Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense

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ABSTRACT. The arrests, detentions, prosecutions, and other legal actions taken against drug-dependent pregnant women distract attention from significant social problems, such as our lack of universal health care, the dearth of policies to support pregnant and parenting women, the absence of social supports for children, and the overall failure of the drug war. The attempts to “protect the fetus” undertaken through the criminal justice system (as well as in family and drug courts) actually undermine maternal and fetal health and discourage efforts to identify and implement effective strategies for addressing the needs of pregnant drug users and their families. In this article, the authors seek to expose some of the flawed premises on which the arrests, detentions, and prosecutions are based. The authors highlight the inherent unfairness of a system that expects low-income and drug-dependent pregnant women to provide their fetuses with the health care and safety that these women themselves are not provided and have not been guaranteed.

KEYWORDS. Women, addiction, pregnancy, civil rights

INTRODUCTION

No human being, not even a parent or a twin, is required to sacrifice his or her life or health for the benefit of another individual.1 Although the state may require sacrifices for the benefit of the community at large (e.g., vaccinations), U.S. courts have steadfastly refused to use state power to weigh the value of two individual lives and require one person to sacrifice his or her life, health, or liberty for another.1 Nonetheless, claims made on behalf of individual fetuses have been used to justify deprivations of women’s liberty,2 bodily integrity,3 and even their lives.4 Such actions reflect increasing and highly contested claims that not only does a fetus have “rights” that must be protected, but that these rights are superior to those of pregnant women and, for that matter, all human beings.

Significantly, these claims of fetal rights are often coupled with and strengthened by drug war propaganda which makes grossly exaggerated claims about the risks posed by prenatal exposure to certain substances. Indeed, the vast majority of punitive interventions based on claims of fetal rights involve the arrest and detention of

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pregnant women alleged to have used an illegal
drug or alcohol. These cases assert that pregnant
women are obliged to subordinate themselves
to state claims of fetal rights. In addition, these
cases reinforce false and misleading ideas about
addiction and its treatment and the availability
of appropriate health services.

The arrests and other punitive measures levied
against pregnant drug-using women also serve a
larger political purpose: they distract attention
from significant social problems, such as our
lack of universal health care, the dearth of poli-
cies to support pregnant and parenting women,
the absence of social supports for children, and
the overall failure of the drug war.2 Relying on
punitive approaches undermines efforts to de-
velop effective responses to the problematic as-
psects of drug use and pregnancy. In this article,
we draw on information from hundreds of cases
that National Advocates for Pregnant Women
has compiled. We seek to expose some of the
flawed premises on which these arrests, deten-
tions, and prosecutions are based. In so doing, we
highlight the injustice of expecting low-income
and drug-dependent pregnant women to provide
their fetuses with the health care and safety to
which women themselves are not deemed to be
entitled.

THE PANIC OVER
DRUG-DEPENDENT WOMEN AND
THEIR PREGNANCIES

The fear-mongering tenor of discourse sur-
rounding women’s drug use cannot be justified
by women’s rates of illicit drug use, drinking,
and smoking. Most women in the United States
use some type of drug on a regular basis. We use
prescription and over-the-counter drugs to help
us sleep, stay awake, alleviate pain, lose weight,
cope with depression and anxiety, and so forth.
We drink coffee and tea and eat chocolate, all
substances that contain caffeine. We consume
alcoholic beverages, and we smoke cigarettes.
However, when we think of “women and drugs”
what comes to mind are users of illegal drugs
even though fewer than 1 in 10 women and
only approximately 4 in 100 pregnant women
use illicit drugs and even fewer are dependent
on them.3,4,5

The drug war of the 1980s and 1990s included
women who used illicit drugs among its targets.
A national panic ensued over “crack mothers”
giving birth to “crack babies.”6 Women who
used illicit drugs (including marijuana, heroin,
and methamphetamine, but particularly cocaine)
were portrayed as hypersexual, out-of-control
women who would “do anything” for drugs.
They were characterized as being completely in-
different to any harm they might cause to them-
selves or others, especially the children they
would give birth to.6,7 At a time when evidence
existed that there was no such thing as “crack
babies” and that poverty explained many of the
health problems that some children were expe-
riencing, Time magazine, the New York Times,
and other leading news outlets continued to de-
scribe cocaine use during pregnancy as an epi-
demic destroying a generation of young people.
Even respected organizations such as Columbia
University’s Center on Addiction and Substance
Abuse discussed the exposure of newborns to
alcohol and cocaine in extraordinarily exagger-
ated and unjustified terms, describing it as “a
slaughter of innocents of biblical proportions”
(p. 7).8

As a consequence of this moral panic sur-
rounding women using drugs, thousands of
women were and continue to be ensnared in the
criminal justice system for non-violent offenses
related to their use of illegal drugs; hundreds
more have been singled out specifically for be-
ing pregnant and using an illegal drug or alcohol.

Consider the case of Cornelia Whitner. On
April 7, 1992, Cornelia Whitner was indicted
for violating South Carolina’s criminal child ne-
glect statute for her alleged unlawful neglect
of a “child.”vi Ms. Whitner, an African Amer-
can woman, was born and raised in South Car-
olina. At the age of 14, her mother suddenly
died, an event which Ms. Whitner described as
the worst thing that ever happened to her. Af-
ter her mother’s death, Ms. Whitner dropped out
of school and started smoking pot and drinking.
By age 15, she was pregnant with the first of her
three children. Her youngest child, Tevin, was
born in good health on February 2, 1992. When
a test indicated that Tevin had been exposed
prenatally to cocaine, Ms. Whitner was arrested and charged with criminal child neglect, even though she was not accused of actually abusing or endangering Tevin. Instead, the prosecutors introduced a new interpretation of an existing child neglect statute, asserting that the statute also criminalized a woman’s failure “to provide proper medical care for her unborn child.”

Like virtually all women who have been prosecuted under similar circumstances, Ms. Whitner could not afford private counsel. Instead, she was represented by a court-appointed attorney who did not meet with her until the day of her scheduled court hearing. Her defense attorney had recently worked in the prosecutor’s office, where she had previously prosecuted pregnant addicted women.

Ms. Whitner was never counseled about her substance abuse problem nor was she offered drug treatment as a way of avoiding arrest. When she was indicted, there was not a single residential drug treatment program in the entire state designed to treat pregnant drug users. Believing that an admission of guilt would help her get access to inpatient treatment, Ms. Whitner pled guilty to the charge of child abuse. At her sentencing hearing, she admitted that she was chemically dependent and requested assistance from the court, stating in part “I need some help, Your Honor.” She stressed her need and desire for inpatient treatment. The judge responded, “I think I’ll just let her go to jail.” The court then sentenced Ms. Whitner to 8 years in prison. Although another court later ruled that there was no basis for the conviction, the South Carolina Supreme reversed that decision, effectively rewriting state law to make the word “child” in the state’s child endangerment statute include a viable fetus.

The panic over women’s use of cocaine abated somewhat in the late 1990s. Today, leading federal government agencies confirm that “the phenomena of ‘crack babies’…is essentially a myth.” As the National Institute for Drug Abuse has reported, “Many recall that ‘crack babies,’ or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation….” It was later found that this was a gross exaggeration” (p. 6). The U.S. Sentencing Commission concluded: “[t]he negative effects of prenatal cocaine exposure are significantly less severe than previously believed” and those negative effects “do not differ from the effects of prenatal exposure to other drugs, both legal and illegal” (pp. 21–22).

Nevertheless, in recent years, we have witnessed the reanimation of deeply rooted prejudice against women who use drugs, again targeting those who are pregnant and continue to term. National Advocates for Pregnant Women has and documented hundreds of known cases in at least 40 states where pregnant women who are identified as drug users have been arrested; dozens of known arrests came to light in 2005 and 2006 alone. Our analysis shows that the brunt of the criminal justice system’s intrusions into women’s pregnancies has been borne by low-income minority women.

White, Black, and Hispanic women have comparable rates of drug use and substance dependence; the percent of White, Black, and Hispanic women in metropolitan areas who have used an illicit drug in the past month is 8.6%, 8.4%, and 5.6%, respectively. However, a 1992 survey of arrests and prosecutions of pregnant women found overwhelming evidence that low-income Black and Hispanic women were singled out. An analysis of more recent cases is underway; the evidence so far suggests ongoing racial bias and an undeniable focus on low-income women.

In addition to racial and class bias, the uncritical acceptance of medical misinformation about drugs and the stereotyping of the people who use them are being revisited today in the methamphetamine scare. Concern about methamphetamine has jumped to the fore much like concern about crack cocaine did in the 1980s. For example, in April 2004 Theresa Lee Hernandez of Oklahoma was charged with first degree murder despite community opposition to her prosecution. The state claimed that the stillbirth that Ms. Hernandez had suffered was caused by her use of methamphetamine, even though research has not found an association between methamphetamine use and stillbirths. In 2007, Ms. Hernandez plead guilty to second degree murder rather than risk a trial by jury and a life sentence. Ms. Hernandez was sentenced to 15
years in prison. In an apparent response to extensive community education and opposition to the arrest and prosecution, Ms. Hernandez was released a year after being sentenced.

Is current media coverage of women’s illicit drug use and drug dependency as sensational as it was in the late 1980s and 1990s? On one hand, leading researchers and medical professionals themselves have insisted that media coverage about drugs and pregnancy be grounded in science, not sensation, asking that experts (rather than the local pediatrician or the local sheriff) are given the opportunity to address what, if any, risks have been linked to prenatal exposure to cocaine, methamphetamine and other drugs. On the other hand, the public is still fed a regular diet of accounts that distort and misrepresent the effects of illicit drug use (including presenting the effects of drug use on populations of mice as if they are applicable to humans), rely on non-experts, and demonize the people who use illicit drugs. Popular media accounts continue to falsely decry an “epidemic” and a “scourge” of drug use despite evidence that rates of methamphetamine use have stabilized since 1999 and have been declining since 2002. Many reports play on exaggerated fears about the impact and addictiveness of methamphetamine and wrongly assert that we lack any effective treatments for methamphetamine addiction. The front page story of the July 11, 2005, New York Times, “A Drug Scourge Creates its Own Form of Orphan,” typifies the problematic ways in which women who use illicit drugs are presented to the public, as well as the biases found among workers in the helping professions. As with earlier media coverage of the crack epidemic, the story discussed methamphetamine’s “highly sexualized” users and depicted the “children of methamphetamine” as lost causes “with so many behavioral problems.” The article twice mentioned that some of the children had lice. The article’s sources were harried social workers, a lawyer for a department of human services, a pediatrician involved in a state program that was run in conjunction with the Department of Justice, and other professionals with a stake in convincing the public of the gravity of the methamphetamine “scourge.” Not one parent was quoted nor were any researchers actually qualified to express an opinion about the effects of prenatal exposure or trends in methamphetamine use, as distinct from trends in child welfare system intervention. The article’s sources provided opinions that fell outside their areas of expertise (i.e., a pediatrician’s “professional” opinion that “The parents are basically worthless.”). A state attorney general urged an audience of hundreds to become foster parents, “Because we’re just seeing so many kids being taken from these homes.” The article never questioned whether taking so many children away from their parents and their homes was justified or even in the best interests of the children. The National Coalition for Child Protection Reform and others convincingly conclude that it is not.

THE PROBLEMS WITH PUNISHMENT

The misinformed public, of course, includes not only journalists, but also police and prosecutors. Operating under false assumptions that a woman’s drug dependency is inevitably and irreversibly harming her future child, police and prosecutors have persisted in arresting and pursing charges against pregnant women. They typically claim that prosecution (or the threat of prosecution) is an effective tool in deterring pregnant women from using drugs, and that it is a useful device for forcing women to get treatment they would otherwise avoid. In reality, these measures are more likely to deter women from seeking prenatal care or from being completely forthcoming with their health care providers.
In another South Carolina case, a woman was charged with and convicted of homicide by child abuse based on the claim that she suffered an unintentional stillbirth as a result of her cocaine use. Despite the medical evidence that Regina McKnight’s pregnancy loss was the result of an infection and research studies finding no link between cocaine use and an increased incidence of stillbirths, Ms. McKnight was convicted and given a 20-year sentence that was reduced to 12-years incarceration. If she had had an early abortion, there would have been no crime. Even if she had intentionally ended her pregnancy through an illegal third-trimester abortion she would have received, at most, a 3-year sentence.

After having served almost 8 years, Ms. McKnight’s conviction was finally overturned. As a result of ongoing post-conviction relief efforts, the court was finally persuaded that the conviction was based on inaccurate science. The Court ruled that Ms. McKnight had not received a fair trial and that her trial counsel was “ineffective in her preparation of McKnight’s defense through expert testimony and cross-examination.” Specifically, the court noted that the research the state relied on was “outdated” and that trial counsel failed to call experts who would have testified about “recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.” However, to avoid a re-trial and a lengthy legal battle, Ms. McKnight plead guilty to manslaughter, permitting her release from prison and removing the threat of reincarceration.

In our ongoing review of this and similar cases, we find that women are often charged with felonies, including murder or manslaughter, child abuse or neglect, and drug delivery (through the umbilical cord) and drug possession, based on evidence of pregnancy and drug use. Women have been sentenced to incarceration or given probation with numerous and sometimes impossible conditions imposed for many years.

Brenda Vaughan, a 30-year-old African American woman from Temple Hills, Maryland, pleaded guilty to felony charges for forging $721.98 in checks. The prosecutor recommended that Ms. Vaughan receive probation instead of jail time. During her sentencing hearing, Ms. Vaughan told the judge she was pregnant. The judge then ordered a drug test. When Ms. Vaughan tested positive, allegedly for cocaine, the judge ordered her to jail for 30 days, pending a decision on whether to admit her to a special intensive probation program. When it turned out that she was not eligible for the intensified probation program because she was not a District of Columbia resident, the judge sentenced her to 6 more months in jail, subject to a motion to reduce the sentence after the baby was born.

At her sentencing hearing, the judge explained: “I’m going to keep her locked up until the baby is born because she’s tested positive for cocaine when she came before me. . . . She’s apparently an addictive personality and I’ll be darned if I’m going to have a baby born that way.” The judge added, “I can’t trust you, Ms. Vaughan, and that’s a hell of a thing to say.” There was no trial or conviction on any charge relating to possession or use of an illegal drug. As noted previously, in many cases women have pleaded guilty or accepted plea bargains rather than risk a protracted legal challenge that could result in an even longer period of incarceration.

When the arrests, detentions, and prosecutions of women have been challenged, they are nearly always found, eventually, to be without legal basis or to be unconstitutional. There has been near unanimity among the country’s appellate courts; all but one have dismissed charges or overturned convictions of women who used drugs or experienced an addiction and sought to continue their pregnancies to term. Courts faced with challenges to such prosecutions have routinely ruled that a plain reading of the applicable criminal statute and the absence of legislative intent to address the issue of drug using pregnant women through the criminal justice system require that the charges be dropped. Many of these courts have recognized that the application of existing criminal laws (such as those prohibiting child abuse, drug delivery, and homicide) to pregnant women in relationship to the fetuses they carry raises significant constitutional issues, including due process principles of notice, vagueness, and overbreadth, as well as privacy and sex discrimination. Numerous
courts have also acknowledged the extraordinary consensus among medical groups condemning these prosecutions as counterproductive and dangerous. That is why the Supreme Court of Florida, in overturning Jennifer Johnson’s conviction for drug delivery, declared: “The Court declines the State’s invitation to walk down a path that the law, public policy, reason and common sense forbid it to tread.”xix

In addition to state appellate courts, in 2001 the U.S. Supreme Court, in a landmark decision, held that health care providers who secretly search pregnant women for evidence of drug use and turn that information over to the police are violating the 4th Amendment’s prohibition on illegal searches and seizures and may be held personally liable for such actions.xx In reaching this conclusion, the Court observed that the numerous amici in the case pointed to “a near consensus in the medical community that programs of the sort at issue, by discouraging women who use drugs from seeking prenatal care, harm, rather than advance, the cause of prenatal health.”xxi

In the remainder of this article, we propose three principles that should guide our responses to pregnant drug-using women: (1) rely on the best available research and the principles of evidence-based medicine and social science rather than flawed assumptions about drug use by pregnant women and its effects; (2) distinguish, as we do with alcohol, between use and addiction and recognize that drug addiction is a chronic, relapsing health condition rather than a crime; and (3) provide support for low-income pregnant women rather than rely on policing and punishment.

**Rely on Science Rather than Sensation About Maternal Drug Use**

If a child is born prematurely or has a low birthweight or if a woman miscarries or delivers a stillborn baby, many hospital staff, medical examiners, social workers, and other officials blame the woman for the outcome. This is especially true if a woman has ingested any amount of an illegal drug, used too much alcohol, or in some way, such as by her race, class, or personality, offended the hospital or agency staff or officials. Also, some health care providers see drug testing as part of defensive medicine. That is, if something has gone wrong with the birth raising the specter of a lawsuit, a positive drug test provides staff with a powerful defense regardless of what actually caused the bad birth outcome.

The use of methamphetamine, cocaine, and other illicit drugs certainly presents a valid public health concern. But medical and scientific evidence suggests that the harms associated with illicit drug use have been greatly overstated. In contrast, not only are alcohol and tobacco more widely used, but the evidence of potential harm to fetuses and children from tobacco use and heavy alcohol use are far better established as a matter of scientific research.31,32 However, our harshest responses have been reserved for those women who consume illicit drugs.

The relationship between using a substance and fetal or infant health is not straightforward. Although a correlation may exist between the use of some substances (and some medical conditions) and some pregnancy outcomes, a causal relationship does not necessarily exist. For example, two well-constructed, independent studies tried to determine whether cocaine could be linked to an increased risk of stillbirths. The authors found that it could not.33,34 A recent article published in the peer-reviewed American Journal of Obstetrics and Gynecology concluded that “despite widespread reports linking methamphetamine use during pregnancy with preterm birth and growth restriction, evidence confirming its association with an increased risk of stillbirth remains lacking” (p. 438, emphasis added).35 Most pregnant women who use substances such as cocaine, methamphetamine, nicotine, caffeine, or alcohol will give birth to healthy babies. Additionally, most pregnancy losses and other negative birth outcomes cannot be traced solely, or even mainly, to the use of an illicit substance, especially when it is likely that substance use is accompanied by other risk factors such as violence, heavy alcohol consumption, cigarette smoking, the use of prescription drugs, poverty, and environmental risks.

The best available medical evidence indicates that the use of illicit drugs and other substances is but one of many other factors which may affect pregnancy outcome. Recognizing this, a wide
A spectrum of respected medical and public health organizations, including the American Medical Association, the American Society of Addiction Medicine, the American Public Health Association, the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the March of Dimes, and the National Council on Alcoholism and Drug Dependence, have voiced their opposition to the arrests and prosecutions of pregnant women who use illicit drugs.

*Treat Addiction as a Public Health Concern, Not a Crime*

Being pregnant is not a crime, nor is being addicted to an illicit substance, as the Supreme Court held in the 1962 case, *Robinson v. California*. Because of the very nature of addiction and dependency, not every person who uses a substance “chooses” or “intends” to continue to use it or can even be said to be indifferent to its consequences. Prolonged drug use can cause dramatic changes in brain function, making it difficult for people to overcome drug dependence on their own without treatment. The National Institute on Drug Abuse (which, in 2007, began to consider a name change to “The National Institute of Diseases of Addiction”) defines addiction as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.” The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) recognizes that an “inability to control drug use” is often a key feature of chemical dependency.

Women’s attempts to cease using drugs completely during pregnancy are common. Indeed, pregnancy and motherhood have been identified as catalysts for change among women who use drugs. Although many women can and do stop or reduce their consumption and tolerance of potentially harmful substances while they are pregnant, permanent abstinence is no more attainable for low-income pregnant women than it is for other people, including affluent White men, such as conservative shock jock Rush Limbaugh. Wanting or intending to stop is an important element of recovery, but the physical, behavioral, and social aspects of dependence are such that it is rarely sufficient.

A woman’s continued drug use should not be assumed to reflect a lack of desire to quit using drugs. Along similar lines, women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment. In a country where 47 million people have no health insurance coverage, where most private insurance programs offer limited coverage for the expenses of mental health and drug treatment services, where state and federal funding for such programs is exceedingly limited, and where the most successful treatment modalities (such as methadone treatment) are deliberately limited, it is simply wrong to assume that lack of treatment is a question of personal intention or desire. Many pregnant women do not enter drug treatment because they cannot afford to, there are no spaces available, or the programs do not provide childcare or account for the fact that most women have family responsibilities. A 1993 study of 294 drug treatment programs in five major cities showed that, although most programs accepted pregnant women on some basis, the method of payment accepted and the availability of child care significantly limited access. Only 55% of residential/detoxification programs accepted pregnant women on Medicaid or for free. Only one-fifth of all programs accepted pregnant women and provided child care, even though past research has found that lack of child care precludes addicted women’s participation in treatment. A survey conducted in 2007 found that only 19 states have created drug treatment programs specifically for pregnant women, and only seven states give pregnant women priority access to state-funded drug treatment programs. Even in these states, the demand exceeds the number of available spaces in treatment programs. Moreover, programs touted as allowing women to bring their children typically limit the number and age of the children. This means that many women must separate from their family to get help. Also, while there is strong evidence that treatment for drug addiction is as effective, if not more effective, than treatment for other chronic relapsing conditions such as diabetes mellitus, asthma, and high blood pressure, treatment often fails patients. As a
result, it is inappropriate to assume that simply entering treatment will be sufficient to “cure” a woman of her dependency on drugs.

Women who do enter treatment are not necessarily insulated from inappropriate or punitive state responses. For example, women already in treatment became the subject of a South Carolina prosecutor’s decision to seek out and punish pregnant drug-using women. National Advocates for Pregnant Women also has documented several cases in which women who were in successful methadone treatment programs became targets of child welfare interventions to remove the child at birth because of a belief that the methadone treatment proved that they had once been drug users and therefore posed a threat to their children.

Incarcerating pregnant women to “protect the fetus” is based on similarly false assumptions that jails and prisons consistently offer high-quality prenatal care programs, nutritional diets, and reproductive health care. Although pregnancy receives more attention than most other health concerns of incarcerated women, the quality of incarcerated women’s care before, during, and after delivery typically leaves much to be desired. Incarcerated women routinely receive little to no education about prenatal care and nutrition, do not receive regular pelvic exams or sonograms, and cannot alter their diets to meet their changing caloric needs. Prison medical staff and administrators may ignore orders from outside OB/GYNs. In most states, pregnant women, even those who pose no security risk, may be shackled or otherwise restrained during transport to the hospital and during labor and delivery.

As we should have learned from the crack panic, the distrust that stigma and prejudice engender among drug-using women may pose greater dangers to maternal and fetal health than the use of an illicit drug itself. Reporting pregnant women to child protection agencies and the police or locking them up in the name of “protecting the fetus” can be expected to have a chilling impact on women’s willingness to seek care and on physicians’ relationships with their patients. Health care workers and hospital social workers, in particular, should play important roles in finding out from the women what services and support they need and, when appropriate, securing drug treatment for women who are addicted to drugs. Frequently, however, a hospital worker’s report of a pregnant woman’s drug use leads, directly or indirectly, to the mobilization of the criminal justice system and highly intrusive interventions by child welfare authorities.

Pregnant women’s fears of being judged by those who are assigned with helping them are not without foundation. Survey results suggest a sizable proportion of hospital medical staff and social workers already support defining illicit drug use as “child abuse” and coercive approaches to addressing a woman’s drug use (e.g., incarceration or threatening women with loss of custody of their children to “encourage” them to complete drug treatment). At the same time, some health care providers may refrain from asking women in their care about drug use for fear they will have to turn their patients over to punitive state authorities.

As the AMA notes: “punishing a person who abuses drugs or alcohol is not generally an effective way of curing their dependency or preventing future abuse” (p. 2667). Furthermore, intimidation and punitive measures are far more likely to deter women from seeking help than from using the drugs upon which they have become dependent. On a strictly pragmatic level, by the time a pregnant woman has experienced a stillbirth or a baby is born testing positive for an illicit substance, valuable opportunities have been missed to provide a woman with support and access to good quality health care, including drug treatment.

Support Low-Income Pregnant Women Rather than Infringe Upon Their Civil and Human Rights

Mobilizing the criminal justice system to address a health concern creates a precedent for the supervision and punishment of pregnant women with regard to all aspects of their lives. In Maryland, two women were convicted of reckless endangerment and sentenced to several years in prison for continuing their pregnancies to term and using cocaine during pregnancy, and three other women faced similar charges.
Maryland Court of Appeals ruled, however, that prosecution of such cases might open the way for pregnant women to be prosecuted for any number of injury-prone activities that might endanger the well-being of an unborn child, such as driving without a seatbelt, skiing, or horseback riding. This ruling, like others before it, is a strong and important recognition of the larger issues of pregnant women’s civil and human rights beyond the issue of drug use and addiction. Indeed, the fact that the same legal arguments used to justify the prosecution of pregnant drug and alcohol using women have been used to justify court ordered interventions and arrests of women who do not accede to doctor’s advice regarding childbirth makes clear that concerns about the application of fetal homicide laws to drug-dependent pregnant women are not speculative.60,61

Court decisions and statutes creating the crime of feticide and unborn victims of violence laws have directly and indirectly become grounds for arresting pregnant drug-using women. In the Whitner case mentioned earlier in this article, the state argued that there was precedent for prosecuting Cornelia Whitner for child abuse. That precedent was a case where a man, Horne, brutally stabbed his pregnant wife, causing her to lose the pregnancy. The South Carolina Supreme Court created the crime of feticide in response. Whitner argued that experiencing an addiction as a pregnant woman is not the same as a third party attacking a pregnant woman. The court disagreed, stating that if they ruled that way “there would be no basis for prosecuting a mother who kills her viable fetus by stabbing it, by shooting it, or by other such means, yet a third party could be prosecuted for the very same acts. We decline to read Horne in a way that insulates the mother from all culpability for harm to her viable child.”xxvi

The court’s reasoning ignores the bald reality that in order to shoot or stab her fetus, the pregnant woman would first have to cut through her own flesh, her own body. The court’s rationale requires treating a pregnant woman as if on becoming pregnant she loses her humanity, her capacity to become psychologically and physically addicted like other human beings, her identity as a unique individual whose actions (including stabbing or shooting herself) have obviously different meanings and implications than when another person commits those actions against her.

This distinction has been ignored in states like Texas, where the Prenatal Protection Act (SB 319) was passed in 2003. This law established that for the purposes of murder and aggravated assault, a fetus is considered “an unborn child at every stage of gestation from conception to birth.” The bill was ostensibly written to ensure criminal liability in the event of a crime against a pregnant woman that harmed or killed her fetus (e.g., a drunk-driving accident or an incident of domestic violence).62 The immediate and primary effect of that law, however, was the arrest and prosecution of more than 40 pregnant women and new mothers who were believed to have had drug problems while pregnant.63 Three weeks after the governor signed the bill into law, 47/ District Attorney Rebecca King sent a letter to Potter County physicians informing them that under the Act, “it is now a legal requirement for anyone to report a pregnant woman who is using or has used illegal narcotics during her pregnancy.” King reasoned that the new definition of “individual” directly affected the Controlled Substances Act, since the Penal Code provides punishment for “delivery” of narcotics to children, and now to fetuses.62 Although defense counsel and civil rights organizations were eventually able to overturn the convictions, women were imprisoned for years while a key case worked its way through the court system.xxvii

While court decisions overwhelmingly reject the expansion of criminal law as a tool for policing pregnant women and it is still true that, as of this writing, no state legislature has passed a law explicitly criminalizing pregnancy for drug users, many other kinds of laws and policies are being used to police and punish drug-using pregnant women. Take, for example, the Child Abuse Prevention and Treatment Act (CAPTA). In 2003, CAPTA was amended so that states could only receive federal funding under the act if they passed laws to require health care providers involved in the delivery and care of infants to report to child protective services infants “affected” by illegal substance use. The act
excludes from consideration fetal alcohol effect or fetal alcohol syndrome.

Neither CAPTA nor any of the civil state reporting laws that pre-dated it mandate universal drug testing. In other words, who gets tested and identified as a drug user, and therefore, who gets reported to authorities is highly discretionary. Nor does CAPTA clearly define what is meant by “drug-affected,” leaving states to decide for themselves the criteria health care providers will use to identify infants to be reported to child protective services. Some states require only an unconfirmed positive toxicology screen at birth, others require physical signs of addiction or dependence, and still others mandate an actual assessment of the newborn’s imminent risk of harm or need for protection.64,65

Although such reporting laws do not mandate that the information be turned over to the police, these laws typically do not prohibit it. As mentioned earlier, hospital workers (including medical staff and social workers) and child welfare workers, who are potentially best situated to provide important care and services to drug-dependent women, are often the very ones who contact law enforcement or who contact child welfare workers, who in turn notify the police.31,64,65 The result has been that many women who used illicit drugs while they were pregnant are being arrested, interrogated, detained, prosecuted, and punished rather than receiving the services and care they need. Punitive state authorities are willing to mobilize resources to punish and separate families but not to treat and support them.

**CONCLUSION**

That punitive measures taken under the auspices of protecting the fetus continue to appeal to the public is not surprising. People are genuinely and understandably concerned about the possibility of poor pregnancy outcomes, including sick babies and pregnancy loss. They are sincerely and justifiably interested in ensuring that pregnancies result in healthy babies.66 Opposing the punishment of pregnant women and the recognition of fetal rights distinct from the rights of pregnant women does not contradict any of these legitimate concerns nor does it deny the value of potential life as matter of religious belief, emotional conviction, or personal experience. Rather, it is to recognize that punitive approaches do not advance either maternal or fetal health, and that on becoming pregnant, women (including those who use drugs and alcohol) do not lose their civil and human rights.

Singling out pregnant women not only for arrest and prosecution, but also for court orders (through family courts and drug treatment courts) and civil commitments, contributes to a climate where pregnant women are increasingly seen as adversaries of the fetuses they carry rather than people who have a stake in a healthy pregnancy and a favorable outcome. There is no question that some people’s drug use has become so chaotic and out of control that it can affect their parenting ability. No one is suggesting that such situations be ignored. Too often, however, a single, unconfirmed positive drug test is accepted as incontrovertible evidence of a woman’s criminality or unfitness to parent. Rather than a thoughtful evaluation of whether drug use or any other factor has rendered someone incapable of parenting, a single positive drug test result becomes the basis for massive and often highly punitive state intrusions on family life.

Punitive actions against drug-using pregnant women persist even though they remain inconsistent with legal, medical, and public health standards of acceptable practice and even though they do not, in fact, advance maternal, fetal, or child health interests. Our knowledge of existing cases suggests that at some of the points at which a woman is most amenable to help or may benefit most from support (e.g., when she becomes pregnant or gives birth or when she is locked up), our official responses are the harshest and least effective.

This speaks to the need to overcome a national tendency to ignore evidence-based medicine and research and to pursue costly and counterproductive punitive state interventions. The harms to both health and human rights posed by institutionalizing coercive forms of state power are significant. Rather than continue to vilify pregnant women and exaggerate the harms of their drug use, research and experience support the
provision of respectful, supportive services to all pregnant women and families who need it as the most effective way to encourage healthy pregnancies and birth outcomes.

NOTES

i. McFall v. Shimp, 10 Pa. D. & C. 3d 90, 91 (1978) PA Court of Common Pleas, Civil Division (1978) (“For our law to compel the Defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits and one could not imagine where the line would be drawn.”)


iv. See In re A.C., 573 A.2d 1235, 1253 (D.C. 1990) (en banc) (vacating court-ordered cesarean surgery in which the newborn did not survive and that was listed as a contributing factor to the mother’s death on her death certificate).

v. Pregnant women also smoke cigarettes and drink alcohol at much lower rates than other women. Less than 1 in 5 pregnant women report smoking cigarettes in the past month (compared to around almost 1 in 3 who were not pregnant). Approximately 1 in 8 pregnant women report drinking alcohol, and less than 4% report binge drinking. By contrast, over half of non-pregnant women report currently drinking alcohol and nearly 1 in 4 report binge drinking.

vi. S.C. CODE ANN. §20-7-50 (Law. Co-op. 1985) (“Any person having the legal custody of any child or helpless person, who shall, without lawful excuse, refuse or neglect to provide...the proper care and attention for such child or helpless person, so that the life, health or comfort of such child or helpless person is endangered or is likely to be endangered, shall be guilty of a misdemeanor and shall be punished within the discretion of the circuit court.”)


xi. In South Carolina, an activist state Supreme Court with a bare majority twice re-wrote state law to make the word “child” in the state child abuse and homicide statutes include viable fetuses. The court devised a new construction of the word “child” to include viable fetuses, and purported to rely on decisions in the completely different context of civil wrongful death and common law feticide. Whitner v. South Carolina reinterpreted these decisions in a new manner, declaring that they “rested on the concept of the viable fetus as a person vested with legal rights.” The court concluded, “South Carolina has long recognized that viable fetuses are persons holding certain legal rights and privileges.” Thus the decision was not based on a state interest in fetal protection, but on the flat assertion that “viable fetuses are persons.” Whitner v. South Carolina, 492 S.E.2d 777 (S.C. 1997), cert. denied, 523 U.S. 1145 (1998).


xiii. Substance dependence is highest among American Indians and Alaskan Natives and lowest among Asians. Native Hawaiians or other Pacific Islander, Whites, and Hispanics all report slightly higher rates of substance dependence than blacks.

xiv. Methamphetamine, also known as speed, crystal, or crank, is a synthetic stimulant that can be dissolved in liquid, ingested orally, snorted, or injected. Some people have used the drug recreationally ever since the 1960s. A researcher at The Sentencing Project reports that methamphetamine is among the least commonly used drugs; the rate of methamphetamine use has remained stable since 1999 and the rate of use by high school students has actually declined between 1999 and 2005. The rate of use is higher in areas such as Los Angeles, San Diego, San Jose, Omaha, and Portland, Oregon.

xv. Jack Shafer has published several articles in Slate documenting the shortcomings of the press corps’ drug coverage, for example “Why Does Drug Reporting Suck?” (August 10, 2005, http://www.slate.com/id/2124298); “Pfft Goes the Methedemic” (July 1, 2006, http://www.slate.com/id/2146303); “Methamphetamine Propaganda” (March 3, 2006, http://www.slate.com/id/2137388). In “How Not To Report About Meth” (March 21, 2006, http://www.slate.com/id/2138398),” he offers the following advice: Start your article with an anecdote, preferably one about a user who testifies about how methamphetamine destroyed his life. Toss out some statistics to indicate that meth use is growing, even if the squishy numbers don’t prove anything. Avoid statistics that cut against your case. Use and reuse the words “problem” and “epidemic” without defining them. Quote law enforcement officers extensively, whether they know what they’re talking about or not. Avoid drug history except to make inflammatory comparisons between meth and other drugs. Gather grave
comments from public-health authorities but never talk to critics of the drug war who might add an unwanted layer of complexity to your story.


xxviii. Whitner v. South Carolina 492 S.E.2d 777 (S.C. 1997). Many charges and convictions of child abuse and neglect, drug distribution, and manslaughter that are leveled against pregnant women have been dropped on the grounds that the legislation was never written with the intent that it be applied to the context of pregnancy. For example, the court in Ward v. State held that it is impossible for a fetus to “possess” the drugs since a fetus would not be capable of handling, manipulating or using drugs. Ward v. State 184 S.W.3d 874, 876 (Tex. App. 2006). See also Reinstein v. Arizona, 894 P.2d 733 (Ariz. Ct. App. 1995); and other cases cited in State v. Martinez, Brief for Sutin, Thayer & Browne, P.C. et al. as Amici Curiae Supporting Respondent, State v. Martinez, 137 P.3d 1195 (N.M. Ct. App. 2006) (No. 29,775) (National Advocates for Pregnant Women was a signatory to the brief).

xxix. Johnson v. State, 602 So. 2d 1288, 1297 (Fla. 1992)

xxx. See Ferguson v. City of Charleston, 532 U.S. 67, 84 n.23 (2001) (noting, in the course of rejecting a Fourth Amendment exception for prosecutorial drug-testing of pregnant women, amicus submissions “claiming a near consensus in the medical community that programs of the sort at issue, by discouraging women who use drugs from seeking prenatal care, harm, rather than advance, the cause of prenatal health”).


xxi. Some people experience remission or recover from substance dependence without formal treatment (a phenomenon referred to in the literature as “maturing out,” “spontaneous remission” or “spontaneous recovery”).


xxiv. Methadone treatment programs can accommodate fewer than 15% of those whom methadone treatment might help.


xxvi. Whitner v. South Carolina, 492 S.E.2d 783.

xxvii. Tracy Yolanda Ward, a 30-year-old African American woman, gave birth on November 3, 2003, to a baby boy. On October 31, 2003, Ms. Ward experienced pregnancy complications and called an ambulance. According to press reports, Ms. Ward told the ambulance personnel that she smoked cocaine during the previous hour. Following a written directive from the Potter County district attorney, hospital staff notified the Amarillo Police Department. Ms. Ward was charged with delivery of a controlled substance to a minor, a second-degree felony. Ms. Ward filed a motion to dismiss on statutory and constitutional grounds. The motion was denied. Ms. Ward pled guilty to the offense in August 2004, reserving the right to appeal the applicability of the law to her. She was sentenced to 5 years probation. Ms. Ward immediately filed an appeal challenging the legality of her conviction. Ruling on narrow statutory interpretation and evidentiary grounds, the court of appeals held that the delivery of a controlled substance statute requires “an actual” transfer of drugs and that neither possession of drugs nor an actual transfer could be established as having occurred in the context of pregnancy and birth. Ward v. State, 188 S.W.3d 874 (Tex. App. 2006).

REFERENCES


