts to control both reproduction and drugs coalesce through the

107. Jodi Wilgoren, *Abstinence Is Focus of U.S. Sex Education*, N.Y. TIMES, Dec. 15, 1999, at A18.

108. Donovan, *supra* note 69, at 5; see also Jeff Stryker, *Abstinence or Else! The Just-Say-No Approach in Sex Ed Lacks One Detail: Evidence that it Works*, THE NATION, June 16, 1997.

109. Donovan, *supra* note 69, at 6.

punishment and prosecution of pregnant drug-using women. Since the late 1970's, approximately 200 women have been arrested based on their status as pregnant, drug-using women, thousands of others -and their families- are being affected by state laws that equate a pregnant woman's drug use with evidence of civil child neglect, and new calls for sterilization of drug using women are receiving significant media attention and private financial support.¹¹⁰ These laws, policies and practices combine the seemingly unrelated arguments that fetal rights should be recognized under the law¹¹¹ and the argument that the war on drugs should be expanded to women's wombs.

In one of these cases, a young African American woman who used cocaine while pregnant was charged under a statute that made it a crime to "deliver" drugs to a minor.¹¹² The state argued successfully at trial that the statute could be applied to the delivery of drugs through the umbilical cord. Although this conviction was ultimately reversed, the woman, Jennifer Johnson, was initially sentenced to 15 years of probation.

At sentencing the judge justified the verdict on two separate but interdependent grounds: she deserved punishment both because "the defendant . . . made a *choice* to become pregnant and to allow those pregnancies to come to term" and because the "*choice* to use or not to use cocaine is just that – a *choice*."¹¹³

"Choice" is a popular term that is equally inappropriate whether used in discussions about illicit drugs or reproductive rights.

In the context of reproduction, the word choice as used by the judge contained numerous assumptions and judgments about Ms. Johnson. In making these pronouncements, the judge assumed that the intercourse that resulted in the pregnancy was voluntary. He assumed that she had "chosen" not to use contraceptives, assumed that despite their imperfections she would not have become pregnant if she had used them,

110. See generally Lynn M. Paltrow, David S. Cohen & Corinne A. Carey, *Year 2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol and Other Drugs* (2000). This report is available at <www.advocatesforpregnantwomen.org>. See also discussion *infra* at 232-237.

111. See CYNTHIA R. DANIELS, AT WOMEN'S EXPENSE: STATE POWER AND THE POLITICS OF FETAL RIGHTS 2-3 (1993) (discussing the prosecution of drug-addicted pregnant women); RACHEL ROTH, MAKING WOMEN PAY, THE HIDDEN COSTS OF FETAL RIGHTS 163-83 (2000) (providing an overview and critique of state laws that expand the scope of fetal rights); JEAN REITH SCHROEDEL, IS THE FETUS A PERSON? A COMPARISON OF POLICIES ACROSS THE FIFTY STATES (2000); Katha Pollitt, *A New Assault on Feminism*, THE NATION, Mar. 26, 1990, at 415-16.

112. *Johnson v. State*, 602 So. 2d 1288, 1297 (Fla. 1992) (reversing conviction of a woman who used cocaine during pregnancy for "delivering drugs to a minor," finding that application of the statute to fetuses and pregnant women violated legislative intent).

113. *State v. Johnson*, No. E89-890-CFA, Verdict, Findings and Opinion (Fla. Cir. Ct. 1989) (emphasis added).

and assumed that contraceptive services were easily accessible to her. The judge also assumed that she made a choice not to have an abortion and clearly believed that was the wrong decision. He undoubtedly ignored that fact that Florida, where Ms. Johnson lived does not fund abortion services – thus making an abortion inaccessible even if her moral and ethical beliefs had allowed her to seek termination of the pregnancy. Hiding behind the language of "choice" the judge felt justified in punishing a low income African-American woman for having a child.¹¹⁴

The judge also felt that her drug use was merely a matter of "choice" and self control and thus should be punished as well. The United States Supreme Court¹¹⁵ and the health community,¹¹⁶ however, have long recognized that drug addiction is an illness that generally cannot be overcome without treatment. The American Medical Association has unequivocally stated: "it is clear that addiction is not simply the product of a failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors. It is properly viewed as a disease, and one that physicians can help many individuals control and overcome."¹¹⁷

In the context of reproductive rights, the term "choice" has increasingly come under attack for the very reasons suggested by the lower court's statements in the Johnson case. The term simply does not reflect the reality of many women's lives. As Ricki Solinger argues in her new book, devoted to critiquing the language of "choice":

114. See Lynn Paltrow, *When Becoming Pregnant is a Crime*, IX CRIMINAL JUSTICE ETHICS 1 (1990) (discussing how the prosecution of pregnant women is a penalty on procreation); ROBERTS, *supra* note 2, at 150-201 (discussing how punitive approaches make reproduction a crime); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

115. See *Linder v. United States*, 268 U.S. 5, 18 (1925) (“[Addicted persons] are diseased and proper subjects for [medical] treatment.”); *cf.* *Robinson v. California*, 370 U.S. 660, 666-67 (1962) (holding unconstitutional a state law making narcotic addiction a crime).

116. See Charles Marwick, *Physician Leadership on National Drug Policy Finds Addiction Treatment Works*, 279 JAMA 1149 (1998); American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 176 (4th ed. 1994) (“The essential feature of substance dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior.”).

117. American Medical Ass'n, PROCEEDINGS OF THE HOUSE OF DELEGATES: 137TH ANNUAL MEETING, BOARD OF TRUSTEES REPORT NNN: DRUG ABUSE IN THE UNITED STATES: A POLICY REPORT 236, 241 (1988).

When Americans began to refer to reproductive liberty by the simple name "choice," they obscured the fact that millions of women in the United States – and abroad – lived in conditions of poverty and oppression that precluded many of the kinds of choices that middle-class American women thought of as a matter of personal decisionmaking. Then and now, many Americans have glossed over this: poor and/or culturally oppressed women in the United States and abroad may lack the money to "choose" abortion. They may live where abortion is inaccessible, illegal, or life-threatening. They may lack the resources to feed the children they have, much less a new baby. They may want to be mothers but lack the resources to escape stigma, punishment, or death for having a baby under the wrong conditions. They may lack the resources to avoid pregnancy from sexual violence. Can women in any of these circumstances be described as in a position to make a choice, a private, personal choice in the way that middle-class Americans generally use that term?¹¹⁸

Similarly, the language of choice when applied to drug use allows the government to evade responsibility for the lack of drug treatment and the social and economic circumstances that contribute to addictive and dangerous drug use. As Nancy Campbell argues:

... policy-makers disclaim their own responsibility by attributing policy failure to human nature, immorality, or bad behavior [choices] on the part of the governed. ... Holding individuals responsible for addiction reproduces deeply held American notions of personal responsibility, risk, vulnerability, and productive citizenship. But not all individuals have the means or the capacities to discharge the responsibilities of citizenship and social reproduction. The uneven distribution of the means to realize autonomy, reduce vulnerability and violence, and carry out responsibilities is simply disregarded in drug policy.¹¹⁹

118. SOLINGER, *supra* note 24, at 21-22; *see also* Rosalind Pollack Petchesky, *Reproductive Freedom: Beyond "A Woman's Right to Choose,"* SIGNS 661 (1980); Roberts, *supra* note 114 (finding that the traditional concept of privacy makes the false presumption that the right to choose is contained entirely within the individual and not circumscribed by the material conditions of the individual's life); Lopez, *supra* note 15 ("By focusing on individual choice, we overlook the fact that choices are primed by larger institutional structures and ideological messages.").

119. CAMPBELL, *supra* note 21, at 6.

X. CHILD PROTECTION

In both arenas, reproductive rights and drugs, calls for prohibition and punishment are often justified by the claim that such punitive approaches are necessary to save the children.

In the drug arena, ongoing criminalization of certain drugs and the refusal to fund many harm reduction approaches is justified by the claim that such measures are necessary to keep young people from obtaining drugs or viewing them as tolerable in any way. For example, a primary reason given by the Clinton administration's drug Czar for not funding needle exchange programs was the claim that such programs would send a message to children that drugs are acceptable.¹²⁰ Similarly, arguments for continuing the war on drugs are frequently based on the claim that harsh and total criminalization is necessary to protect children. As the Altoona police chief argued in a letter to the editor:

. . . when young people get the message that drugs are helpful and should be legalized, their drug usage increases. Legalization tells our children that adults believe that drugs can be used responsibly and even for fun. With such an atmosphere it becomes difficult, if not impossible, to reach children and convince them that "doing drugs" is dangerous.¹²¹

And, recently, President Bush, when asking for the largest budget in history for drug control, seeking "approximately \$19 billion in total federal drug control funding," the Acting Director of the Office of National Drug Control Policy (ONDCP) justified this predominantly law enforcement budget explaining, "[t]he President's budget will allow us to better protect our *youth* and our safety."¹²²

120. See *Cowardice on Clean Needles*, N.Y. TIMES EDITORIAL DESK TOPICS OF THE TIMES, April 22, 1998, at A26; Stolberg, *supra* note 59; see also Drucker, *supra* note 10, at 28, n. 44 (citing advertisements by the Partnership for Drug Free America as contributing to "a public systematically frightened about our children's almost inevitable exposure to drugs"); GRAY, *supra* note 10, at 186, 187 (describing how Drug Czar William Bennet announced that "the children of the boomers were facing a far more powerful form of cannabis than the stuff their parents experimented with in the sixties;" claiming without evidence that the amount of THC in the new plants was forty times greater when the best evidence was that it was probably the same or only slightly higher).

121. Letter to the editor, John L. Gray, Altoona Police Chief, THE ALTOONA HERALD - MITCHELLVILLE INDEX, Nov. 27, 1997, at 4A.

122. See Office of National Drug Control Policy, Press Release, *Bush Administration Requests Increases In Drug Funding For Prevention, Treatment, Interdiction, and Andean Assistance* (visited February 28, 2001) <<http://www.whitehousedrugpolicy.gov/news/press01/022801.html>> (emphasis added).

In the case of reproductive rights – the children are embryos and fetuses who must be saved from death that results from abortion and even contraception. Claims that abortion is child-murder are simply too numerous to cite, but there is a recent notable example of applying child abuse rhetoric to contraceptive services. In May of 2001, Representative Chris Smith called Planned Parenthood Federation "Child Abuse Incorporated."¹²³ By its own self description, Planned Parenthood is "the world's largest and oldest voluntary family planning organization."

The claim of child protection is particularly apparent where the issues coalesce, in the case of pregnant drug using women. Numerous approaches including arrest, sterilization and other violation of fundamental constitutional rights have been justified in the name of children's rights.

In *Whitner v. South Carolina*,¹²⁴ the Supreme Court of South Carolina declared that viable fetuses are "persons," and as a result, the state's criminal child endangerment statute applied to a pregnant woman who used an illicit drug or engaged in any other behavior that might endanger the fetus.¹²⁵ In *Ferguson v. City of Charleston*, the defendants argued that a hospital policy of secretly searching pregnant women for evidence of drug use and then turning that information over to the police did not violate the Fourth Amendment's prohibition on unreasonable searches because the search served the special need of protecting children.¹²⁶ Although the US Supreme Court recently rejected this argument, finding that the policy was in fact about criminal punishment, not treatment, a draconian program of dragging pregnant and newly delivered mothers out of their hospital beds in chains and shackles had nevertheless been in effect for five years based on claims of children's rights.¹²⁷

123. *Planned Parenthood President Calls Statement by Rep. Chris Smith Defamatory and "Over the Line"* (visited June 5, 2001) <<http://www.plannedparenthood.org/About/PRESSRELEASES/O51601chrissmith.html>>.

124. *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997), *cert. denied*, 523 U.S. 1145 (1998).

125. *Id.* at 779-80, 84 (reinterpreting case law precedent in South Carolina as resting "on the concept of the viable fetus as a person vested with legal rights," holding that a viable fetus is a "child" and expressly declining to follow the case law precedent of several other states holding otherwise).

126. *Ferguson v. City of Charleston*, 121 S. Ct. 1281 (2001); Brief of Respondents, *Ferguson v. City of Charleston*, No. 99-936, U.S. Supreme Court at 24-29 (arguing that protection of "pregnant patients *and their children*" provided a special needs exception to the 4th Amendment's requirement) (emphasis added).

127. *See, e.g.*, Charles Molony Condon, *Bureaucrats Stopped Crack-Baby Prevention Program*, THE GREENVILLE NEWS, May 28, 1995, at 3 (portraying policy as child abuse prevention program); *see also* Frank Heflin, *Charleston Plan Saving Unborn Babies From Addiction*, THE STATE, June 4, 1990, at A2.

Child protection is also a claimed rationale for the C.R.A.C.K. program. In 1994, Barbara Harris founded C.R.A.C.K. ("Children Require A Caring Kommunity") after unsuccessful efforts to convince the California state legislature to pass a law that would punish women who give birth to drug exposed infants.¹²⁸ When a bill to make it a crime to give birth to a "drug baby" died in committee,¹²⁹ Ms. Harris created a non-profit organization that offers \$200 to any drug-addicted or alcoholic woman who agrees to be sterilized or to use a long acting contraceptive such as Norplant or Depo-Provera. Her rationale is that the children suffer and would be better off having never been born.

The group's literature and statements until recently, portrayed all drug exposed children as severely damaged. The organization's web site provides examples only of stillbirths, or children born with "severe disabilities (deaf, feeding tubes, one in a wheelchair)."¹³⁰

The C.R.A.C.K. program targets one group of women,¹³¹ women who use drugs, and launched a significant public relations campaign¹³²

128. Jeff Stryker, *Cracking Down*, SALON, July 10, 1998; <http://www.salonmagazine.com/mwt/feature/1998/07/cov_10feature.html>; *see also* <<http://www.cashforbirthcontrol.org>> ("Ms. Harris had first lobbied legislators to pass a bill that would make people accountable for their inhumane acts against their own newborns.").

129. Stryker, *supra* note 128.

130. <<http://www.cashforbirthcontrol.org>> (visited April 10, 2001). Recent changes in their web site, in apparent response to criticism, now grudgingly acknowledge "that there are some that are more fortunate than others, coming away with their lives and health" and now states that ". . . there are some children that have minor problems, or even more rarely have no problems at all." The site, however, continues to provide stories only of children born with severe disabilities and who were born "drug addicted" – a term that in itself has proven inaccurate when applied to children prenatally exposed to cocaine. Research has proven that no addiction or withdrawal syndrome exists for cocaine exposed newborns. Morgan & Zimmerman *supra* note 19, at 152. Earlier versions of the C.R.A.C.K. website spoke only of children born "permanently disabled" and stating that "the chances of a normal life are dim." Site at 9/22/99 (printed version on file with author). The web site also relies on data that has been repeatedly shown to be inaccurate. For example, their site states that "perhaps as many as 375,000 cocaine exposed babies are born each year in the U.S." This figure refers to a prevalence study done by Dr. Ira Chasnoff, in which, based on the urine samples of recently delivered women at 36 public hospitals in urban areas, he extrapolated that 375,000 American babies annually were prenatally exposed to "some amount of alcohol or illicit drug." GÓMEZ, *supra* note 20, at 23. In addition to there being significant questions raised about the reliability of the number based only on research at public and urban hospitals, the number never applied exclusively to cocaine. *Id*; *see also* ROBERTS, *supra* note 2, at 155-156; HUMPHRIES, *supra* note 85, at 49, 50.

131. *See* <<http://www.cashforbirthcontrol.org/stats/stats.html>> (visited March 22, 2001) (Although the program purports to be available to men and women, it has overwhelmingly been applied to women. As of March 22, 2001, 392 people had been paid only four of them men.)

that focuses not on those barriers that prevent them from making reproductive choices or on the barriers to drug treatment - but rather on the harm they do to their children, the cost to society of their supposed irresponsibility, and on the value of controlling certain women's reproduction as a solution to complex public health and economic problems.

C.R.A.C.K. supporters suggest that alternative approaches, such as drug treatment, increasing access to contraception and abortion services, and responding to the social conditions of poverty that many of the women face are simply too costly or time consuming compared with their child protection "solution."¹³³

Although, as of early 2001, the program had reached a relatively small number of women, fewer than 400,¹³⁴ C.R.A.C.K. has received significant media attention and appears to be a powerful force in promoting the principle that underlies both the war on drugs and efforts to control reproduction: that complex social problems including child health and welfare, poverty and ill-health can be blamed on individual "choices" and solved through quick fix solutions like sterilization or prohibition.¹³⁵

Similarly, child protection has been the rationale for an increasing number of states to pass laws that treat a pregnant woman's drug use as evidence of parental neglect and unfitness.¹³⁶ "While bills proposing

132. See, e.g., Stryker *supra* note 128, at 3 (describing how Ms. Harris "took her plea to the media" and her numerous successful efforts in appearing on such programs as *Oprah* and becoming "a darling of talk radio hosts and newspaper pundits across the nation").

133. See, e.g., *Fox the Edge with Paula Zahn* (Fox News Network television broadcast, July 7, 2000) (Harris: "Drug treatment is not the solution. Most of our women have been in drug treatment 10 or 12 times and relapsed. That's not the solution."); see also Women's Economic Agenda Project, *Lots of People Just Don't Get It*, <http://www.weap.org/crack_editorial.html> (arguing that "C.R.A.C.K. is just the latest in a long line of efforts to marginalize and snuff out the lives of the poor" and that "that C.R.A.C.K. could do lots of good with its money if instead of buying the souls of desperate women for a mere \$200, it would instead support the current *Just Health Care* campaign, which promises universal health care for all people, including treatment on demand"). C.R.A.C.K.'s cynicism and disdain are apparent from one of their flyers: It states: *Don't Let a Pregnancy Ruin Your Drug Habit*. Copy of Flyer on file with author. See also Stryker, *supra* note 128.

134. See <<http://www.cashforbirthcontrol.com/stats/stats.html>> (visited April 12, 2001) (stating 392 people were paid to be sterilized or use long acting contraception).

135. See GRAY *supra* note 10, at 187 (stating that drug use cannot be stopped by prohibition).

136. These statutes equate a single drug test result with actual evidence of an inability to parent. A urine sample, however, cannot be considered proof of either drug dependence or addiction, much less an inability to parent. See American Medical Association Policy H-95.985 ("Drug testing does not provide any information about

criminal penalties have failed, eighteen states have amended their civil child welfare laws to address the subject of a woman's drug use during pregnancy."¹³⁷ Some of these statutes treat a single positive drug test as the basis for presuming parental unfitness.¹³⁸ Recent court decisions, relying on medical misinformation, have also expanded the scope of their civil child welfare laws to reach the conduct of pregnant women.¹³⁹ In fact, research has found no significant difference between addicted and non-addicted mothers in childrearing practices and addicted and drug-using mothers have been found to look after and care adequately for their children.¹⁴⁰ Thus these cases and statutes permit significant state intrusion

pattern of use of drugs, abuse of or dependence on drugs, or about mental or physical impairments that may result from drug use.”).

137. Paltrow, *supra* note 110 (identifying the eighteen states that address the issue of a pregnant woman's use of drugs in their civil child welfare statutes as: Arizona, California, Florida, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Nevada, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Virginia, and Wisconsin). See ARIZ. REV. STAT. ANN. § 13-3620(B); CAL. PENAL CODE § 11165.13; FLA. STAT. ANN. § 39.01(30)(g); 325 ILL. COMP. STAT. 5/7.3b; IND. CODE § 31-34-1-10, 11; IOWA CODE ANN. §§ 232.68(2)(f), 232.77(2); MD. CODE ANN., FAM. LAW § 5-313(d)(1)(iv); MASS. GEN. LAWS ANN. ch. 119, § 51A; MICH. COMP. LAWS § 722.623a; MINN. STAT. ANN. § 626.5561-5563; NEV. REV. STAT. ANN. § 432B.330(1)(b); OKLA. STAT. ANN. tit. 10, § 7103(A)(2); R.I. ADMIN. CODE § 03-040-420.II.D.4.a; *id.* § 03-141-000.II.F.2.c.1.; S.C. CODE ANN. § 20-7-736; TEX. FAM. CODE ANN. § 261.001(1) & (7); UTAH CODE ANN. § 62A-4-404; VA. CODE ANN. §§ 54.1-2403.1, 63.1-248.3(A1); WIS. STAT. ANN. § 146.0255.

138. See, e.g., S.C. CODE ANN. § 20-7-736(G). A newborn child is presumed to be neglected and “cannot be protected from further harm without being removed from the custody of the mother” if there is a positive toxicology test of either the mother or the child at birth that indicates the presence of any amount of a controlled substance.

139. *In re Baby Boy Blackshear*, 90 Ohio St. 3d 197 (2000) (assuming harm to a newborn from prenatal exposure to cocaine even though no evidence of harm existed in the record and holding that a drug-exposed newborn is “per se an abused child.”); *In re Guardianship of K.H.O.*, 736 A.2d 1246 (N.J. 1999) (finding that evidence of a woman's drug use during pregnancy satisfies the endangerment to child's health and development prong of a four part statutory test for termination of parental rights.); *contra* *In the Matter of the Unborn Child of Julie Starks*, Amended *In the Matter of J.B.C., Julie Starks*, Appellant, v. State of Oklahoma, Appellee, No. 94,104 Supreme Court of Oklahoma (2001). (holding that a fetus was not a child for purposes of states' civil child protection laws and does not provide a vehicle for taking temporary emergency custody of a fetus).

140. SUSAN C. BOYD, MOTHERS AND ILLICIT DRUGS: TRANSCENDING THE MYTHS 14-16 (1999) (listing at least fourteen studies demonstrating that women who use illicit drugs can be adequate parents); M. Kearney et al., *Mothering on Crack Cocaine: A Grounded Theory Analysis*, 38 SOC. SCI. & MED. 351, 355 (1994). A book published by the Foster Care Project of the American Bar Association observes, “many people in our society suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children.” American Bar Association, Foster Care Project, National Legal Resource Center for Child Advocacy and Protection, FOSTER CHILDREN IN THE COURTS 206 (Mark

on certain women's lives and families without protecting children from actual harm.¹⁴¹

These state laws and policies have resulted in removal of custody from women who on occasion smoked marijuana and from those women who tested positive for legal drugs prescribed by doctors during labor and delivery.¹⁴²

In both the drug and reproductive arenas punitive policies do *not* benefit real children. To the contrary: they increase public costs related to incarceration and foster care, and do so at the expense of drug treatment and other forms of health care. Indeed, South Carolina's punitive approach to pregnancy and drug use coincides with a new and significant increase in statewide infant mortality figures.¹⁴³

Hardin ed., 1983). *See also* Nat'l Council of Juvenile and Family Court Judges, PERMANENCY PLANNING FOR CHILDREN PROJECT, PROTOCOL FOR MAKING REASONABLE EFFORTS TO PRESERVE FAMILIES IN DRUG RELATED DEPENDENCY CASES 17 (1992) (concluding that "Juvenile and family court proceedings are not necessary, and probably not desirable, in most situations involving substance-exposed infants").

141. Studies have found that unnecessarily removing children from their parents' care can inflict grave harm on the children. *See, e.g.*, BONITA EVANS, YOUTH IN FOSTER CARE: THE SHORTCOMINGS OF CHILD PROTECTION SERVICES (1997); Scott J. Preston, Note, "Can You Hear Me?": *The United States Court of Appeals for the Third Circuit Addresses the Systemic Deficiencies of the Philadelphia Child Welfare System in Baby Neal v. Casey*, 29 CREIGHTON L. REV. 1653 (1996); *see also* Dorothy E. Roberts, *Access to Justice: Poverty, Race and New Directions in Child Welfare Policy*, 1 WASH. U. J.L. & POL'Y 63, 69, 71 (noting that "Children, even neglected children, typically value and want to maintain a relationship with their parents." And that "[u]necessarily taking children from their families is comparably harmful to children as returning them to dangerous homes.").

142. *See, e.g.*, Cathy Singer, *The Pretty Good Mother*, LONG ISLAND MONTHLY, Jan. 1990, at 46 (reporting that a mother who had smoked marijuana to ease labor pain lost custody of her baby even though the mother had acted responsibly throughout her entire pregnancy); Associated Press, *Woman Given Labor Sedative Loses Custody of Children*, THE SACRAMENTO BEE, Feb. 11, 2000 (describing a California woman who lost custody of her newborn and other children for three months based on a drug test of the newborn that reflected a sedative given to the woman during labor); Cathy Zollo, *When Policy Meets Reality*, TIMES RECORD NEWS (Wichita Falls, Texas), Nov. 11, 1999 (reporting a case in which the state took into emergency custody a newborn and three older siblings based on a single positive marijuana test on the newborn); Melissa Hung, *Reefer Madness? Angela Took a Hit. And CPS Took Her Babies Away*, HOUSTON PRESS, Nov. 4, 1999, at 8 (reporting another Texas case in which the child welfare agency removed custody of a newborn and a one-year-old sibling based solely on a positive drug test for marijuana); *see also* Abigail English, *Prenatal Drug Exposure: Grounds for Mandatory Child Abuse Reports?* YOUTH LAW NEWS 3-8 (1990) (arguing that laws that rely on positive drug tests are both too narrow and too broad and fail to give children greater protection than individual assessments of parenting ability); YOUTH LAW NEWS 1-40 (July-Oct. 1995) (revising and reprinting the Special Issue from 1990).

143. *See Infant Mortality on Rise in '97*, POST & COURIER (Charleston, S.C.), Feb. 19, 1999, at B1; *Kids Count Data Book*, The Annie E. Casey Foundation at 160

Moreover, as Jean Schroedel documents, states most protective of fetal rights are the ones least likely to support health, education and welfare programs that actually benefit children.¹⁴⁴ Similarly, drug prohibition has, by in large, failed to reduce drug use by young people.¹⁴⁵

XI. EFFORTS TO CONTROL BOTH HURT EVERYONE, BUT ESPECIALLY
AFRICAN-AMERICAN WOMEN

Laws criminalizing and unnecessarily controlling illicit drug use and reproduction hurt a wide expanse of the population. As many commentators have noted, the war on drugs in particular has "shattered" numerous lives, placing hundreds of thousands of non-violent drug offenders into a criminal justice system that destroys families and fails to reduce drug use.¹⁴⁶

The drug war's effects extend far beyond those who use illegal drugs. For example "one of the saddest by-products of the drug war – people who legitimately need narcotic painkillers and find it almost impossible to get them."¹⁴⁷ "Victims of accidents, botched surgery, degenerative diseases – sometimes require massive doses of drugs like morphine just to get out of bed" but too often find that the "medical profession, terrorized by federal drug agents," has abandoned them.¹⁴⁸

(2001); <http://www.aecf.org/kidscount/kc2001/pdfs/ri_wy.pdf> (reporting that infant mortality decreased from 11.7 in 1990 to 8.4 in 1986, but increased to 9.6 for 1997 and 1998, the two years following the *Whitner* decision).

144. SCHROEDEL, *supra* note 111. In her comprehensive review of fetal rights and anti-abortion policies, Dr. Schroedel concluded:

...no evidence was found that pro-life states have adopted a comprehensive range of policies designed to protect and assist the weakest and most vulnerable in our society. Instead, the opposite appeared to be true. I examined policies toward the group most closely related to fetuses - born children. Pro-choice states were more likely to favor adoption and to provide aid to needy children. Simply, pro-life states make it difficult for women to have abortions, but they do not help these women provide for children once born. Pro-life states also spend less money per pupil on kindergarten through twelfth grade education.

145. See generally *Common Sense for Drug Policy Presents the Facts: Adolescents*, <<http://www.drugwarfacts.org/adolesce.pdf>> (compiling data and facts regarding drug use by adolescents and the extent to which the war on drugs has in fact reduced adolescent drug use).

146. See generally MIKKI NORRIS, CHRIS CONRAD & VIRGINIA RESNER, *SHATTERED LIVES: PORTRAITS FROM AMERICA'S DRUG WAR* (1998).

147. GRAY, *supra* note 10, at 132.

148. *Id.* at 183-84. In addition, it is also apparently not uncommon for African American's who seek emergency room care for the sudden and extreme pain that results from sickle cell anemia, to be denied care – including pain medication – based on the

Other examples include people who have died in various police sponsored drug raids on private homes using excessive force and no-knock laws,¹⁴⁹ people who did not use illegal drugs but who have lost personal property under civil forfeiture laws that permit the government to seize property based on suspicion, rather than proof of involvement with illegal drugs,¹⁵⁰ people who are kicked out of public housing because one person in the household was identified as possessing drugs,¹⁵¹ the thousands of people subjected to suspicionless searches while driving on the nation's highways,¹⁵² and countless employees¹⁵³ and students subjected to urine drug screens.¹⁵⁴ And, increasingly, people who do use drugs are not only at risk of arrest, but also subject to loss of a wide array of government support including welfare,¹⁵⁵ housing¹⁵⁶ and federal college loans.¹⁵⁷

presumption that such patients are really addicts "just trying to get drugs." Arthur Allen, *Orphans of Managed Care: Sickle Cell Patients are in the Middle of a Dilemma over the Cost of Effective Drugs* (Dec. 15, 1999) <http://www.salon.com/health/feature/1999/12/15/sickle_cell/index.htm>.

149. NORRIS, *supra* note 146, at 1, 60-87 (describing people uninvolved in the drug trade who were "accidentally" shot to death or who died during such a raid).

150. *Id.* at 1-2, 52-59; see LEONARD W. LEVY, *A LICENSE TO STEAL: THE FORFEITURE OF PROPERTY* (1995); The Drug Policy Foundation, *Policy Briefing: Asset Forfeiture* (1999); see also <<http://www.fear.org/>>, the website of Forfeiture Endangers American Rights, a national nonprofit organization dedicated to the reform of federal and state asset forfeiture laws to restore due process and protect property rights in the forfeiture process.

151. See, e.g., Stacy Fitz, *Eviction of Seniors Assailed in Court*, SAN FRANCISCO CHRONICLE, Sept. 20, 2000 (describing a 77 year old disabled man who required around the clock care who was evicted from a public housing project because his care provider was caught two years before with a crack pipe in her possession) <<http://wwwmapnic.org/drugnews/v00/n1403/a06.html?4015>>.

152. See David A. Harris, *Driving While Black: Racial Profiling on our Nation's Highways, an American Civil Liberties Union Special Report* (June 1999) <<http://www.aclu.org/profiling/report/index.html>>.

153. See, e.g., Lewis L. Maltby, *Drug Testing: A Bad Investment* (ACLU 1999) <<http://www.aclu.org/issues/worker/drubtesting1999.pdf>>.

154. See *ACLU Fact Sheet #2: Social Science Research on Adolescent Drug Use and School Involvement* <<http://www.aclu.org/library/earlsfact2.html>>.

155. See, e.g., Amy E. Hirsch, "Some Days are Harder than Hard": *Welfare Reform and Women with Drug Convictions in Pennsylvania* (Dec. 1999) (A report published by the Center for Law and Social Policy); Corinne A. Carey, *Crafting a Challenge to the Practice of Drug Testing Welfare Recipients: Federal Welfare Reform and State Responses as the Most Recent Chapter in the War on Drugs*, 46 BUFFALO L. REV. 281 (1998); *Marchwinski v. Howard*, 113 F. Supp. 2d 1134 (E.D. Mich. 2000); *Marchwinski v. Family Independence Agency*, *ACLU Fact Sheet 31: Michigan's Drug Testing Law* <<http://www.aclu.org/features/factsheet.html>>.

156. See *Rucker v. Davis*, 237 F.3d 1113 (9th Cir. 2001) (limiting scope of statute permitting eviction of drug users in public housing).

157. See <<http://www.raiseyourvoice.com/heainfo.html#hea1>>.

Perhaps most obvious is the unprecedented rate of incarceration in the United States. Today, more than 2 million people are behind bars¹⁵⁸ and the U.S. nonviolent prisoner population is larger than the combined populations of Wyoming and Alaska.¹⁵⁹ By the end of 1998, there were 5.9 million adults in the "correctional population"; a rubric that encompasses people who are incarcerated, on probation or on parole.¹⁶⁰

The increase in prison population is directly linked to the war on drugs.¹⁶¹ The decision to address drug issues through a predominately criminal justice approach has profound effects on virtually everyone in our society. As Angela Davis explains:

As prisons take up more and more space on the social landscape, other government programs that have previously sought to respond to social needs –such as Temporary Assistance to Needy Families – are being squeezed out of existence. The deterioration of public education, including prioritizing discipline and security over learning in public schools located in poor communities, is directly related to the prison "solution." . . . [The prison industrial complex] devours the social wealth that could be used to subsidize housing for the homeless, to ameliorate public education for poor and racially marginalized communities.¹⁶²

Expenditures on a wide range of drug interdiction programs including but not limited to incarceration "cost American taxpayers billions of dollars that otherwise might be devoted to improving housing,

158. Allen J. Beck, PhD, U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999* at 1 (Washington, D.C.: U.S. Department of Justice, Aug. 2000).

159. DRUG WAR FACTS (Douglas A McVay ed., March 2001) (quoting John Irwin, PhD, Vincent Schiraldi & Jason Ziedenberg, *America's One Million Nonviolent Prisoners* at 4 (Washington, D.C.: Justice Policy Institute, 1999)).

160. Thomas Bonczar, & Lauren Glaze, U.S. Department of Justice, Bureau of Justice Statistics, *Probation and Parole in the United States* at 1 (Washington, D.C.: U.S. Department of Justice, Aug. 1999).

161. See Beck, *supra* note 158, at 10 (Table 15), 12 (Table 21) ("Prisoners sentenced for drug offenses constitute the largest group of Federal inmates (58%) in 1998, up from 53% in 1990 and in 1998, drug law violators comprised 21% of all adults serving time in State prisons - 236,800 out of 1,141,700 State inmates.); U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1996* (Washington, D.C.: U.S. Department of Justice, 1997) (Over 80% of the increase in the federal prison population from 1985 to 1995 was due to drug convictions.).

162. Davis, *supra* note 18; see also National Association of State Budget Officers (NASBO), 1999 State Expenditure Report at 38, 68 (Washington, D.C.: NASBO, June 2000) (States spent \$32.5 billion on Corrections in 1999 alone. To compare, states only spent \$22.2 billion on cash assistance to the poor.).

education, employment opportunities and access to health care (one of every six residents in the world's wealthiest nation has no health insurance!)"¹⁶³

While the war on drugs and the closely related war on reproductive freedom both have far reaching impact on all people in the United States, these effects fall disproportionately on certain populations.

While black, Hispanic, and white Americans use illegal drugs at comparable rates, there are dramatic differences in the application of criminal penalties for drug offenses. African Americans are more than 20 times as likely as whites to be incarcerated for drug offenses, and drug-related emergency department visits, overdose deaths, and new HIV infections related to injecting drugs are many times higher for blacks than whites.¹⁶⁴

The drug war has increasingly been recognized as a mechanism for controlling and punishing certain populations – particularly African Americans. Joseph McNamara, former San Jose police chief, put it succinctly: "The drug war has become a race war."¹⁶⁵ More than 70 percent of the imprisoned populations are people of color. Moreover, the war on drugs has provided justification for an extensive system of profiling, surveillance, and harassment of African Americans in the United States today.¹⁶⁶

And while women continue to represent a minority of those behind bars, in recent years their numbers have increased at nearly double the rate for men.¹⁶⁷ This dramatic and disproportionate increase has a great

163. Newman, *supra* note 47, at 20 (2000).

164. Drucker, *supra* note 10, at 23. ("A common stereotype, fostered by the media, is that some 'racial' or ethnic groups use drugs more than others. This is not borne out by the data.")

165. Horowitz, *supra* note 9, at 22, 30.

166. See Ira Glasser, *American Drug Laws: The New Jim Crow*, 63 ALBANY L. REV. 703, 724 (2000); Ronald H. Welch & Carlos T. Angulo, Leadership Conference on Civil Rights, Justice on Trial: Racial Disparities in the American Criminal Justice System at 7 (Washington, D.C.: Leadership Conference on Civil Rights, May 2000) ("blacks are just 12 percent of the population and 13 percent of the drug users, and despite the fact that traffic stops and similar enforcement yield equal arrest rates for minorities and whites alike, blacks are 38 percent of those arrested for drug offenses and 59 percent of those convicted of drug offenses. Moreover, more frequent stops, and therefore arrests, of minorities will also result in longer average prison terms for minorities because patterns of disproportionate arrests generate more extensive criminal histories for minorities, which in turn influence sentencing outcomes.")

167. Marc Mauer, C. Potler & R. Wolf, *Gender and Justice: Women, Drugs and Sentencing Policy*, The Sentence Project at 1, 3 (Nov. 1999).

deal to do with the war on drugs.¹⁶⁸ Drug offenses accounted for half (49%) of the rise in the number of women incarcerated in state prisons from 1986-1996 and Black and Hispanic women represent a disproportionate share of those sentenced for drug offenses.¹⁶⁹ "From 1986 to 1991, the number of black female drug offenders in state prison rose by 828%, Hispanic women by 328%, and white non-Hispanic women by 241%."¹⁷⁰

At the end of 1999, the number of women held in state or federal prisons, had risen to 90,668, an incarceration rate of almost 60 per 100,000 or 1 out of every 1,695 U.S. females. More than 10% of the female prison population has been sentenced to federal institutions, and most women incarcerated in the federal system were there for drug offenses. The majority of these women had little or no prior criminal record and were directly involved in dealing or possessing only a relatively small

<<http://www.lindsmith.org/library/sentenceproj2.html>>. This increase is not necessarily the result of an increase in women's drug use. As the report notes: "It is unclear to what extent our findings reflect changes in behavior and criminality or changes in official responses to those behaviors. On a national level the rate at which women used drugs actually *declined* substantially during the period 1986-1995—a time frame that coincides with the escalation of the war on drugs." *Id.* at 6. See also Stephanie Bush-Baskette, *The War on Drugs and the Incarceration of Mothers*, 30 J. DRUG ISSUES 919, 924 (2000) (hypothesizing that two initiatives stand out as possible explanations for the differential impact of the War on Drugs on the incarceration of women and men. The first included the provisions written in the Anti-Drug Abuse Acts for penalties specifically linked to small amounts of drugs and sanctions for conspiracy equivalent to those for the actual commission of the substantive crime. These provisions effectively shifted the focus of drug control efforts from trafficking activities by major dealers and treatment for users to the actions of street-level dealers, particularly those involved in crack cocaine, and to the prosecution of users. The second concerned the return to mandatory minimum sentencing for drug law violations . . . "As a result of these laws, the "actual role the offender plays in the crime can no longer be considered in the determination of the sentence, except for sentence enhancement. Furthermore, family situations, such as being the sole caretaker of minor children, can no longer be considered for sentencing purposes. These changes have resulted in increasing numbers of women being placed in state and federal prisons, which in turn leads to increasing numbers of dependent children being left to the care of relatives, guardians, and the state.")

168. CAMPBELL, *supra* note 21, at 17 ("Poor women, who are disproportionately women of color in the United States, are unevenly subject to all drug policy modes including surveillance."); see also NORRIS, *supra* note 146, at 39-42.

169. Mauer, *supra* note 167, at 3. The degree to which women are affected varies somewhat by state. "In New York, virtually the entire increase in women's prison population over the ten-year period was driven by drug arrests and prosecutions. Further, virtually all (91%) of the women incarcerated for these offenses were black or Hispanic. The increases in women's drug offenses in California and Minnesota are substantial as well, but not nearly as overwhelming as in New York."

170. *Id.* at 4.

amount of drugs. More than 80% were sentenced under mandatory minimum sentencing laws . . . Approximately 70% of these women were mothers of one or more children under the age of 18.¹⁷¹

Imprisonment has profound effects both on the women and the children for whom they are responsible. Two-thirds of the women in prison are mothers to children under the age of 18.¹⁷² A 1991 survey found that 10% of the women prison inmates reported that their children were living in a foster home or children's agency.¹⁷³ Unnecessary separation of children from these mothers is not only enormously expensive in fiscal terms but is traumatic and harmful for all involved; it bodes ill for the next generation.¹⁷⁴

Separation of children from their primary caretaker-parents can cause harm to children's psychological well-being and hinder their growth and development; many infants who are born shortly before or while their mothers are incarcerated are quickly separated from their mothers, preventing the parent-child bonding that is crucial to developing a sense of security and trust in children.¹⁷⁵

171. Bush-Baskette, *supra* note 167, at 924.

172. Mauer, *supra* note 167, at 2.

173. *Id.* at 2 (citing Tracy Snell, *Women in Prison*, Bureau of Justice Statistics 6-7 (1994)).

174. United States of America Rights for All, Amnesty International's Campaign on the United States, AI Index No. AMR 51/01/99, *Not Part of My Sentence*, VIOLATIONS OF THE HUMAN RIGHTS OF WOMEN IN CUSTODY 23 (Mar. 1999) (The imprisonment of pregnant women and new mothers is a violation of international standards, and the Eighth United Nations Congress has recommended that "[t]he use of imprisonment for certain categories of offenders, such as pregnant women or mothers with infants or small children, should be restricted and a special effort made to avoid the extended use of imprisonment as a sanction for these categories."). *Id.* (quoting Report of the 8th UN Conference on the Prevention of Crime and Treatment of Offenders, U.N. Doc. A/Conf. 144/28, rev. 1 (91.IV.2), Res. 1(a), 5(b) (1990)); see *State v. Gethers*, 585 So. 2d 1140, 1143 n.17 (Fla. Dist. Ct. App. 1991) ("Criminal prosecution would needlessly destroy the family by incarcerating the child's mother when alternative measures could both protect the child and stabilize the family." (citation omitted); Bush-Baskette, *supra* note 167, at 924.

175. See United States of America Rights for All, *supra* note 174; *The Osborne Association, How Can I Help?*, WORKING WITH CHILDREN OF INCARCERATED PARENTS 3 (1993) (noting that "[t]he arrest and incarceration of a parent can have a profound effect on a child. It can cause financial dislocation to the family, family dismemberment or dysfunction, and great social and emotional pain"). Moreover, according to experts cited in a recent *New York Times* article "having a parent behind bars is the single largest factor in the making of juvenile delinquents and adult criminals." Fox

The harm that results from refusing to fund public health measures such as needle exchange also falls most heavily on African American women and children, who are now the fastest growing population of people becoming infected with HIV.¹⁷⁶

Again, there is a direct parallel with restrictions on reproductive health care, which also disproportionately affect African American women. As Dorothy Roberts explains:

This connection between denying reproductive choice and oppression will necessarily be the hardest for poor women and women of color. Because of poverty, these women have fewer real options and are dependent on government funds to realize the decisions they make. Because the government is more involved in their lives through their use of public facilities and bureaucracies, they are more susceptible to government monitoring and supervision. Because it is harder for them to meet the ideal middle-class standard of what a woman or mother should be, society is more likely to approve of, or overlook, punishing them for making reproductive decisions. Because they have less access to lawyers, the media and advocacy organizations, and because society has convinced many that they are powerless, they are less likely to challenge government restrictions of their rights. Reproductive freedom is a right that belongs to all women; but its denial is felt the hardest by poor and minority women.¹⁷⁷

Similarly, African American women leaders in the 1980's wrote an open letter to African-Americans explaining:

Butterfield, *Prisons Confront New Problem: Children and Parental Incarceration*, N.Y. TIMES, Apr. 7, 1999, at A1.

176. According to the *New York Times*: "Intravenous drug use is responsible for most of the growth in the spread of the AIDS virus, particularly among the poor and minorities. Dr. David Satcher, the Surgeon General, said today that 40 percent of new AIDS infections in the United States are either directly or indirectly attributed to infection with contaminated needles; among women and children, the figure is 75 percent." Stolberg, *supra* note 59.

177. Dorothy E. Roberts, *The Future of Reproductive Choice for Poor Women and Women of Color*, 12 WOMEN'S RTS. L. REP. 59, 61-62 (1990); see also, Marsha J. Tyson Darling, *The State: Friend or Foe*, in DANGEROUS INTERSECTIONS (Jael Silliman & Ynestra King eds., 1999); Jessie M. Rodrique, *The Black Community and the Birth Control Movement*, in PASSION AND POWER: SEXUALITY IN HISTORY (Kathy Peiss & Christina Simmons eds., 1989).

More than other Americans, we know what it is to be without reproductive options – to be forced to reproduce, as our forebears were in slavery; to be sterilized against our will or knowledge; and to be victims of crude abortion practices when the procedure was illegal . . . African-American women and other women of color have the most to lose if access to legal abortion is denied in any way.¹⁷⁸

African American women in particular are caught at the intersection where the war on reproductive rights and the war on drugs meet. Despite the fact that substance abuse crosses all race and class lines,¹⁷⁹ African-American women have been targeted for harsh and punitive prosecutorial responses and account for the vast majority of those arrested.¹⁸⁰

While this disproportionality has been true nationwide, nowhere is it more apparent than in South Carolina. In Charleston, the Medical University Hospital ("MUSC") instituted a policy of reporting and facilitating the arrest of pregnant women who tested positive for cocaine.¹⁸¹ Although the hospital claimed that their policy was required by state law, their hospital, a public teaching institution with a patient population base that is 70 percent African American, was the only one to systematically adopt and carry out such searches. Women were selectively searched, through urine drug screening, for evidence of cocaine use. If they tested positive, they were taken out of hospital in chains and shackles, evoking sharp modern images of black women in slavery. All but one of the thirty women arrested at the hospital was African American.¹⁸² The white nurse, Shirley Brown, who implemented

178. Dorothy I. Height, National Council of Negro Women; Eleanor Holmes Norton, Georgetown University Law School; Cardiss Collins, Member of Congress; Faye Wattleton, et al., Planned Parenthood Federation of America; Open Letter to African-Americans (1989) (announcing release of a public statement entitled, *African American Women Are For Reproductive Freedom, We Remember*).

179. Drucker, *supra* note 10, at 15-28 ("A common stereotype, fostered by the media, is that some 'racial' or ethnic groups use drugs more than others. This is not borne out by the data."); *id.* at 23; *see also* SHELLY GEHSAN, A STEP TOWARD RECOVERY 1 (Southern Reg. Proj. on Infant Mortality 1993) "It is clear from the women we interviewed that substance abuse among women is not a problem confined to those who are poor, black, or urban, but crosses racial, class, economic and geographic boundaries."

180. CAMPBELL, *supra* note 21, at 187 ("there is no better illustration of the effects of a racially uneven policy than the wave of criminal prosecutions that engulfed pregnant women of color in the late 1980's and early 1990's").

181. *See* Ferguson v. City of Charleston, 121 S. Ct. 1281 (2001).

182. *See* Kathleen Parker, *State Goes Too Far With Drug Addicted Moms*, ORLANDO SENTINEL, Dec. 4, 1996, at E1 ("The women's claim of racial discrimination has

the program admitted that she believed mixing of the races to be against "god's way,"¹⁸³ and noted in the medical records of the one white woman arrested pursuant to the policy that she lived "with her boyfriend who is a Negro."¹⁸⁴ Thus every woman arrested was either African American or gave birth to a mixed-race baby.

Medical staff at MUSC, working in collaboration with the prosecutor and police, in effect conducted an experiment to see if threats of arrest and actual arrest would be effective tools in deterring pregnant women's drug use.¹⁸⁵ The subjects of this Tuskegee-like experiment: poor black women.¹⁸⁶ As one local journalist observed: "The women were part of an unprecedented experiment between medical and law enforcement entities suffering the noble delusion that pregnant women would stop using drugs if they were sufficiently punished. The manner by which these dubious social cures were administered reads like something out of

been backed up even by hospital personnel who expressed concern during the policy's execution that poor, black women were being singled out.").

183. Brown Trial Transcript, *Ferguson v. City of Charleston*, U.S. District Court for the District of South Carolina, Charleston Division, C/A No. 2:93-2624-2, Dec. 10, 1996, at 5, lines 18-21.

184. Plaintiffs' exhibit 119, *Ferguson v. City of Charleston*, U. S. District Court for the District of South Carolina, Charleston, Division, C/A No. 2:93-2624-2. This aspect of the case deserves serious exploration as part of a long tradition in drug policy of associating drug use with miscegenation and racial mixing. *See also* CAMPBELL, *supra* note 21, at 69.

185. *See* Edgar O. Horger, et al., *Cocaine in Pregnancy Confronting the Problem*, 86 J. S.C. MED. ASSOC. 527 (Oct. 1990) (In 1994, the National Institutes of Health found this experiment to violate the laws concerning research on human subjects.). *See* Letter from J. Thomas Puglisi, Ph.D., Chief Compliance Oversight Branch, Division of Human Subject Protections, OPRR, OER, OD (Sept. 30, 1994) (on file with author). (The Office of Civil Rights also investigated the hospital for violating Title VI prohibitions on race discrimination; the hospital agreed in a settlement with OCR to stop arresting patients.). Settlement Agreement between Medical Center of the Medical University of South Carolina and Office for Civil Rights, Department of Health and Human Services (Sept. 8, 1994) (on file with author).

186. *See* Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, in *ETHICAL ISSUES IN MODERN MEDICINE* at 547 (John D. Arras & Bonnie Steinbock, eds., 5th ed. 1999). This article addresses the underlying assumptions that fueled this research including the belief that "even the best educated black . . . could not be convinced to seek treatment for syphilis." *Id.* at 548. It is interesting that the MUSC policy was often justified on the claim that threats of arrest were necessary because the women would not go to treatment voluntarily. *See* Horger, *supra* note 185. These claims were made despite the lack of treatment or treatment referrals and in spite of the defendant's admission that at least for the first three months of the policy no treatment was offered. *See* Opposition to Petition for Certiorari, *Ferguson v. City of Charleston* at 7, n.4 (defendants admitting that "[d]uring a short period of time when the Policy was first initiated, a positive test was immediately reported and the patient was arrested"); American Public Health Association Amicus Brief, filed on behalf of Appellants in *Ferguson v. City of Charleston* (October Term, 1999).

a C-grade Nazi movie."¹⁸⁷ This policy was challenged in a federal civil rights action, *Ferguson et al. v. City of Charleston*, filed in 1994.

One of the few people to speak up against the policy when it was first instituted was the Medical Director of the hospital's Neonatal Intensive Care Unit, Celeste Patrick. Dr. Patrick wrote a letter to the president of MUSC, Dr. Edwards, raising numerous concerns about the fairness and efficacy of the policy, which she described as "thinly veiled discrimination against a class of poor, black women who do not have the resources to defend themselves."¹⁸⁸

The racial bias at the heart of many of these cases is also apparent in the statement a South Carolina state court judge made while reviewing the prosecution of a woman who had used cocaine while pregnant. He said:

You know, we've got enough trouble with normal children. Now this little baby's born with crack. When he is seven years old, they have an attention span that long [holding his thumb and index finger an inch apart]. They can't run. They just run around in class like a little rat. Not just black ones. White ones too.¹⁸⁹

Not only are the children viewed as animals, the mothers are as well. Throughout the *Ferguson* case, the policy of testing and arresting was justified as a "carrot and stick approach."¹⁹⁰ As explained by defendant Charles M. Condon, the carrot was treatment and the stick was the threat of arrest.¹⁹¹ This metaphor derives from an approach used to

187. See Kathleen Parker, *From Delivery Room, Next Stop Was Jail*, THE OBSERVER (Charlotte, N.C.), Dec. 5, 1996.

188. Letter from Celeste H. Patrick, M.D. Medical Director of the NNICU, Assistant Professor of Pediatrics to Dr. James B. Edwards, President, Medical University of South Carolina (Dec. 11, 1989) (on file with author).

189. Transcript of Record at 3, *State v. Collins*, No. 93-CP-39-859 (S.C. Ct. Gen. Sess. Pickens County, Dec. 18, 1991).

190. See, e.g., *Ferguson v. City of Charleston* (testimony of Charles M. Condon, Dec. 17, 1996, at 13, lines 14-15) ("So, we were trying to use a carrot-and-stick approach.") at 23, line 25, at 24, line 2 ("And the idea being that the carrot and stick, there would be a potential penalty over someone's head that could be imposed if they didn't change their behavior.") at 72, lines 15-21 ("And I felt that it would [be] a waste of resources and time trying to get someone to cooperate that didn't want to cooperate, and we could use the arresting process as a carrot and stick, legal intervention to something done to help solve the problem quickly.").

191. The South Carolina Attorney General Charles Condon also defended his state's policy as one that: "allows health-care experts to control the destiny of cooperative women--while law enforcement officials wait in the wings, prepared to act only in worst-case scenarios." Emily Figdor & Lisa Kaeser, *Concerns Mount over Punitive Approaches*

motivate donkeys and mules to carry their loads.¹⁹² The women subject to the policy – whether stigmatized as African American – as most in fact were, or as drug users, or simply as mothers – were to be handled as obstinate beasts of burden.¹⁹³

Disturbing animal metaphors also pervade the C.R.A.C.K. program. Its founder insists on comparing drug using pregnant women to dogs: "I'm not saying these women are dogs, but they're not acting any more responsible than a dog in heat."¹⁹⁴ She has also stated "we don't allow dogs to breed. We spay them. We neuter them. We try to keep them from having unwanted puppies, and yet these women are literally having litters of children."¹⁹⁵

to Substance Abuse Among Pregnant Women, THE ALAN GUTTMACHER REPORT ON PUBLIC POLICY (visited Mar. 6, 1999) <<http://206.215.210.5/pubs/journals/gr010503.html>>.

192. While there is some debate about the origin of the expression – some argue that it originally referred to a carrot on a stick – with a carrot dangled at the end of a stick to get the donkey to move forward, it has also been used to describe a system of reward and punishment with carrot as a reward and a beating with a stick or switch as punishment if the donkey has failed to do its job. *See, e.g.*, <http://www.shu.ac.uk/web-admin/phrases/bulletin_board/3/messages/236.html>.

193. Whether intended or not, the analogy was particularly insensitive when applied to a group that was almost exclusively African American women in a state that was still flying the Confederate Flag over its capitol dome. As a statement by African American women in favor of abortion recounted:

This freedom – to choose and to exercise our choices – is what we've fought and died for. Brought here in chains, worked like mules, bred like beasts, whipped one day, sold the next – for 244 years we were held in bondage.

Byllye Avery et al., *We Remember: African American Women Are For Reproductive Freedom* (1989) (on file with author). *See also* Darling, *supra* note 177, at 214, 224 (describing black females as “[I]ong accustomed to being treated as the mules of the world by most whites”).

194. DATELINE, NBC, NBC News Transcripts, *The Crusader; One Woman's Crusade to Help Babies Born to Drug Addicted Mothers*, Sept. 9, 1998, at 10, National Broadcasting Co. Inc., NBC News Transcripts (1998). *See also* Stryker, *Cracking Down*, (quoting Harris saying, “They're having litters. They are literally having litters.”).

195. *CRACK Uses Unethical Tactics to Stop Women with Substance Abuse Problems from Becoming Pregnant*, POL. ENV'T, 8 (citing *Mothers Paid to Stop Having Children*, MARIE CLAIRE, Dec. 1998).

The C.R.A.C.K. program leadership vehemently denies that it is racist.¹⁹⁶ Whether intentional or not, however, the choice of the name, C.R.A.C.K., a form of cocaine widely associated with African Americans, clearly suggests an emphasis on black women. Moreover the program's own data reflect a focus on African Americans. Although they make up approximately 12% of the population, and use drugs at about the same rate as people of other races, fully 40% (157 of a total of 392) of the women paid by the C.R.A.C.K. program to date, are African American. Adding other non-white people who have been paid, more than half are people of color.

African American women are also far more likely to be tested for the presence of drugs under civil child abuse reporting statutes even though white women have been shown to use illegal drugs at a higher rate.¹⁹⁷ This is one reason why African American women and their children are greatly over represented in the child welfare system:

In January 1999, Black children made up forty-five percent of the foster care population although they were only fifteen percent of the general population under age eighteen. The disparity is even more alarming in the nation's big cities. Removal of children because of maternal substance abuse has contributed significantly to the increase in numbers of poor Black children pouring into foster care.¹⁹⁸

Thus, while punitive restrictions on certain drugs and reproductive options have consequences on all people, both have particularly harsh and disproportionate effect on African American women and families.

196. See <[http://www.cashforbirthcontrol.com/web site](http://www.cashforbirthcontrol.com/web_site)> (Director and Founder's Message, March 21, 2001).

197. See Ira Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 *NEW ENG. J. MED.* 1202-06 (1990); Brenda Warner Rotzoll, *Black Newborns Likelier to be Drug-Tested: Study*, *CHICAGO SUN-TIMES*, Mar. 16, 2001 (reporting on the Chicago Reporter, a monthly publication on race and poverty that surveyed the 53 public and private hospitals in Cook County that deliver babies, finding that hospitals serving primarily black low-income women are far more likely to test their patients than suburban hospitals serving primarily middle class white women, and that black babies in Illinois are more likely than white babies to be taken from their mothers and placed in foster care because of exposure to drugs while in the mother's womb).

198. Roberts, *supra* note 64, at 84; see also Roberts, *supra* note 141, at 63 ("If an outsider looked at the American child welfare system, she would likely conclude that this is not a system designed to promote the welfare of America's children. Rather, it is a system designed to regulate, monitor, and punish poor families, especially poor Black families.").

XII. CONCLUSION

Those who are concerned about fundamental issues of social justice may be losing ground, missing opportunities to build coalitions and strengthen their respective arguments by refusing to recognize the relationship between the drug policy and reproductive rights issues. Single-issue organizations are understandably concerned that their legitimacy or respectability even among their own constituencies will be tainted if they stretch too far and take a position on what appears to be a drug case, or an abortion-rights case, or both.

The "Right" however, seems to understand the fundamental similarities all too well and is willing to exploit a range of intersectional issues¹⁹⁹ to promote its broad agenda. As Nancy Campbell argues "Neoconservative groups such as the Heritage Foundation or the American Enterprise Institute (AEI) use such policy debates as welfare reform, crime control, immigration, and illicit drug policy to gain an advantage in reproductive rights debates and cultural conversations about family formation."²⁰⁰

Samuel Friedman suggests that drug policies that ignore medical recommendations and maximize harm serve useful political purposes for those in power. Drug war polices use " 'divide and rule' politics in which 'scapegoating' divides and distracts potential opposition."²⁰¹ He believes that:

Politically, scapegoating drug users distracts attention from policies that aggravate the problems people face. Blaming unsafe streets, AIDS, poor services in hospitals, and the existence of children who act out in school on drug user's immorality points to certain solutions that are in tune with a belt-tightening, competition-oriented, fundamentalist world-view. More police, longer prison sentences, and family values, and also points to an analysis that says that problems are the result of guilty

199. CAMPBELL, *supra* note 21, at 18.

200. *Id.* at 139 (explaining that "Proponents of fetal rights use drug policy as a means to an end, a way to justify limiting women's rights while expanding a culturally conservative agenda").

201. Samuel R. Friedman, *The Political Economy of Drug-User Scapegoating – and the Philosophy of Resistance*, 5 *DRUGS: EDUCATION, PREVENTION, AND POL'Y* 15 (1998); see also GRAY, *supra* note 10, at 185 ("The seamless propaganda campaign that has blanketed the drug war for eighty years has always had as its central focus the image of the Drug User as Vampire. As long as these wretched monsters could be completely stigmatized – like the Jews in Nazi Germany – anything was possible.") (citing RICHARD LAWRENCE MILLER, *DRUG WARRIORS AND THEIR PREY* (1996)).

individuals. This distracts attention from the structural problems that cause problems for people and communities, such as the economic situation ...governments that accept the need for profitability as a "given"; cutbacks in education, health, and welfare; racism and sexism.²⁰²

Nancy Campbell, likewise observes that "[w]hile evidence mounts that U.S. drug policy is seriously flawed, it has proven immune to charges of failure. This immunity stems from the utility of illicit drug policy in reinforcing class-and-race-based social divisions."²⁰³

The issue of drug using women is similarly seen by some commentators as an effective tool in a larger conservative political agenda. As Sheigla Murphy and colleagues argue:

...pregnant drug users served as ideological offensives in the United States war on drugs. Pernicious images of drug using mothers having babies for the sole purpose of qualifying for government handouts in order to buy drugs and then neglecting and abusing these children were promulgated by the media and politicians. This contributed to the passage of legislation and funding allocations that resulted in the wholesale reduction of social welfare services to all poor women and children. The war on drugs has always been a war on the poor, particularly people of color. In 2001 it is very clear that drug use and drug users have played a very important role in defining women and children's poverty as an individual behavioral problem rather than the result of structural economic inequities.²⁰⁴

Dorothy Roberts argues that this issue advances both anti-abortion politics and the kind of government withdrawal of social supports articulated by Friedman and Murphy.

In addition to legitimizing fetal rights enforcement, prosecuting crack-addicted mothers shifts public attention from poverty, racism, and a deficient health care system, implying instead that poor infant health results from the depraved behavior

202. Friedman, *supra* note 201.

203. CAMPBELL, *supra* note 21, at 16.

204. Sheigla Murphy, Paloma Sales & Moira O'Neil, *Pregnant Drug Users: Scapegoats of the Reagan/Bush and Clinton Era Economics* at 2, forthcoming in *INTERNATIONAL JOURNAL OF SOCIAL JUSTICE* 2002 (on file with author); see also CAMPBELL, *supra* note 21, at 13.

of individual mothers. Poverty – not maternal drug use - is the major threat to the health of Black Children in America.²⁰⁵

Focusing again on both issues simultaneously, through pregnant drug users, it is clear that combining both political hot-button topics has been a highly successful strategy for advancing specific goals of the right regarding drugs and reproduction. The South Carolina *Whitner v. State*, decision for example, reflects enormous gains for both those who oppose abortion, as well as those who support the war on drugs. The holding in *Whitner* goes to the heart of today's abortion debate, lending support to the anti-abortion position that fetuses have rights and that pregnant women's health and freedom may be subordinated to those rights. Indeed, conservative pundits, like Rush Limbaugh and opportunistic politicians seized on *Whitner* as the long-awaited chance to undermine and potentially overturn *Roe v. Wade*. The opinion has provided grounds for the South Carolina State Attorney General's office to assert that it now has legal authority to make all post-viability abortions murder and to put to death women who have them, as well as the doctors who perform them.²⁰⁶

By focusing on pregnant women and harm to fetuses, the *Whitner* decision also creates a basis for prosecuting people solely because they suffer from the disease of addiction – opening new terrain in the war on drugs. In 1964, the Supreme Court held that people couldn't be arrested simply for having the status of being addicts.²⁰⁷ While subsequent cases have made clear that people can be arrested for possession of even the smallest quantity of an illegal substance, the Supreme Court's 1964 decision recognized that it would be cruel and unusual punishment to lock people up simply because they have a problem with drugs. But Cornelia Whitner was imprisoned for precisely this reason – not because she was found with drugs in her possession – but because medical tests performed at the time of delivery suggested that she was an addict.

The need to address the policies and practices at this intersection is clear. Drug policy reform efforts to de-stigmatize drug users and to shift emphasis from punishment to treatment cannot succeed if myths regarding "crack babies" and "crack mothers" destroying a generation of children are left unchallenged. Similarly, efforts to protect reproductive freedom cannot succeed as long as the rhetoric of the drug war is able to pit fetal rights against women's legal status as autonomous persons. Without a comprehensive strategy to undo decades of misinformation and political

205. ROBERTS, *supra* note 2, at 179.

206. Lynn Paltrow, *Pregnant Drugs Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALBANY L. REV. 999, 1035-38 (1999).

207. *Robinson v. California*, 370 U.S. 660 (1962).

posturing about both pregnancy and drug use, an ever-widening circle of women will be caught in increasingly punitive, intrusive, and coercive government controls that hurt rather than help women and their families.

Looking more broadly, the effectiveness of scapegoating drug users and certain pregnant women is clear. For example, if attention can be focused on selfish drug users, women who want abortions, or women who have too many children, it is unlikely that an effective coalition for a meaningful national health care system will ever get organized. If child welfare problems can be blamed on drug-using parents, or welfare mothers, or teens and drug users having too many children, then meaningful reform of the child welfare system, that will require addressing poverty and educational opportunity and pervasive violence in the lives of women, is unlikely ever to occur.²⁰⁸

Taking on these issues in a coherent manner affords a unique opportunity to develop the support of a broad coalition of organizations and communities in the struggle for reproductive freedom, drug policy reform and a more just society. We also have the opportunity to develop programs and institutions that recognize the ways in which intersecting issues and identities create barriers to treatment, recovery and well-being.

Following Mari Matsuda's advice, it is by listening to the actual experiences of those people who "experience life on the bottom" that we can have a basis for "defining the elements of justice."²⁰⁹ Many drug-using pregnant women experience that life, and by listening to their experiences, we have the opportunity to develop an agenda and programs that are more effective and responsive.²¹⁰ Few people fall into any one category. Drug treatment programs and shelters for women are often less effective than they should be, not because they can't work – but rather because they do not address comprehensively people who have more than

208. For example, focusing on individual women's drug use for the problem's their children may suffer distracts attention from the fact that "[h]alf of all Black children are born into poverty in the United States." Roberts, *supra* note 141.

209. Mari Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, in *CRITICAL RACE THEORY* 63 (Kimberlé Crenshaw, Neil Gotanda, Gary Pellar & Kendall Thomas eds., 1995).

210. There is a growing body of ethnographic research that provides insight into the lived experiences of drug using-women. See, e.g. MURPHY, *supra* note 55, at 100; CLAIRE E. STERK, *FAST LIVES, WOMEN WHO USE CRACK COCAINE* (1999); BOYD, *supra* note 140. See also Nadelmann, *supra* note 53, at 111 (noting that American "drug policies are designed, implemented, and enforced with virtually no input from the millions of Americans they affect most: drug users"). Participation in training sponsored by groups such as Be Present Inc., an Atlanta based non-profit organization that works to empower women and girls, also provides a starting place for sharing and listening to the lived experiences of a wide and diverse group of women.

one identity²¹¹ – and in this case more than one problem.²¹² A person can be a woman, of color and both addicted and pregnant, or battered and addicted,²¹³ or all of these and also lack the income that makes it possible to have housing, transportation and child care necessary to take advantage of any treatment that might be available.²¹⁴ Comprehensive programs that acknowledge and respond to the multiple and overlapping identities and issues have far greater evidence of success than those that do not.²¹⁵ In

211. See Crenshaw, *supra* note 209, at 358. “Where systems of race, gender, and class domination converge, as they do in the experiences of battered women of color, intervention strategies based solely on the experience of women who do not share the same class or race backgrounds will be of limited help to women who face different obstacles because of race and class.”

212. Interviews with 126 women regarding their experiences with pregnancy, violence and drug use, researcher found:

The needs of the women we interviewed were multilayered as well as overlapping, making available help inaccessible and insufficient. Their problems were treated individually, rather than holistically. Each service area focused on women’s drug use, pregnancy or violence, addressing only one problem at a time. Our participants were not only drug users. They were mothers, daughters, victims, poor, homeless, malnourished and stigmatized in conventional and illicit drug-using worlds. Drugs helped them to cope and to survive. It also caused them serious problems. They were demonized for their means of survival, but not given feasible or reasonable alternatives.

Sheigla Murphy & Paloma Sales, *Let’s Get Real Looking at the Lives of Pregnant Drug Users*, HARM REDUCTION COMMUNICATION 22, 24 (Spring 2001).

213. Amy Hill, *Applying Harm Reduction to Services for Substance Using Women in Violent Relationships*, HARM REDUCTION COALITION 7-9 (Spring 1998) (discussing the reasons why the development of services for battered, substance-abusing women is limited).

214. Murphy & Sales, *supra* note 212, at 24 (“Being a woman was a strike against them, being a pregnant woman was a second strike and being a drug-using pregnant woman was the third and final blow to their social standing.”).

215. See, e.g., Center for Substance Abuse Treatment, *Pregnant, Substance-Using Women* 6 (1993) (U.S. Dept. of Health & Human Servs. Publication No. (SMA) 93-1998) (discussing the comprehensive services needed to address successfully the treatment of drug using women, noting that it “is imperative that programs include services designed specifically for women, particularly pregnant women”); Stephen Magura et al., *Effectiveness of Comprehensive Services for Crack-Dependent Mothers with Newborns and Young Children* (1998) (discussing New York City’s experience with the Family Rehabilitation Program and citing numerous studies describing how comprehensive, coordinated, holistic treatment is better at engaging pregnant and parenting women); Claire McMurtrie et al., *A Unique Drug Treatment Program for Pregnant and Postpartum Substance-Using Women in New York City: Results of a Pilot Project, 1990-1995*, 25 AM. J. DRUG & ALCOHOL ABUSE 701, 701-02 (1999) (describing a comprehensive model of drug treatment for pregnant and postpartum women that included children and did not view relapse as a failure, concluding that it “seem[ed] to improve mother’s lives, fetal drug exposure, and birth outcome significantly”); Center for

order to be fully effective, these programs must necessarily consider and respond to the particular circumstances, prejudices and stigmas African-American and other women of color face.

By recognizing the similarity in the issues concerning reproductive rights and the drug war there is an opportunity not only for a deeper understanding of each issue, but also a basis for developing analysis and action that can counteract the dominating forces of punishment and prohibition and begin to build coalitions and movements toward preserving and expanding those social programs that can in fact empower women, preserve families, and create a more just society.

Substance Abuse Treatment, *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs* 124-26 (1994) (U.S. Dept. of Health & Human Servs. Publication No. (SMA) 94-3006) (providing guidance to treatment providers to meet the specific needs of women with substance abuse problems). *See also* Stephanie Covington, *Helping Women Recover: A Program for Treating Substance Abuse: Facilitator's Guide*, Covington, *Helping Women Recover : A Program for Treating Substance Abuse : Special Edition for Use in the Criminal Justice System* (2000);