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Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs

by

MICHELLE OBERMAN*

I. Introduction

The way in which a story is told inevitably shapes a listener’s response to it, summoning and ordering emotions so that they settle like a halo around the flame of a candle that is the truth as seen by the storyteller. I remember my first response to the story of Pamela Rae Stewart. Journalists wrote of a woman who defied her doctor’s advice to refrain from sexual intercourse during the last weeks of her troubled pregnancy.¹ When she was thirty-nine weeks pregnant, she had sexual intercourse and immediately began to hemorrhage. She then waited hours before reporting to a hospital.

Shortly after her arrival at the hospital, her baby was born with multiple handicaps. Two weeks later, the baby died. Reading the stories, I felt angry and disgusted by Ms. Stewart’s irresponsibility, bitter about her child’s wasted life, and while I did not applaud the decision to prosecute her,² I certainly empathized with the impulse to punish Ms. Stewart.


². Ms. Stewart was charged with “failing to follow her doctor’s advice to stay off her feet, refrain from sexual intercourse, refrain from taking street drugs, and seek immediate medical attention if she experienced difficulties with the pregnancy.” Konon, supra note 1, at B12. The only illegal act alleged was the use of illegal drugs, which was based on finding a substance in her blood that could have resulted from an over the counter antihistamine. Id.
Some time later, I read a second version of the story, one with a detailed factual background, and I found myself reordering my thoughts in response to answers it gave to questions I had never even thought to ask.3 Where was her husband throughout this pregnancy? Didn’t he bear some responsibility for the sexual intercourse they engaged in? And how many women thirty-nine weeks pregnant actually seek out sexual intercourse?

This second journalist’s version told of Ms. Stewart’s life with a violent, abusive husband, who beat her and regularly threatened her and other family members. It described how she lived with him in her mother-in-law’s mobile home, along with their two children, dependent on him for transportation and for the erratic income he brought home from occasional odd jobs.4 This new, fuller version of the story presented another writer’s “truth,” and effectively channelled my emotions so that I focused not solely on the actor, Ms. Stewart, but also on the context in which she acted.

Perhaps only Ms. Stewart knows the real truth of what happened to her on the day she delivered, of how she felt as she was hemorrhaging, of why she waited to seek care. But from a broader perspective, obtaining that particular truth is relatively unimportant. A more significant task for those of us who deal with social and legal policy is to understand the context in which she lived, because, to the extent that her actions were responsive to her environment, were inevitable and perhaps even rational, similar actions will be repeated over and over again by women like her.

Pamela Rae Stewart’s story already is being replayed for us. Week after week, Americans are bombarded with media coverage of the “crisis” of pregnant addicts.5 The wealth of evidence regarding maternal

4. Id.

A discussion of women using controlled substances during pregnancy is complicated by terminology. While the use of certain controlled substances is commonplace and consistent with societal norms, the line between use and abuse is not well defined. This line becomes still less clear when the referent is a pregnant woman. Is a pregnant woman who smokes marijuana once an abuser while her nonpregnant counterpart is not? Because treatment programs are the normative response to those who are unable to stop their use of a controlled substance, I will refer to those needing treatment as “addicts.” In general, the term pregnant substance “user” is intended to include all categories of pregnant women using controlled substances.
and child health conditions in the United States has been ignored in favor of a bizarre and inappropriate obsession with drug use by pregnant women. Integral to this portrayal is the casting of pregnant drug users as the sole agents of harm to children’s health. The mother has become the fetus’ greatest enemy. A recent *Time* magazine cover story purported to discuss whether “the innocent legacies of drug use [can] be rescued by care and compassion.” Typically, no attempt is made to describe the suffering or even the life circumstances of the pregnant addicts; we are left to devise our own horrific images of the “guilty” victims of drug use.

The media stands poised at bedsides in delivery rooms across the nation, reporting shocking numbers of newborns testing positive for exposure to illicit substances. The statistics most frequently cited are that 375,000 newborns per year, 11% of all births, are exposed to cocaine, marijuana, or heroin in utero. These figures, and a growing awareness of the harm such substances cause to the fetus, have gained national

6. Other than drugs, a woman may encounter any number of serious threats to her and her child’s health. These threats come from many different sources, e.g., tobacco, alcohol, aspirin, etc. Moreover, many of the risks which women face are beyond the woman’s control, such as exposure to environmental hazards in the workplace. See UAW v. Johnson Controls, 111 S. Ct. 1196, 1199 (1991). More importantly there are contextual factors which will influence the child’s health. These factors include limited access to prenatal care due to financial, practical, or cultural barriers, unavailability of decent food because the funds for programs such as the Women, Infants, and Children Food Supplement Program (WIC) have been severely reduced, and lack of adequate shelter and a stable environment. Molly McNulty, Note, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. Rev. L. & Soc. CHANGE 277, 293-99 (1988). Thus, there is a whole constellation of shortcomings in the system about which society should be outraged, but instead we have seen an increased focus on women who use illicit drugs during pregnancy.

7. The focus on pregnant drug users also seems quite hypocritical considering the fact that many women use tobacco and alcohol during pregnancy which can be just as harmful to the fetus, yet society accepts this maternal behavior much more readily.

8. Toufexis, supra note 5, at 1, 3, 56. The cover of this issue of *Time* proclaimed, “Crack Kids: Their Mothers Used Drugs, and Now It’s the Children Who Suffer.”

9. By “illicit substances” I mean those drugs which are commonly considered “controlled substances.” According to the Controlled Substances Act, 21 U.S.C. §§ 801-904 (1988), this includes all opiates, opium derivatives, hallucinogenic substances, depressants, stimulants and narcotics. Id. § 812(c). Alcohol, wine, malt liquor, and tobacco are not included as controlled substances. Id. § 802(6). Because the list encompasses the substances that most people call “drugs,” i.e., cocaine, heroin, and marijuana, the term “drugs” will be used interchangeably with “controlled substances” or “illicit substances.”


11. Although researchers readily acknowledge the potential harm inherent in fetal drug exposure, there is a dearth of precise information about causes and effects. Cocaine can cause serious effects for the fetus, including strokes, spontaneous abortion, and *abruptio placentae* (which necessitates a cesarian section delivery). On average, cocaine exposed newborns have lower birth weights and smaller head circumferences, both of which may impact infant sur-
attention and have led some members of society to call for draconian solutions.  

Generally, there have been two responses to this issue, both punitive. The overtly punitive response is seen in the criminal prosecution of pregnant substance users, on charges ranging from delivering drugs to a minor to manslaughter or assault with a deadly weapon. This practice has been criticized on both legal and policy grounds as being unconstitutionally discriminatory and unlikely to deter substance use by pregnant addicts. The second response to this problem has been increased vigilance in the enforcement of child abuse and neglect laws against pregnant users of controlled substances. While ostensibly benign, in the context of a society rife with inequality such enforcement emerges as a covertly punitive measure. Charging pregnant substance users with child abuse penalizes women who use drugs by separating them from their children, while failing to provide them with access to the means by which they might regain custody. Because the widespread application of these laws will affect many more lives than will ever be reached through the criminal prosecution approach, I have chosen to focus exclusively on the application of child abuse and neglect laws to pregnant drug users, and will

vival. They also have a higher incidence of physical abnormalities, including deformed kidneys and neural tube defects. They may experience behavioral problems as they mature, such as irritability and difficulty in bonding. Helene M. Cole, Legal Interventions During Pregnancy, 264 JAMA 2663, 2666 (1990).

However, not all exposed infants are affected by cocaine use. Furthermore, some researchers believe that "whatever negative effects occur at birth gradually dissipate and eventually leave the child unaffected." Susan E. Lockwood, What's Known—and What's Not Known—About Drug-Exposed Infants, 11 YOUTH L. NEWS 15, 16 (1990).

12. One neonatal intensive care unit nurse at Detroit's Hutzel Hospital suggested the following, "I know it sounds harsh .... but I think we should offer these mothers a week's supply of free drugs if they would let us take out their uterus [sic]." Tom Hundley, Infants: A Growing Casualty of the Drug Epidemic, CHI. TRIB., Oct. 16, 1989, § 1, at 1.

13. In Michigan, two separate cases were filed recently against women for delivering cocaine to their babies through the umbilical cord. Prosecutor Will Continue Cocaine Case, UPI, June 14, 1990, available in LEXIS, Nexis library, Wires file; see also Johnson v. Florida, No. 89-1765, 16 Fla. L. Weekly D1053 (Fla. Dist. Ct. App. filed Apr. 18, 1991). In Illinois, a woman was charged with involuntary manslaughter, but not indicted, after her baby daughter died from the cocaine in her system. Patrick Reardon & Rick Pearson, Baby's Drug Death Stirs Mothers' Rights Flap, CHI. TRIB., May 10, 1989, § 1, at 1. A woman in North Carolina was charged with assault with a deadly weapon following her newborn's positive toxicology test. Jan Hoffman, Pregnant, Addicted—and Guilty?, N.Y. TIMES, Aug. 19, 1990, § 6 (Magazine), at 32-35.

demonstrate in this Article the means by which these laws worsen, rather than remedy, the problems surrounding perinatal drug use.

My arguments rest on a belief that in order to understand the issue of perinatal use of controlled substances, one’s focus must be shifted from bedside at delivery to bedside at conception. Given the widespread prevalence of drug use in society, the relevant questions are: Why do women users get pregnant, why do they continue using controlled substances during pregnancy, and how can they be persuaded to curtail their use during—and after—pregnancy?

In seeking answers to these questions, I aim to restructure the stories of pregnant addicts depicted in the media and by the legal system. I begin my discussion by describing some of the contextual factors that shape the lives of women who use drugs, and especially of pregnant addicts. Given that background, I then examine the likely impact of child abuse and neglect laws on these women and their fetuses. Next, I demonstrate how present policy violates the Fourteenth Amendment’s equal protection guarantees against gender discrimination. Finally, I offer an alternative approach to addressing the problem—one which I believe is both legally and practically more cogent, humane, and effective.

II. Situational Overview

The lives of women who use drugs are shaped by a constellation of factors: psychological, sociological, physiological, and economic. After examining current statistics on the prevalence of substance use by pregnant women, I will explore these factors, first addressing the psychosocial make-up of pregnant drug users, and second, discussing the dilemmas posed by lack of access to necessary care.

A. Facts, Figures, and Pregnant Addicts

A recent study of the prevalence of substance use in women reporting for their first prenatal examination in Pinellas County, Florida received considerable attention from the media.15 This study, which tested the women’s urine for alcohol, cannabinoids, cocaine, and opiates, revealed that 14.8% of the 715 women tested screened positive.16 In addition, 13.3% of the tests were positive for illicit drugs other than alcohol.17 Extrapolated to the population at large, this study indicates

15. Ira J. 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 (1990) [hereinafter Chasnoff et al., Illicit Drug Use].
16. Id. at 1203.
17. Id. at 1203-04.
that approximately 375,000 newborns per year are exposed to controlled substances in utero.\textsuperscript{18}

The Pinellas County study is significant for several reasons. First, its results parallel the findings of the National Institute on Drug Abuse’s 1985 household survey, which estimated that of the fifty-six million American women between fifteen and forty-four years of age, 15\% are currently “substance abusers.”\textsuperscript{19} Additionally, the 1985 survey found that use of controlled substances among women of reproductive age did not vary with socioeconomic status.\textsuperscript{20} The Pinellas County study replicated this finding by drawing its sample from public and private paying patients, and showing that drug use did not vary with income.\textsuperscript{21}

Second, the study reveals, in an indirect manner, the racism and sexism which underlie the societal response to this issue. When comparing toxicology screens across racial lines, white women tested positive at slightly higher rates than black women.\textsuperscript{22} Yet, despite relatively equal rates of drug use, black women are nearly ten times more likely than white women to be reported to state agencies for substance use during pregnancy.\textsuperscript{23}

While black and poor women more frequently use drugs that may cause greater harm both to themselves and to their fetuses,\textsuperscript{24} this factor neither accounts for nor justifies the reporting differential. None of the reporting laws passed in response to this problem differentiate among the various illicit substances; there is no discretion given to health care providers and others mandated to report. Thus, marijuana users should not be treated differently than cocaine users. The underlying premise of the nondiscretionary reporting policy is the assumption that state child protection agencies, rather than individuals, are best qualified to ascertain whether a parent’s drug use poses a risk to the child’s well being. Therefore, the relatively equal extent of drug use among black and white wo-

\textsuperscript{18} See id. Some studies have recorded much higher rates of positive toxicology screens in newborns. For example, a 1989 survey at Hutzel Hospital in Detroit revealed that 42.7\% of all newborns tested positive for marijuana, heroin, or cocaine. Hundley, \textit{supra} note 12, at 1.

\textsuperscript{19} Edgar H. Adams et al., \textit{Epidemiology of Substance Abuse Including Alcohol and Cigarette Smoking}, 562 \textit{ANNALS N.Y. ACAD. SCI.} 14, 15 (1989).

\textsuperscript{20} Chasnoff et al., \textit{Illicit Drug Use, supra} note 15, at 1204.

\textsuperscript{21} Id. at 1203.

\textsuperscript{22} Id. at 1204. Black women tested positive for cocaine more frequently than did whites (7.5\% black compared to 1.8\% white), while the opposite was true for marijuana (6.0\% black compared to 14.4\% white). Id.

\textsuperscript{23} Id.

\textsuperscript{24} See \textit{supra} note 22; see also PADDY S. COOK ET AL., U.S. DEP’T OF HEALTH AND HUMAN SERVICES, \textit{ALCOHOL, TOBACCO AND OTHER DRUGS MAY HARM THE UNBORN} (1990).
men should generate equal numbers of reports to state agencies. The fact that the numbers are nowhere close to equal is evidence of race bias in reporting.

The problem of gender bias is more subtle than that of racial bias. Gender bias is reflected in the prevalent attitude that a pregnant woman's use of illegal drugs constitutes a singular menace to her child. The Pinellas County study and the myriad media exposés on the subject fail to mention the avoidable harms suffered by the fetus whose mother lacks medical insurance and cannot obtain prenatal care or drug treatment. Little attention is paid to the harmful effects on the fetus of a broad spectrum of legal behaviors, including cigarette smoke, alcohol, and many prescription or over the counter medicines. Moreover, no mention is made of fetal risks that are not in the pregnant woman's control, such as exposure to hazardous chemicals, which "heighten[] the risk for spontaneous abortion, premature birth, stillbirth, low birth weight, and birth defects." In addition, differences among types of drugs and between infrequent and habitual use are blurred, thus giving the false impression that women who use drugs even once during pregnancy threaten their fetuses' health in a manner that is exponentially more severe than any other threat to fetal well being. Most notably, despite the narrowness of the media focus on pregnant women using controlled substances, virtually no effort is made to understand the women at issue—their drug use, the meaning of and reasons for their pregnancies, or the amount of control they have over their lives.

B. Pregnant Addicts as Women and as Addicts

There is no doubt that a significant percentage of women use drugs during pregnancy. Many of these women may be addicts. The

26. Note that the Pinellas County study is not a perfect model for estimating drug use among pregnant women. First and foremost, as many as 27% of women of reproductive age lack health insurance to cover maternity care, and therefore obtain prenatal care late in pregnancy, if at all. COMMITTEE TO STUDY OUTREACH FOR PREGNATAL CARE, INSTITUTE OF MEDICINE, PREGNATAL CARE: REACHING MOTHERS, REACHING INFANTS 56 (Sarah B. Brown ed., 1988) [hereinafter PREGNATAL CARE: REACHING MOTHERS, REACHING INFANTS]. These women were excluded from the study, and it is difficult to predict how their levels of substance use might differ from those who obtain early prenatal care. Second, urine toxicology screens only reveal substances ingested during the 72 hours preceding the screen. Children of Substance Abusers: Hearings Before the Subcomm. on Children, Family, Drugs and Alcoholism of the Senate Labor and Human Resources Comm., 101st Cong., 2d Sess. (1990) (statement of Kary Moss, Attorney, ACLU, and Judy Crockett, Legislative Representative, ACLU). Thus, women who screen negative actually might be users. Moreover, because these tests are qualitative, not quantitative, they do not distinguish between one-time and chronic use of a substance. Finally, since the screens in the study were performed at the first prenatal
problems of pregnant addicts may be viewed as outgrowths of their status as both women and addicts. Addicted women differ from addicted men in ways that parallel differences among men and women within the general culture. In general, addicted men develop psychological defenses which prevent them from recognizing the consequences of their behavior, thus protecting their self esteem and allowing their abusive habit to continue. By denying the existence of a problem, men avoid experiencing shame and fear, but they increase the likelihood of arguments with family and friends.

In contrast, addicted women are far more likely to acknowledge the existence of their problem. However, they are less likely to see their addiction as a major problem, since they tend to view their habits as “therapeutic” or coping devices. These women often report “extreme levels of depression and anxiety,” in addition to very low self esteem. Dr. Amin Daghestani has found that addicted women “are often involved in abusive relationships,” and he hypothesizes that “[t]his vulnerability to physical abuse may stem from a history of being abused as children.”

Given their relatively weak self esteem, addicts run a high risk of pregnancy. Even for a woman who is psychologically strong, or even physically strong, it is often difficult to refuse unwanted sexual advances, or to insist on the use of contraception when engaging in sexual relations. The addicted woman’s low self esteem, coupled with the fact that her partner may be abusive, renders her still less able to control the

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28. Id. at 155.
29. Id. at 152, 155; see also Amin Daghestani, Psychosocial Characteristics of Pregnant Addicts, in DRUGS, ALCOHOL, PREGNANCY AND PARENTING 10 (Ira J. Chasnoff. ed., 1987).
30. Reed, supra note 27, at 155.
31. Daghestani, supra note 29, at 11. Researchers estimate that between 70% and 100% of all women drug abusers are victims of incest or sexual violence. Renee M.Popovits, Criminalization of Pregnant Substance Abusers: A Health Care Perspective, 24 J. HEALTH & HOSP. LAW 169,172 (1991) (discussing studies on drug dependency that found “up to seventy-four percent of alcohol and drug dependent women reported incidents of sexual abuse” and noting that the studies were “consistent with anecdotal reports from the few programs that treat pregnant addicted women that eighty to ninety percent of their clients have been victims of rape or incest”).
32. See DIANA E.H. RUSSELL, SEXUAL EXPLOITATION: RAPE, CHILD SEXUAL ABUSE, AND WORKPLACE HARASSMENT 34-41 (1984) (citing statistics showing that out of 930 women surveyed, 24% reported at least one completed rape and 31% reported at least one attempted rape); see also Laurie Goering, Fear Grips Women on Campuses, CHI. TRIB., Feb. 11, 1990, at D1 (survey by Mary Koss, Professor of Psychiatry at the University of Arizona, reports that one out of four women have been the victim of rape or attempted rape).
circumstances of intercourse. She may, in other words, be in a less powerful position than an otherwise similarly situated nonaddicted woman. Furthermore, whether implicitly or explicitly, substance using women often obtain their drugs in exchange for sex, and therefore may be unable to refuse sexual relations without jeopardizing their drug supply.\textsuperscript{33}

Unwanted pregnancy can be avoided by the use of contraception, yet most contraceptive methods are not well suited to the needs of addicted women. Barrier methods, such as the condom or the diaphragm, require a high degree of user motivation and partner cooperation. A study of female intravenous drug users in New York City found that "proposals to change sexual practices (including the use of condoms) require redressing the balance of power within intimate relationships. For these women, asking a man to use a condom provokes the fear of breaching relations that may fulfill the woman's sexual, personal, financial, and drug needs."\textsuperscript{34} Oral contraceptives, which are perhaps the most effective means of preventing conception, are not appropriate for addicted women because consistent pilltaking is crucial to their efficacy. The chaotic schedules of these women essentially preclude them from taking a pill once every twenty-four hours.\textsuperscript{35} A third option, the intrauterine device (IUD), is undesirable because addicted women have a high incidence of sexually transmitted diseases, increasing the likelihood of contracting pelvic inflammatory disease, which may be fatal.\textsuperscript{36} The advent of Norplant, a long lasting contraceptive that is surgically implanted in a woman's arm, may provide a suitable method for some addicted women. At present, however, it not only is exceptionally costly (implantation costs average $500), but also is restricted to a narrowly defined population of medically eligible users.\textsuperscript{37}

\textsuperscript{33} Telephone Interview with Beth Reed, Ph.D., University of Michigan School of Social Work, Ann Arbor, Michigan (May 21, 1990).


\textsuperscript{35} Telephone Interview with Gay Chism, Registered Nurse, National Association for Perinatal Addiction Research and Education (NAPARE), Chicago, Illinois (June 6, 1990).

\textsuperscript{36} Id.

\textsuperscript{37} Present guidelines limit Norplant to use in women who weigh less than 150 pounds, and who are free of complicating medical conditions such as diabetes, heart conditions, or high blood pressure. Interview with Ms. Susan Nankin, Clinic Manager, Chicago Area Planned Parenthood, Northside Clinic, in Chicago, Ill. (December 10, 1991).
Birth rates for addicted women have been shown to exceed those for nonaddicted women. In part, this is because many of these women want to have children, regardless of their life circumstances. In addition, chronic drug or alcohol use can lead to a decreased awareness of body changes. Thus, addicts tend to attribute their missed menses to drug use, rather than to pregnancy, and often wait until late into pregnancy to seek care. The addicted woman who discovers her pregnancy prior to the point of fetal viability and wishes to abort faces the same financial barriers encountered by all indigent women. However, because she is more likely to discover her pregnancy in the mid-trimester, her abortion will be considerably more expensive than an early trimester procedure, a factor which may preclude abortion as an option.

C. Access to Care

Without a doubt, the best interests of society, as well as those of the pregnant woman and the fetus she carries, are served by enabling the pregnant drug user to obtain prenatal care and, when necessary, drug abuse treatment, as early as possible in her pregnancy. Research has shown that the chances for a healthy baby significantly increase the sooner in the pregnancy the substance using woman seeks medical care.

From an economic perspective, providing care will save society millions of dollars because insurance coverage for these women is so limited that society eventually absorbs most of the costs incurred for childbirth, delivery, and for the baby's health care. The National Association for Perinatal Addiction Research and Education estimates the health care costs for treating a cocaine addicted woman who obtains prenatal care at

38. AIDS: Sexual Behavior and Intravenous Drug Use, supra note 34, at 200.

39. The desire to procreate is fundamentally human, and regardless of their status in society, people look to their children as sources of love, support, and meaningfulness. Because of this, the U.S. Supreme Court long has viewed the right to procreate as fundamental, and has reviewed with strict scrutiny any state actions limiting this right. See Carey v. Population Servs. Int'l, 431 U.S. 678, 685 (1977); Skinner v. Oklahoma, 316 U.S. 535, 541 (1942).

40. Daghestani, supra note 29, at 9. The majority of addicted women who seek prenatal care do so in the third trimester. Id.

41. See Harris v. MoRae, 448 U.S. 297 (1980); see also Maher v. Roe, 432 U.S. 464 (1977). In addition to financial barriers, women, and especially poor women, soon may face "informational" barriers as well, due to the recent U.S. Supreme Court ruling in Rust v. Sullivan, 111 S. Ct. 1759 (1991). Since the summer of 1991 health care practitioners who receive federal funding have been now prohibited from counseling pregnant women about the option of abortion. Id.

42. Ira J. Chasnoff et al., Temporal Patterns of Cocaine Use in Pregnancy, 261 JAMA 1741, 1742 (1989) [hereinafter Chasnoff et al., Temporal Patterns].
This figure includes prenatal care, the maternal hospital stay, and two days of neonatal care.

In contrast, the costs incurred by an addict who fails to obtain prenatal care are strikingly higher, averaging $31,000, due to the increased need for neonatal intensive care. These estimates do not include social service interventions, educational costs, or the long term care which the child affected by maternal drug use may require. They also omit all costs relating to the rehabilitation of the mother and her additional children.

(I) Pregnant Addicts' Access to Care Generally

Despite the foregoing, access to prenatal care has diminished in recent years, particularly among poor women. As a result, the incidences of low birth weight, infant mortality, and maternal mortality have risen. While the principal reason for the failure to obtain care is financial, and women with private health insurance obtain prenatal care more easily than uninsured or Medicaid-enrolled women, even private insurance plans often provide only limited maternity coverage. Women covered by Medicaid generally rely on overburdened clinics for prenatal care and, as a result, tend to obtain prenatal care later in pregnancy and to make fewer visits to providers than women with private insurance. Moreover, more than one quarter of "women of reproductive age . . . have no


44. Id.


46. We could, of course, allow the babies to die. One way to change the numbers is to change the standard of practice. As of yet, no one advocates such overt neglect. This suggestion, however, is not as implausible as it may sound if one examines present policy. Essentially, current practice condones the more pernicious, and ironically more costly, process of taking virtually no action that might prevent harm to women, fetuses, and babies, such as increasing access to obstetrical care and drug treatment, or providing women and children with safe shelter and adequate nutrition. It should be noted that the United States ranks higher than nineteen other countries in infant mortality, with nearly 40,000 babies dying annually before they reach their first birthday. Robert Pear, Study Says U.S. Needs to Battle Infant Mortality, N.Y. TIMES, Aug. 6, 1990, at A1.

47. PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS, supra note 26, at 4-5.

48. Id. at 5.
insurance to cover maternity care, and two-thirds of these . . . have no health insurance at all.”

In addition to the lack of access to prenatal care, drug abuse treatment programs are insufficient to meet demand. Even by the Bush administration’s account, there are over one million addicts in this country who currently want drug abuse treatment but are unable to get it. Moreover, if an addict lacks private insurance, her treatment options are far more limited, and she typically must wait several months prior to commencing even outpatient services.

Given these treatment shortages, it comes as no surprise that care designed to address the special needs of pregnant addicts is almost nonexistent. Pregnancy complicates the ordinary drug rehabilitation process, in part because the impact of withdrawal on the fetus must be taken into consideration. For example, too rapid a withdrawal from heroin may induce a miscarriage. Additional problems are posed by pregnant women addicted to cocaine and crack. Because these addictions are relatively new, there are few established methods for treating the addictions themselves, let alone for addressing the effect on the fetus of withdrawal from these drugs. Moreover, substance abuse treatment must address the pregnant addict’s special needs, which are substantially broader than those of other addicts. Compounding the problems of personal and financial instability, the pregnant addict generally already has at least one living child. Therefore, in addition to the therapeutic assistance she requires in order to break her drug habit, she should be trained in parenting skills, self esteem, skills for autonomous living, stress management, financial planning, and nutrition to meet both her own needs and those of her children. Moreover, she likely will need child care assistance dur-

49. Id.
51. See id. In spite of this, President Bush’s 1990 National Drug Control Strategy emphasizes law enforcement rather than treatment. Herbert D. Kleber, Deputy Director for Demand Reduction at the Office of National Drug Control Policy, justifies this by stating that, “only half, at best, of cocaine addicts are drug-free one to two years after treatment,” and by noting that “private treatment centers are, on average, only 55 percent full.” No Quick Fixes for Drug Addicts, N.Y. Times, Jan. 26, 1990, at A31. In other words, we need not assist those seeking to break their habits since they may fail anyway, and those who want to quit must find the thousands of dollars necessary to pay for private treatment on their own.
53. Interview with Beth Reed, supra note 33.
54. Reed, supra note 27, at 156-57.
Few existing treatment programs are capable of providing this scope of services.56

(2) Pregnant Addicts and Drug Abuse Treatment Programs

In order to gain a sense of the barriers which women who choose to seek drug abuse treatment may encounter, my assistants and I conducted a brief survey of treatment programs in the Chicago area on behalf of a hypothetical friend, whom we described as twenty years-old, employed part-time, lacking health insurance, eight weeks pregnant and using cocaine on a daily basis.

We began our survey in August 1989 by contacting the Illinois Department of Alcoholism and Substance Abuse for a list of all licensed treatment facilities. They informed us that they had run out of their 1988/1989 lists, and that there would be a six month wait until the new list was published, which we could purchase for $25. Admittedly, a state agency is an unlikely place for a pregnant addict to begin her search for treatment, but that response was enough to deter even a hearty researcher. We therefore contacted all twenty-seven of the substance abuse treatment centers listed in the greater Chicago area Yellow Pages and asked a series of treatment related questions on behalf of our hypothetical friend.57

Almost all of the twenty-seven facilities we contacted indicated that inpatient treatment is recommended for pregnant cocaine addicts. Of the nine inpatient programs we contacted, seven accepted pregnant women. The minimum cost for these programs, however, was $12,000 per month, and none of them accepted Medicaid or offered any substantial financial assistance.

Next, we attempted to locate an outpatient program for our friend. Of the fifteen outpatient programs we identified, eight accepted pregnant women, but only four of these accepted Medicaid. Of further interest was the frequency with which we were referred to other programs. Virtually every program we contacted referred us to other local programs, giving us the distinct impression that our friend was unwelcome. Surprisingly, only eight of the twenty-seven programs mentioned Northwestern’s Perinatal Center for Chemical Dependence, which accepts

55. Id.
56. Telephone Interview with Dr. Ira Chasnoff, Director of the Perinatal Center for Chemical Dependence, Northwestern University Memorial Hospital, Chicago, Ill. (Aug. 9, 1989).
57. While we contacted 27 facilities, many were hesitant to discuss their programs with us once we mentioned that we sought services for a pregnant woman. In fact, three facilities hung up before we were able to discern the nature of the services they provided.
Medicaid and is the nation's leading program for treatment of pregnant addicts. One certainly would expect that anyone working in this field, especially in the Chicago area, would know of this program. Moreover, seven programs referred us to centers which, when contacted, refused to accept pregnant women.

Our results indicate that access is limited by an addict's financial status and also by less predictable variables such as luck and perseverance. If she is willing to call enough facilities, a pregnant addict may eventually find one that is willing to accept her. While our survey did not aspire to statistical validity but, rather, aimed only to document the availability of treatment, our findings closely paralleled those of Dr. Wendy Chavkin of Columbia School of Public Health. In a comprehensive 1989 study, Dr. Chavkin surveyed treatment programs in New York City and found that 87% would not accept pregnant crack addicts receiving Medicaid.58

There seem to be four basic reasons for the treatment shortages for pregnant addicts. First, there is little incentive to provide such services, as these patients tend to be noncompliant and costly. Pregnant addicts miss almost 38% of their scheduled medical appointments.59 Those receiving public assistance, like all patients receiving public assistance, are even less attractive, due to the low reimbursement rates paid by Medicaid and the time consuming paper work required for filing claims.

Second, women who are addicts tend to experience complications during pregnancy. Physicians and treatment centers fear treating women with high-risk pregnancies because the potential for legal liability is greater when a baby is born with problems.60 Added to this is the possibility of a lawsuit claiming that the withdrawal process itself damaged the fetus. While the success of any lawsuit based on negligence requires proof of causation, which is virtually unobtainable due to the confounding effect of maternal drug use, the financial and emotional costs incurred by the defendant in successfully defending a lawsuit are by no means insignificant.

Third, many pregnant addicts are at high risk for contracting the human immunodeficiency virus (HIV), which may later progress to AIDS.\textsuperscript{61} This is especially true for female intravenous drug users, a large percentage of whom are known to be HIV positive.\textsuperscript{62} Therefore, in addition to the other barriers to treatment, these women will face resistance from practitioners who avoid treating HIV positive patients.

Finally, access to treatment is limited simply because drug rehabilitation programs and individual practitioners are not prepared to handle the complex needs of a pregnant addict. As previously noted, pregnant addicts require a broad range of services. Treatment programs already are struggling for funding and are unable to provide the extended care needed by this special group of addicts.

This discussion ignores the question of whether drug abuse treatment, even if provided free of cost and with acute sensitivity to the needs of pregnant addicts, actually will work. I have reserved my discussion of this question because the legal system has not considered it relevant in its response to problems of addiction. Generally, society views addicts as sick individuals in need of help and uses the law to encourage or force them to obtain whatever treatment exists.\textsuperscript{63} In this Article’s final section I will return to the question and will discuss methods for enhancing treatment’s chances of success.

III. Child Abuse and Neglect Reporting Laws and Their Impact on Pregnant Users of Controlled Substances

States’ principal legal response to the problem of controlled substance use by pregnant women has been the attempt to invoke child abuse and neglect reporting laws. Such an approach is inadequate for reasons of constitutionality and statutory construction, as will be addressed in the next section of this Article. In this section, I will discuss the equal inadequacy of looking to the nation’s chronically underfunded child welfare system, with its decaying infrastructure, for a solution to this problem.

\begin{itemize}
\item \textsuperscript{61} See Daghestani, \textit{supra} note 29, at 10-11.
\item \textsuperscript{62} \textit{Id.} at 10; see also Ellie E. Schoenbaum et al., \textit{Risk Factors for Human Immunodeficiency Virus Infection in Intravenous Drug Users}, 321 \textit{New Eng. J. Med.} 874, 875 (1989) (of 219 female intravenous drug users enrolled in a methadone treatment program, 37.4\% tested HIV positive).
\item \textsuperscript{63} See, e.g., Robinson v. California, 370 U.S. 660, 667 (1962).
\end{itemize}
A. Reports to State Agencies and Their Consequences

Given the difficulties involved in securing treatment for drug abuse, a pregnant addict might be well advised to seek out prenatal care before attempting to find an addiction treatment program. If she manages to find an obstetrician, she then must decide whether or not to inform the doctor of her addiction. The reasons favoring disclosure are obvious, yet intangible: disclosure will enable the doctor to tailor a special course of prenatal care for her; it will permit the diagnosis and treatment of any unusual signs of maternal or fetal distress during the pregnancy; and the doctor should be able to direct her to a drug abuse treatment program—albeit one which may have no room for her or one that she cannot afford.

Assuming, however, that the woman wishes to carry the pregnancy to term and to retain custody of her child, there are several very concrete reasons for her to hide her addiction from the doctor. In essence, by telling the doctor, the pregnant addict may trigger a state child abuse and neglect reporting statute, thereby inviting state scrutiny of her pregnancy, addiction, and recuperation, and jeopardizing her present and future custody of the child she is carrying.

To better understand why a woman might choose not to tell her physician that she is addicted, one need only review the sequence of events triggered by the filing of a report with the child protective services agency. I use Illinois’ scenario as an example. Illinois law defines use of a controlled substance by a pregnant woman as child neglect, and requires that newborns who test positive for controlled substance exposure...

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64. For example, some judges who believe that a fetus’ well being is jeopardized by the decisions of the pregnant woman have awarded temporary custody of the fetus to a court appointed guardian. Thus, in what is perhaps the ultimate legal fiction, the pregnant woman loses “custody” of the baby she carries with her 24 hours a day. For an excellent discussion of this problem, see, Lawrence J. Nelson et al., Forced Medical Treatment of Pregnant Women: “Compelling Each to Live as Seems Good to the Rest,” 37 HASTINGS L.J. 703 (1986). See also Michael Vitello, Baby Jane Doe: Stating a Cause of Action Against the Officious Intermeddler, 37 HASTINGS L.J. 863 (1986) (suggesting parents should be able to bring a privacy action against official intermeddlers).

65. Normally, all the information that a patient reveals to her physician in the course of seeking medical treatment is protected from disclosure by the physician-patient privilege. E.g., Horne v. Patton, 291 Ala. 701, 706-07, 287 So. 2d 824, 829-30 (1973); Smith v. Driscoll, 94 Wash. 441, 443, 162 P. 572, 572 (1917). However, this privilege is overridden by both federal and state laws mandating that a health practitioner who has reason to suspect that her patient is committing child abuse or neglect report the patient to the state agency charged with implementing the child protection act. See Child Abuse Prevention and Treatment Act of 1974, 42 U.S.C. §§ 5101-5107 (1988) and various state laws. The federal statute establishes criteria with which each state must comply in order to receive federal funding. Accordingly, with some minor differences, state reporting laws basically resemble the federal law. See, e.g., ILL. REV. STAT. ch. 23, para. 2054 (1989).
be reported to the Department of Children and Family Services (DCFS). 66 While the law does not require doctors to test all newborns, a pregnant woman who reveals a history of drug abuse provides her doctor with reasons 67 for notifying DCFS immediately or for testing the newborn at birth.

Maternal custody is revoked temporarily by the DCFS immediately upon receipt of a report of a positive toxicology screen in a newborn. 68 In other words, on the basis of one test, the baby is separated from its mother for the first week of its life. This effectively precludes the mother from breastfeeding, which is tremendously important for the newborn’s well being. 69 Within seven days of the report, the DCFS conducts an informal investigation to determine whether it is in the child’s best interests to stay with the mother, who is not provided with legal counsel. A formal hearing on the matter of temporary foster care is held within thirty days of the informal investigation. Again, the state does not provide counsel. If the mother is found unable to care for her child, she is expected to begin a treatment program tailored to meet her needs, and only upon the DCFS’s determination that she is capable of caring for her child may she resume custody. 70

67. The Illinois statute requires that doctors who have “reasonable cause to believe a child known to them in their professional or official capacity may be an abused or neglected child shall immediately report . . . to the Department.” ILL. REV. STAT. ch. 23, para. 2054 (1989). However, not all newborns who have been exposed to a controlled substance fit the statutory definition of a neglected child. Only newborns “whose blood or urine contains any amount of controlled substance” is a neglected child. Id. para. 2053(e). Nonetheless, when a pregnant patient informs her doctor that she has used a controlled substance, the doctor may consider this to be reasonable cause to believe the child or fetus is neglected, triggering the doctor’s duty to file a report. Likewise, the doctor may chose to store the information and test the baby at birth, or may chose to do nothing with it, depending on what the doctor construes as reasonable cause to suspect neglect.
69. Interview with Dr. Lori Walsh, Chicago area Pediatrician, in Chicago, Ill. (June 9, 1991).
70. ILL. REV. STAT. ch. 23, para. 2055; ch. 37, para. 802-10 (Supp. 1991). Not only is this protocol rife with internal weaknesses, due to inadequate funding which has severely hampered DCFS’s ability to operate, see infra notes 83-90 and accompanying text, it is also susceptible to significant abuse, as illustrated in the case of Theresa L., In re Ryan, 74 N.Y.2d 892, 547 N.E.2d 104, 547 N.Y.S.2d 849 (1989). Theresa L.’s ordeal took place in New York, whose law in this area is similar to Illinois’ law. When Theresa learned she was pregnant, she sought prenatal care. At her first visit to the doctor, she reported having used both marijuana and cocaine a few years earlier, although she was not a current user. Theresa was very responsible during her pregnancy: She attended Lamaze classes and eliminated all caffeine and medications from her diet. When she went into labor at home, a friend who was a registered nurse...
It is important to note that not only doctors report the use of controlled substances by pregnant women. Depending on state law, a wide range of health care professionals may be required to report suspected child neglect to the state. At least one state even encourages voluntary reports from members of the community at large.

B. Structural Disincentives to Obtaining Medical Care

The scenario triggered by a report during or immediately following pregnancy of maternal drug use is so frightening from the woman's perspective that these child abuse laws may have the ironic result of encouraging abortion. An equally perverse consequence is that pregnant drug users who hope to continue their pregnancies and to retain custody may be discouraged from seeking the health care treatment that is needed for maternal and fetal welfare alike.

The woman wishing to maintain custody has three basic options: not seek any care; seek prenatal care, but not disclose her addiction; or disclose her addiction and seek both prenatal and substance abuse treatment. If she does not seek any care, she jeopardizes her own health, as well as that of her fetus, but minimizes the risk of losing custody. She only risks losing custody if she delivers the child at a hospital and it is tested for drugs. Provided that the child is not significantly premature, which is one possible consequence of maternal drug use, and that the mother is not delivering at an inner city public hospital, where testing suggested she smoke some marijuana to relieve the stress and pain of her contractions. Later, she delivered a healthy baby boy at the hospital.

For unknown reasons, the hospital tested the baby and found that he screened positive for THC, the active ingredient in marijuana. Child Protective Services were notified, and they immediately filed for and received temporary custody. The baby was placed in foster care. Theresa's doctor, mother, and social worker all testified to her ability to care for the child. Nevertheless, the judge reviewed the medical record and decided that Theresa had exercised "bad judgment." Custody was given to Theresa's mother. Theresa was not allowed to see the baby alone and was ordered to attend a drug treatment program. Several hearings and some nine months later, the case was dismissed for lack of evidence that Theresa was neglectful and Theresa finally regained custody.

1. See, e.g., ILL. REV. STAT. ch. 23, para. 2054 (list includes various law enforcement personnel, child care workers, and some state agency personnel).
2. MINN. STAT. ANN. § 626.5561 (West Supp. 1992). Minnesota law encourages reports by any person suspecting that a pregnant woman has used a controlled substance for a nonmedical purpose. See infra notes 91-143 and accompanying text for a full discussion of this law.

3. In South Carolina, where prosecutors have filed criminal charges against 18 women who allegedly took drugs during pregnancy, sources in the medical community report "a rise in the number of women giving birth at home, in taxis and in bathrooms." Pregnant and Newly Delivered Women Jailed on Drug Charges, REPROD. RTS. UPDATE 6 (ACLU/Reprod. Freedom Project, New York, N.Y., Feb. 1, 1990).
rapidly is becoming universal,\textsuperscript{74} chances are that the child \textit{will not} be tested.\textsuperscript{75} If she seeks prenatal care but does not disclose her addiction, her chances of a healthy delivery are enhanced, but she runs the risk of the doctor discovering her drug use and choosing (or, in Minnesota, being obligated) to report her to the state agency. Disclosing her addiction and seeking both substance abuse and prenatal treatment would be ideal if treatment were available, and if the woman felt confident that she could overcome her addiction. However, not only is there little treatment available, but few addicts feel secure about their ability to overcome their addictions, even without the existence of a nine month (or shorter) time period in which to do so.\textsuperscript{76}

A related disincentive to seeking health care derives from a fear of criminal prosecution. The likelihood that a health care provider will discover the use of controlled substances and report a pregnant woman to law enforcement authorities may be remote. Yet once her status as a drug user is known by others, the risk of disclosure to the criminal justice system increases. An example of the limitations on confidentiality are revealed in a case\textsuperscript{77} involving a Michigan woman whose obstetrician ordered her tested because she told him of her cocaine use. Once she tested positive, the hospital kept the baby for observation, tested the baby and then notified the Department of Social Services (DSS) of the positive result. Both the doctor's decision to test and the hospital's decision to report were optional. However, once DSS received the report, it was obligated to notify the local prosecutor.\textsuperscript{78} On the basis of the baby's test results, the Muskegon County Prosecutor charged her with delivering drugs to a minor.\textsuperscript{79}

C. Public Health Pitfalls and Shortcomings Inherent in a Reporting Policy

The resort to child abuse and neglect reporting systems for tracking and contending with pregnant addicts is a policy replete with logistical

\textsuperscript{74} See Gina Kolata, Bias Seen Against Pregnant Addicts, N.Y. TIMES, July 20, 1990, at A13.

\textsuperscript{75} Hoffman, supra note 13, at 44.

\textsuperscript{76} Note that the Minnesota law authorizes emergency involuntary admissions of pregnant women who fail recommended treatment. MINN. STAT. ANN. § 626.5561(2) (West Supp. 1992).

\textsuperscript{77} Hoffman, supra note 13, at 33.

\textsuperscript{78} Under Michigan law, DSS must notify the county prosecutor whenever it finds instances of child abuse. MICH. COMP. LAWS 722.623 § 3(6) (1991). Tony Tague, the county prosecutor, has chosen to define evidence of cocaine or alcohol abuse by a woman during pregnancy as child abuse. Hoffman, supra note 13, at 53. Most states consider this to be at most neglect, and thus their criminal justice systems do not receive notice of it. See, e.g., ILL. REV. STAT., ch. 23, para. 2053 (Supp. 1989).

\textsuperscript{79} Lisa Perlman, Cocaine Babies, ANN ARBOR NEWS, April 22, 1990, at A7.
problems, such as the lack of sufficient drug rehabilitation programs that meet the needs of pregnant women and new mothers, and the fact that there are geographical areas in which there are no drug rehabilitation programs at all. Because subsidized treatment programs are in short supply, new mothers needing treatment may be separated from their newborns, yet unable to begin the therapy designed to reunite them. This result looks a great deal more like punishment than rehabilitation. Additionally, existing treatment programs are ill-suited to women's needs. Sociologist Beth Reed explains that standard treatment for both alcoholism and drug addiction is premised on a male model: "[I]n many programs, a woman's experiences . . . may increase her difficulties . . . . Tactics that are used early in treatment, which were developed to help men face what they have long denied, may cause women with learned helplessness patterns to feel even more hopeless and out of control." 80

Without appropriate treatment, these women are not likely to break their addictions. Moreover, they remain fertile and capable of repeating the cycle with yet another pregnancy.

One might find consolation, if not justification, for such a policy if it protected the welfare of the children. Unfortunately, this is not the case. Nationally, the foster care system is in a state of crisis. A recent article described it as "a multibillion-dollar system of confusion and misdirection, overwhelmed by the profusion of sick, battered and emotionally scarred children who are becoming the responsibility of the public." 81 This crisis is the result of a precipitous rise in the number of reports of abuse, and in the number of children in foster care, coupled with a radical decline in the number of foster parents. 82

As a result, child protection agencies are strained to the point that they are unable to insure their wards' safety. 83 In Fall 1989, a class action lawsuit was filed against the Illinois DCFS on behalf of all children who have been or will be removed from their parents' custody. 84 The suit alleges that the DCFS has not placed the children in safe and stable

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80. Reed, supra note 27, at 151, 155.
82. See id. Reports of abuse have risen from 0.5 million in 1976 to almost 2.5 million in 1986. In 1980, there were 147,000 foster homes, while today there are only 100,000. Today's foster family averages more than three children per home, double the number in 1980. Id.
83. See Michael B. Mushlin, Unsafe Havens: The Case for Constitutional Protection of Foster Children From Abuse and Neglect, 23 HARV. C.R.-C.L. L. REV. 199, 207-09 (1988) (citing findings that 43% of foster children are placed in unsuitable foster homes and 57% of children in the foster care system are at serious risk of harm due to instability of care, lack of access to medical care, and high incidence of physical and sexual abuse).
homes, and that "plaintiffs frequently have been shuffled among six or more temporary living arrangements for two or more years and hundreds of them have been victims of neglect or abuse at an increasing rate." Mr. Benjamin Wolfe, one of the attorneys for petitioners, explains that case workers whose case load would normally be twenty to twenty-five cases per month now are assigned between eighty and one hundred cases. Case workers therefore are unable to supervise and protect the children in their care. A shortage of foster homes has led to the "warehousing" of children in overcrowded and dangerous shelters. The complaint cites a May 1988 incident in one such shelter, where an eight year-old child was raped by two twelve year-olds after the state "failed to respond to repeated and consistent reports that the institution was unable adequately to protect the children residing there."

The warehousing of children in temporary shelters is not limited to older children, but also is a common response to newborns who have tested positive for exposure to illicit substances. In Illinois, for example, the DCFS has a subcontract with Catholic Charities, which runs a foster care shelter in a former hospital on Chicago's North Side. Babies who are removed from their mothers because of a presumption of neglect are housed there pending either placement in a foster home or reunification with their families. The shelter provides for an average of forty babies at any given time, the overwhelming majority of whom are minorities. Placing these babies is difficult, both because of their race and their uncertain health status, but many of them do leave the shelter for "emergency placements." These placements are advantageous to foster parents because the reimbursement is significantly higher than that for ordinary temporary custody placement. There is, however, a thirty day limit on an emergency placement, so many of the babies cycle repeatedly into and out of the facility, deprived of consistency in caretakers and of any sense of a stable environment.

85. Second Amended Complaint at 2, Johnson, (No. 88 C 5599).
86. Telephone Interview with Benjamin Wolfe, staff attorney, Illinois Civil Liberties Union (Sept. 7, 1989).
87. Second Amended Complaint at 9, Johnson, (No. 88 C 5599).
88. During my visit there, on November 29, 1990, all of the babies were black, except one who was hispanic.
89. Bardon, supra note 81, at A1.
90. Interview with Sister Honora, Executive Director, Columbus-Maryville Children's Reception Center in Columbia, Ohio (Nov. 29, 1990).
IV. Child Abuse and Neglect Laws and the Pregnant Woman: A Case of Gender Discrimination

As a matter of public policy, applying child abuse and neglect laws to pregnant women who use controlled substances is short sighted and pernicious. As a matter of law, the practice violates common law principles and constitutional rights. The following section will provide a legal critique of this policy by analyzing it under current laws governing gender discrimination. The Minnesota law regarding reporting of prenatal exposure to controlled substances will serve as a model for this analysis.91

A. Pregnancy Based Discrimination and Heightened Scrutiny

The first step in analyzing a statute under the Equal Protection Clause is to determine whether it represents discrimination against a protected class and therefore merits heightened scrutiny.92 Because the Minnesota law is directed solely at pregnant women, it draws a gender based distinction and, thus, raises an equal protection issue. In the past, however, laws that discriminate against women but are based on biologi-

91. MINN. STAT. ANN. §§ 626.5561-626.5562 (West Supp. 1992). In pertinent part, the statute reads:

626.5561 Reporting of Prenatal Exposure to Controlled Substances
Subdivision 1. Reports Required. A person mandated to report ... shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. ...

Subd. 2. Local Welfare Agency. If the report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. ... The local welfare agency shall seek an emergency admission ... if the pregnant woman refuses recommended voluntary services or fails recommended treatment. 626.5562 Toxicology Tests Required
Subdivision 1. Test; Report. A physician shall administer a toxicology test to a pregnant woman under the physician's care ... to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose. If the test results are positive, the physician shall report the results. ...

Subd. 2. Newborns. A physician shall administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy. If the test results are positive, the physician shall report the results as neglect. ...

rical differences between the sexes have caused reviewing courts much consternation. For example, in *Geduldig v. Aiello*, the Supreme Court used a minimal rationality standard to analyze a California disability insurance policy that exempted coverage for normal pregnancy and child-birth. The Court refused to view a distinction based on pregnancy as a sex based classification, subject to heightened scrutiny. Instead, the majority reasoned that "absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis." While the Supreme Court has not faced an equal protection challenge of gender discrimination based on pregnancy since *Geduldig*, several factors make it likely that if a law governing the use of controlled substances by pregnant women were challenged as discriminatory today, it would be reviewed under heightened (or intermediate level) scrutiny.

First, Congress rejected the Court's approach in *Geduldig* by enacting the 1978 Pregnancy Discrimination Act, which established that workplace discrimination on the basis of "pregnancy, childbirth or related medical conditions" is tantamount to sex discrimination. Thereafter, the Supreme Court acknowledged that "for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex." The recent Supreme Court opinion in *UAW v. Johnson Controls*, a Title VII case involving employment discrimination, demonstrates the Court's present understanding of pregnancy based discrimination as sex discrimination in the workplace:

The bias in Johnson Controls' policy is obvious. Fertile men, but not fertile women, are given a choice as to whether they wish to risk their reproductive health for a particular job. . . . The court [of appeals] assumed that because the asserted reason for the sex based exclusion (protecting women's unconceived offspring) was ostensibly benign, the policy was not sex based discrimination. That assumption, however, was incorrect.

Even though the Pregnancy Discrimination Act has no bearing on the Court's interpretation of the Equal Protection Clause, it would be ludi-
crous for the Court to recognize pregnancy based discrimination as sex discrimination in the workplace, but not in other settings.

Second, statutes like Minnesota's make broader gender based classifications than did the statute at issue in Geduldig. For instance, while Geduldig dealt specifically with the permissibility of pregnancy based discrimination, the Minnesota law regulates the actions of all women of reproductive age. Specifically, by requiring reports on women believed to be pregnant and using drugs for a nonmedical purpose, the statute sanctions the state investigation and supervision of virtually all women, but not men. Thus, regardless of whether this discrimination is justified by virtue of women's unique capacity to bear children, it is undeniable that the law draws a line based on gender, requiring heightened scrutiny.

One might argue that, even if these laws discriminate against women, they do not do so intentionally, and therefore do not merit heightened scrutiny. The Supreme Court case of Personnel Administrator of Massachusetts v. Feeny limits heightened scrutiny to cases in which there is overt discrimination on the basis of sex or in which a facially neutral policy is intentionally adopted because of its discriminatory effect. Statutes like Minnesota's, however, explicitly govern the actions of pregnant women. This constitutes overt discrimination on the basis of sex, and therefore, these statutes should receive heightened scrutiny.

B. Protecting Fetal and Newborn Health: An Important Government Function?

Under the analysis of gender discrimination set forth in Craig v. Boren, in order to be constitutional, the purpose of the Minnesota law must represent an important government function, and the gender based distinction must closely serve to achieve that purpose. By classifying it under the state's child abuse and neglect law, the implied purpose of Minnesota's statute seems to be the protection of the health of fetuses and newborn babies. There is clear evidence that both licit and illicit substances can harm fetal development, potentially causing miscarriage or lifelong impairment. At first blush, then, it seems that causing such harm should constitute child abuse and should be prohibited by the child abuse and neglect statutes. However, the problematic nature of the statute's purpose of protecting fetuses is that, prior to viability, it is not clear

103. 429 U.S. 190 (1976).
104. Id. at 199-200.
105. Chasnoff et al., Temporal Patterns, supra note 42, at 1743.
that fetuses possess legal rights sufficient to permit state regulation of their mother's bodies.

Historically, the fetus had no rights independent of its mother, and thus, the common law barred recovery for injuries sustained \textit{in utero}.\footnote{106} In this century, suits based on harms inflicted prior to birth have been allowed, but only when the fetus survives and is live born.\footnote{107} The decisions allowing such recovery, however, do not recognize fetal rights, but instead focus "on the need for compensation of a living person wrongfully injured."\footnote{108}

Recently, some courts have recognized a child's "legal right to begin life with a sound mind and body."\footnote{109} This right does not reflect a state interest in protecting the fetus, but instead sidesteps the issue of the fetus' legal status by addressing the live born child. However, if this right is to have any beneficial impact on newborn health other than providing potential financial compensation for an injured newborn, a mechanism for protecting the well being of a developing fetus must be discerned. This is the heart of the legal dilemma. The only way to prevent harm to the fetus entails regulating maternal behavior, and such regulation infringes upon the mother's fundamental constitutional rights to liberty and privacy.\footnote{110}

In \textit{Roe v. Wade},\footnote{111} the Supreme Court addressed the conflict between these maternal rights and the state interest in the developing fetus' life in the abortion context. While the court, in dicta, recognized a state interest in fetal life, it indicated that it became "compelling" only at the point of viability, when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid."\footnote{112} Thus, while there may be a state interest in previable fetal life, it is never strong enough to overcome the mother's right to bodily integrity. She can choose to terminate the fetal life she carries at any point prior to viability.

\begin{itemize}
\item \footnote{106}{Dawn M. Johnsen, \textit{Note, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection}, 95 \textit{Yale L.J.} 599 (1986).}
\item \footnote{107}{See Bonbrest v. Kotz, 65 F. Supp. 138, 142 (D.D.C. 1946).}
\item \footnote{108}{Nelson et al., \textit{supra} note 64, at 733.}
\item \footnote{110}{Beginning with \textit{Griswold v. Connecticut}, 381 U.S. 479 (1965), the Supreme Court recognized a constitutionally guaranteed right to privacy. This right protects against state intrusion in intimate decisions, such as those involving contraception, procreation, marriage, and family. Additionally, numerous decisions protecting similar autonomy related interests have been grounded in the Fourteenth Amendment's right to liberty. \textit{See Laurence Tribe}, \textit{American Constitutional Law} 775 (2d ed. 1988).}
\item \footnote{111}{410 U.S. 113 (1973).}
\item \footnote{112}{\textit{Id.} at 160.}
\end{itemize}
Despite its amorphous nature, Roe's reference to a state interest in fetal life\textsuperscript{113} often is used as the basis for justifying forced medical treatment of pregnant women.\textsuperscript{114} This use of Roe's holding is inappropriate, since Roe v. Wade dealt with a woman's right to terminate her pregnancy, not with her duties toward a fetus whom she intended to carry to term.\textsuperscript{115} An argument founded on Roe v. Wade suffers from the sense of precariousness and incipient doom that presently surrounds that case. We may soon be left with a patchwork quilt of common law attempts to establish a pregnant woman's affirmative duties vis-à-vis her fetus.

One legal commentator, John Robertson, claims that the state interest in fetal life need not be grounded in Roe, but may be seen as the logical extension of child abuse and neglect laws. Robertson theorizes that the child abuse laws are evidence of a mother's "legal and moral duty to bring the child into the world as healthy as is reasonably possible."\textsuperscript{116} "Having decided to use her body to procreate, [a woman] loses the bodily freedom during pregnancy to harm the child."\textsuperscript{117} His argument is flawed for several reasons. First, as was discussed earlier, pregnant women, especially addicted ones, do not necessarily choose to get pregnant.\textsuperscript{118} Furthermore, pregnant addicts often discover they are pregnant well beyond the time when abortion is a safe, easy, and affordable option. More importantly, even if real reproductive choices were available to women, how could a right as fundamental as autonomy be waived without notice to the woman? Finally, in making this assertion, Robertson ignores the following key facts about child abuse and neglect laws: they establish no positive obligations, but instead serve only to set a minimum threshold beneath which parents may not fall; and they are based on well established legal duties owed by parents to their children while no such tradition of legally enforceable duties exists between a pregnant woman and her fetus.

\textsuperscript{113} The Supreme Court acknowledged only a limited state interest in fetal life, one sufficient to permit it to ban abortions in the third trimester, except when the woman's health is at stake. Id. at 163-64.


\textsuperscript{116} John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 VA. L. REV. 405, 438 (1983).

\textsuperscript{117} Id. at 442.

\textsuperscript{118} See supra notes 32-41 and accompanying text.
To date, courts have refused to apply child abuse laws to claims of “fetal abuse.” However, should the Minnesota law be enforced, the creation of such a claim will be the result. As of this writing, the Minnesota law has not been challenged. Moreover, no one at the Minnesota state level is tracking the reports that have been filed for restrictive measures imposed on pregnant women.

Because the Minnesota law draws a gender based line, it must represent an important government function. To the extent that laws like Minnesota’s are intended to protect the nonviable fetus from its mother, the governmental interest is at most tenuous and certainly hard to construe under present law as reflecting an important government function. Such regulation of women’s behavior, therefore, is unconstitutional.

Under present legal precedent, a state seeking to legislate in this area must limit its scope of protection to viable fetuses or newborns. One source of authority for such regulation lies in the state’s role as parens patriae, which refers to the “role of state as sovereign and guardian of persons under legal disability,” and requires that the state act to protect minors in the event that their guardians fail to do so effectively. However, the extent to which a parens patriae role enables the state to act affirmatively to further its interest in viable fetuses is unclear. The state’s interest, as defined by Roe v. Wade, prevents the abortion of a viable fetus unless the mother’s life or health is endangered. Roe does not establish a state duty to protect or enhance fetal well being beyond this minimal level. For purposes of this analysis, however, I will accept that the state has a legitimate and important interest in protecting the viable fetus and the newborn because of its parens patriae role. Given that the Minnesota law’s purpose derives from this important government function, the constitutional inquiry then turns on whether the gender based classification closely serves to achieve that purpose.

121. Telephone Interview with Judith Cook, Staff Counsel, Minnesota Civil Liberties Union (May 16, 1990).
122. Telephone Interview with Pamela Young, Women’s Coordinator, Chemical Dependency Division of Minnesota Department of Human Services (May 16, 1990).
126. The analysis herein is premised on Craig v. Boren’s holding that, in order to be constitutional, the purpose of a law creating a gender based distinction must represent an important government function, and the gender based distinction must closely serve to achieve that purpose. Craig, 429 U.S. at 200.
C. Laws Inferring Child Neglect From Suspected Use of Controlled Substances by Pregnant Women

States are applying child abuse and neglect laws to substance using pregnant women in two ways, both of which are seen in the Minnesota law. First, the law attempts to protect the fetus by requiring reports from those who know or suspect that a pregnant woman is using a controlled substance for a nonmedical purpose. Second, it construes a newborn's positive toxicology screen for a controlled substance as presumptive evidence of child neglect, and requires that both mother and child be reported to child protective services. In order to be constitutional, both of these applications must closely serve to achieve the government objective of protecting the viable fetus or newborn's health. This section will assess the constitutionality of regulating the behavior of pregnant women. The use of newborn toxicology screens will be addressed in the section that follows.

The impetus for laws equating maternal drug use with child neglect arose in response to evidence indicating that drugs ingested by a pregnant woman can cross the placenta and may affect the fetus. The extent to which various substances will harm the fetus is subject to much debate. Some experts claim that even minimal exposure may be harmful, while others find that many babies survive chronic exposure without evidence of harm. One major difficulty in linking drugs and poor pregnancy outcome is the compounding factor of poverty, which is tied to infant distress and mortality regardless of maternal drug use.

Fetal and newborn health is influenced by a broad matrix of social and environmental factors, the significance of which are well established and revealed in United States infant mortality statistics. A 1990 report by the White House Task Force on Infant Mortality noted that the national infant mortality rate is higher than in nineteen other countries, including Hong Kong, Ireland, Italy, and Singapore. The report also noted that the infant mortality rate of blacks is twice that of whites. The task force concluded that, "merely through the application of existing knowledge," the United States could prevent 10,000 infant deaths and save 100,000 infants from disabilities such as blindness, deafness, and mental retardation every year.

At work behind these statistics is the disabling influence of poverty. Poor maternal socioeconomic status obviously implies a higher likeli-
hood of poor nutritional intake, inadequate housing, and insufficient access to prenatal care, all of which are considered fundamental for assuring healthy pregnancies and healthy babies.\textsuperscript{131} A 1990 Chicago study of low birth weight, which is the primary risk factor in neonatal morality, found that residing in a very low income urban neighborhood so closely correlated with low birth weight in black women’s babies that even the presence of factors known to enhance fetal and newborn outcome (such as education, age, and marital status) failed to yield improved health.\textsuperscript{132}

In light of this data, a law attempting to enhance fetal and newborn well being by identifying pregnant women who use drugs and requiring them to undergo drug rehabilitation treatment evokes visions of the proverbial tail wagging the dog. Recall that in order to be constitutional, such a law must “serve important governmental objectives and must be substantially related to achievement of those objectives.”\textsuperscript{133} A brief analysis reveals not only that existing laws are poorly targeted at the underlying problem, but also that their effect is to hinder, rather than enhance, fetal and newborn well being.

The Minnesota law requires health care providers to file child neglect reports regarding women they “know or ha[ve] reason to believe” are pregnant and have “used a controlled substance for a non-medical purpose during the pregnancy.”\textsuperscript{134} The law provides no guidance for identifying these women, nor does it require screening all patients for substance abuse. Experts estimate that drug abuse may be the most commonly missed diagnosis in obstetrics, being overlooked in as many as 80\% of all cases.\textsuperscript{135} The predictable outcome of this law is to permit, if not encourage, health providers to report those with whom they associate drug use because of prevalent stereotypes or prejudicial beliefs. Clear evidence that this is occurring already exists. Despite the fact that pregnant women test positive for controlled substances at relatively equal rates regardless of race, black women are ten times more likely than

\begin{itemize}
\item \textsuperscript{131} PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS, supra note 26, at 4-5.
\item \textsuperscript{133} Craig v. Boren, 429 U.S. 190, 197 (1976).
\item \textsuperscript{134} MINN. STAT. ANN. § 626.5561(1) (West Supp. 1992).
\item \textsuperscript{135} Ira J. Chasnoff, Drug Use and Women: Establishing a Standard of Care, 562 ANNALS N.Y. ACAD. SCI. 208, 209 (1989).
\end{itemize}
The demand for consistent application of these laws becomes all the more compelling in view of the fact that laws like Minnesota’s focus not on the child’s health status, but instead, on the mother’s illegal conduct. Since the legal consequences to the mother do not vary with the child’s health status, but instead turn on the evidence of her drug use, there is no rationale to distinguish between the population now monitored by the law (poor pregnant women of color), and those left virtually untouched by it (white middle class pregnant women and all men).

Yet, when we try to imagine a law limiting custodial rights of white middle class men and women (for instance, testing men whose wives or lovers are pregnant, and forcing those who test positive to undergo substance abuse treatment—or simply severing paternal custody at birth), we recognize that such a policy would never be permitted. Laws like Minnesota’s may be politically tolerable only because members of the white middle class are effectively exempt.

Additional evidence that these laws are not substantially related to the government’s purpose lies in the severe shortage of treatment facili-

138. Id. at 1956.
ties for those women who are addicts. There simply are not enough treatment programs available, and the small minority of treatment programs that are willing to accept pregnant addicts are unlikely to provide the full range of services they need. The Minnesota law ignores this shortage so completely that it includes in its law a provision for “emergency admission” (i.e., civil commitment) of those pregnant women who refuse or fail the “voluntary” treatment made available to them.

Involuntary commitment for pregnant women who refuse drug abuse treatment services is extremely troublesome on both due process and equal protection grounds. Moreover, this law is not limited to pregnant addicts and, thus, could be applied as a form of punishment to pregnant women not needing treatment. This policy appears even more ridiculous in view of data demonstrating that the health status of incarcerated pregnant women is so poor that both the mother and the fetus are likely to suffer as a result of such confinement. Given the paucity of adequate treatment for pregnant addicts in either the public or private sector, it is hard to imagine that state run mandatory programs will receive sufficient funding to meet the demanding and comprehensive health care needs of this population.

In light of the foregoing, it seems evident that a law requiring health care practitioners to report pregnant women suspected of using drugs is, at best, remotely related to preserving or enhancing fetal health. The only plausible positive effect of such a law would be to scare women out of using drugs by threatening them with the loss of autonomy and the eventual loss of child custody. Yet those women who are addicts, and whose drug use therefore poses the greatest risk of harm to their fetuses, are the least likely to be able to quit in response to a threat.

A more predictable outcome of laws like Minnesota’s will be to create a profound disincentive for pregnant drug users to seek health care. Since the laws charge health care practitioners with monitoring their patients, they drive a wedge between the provider and the patient. While this same conflict of interest is present in other circumstances such as

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139. See supra notes 53-56 and accompanying text, regarding prenatal care, child care, parenting skills, self esteem, support, etc.


141. See, e.g., Batey & Garcia, supra note 14, at 99.

142. See Cole, supra note 11, at 2667 (“Pregnant women in jail are routinely subject to conditions that are hazardous to fetal health, such as gross overcrowding, 24-hour lock up with no access to exercise or fresh air, exposure to tuberculosis, measles, and hepatitis, and a generally filthy and unsanitary environment.”).

143. Recall that as early as 1962, the Supreme Court acknowledged that addiction was an illness and should not be treated as a crime. Robinson v. California, 370 U.S. 660, 666 (1962).
mandatory reporting of suspected child abuse, its operation is different in this case because prenatal care, unlike emergency treatment of injured children, is already foregone by so many women because of lack of access. A policy that drives women away from care, when the only established means of enhancing maternal and fetal well being is comprehensive health care, cannot be construed as closely related to the government purpose of protecting fetal and newborn well being.

Therefore, a law requiring the testing, reporting, and possible incarceration of pregnant women who use drugs fails to promote the government purpose of protecting fetal and newborn well being. Because such a law cannot be shown to be substantially related to the government purpose, the state lacks justification to support its overt discrimination on the basis of sex. The law is therefore unconstitutional.

D. Newborns, Positive Toxicology Screens, and Presumptive Neglect

Another method by which states have applied child abuse and neglect laws to the problem of perinatal use of controlled substances is testing newborns suspected of having been exposed to such substances in utero. Rather than using the Minnesota law's provision requiring newborn testing as an example, I will focus on an essentially identical Illinois law about which more information is available. As discussed in Part III.A. above, in August 1989, the Illinois state legislature passed a law requiring notification of the state DCFS whenever a newborn's blood or urine tests positive for an illicit substance. The law does not require that newborns be tested. Therefore, its effect is limited by the frequency with which health care practitioners fail to diagnose maternal drug use, as well as by the discretionary use of the tests.

The Illinois law is premised on a belief that a newborn whose mother ingested drugs while pregnant likely will be neglected in the future. The law thus permits the state to seize custody preemptively, rather than waiting for the child to be injured. There are two underlying assumptions which must be explored in assessing whether laws like Illinois' closely relate to protecting fetal or child well being: First, these laws assume that toxicology screens are an adequate proxy for establishing a presumptive case of child neglect; second, they assume that a child

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is better protected in state or temporary foster custody than with a natural mother who has used a controlled substance.

Drawing an inference of child neglect from a newborn’s positive toxicology screen initially might seem to be justifiable; after all, the test result proves that the mother ingested a controlled substance while pregnant. However, a more thorough consideration of what the test does and does not reveal about both maternal and child welfare demonstrates the inappropriateness of this inference. While a newborn’s positive toxicology screen may result from a pregnant woman’s chronic use of an illicit substance, a single exposure to a drug also can result in a positive screen. While a woman who uses an illicit substance once or twice during pregnancy may not have exercised good judgment, it is not clear that poor judgment constitutes grounds for revoking custody. Even though loss of custody presumably would be temporary in these cases, such a loss is not warranted under the child abuse and neglect statutes unless these women pose a threat to their children. Ms. Judith Rosen, the San Diego attorney who defended Pamela Rae Stewart,147 explains that, “one positive test ‘is only a snapshot at one point in time. . . . [It] doesn’t indicate [the mother’s] ability to parent, the extent of her drug abuse or the extent of her motivation to rehabilitate if she is an addict.’”148 Moreover, the policy of severing custody during the pendency of the informal investigation actually harms mother and child by eliminating the possibility of breast-feeding and by impeding mother-child bonding.149

While one problem with reporting laws based on newborns’ positive toxicology screens is that they catch women who may not pose significant threats to their children, perhaps a more striking problem is that they fail to identify many whose behavior clearly threatens their children. This problem is illustrated by the fact that the reporting laws address maternal use only of illicit substances, and ignore the tremendous body of evidence regarding the toxic fetal effects of alcohol and cigarettes.150 Therefore, the laws offer no protection to those newborns whose mothers are addicted to lethal, but licit, substances.

A more revealing omission is seen in the law’s focus on maternal drug use. The screen is not designed to identify babies who have been injured by maternal drug use; rather, it is designed to identify babies with

147. See supra notes 1-7 and accompanying text for a discussion of the Stewart case.
149. Interview with Dr. Lori Walsh, Chicago area Pediatrician, in Chicago, Ill. (June 9, 1991).
a drug using caretaker who is likely to deprive them or abuse them. Since both parents could deprive or abuse a child, information should be sought on male parents as well as female ones. Since the trigger for state intervention is contact with health care providers, all health care providers should be required to screen all patients of childbearing capacity for the presence of illicit drugs. All individuals who test positive should be required to show proof that their partners are not pregnant and that they do not have children. If they cannot do so, the state will need to take temporary custody of their children and investigate the household to see if the child's best interests are served by remaining there. Furthermore, this policy must apply to parents with a child of any age, as children of all ages can be abused or neglected by drug using parents. Before dismissing this suggestion as absurd, recognize that it is perfectly consistent with the policy underlying the newborn toxicology screening laws. The reason it would never be pursued is not because of logistical difficulties, but rather because of its infringement on male autonomy.

A toxicology screen reveals only that the child was exposed to an unknown quantity of an illicit substance at some point while in utero. It does little to estimate the potential harm a newborn faces from its home environment. It fails to reveal a host of additional factors with far greater bearing on fetal and child well being, such as the family's access to medical care, housing, and nutrition. As such, it constitutes a poor, clumsy, and inadequate instrument for predicting harm to children, and is only remotely related to the government's goal of protecting child welfare. Treating maternal drug use as the principal factor in determining child well being so ignores the glaring and devastating problems posed by poverty that it raises the question whether these laws are simply vehicles for punishing mothers rather than for protecting children.\textsuperscript{151}

Finally, since newborn toxicology screens are not mandatory, but rather are administered at the discretion of the health care provider, the same racial bias that generates ten times more prenatal substance abuse reports against pregnant black women than white women is left unchecked.\textsuperscript{152} Racism, whether benign or purposeful, is causing black chil-

\textsuperscript{151} For example, experts have estimated that an appalling 17\% of all urban children in the country have ingested potentially dangerous levels of lead. Maura Dolan, \textit{Study Finds Perilous Level of Lead in 20\% of Children}, \textit{L. A. TIMES}, June 2, 1989, § 1, at 1. Additionally WIC, a government program which subsidizes the costs of nutrition for women, infants and children, thus averting thousands of potential health problems, has suffered continual funding cutbacks which result in many women and children being removed from the program. \textit{Food Program for Poor Women, Children Cut Back}, \textit{REUTERS NEWS SERV.}, June 27, 1990.

\textsuperscript{152} See supra text accompanying note 23.
dren to be ripped away from their mothers, thus systematically dismantling the black community under the guise of child protection.\textsuperscript{153}

Even were the toxicology screen a perfectly sensitive test, and even were it administered across the population in a nonracist manner, and even were it based on a valid distinction between maternal and paternal drug use, it would still not be clear that equating maternal addiction with child neglect and severing custody are helpful, let alone closely related, to protecting and promoting child welfare. As the remarks in Part III of this Article indicated, viewing the nation’s foster care system as a safe haven for children is naive, for it is no longer the case that the care provided to children in state custody is, in fact, protective.

One would hope that the state removes from maternal custody only those newborns whose mothers’ addictions are so debilitating as to prevent them from caring for their children\textsuperscript{154} and whose extended families are unable to substitute as caretakers. However, stories like that of Theresa L.\textsuperscript{155} raise the suspicion that custody determination decisions may be made on irrational, subjective grounds.

More troubling than the unjustifiable temporary severing of child custody from women who indeed are capable of caring for their children—if it is possible to imagine anything more troubling than such injustice—is the effect of the system on women who are addicts and who will need help if they are to regain custody of their children. These mothers essentially have been abandoned by the state, despite its mission to keep foster care a temporary solution for families in crisis and despite its duty to work toward reuniting families.\textsuperscript{156} Because these women lack access to drug abuse treatment programs, there is little hope that they will be able to take the steps toward recovery needed to stabilize their own lives, let alone regain custody. Instead, they are returned to the same situations from which they came, and having been given no help in accessing services that might empower them to change their situations, there is no reason to believe that they will not become pregnant again.

\textsuperscript{153} I am thankful to Patricia Williams, Professor of Law at the University of Wisconsin, Madison, for her insight into this aspect of the child abuse and neglect paradox.

\textsuperscript{154} This is not to suggest that all children of addicted mothers should stay in the home. I simply question the wisdom of a policy that separates children from those capable and willing mothers who happen to have used controlled substances. The problems suffered by children of drug abusing parents are numerous and real, but they must be compared to the significant harms faced by children living in foster care. See supra notes 81-90 and accompanying text. Moreover, it is interesting to note that in all the years of studies on alcoholism’s effect on a family, no one has ever suggested removing all children from homes of alcoholic parents.

\textsuperscript{155} See supra note 70 and accompanying text.

\textsuperscript{156} Bardon, supra note 81, at A1.
The inevitable effect of the Illinois law was made clear to me in my visit to the Columbus-Maryville Children’s Reception Center, where Chicago babies who screen positive are held pending foster care placement. In the nine months that the facility has been operating, it has housed over three hundred newborns. Yet, during that time there have been only six visits from family members. Sister Honora, the facility’s director, expressed her confusion and dismay over this breakdown in family ties. When I asked her why more families didn’t visit, she remarked: “I refuse to believe that so many of these families just don’t care about their babies.” Instead, she thinks that a combination of ignorance, fear, and logistics combine to deter visiting. Many of the babies’ mothers still are using drugs and may spend much of their time pursuing their habits. Depending both on the extent to which she abuses drugs and on her skill at working through the bureaucratic morass of the state child placement agency, a mother may be totally unaware of her child’s location. Likewise, extended family members may find it exceedingly difficult to obtain the placement agency’s cooperation in tracking down a child in state custody.

Additionally, the publicity surrounding the issue of criminalizing perinatal drug abuse causes mothers a tremendous amount of fear. Sister Honora suspects that many of the mothers, especially those still using drugs, do not come to visit for fear they will be arrested.

Logistical problems also must be taken into consideration. Columbus-Maryville is on Chicago’s North Side, yet most of the babies in the facility come from homes located on the city’s South or West Sides. Therefore, visiting the facility, especially if travelling by public transportation, may entail a trip of over an hour and require several transfers. Add to this the fact that the visitor may be the caretaker for additional children, and it becomes apparent why there are not more family visits. It is simply too difficult.

Legally, the important question arising from this backdrop is whether the policy of testing newborns and seizing custody of those with controlled substances in their systems is closely related to the state purpose of protecting child well being. There are several reasons for finding that it is not. In addition to being an overly broad and crude proxy for discerning children at risk of neglect, this policy is applied in an arbitrary

157. Interview with Sister Honora, supra note 90.
158. Id.
159. Id.
160. Id.
161. Id.
and racist fashion against women and children of color. The system cannot be viewed as protecting newborns. At best, it takes them from one potentially harmful situation and places them in another.162

Anyone familiar with this issue knows that there are mothers who are so consumed by their addictions that they are unable to engage in even a minimally responsible level of childrearing. I do not maintain that newborns should be left with such mothers. However, the state interest in protecting child well being requires that the state identify these mothers with far greater specificity and do more for them than remove their children to institutions, thereby severing ties with extended family and leaving the children suspended in a world of temporary caretakers.

E. Gender Discrimination: From Difference Analysis to Dominance Analysis

Though the asserted state interest in addressing the problems deriving from perinatal drug abuse is to protect the health of fetuses and babies, it is apparent from the foregoing that applying child neglect laws to pregnant women will not accomplish this. Instead, these laws simultaneously punish women who use drugs during pregnancy and jeopardize fetal and newborn well being. The only plausible justification for subjecting women, but not men, to these laws is a belief that women have a unique capacity to harm a fetus by ingesting a controlled substance during pregnancy. As I already have demonstrated, that assumption is false; in fact, the developing fetus may be harmed by many external variables, including the environment (x-rays, battery acid, maternal exposure to cigarette smoke), the mother’s nutritional status and her access to health care, paternal alcohol consumption, and possibly paternal drug use as well.163 Furthermore, even if maternal drug use was significantly more damaging to the fetus than any other factor, that evidence would not, in and of itself, justify the differential application of these laws to women only unless the laws closely served to achieve the important government function of protecting fetal and newborn well being. As already demonstrated, they do not.164

More importantly, the focus on biological differences between women and men obscures the purpose of these laws entirely. The laws are supposed to be about protecting the health of babies whose health is affected by a broad variety of social and environmental factors.

162. See supra note 83 and accompanying text (discussing abuse of children in state custody).
163. See supra notes 6, 137 and accompanying text, and note 151.
164. See supra Part IV.B.
The tendency to justify differential treatment for men and women on biological bases is inherent in traditional Fourteenth Amendment discrimination analysis. As Catharine MacKinnon explains, this analysis is premised on a "sameness/difference" approach, the general thrust of which is that, "to the extent that women are no different from men, women deserve what men have."

In application to biological differences, this analysis reasons that "because there is no man to set a standard from which women's treatment is a deviation, there is no sex discrimination, only a sex difference." MacKinnon writes:

What sex equality law fails to notice is that men's differences from women are equal to women's differences from men. Yet the sexes are not equally situated in society with regard to their relative differences. Hierarchy of power produces real as well as fantasied differences, differences that are also inequalities. The differences are equal. The inequalities, rather obviously, are not.

MacKinnon suggests an alternative approach to traditional gender discrimination analysis: the "dominance" approach. Her model is derived from the race discrimination cases of the 1960s, which were "based on the realization that the condition of Blacks... was not fundamentally a matter of rational or irrational differentiation on the basis of race but was fundamentally a matter of white supremacy, under which racial differences became invidious as a consequence."

The crucial distinction between the difference approach and the dominance approach lies in the focus of judicial inquiry. A court analyzing a statute from a dominance perspective will focus not on the intentions of the state actors, but instead on the impact their actions have on particular social groups. This approach was central to the Supreme Court's decision in *Brown v. Board of Education*, which focused on segregation's effect on the "hearts and minds" of black children. The decision, according to commentator Laurence Tribe, reflects the Court's understanding "that racial segregation in public schools and other facilities in fact subjugates blacks, despite its appearance of symmetry, because it stands for and reenforces white supremacy—a regime we now

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165. Catharine A. MacKinnon, **Toward a Feminist Theory of the State** 220 (1989) [hereinafter MacKinnon, **Toward A Feminist Theory**].

166. Id. at 223.

167. Id. at 224-25.


169. Id.


171. Id. at 494.
recognize to be utterly at odds with the concept of 'equal protection of the laws.' "

Essentially, the dominance approach positions gender as an inequality first, then analyzes the socially constructed rules which purportedly derive from sex differences in terms of their tendency to keep gender inequality in place. Dominance analysis begins by examining women’s reality, or what I have called the context in which women live. From this perspective, the creation of “individual rights” in law is examined in terms of their effect on women’s lives. In this manner, laws which under traditional analysis appear to be gender neutral emerge as a discriminatory means of perpetuating the subordination of women.

An excellent example of this approach is seen in Sylvia Law's article, Rethinking Sex and the Constitution, in which she advocates a revised equal protection analysis of abortion-restrictive regulation. The article documents the ways in which pregnancy and childbirth profoundly shape women’s health, mobility, and independence, and shows how women are uniquely and significantly disadvantaged because they alone bear these burdens.

After demonstrating how abortion-restrictive regulations implicate equality concerns, Law posits a legal standard which acknowledges women's subordinated position in society and which is intended to limit state actions which enforce that inequality:

[L]aws governing reproductive biology should be scrutinized by courts to ensure that (1) the law has no significant impact in perpetuating either the oppression of women or culturally imposed sex role constraints on individual freedom or (2) if the law has this impact, it is justified as the best means of serving a compelling state purpose. Given how central state regulation of biology has been to the subjugation of women, the normal presumption of constitutionality is inappropriate and the state should bear the burden of justifying its rule in relation to either proposition.

As applied to laws addressing perinatal drug use, dominance analysis might proceed along the following lines. For reasons ranging from gendered norms in sexuality to relative economic powerlessness, women—especially those who are addicts—have little control over the circumstances of their sexual relations with men. This lack of control

172. Tribe, supra note 110, at 1477-78.
173. Id. at 42.
176. Id. at 955-56.
177. Id. at 1008-09; see id. at 1016-28 (applying this standard to abortion regulation).
178. See supra notes 29-33 and accompanying text.
extends to the use of contraception. As a result, they have limited control over their fertility and often experience unplanned or unwanted pregnancies. If a woman wishes to terminate her pregnancy, she will find access to abortion limited by cost and location. This is especially true if she is beyond the first trimester of pregnancy, if she lives in a rural area, or if she is a minor.

Pregnant women who are addicted to drugs require a broad spectrum of health care services ranging from prenatal care to drug abuse treatment, all of which are extremely costly, if they are available at all. More than one in four women of reproductive age are without health insurance for maternity care, and two-thirds of these women lack any medical insurance whatsoever. Poor pregnant addicts lack access to treatment not only because they lack the financial means to obtain treatment, but also because providers are reluctant to treat this population.

States applying child abuse and neglect laws to pregnant women who use drugs claim they are acting to protect fetal and newborn lives. Yet, such recognition of fetal and newborn rights implicitly diminishes women's autonomy. Applying Sylvia Law's proposed standard for analysis of gender based laws premised on reproductive differences between the sexes, the state must show either that the law does not perpetuate "the oppression of women or culturally imposed sex role constraints on individual freedom," or that the law "is the best means for meeting a compelling state purpose."

Laws like Minnesota’s, which require testing and reporting of pregnant women and newborn babies suspected of exposure to drugs, plainly contribute to the oppression of women. It subjects all women to the scrutiny of others, to the possibility of random drug (and pregnancy) testing by state officials, and to the loss of privacy entailed by such measures. It imposes sex role constraints on individual freedom both at a concrete level, by incarcerating pregnant women who use drugs, and

179. See supra notes 33-37 and accompanying text.
181. In addition to shortages of substance abuse treatment programs, many areas of the country are experiencing severe shortages of obstetricians. Hatlie, supra note 60, at 584 (noting that "67 counties in Georgia, 28 in Alabama and 19 in Colorado lack a single physician provider of obstetric care").
182. PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS, supra note 26, at 56.
183. See supra notes 59-61 and accompanying text.
184. Law, supra note 175, at 1017.
185. See, e.g., United States v. Vaughn, 117 Daily Wash. Rptr. 441, 442 (D.C. Super. Ct. 1989) (cocaine addicted pregnant woman, convicted of forging a check, was incarcerated for the term of her pregnancy; presiding judge acknowledged that ordinarily the defendant would
in an abstract sense, by perpetuating the myth that the health of newborns is solely a function of maternal restraint during pregnancy.

Even if a law oppresses women, Professor Law's test will permit it if it is the best means of meeting a compelling state purpose. As my earlier analysis indicates, these laws do not meet the intermediate standard of being "closely related to an important state interest." Therefore, they cannot pass this strict review. It is by no means clear that the state possesses a compelling interest in fetal life. Even if it did, these laws are far from the best means of protecting that interest. As discussed above, the effects of these laws will be: to drive pregnant women away from treatment that might help both themselves and the babies they carry; to separate children from their mothers; to dump the children into the bureaucratic morass of the foster care system; and to leave the mothers without access to the services they need to be reunited with their children.

The present policy, one of polarizing maternal and fetal rights and attempting to tip the balance in favor of protecting the fetus, not only leads to pernicious outcomes, such as women avoiding the few health care services available to them, but also operates to perpetuate gender inequality. Women remain outside the health care system, vulnerable to a cycle of unwanted pregnancies, state regulation of their bodies during pregnancy, and the loss of their children or families after delivery. These results are so removed from the asserted state goals that they render the laws irrational and therefore unconstitutional under any standard of review.

V. Concluding Remarks: Notes for the Development of a Healthy Alternative

Over fifteen years ago, Adrienne Rich observed that, "[t]he value of a woman's life would appear to be contingent on her being pregnant or newly delivered." To the extent that society's sudden obsession with pregnant addicts can be called a "value," Rich is correct. The problem of treating addiction in women was largely ignored until evidence

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187. Examples of such services include health care, appropriate substance abuse treatment programs, and child care.
showed that the harmful substances they were ingesting crossed the placental boundary. In other words, no attempt was made to develop treatment programs for women until society became worried about female addicts who were mothers. "In 1979, after a half decade of encouraging treatment programs to recognize and provide for the specific needs of addicted women, [the National Institute on Drug Addiction] surveyed those drug treatment programs which described themselves as specifically geared to female addicts." Nationwide, only twenty-five such programs were found; of these, more than half reported no provision of gynecologic care, and three-quarters gave no contraceptive counseling.

The logical alternative to addressing the problem of perinatal drug use through an ineffective, unconstitutional policy based on threats and coercion is to encourage addicted women to obtain treatment. But treatment that truly is designed to meet the needs of this population is only now being developed. In order to discuss the content of an appropriate or progressive policy I return to the question I raised at the end of Part II: Does treatment work? For pregnant addicts, this question cannot be answered with certainty because aside from several excellent, small scale programs we have yet to try it. However, some consistent findings arising from research on the success of standard male oriented treatment programs may be of use in designing treatment for addicted women.

Most treatment evaluation research focuses on alcohol addiction. The highest reported success rates among alcohol treatment programs are found in multicomponent programs. These integrate traditional Alcoholics Anonymous therapy with occupational and recreational therapy, individual and group counseling, medication, and after care. One such program, the Hazelden program in Minnesota, shows 43% of the original patient population abstinent at one year post-treatment.

189. Chavkin, supra note 58, at 485.
190. Id.
191. As for evaluations of women in treatment, Beth Reed notes that "(t)here is still very little . . . that examines the outcomes associated with different types of services, or whether . . . matching women's needs with particular types of services or programs produces better outcomes . . . ." Reed, supra note 27, at 152. Furthermore, in studies of drug dependent treatment models, "[w]omen were either ignored, combined with men for data analysis, assumed to be the opposite of men, or their results were so puzzling that they were called unpredictable and thus, not interpreted." Id. But note that the Hutzel Recovery Center, Dr. Ira Chasnoff, and others are reporting success in programs that integrate prenatal care, child care, housing, and drug rehabilitation. See Kathleen Teltsch, In Detroit, a Drug Recovery Center that Welcomes the Pregnant Addict, N.Y. TIMES, Mar. 20, 1990, at A14; see also Interview with Dr. Ira J. Chasnoff, supra note 56.
192. PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS, supra note 26, at 185.
193. Id.
Although it was not directed at women, and certainly did not include pregnant alcoholics among its population, Hazelden's attempt to meet the addict's full range of needs through a multicomponent approach is consistent with the evidence regarding the diverse needs of women addicts.

A second significant finding is that motivation to quit plays a key role in addiction recovery. Because the drug abuse treatment community "has no idea how to work with women (or any patients) not ready to acknowledge their substance abuse problems," Reed advocates social changes that would at least facilitate entry into treatment, if not motivate a desire to end dependency.

Among the barriers women face to entering treatment are the lack of economic resources and the burden of child related responsibilities. In addition, there are barriers to engagement in treatment, primarily arising out of the psychosocial make-up of drug dependent women. Finally, chances of long term abstinence and an improved quality of life are hindered by the lack of meaningful roles available to women upon completion of the program. Therefore, Reed would include assertiveness training and skills for autonomous living, in addition to the general vocational training and therapy provided by the treatment program.

A cynic might respond to all of this by claiming that there is no reason to believe that treatment, even if perfectly tailored to meet women's needs, will work. While the cynic may be correct, this observation does not really take us anywhere. The fact remains that, unless society wishes to pursue a sterilization campaign, no other "solution"—neither criminalization nor child abuse and neglect laws—addresses the fact that addicted women of reproductive age will continue to use drugs and will continue to bear children.

Ever since the story of Pamela Rae Stewart made headlines, calls for draconian measures against pregnant women who behave in a manner that is less than altruistic have proliferated. It is as if these pregnant

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194. For example, recent data from smoking cessation programs show that much higher success rates exist among those who quit smoking on their own (48%) as opposed to through cessation programs (24%). Michael C. Fiore et al., Methods Used to Quit Smoking in the U.S.: Do Cessation Programs Help?, 263 JAMA 2760, 2765 (1990); see also PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS, supra note 26, at 193 (discussing patient motivation as a factor in successful alcohol treatment).

195. Telephone Interview with Beth Reed, supra note 33.


197. Id.

198. Id.
women had somehow betrayed society, when in reality it is society that has betrayed them.

The image of the pregnant drug user as a betrayer, as one whose interests are diametrically opposed to those of her fetus, as one who will intentionally harm her fetus unless stopped by the state, surely is a seductive one. It requires only that we purge society of these bad women, rather than forcing us to address the more troubling issue of why drug abuse is so prevalent in this country. However, it is also a pernicious image. To the extent that such an image drives public response, laws and policies will continue to discourage pregnant addicts from seeking out the medical care they so desperately need. Therefore, it is incumbent upon those of us familiar with the problems women face generally and with their lack of access to prenatal care and drug abuse treatment to make our voices heard.