

THE CRIMINALIZATION OF PREGNANCY: RIGHTS, DISCRETION, AND THE LAW

by

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## ABSTRACT OF THE DISSERTATION

The Criminalization of Pregnancy: Rights, Discretion, and the Law

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In my dissertation I conduct an inquiry into the legal phenomenon of pregnancy-specific crime. I discuss my theory of pregnancy exceptionalism in US jurisprudence, explore whether these laws are applied evenly in the population, and if not, why, and ultimately ask how, when, and if the law matters in practice. In order to answer these questions, I analyze pregnancy related US Supreme Court opinions to understand the court's interpretation of the constitution as it relates to pregnant or potentially pregnant women. Next, I conduct a systematic analysis of state bills and statutes creating pregnancy-specific crimes, with an emphasis on the prosecution of pregnant women for crimes against the fetuses they gestate. Then, I examine arrest cases of pregnant women for crimes against their fetuses in the three states where such crimes have been officially codified: South Carolina, Alabama, and Tennessee. Next, I present my analysis of interviews with prosecutors involved in developing these punitive policies, in order to understand their motivations for doing so. This project addresses the treatment of pregnant women as a separate

class of person with reduced legal status. While pregnancy exceptionalism defines all pregnant women as a separate class, it is clear that some women are targeted more than others.

## Table of Contents

Abstract.....	ii
Chapter 1. Introduction.....	1
Chapter 2. “The limitations which this statute places upon her... are not imposed solely for her benefit, but for the benefit of all.”.....	12
Chapter 3. “The dead babies may be the lucky ones.”.....	28
Chapter 4. Pregnancy Specific Crime and the Peril of Protection.....	40
Chapter 5. Case Studies of Pregnancy-related Arrests in Three States.....	62
Chapter 6. Wielding the Velvet Hammer.....	97
Chapter 7. Conclusion.....	119
References.....	127
Court Cases.....	133
Appendix.....	134

## ***Chapter 1. Introduction***

In 2011, a 25-year-old woman named Heather Capps gave birth to a healthy baby boy via cesarean section (Calhoun 2012). Heather was addicted to oxycodone, and her newborn baby tested positive for the drug after birth. She had heard about a local policy ordering the prosecution of women who used drugs during pregnancy on the basis that their drug use constituted a form of child abuse. She had also heard that the withdrawal symptoms from quitting the oxycodone could be dangerous for her pregnancy. She needed help. Heather was referred to an inpatient drug treatment facility located nearly an hour and a half drive away from her home, but with her two young children at home, inpatient treatment was not an option. Seeing no other solutions, Heather decided to gradually taper down her drug use and take the lowest possible dose to try and reduce harm to her unborn baby. Two days after she gave birth, and still recovering from her cesarean section, Heather was arrested at the hospital. She spent the next three months in jail, separated from her newborn and her two other children, unable to post \$500,000 bail.

Throughout the United States, pregnant women have and continue to face charges for committing crimes against the fertilized eggs, embryos, and fetuses that they gestate. Women who test positive for drugs during or immediately after pregnancy, women who survive suicide attempts but lose their pregnancies, women injured in car accidents who have stillbirths or miscarriages, for example, face the possibility a lengthy prison sentence. Three states, South Carolina, Alabama, and Tennessee, have explicitly criminalized maternally-mediated harm to fertilized eggs, embryos, or fetuses. Yet, arrests of pregnant women for crimes against their own pregnancies have been made in almost every state. These arrests have occurred in the absence of any declarative criminal

law, and even in the presence of statutes specifically excluding the application of a such laws to pregnant women and their fetuses.

The criminal prosecution of pregnant women for crimes against the fertilized eggs, embryos, and fetuses they gestate relies on a legal understanding that pregnant people are legally distinct from other kinds of persons. Typically, a positive drug test at a doctors' office cannot be legally shared with law enforcement personnel, but pregnant and newly postpartum women have been arrested after their healthcare providers report a single positive drug test. Generally, adults who survive a suicide attempt are not criminally prosecuted, but pregnant and newly postpartum women have been charged with felonies when they survive. Pregnant women are being held criminally accountable for actions and behaviors that would otherwise be legal, or at least, non-prosecutable, such as drinking a beer, smoking marijuana, or taking their legal prescription medication. Pregnant women have also been presented with charges that are far more severe than the illicit behavior would typically warrant. For example, a pregnant woman who is caught in possession of methamphetamine might be charged with unlawful neglect of a child or delivery of drugs to a minor instead of drug possession. Pregnant women occupy a different space in the United States system of criminal law.

These examples of differential treatment are not limited to the criminal justice system. Pregnant women are treated differently and can face limitations on their fundamental rights in a variety of areas, because of the fact of their pregnancies. I call this *pregnancy exceptionalism*—pregnancy, *ipso facto* reduces the legal status of the pregnant person. The different reproductive anatomy of women, especially their potential (assumed or actual) ability to gestate children has been presented as a dilemma for the

advancement of women's equality in law. How can men and be treated equally when they are biologically different? As Kenney writes, "'If women are different from men,' society 'can treat them less favorably'" (quoted in Baer). Historically, these differences have been used to reduce the legal status of women as a class, either by legally addressing women and men identically, or by addressing them differently. Sex-neutral law may result in identical treatment with different impact. For example, banning abortion for both males and females will have a disparate impact on females. Shackling both male and female prisoners will have a more punitive effect on females who can become pregnant. Sex-conscious law, might address the above issues. Because the sexes, especially when one experiences pregnancy, are not similarly situated, differential treatment on the basis of sex is not necessarily discriminatory, but it may open the door to a host of other inequities. A person may be forced to submit to invasive medical procedures that would be considered unconstitutional if not for her pregnancy. A pregnant woman found to be out of control may be detained without a criminal trial for the duration of her pregnancy. A pregnant woman who is brain dead or in a persistent vegetative state may be kept on life-support until the fetus has sufficiently developed to survive outside of her uterus, in violation of her advanced medical directive.

This choice between sameness and difference in legal treatment is a false one. Baer writes, "Our gender-neutral law of reproductive rights treats women worse than men, but so did "protective" labor legislation. Conversely, both gender-neutral and gender-specific laws can promote sexual equality." MacKinnon notes,

"Affirming differences sometimes has, in any case, not overcome the imposed homogeneity and affirmation of privilege of the sameness mode. If 'same treatment' for sameness has offered an illusory equality, 'different treatment' for differences has



been demeaning and dangerous, at times catastrophically so.”

As MacKinnon puts it, “If the point of equality law is to end group-based dominance and subordination, rather than to recognize sameness or accommodate difference, a greater priority is placed on rectifying the legal inequality of groups that are historically unequal in society, and less priority is accorded to pure legal artifacts or rare reversals of social fortune.”

Much of the work on the reproductive rights has centered on the right to abortion. While certainly important, the regulation and control of pregnant women is not limited to women who seek to end their pregnancies. In the 1980s and 1990s, organizations dedicated to the reproductive health of women of color, and of Black women specifically, noted the shortcomings of the bipolar “pro-life” and “pro-choice” framing of the fight over reproduction, arguing that it “masked the ways that laws, policies, and public officials punish or reward the reproductive activity of different groups of women differently” (Ross 2006). These organizations emphasized the importance of a more holistic and expansive view of reproductive health, including issues that disproportionately impact poor women and women of color, such as forced sterilizations and sexually transmitted infections like HIV. The leader of one of these organizations, Loretta Ross, called this more expansive view “reproductive justice,” defined as “reproductive health integrated into social justice” (Ross 2006). Women who intend to carry their pregnancies to term, give birth, and parent their children face an obstacle course of laws and regulations that limit their reproductive autonomy. State regulation of abortion and of continued pregnancy and birth are two sides of the same coin. I adopt the

reproductive justice framework to expand the scope of the conversation on reproductive law, asking what rights might a woman lose upon becoming pregnant.

Several studies have identified and discussed the arrests of pregnant women for crimes against the fertilized eggs, embryos, and fetuses they gestate (*see* Kolder, Gallagher, and Parsons 1987; Gallagher 1987; Roberts 1991; Paltrow et al. 1992; Daniels 1996; Gómez 1997; Ikemoto 1998; Nelson and Marshall 1998; Roberts 1997; Adams, Mahowald, and Gallagher 2003; Cherry 2007; Samuels et al. 2007; Fentiman 2006 and 2009; Flavin 2009; Cantor 2012). A study conducted by Paltrow and Flavin (2013) identified and analyzed 413 arrests or detentions of pregnant women for crimes against the fetus made from 1973-2005. They found dramatic disparities in the race and socioeconomic status of the women who had been arrested, and found that arrests or detentions had been made in 44 states. Since 2005, four more states have joined the ranks, making Delaware and Vermont the only states in which arrests and detentions have not been identified.

During the bracketed span of time included in the Paltrow and Flavin study, only one state—South Carolina—had explicitly criminalized a pregnant woman’s conduct as it relates to the fetus. Subsequently, two additional states, Alabama and Tennessee, have also formally criminalized a pregnant woman’s conduct—Alabama in 2013 and Tennessee in 2014. The legal developments in Alabama and Tennessee allow for a further study of arrests of pregnant women over time, and in varied legal contexts, allowing for a comparison of pre-and post-formal codification prosecutorial behavior. My project contributes to the literature on the prosecution of pregnant women by engaging in a detailed analysis of all pregnancy-related arrests prior to, and after, formal codification

in the only three states to explicitly criminalize a pregnant woman's actions with regard to her pregnancy. In this way, it will be possible to examine arrest and prosecution patterns, what motivated the arrests, and what the impact of these arrests has been for pregnant women.

In my dissertation, I examine *pregnancy exceptionalism* through the lens of pregnancy-specific crime. I focus on arrests of pregnant women made in South Carolina, Alabama, and Tennessee, as these are the only three states to explicitly criminalize the actions of pregnant women with regard to the fertilized eggs, embryos, or fetuses they gestate. By examining arrests of pregnant women in a context where there is no legal foundation for making arrests (arrests made in the three states prior to formal codification), and then in a context where the action has been explicitly criminalized, I will be able to make comparisons about the impact of criminalization on actual legal practice. If pregnant women can be arrested in the absence of, or even in defiance of, existing criminal law, it begs the question: does the law really matter? After providing a detailed image of the status of law surrounding pregnancy and crime in the United States, and taking aim at the general tendency to define pregnancy as separate and unique in US jurisprudence, this study also makes a critical intervention into the relevance or irrelevance of law in governing the reproductive lives of pregnant women.

*In this study, I ask:* What does current state and federal law say about pregnancy-specific crime? What was the formal codification process for charging pregnant women with crimes against the fertilized eggs, embryos, or fetuses they gestate? How are those laws carried out, and does formal codification have an impact on the criminalization of

pregnancy? Who started these policies, and what were their motivations and goals for starting the policies?

By answering these questions, I will be able to better understand how women are conceptualized and dealt in both law and legal practice—in this case, how the law considers the actions of pregnant women in relation to the fertilized eggs, embryos, and fetuses they gestate. The criminal prosecution of pregnant women, as a legal issue, encompasses the suspension of many fundamental rights, and arguably embodies many legal areas that historically have excluded women, including pregnancy-protective labor employment restrictions, fetal personhood, due process, equal protection, medical privacy, liberty, and reproductive rights.

### **Methodology:**

In this study, I use mixed-methods research to address these questions. The benefits of using mixed-methods are numerous. Greene et al. outlined five strengths of multi-method research, including triangulation, complementarity, development, initiation, and expansion (1989). Madey writes that “combining quantitative and qualitative research helps form a conceptual framework, to validate quantitative findings by referring to information from the qualitative phase of the study, and to construct indices from qualitative data that can be used to analyze quantitative data” (Cited in Onwuegbuzie and Leech 2005). Mixed-methods research can also provide a “bi-focal” lens allowing for study at both the macro and micro level (Willems & Raush 1969).

### **Organization of the Dissertation**

*Chapter 2. “The limitations which this statute places upon her... are not imposed solely for her benefit, but also largely for the benefit of all.”*

In this chapter I present a legal foundation for pregnancy exceptionalism in US jurisprudence, examining labor regulations for pregnant women, eugenic policies, and privacy law around the right to abortion. I show that the state has long expressed an interest in pregnancy and reproduction, and that it has sought to pursue those interests under the umbrella of ‘protecting’ women from exploitative labor practices and prohibiting reproduction in certain communities of ‘undesireables.’ Indeed, even in court decisions that expanded reproductive rights like *Roe v. Wade*, the state interest in regulating pregnancy is preserved.

*Chapter 3. The dead babies may be the lucky ones.*

Next, I explore the collision of pregnancy exceptionalism and the War on Drugs, showing how contemporary drug crises have exercised a specific focus on prenatal substance use and maternally mediated fetal harm. Pregnant drug users were maligned and villainized. Not only were these women behaving in ways that are seen as the antithesis of true motherhood, but they were responsible for spawning ruined generations of children that would drain state resources and grow up to be unproductive members of society.

*Chapter 4. Pregnancy-specific Crime and the Peril of Protection*

In this chapter I discuss my analysis of all bills introduced in the states that would create pregnancy-specific crimes from 1973-2016. These were divided into three types: first, are laws that extend victimhood status to the fetus. Second, are laws that define the pregnant woman as a special kind of crime victim. Third, are laws that explicitly criminalize a pregnant woman’s behaviors as they might impact the fertilized egg, embryo, or fetus that she carries. I show how laws originally framed by the need to

protect pregnant women from brutal violence have ultimately grown into laws meant to punish these very same women in the name of protecting the fetus.

#### *Chapter 5. Case Studies of Pregnancy-related Arrests in Three States*

In this chapter I analyze all known cases in which a pregnant woman was arrested for a pregnancy-specific crime in Alabama, South Carolina, and Tennessee, from 1973-2015. I code these cases for variables, including the race, income level, county of residence, place of arrest, and pregnancy status of the defendant. I also code for case outcome, bond level, lawyer type, whether the defendant was receiving public assistance, and what action was cited as leading to the arrest. I contextualize these demographic variables with state and county level census data on race, income, state and county level data on drug-related crime, state and county level medical data, including emergency room admissions for overdoses, drug treatment admissions, and maternal and infant mortality and morbidity rates, and with substance use data from the Substance Abuse and Mental Health Services Administration (SAMHSA).

#### *Chapter 6. Wielding the Velvet Hammer*

In this chapter I discuss and analyze my interviews of actors involved in reporting and prosecuting pregnant women. We discussed their motivations, goals, strategies and challenges. Prosecutors are left with a great deal of discretion over when and how the policy to charge pregnant women is applied. Prosecutors tended to focus on certain kinds of highly stigmatized and politically salient controlled substances. The prosecutors I spoke with hoped to use their authority to solve the problem of prenatal substance use in the absence of other resources. With cooperation between healthcare providers, social workers, police, and judges, the introduction of official laws wasn't necessary—so long

as the parties involved were willing to extend legal personhood to the fetus. Sometimes, however, there were unexpected negative consequences, including incentivizing abortion and discouraging patients from accessing medical care.

### *Chapter 7. Conclusion*

In this chapter I draw out the potential consequences of the criminalization of pregnancy for women's rights, including the right to medical privacy, due process, equal protection, and liberty. I discuss how even seemingly benevolent laws concerning pregnant women can ultimately lead to uniquely punitive treatment, and can even result in a reduction of the personhood of pregnant and potentially pregnant women as a class. Finally, I discuss some solutions to addressing the problem of prenatal substance use that do not have the effect of undermining the rights of pregnant women.

#### **Definition of Terms:**

*Pregnancy-specific crime-* in this study, I use the term “pregnancy-specific crime” to describe criminal laws dealing with crimes against pregnant women or unborn children. There are three general types: 1. Harm committed against a pregnant woman 2. Harm committed against an unborn child 3. Harm committed by a pregnant woman against her unborn child. So, for example, if a pregnant woman is found to be in possession of a controlled substance, and she is charged with possession of a controlled substance, the case would not be included in the study. If a pregnant woman in possession of a controlled substance is charged with, endangering her ‘unborn child,’ the case would be included in the study.

*Prosecution of pregnant women-* for consistency and brevity I will use this phrase to describe the prosecution of pregnant women for crimes against the fertilized eggs,

embryos, or fetuses that the pregnant woman gestates. In most cases, the women are arrested immediately post-partum, but their charges are based on conduct that occurred while they were pregnant. As such, I will generally use the term “pregnant woman” to describe a defendant, whether or not she is currently pregnant when she charged.



***Chapter 2. “The limitations which this statute places upon her...are not imposed solely for her benefit, but also largely for the benefit of all.”***

Women, as a class, have been defined as distinct from others in the United States legal system. While voting rights, educational rights, and protections from workplace discrimination for women are currently in place, women continue to be defined as an exceptional case justifying the suspension of otherwise fundamental rights in a variety of legal areas. The gestational abilities that many women possess has, historically, provided a legal basis for the suspension of equal protection, due process, liberty, privacy, and other rights. Even in areas where women’s rights and legal personhood have been expanded in recent decades, these laws have been shaped and influenced by an ideology that defines pregnant women a lower class of person. I call this pregnancy exceptionalism.

In this chapter I trace the roots of pregnancy exceptionalism in United States jurisprudence. I analyze exceptions to Lochner Era anti-labor regulation made on the basis that women are the weaker sex, unable to negotiate contracts like their male counterparts, at great peril to their gestational abilities and the quality of their potential offspring. I discuss the emergence of an explicit state interest in reproduction, and the invocation of this interest to justify the suspension of the fundamental rights of those deemed unfit to reproduce. I also discuss the reiteration of this state interest in controlling reproduction, even as the rights of women to access abortion and contraceptives were expanded. Next, I analyze and discuss how this state interest in controlling the reproductive capabilities of pregnant women crashed into the War on Drugs, showing

how contemporary drug crises have been accompanied by a specific focus on prenatal substance use and the possibility of maternally mediated fetal harm.

### **Maternal Protection**

In 1905, the United States Supreme Court gave its opinion in *Lochner v. New York*. The case concerned the constitutionality of the Bakeshop Act, a state law that limited the maximum working hours for bakers. Lochner, the owner of multiple bakeries, challenged the Bakeshop Act on the basis that maximum hours regulations were an unconstitutional limitation on the right to contract, violating the right to privacy and due process under the 14th Amendment. New York argued that the Bakeshop Act was passed in the interest of promoting public health, but the court's majority opinion asserted that this was merely a labor law in disguise, siding with Lochner and striking down the law.

The court asserted,

“there is no reasonable ground, on the score of health, for interfering with the liberty of the person or the right of free contract, by determining the hours of labor, in the occupation of a baker. Nor can a law limiting such hours be justified as a health law to safeguard the public health, or the health of individuals following that occupation.”

New York claimed that commercial baking, a predominantly male occupation, was in need of state regulation in the interest of promoting public health. The state asserted that long work shifts in poorly ventilated, hot, and dusty industrial bakeries not only endangered the health of bakers, but of bread consumers as well. The court found, however, that this risk was not significant enough to justify the regulation of the profession, as it curtailed the rights of bakers to contract their working hours with their employers freely.

This case marks the beginning of what is called the *Lochner* Era.<sup>i</sup> In the decades that followed this case, the Supreme Court applied substantive due process to labor regulation, striking down regulatory and protective laws on the basis that laborers and employers are equally free to negotiate, and that infringing on the right of these parties to create contracts is unconstitutional. The Supreme Court of this era has often been accused of overstepping the proper role of the court— exercising their laissez-faire activism rather than interpreting the constitution (Gillman 1993). The court struck down legislation regulating foreign corporations,<sup>ii</sup> banning yellow-dog contracts,<sup>iii</sup> regulating child labor,<sup>iv</sup> and regulating the coal industry,<sup>v</sup> among other things. However, as I shall discuss below, the *Lochner* Era court made some exceptions to its anti-regulation rule. When presented with laws imposing regulations on the right of women to contract, the court found in favor of regulation.<sup>vi</sup>

Only three years after the *Lochner* opinion, the Court upheld an Oregon law that set limits on the number of hours that women were permitted to work (*Muller v. Oregon* 1908). Like the Bakeshop Act, the Oregon law was passed with the stated purpose of

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<sup>i</sup> In reality, the *Lochner* Era started several years earlier, in *Allgeyer v. Louisiana* (1897). This is the first case in which the Supreme Court found the word liberty to mean financial liberty.

<sup>ii</sup> *Allgeyer v. Louisiana* (1897)

<sup>iii</sup> *Adair v. United States* (1908); *Coppage v. Kansas* (1915)

<sup>iv</sup> *Hammer v. Dagenhart* (1918); *Bailey v. Drexel Furniture Co.* (1922)

<sup>v</sup> *Carter v. Carter Coal Company* (1936)

<sup>vi</sup> But, see *Adkins v. Children's Hospital of DC* (1923). Justice Sutherland asserted that *Adkins* was fundamentally different from *Muller*, in that the maximum hours law in *Muller* still permitted employees to negotiate their wages, whereas the minimum wage law in *Adkins* did not, restricting the employer in negotiating employment contracts. Additionally, Sutherland asserted that the passage of the 19th amendment had essentially erased the differences between women and men, and as such, the special protection given to women in the *Muller* decision was no longer necessary.

promoting public health, one of the few instances in which the state was allowed to use its police powers to regulate private business.<sup>i</sup> The majority opinion in *Muller* read that though the maximum hours law for the bakers in *Lochner* “was not, as to men, a legitimate exercise of the police power of the state, but an unreasonable, unnecessary, and arbitrary interference with the right and liberty of the individual to contract in relation to this labor,” that this precedent was not applicable to the Oregon law. *Lochner* did not apply, because to do so would “[assume] that the difference between the sexes does not justify a different rule respecting a restriction of the hours of labor.” Allowing women to work shifts longer than ten hours was a threat to public health, safety, morality, and general wellbeing. Due to their “physical structure” and “performance of maternal functions,” women were at a disadvantage and required state intervention and protection.

The court wrote:

“[a]s healthy mothers are essential to vigorous offspring, the physical wellbeing of woman is an object of public interest. The regulation of her hour of labor falls within the police powers of the State, and a statute directed exclusively to such regulation does not conflict with the due process or equal protection clauses of the Fourteenth Amendment. The right of a State to regulate the working hours of women rests on the police power and the right to preserve the health of the women of the State, and is not affected by other laws of the state granting or denying to women the same rights as to contract and the elective franchise are enjoyed by men.”

The court articulated several key arguments used to justify the regulation of women as a class of laborers. Women were generally found to be incapable of bargaining or otherwise making claims for themselves in job markets. This argument was made on both biological and sociopolitical grounds. The former stated that women, much like children, occupied a secondary class, and were incapable of self-dependence: “As minors,

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<sup>i</sup> Other exemptions to the prohibition on labor regulation included safety, morality, and “general wellbeing.”

though not to the same extent, she has been looked upon in the courts as needing special care that her rights may be preserved.” As such, the state had a responsibility to intervene and create protections for women in the interest of public health and general wellbeing.

The court stated that the maximum-hours law was reasonably related to women’s health:

“Even though all restrictions on political, personal, and contractual rights were taken away, and she stood, so far as statutes are concerned, upon an absolutely equal plane with him, it would still be true that she is so constituted that she will rest upon and look to him for protection; that her physical structure and a proper discharge of her maternal functions -- having in view not merely her own health, but the wellbeing of the race -- justify legislation to protect her from the greed, as well as the passion, of man. The limitations which this statute places upon her contractual powers, upon her right to agree with her employer as to the time she shall labor, are not imposed solely for her benefit, but also largely for the benefit of all.”

The court’s second argument addressed the social status of women. The state, they argued, needed to protect women who were vulnerable in part because of their unequal social status and the burden of childrearing. In this way, *Muller* can be read as the court affirming a piece of protectionist legislation—one that the labor movement was also seeking to apply to the male workforce at the time. The court was clear in its stance that the state had a duty to protect women in a way that would be inappropriate were it applied to men.

*West Coast Hotel Co. v. Parrish* (1937), a case testing the constitutionality of a Washington minimum wage law for women, is said to have ended the *Lochner* Era. The Supreme Court found that a Washington law establishing a minimum wage for women was constitutional, suggesting that the regulation of the liberty to contract is reasonable if “adopted for the protection of the community against evils menacing the health, safety, morals and welfare of the people.” The Court wrote that the State has a “special interest” in protecting women from poor working conditions, long hours, and insufficient pay that

might leave them inadequately supported, and undermine their health on the following grounds:

- “1. The health of women is peculiarly related to the vigor of the race;
2. Women are especially liable to be overreached and exploited by unscrupulous employers; and
3. This exploitation and denial of a living wage is not only detrimental to the health and wellbeing of the women affected, but casts a direct burden for their support upon the community.”

The court re-articulated its previous arguments about social and biological female inequality/inferiority, and the state’s special interest in the female reproductive capacity from *Muller*, but it also expressed an affirmative interest in a minimum wage for women on the basis of promoting morality and protecting the public welfare by shifting the burden of maintaining such women and their children from the state onto the employer. After *West Coast Hotel*, the court was more reluctant to strike down regulatory laws, resulting in improved working conditions for many, but certainly not all, workers.

The State’s “special interest in women” during the *Lochner* Era was not limited to labor regulation. *Buck v. Bell*, a 1927 decision written by the much beloved civil libertarian, Justice Oliver Wendell Holmes, argues that the right to freedom from bodily intrusion does not outweigh the state’s compelling interest in who gives birth, under what conditions, and the quality of the offspring. In this case, the Supreme Court found that a Virginia law permitting the involuntary sterilization of individuals thought to be inadequate was a constitutional exercise of state police powers.

The Commonwealth of Virginia alleged that the compulsory sterilization statute was meant to promote the “health of the patient and the welfare of society.” Influenced by eugenic beliefs in the heritability of social “inadequacies” such as poverty, promiscuity, criminal conduct, and medical conditions such as epilepsy, the statute

essentially permitted the use of a “trap, neuter, release” style sterilization program, not altogether dissimilar from that employed for the humane reduction of feral cat populations. Multiple generations of families were forcibly institutionalized at work farms, often not released until they had been sterilized and work replacements had been found. Many of the victims were only children at the time of their institutionalization, and did not understand the purpose of the surgery. Some only discovered what had been done to them when they were unable to conceive children later in life.

The Court argued that individuals thought to be socially, mentally, or physically inadequate posed a threat to the wellbeing and strength of the white race. The Court also asserted that the unfettered reproduction of these undesirables would drain the state coffers, foreshadowing the language it would use ten years later in *West Coast Hotel*. Rather than allow these individuals to breed new generations of inadequates and live out their lives in costly state funded institutions, the Court found in favor of proactively, and cost effectively, sterilizing those deemed unfit. Once made incapable of reproducing, these individuals would no longer pose a substantial threat to society, would be more capable of self-dependence, and thus, would not need to be institutionalized. The concept was thought by many to be progressive. Future generations would remain unburdened by poverty, crime, and other social ills. Utopia could become a reality with careful breeding.

The term “eugenics,” coined by Francis Galton in 1883, literally means well born, derived from the Greek *eugenes*. Galton’s positive eugenics sought to improve the race by facilitating increased reproduction of the “best stock,” as opposed to negative eugenics, which sought to reduce or eliminate reproduction of the worst. Justice Holmes echoes many of Galton’s social policy prescriptions in the *Buck v. Bell* opinion (Roberts

1997). Galton believed that charity was counter-productive, his *eugenics* mingling with social Darwinism—survival of the fittest. He argued that, “the time may come when such persons [the poor] would be considered enemies to the state, and to have forfeited all claims to kindness.” Better to let the natural order take over and, in the words of Charles Dickens’ Ebenezer Scrooge, “decrease the surplus population” (1843).

The Supreme Court shared this view in *Buck v. Bell*, arguing that the state’s interest in preserving the integrity of the race, and preventing future generations of costly social inadequacy, was sufficiently compelling for the purposes of limiting due process and equal protection. In the opinion, Justice Holmes wrote,

“It would be strange if [the state] could not call upon those who already sap the strength of the State for these lesser sacrifices, not often felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world if, instead of waiting to execute degenerate offspring for crime or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind...Three generations of imbeciles are enough.”

By invoking the constitutionality of the war draft and mandatory vaccination, and warning of the threat of being “swamped with incompetence,” Holmes describes the existence of the genetically/socially unfit as a national security crisis.

Indeed, while the court’s decision in this case was undoubtedly influenced by eugenic thought, this opinion falls within the longstanding Constitutional principles that give the state the power to intervene in even the most private and personal affairs, so long as the need is sufficiently compelling. Although the specific brand of eugenic science that led to the creation of this law has generally fallen out of favor, the government maintains an interest in reproduction. The last of the state-level sterilization laws was repealed only in 2003, and the precedent set in *Buck v. Bell* has not been overturned.



Though eugenic sterilization originally targeted the “shiftless, ignorant, and worthless class of anti-social whites” in an attempt to strengthen and bolster the white race against the threat imposed by the other, “lesser” races, Dorothy Roberts argues that the inhuman treatment of Blacks served as a precedent for sterilization as a curative of anti-social behavior (*Buck v. Bell* 1927; Roberts 1997). Castration was imposed on male slaves both as a punishment and a deterrent for future misbehavior. One physician wrote of a “vicious, disobedient, drunken Negro” suspected of raping black women (Roberts 1997). The physician claimed, “After discovering that he had impregnated an idiot white girl, three men went into the field where he worked and castrated him. Less than two years later I heard his mistress say that he had become a model servant” (Roberts 1997).

Eugenic ideology continued to be expressed and practiced in law and policy throughout the United States through the 1970s. As Stern notes, the sterilization of Mexican-origin women was used to solve the so-called “Mexican problem” of irresponsible immigrant breeding (2001). Stern cites notable eugenic scientist Goethe: “It is this high birthrate that makes the Mexican peon immigration such a menace. Peons multiply like rabbits” (2001). Hundreds of working-class migrant women were sterilized in County Hospital in Los Angeles in the 1960s and 1970s. A 1973 survey found that 43 percent of all federally funded sterilization patients were black women. Between 20 and 50 percent of women of childbearing age in some Native American communities were sterilized without their consent. In New York City, the majority of women sterilized in the late 1960s and early 1970s were Puerto Rican. Stern writes,

“From the 1920s to the 1970s the rationale for sterilization had gradually but never entirely shifted from one based on the transmission of faulty genes down to the family line to one centered more and more on the purported negative consequences of unfit parenthood, dysfunctional families, and overpopulation. Nevertheless, there was one

constant refrain throughout the twentieth century: reproductive surgery could serve as a techno-surgical fix that, in whatever instance, would save the state money, impede irresponsible parents from having more children, and boost the well-being of society” (2001).

### **Fetal Protection and Maternal-Fetal Conflict**

Protectionist law has morphed over time in response to expansions in civil rights law. Title VII of the Civil Rights Act of 1964 prohibits discrimination against employees on the basis of, among other things, sex. Further, in 1978, the Pregnancy Discrimination Act amended Title VII to prohibit discrimination “on the basis of pregnancy, childbirth, or related medical conditions.” Cynthia Daniels notes the impact of the passage this legislation on protectionist law as it applies to pregnancy. She writes, “just as the spectre of gender difference appeared to breathe its last, taking with it the basis for state protectionism, it was infused with new life by the powerful ideology of fetal rights” (1996). Different from maternal protection, fetal protection generally positions the pregnant woman as a living vessel. The fetus and the pregnant woman are conceptualized as separate entities in this formulation, and their interests are generally placed in opposition to one another.

Fetal protection did not originate after the passage of these kinds of legislation. Indeed, the concept of fetal protection and the separation of the pregnant woman from her pregnancy pre-date civil rights legislation by more than a century. Roberts describes an early instance of fetal protection within the institution of slavery in the United States, where the fetus was conceptualized not as a person in need of protection, but as property. She shares the words of a former slave named Lizzie Williams: “Dey [the white folks] would dig a hole in de ground just big ‘nuff fo’ her stomach, make her lie face down an whip her on de back to keep from hurtin’ de child” (Roberts 1997). Roberts explains,

“the beating of pregnant slaves reveals that slave masters created just such a conflict between Black women and their unborn children to support their own economic interests. The black mother’s act of bearing a child profited the system that subjugated her... It is the most striking metaphor I know for the evils of policies that seek to protect the fetus while disregarding the humanity of the mother” (Roberts 1997).

Roberts compares this early moment of brutality to contemporary instances of fetal protection and maternal-fetal conflict. For example, courts have been known to construct a pregnant woman’s opposition to certain birth interventions, like induced labor or cesarean sections, as an “adversarial relationship between the pregnant woman and her unborn child” (Roberts 1997). By inventing an adversarial relationship between the pregnant woman and her own pregnancy, the government is given reason to restrict the pregnant woman’s autonomy in favor of protecting the innocent fetus. Fetal protectionism generally rests on the assumption that third party intervention in a pregnancy is necessary to represent the best interests of the fetus, because the pregnant woman is incapable of doing so. Contemporary examples of fetal protectionism in action are laws appointing attorneys to represent the interests of fertilized eggs, embryos, and fetuses in civil child abuse trials, or in judicial bypass hearings for juveniles seeking abortion.

### **Privacy**

The state has invoked its ‘legitimate and compelling interests’ in articulating the regulatory frameworks surrounding several other reproductive issues. The court stated its interest in both maternal health, and fetal life (or the potentiality of life) in *Roe v. Wade* (1973). While often regarded as a victory for those who desired expanded reproductive rights for women, *Roe* leaves room for the imposition of state regulation of gestating bodies. As Reva Siegel writes, “*Roe* expressed the abortion right as a form of liberty

protected by the Due Process Clause, never mentioning equal protection or reasons rooted in sex equality” (2010). At the same time, the court contended that this liberty right was not absolute, and that the state could intervene when the interest in maternal health or the potential life of the unborn becomes sufficiently compelling. This decision left room for further state intervention, not only in the area of abortion rights, but for reproductive life in general. The decision stated that once the fetus was viable, “the woman’s privacy is no longer sole and any right of privacy she possesses must be measured accordingly.” The decision, written by Justice Blackmun, states,

“[I]t is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one’s body as one pleases bears a close relationship to the right of privacy previously articulated in the Court’s decisions. The court has refused to recognize an unlimited right of this kind in the past.”

The court asserted that the regulation of reproduction fit well within the state’s proper assertion of “important interests in safeguarding health, in maintaining medical standards, and in protecting potential life.” By finding a legal basis for the right to abortion in privacy, rather than equal protection, the right was weakened from the start. Siegel notes, “It is relatively safe to challenge constitutional privacy rights as ‘unenumerated,’ but, calling for the deprivation of rights that vindicate women’s equal citizenship is an altogether riskier business—not simply because equality rights have a clear textual basis in the Constitution, but also because equality rights have trumping political authority” (2010).

In *Planned Parenthood v. Casey* (1992), the Supreme Court dramatically changed its position on privacy in abortion cases. In their re-articulation of the findings in *Roe*, the court held that, among other things, “the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may

become a child.” Yes, the right to abortion is protected by the Due Process Clause, “but States may regulate abortion procedures in ways rationally related to a legitimate state interest.” *Casey* imposed a clear state interest in pregnancy from conception onward. The court was not only articulating an interest in whether a fetus is born or aborted, but was also setting a legal precedent for state concern over the pregnant or potentially pregnant individual’s behaviors and actions leading up to the birth of a possible future person. Of course, in affirming minimum wages and maximum hours laws for women in *West Coast Hotel* and *Muller*, and justifying compulsory sterilization in *Buck v. Bell*, the court had already articulated this state interest. However, by describing the fetus specifically as a potential life, the *Casey* opinion gives the state more flexibility to pursue this interest. Whereas the potentially pregnant woman in *Muller v. Oregon* and *West Coast Hotel v. Parrish* was regarded as a sole entity, the pregnant woman in *Roe* and *Casey* is explicitly positioned as a dual entity, one entity perhaps in conflict with the other.

The court’s reference to state interest in viability, and the potential child’s ability to live a meaningful life, could be interpreted to support additional pregnancy-related regulations beyond abortion. If, as the *Casey* court says,

“With respect to the State’s important and legitimate interests in potential life, the ‘compelling’ point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother’s womb. State regulation protective of fetal life after viability thus has both logical and biological justifications,”

could it be found that the regulation of the pregnant person’s behaviors and activities are within the state’s legitimate interest in protecting the potentiality of life?

### **The Hard Turn Away from Equality**

While outlining an affirmative state interest in the potentiality of life from the moment of conception, the US Supreme Court in *Casey* also integrated the pro-woman

frame increasingly invoked by anti-abortion advocates. That is, while it signaled interest in protecting the fetus, the court also made claims about the lingering necessity of state intervention for the protection of pregnant women. One of the state regulations addressed in *Casey* was state-mandated and produced informed consent requirements for patients seeking abortion—a requirement that is not infrequently coupled with mandatory waiting periods that must be fulfilled between the delivery of the state-mandated information and the actual performance of an abortion. In *Casey*, the court found in favor of the constitutionality of these measures on the basis that they serve the legitimate purpose of protecting the physical and psychological wellbeing of the pregnant woman, citing *Akron I*, *Thornburgh*, and *Danforth*. The court wrote,

“Those decisions [*Akron I* and *Thornburgh*] recognize a substantial government interest justifying a requirement that a woman be apprised of the health risks of abortion and childbirth [...] It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehended the full consequences of her decision, the state furthers the legitimate purpose of reducing that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.”

The court reiterated the state’s responsibility for protecting the psychological wellbeing of pregnant women again in its opinion in *Gonzales v. Carhart* (2007). This case concerned the constitutionality of a 2003 law prohibiting, the performance of an abortion method known as intact dilation and extraction (or D&E), most commonly used in abortions performed after the sixteenth week of pregnancy.<sup>i</sup> While intact D&E is very

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<sup>i</sup> Intact D&E involves the dilation of the cervix, removing by suction the contents of the fetal skull, and collapsing the skull, making it easier to remove the fetus, whole, from the uterus. Intact D&E is exceedingly rare, but is the preferred method of abortion during the second half of the pregnancy, both because removing an intact fetus rather than a non-intact fetus reduces some health risks like cervical lacerations. Patients who are aborting

rarely performed, the court's decision in *Carhart* is significant in that the court once again found in favor of restricting the right to abortion both for the protection of the fetus and for the person gestating it. The court wrote,

“It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.”

Here, the court relied simultaneously on fetal protection and maternal protection to justify its stance on outlawing a surgical procedure. Going beyond its physically and socially protective measures for women outlined in cases like *Muller*, in *Carhart*, *Danforth*, and *Akron I*, the court endorsed state interventions in defense of women's psychological well-being. These decisions purported to protect women from their own ignorance of medicine and pregnancy, from “sorrow” and “anguish”, from “grief.”

## **Conclusion**

Feminist legal theorists have pointed to a way out of the continued definition of women as a lower class. If legal advances for women were framed in terms of a legal argument for sex equality—for equal protection—many of the loopholes that allow for the continued exceptional treatment of women would be forced to close. Framed in terms of abortion rights, Siegel notes,

“The sex equality argument for abortion rights grows out of a vision, and a structural understanding of what genuine freedom of choice looks like, which locates responsibility for the conditions in which women conceive and rear children in the society that would criminalize abortion, and imagines equal citizenship for women as requiring fundamental change in the form of our intimate and family lives” (Siegel *Roe's Roots*).

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a wanted pregnancy due to partial miscarriage or severe congenital abnormality sometimes choose intact D&E, wishing to hold and grieve the loss of their child.

MacKinnon states it differently,

“If the point of equality law is to end group-based dominance and subordination, rather than to recognize sameness or accommodate difference, a greater priority is placed on rectifying the legal inequality of groups that are historically unequal in society, and less priority is accorded to pure legal artifacts or rare reversals of social fortune. (MacKinnon 2005).

The criminal prosecution of pregnant women is not an aberration. Rather, I argue that it is the likely result of a legacy in which pregnant women have been defined both legally and socially as in unique need of regulation, either because they are seen as incapable of self-advocacy, as biologically vulnerable, or as potential perpetrators of harm to their unborn children. Even when framed as a form of state benevolence, by defining pregnant women as unique and exceptional, these laws, policies, and attitudes have opened the door for abuse of, and discrimination against, pregnant women. Though protectionist law has shifted over time in response to expanded women’s rights in some areas, like employment, the legal road for depriving women of rights in other areas was already paved.



### ***Chapter 3. “The dead babies may be the lucky ones.”***

Concern about maternal deviance and the quality of offspring post-*Roe v. Wade* has been intimately tied to concern about drug use. Likewise, the policy response to pre- and post-partum drug use has been highly punitive—a part of the War on Drugs. In this chapter, I discuss the emergence of three waves of concern about highly racialized drug types and the concurrent focus on the pregnant women who use these drugs. Echoing earlier eugenic thought about irresponsible breeding and damaged children that threatened the social and financial wellbeing of the nation, mothers who exposed their children to drugs recklessly and carelessly created hordes of children who were said to grow into erratic, violent, irresponsible adults, while good, honest Americans were stuck with the social and financial costs. The Crack cocaine crisis in the 1980s and 1990s was associated with low-income blacks, while the methamphetamine epidemic of the 2000s and the opioid epidemic of the 2010s were both discursively connected with low-income whites. Concern about prenatal exposure to drugs has been a key feature of each of these waves of racialized drug panic.

#### **Cocaine**

In 1985, Dr. Ira Chasnoff’s study of cocaine use during pregnancy was published in the *New England Journal of Medicine*. Though limited in its scope, and cautioning that the study was preliminary, not generalizable, and not demonstrating causality, the study was picked up by the media. Chasnoff recalled, “Soon after our paper was published, within days, we were getting calls from media all over the country, and started hearing the term crack babies” (Winerip 2013). Chasnoff found that babies exposed to cocaine in utero “had significant depression of interactive behavior and a poor organizational

response to environmental stimuli” (1985). A 1989 study by the National Association for Perinatal Addiction Research and Education (NAPARE) reported that 375,000 children had been born affected by prenatal drug use, including, crack cocaine (Chasnoff).

These claims were taken up and exaggerated by news media. In 1986, *Newsweek* declared crack to be, “The Plague Among Us” (Smith 1986). The *Washington Post* published a column by Charles Krauthammer that warned, “The inner-city crack epidemic is now giving birth to the newest horror: a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth” (1989). Krauthammer asserted that these babies constituted a

“race of (sub) human drones, [whose] future is closed to them from day one. Theirs will be a life of certain suffering, of probable deviance, of permanent inferiority. At best, a menial life of severe deprivation. And all of this is biologically determined from birth. The dead babies may be the lucky ones.”

A CBS story featured a social worker who said the toddler she was treating, “would grow up to be a 21-year-old with an IQ of perhaps 50, barely able to dress herself” (Blake 2004). Representative George Miller told ABC news, “These children, who are the most expensive babies ever born in America, are going to overwhelm every social service delivery system that they come in contact with throughout the rest of their lives” (Winerip 2013). Roberts notes,

“The media parlayed the NAPARE report into a horrific tale of damage to hundreds of thousands of babies [...] Even the most careful reporters felt free to make wildly exaggerated claims about the effects of prenatal drug use [...] Some articles attributed all 375,000 cases to crack, although experts estimate that 50,000 to 100,000 newborns at most are exposed specifically to cocaine (both powdered and crack) each year” (Roberts 1997).

The impact of so-called “crack baby syndrome” went beyond the supposed symptoms of jitteriness, crying, and weight loss immediately post-partum like that

described above. It was said to have a permanent, lifelong impact on overall development. So, crack cocaine did not just destroy families and increase rates of violent crime. It was thought that crack was creating hordes of permanently damaged children--a lost generation. Chasnoff himself challenged the media's representation of his research: "I was at first stunned, and then angry that they would distort the information. That's when I started realizing how a lot of this can be taken out of context and used to bolster any kind of argument" (Winerip 2013). As Chasnoff explains it, "It's interesting, it sells newspapers and it perpetuates the us-vs.-them idea."

Media outlets weren't the only ones spreading this misleading information. Healthcare providers and researchers joined in the fray. In 1989, a National Institute on Drug Abuse (NIDA) psychologist argued that prenatal substance use "was interfering with the central core of what it is to be human" (Blakeslee 1989). Nurses reported that these babies stiffened when cuddled, displayed "emotional detachment" and "impaired human interaction" (Chasnoff 1989; Chasnoff 1985). Another nurse said, "The most remarkable and hideous aspect of crack cocaine seems to be the undermining of the maternal instinct," (Trost, 1989).

The "crack mom" was discursively joined in with existing cultural frames for bad black motherhood and pathological black children. She embodies the promiscuity and dysfunction of the Jezebel and stubbornness of the Sapphire. She is aggressive like Mammy, and is abusive of social services like the Welfare Queen (Carpenter 2012). As Roberts explains, this discursive drama had two leading characters:

"the pregnant addict and the crack baby, both irredeemable, both Black. The pregnant crack addict was portrayed as an irresponsible and selfish woman who put her love for crack above her love for her children" (1997).

The voice of the scientific community was not united in support of the findings about the devastating impact of crack cocaine on a developing pregnancy. Some medical researchers were more skeptical. Dr. Claire Coles asserted,

“The effects didn’t seem consistent with the action of the drug itself... You could have taken any premature baby and gotten the same image. I think that people got very focused on cocaine is the cause of this rather than thinking, substance abuse is a cause of this, maternal lifestyle is the cause of this, social issues are the cause of this” (Winerip 2013).

Frank notes, “Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child’s environment” (2001).

There were significant flaws in much of the research on prenatal cocaine exposure. Lack of experimental controls, and a pool of poor, inner-city research subjects who were already at high risk for negative birth outcomes, rendered much of the research unreliable. Morgan and Zimmer report three major problems with much of the research on prenatal cocaine use, including the lack of control groups, the lack of research on long-term effects of the drug, and an inability to distinguish between the impact of powder and crack cocaine (1997).

This combination of flawed research and exaggerated media reporting created an image so lasting that decades of research disproving the crack-baby myth have been unable to dispel it. More recently, Betancourt et al. found in their study of adolescents who had been exposed to cocaine in utero “no evidence of latent effects of gestational cocaine exposure on inhibitory control, working memory, or receptive language” (2011). Hallam Hurt et al. found no effect of exposure on neurocognitive function at middle-school age, or, that that effect is less pronounced than the effect of age or childhood

development (2009). In a 25-year longitudinal study, Hurt et al. found “no significant differences between... cocaine-exposed children and the controls” (2013). They argued, “Poverty is a more powerful influence on the outcome of inner-city children than gestational exposure to cocaine.”

### **Methamphetamine**

Heightened attention to the use of methamphetamine emerged in the early to mid 2000s, echoing much of the early alarm of the crack cocaine panic. With methamphetamine, images of bad black mothers and damaged black children in poor urban areas were replaced by poor, rural white women in trailer parks, and their damaged white children. Cheaper and more accessible to the poor than other prescription stimulants, like pharmaceutical grade methamphetamine or amphetamines like Ritalin and Adderall, methamphetamine could be manufactured or “cooked” at home using items that could be found at the grocery store.

Reports of the sudden saturation of communities with the drug, and its uniquely harmful effects were plentiful. One sheriff stated, “meth is the overwhelming drug of choice among... murderers” (Armstrong 2007). The director of the DEA said, “States are ‘literally drowning in meth activity’” (Armstrong 2007). Representative Brian Baird, a Democrat from Washington State claimed that meth was the number one cause of crime (Armstrong 2007). In 1998, President Clinton’s Drug Czar Barry McCaffrey announced, “Meth is the worst drug ever to hit America, and officials need to work to eradicate the ‘poor man’s cocaine’” (Byram 1998). A Rolling Stone headline cautioned, “Crystal Meth: Plague in the Heartland” (Solotaroff 2003). One Alabama newspaper painted a dramatic picture:

“Meth, in fact, has replaced moonshine alcohol stills in the rural South. The highly addictive potion is brewed in kitchen sinks all through the back roads, and it’s destroying a generation of young men and women, and threatens to destroy a succeeding generation.”

Reports about the harmful medical impact of the drug painted a similarly apocalyptic picture. One NIDA report stated that meth was associated with brain damage, memory loss, psychotic behavior, heart damage, hepatitis, and HIV transmission (Armstrong 2007). One DEA official said, “it’s the most insidious drug... it eats up [users’] brain cells” (Armstrong 2007). Meth users were described as monsters, or as suffering from chronic wasting disease (Armstrong 2007). Meth was also supposed to be uniquely addictive. Law enforcement experts attested that “only 1% of meth users can overcome their addiction” (Armstrong 2007). Meth addicts were almost described as zombies—the new, fast kind. Meth was said to turn people into monsters (Armstrong 2007). One popular anti-meth campaign called “The Faces of Meth” would show a time-ordered sequence of a meth user’s mugshots—a series of deteriorating faces that seemed to age too quickly.<sup>i</sup> Meth was said to be impossibly addictive, and was associated with brain damage, memory loss, and psychotic behavior.

Several policies were developed to try to cope. Senator Jeff Sessions arranged for all of Alabama’s Drug Task Force members to train at Quantico on clandestine methamphetamine labs. Walmart employees were trained to flag customers who purchased large quantities of the household ingredients that can be used to make methamphetamine, like pseudo-ephedrine and matches. Pharmacies established networks

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<sup>i</sup> The faces of meth campaign is run by the Multnomah County Sheriff’s Office in northwest Oregon, and was originally created for use in an educational slideshow for Oregon high school students.

to identify patients making smaller purchases of pseudo-ephedrine at lots of different pharmacies, a strategy called “smurfing.”

Methamphetamine was not a new drug. Chemically synthesized in 1887, it was not used medicinally until 1927, and it began to be sold commercially in 1932 (Armstrong 2007). Prescription methamphetamine is typically sold under the name “Desoxyn,” and is approved for weight loss, attention-deficit disorder, and sleep disorders. Methamphetamine is chemically and pharmacologically similar to amphetamine, and even “appear[s] to produce a similar dose-related profile of effects in humans” (Kirkpatrick et al. 2012). Another study went so far as to say that, “There are no known neurobiological differences in action between [methamphetamine and amphetamine]” (Shoblock et al. 2003).

Despite popular claims to the contrary, Hart et al. find that short-term, acute methamphetamine use can improve cognitive performance in some ways, including visuospatial perception, focus, and response speed (2012). U.S. Air Force pilots have been authorized to use amphetamines ‘to sustain the performance of sleep-deprived pilots’ since 1961 (Caldwell et al. 2003). Another study indicated that “amphetamines bring the performance of fatigued individuals ‘back up to the baseline’” (Shanker & Duenwald 2003). Amphetamine use is not uncommon among college students in the United States. McCabe et al.’s study of non-medical use of prescription stimulants found that 6.9 percent of US college students had used non-medical stimulants (2005).

The nation-wide concern about methamphetamine seemed out of proportion with the data on meth use. Compared to annual deaths related to other substances, with tobacco causing more than 480,000 deaths annually, and 88,000 annual deaths attributed

to alcohol consumption, deaths involving methamphetamine were low, at less than 5,000 annually (2014 Surgeon General’s Report; Excessive Alcohol Use 2013; Warner et al. 2016).<sup>i</sup> Methamphetamine is less popular than other illicit drugs. In 2008, only heroin was used by fewer people (NSDUH 2009). Crack cocaine and ecstasy are marginally more commonly used, with 359,000 and 555,000 annual users (NSDUH 2009). Non-medical psychotherapeutic drugs, and marijuana are far more popular, with 6.1 million users and 15.2 million users respectively (NSDUH 2009). Meth use had steadily declined since 1999 (NSDUH 2009).

## **Opioids**

At the time of this writing, opioids represent the primary concern in so-called “drug epidemics.” Opioid drugs are narcotics, including prescription painkillers like oxycodone and morphine, and illicit drugs like heroin. According to the Department of Health and Human Services “more people died from drug overdoses in 2014 than in any year on record, and over 60 percent of drug overdose deaths involved an opioid” (The Opioid Epidemic 2016). “Since 1999, the rate of overdose deaths involving opioids [...] nearly quadrupled” (The Opioid Epidemic 2016). Over prescription of opioid pain killers, inability to access medication-assisted treatment, and pervasive chronic pain have been identified by HHS as contributing factors.

Some efforts to remedy opioid addiction have sparked new problems. For example, efforts to reduce so-called “doctor shopping”—a patient using a series of

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<sup>i</sup> The measure of methamphetamine-related deaths is not limited to deaths caused by methamphetamine alone. For example, of the 3728 methamphetamine-related deaths in 2014, 45% involved another drug, most often an opioid. 734 meth-related deaths involved heroin, and 300 involved morphine (Warner et al. 2016).



physicians to access multiple opioid prescriptions simultaneously, or to ensure a steady supply in case a physician does not renew the prescription—have pushed people who are dependent on the substance to use heroin as an alternative (Cicero et al. 2014). This is particularly alarming given that increasingly, heroin has been laced with Fentanyl—an opioid that the CDC claims is 50 to 100 times more potent than morphine. What would be typically be a non-lethal dose of heroin can become lethal in a heroin-fentanyl mixture (Rudd et al. 2016).

The third wave of prosecutions included in this study, and the one that lines up with Tennessee’s adoption of their fetal assault law, involved opioid drugs— prescription pain medications and heroin. Unlike methamphetamine and even crack cocaine, abuse of opioid drugs is widespread, common, and frequently begins with the use of legally prescribed pain medication. According to one recent study from the CDC, the rate of overdose deaths related to opioids tripled between 2010 and 2014, and was twice as high as the rate of drug overdoses related to cocaine (Rudd et al. 2016). At present, rates of fatal drug overdose are higher than they ever have been-- higher than both the rate of deaths involving guns and car accidents—and 61% of those deaths involved opioids (Rudd et al. 2016). In 2012, Tennessee has the second highest rate of opioid prescribing in the United States-- enough for every person in the state to have one and 1/5 bottles of pain killers (Paulozzi et al. 2014).

Policy responses to and depictions of this epidemic, however, adopt a different tone than those related to methamphetamine and crack cocaine. Hernandez D. Stroud describes these differences (2016). Now, instead of harsh mandatory minimum sentencing laws and “just say no” campaigns, there are diversion programs and drug

treatment. At present, 90 percent of new heroin users are white (Cicero et al. 2014). An analysis of media coverage on white opioid use by Netherland and Hansen similarly finds that white drug users are typically described in more sympathetic terms than blacks and latinos (2016). However, they also describe differences in the depictions of middle and upper-middle class drug users and low income whites. For example, one news article from rural Virginia, written by a former member of the House of Delegates, stated

“I’m not talking about homeless, bum-looking street people—I’m talking about relatively affluent, well-dressed, high-achieving Volvo-driving kids, kids who belong to the honor societies, who play soccer and lacrosse, kids headed to the good schools” (Netherland & Hansen 2016).

While methamphetamine users tended to be described as a “white trash,” white opioid users were not generally seen as “socially disposed and ungrievable” (Linneman & Wall 2013). Rather, they are usually described as young people who started using their parent’s prescriptions, people who “fell in with a bad crowd,” and people who became addicted to pain killers after they were given a prescription for an illness or injury (Netherland & Hansen 2016).

The impact of opioid drugs unborn children has, like with methamphetamine and crack cocaine, been a major cause of concern. Opioid exposure in utero is associated with a specific set of symptoms post-partum, known as Neonatal Abstinence Syndrome, or NAS. Essentially, NAS is the term used to describe withdrawal symptoms in newborns, including jitteriness, crying, and weight loss. Not every child exposed to opioids in utero will develop NAS. After the withdrawal symptoms cease, a child born with NAS are much like any other child. NAS is not permanent. Opioids do not cause life-long developmental delays or damage.

Media descriptions of so-called “oxy-tots” report “infants born into excruciating misery,” who “shake, struggle to eat and often sputter and choke during feedings,” and have “fits of sneezing and severe diarrhea” (Wilson & Shiffman 2015). These babies are supposedly “rattled by even the slightest visual or audio stimuli, ‘including a mother’s smile’” (Wilson & Shiffman 2015). A nurse described the cry of a baby with NAS as “a panicked, high-pitched wail, almost desperate, a sound you don’t forget” (Wilson & Shiffman 2015).

Much the same way that methamphetamine was compared to the crack, parallels were also drawn between heroin and crack. Heroin is far less expensive than its FDA regulated counterparts, especially for individuals who lack insurance coverage. Prescription opioids might cost about \$1 per milligram, so a single 60mg pill could cost \$60 (Carey 2014). An equivalent amount of heroin can be purchased for a tenth of the price. And though far more pregnant women use prescription opioids than heroin, the rhetoric paints a picture of heavily pregnant women nodding off with needles sticking out of their arms.

## **Conclusion**

The supposed veneration of pregnant women and mothers quickly transforms into disdain if the woman violates the norms associated with virtuous motherhood, either by way of her identity, reputation, or actions. Crack cocaine, methamphetamine, and opioid drugs are all described as creating mothers devoid of maternal feeling and warmth. A pregnant drug user may not only violate drug laws, but also the social expectation that a mother be self-sacrificial and morally pure. If the impact of recreational substances on fertilized eggs, embryos, or fetuses is as bad as it seems, these women are not only seen

as irresponsible and selfish, they are also cruel, deliberately harming their babies, and unleashing them upon the world.

#### ***Chapter 4. Pregnancy Specific Crime and the Peril of Protection***

Laci Peterson went missing on December 24, 2002 (Wakeman 2017). She was 32 weeks pregnant. Her body was found four months later, as was the body of her 32-week fetus, who she planned to name Connor. Scott Peterson, Laci's husband, was charged with Laci's murder. The Peterson's lived in California, one of a number of states that define the fetus as a potential victim of crime. As such, Scott was also charged with causing Connor's death. He was found guilty of first degree murder for killing Laci, and second degree murder for causing Connor's death. Peterson was sentenced to death.

If Laci had been killed in Colorado, for example, instead of California, the loss of her pregnancy would not have been considered a crime. Laci's family supported an end those state legal differences, and they campaigned in support of federal legislation that would legally recognize fertilized eggs, embryos, and fetuses as victims if they are harmed or killed during the commission of a violent crime with federal jurisdiction. Laci's mother, Sharon Rocha, addressed Senator John Kerry, who opposed such legislation. She wrote,

“What I find difficult to understand is why groups and senators who champion the pro-choice cause are blind to the fact that these two-victim crimes are the ultimate violation of choice. What about mothers who survive criminal attacks but lose their babies? I don't understand how any senator can vote to force prosecutors to tell such a grieving mother that she didn't really lose a baby—when she knows to the depths of her soul that she did. [...] There were two bodies that washed up in San Francisco Bay, and the law should recognize that reality” (Johnson 2004).

After Peterson's death, a bill was introduced by Representative Melissa Hart, and was signed into law by George W. Bush in 2004. Named the Unborn Victims of Violence Act (UVVA), or Laci and Connor's Law, the UVVA creates a separate criminal offense for the death of or bodily injury to an unborn child in federal jurisdictions. The law applied

to unborn children “at any stage of development,” and includes exemptions for “conduct relating to an abortion for which the consent of the pregnant woman... has been obtained,” “for medical treatment of the pregnant woman or her unborn child,” or, “of any woman with respect to her unborn child.”

The UVVA spawned a debate over the rights of pregnant women and the personhood of fertilized eggs, embryos, and fetuses. Some UVVA supporters felt that the recognition of a fetus was essential to recognizing the full scope of violence against pregnant women, and perhaps advance a legal agenda in favor of full fetal personhood. Others expressed concern over the impact of the UVVA on women’s rights. Though the law is named after both Laci and her unborn son, the UVVA only legally addresses the harm done to fertilized eggs, embryos and fetuses, not the harm done to the pregnant woman. There was fear that by establishing a kind of fetal personhood in the criminal code, these laws would erode the right to have an abortion, or that they might result in punishing pregnant women for behaviors that, but for the fact of their pregnancies, would not be considered crimes. Some pro-life activists opposed the UVVA because they feared, if it were used to prosecute pregnant women, it might have the effect of incentivizing abortion as a way to avoid criminal charges.

In this chapter, I present my analysis of pregnancy-specific criminal law in the United States and discuss three typologies of pregnancy-specific criminal law. I provide an in-depth account of the criminalization process for maternally-mediated fetal harm in South Carolina, Alabama, and Tennessee, and discuss two primary findings. First, gaps between legislative intent, criminal law as codified, and actual arrest and prosecutorial practice undermine the legitimacy of the law and the right to due process. Second, the

evolution of these laws, from protection to punishment, demonstrates the peril of fetal and maternal protection in law.

## **Methodology**

In order to chart the legislative behavior of states with regard to pregnancy-specific crimes, I first searched for all introduced bills on state legislative online archives by year, between 1973-2016, using a fixed set of search terms.<sup>i</sup> I coded these bills for legislative content, bill status, and the names of bill sponsors, and sorted them into three legal typologies: 1. Laws criminalizing harm to fertilized eggs, embryos, and/or fetuses; 2. Pregnant victims of violence; 3. The prosecution of pregnant women for crimes against the fertilized eggs, embryos, or fetuses they gestate. I further coded these bills for content on the gestational age at which the law applies, and finally, coded the bills for legal exceptions in the areas of medicine, abortion, and the pregnant woman's actions or inactions. Identical bills introduced by the House and Senate in the same session were counted as a single bill. I omitted fetal personhood bills that were abortion focused, but contained no explicit criminal content, from the analysis. Bills with a civil rather than criminal focus, such as bills concerning parental custody or bills concerning damages for certain prenatal harms were also omitted from the analysis. This resulted in a total of 697 introduced bills. Next, I conducted full-text searches of the legal code for each state, as of 2016, using the aforementioned set of search terms. These statutes were coded for content using the same scheme detailed above.

### *Methodological Challenges and Limitations*

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<sup>i</sup> fetus, fetal, embryo, ovum, zygote, unborn, pregnant, pregnancy, feticide, stillbirth, stillborn, miscarriage, gestation, gestate.

State online legislative archives vary significantly, some permitting a full text search for bills introduced from the state's founding (ex. Iowa, Utah), and others only showing bills from the mid-2000s onward (ex. Massachusetts). Additionally, some websites have no online in-text search function for their legislative bills (ex. Kansas). Further research will be necessary to complete the legislative timeline for each of these states. As such, the conclusions that can be drawn from the earlier years included in this study are limited. Data is reliably complete from the mid—2000s onward.

When I endeavored to collect information on all bills introduced during this span of time, I had hoped to also access nationwide data about pregnancy-specific crime. Thus far, I have been unable to do so. However, in a future study, I hope to examine the relationship between introduced bills, the success of those bills, and rates of pregnancy-specific crime. For now, I present some general descriptive findings about legislative activity in the area of pregnancy-specific criminal law.

### **Law Typologies**

#### *Type 1: Laws Criminalizing Harm to Fertilized Eggs, Embryos, and/or Fetuses*

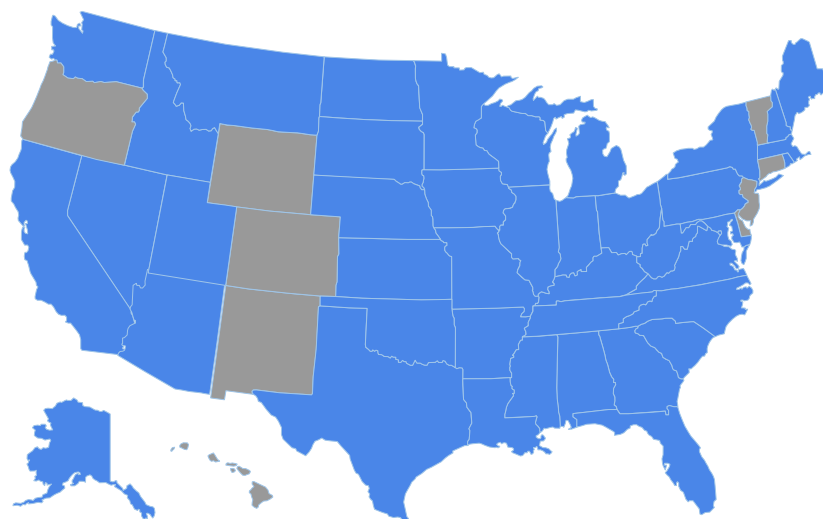
The UVVA, the federal law described above, is an example of this law type. These types of laws may reference specific cases of violence against pregnant women—in the case of the UVVA, the 2002 murder of Laci Peterson. These laws can do a number of things in order to criminalize harm to fertilized eggs, embryos, and fetuses, including penalty enhancements for harm to pregnant women that results in fetal demise or injury, separate and equivalent criminal charges for violence against pregnant women and the unborn as individual and separate victims (two murder charges instead of one murder charge), or the creation of separate and unique crimes which are only applied to harm



against the unborn, for example, feticide or murder of unborn child. Many of these laws contain “exception” sections. These exceptions commonly bar the application of the law in cases involving legal abortion, medical care, and actions or inactions by the pregnant woman that could have a negative impact on a fertilized egg, embryo, or fetus, such as not receiving prenatal care, or using a substance during pregnancy. Forty-four states have adopted this kind of law.

Laws vary from state to state in terms of the gestational age at which the criminal law would become active. In most states, the criminal law applies from the moment of conception. In others, the law would only apply to fetuses that had reached viability. Still others do not explicitly state at what stage the law would apply, as is the case in California, Maine, and Virginia.

#### **States with Laws Criminalizing Harm to Fertilized Eggs, Embryos and/or Fetuses**



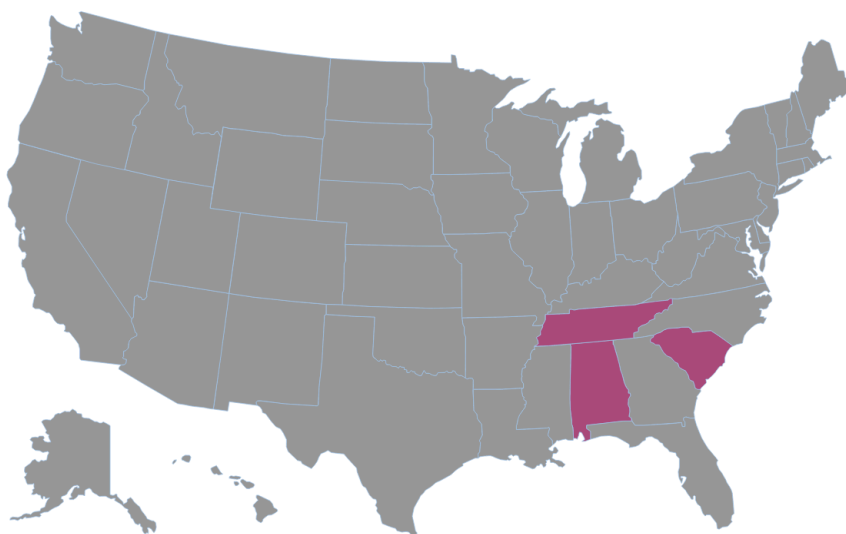
#### *Type 2: Pregnant Victims of Violence*

This second law type specifically addresses harm done to the pregnant woman, regardless of its impact on the fertilized egg, embryo, or fetus, and as separate from crimes against non-pregnant persons. Laws of this type sometimes define pregnancy as



woman, intentionally or unintentionally, harming or potentially causing harm to a fertilized egg, embryo, or fetus. These laws have a profound effect on the legal rights of pregnant or potentially pregnant women, including privacy and due process, and may have the effect of criminalizing behaviors which, but for the fact of the pregnancy, would not be considered criminal. For example, a person who fails a drug test is usually protected from criminal charges by medical privacy rights. However, states with this type of crime law *require* the violation of medical privacy much in the same way that mandated reporters are required to report serious and imminent threats of harm to the self or others. Laws of this sort do not only criminalize the use of illegal drugs, but can also criminalize the use of legally prescribed and obtained medications, as is currently the case in Alabama. Currently only three states have adopted this third law type in the post-Roe era: Alabama, South Carolina, and Tennessee.

**States with Laws Criminalizing a Pregnant Woman's Actions with Regard to the Fertilized Egg, Embryo, or Fetus She Gestates**



## US Supreme Court

The US Supreme Court has only heard one case involving the prosecution of pregnant women for their actions during pregnancy. *Ferguson v. City of Charleston* (2001) concerned women receiving prenatal and birth care at a public hospital, who allegedly used cocaine during their pregnancies. Nurses and doctors in obstetrics at the Medical University of South Carolina (MUSC), were concerned by the apparently increasing incidence of cocaine use among pregnant women. Drug treatment referrals and educational campaigns did not a substantive difference in rates of cocaine abuse in this population. These healthcare providers partnered with law enforcement and the Circuit Solicitor, Charles Condon, to develop a protocol to drug test pregnant women and submit positive results to law enforcement. Hospital representatives alleged that this policy was meant to ultimately help pregnant drug users to discontinue their drug use.

Thirty women were arrested, and they later sued MUSC, arguing that the urinalysis tests were illegal searches in violation of the Fourth Amendment. The case was heard before the U.S. Supreme Court. The thirty women asserted that they had not consented to these warrantless drug tests. They gave urine samples in the context of a medical setting, but the urine was not taken for medical purposes. It was taken to be tested and used as evidence against them in a criminal case. The court agreed with the women, finding that “the interest in using the threat of criminal sanctions to deter pregnant women from using cocaine cannot justify a departure from the general rule that an official nonconsensual search is unconstitutional if not authorized by a valid warrant.” The court went on to state that because MUSC was a state hospital, it is subject to the

Fourth Amendment, and as such, it required a warrant or “probable cause” to conduct such searches without the patient’s informed consent.

The court wrote that the individual patient’s privacy was being weighed against the test-and-report program’s “special need” of protecting the health and well-being of mothers and potential children. They found that because the immediate result of the arrests was not assistance with substance abuse, but simply detention or criminal charges, the “special need” present in the case was not enough to outweigh the need for probable cause or a warrant prior to the use of urinalysis as a form of evidence collection. In other words, the use of a warrantless urinalysis test as a form of evidence collection without the consent of the patient, is unconstitutional.

This case did not address the central question of whether a pregnant woman could be held criminally responsible for crimes against the fertilized eggs, embryos, or fetuses they gestate. Thus, if, for example, a state policy required that all women receiving prenatal care or giving birth at medical facilities consent to such urinalysis tests as a requirement for receiving care, or if evidence was collected otherwise (via a blood, feces, or urinalysis test from the newborn, for example), it may be found to be Constitutional, given the state’s interest in promoting morality, maternal health, and potential life.

### **South Carolina**

South Carolina was the first state to adopt a law criminalizing maternally mediated harm or risk of harm. This was a gradual process that moved through the judicial system, beginning with tort law. In *Fowler v. Woodward* (1964), the state supreme court found in favor of an action for damages for the “wrongful death of an unborn, viable infant.” In this case, a woman was in a car accident “caused by the

negligent and willful misconduct of the defendant,” Freddie Woodward. The woman was in in her eighth month of pregnancy, and experienced a stillbirth as a result of her injuries. The administrator of the estate of “Baby Fowler,” the deceased, sought damages from Woodward for causing this stillbirth. The court found in favor of Baby Fowler’s estate, agreeing that “a viable child is a person before separation from the body of its mother,” and as such, its death is actionable.

Twenty years later, the South Carolina Supreme Court gave its decision in *State v. Horne* (1984). Terrance Horne attacked Deborah Horne, his wife. She sustained multiple stab wounds to the neck, arms, and abdomen. Deborah was about nine months pregnant when she was attacked. She experienced a stillbirth after losing a considerable amount of blood. Terrance Horne was convicted of assault and battery with intent to kill for the injuries to Deborah. He was also convicted of voluntary manslaughter for causing “the death of an unborn full-term viable female child.” Terrance Horne appealed his conviction for voluntary manslaughter, asserting that there was no law explicitly criminalizing harm against a viable fetus in South Carolina. Citing *Fowler*, the court found, “it would be grossly inconsistent for us to construe a viable fetus as a person for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context.”

After *Horne*, South Carolina clarified the law’s application to a woman’s own actions as they relate to her pregnancy. In 1992, Cornelia Whitner pled guilty to criminal child neglect after her newborn tested positive for cocaine at birth. She was sentenced to eight years in prison and filed a petition for post-conviction relief on the basis of ineffective council, arguing that her attorney should have challenged the interpretation of

the child neglect statute that included prenatal drug use. The petition was granted and the state appealed. In *Whitner v. State* (1997), the South Carolina Supreme Court drew from the precedent set in *Horne*, arguing “It would be absurd to recognize the viable fetus as a person for purposes of homicide laws and wrongful death statutes but not for purposes of statutes proscribing child abuse.”

In 2006, the South Carolina legislature adopted a bill that would go even further than the courts had. Case law had only defined viable fetuses as victims of crime. State Senator Glen McConnell introduced SB 1084, which defined fertilized eggs, embryos, and fetuses as potential victims of crime. This law explicitly excludes pregnant women from prosecution, stating intent “to prohibit the prosecution of a woman with respect to her unborn child.” This legislative exclusion contradicts the court’s finding in *Whitner*, and arrests have continued even after its passage.

## **Alabama**

In 2006, state Senator Lowell Barron sponsored a bill creating the crime of Chemical Endangerment of a Minor. Lowell was concerned with a rise in meth manufacturing and introduced the bill to create specific penalties related to the presence of children in home meth labs. Alabama 26-15-3.2 states:

- “(a) A responsible person commits the crime of chemical endangerment of exposing a child to an environment in which he or she does any of the following:
- (1) Knowingly recklessly, or intentionally causes or permits a child to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia as defined in Section 13A-12-260. A violation under this subdivision is a Class C felony.
  - (2) Violates subdivision 1 and a child suffers serious physical injury by exposure to, ingestion of, inhalation of, or contact with a controlled substance, chemical substance, or drug paraphernalia. A violation under this subdivision is a Class B felony.
  - (3) Violates subdivision (1) and the exposure, ingestion, inhalation, or contact results in the death of the child. A violation under this subdivision is a Class A felony.”

Approximately six months after the new Chemical Endangerment law went into effect, law enforcement and prosecutors began using it to charge pregnant or newly postpartum women who tested positive for drugs. Before 2006, the Alabama legislature had considered bills creating fetal crimes on five separate occasions since *Roe*: twice in 2002, and three times in 2004. They had also twice declined to extend legal personhood to fetuses of any gestational age. In 2006, 7 bills were introduced in pursuit of fetal personhood—one of which was sponsored by Lowell Barron, the man who sponsored the chemical endangerment law.

In January 2013, the Alabama Supreme Court gave its decision in *ex parte Ankrom*. The case addressed the consolidated appeals of two women who had been charged with chemical endangerment against their unborn children. The case considered the criminal prosecutions of two women who used drugs during their pregnancies: Hope Ankrom, and Amanda Kimbrough.

Hope Ankrom gave birth to a baby boy on January 31, 2009. According to her medical records, Ankrom tested positive for cocaine while she was pregnant, and her child tested positive for the drug at birth. Eighteen days after she gave birth, she was charged with chemically endangering her son and was arrested. Ankrom pled guilty and was given a three-year prison sentence, suspended on successful completion of one year of probation.

On April 29, 2008, Amanda Kimbrough was 25 weeks and 5 days pregnant with a boy she named Timmy. She went to the hospital when she started experiencing labor pains. Her obstetrician diagnosed her with “occult cord prolapse” and premature labor. Occult cord prolapse is a condition in which the umbilical cord descends through the



cervical os ahead of the fetus. As the fetus descends through the cervical opening, the umbilical cord is compressed, cutting off blood flow. Her obstetrician also ordered a drug screen, which showed a positive result for methamphetamine. Kimbrough consented to an emergency cesarean section. Her son lived for 19 minutes. The pediatrician who treated Timmy asserted that he had died from respiratory arrest secondary to prematurity, but the medical examiner thought that Timmy had died from “acute methamphetamine intoxication.” Kimbrough was sentenced to 10 years in prison.

Ankrom and Kimbrough appealed their convictions. First, they argued that these charges were a misapplication of the chemical endangerment law. At no place in that law, or anywhere else in the criminal code, had fetuses been defined as potential victims of crime. The legislative intent, they asserted, was clearly to protect born children.

The court disagreed with Ankrom and Kimbrough, arguing that the plain meaning of the word “child” in the chemical endangerment statute includes an “unborn child or fetus,” from the moment of conception. Further, the court asserted that the legality of the substance, and the pregnant woman’s knowledge of her own pregnancy are also of no consequence. In the language of the law, according to this ruling, a pregnant woman’s uterus is an environment that she contaminates when she uses drugs or medications. So, for example, if a woman is two weeks pregnant and takes her legally prescribed epilepsy medication, she has committed felony child abuse. Penalties for chemical endangerment are dependent on the birth outcome. A healthy baby triggers a charge of 1-10 years. An injured baby triggers a charge of 10-20 years. A miscarriage or stillbirth would trigger a sentence of up to 100 years in prison.

In 2016, a bill sponsored by Senator Clyde Chambliss was signed into law, creating an explicit statement of legislative intent to prosecute pregnant women for crimes against their own pregnancies, making no specification about the gestational age at which a fetus is a person, and no exemption for abortion, though it does include a general exemption for fetal medical treatment. Chambliss told reporters, “If a woman is taking a drug prescribed by a doctor, and it unintentionally causes harm to the fetus, she should not be prosecuted” (Martin 2016).

### **Tennessee**

In 1989, Tennessee adopted a law that criminalized third party harm against viable fetuses. Then, in 2011, the legislature adopted a law defining victims of violent crimes and vehicular offenses to include “a fetus of a human being” (Tennessee Public Act Chapter 1006). This was adjusted the following year to adopt language that more explicitly included embryos and fetuses “at any stage of gestation in utero.”

In May 2013, the Safe Harbor Act was signed into law. Before this law went into effect, if a pregnant woman tested positive for drugs, her parental rights may be terminated and the baby removed from her custody after birth. The Safe Harbor Act was meant to encourage pregnant women with drug problems to seek help by reducing the likelihood that she would automatically lose custody of her children. Under this law, if a pregnant woman agrees to comply with a drug treatment plan, her drug use during pregnancy would not trigger the termination of her parental rights.

In 2014, Tennessee adopted a bill creating the crime of fetal assault, which specified that it was for narcotic drugs, only if they could prove that the narcotic use had a negative impact on the baby (SB 1391). The Tennessee legislature had declined to

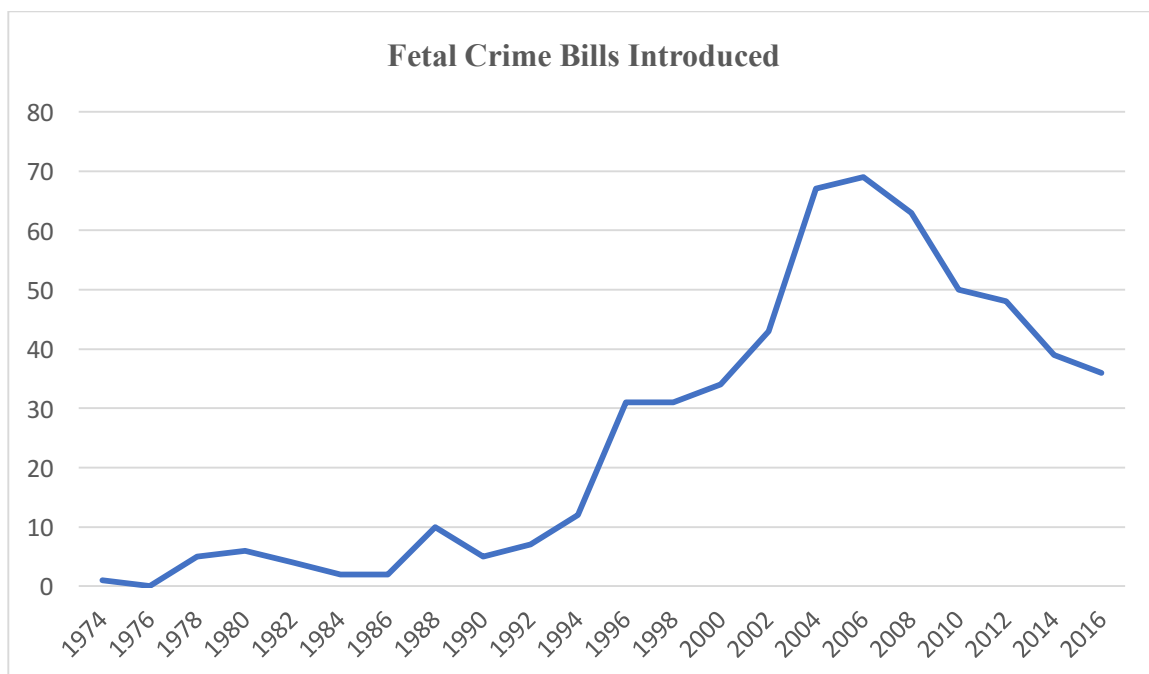
approve similar legislation at least fifteen times. The sixteenth time, it stuck. Co-sponsored by Representative Weaver and Senator Reginald Tate, SB 1391 included an affirmative defense if the pregnant woman completed a drug rehabilitation program prior to giving birth. District attorneys had approached Weaver and Tate, seeking to use the threat of criminal punishment to coerce pregnant drug users into treatment programs.

The bill contained a sunset provision whereby approximately 2 years after the legislation went into effect, it would expire and no longer be law. This was set to happen in June, 2016. Weaver and Tate sought to make the new law permanent, but the legislation, SB 1529, did not pass. Though formal law may no longer explicitly define the fetus as a victim vis-à-vis the actions of a pregnant woman, it remains to be seen whether this will mean an end to arrests and prosecutions of pregnant women. Reginald Tate has not backed down on the issue, and in February 2017, he introduced a bill that would once again define substance abuse during pregnancy as a crime.

### ***Findings***

#### *1. High-publicity violence against pregnant women invoked in introduction of legislation*

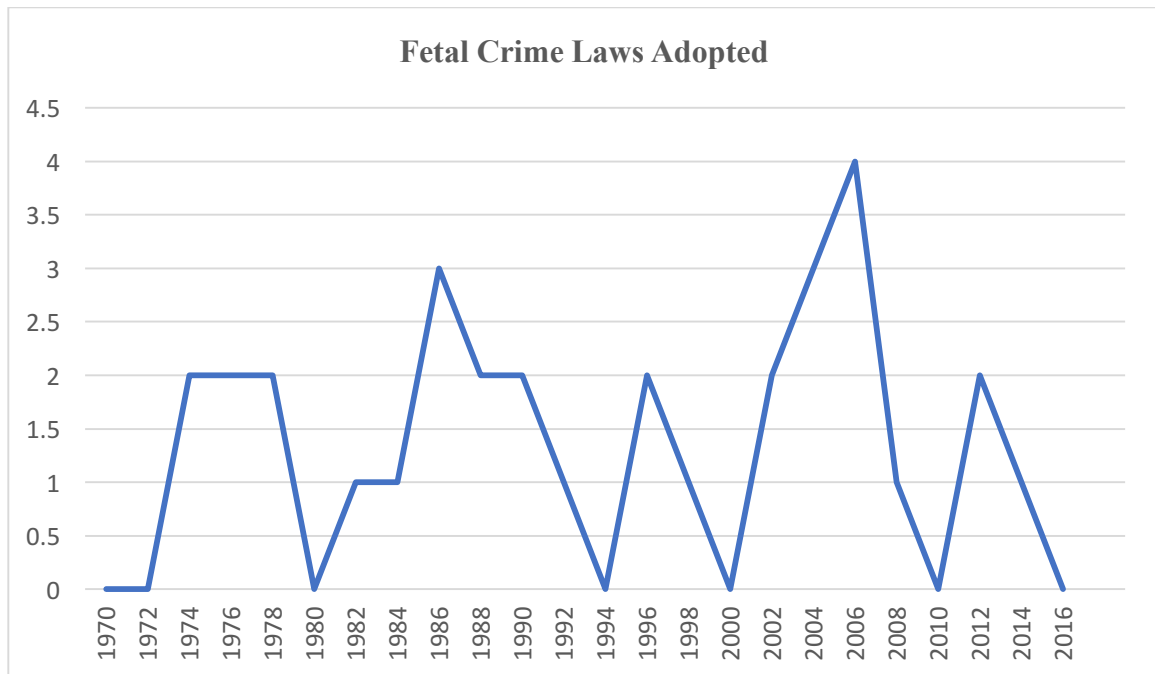
Charting the introduction of feticide bills, there are two noticeable spikes in the introduction of this legislation. From 1994 to 1996, the number of introduced bills jumped from 12 to 31. From 2000 to 2006, introduced bills increased even more dramatically, from 34 to 69 introduced bills. The Federal UVVA was introduced on 2004, after Laci Peterson's murder in 2002. The number of introduced bills has declined every year since 2006.



States also explicitly linked their feticide legislation to specific and notable crimes against pregnant women, just as the UVVA was linked to Laci Peterson's murder.<sup>i</sup> For example, Kansas' 2007 feticide law, *Alexa's Law*, was named after 14-year-old Chelsea Brooks' unborn daughter. Brooks was 9 months pregnant and had just graduated from middle school when was murdered by the 20-year-old man who impregnated her. North Carolina's feticide law, called *Ethen's Law*, was named after the unborn son of Jennifer Neilson. Neilson was murdered while she delivered newspapers early one morning. She was 8 months pregnant. West Virginia's bill was passed in the wake of the murder of Christina Renee Alberts, who was nine months pregnant. The murder of Heather Fliegelman led to the passage of Maine's feticide law.

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<sup>i</sup> Laws in Kansas, Kentucky, Wisconsin, Maine, West Virginia, and North Carolina were linked to specific criminal cases.



As one lawmaker explained, “generally, the only way we get things like this is public outcry... so if the public gets incensed enough and lets the legislators know, that’s about the only way we’ll get this heard” (Coleman 2007). Brooks’ mother worked to advance a law to recognize unborn children as victims of crime: “Two lives were taken from us last week and we will do whatever it takes to make sure that the law in the future, recognizes all life, even if it is too late for our girls” (Rocha 2006). Jennifer Neilson’s family felt that the inability to legally recognize the loss of the pregnancy erased the unborn child’s existence. Jennifer’s husband, Tim, told reporters, “with [North Carolina] not having a fetal homicide law at the time this happened, I do feel like [Ethen] was overlooked” (Yi & Page 2011). Christina Alberts’ mother presented a photograph from her daughter’s open-casket funeral to the West Virginia Senate (National Right to Life Committee 2004). It showed Christina and her dead infant together in a coffin. Fliegelman’s mother shared a photograph of the autopsy of her unborn granddaughter on

the floor of the U.S. Senate so that people would understand why she considers her daughter's murder a crime with two victims (Family Members... 2004).

Women who survive violent attacks resulting in pregnancy loss, and families of homicide victims, have also publically advocated for the passage of these laws, sharing heartbreaking stories and shocking photographs. Tracy Seavers, a pregnant woman who survived an attack that ended her nine-month pregnancy gave testimony before a U.S. House Judiciary Subcommittee in support of the UVVA, showing a photograph of herself holding the body of her dead child (Family Members... 2004).

## *2. Laws introduced to protect pregnant women are used to punish pregnant women*

According to the Paltrow & Flavin study, no arrests or detentions of pregnant women had been documented in West Virginia through 2005 (2013). In 2005, West Virginia's new fetal assault law, the Unborn Victims of Violence Act, went into effect. This law asserted that, from the moment of conception, "a pregnant woman and the embryo or fetus she is carrying in the womb constitute separate and distinct victims." The West Virginia law also prohibited the application of this law to a pregnant woman and her own pregnancy. After this law went into effect, West Virginia made its first documented arrests of pregnant women. Take, for example, *West Virginia v. Stephanie Louk* (2014). Louk was 37 weeks pregnant when she overdosed on methamphetamine. She survived the overdose and underwent an emergency cesarean section to save her baby, but her baby daughter only lived for 11 days. Louk was indicted by a grand jury for causing her child's death, and she was eventually convicted of felony child neglect resulting in death. She was given a 3-15 year prison sentence.

Another example comes from Texas. The Texas feticide law was introduced in 2003, apparently inspired by the murder of Laci Peterson. Like the West Virginia law, the Texas feticide law prohibits the application of the charge to a pregnant woman and her own pregnancy. The following year, Alma Baker gave birth to healthy twins and admitted that she smoked marijuana when she was pregnant to treat a condition called *hyperemesis gravidarum*, or chronic nausea concurrent with pregnancy (Newman 2010). Baker was found guilty for “delivering a controlled substance to a minor,” a second-degree felony. She was given a suspended sentence of 5 years in prison, and confessed, “If I would have known that I’d get in trouble for telling my doctor the truth I would have either lied or not gone to the doctor” (Newman 2010).

Neither woman was charged with violating the new feticide law in their state. The West Virginia defendant was charged with child neglect resulting in death. The Texas defendant was charged with delivery of a controlled substance to a minor. However, by defining the fetus as a victim in one area of the criminal code, prosecutors are empowered to apply that legal definition to other crimes.

### *3. Law and Practice Are Not Aligned*

Women have been arrested and detained in states under several different legal conditions, including in states with vague laws about crimes against fetuses, states with no laws about crimes against fetuses, and in states that explicitly bar the application of crimes against fetuses to maternal conduct. Here, I present some illustrative cases.

The Maine feticide law went into effect in 2005. Paltrow and Flavin documented no arrests of pregnant women in Maine through that same year, but in the years since, pregnant women have been arrested in Maine. The Maine feticide law does not say

anything about a pregnant woman's actions, and as such, vagueness doctrine would dictate that this law should not be applied to punish the actions of pregnant women. Perhaps the lack of an explicit statement barring the application could be interpreted by prosecutors as passive approval.

In West Virginia, there were no documented arrests of pregnant women prior to 2005. West Virginia's feticide law went into effect in 2005. West Virginia is one of 23 states with feticide laws that include an explicit exemption for maternal conduct. Despite that prohibition, arrests of pregnant women have been documented in West Virginia since the passage of this law. This is also true of the other 22 states including explicit exemptions. This means that rather than only operating in a condition of legal vagueness, arrests and prosecutions occur in explicit opposition to written law. Indeed, as was the case in West Virginia, even laws with written-in protections for pregnant women can be used to punish those same pregnant women.

Arrests of pregnant women have also been made in states with no legal recognition of the fetus as a crime victim—even third party harm. For example, Colorado, Connecticut, Hawaii, New Jersey, New Mexico, Oregon, and Wyoming do not legally recognize the fetus as a victim in their criminal code, and yet, pregnant women have been arrested in these states as well. Delaware and Vermont, have no legal recognition of the fetus in their criminal code, like the seven states mentioned above. But in Delaware and Vermont, no arrests of pregnant women have been documented.

## **Conclusion**

These gaps between the stated purpose of a law and the law's ultimate use, and between codified law and law enforcement, undermine the legitimacy of the law. They



show that a person can be arrested and successfully prosecuted for actions that are not actually criminal. They show that even when legislative intent is explicit, possibly even written into the law with statements of exemption, that law enforcement, prosecutors, and judges may simply reinterpret those laws, essentially suspending the rights of due process and right to fair notice of law for the women charged with these crimes. The only two states without documented arrests, Delaware and Vermont, have no legal recognition for the fetus, but other states lacking feticide laws *have* made such arrests. While it seems that having a written law does facilitate the criminal prosecution of pregnant women, it is not necessary for the practice go to on. The will to protect and punish pregnant women exists outside of the scope of the law.

Maternal protection is undergirded by the idea that the environment and lifestyle of a pregnant woman influence the quality of the offspring. Because pregnant women are, for any number of reasons, considered vulnerable, it is thought that need to be protected by others in a way that is unique among competent adults. Maternal protection in the law has largely, but not entirely, been replaced by a greater focus on the protection of fetuses. Legally, it was perhaps most visible in laws regulating workplace environments, or excluding women from certain kinds of employment.

Fetal protection generally rests on the assumption that a third party needs to intervene in order to represent the best interests of the fetus, because the pregnant woman is incapable of doing so. Laws requiring the appointment of lawyers to represent the interests of fertilized eggs, embryos, and fetuses in civil child abuse trials or laws appointing attorneys to represent the interests of “unborn children” in judicial bypass hearings for minors seeking abortion are two contemporary examples of the state

constructing policy based on this idea. The idea that the woman doing the gestating, and the fertilized egg, embryo, or fetus that she gestates, are separate entities, perhaps with opposing interests, is central to this understanding.

Protection is a two-sided coin—on one side, is the kind of freedom from fear, insecurity, violence, and other threats that compose the “state of nature,” earned by giving up certain kinds of autonomy or rights. This is the kind of benevolent protection behind the UVVA and other such laws. The other side, however, is not benevolent. It is the punitive force that lashes out when people are out of order—not willing to give up autonomy or rights. This is the kind of protection at work behind laws that seek to punish pregnant women with crimes against their own fetuses.

### ***Chapter 5. Case Studies of Pregnancy-related Arrests in Three States***

How are punitive policies targeting pregnant women enforced in practice? Does formal codification have an impact on the enforcement of these policies? In this chapter, I address those questions by providing a general description of defendant and arrest case characteristics drawn from a unique data set of over 700 arrest cases from South Carolina, Alabama, and Tennessee. I will then share my four key findings. **First**, I found that formal criminalization made no noticeable impact on arrest numbers or locations. **Second**, formal criminalization did not reduce disparities between the drug types implicated in pregnancy-specific arrests and other drug use measures or crime statistics, but may have increased these disparities in some cases. **Third**, formal criminalization did not correct the racial disparities between the defendant makeup and the state population, but was associated with larger disparities. **Fourth**, while arrests involving drugs are shown to be in decline overall, pregnancy-specific arrests involving drugs are on the rise. I will conclude with a discussion of the implications of the above findings as they relate to the legal status of pregnant women and the reproductive autonomy of women who do not seek abortion, the legitimacy of the legal system, and the utility of law.

#### **Methodology**

To address these questions, I collected case records for arrests involving maternally mediated fetal harm in South Carolina, Alabama, and Tennessee occurring from 1973, post-*Roe v. Wade* through 2015. The case identification and collection process presented many challenges. Because this study addresses arrests conducted prior to criminalization, the charges brought against defendants can vary significantly, from reckless endangerment to delivery of drugs to a minor and aggravated assault and

homicide, to name a few. Though these documents are on the public record, the non-existence of a uniform charge greatly reduces the feasibility of a freedom of information request for a list pregnancy related criminal charges. My first steps in the search for case documents involved outreach to non-profit organizations like National Advocates for Pregnant Women (NAPW), journalists, public defenders, media outlets, police blotters, and internet search tools. Case files included documents like arrest reports, warrants, affidavits, and sentencing sheets. Occasionally, these files also included medical records, interview transcripts, and letters written in jail or prison.

I coded case records for several variables, including information about the nature of the cases. as they were collected, including information about the nature of the cases, how the cases came to the attention of law enforcement, the birth outcome or pregnancy status of the defendant, and the defendant's race. I also coded the data to indicate whether the arrest occurred prior to formal codification, or after.<sup>i</sup> The coded case data was contextualized by census data on state and county race demographics, state-level data on non-pregnancy specific drug charges, and SAMSHA survey data on substance use and drug treatment admissions.

I identified 786 arrest cases. 182 cases were documented in South Carolina. 501 cases were found in Alabama. 99 cases came from Tennessee. This is, no doubt, an undercount, and I continue to pursue new avenues for case selection. At present time, I am waiting on the results of FOIA requests in Alabama and Tennessee that should be illuminating. Tennessee has proven to be the most challenging state to study, as it has no

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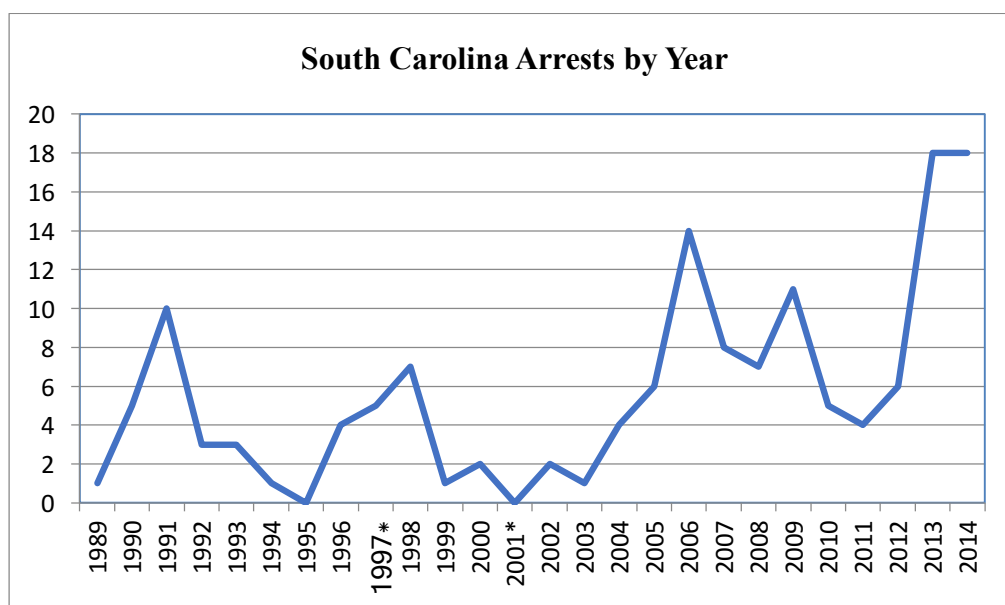
<sup>i</sup> For South Carolina, the 1997 decision in the *Whitner* case serves as the moment of codification. For Alabama, the 2013 *Ankrom* case marks formal codification. For Tennessee, the implementation of the Fetal Assault law marks formal codification.

online case-lookup system, and arrests have been made under such a wide variety of charges. As such, I present some general findings for Tennessee, but am unable to make claims as to the impact of formal codification on arrest and prosecutorial practice from the state based on case data.

## General Descriptive Findings

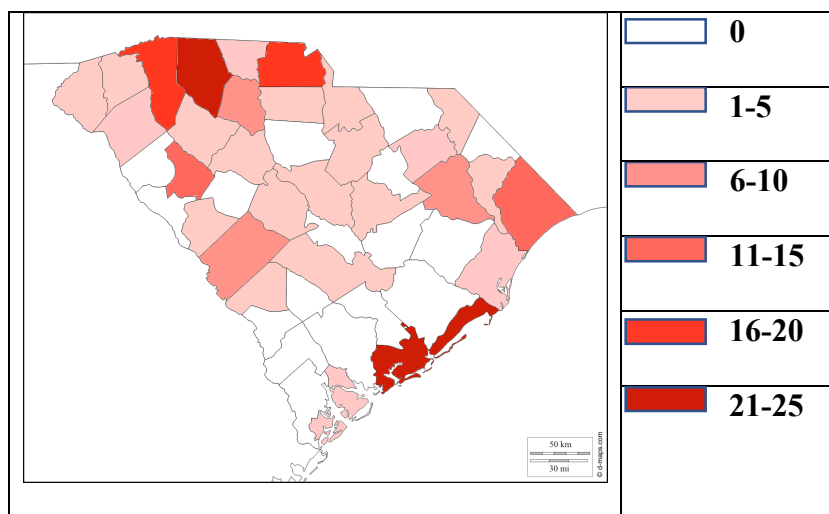
### *South Carolina*

The first cases documented in South Carolina occurred in 1989, after two women in Greenville County gave birth to babies that tested positive for drugs—one for opioids and one for cocaine. The babies reportedly presented negative symptoms of drug exposure at birth. These first arrests were made nine years before the state of South Carolina formally and explicitly criminalized maternal actions against the fertilized eggs, embryos, and fetuses they gestate. Annual arrest numbers in South Carolina from 1989-2015 show multiple peaks and declines. The highest numbers of documented arrests were made in 2013 and 2014.

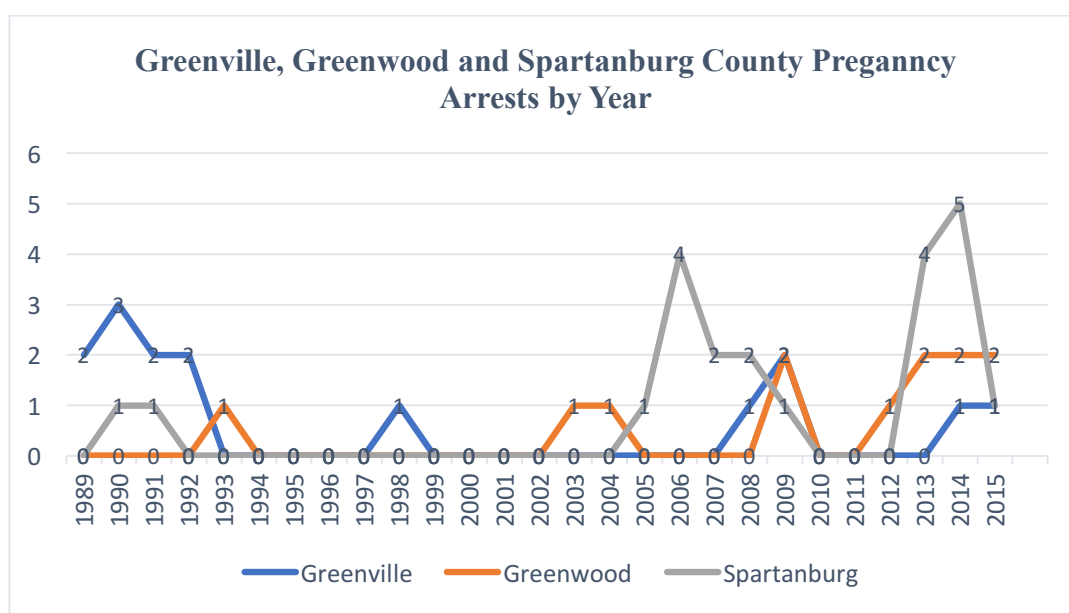


Arrests were not made uniformly across the state. I found that arrests had been made in 28 of the state's 46 counties, with Charleston County and Spartanburg County found to have made the highest number of arrests in the state over the study period, at 25 and 23 respectively.

**Total South Carolina Arrests by County**



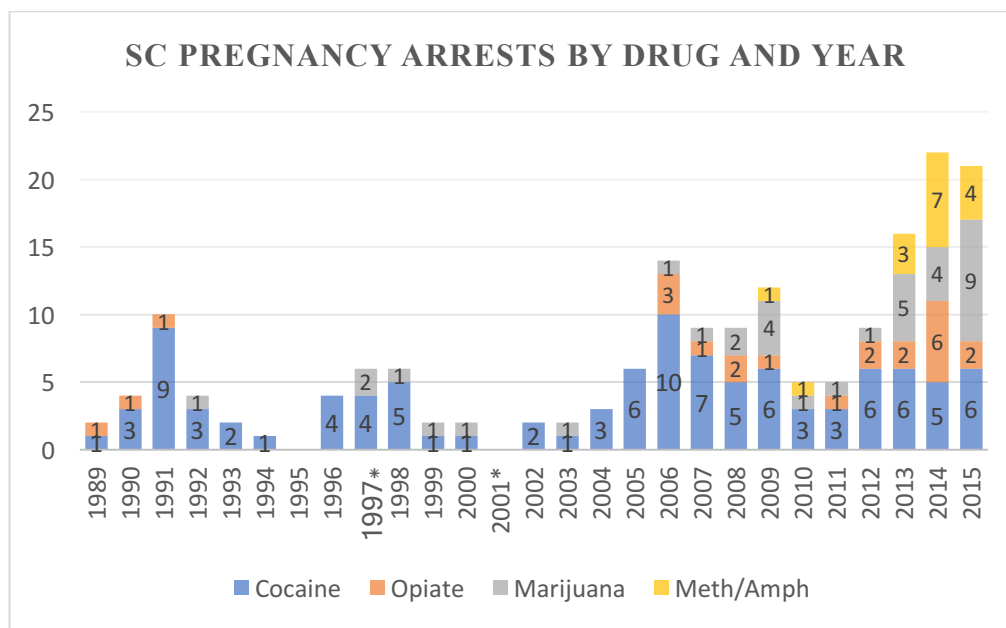
Counties adopted and ended these policies at different times, with county-level arrests showing multiple increases and decreases over the study period. Arrests from Greenville, Greenwood, and Spartanburg counties are illustrative.



This pattern could be explained by limitations of the study, including an overreliance on media reporting to identify arrest cases. Or, perhaps after the novelty of the arrest practices wears off, fewer arrests are reported in local media. It is also possible that, for any number of reasons, local law enforcement and prosecutors stop pursuing criminal charges, or healthcare providers decrease their reporting of prenatal drug use. There is also some evidence suggesting that once women learn about prosecutions being made after giving birth at the local hospital, they are more likely to give birth in a county that is not arresting and prosecuting initial local interest in arrests made because of a new law or policy.

Defendants in South Carolina charged with a variety of crimes, including inflicting great bodily injury to a child, unlawful performance of abortion, homicide by child abuse, distribution of drugs to a minor, unlawful exposure of a child to drugs, and involuntary manslaughter. The most common charges were for unlawful neglect of a minor and unlawful conduct toward a minor.

Most arrest cases involved a positive test for cocaine (106 cases). Marijuana is next, with 38 cases, followed by opiates (24). Amphetamines were involved in 16 arrests, and alcohol was involved in 7 cases. Other cases involved benzodiazepine and methadone.

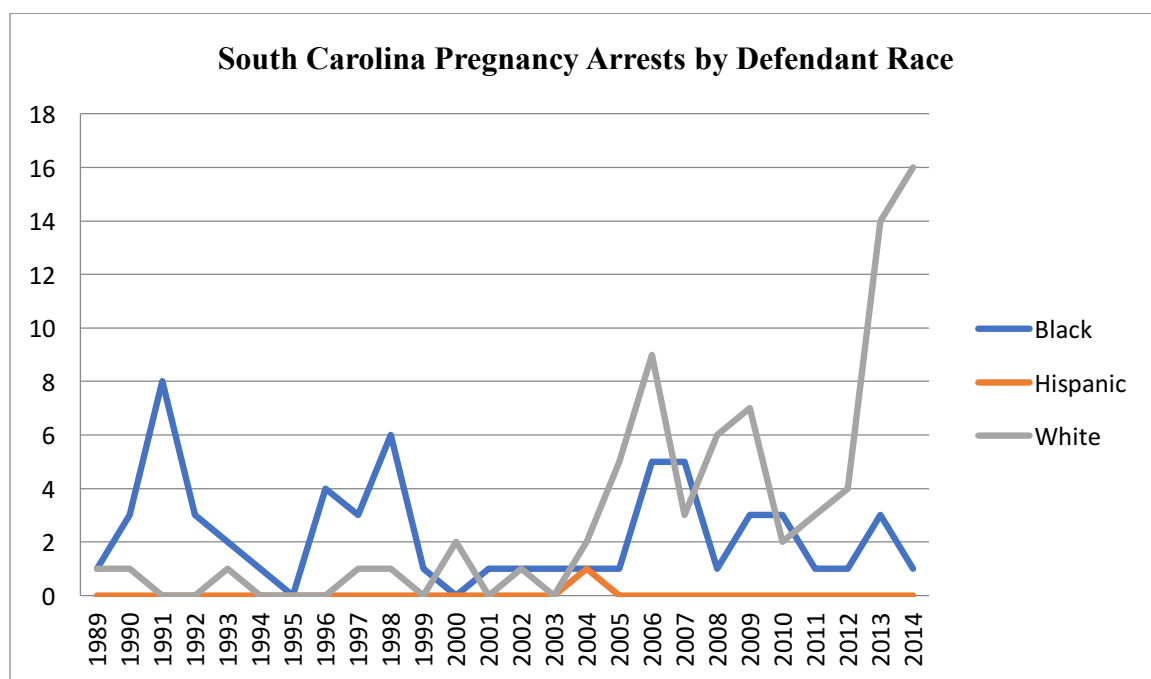


Notably, one of the marijuana cases involved a woman who anonymously surrendered her healthy newborn to a safe-haven site. The baby was subsequently tested for drugs, triggering a highly-publicized search for its mother. She was arrested and charged. Another woman, was charged with unlawfully performing an abortion. She had immigrated to the United States from Mexico and had three children. After discovering that she was pregnant, she took misoprostol, an abortifacient drug, that she illegally obtained from Mexico. She originally faced a murder charge for which the prosecutor sought the death penalty. In another case, a pregnant woman attempted suicide by jumping from her third-story apartment window. She sustained life-threatening injuries and lost her pregnancy, but ultimately survived. Once her medical condition stabilized, she pled guilty to involuntary manslaughter of her unborn child.

Out of the 161 cases for which race was indicated, defendants in South Carolina were predominantly white at 90 (55.9%). Black defendants numbered 67 (41.61%). Two



were identified as American (1.24%), and one each was identified as Asian and Hispanic (.62%).



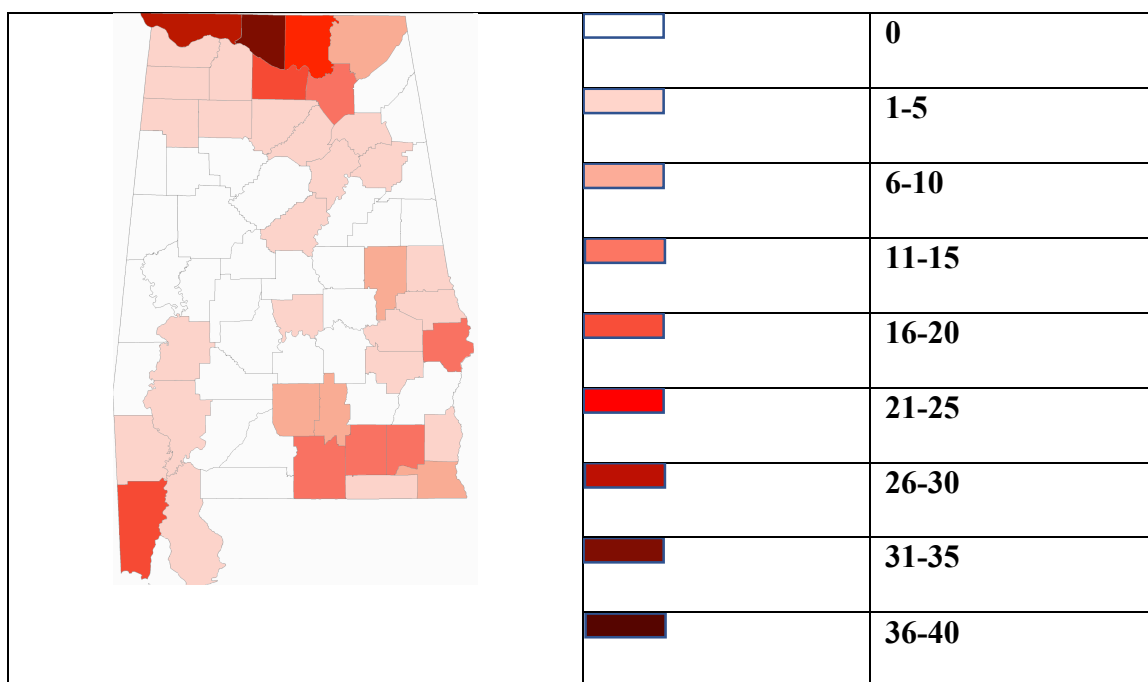
### *Alabama*

The first arrest documented in Alabama occurred over a decade before the chemical endangerment law went into effect. In 1994, a woman gave birth to a premature baby who died shortly after birth. The baby tested positive for cocaine, and the mother was charged with willful abuse of a child, unlawfully furnishing a controlled substance to a minor, and unlawful possession of controlled substance. These charges were later dismissed for improper application—there was no legal recognition of the unborn child as a potential victim of crime. Arrests made under the chemical endangerment charge began about 6 months after the law was implemented, when one woman in Franklin County and another woman in Butler County were arrested on June 19, 2006. The Franklin County defendant was white, and tested positive for methamphetamine when she gave birth. The

Butler County defendant was black, and tested positive for cocaine. Both babies were healthy at birth.

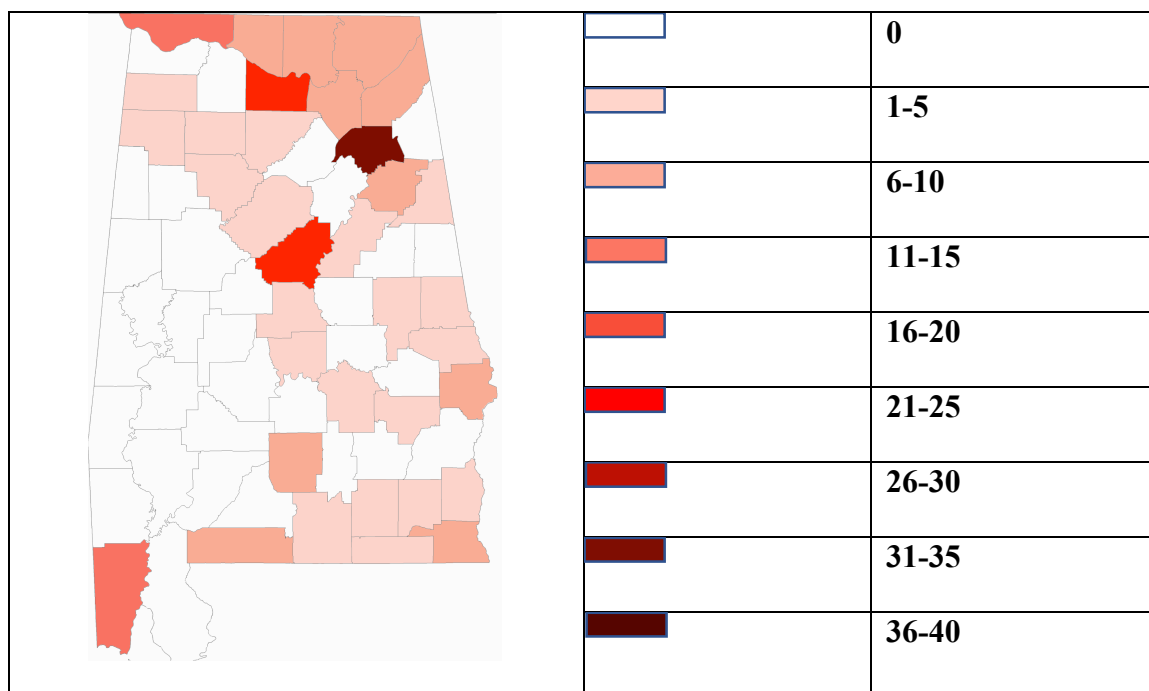
Alabama arrests made under the Chemical Endangerment charge continued in a general upward trend from 2006 onward. If arrests continue at the rate measured through September of 2015, it will be the highest number of arrests in a single year thus far. Arrest rates differed by county, showing independent initiation of the application of chemical endangerment law to pregnancy, and often followed by a peak and then a decline in arrest numbers. For example, in the pre-*Ankrom* period, the highest rates of arrest occurred in Limestone County (32 arrests), Lauderdale County (26 arrests) and Madison County (25 arrests), while Etowah County made only one arrest.

#### Pre-Ankrom Alabama Pregnancy Arrests by County



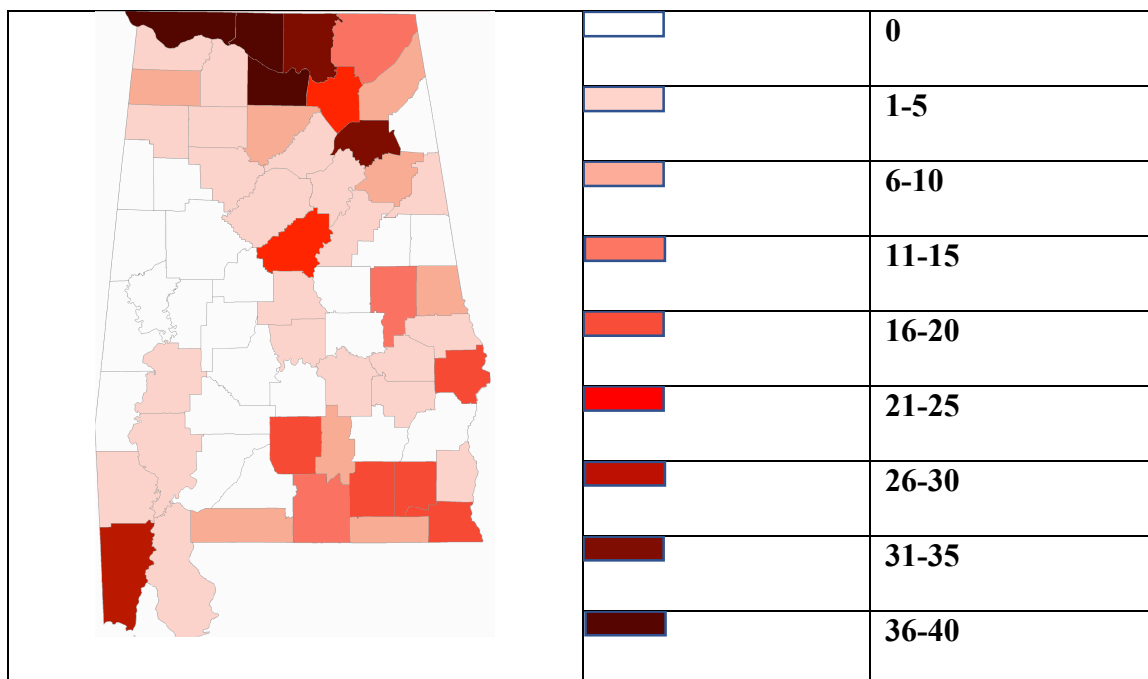
However, in the post-*Ankrom* period, the *highest* number of arrests occurred in Etowah County (25) while Limestone County only made 5 arrests—4 in 2013 and 1 in 2014.

### Post-Ankrom Alabama Pregnancy Arrests by County



Pregnant women were arrested under CETM charges in 43 of Alabama's 67 counties, with the highest concentration of arrests in the far north of the state.

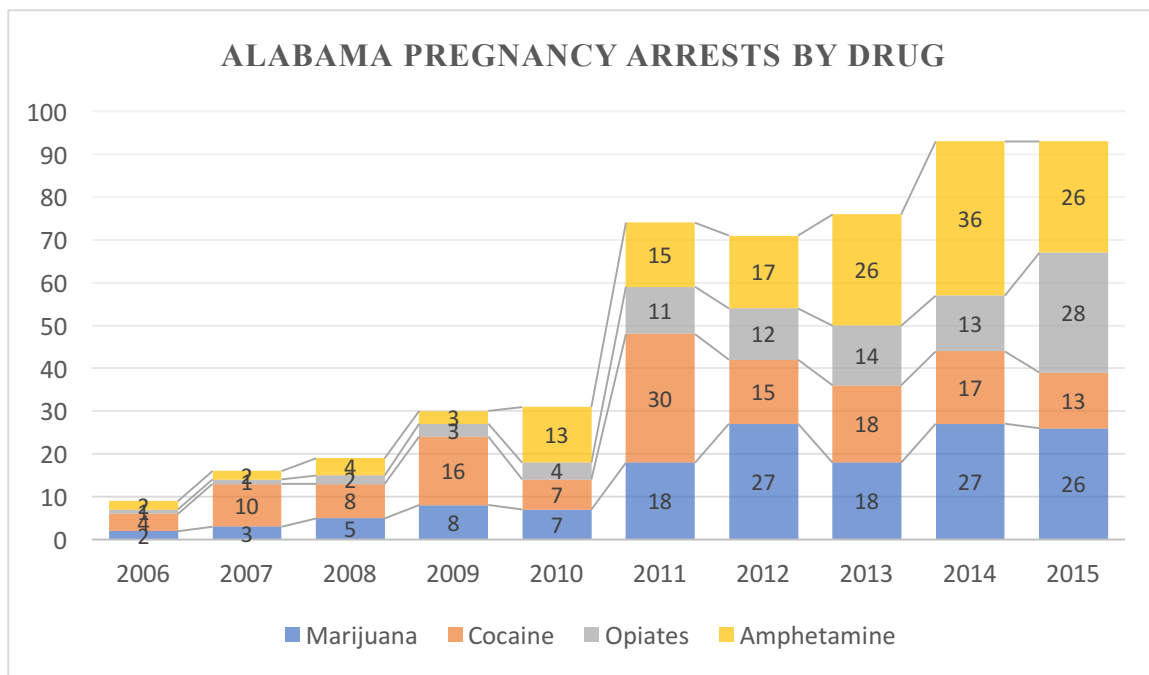
### Total Alabama Pregnancy Arrests by County



The majority of the documented arrest cases in Alabama involved an initial chemical endangerment charge, but some defendants were ultimately offered lesser charges as part of a plea bargain. Still others were *initially* charged under a different law, with the charge later changed to chemical endangerment. Some of these initial charges included willful abuse of a child, distribution of drugs to a minor, contributing to the delinquency of a minor, reckless endangerment, manslaughter, assault, domestic violence, and possession of a controlled substance.

In Alabama, most the drug-related arrests involved marijuana, with 154 cases, followed by 144 arrests involving amphetamine and methamphetamine and 138 arrests involving cocaine. Opiates were implicated in 89 cases, followed by 43 arrests involving benzodiazepine. Other drugs implicated in the arrests include methadone, barbiturates,

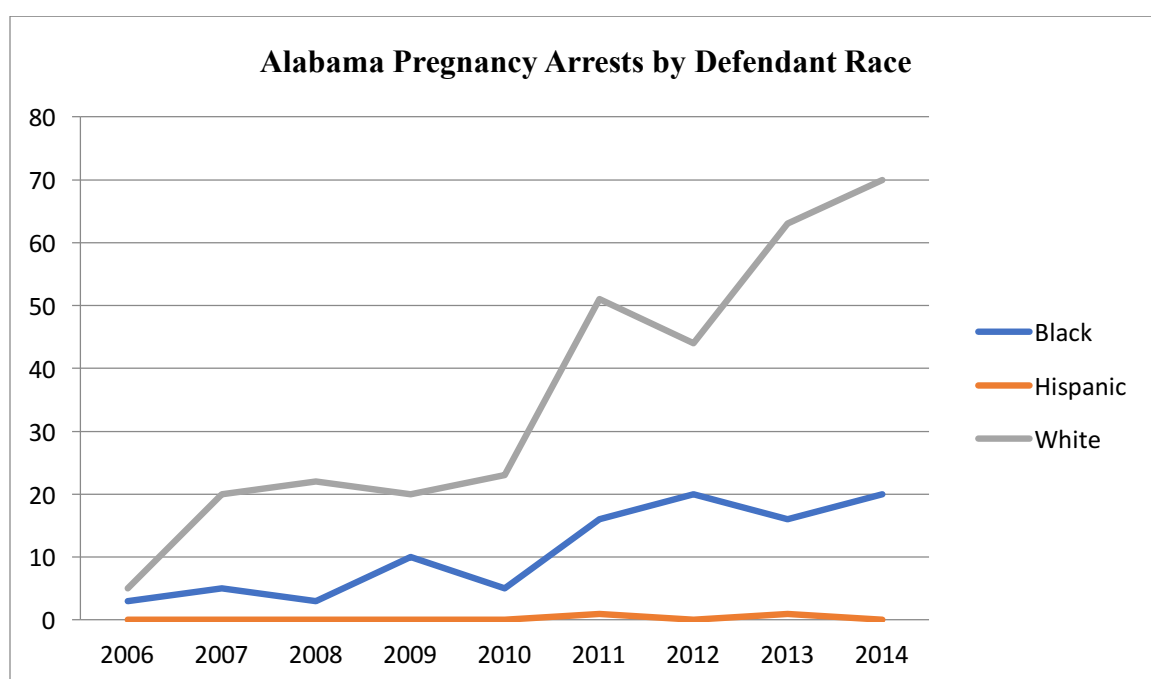
spice, PCP, tricyclic antidepressants, and promethazine.



One defendant who was arrested after a positive test for benzodiazepine had been advised to use Unisom to treat her chronic insomnia. The Unisom was ineffective, and so she took half a tablet of her husband's legally prescribed Valium. The following day, she gave birth to a healthy baby, but after the defendant tested positive for drugs at the hospital, she was charged with chemical endangerment (Martin & Yurkanin 2016; Case documents on file with author). In another case, a woman was charged with chemical endangerment when the car she was riding in was pulled over, and the driver of that car was found to be in possession of methamphetamine (Case documents on file with author). In yet another case, a woman was the victim of a car accident with a driver who was under the influence of alcohol. The woman, who was eight months pregnant at the time of the accident, had a stillbirth because of the accident. While receiving medical treatment for her injuries, the woman tested positive for drugs. As the district attorney prosecuting the case explained, "The issue is, whether the death was caused by the

trauma versus the chemicals. So... we charged [the driver] with manslaughter for the child. And we charged her with chemical endangerment of the child” (Interview on file with author). He explained that this was her second time facing criminal charges for losing a pregnancy in his jurisdiction.

Alabama arrests predominantly involved white women, making up 375 cases (75.9%). The defendant was identified as black in 113 cases (22.87%), as Hispanic in one case, and as both white and Latina in another. Race was unknown in four cases.

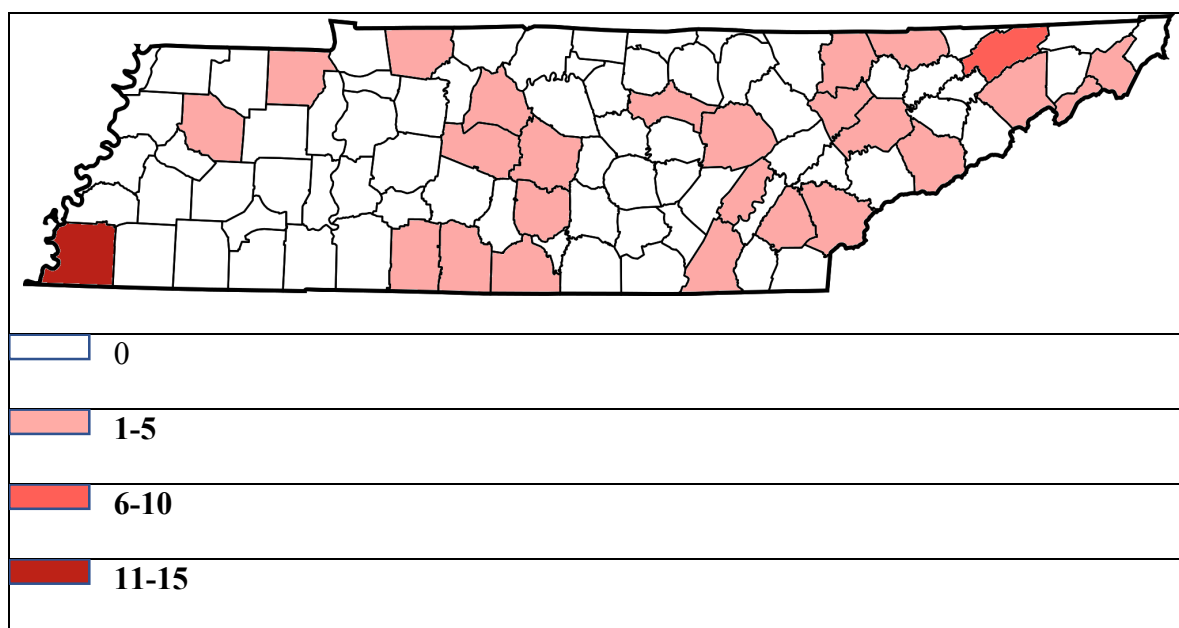


### *Tennessee*

In Tennessee, the first documented arrest occurred in 1986, 28 years before the adoption of the fetal assault law. The defendant, a white woman, was charged with criminal abortion after she attempted suicide and had a stillbirth (Court documents on file with author). The first arrest under the 2014 fetal assault law was made about a month after the law went into effect, when a woman gave birth to a baby that tested positive for marijuana and amphetamines (Court documents on file with author). The baby was

reportedly suffering from the negative impact of the prenatal drug use. Documented arrests in Tennessee trickle in after 1986, with one or two recorded arrests made every few years until 2008, at which time arrests increased steadily. Tennessee arrests were recorded in 26 of the state's 95 counties, concentrated in the north-eastern part of the state. Shelby County, in the far southwest of the state, made 16 arrests, more than any other county in the state, followed by Hawkins County in the northeast, with 6 reported arrests.

**Total Tennessee Pregnancy Arrests by County**



In Tennessee, women were charged with crimes including unlawful abortion, assault, reckless endangerment, vehicular homicide, and child abuse. Most arrests involved drug use, but other kinds of actions were charged as well. In one case from Greene County, a pregnant woman was pulled over in her car because she was not wearing a seatbelt. She was also driving with a suspended license, and to avoid criminal penalties, she tried to flee the scene (Court records on file with author). After a vehicle

chase, the defendant ran on foot from the police officer, but she was eventually apprehended. She was charged with felony evading arrest and driving on a suspended license—standard charges for her actions. However, because she was nine months pregnant when she attempted to evade the police, she was also charged with felony reckless endangerment of her unborn child. In another case, a pregnant woman survived an attempted suicide but lost her pregnancy (Court records on file with author). She was charged with performing an illegal abortion. Another defendant was found to be at fault in a car accident (Court records on file with author). She received injuries that caused the miscarriage of her pregnancy. Because she was found to be at fault in an accident that caused a fetal demise, she was charged vehicular homicide.

Of women charged with drug-related crimes in Tennessee, the majority involved opiates, with 21 arrests. The next most prevalent drug was cocaine, with 20 arrests, and then 10 arrests for methamphetamine or amphetamine. Other substances included methadone, benzodiazepine, and barbiturates. Two cases involved alcohol, and two involved cigarettes. In one case, a woman pulled over when she was driving and was asked to take a breathalyzer test (Court records on file with author). She was arrested and charged for endangering her own pregnancy, despite her blood alcohol content being well under the legal limit. She was four months pregnant.

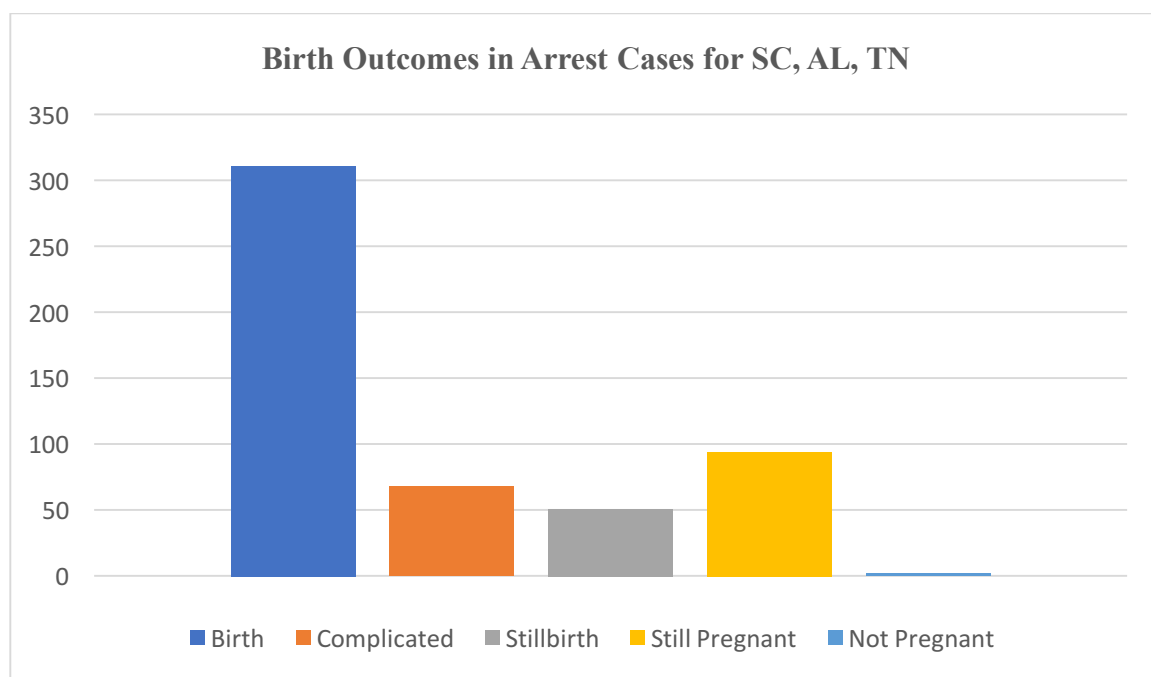
Of the 55 cases for which the race of the defendant was reported, 41 were white (74.5%), one was Hispanic (1.81%), and 13 were black (23.64%).

### **Birth Outcomes**

Most cases in all states involved the birth of a healthy baby (450 cases).



In 68 cases, the health of the infant was recorded as being compromised in some way—typically babies born prematurely, babies that were lower in weight than is typical, and babies that were reported to exhibit symptoms of withdrawal.<sup>i</sup> The pregnancy ended with a miscarriage or stillbirth in 51 cases. It is likely that cases involving a compromised birth outcome, or a miscarriage or stillbirth are overrepresented, as pregnancy complications generally trigger autopsies and toxicology reports, whereas healthy babies may not.



The 11 twin pregnancies in the study triggered multiple charges—at least one charge for each fetus. Twin pregnancies are likely also overrepresented in arrest cases, because they are medically riskier than singleton births. Twin pregnancies are more likely to end with premature birth, low birth weight, and are more likely to result in miscarriage or stillbirth.

<sup>i</sup> In a future study, I plan to analyze the designation of a “complicated birth” with the race of the defendant, as some studies have shown a racial bias in the application of the tools used to assess withdrawal symptoms in neonates. Ex. When a white baby is shaky, it is less likely to be said to be suffering from withdrawals than when a black baby is shaky.

Curiously, two of the defendants who were charged with crimes against their pregnancies in Alabama were not pregnant. It isn't clear how this happened—if there was a false positive test, if the defendant mistakenly thought she was pregnant, or if law enforcement assumed a defendant was pregnant.

While most arrest cases involved a newly post-partum defendant, each state made arrests of women who were still pregnant—20 from South Carolina, 65 from Alabama, and 9 from Tennessee. Cases involving still-pregnant women typically involved probationary drug testing related to a prior offense, or from a concurrent, unrelated charge, like check fraud or possession of a controlled substance. Some of these cases involved reports made to law enforcement by prenatal healthcare providers.

Some of these arrests involved pregnancies that could have legally been aborted. Before May 2016 elective abortion was legal in South Carolina and Tennessee through the end of the second trimester of pregnancy. Though gestational ages are unknown for all cases, at least three arrests from South Carolina and Tennessee involved pregnancies within the legal limit for abortion. At least one case from South Carolina involved a second trimester pregnancy. In Alabama, abortion is legal prior to 20 weeks from the last menstrual period. At least 18 arrest cases involved pregnancies under that limit.

### **Sentences**

Sentences ranged considerably. Prison time was not uncommon, sentences generally ranging from 2 to 20 years in prison, though these upper range sentences were typically reserved for cases involving stillbirth, miscarriage, or a seriously medically compromised birth. Other defendants received deferred sentences involving drug court or probation. Two women from South Carolina were ordered to use long acting reversible

contraceptives as a condition of probation, forced to choose between state-mandated infertility and prison time.

Many of the drug rehab facilities were religiously affiliated. On at least one occasion, a woman's deferred sentence was terminated and she was sent to prison because she was found to be joking around with another patient during prayer time. Others had their deferred sentences terminated because they did not report to drug rehab when they could not find care for their children, as drug treatment facilities generally do not permit a parent to bring their children along.

### **Avoidance**

There is evidence that women intentionally avoided prenatal care so that they would not be reported to authorities and arrested. Indeed, when health-care providers have essentially become an arm of local law enforcement, patients in need of care make other plans. One defendant from Tennessee gave birth on the side of the road when she attempted to flee the state. Two other women told police that the reason they had no prenatal care was because they did not want to get in trouble. Other women's case files indicated that they had given false names at the hospital, or had fled the hospital immediately after birth, to avoid arrest.

These fears were not unfounded. Most arrests occurred after women were reported to authorities by healthcare providers. One woman reported to the hospital with preeclampsia and was arrested and sent to jail. Another woman was arrested after she came to the hospital seeking help for an adverse reaction to cocaine. Another woman went to the hospital presenting signs of premature labor, and spent the subsequent three weeks in jail awaiting delivery. One defendant miscarried in jail. In another case, a

defendant with epilepsy, who had a previous miscarriage suspected to have been caused by her epilepsy medication, was arrested after she tested positive for marijuana—an alternative medical treatment for epilepsy that does not carry the same risks to pregnancy. She was separated from her newborn baby and put on suicide watch—like solitary confinement, but with a see-through door and no blankets, clothing, or other items that could be used for self-harm. She was given nothing for her postpartum bleeding or leaking breast milk, and went days without soap to properly bathe herself. She was also denied medical treatment for her epilepsy while in state custody, and eventually had a seizure which caused her to fall and injure her head.

While more systematic research is needed to understand the scope of the avoidance problem, the leaders of healthcare advocacy groups and some healthcare providers provide anecdotal evidence that fewer women are seeking treatment after these punitive policies go into effect, or that they planned to give birth after. Drug treatment providers specializing in the treatment of pregnant women in northern South Carolina indicated that the *Whitner* decision had a negative impact on her patients. One of these drug treatment specialists, Della Bricker,<sup>i</sup> reported that news vans were following pregnant women home from her treatment facility. “Then the women, uh, because they were being incarcerated, stopped coming to treatment. Or... they would go over the South Carolina line into North Carolina and give birth” (Interview on file with author). When asked what percentage of women they think are crossing state lines, Bricker replied, “If ten women were pregnant in [our city], I would say—and using drugs—three went across the line” (Interview on file with author).

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<sup>i</sup> Pseudonym

Allison Glass, state director of Healthy and Free Tennessee, a health advocacy organization, reported, “We are getting lots of anecdotal information about women not seeking critical prenatal care, and avoiding going to the hospital to give birth, because they are scared of being arrested and having their baby taken away” (Jeltsen 2015). Mary Linden Salter, executive director of the Tennessee Association of Alcohol, Drug, and Addiction Services asserted that fewer pregnant women were seeking treatment after the introduction of the Tennessee law as well. As arrests made headlines and stories spread about the arrests, “there was definitely a drop-off after that point” (Jeltsen 2015). A Tennessee obstetrician specializing in opioid dependency and pregnancy reported that patients were planning on delivering out of state, and that others stopped coming for their appointments (Jeltsen 2015). She continued, “We often don’t know why, but we would not be surprised if the law was part of that reason” (Jeltsen 2015).

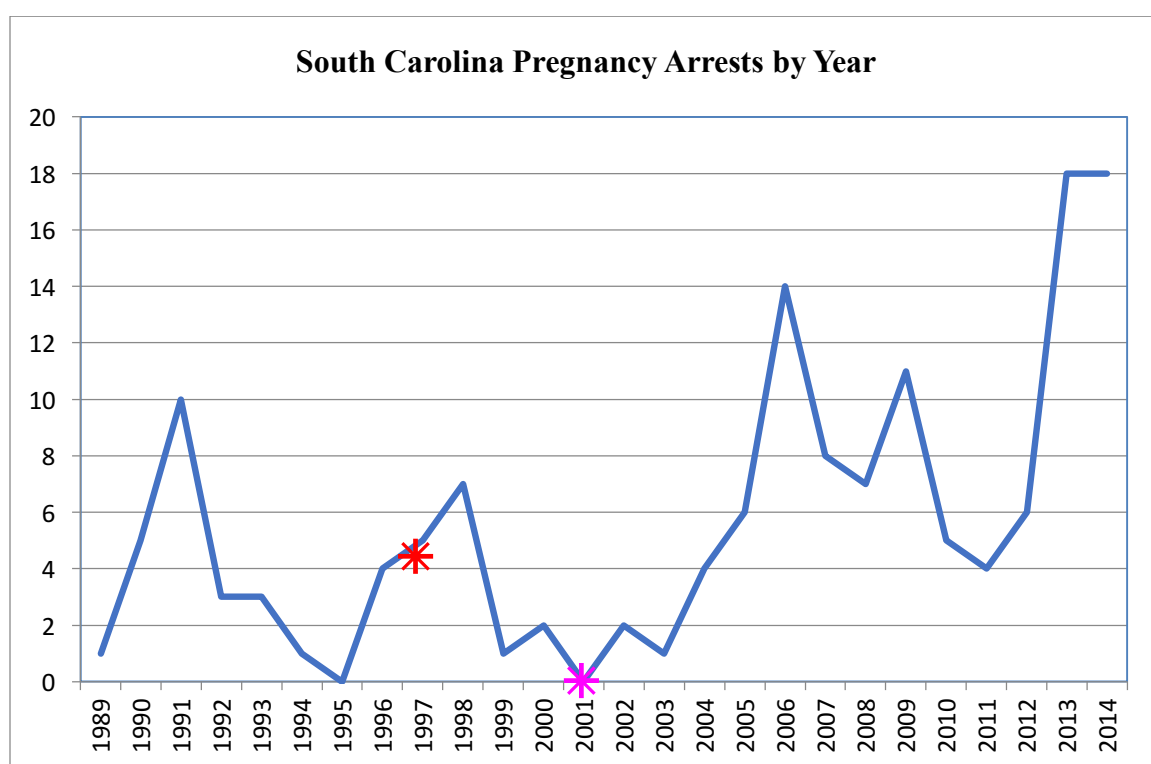
Studies of the impact of punitive laws infiltrating the medical sphere echo these concerns. One study indicated that “one of the reasons why pregnant drug users don’t use care is because they are afraid that they will be reported to CPS” and that their children will be taken away” belying assumptions that these women do not care about their children (Roberts & Pies 2011). One woman from the study said, “When you’re using and you think about prenatal care, you’re nervous and you’re scared because you don’t want anybody to take your baby. That’s the first thing on your mind.” Another woman confessed, “That whole time, that whole 9 months, you’re like, I cannot go to this doctor because if I do, they’re gonna take my kid or put [me] in jail for the rest of [my] 9 months just to take the baby when [I deliver].” Another study of low-income, newly post-partum

women indicated that punitive responses were more likely to drive people underground than they were to push pregnant women into treatment (Poland et al. 1993).

## Findings

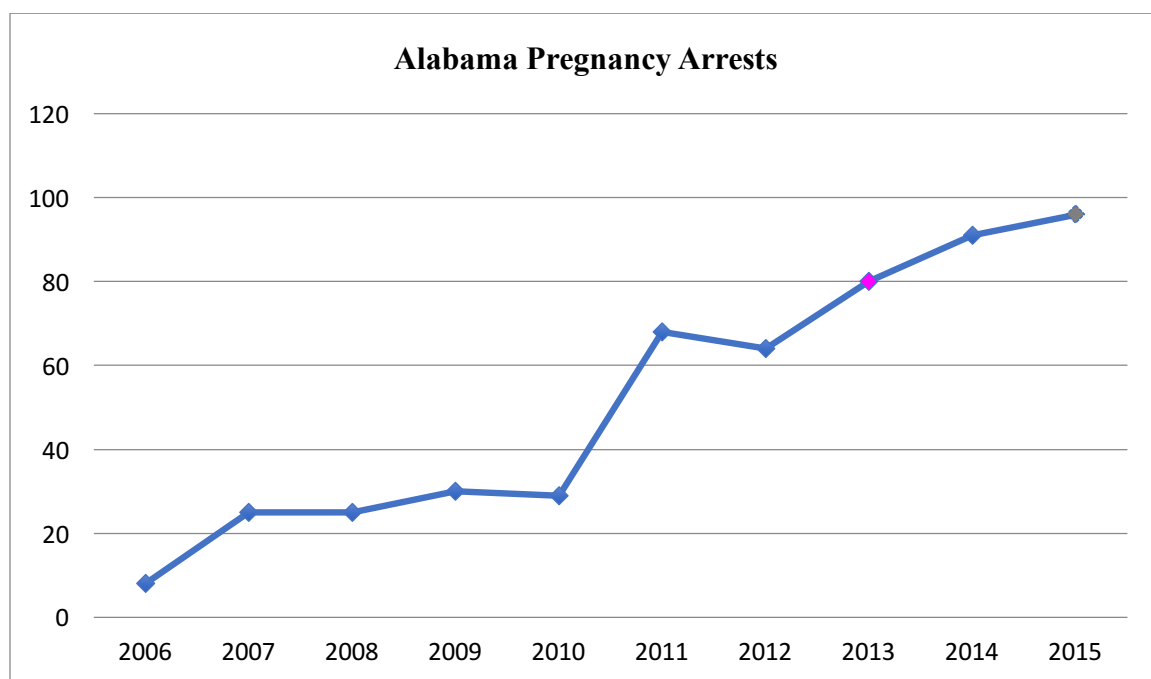
*Finding 1: Codification had little impact on overall arrest numbers in SC and AL.*

South Carolina arrest numbers briefly rose after the 1997 *Whitner* case, after which time they declined until after the US Supreme Court's 2001 decision in *Ferguson*. Post-*Ferguson* South Carolina arrests follow a general upward trend.

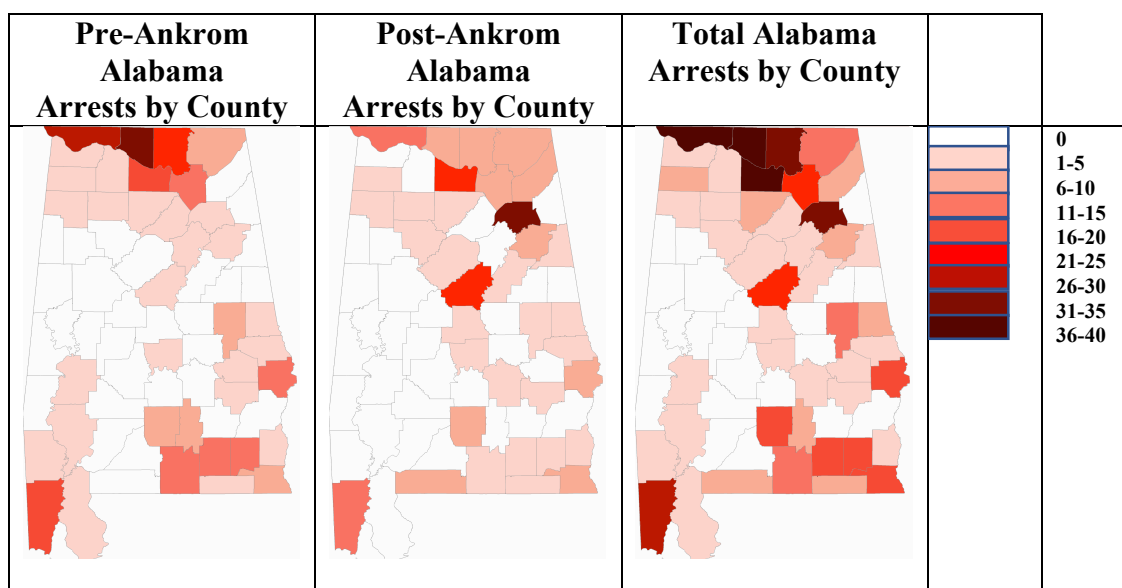


Charleston, the city facing a lawsuit in the *Ferguson* case, pursued prosecution more vigorously than other counties in the state. As such, it seems likely that the city, and perhaps other counties as well, paused its prosecutorial activity while waiting for the Supreme Court's ruling on the lawsuit, and reformulated the practice after the Supreme Court gave its decision.

Codification in Alabama (the 2013 *Ankrom* case) made no noticeable impact on arrest numbers.

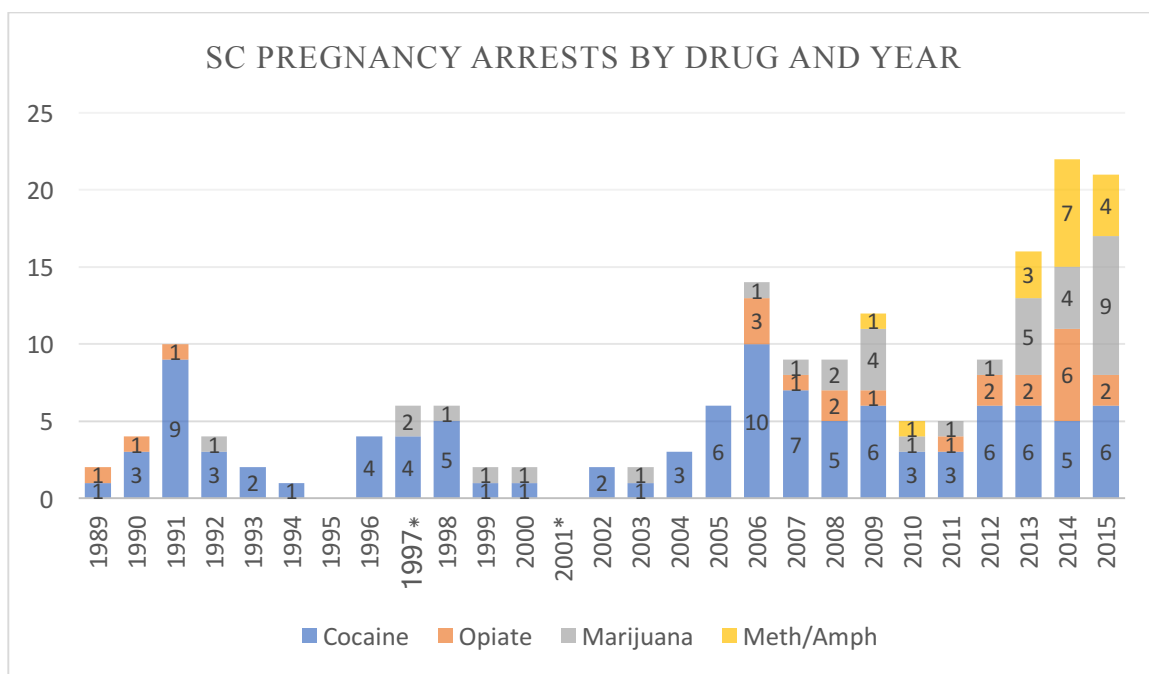


Though more counties joined the move to prosecute in both Alabama and South Carolina, these changes are not substantially different from any other year. As time went on, more counties brought chemical endangerment charges against pregnant women. It appears that the post-codification increase is a continuation of this trend and not indicative of the actual impact of codification.



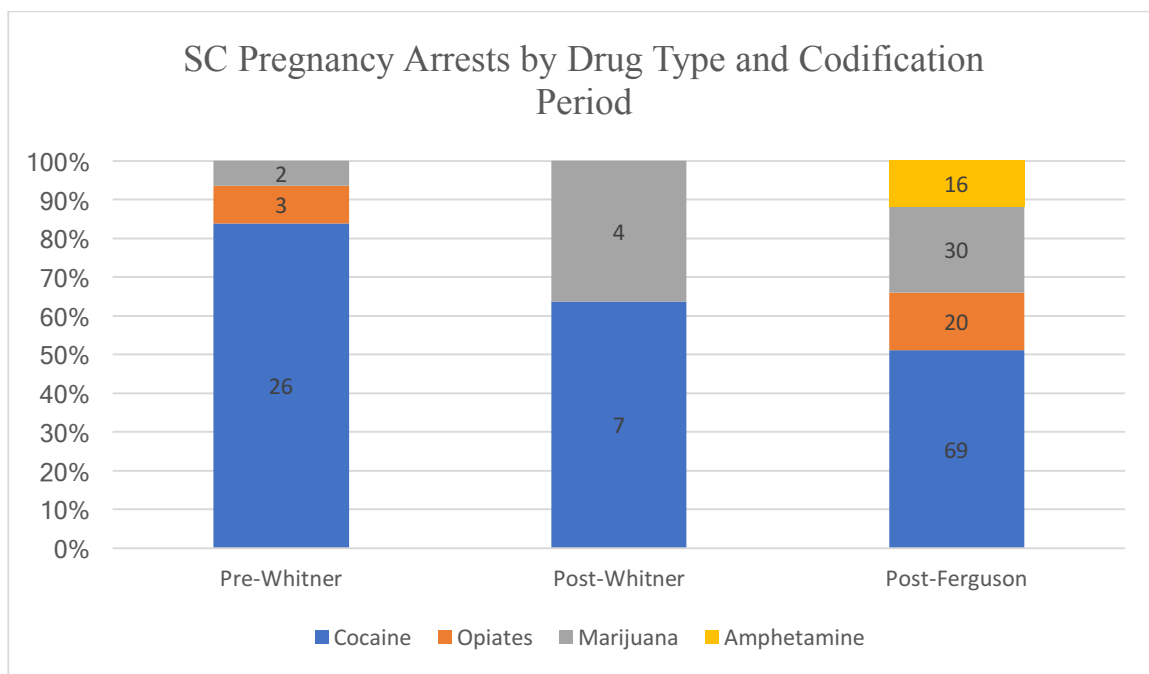
### *Finding 2: Drug Types and Drug Trends*

Cocaine was the most common drug involved in the arrests of pregnant women in South Carolina, outnumbering all other drugs annually from 1989 until 2014.

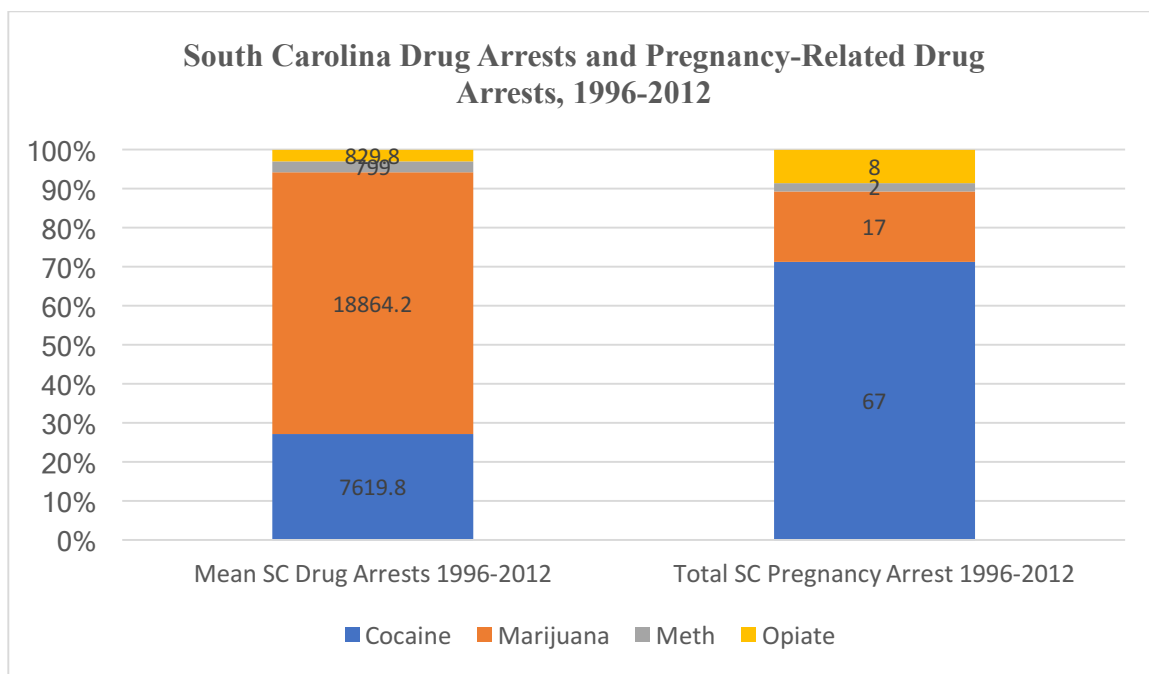


There was no noticeable difference in pre- and post-codification drug types in either the State Supreme Court case (*Whitner*, 1997) or the SCOTUS case (*Ferguson*, 2001).

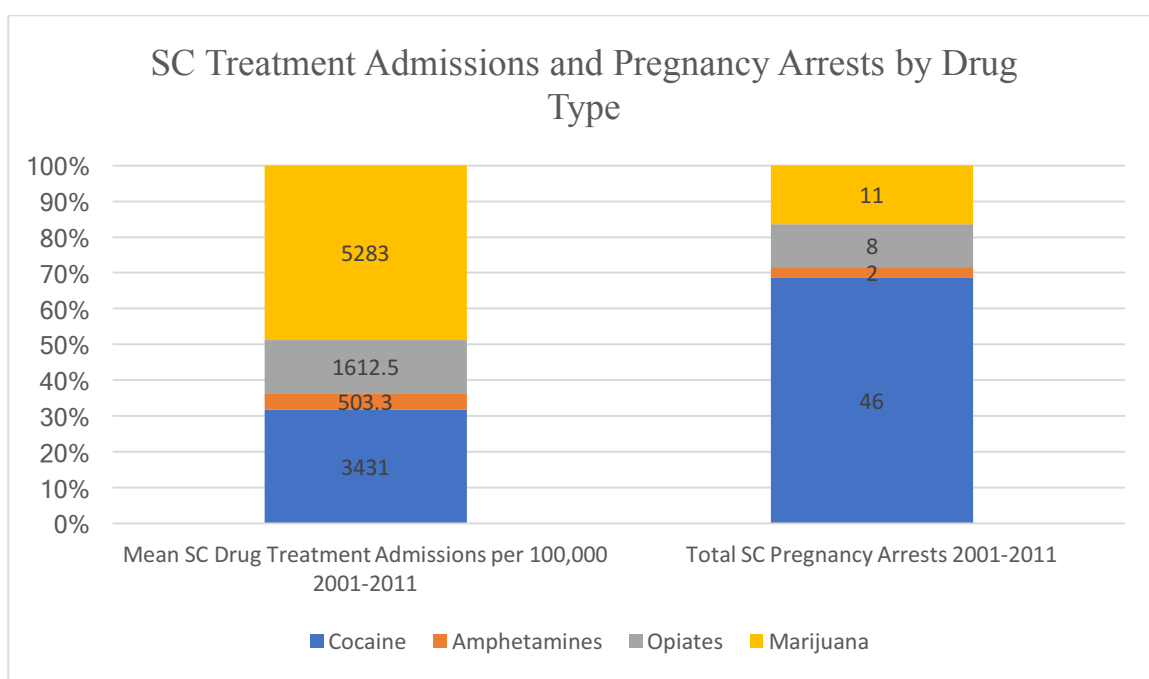




The numbers and proportions of drugs reported in records for pregnancy-related arrests are different from other state drug data. Marijuana was by far the most common drug present both in non-pregnancy related drug arrests in South Carolina from 1996-2012, and in drug treatment admissions, comprising nearly 70% of arrests and 50% of admissions, while less than 20% of pregnancy-specific arrests involved the drug.



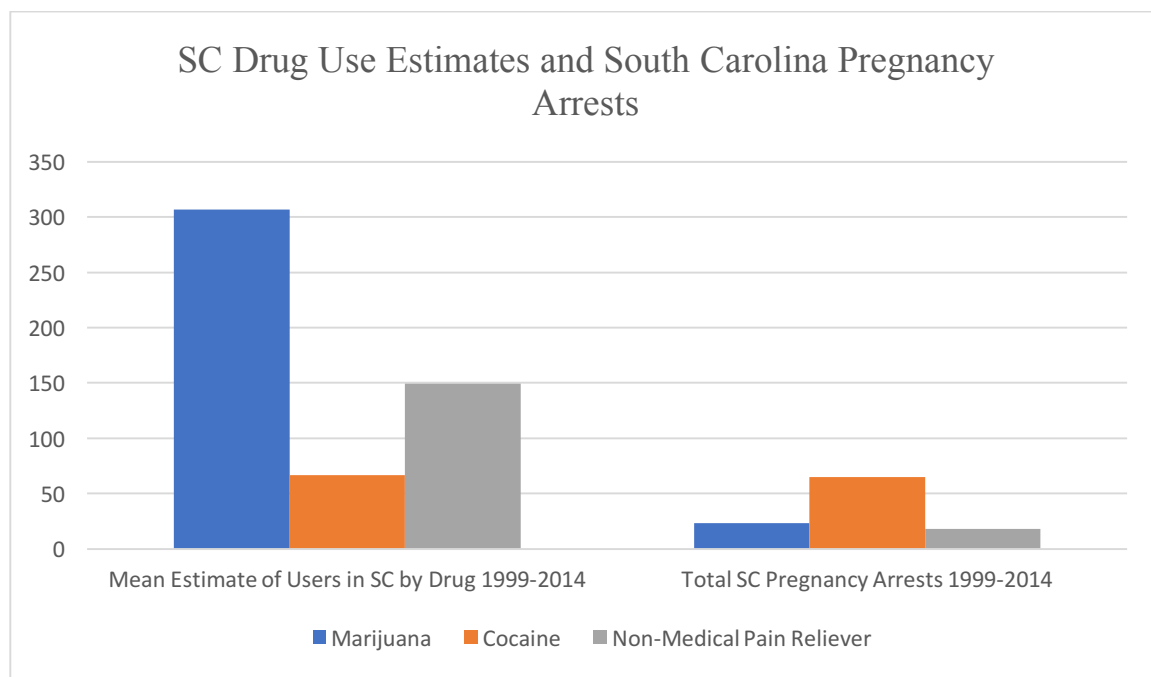
(See McManus, Altered States; High Crimes 2014)



(See TEDS 2001-2011)

Pregnancy-related arrests overwhelmingly involved cocaine, identified in over 60% of cases, but less than 30% in arrests and approximately 30% in treatment admissions. Relative to non-pregnancy related drug arrests in the state, opiates are also

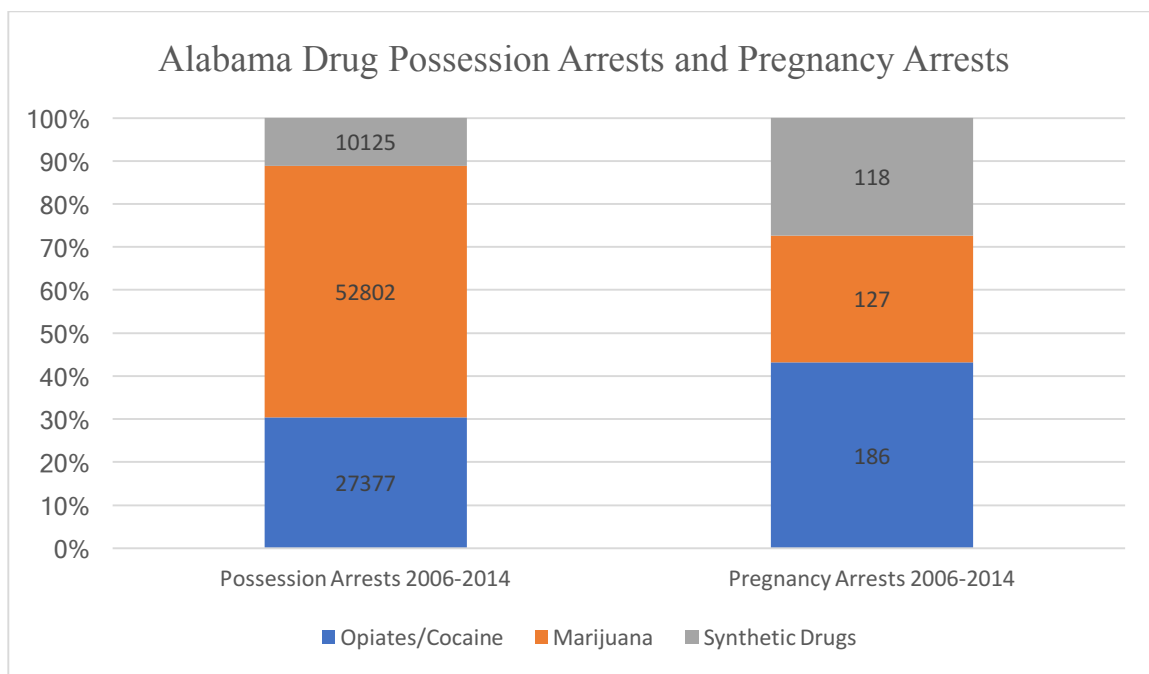
overrepresented in pregnancy cases. A comparison of drug types implicated in pregnancy related arrests to estimates of drug use shows a similar trend, with cocaine appearing in less than 15% of drug use estimates, to its appearance in 60% of pregnancy cases.



(See NSDUH 1999-2014)

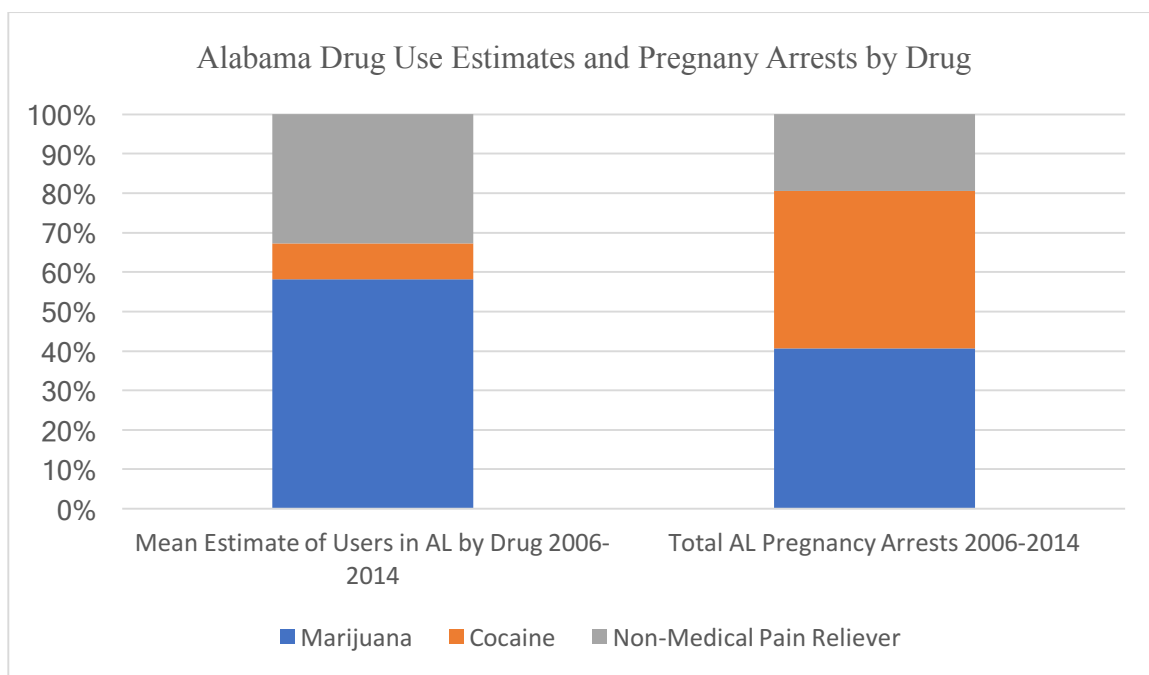
Marijuana, meanwhile, made up nearly 60% of drug use in estimate measures for South Carolina, but appeared in just over 20% for pregnancy cases.

Drug types implicated in Alabama pregnancy-related arrests were similarly discordant with other drug measures. Arrests made for drug possession in Alabama overwhelmingly, involved marijuana while slightly over 10% involved synthetic drugs, including methamphetamine and amphetamine. Methamphetamine and amphetamine are implicated in 118 pregnancy cases in this period, nearly 30% of pregnancy-related arrests, only slightly less than the number of arrests of pregnant women involving marijuana (127 cases, over 40%).



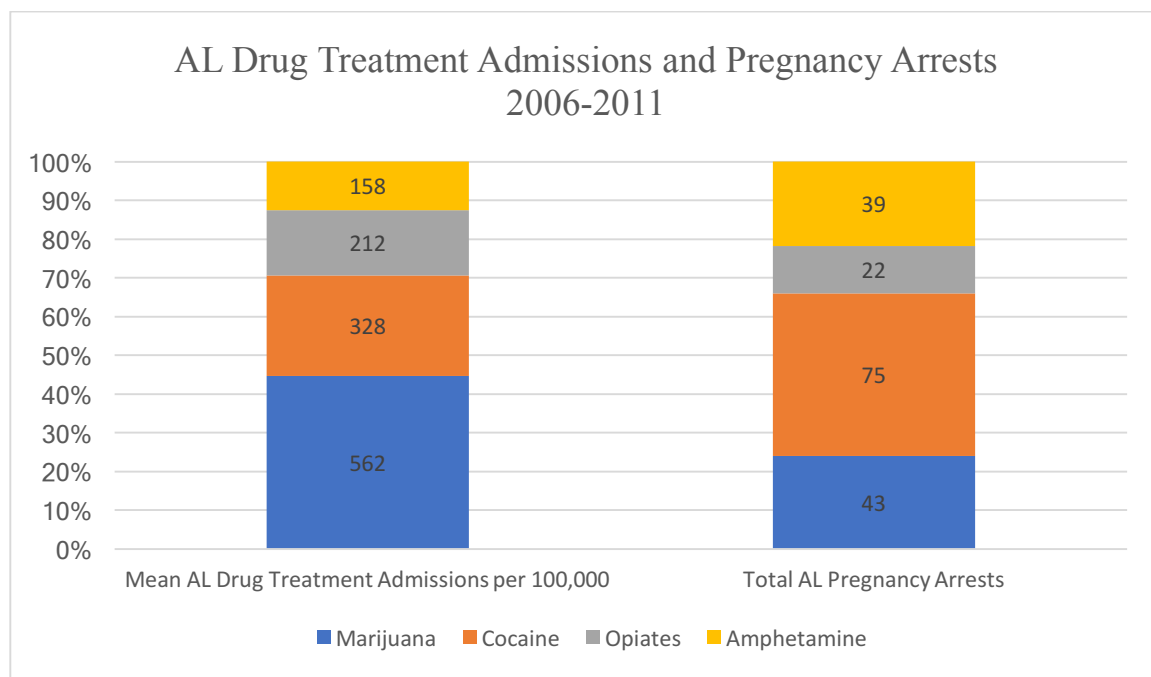
(See Alabama Law Enforcement Agency)

A comparison of drug use estimates with pregnancy related arrests also shows disparities, with cocaine involved in approximately 40% of pregnancy cases, compared to the estimate of use at 10%.



(See NSDUH 2006-2014)

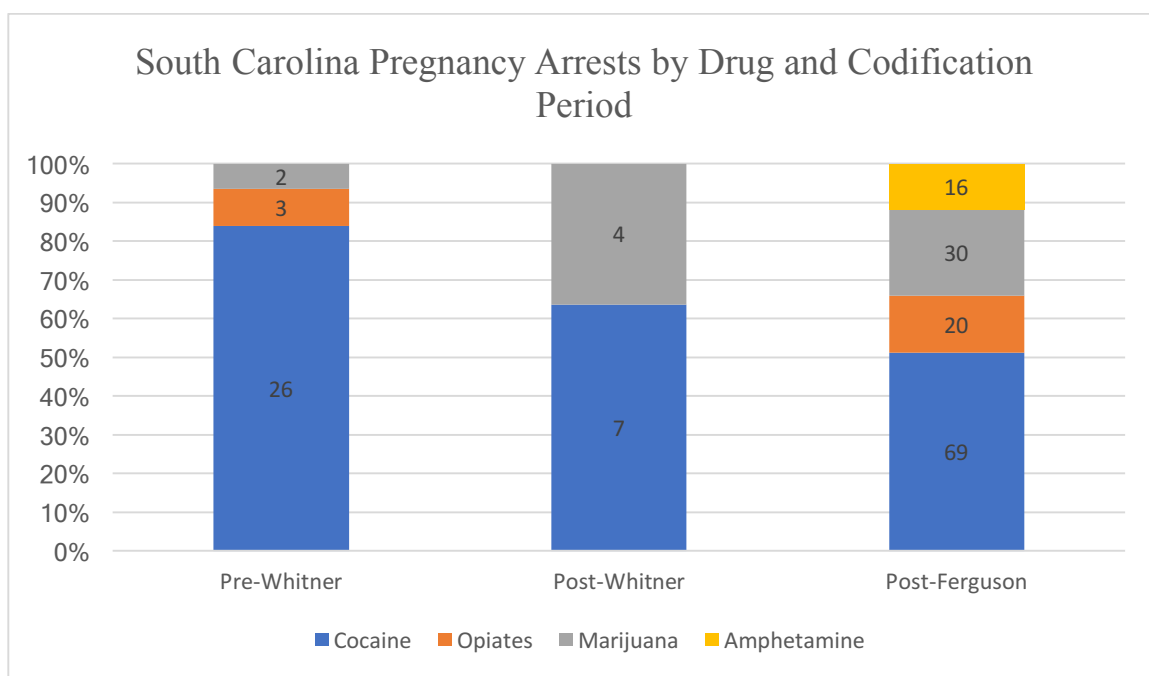
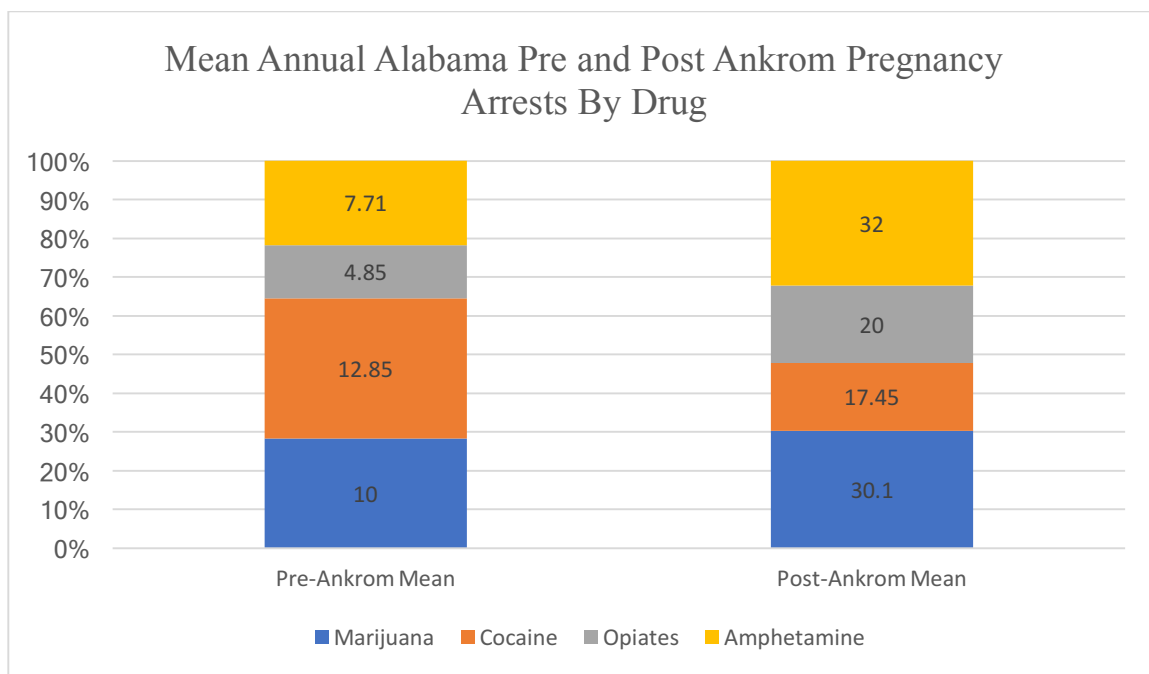
Comparison of drug treatment admissions and pregnancy-related arrests also shows disparities, with cocaine and amphetamines overrepresented in pregnancy-related arrests, almost double the percentage of cases involving those drugs for treatment admissions.



(See TEDS 2001-2011)

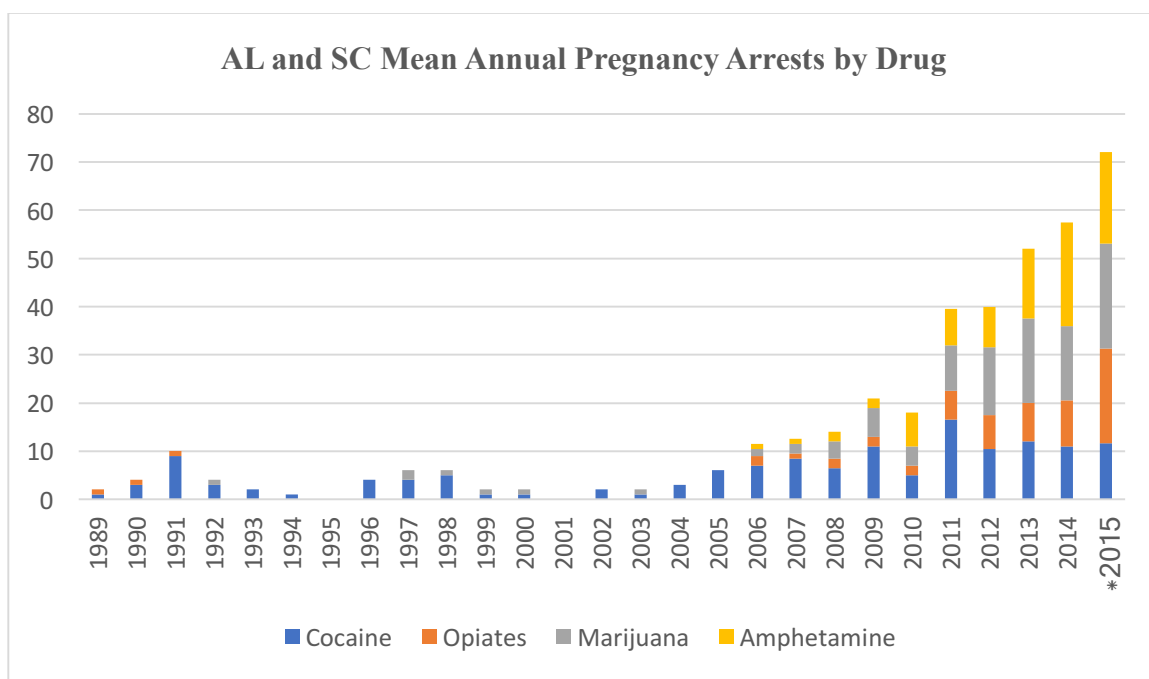
Marijuana and opiates are underrepresented in pregnancy-related arrest cases, each roughly half the percentage reported in drug treatment admissions.

There is a difference between drugs implicated in arrests made prior to formal codification and arrests made afterward, though it is not clear that formal codification caused the change.



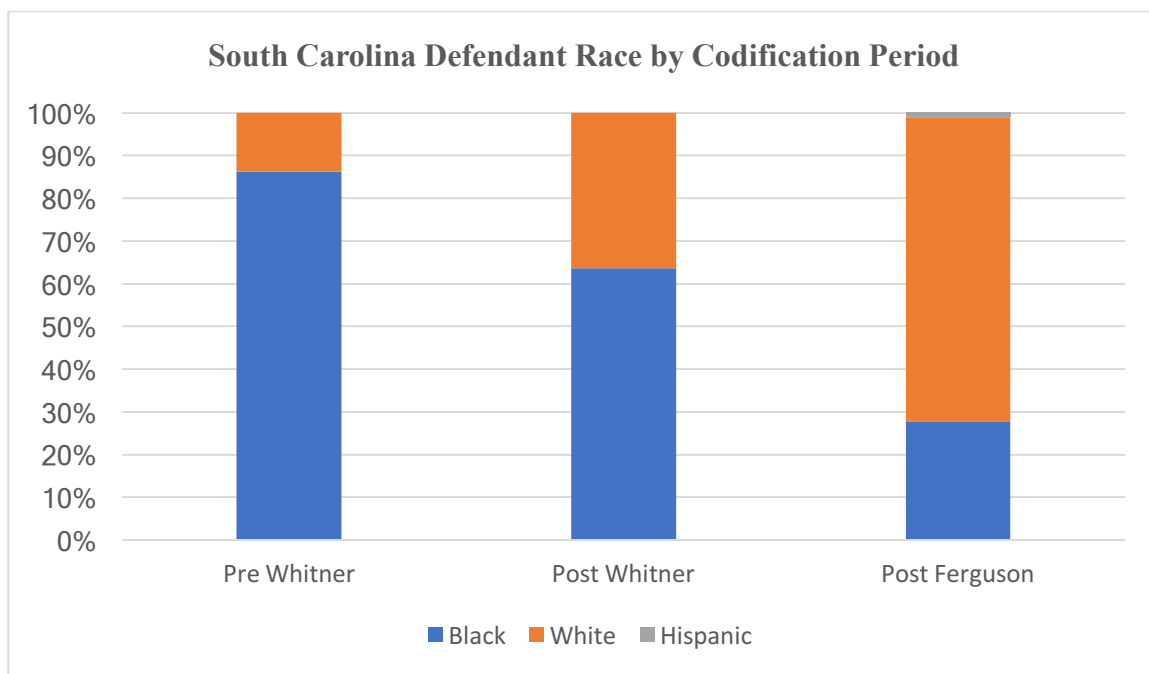
In Alabama, the percentage of cases involving cocaine declines, while cases involving opiates and amphetamines increases. In South Carolina, the percentage of cases involving cocaine experiences a similar decline, while cases involving amphetamine do not appear

until after the *Ferguson* case. For both states, these changes seem to be part of a general trend over time, and not driven by formal codification.



### *Finding 3: Race Disparities and Trends*

South Carolina arrest data showed no noticeable change in racial composition stimulated by formal codification.

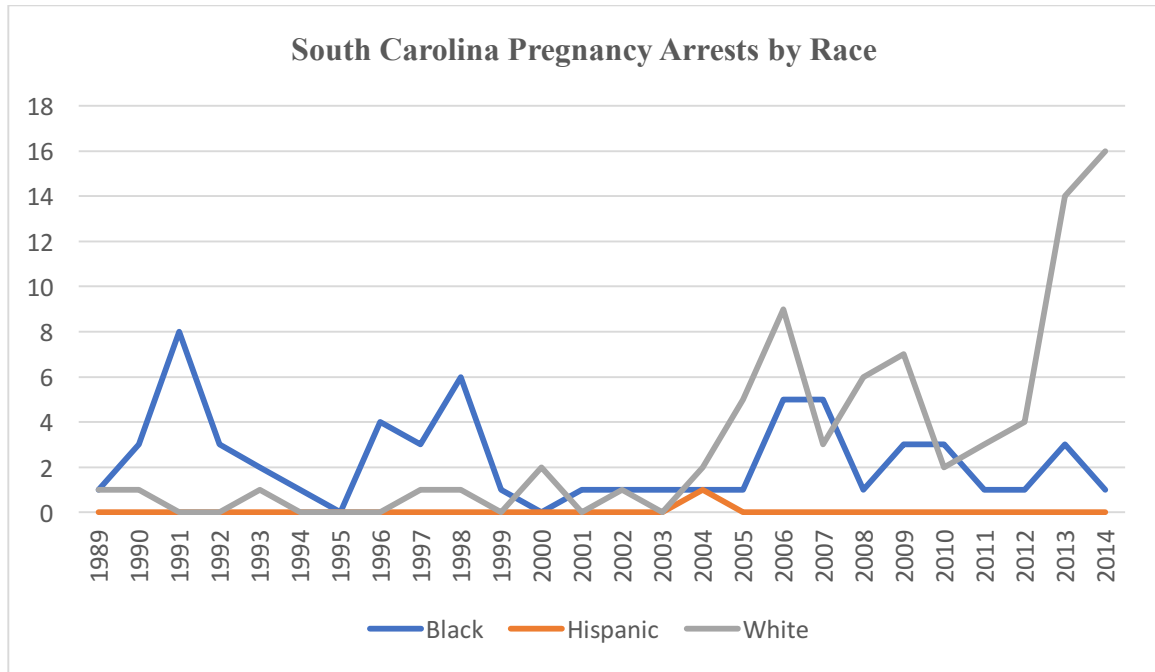


Rather, these changes are part of a general trend over time. Annually, black defendants outnumber white defendants in South Carolina through 2003.<sup>i</sup> After 2003 the demographic composition of women arrested for pregnancy-related crimes in the state shifted dramatically. In 2014, the ratio of white to black defendants was 16:1.

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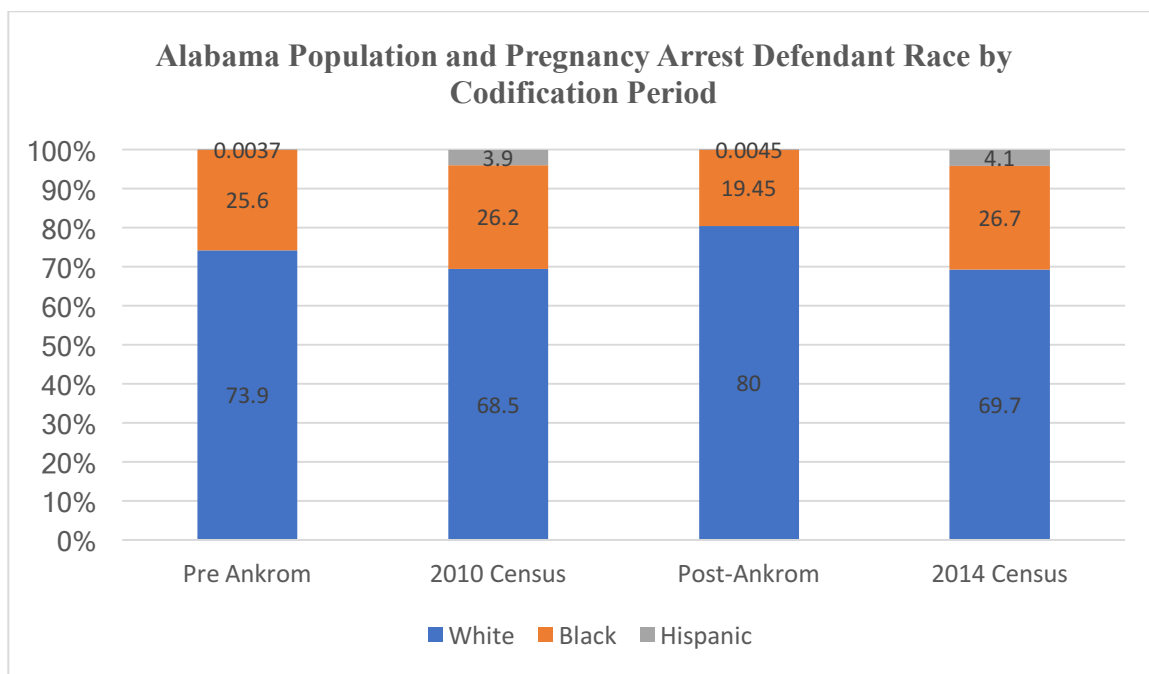
<sup>i</sup> Apart from 2000, in which two white women and no black women were arrested.





The racial demographics of pregnant women arrested in South Carolina are generally out of proportion with the state population. Census data indicates that the South Carolina population was 26.2% black in 2010, while 43% of arrests made from 1986-2014 involved black defendants—a 16.8% overrepresentation.

The racial composition of the arrests made in pre-*Ankrom* Alabama is comparable to the composition of the population than post-*Ankrom*.



Black defendants are under-represented in post-*Ankrom* arrests (7.25% below population), while White defendants are over-represented in both time periods, with the difference growing over time: 5.4% over population pre-*Ankrom* and 10.3% over population post-*Ankrom*. The racial composition of the defendant pool in Alabama is also different from the racial makeup of the state population. In 2010, Alabama was 26.2% Black, while 22.8% of the arrests involved Black defendants. Alabama was 68.5% White, but 76.73% of the defendants were White.

## Discussion

This project has indicated that though one might expect formal criminalization to result in an increase of arrests and prosecutions, there is no evidence that state-level criminalization drives a difference in this case. There is some evidence that the US Supreme Court decision was associated with higher arrest rates, but it is not clear if this caused the change or if it just corresponded with an existing trend of higher arrest rates.

The evidence presented in this paper also suggests that formal criminalization does not remedy the disparities in the race of defendants and the disparities between the drugs implicated in pregnancy-related drug crime and regular drug crimes, or between drugs implicated in pregnancy cases and general drug use estimates. If anything, it appears formal codification does the opposite—disparities in drug type and race of defendants become even greater—though again, this may be related to a general trend in drug types that is independent of legal changes. However, it could be that rather than creating a common standard, formal codification facilitates further discretion on the part of the health care providers, social workers, police officers, prosecutors, and judges involved in these cases.

Though further research is needed to confirm this proposition, it appears this discretionary behavior is not simply racially discriminatory, but rather, is driven by panic about specific racialized drug types at specific times. The stated motivation for prosecuting women in South Carolina was the use of crack cocaine—a drug overwhelmingly associated with poor black women. South Carolina’s early arrest period primarily involved black women who tested positive for cocaine. The *Whitner* case occurred only one year after, the year that New York Times mentions of crack cocaine reached their peak.<sup>i</sup> Alabama’s drug testing was primarily motivated by concern about methamphetamine—a drug overwhelmingly associated with poor whites. Alabama’s arrests disproportionately involved white women who tested positive for methamphetamine. If this is true, I would expect that arrests in Tennessee would

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<sup>i</sup> The NYT Chronicle data tool indicates that there were 108 articles mentioning crack cocaine in 1996.

predominantly involve poor white women who test positive for opiates, the contemporary drug-panic of choice.

The implications of these findings are vast, beginning with the idea that these charges are not only used against women who are pregnant—they can be used against anybody who looks like they could become pregnant. This universal impact is then run through a time-specific multi-layered discretionary filter. The county you live in, your race, age, drug, birth outcome, class, and type of drug you test positive for determine your chances of being tested, reported, and criminally charged for actions that *only* pregnant women can be charged with. It is possible that as certain racialized drugs are identified as being newly and suddenly pervasive and uniquely dangerous and addictive, healthcare providers then selectively test patients who fit the profile of a typical user of that drug, and interpret the use of that drug as uniquely and especially threatening for the “unborn child,” justifying a breach of medical privacy and a report to social services or law enforcement.

This is, in some cases more boldly than others, in direct contradiction of the precedent established in *Roe v. Wade*. Especially for defendants arrested in the first and second trimesters, criminal charges levied for crimes against the fetus are puzzling. Applying the logic of criminalization of pregnancy, this means that it is legal to intentionally kill your fetus, but it is not legal to unintentionally, potentially harm your fetus.

While the majority of these pregnancies are unplanned, only a couple of cases report that the pregnancy is unwanted—the majority of these women want to give birth and mother their children. However, when faced with the possibility of being charged

with a felony for giving birth, abortion becomes the only way out. As such, in addition to creating a legal contradiction about the legality of abortion, the prosecution of maternal behavior may in some cases *incentivize* abortion. This threat to reproductive autonomy—in this case, the autonomy of women who want to give birth and mother their children—generates risky responses from women who do not want to go to jail or lose custody of their children. These might involve giving a false name at birth, avoiding prenatal care, giving birth unattended at home, or even fleeing the state while in labor, hoping to make it across the border to a state where giving birth is not criminalized.

### **Conclusion**

My analysis has not indicated that formal codification lends stability or clarity to this process—far from it. It does not have the effect of reducing discretionary behavior on the part of health care providers, social workers, police, prosecutors, or judges. Indeed, this research Formal codification does not lend stability to this process. So, does the law matter? This depends on what is meant by the question. If the question is asked with respect to the law's ability to standardize prosecution, or about the necessity of a law for bringing charges, the answer is no.

## ***Chapter 6. Wielding the Velvet Hammer***

“I liken that to being a parent. You know, you have parameters, you have borders, and you say to your baby or your child or your toddler, ‘Little Johnny, don’t do that! Don’t do that Little Johnny, or you’re going to get a little spanking on your butt! And they test you and they test you and then you have to spank them, and you’ve got some accountability there because you’re trying to train them. This bill, in its heart and in its intent is not punitive.”

-Representative Terri Weaver

### **Introduction**

This chapter explores the motivations and goals of prosecutors who were leaders in the effort to charge pregnant women with crimes against the fetus, what tactics they used to reach those goals, and the consequences of those efforts. I found that trends in concern about certain drugs was a strong motivating factor behind the criminal prosecutions. Prosecutors generally expressed a desire to use their prosecutorial authority to solve a public health problem—using the threat of punishment to push women into drug treatment—a tactic that most referred to as “the velvet hammer.” I discuss how prosecutors attempted to use punishment to solve what they identified as an unaddressed social problem—in this case, a race and class biased and medically inaccurate understanding of addiction, and poor infant and maternal health. The efforts to address this social problem are undergirded by the legal understanding that pregnant women should be legally prevented from engaging in behaviors that non-pregnant persons can freely enjoy.

### **Methods**

My preliminary research indicated that district attorneys played a central role in the criminal prosecution of pregnant women, working as a kind of conduit between different state and county agencies with an interest in pregnancy and substance use. After

coding arrest case data by county, year, and prosecutor, I created an index of the earliest and most active prosecutors in each state. Starting at the top of the list, I found professional contact information and began the recruiting process. Our initial point of contact was typically over the phone, followed by email exchanges.

During June and July 2016, I conducted in-person, audio-recorded, semi-structured interviews that averaged 60 to 90 minutes in length. We discussed policy development, goals and motivations, challenges, and the legal strategies they used to overcome these challenges. The interviews were then transcribed and imported into NVivo, which I used to code the interviews for themes. I interviewed 6 prosecutors who were among the first to adopt the policies in their states. One prosecutor referred me to a local drug rehabilitation facility that specializes in the treatment of pregnant women, the founders of which heavily influenced the prosecutor's approach to the issue of prenatal substance use. I interviewed the two women who started the prenatal substance abuse rehab program. Their brief, vague biographies are as follows. All names listed are pseudonyms.

*Julia Graham* worked as a prosecuting attorney and child advocate in South Carolina. She initiated the development of the first policy related to prosecuting pregnant women that tested positive for drugs. Later, she was charged with educating every county in the state on how to use that policy. She currently works in private practice in South Carolina. *Matthew Payne* was the Circuit Solicitor for the circuit where Julia Graham worked, and he supported Graham's development of the prosecution policy. He currently works in private practice in South Carolina.

*Peter Hermann* was a Circuit Solicitor in South Carolina starting in the early 1990s. At the time of our interview, he was working in a private legal practice and serving as an elected member of government.

*Michael Miller* worked as a prosecutor in the district attorney's office in Alabama for nearly twenty years. He currently works in private practice in Alabama.

*David Campbell* was a district attorney in Alabama who was involved in developing an arrest policy that would eventually be adopted in counties throughout the state. He currently works as a public defense attorney.

*George Lester* has been a district attorney in Alabama for several decades.

*James Palmer* is an Alabama district attorney. He was involved in the prosecution of a pregnant drug user in her first trimester who subsequently requested to have an abortion. This case garnered nation-wide press coverage.

*Maureen Gimlet* is the executive director of a drug treatment facility and has been working in the field for 26 years. Prior to becoming the executive director, she worked as the drug treatment director at the same facility.

*Della Bricker* was formerly the associate director and director of treatment at a drug treatment facility. During her time there, she developed an outpatient treatment program for women and a treatment program for pregnant women.

### *Methodological Challenges*

Several notable actors from South Carolina could not be interviewed for this project. One, Charles Condon, was the Solicitor for Charleston, South Carolina, and was one of the major parties involved in developing the drug testing protocol at the Medical University of South Carolina (MUSC) challenged in the *Crystal Ferguson v. City of*



*Charleston* case. He eventually became the state Attorney General. Another, Robert “Bobby” Hood, was the attorney who represented Medical University of South Carolina in the *Ferguson* case. In lieu of audio-recorded interviews, I draw from statements that Hood and Condon gave to media.

I was unable to recruit prosecutors from Tennessee. Contact information for relevant actors was less readily available as, apparently, some of these individuals are now retired. Furthermore, at the time when I was recruiting subjects and conducting interviews, the Tennessee law had just expired, and its supporters were unwilling to speak with me at that time. However, because the Tennessee’s law was formally codified by the legislature, were other sources of information available. Videos of the legislative hearings in which the bill was debated and discussed are available online, and these include explicit statements of intent and support from the district attorneys that were involved in developing and advocating for the law. In lieu of interviews with Tennessee prosecutors, which I hope to conduct in the future, I include analysis of the statements that prosecutors made at these legislative hearings.

### **Motivations**

Prosecutors expressed a primary concern with prenatal substance use. In 1989 Julia Graham developed what would become the first policy to use the threat of prosecution to compel pregnant women into treatment. She explained what drove her to develop the new policy. One day, while she was working in family court, she encountered three drug exposed babies who had been taken into protective custody by the police. As she explained it,

“so, it just struck me, as we had two babies born um, drug impaired, with crack cocaine and one with heroin, and so in these three hearings in one day, and it just

came to me that nothing was really... that this was a serious issue and nothing was really being done about it" (Interview on file with author).

### *Crack Cocaine*

All the South Carolina attorneys, and an Alabama attorney who worked in a city with a large African American population, agreed that when they started their prosecution policies in the 1980s and 1990s, prenatal crack cocaine use was their primary concern.

Matthew Payne related a story about a friend who fostered children who had been exposed to drugs in utero that describes children exposed to crack in utero.

"So, they would take in, um, drug addicted babies. And he would tell me stories about, you know, um... You couldn't, you know, usually if you pick... a baby's crying, you pick him up, you now, just holding them, whatever, console them. But you, these were, babies were inconsolable. 'Cause basically they were going through withdrawal. You know, the babies would, you know, rub themselves raw in the cribs 'cause they were so agitated. Um, you know, most babies gain a little weight when they're born, these babies would lose weight" (Interview on file with author).

Bobby Hood explained, "I have seen these children die or become teen criminals and commit crazy crimes because their brains have been messed up by drugs in the womb" (Taylor 2001). Sometimes dramatic physical abnormalities were also attributed to prenatal exposure to crack cocaine. The primary sponsor of the fetal assault bill in Tennessee, Terri Weaver, invited the adoptive father of a cocaine-exposed child to testify before the House Criminal Justice Subcommittee. He reported that his first cocaine-exposed child was born without an esophagus, that "half his brain was dead," and he had almost died twice while in the neonatal intensive care unit (NICU). This child's younger brother, also exposed to cocaine in utero, did not live past his first birthday. While much of the early research on the ruin caused by prenatal exposure to crack cocaine has now been discredited, the image of the crack baby still looms over the issue of prenatal

substance use. While the medical condition of these children is tragic, it was almost definitely not caused by in-utero exposure to crack cocaine.

### *Methamphetamine*

And the influence of these of these images can be seen in subsequent drug crises. In some instances, methamphetamine seemed to take crack cocaine's place as the chemical enemy number one. Campbell, dramatically described the emergence of methamphetamine as a popular drug using the language of epidemics.

"This was something where, you know, everybody was, was screaming, you know, 'Good Lord, what's going on!' [...] When the meth epidemic hit—and I call it an epidemic because it spread like wildfire throughout our county, it felt like it was almost overnight that, all of a sudden, we weren't just facing meth cases, we were facing huge meth busts, with, just, very large quantities of methamphetamine" (Interview on file with author).

Campbell emphasized the scale of the problem, as he saw it:

"It became very easy to make the meth cases. And so, our numbers just, just get blown out of the water. I mean, you couldn't spit on somebody without hittin' a meth lab [...] It was unbelievable. And it was obnoxious. And, our court system was overwhelmed. I mean, our case load went up over 200%. And it was virtually... in a period of months that this happened" (Interview on file with author).

Meth seemed to take a devastating toll on its consumers. Julia Graham explained, "If they're really heavy—you can really tell. I mean it's a little different than cocaine or um... other drugs" (Interview on file with author). Campbell described meth users as follows: they "are up for days without sleep, um... they act very erratically. Ah, they don't think very rationally" (Interview on file with author). One Alabama police chief told reporters, "A person who is on meth forgets and forsakes everything... nothing else matters to them, and they will tell you they'll give up everything for the chance at that high" (Smith 2009).

The image of drug-using pregnant women and damaged newborn babies plays a notable role in the meth crisis narrative. One police chief told a local reporter, “On more than one occasion, we’ve gone into a house and found pregnant women on their hands and knees smoking methamphetamine or shooting it up” (Smith 2009). Campbell recalled the increase of children born in the local hospital who tested positive for methamphetamine at birth. He continued,

“Another thing that was fairly alarming about it is that, many of those children were being born very premature. And the statistics on premature children and the challenges that they face are, uh, pretty strong. Um... And so, at that point, we did not have a lot of scientific literature out there that would tell us the long-range effect. Um... The thing that concerned me the most was, was that premature part of it” (Interview on file with author).

Katherine Watson, program supervisor with Lauderdale County DHR stated publically that children born exposed to methamphetamine experience growth delays and learning disabilities. A local doctor from Marshall County, Alabama shared a story that his friend told him:

“Five or six years ago he had an 8 or 9-year-old child that was born to a meth-addicted mother. The child was psychotic. You generally don’t see that in a person that young [...] There is definitely damage done to the babies’ neurological systems. You see a lot of problems that can be traced back to being exposed to drugs like this in the womb” (Taylor 2001).

Yet, just as the early research on crack cocaine was later debunked, the medical research on methamphetamine exposure in utero has evolved to acknowledge that it does not cause, long-term permanent harm. I discuss this in more detail in Chapter 3.

Peter Hermann, explained that meth and crack cocaine are similar in some ways. “Obviously, meth is a, is a, you know... It’s like crack was, you know, twenty years ago or twenty-five years ago. It’s, It’s the cheap drug that’s out there, that everybody can get a hold of, and, and, you know, people can make” (Interview on file with author). While

wealthier drug users may reach for cocaine or a prescription amphetamine, crack and meth were cheaper, and they could be produced at home by the drug user. This had the effect of making the drugs more accessible. As Campbell described it, internet instructions on how to make methamphetamine at home, together with the availability of pseudoephedrine and other ingredients used to cook meth is part of why the use of the drug seemed to explode overnight (Interview on file with author).

Another part of the emphasis on methamphetamine as a public health crisis involved the production of the drug—not simply its use. Michael Miller recounted,

“I can remember a lieutenant in the sheriff’s department giving us a lecture about, um, how dangerous these meth facilities were, for everybody [...] There could be explosions, and chemical burns, and all these other things, uh... Even the, uh, I guess just noxious fumes” (Interview on file with author).

It was concern about the hazards of amateur meth production that inspired the creation of the chemical endangerment law that would come to be used to prosecute pregnant women. David. Campbell explained, “We were going into these meth labs, and there was just heavy, toxic air in these labs. And, you know, we were going in, and we were finding babies, and... uh... It just... It was horrible” (Interview on file with author).

### *Opioids*

As worry about the over-prescription of opioid pain killers and opioid addiction grew, it was accompanied by another fill-in-the-blank baby syndrome. This time, children exposed in utero were called “oxytots” or “snow babies.” The language these children is strikingly similar to that used to describe the children exposed to crack in utero. Terri Weaver, the co-sponsor of the Tennessee fetal assault law explained to the state legislature, “Of the nearly 1000 babies born, how have the lives of these children been affected? Particularly when these babies reach school age? These are the questions we’ve

got to deal with going forward [...]. It takes all resources to attack this deadly demon.”

The imagined life-long negative impact of prenatal exposure to opioids was expected to create a tremendous financial burden to the state of Tennessee, because the children would need long-term treatment and care, and would likely spend time in foster care.

Weaver told the house criminal justice subcommittee, “These babies are being born in our state being a huge liability to us, because there’s nobody who will take them.”

Charme Knight, the Assistant District Attorney of Knox County Tennessee, echoed this concern: “30% of children with 15-30 day stays, at thousands of dollars, ranging from 35 to 50 thousand dollars, and then the cost of children that are born this way with these cognitive... you think, what future do they have?”

## **Goals**

Every prosecutor interviewed said that their ultimate goal was to help the baby and the mother by incentivizing drug treatment with the threat of prosecution, and was emphatic that locking up the pregnant women was not their goal. For example, Julia Graham described the need for an approach that addressed the needs of the mother and her child together:

“How can we get to the bottom of this [...] and protect the children but also get the mothers well. Because from the get go, we did not want the state of South Carolina to become the parent, but we wanted to try and come up with way in which to um... outreach for the moms and the other family and to keep the babies safe. So, trying to you know, do these goals together [...] because the, the goal was just like I said, to protect the children and, and get the mothers well and get us out of their lives” (Interview on file with author).

Prosecutors also voiced an understanding that the baby was innocent and needed to be protected from its mother, sometimes opening the door to more punitive attitudes. Bobby Hood told reporters that the appropriate focus should be on the protection of the

fetus, saying “These women are pathetic human beings, they lead pathetic lives, and they need help. The mother and the fetus both have rights, but society has a duty to protect the weaker of the two” (Taylor 2001). Prosecutors compared maternal drug use to “taking a pistol and shooting the baby right through the mother’s stomach or taking a knife and sticking it in there,” drunk driving, planting and then detonating a bomb in a building, lacing baby formula with drugs or injecting drugs into a child with a syringe, and driving without a seatbelt (Taylor 2001; interview on file with author).

### **Tactics**

The prosecutors I spoke with all used a similar strategy, which they could refer to as “carrots and sticks” or “velvet hammers.” They used their prosecutorial authority to create networks of healthcare providers, law enforcement, and social workers to find prenatal drug users and offer two options: prison, or drug treatment. The understanding was that, prior to their policy innovation, there was no incentive for women to access available services to help themselves. As DA Amy Weirich of Shelby County, Tennessee said,

“None of us care about locking up mothers who are addicted to drugs. I think a lot of us would agree that that doesn’t do the public any good. What we’ve got to do is fix the addiction, and encourage women to do that. And unfortunately encouraging them with a gentle word isn’t enough. It’s the ‘velvet hammer’ of prosecution that sometimes inspires them to do the right thing and get into those programs.”

George Lester expressed a similar sentiment. He felt that the threat of prosecution would encourage women to get off drugs. He explained,

“The prosecution side, to me, gives you teeth to affect behavior that you probably can’t do as successfully through a social service... You know, what can they do? The worst they can do is take your kid, right? I mean... so what? But we can put you in prison” (Interview on file with author).

Julia Graham explained, “The ultimate goal was to use the, sort of, the heavy hammer of the law [...] that would hopefully, you know, scare the mothers into, uh, at least trying to complete their treatment plan” (Interview on file with author). Defendants would be offered deferred sentences. The deal was, complete drug court, complete probation, and then you will not have to serve time in prison, and you regain custody of your child.

### *Team Approach*

Julia Graham spoke at length about the benefits of the team approach. She developed two teams that included prosecutors, law enforcement, hospital personnel, doctors, hospital social workers, as well as representatives from the Department of Social Services: a response team and a review team. Graham’s teams worked to develop response plans tailored to the pregnant woman’s needs—inpatient or outpatient drug treatment, and programs like parenting classes and job training. Graham said, “It wasn’t a cookie cutter way to deal with these cases. It was an individual way to deal with them” (Interview on file with author). The response team was involved in developing the initial treatment and safety plan, while the review team was responsible for fine-tuning and tailoring the plans to meet the women’s needs through trial and error. The healthcare providers on the team developed the protocol indicating when a drug test should be made. The prosecutors used the threat of prosecution to coerce women into drug treatment. The social workers developed safety plans and handled child custody issues.

### *Legal Interpretations*

Prosecutors who started pursued defendants prior to formal codification argued that the laws already on the books permitted these new policies. Julia Graham, felt that existing legislation and case law gave her everything she needed (Interview on file with



author). Though South Carolina at this point had never explicitly defined the pregnant woman as a potential perpetrator against the fetus she gestated, they had already extended victimhood status to the fetus in case law. George Lester said, “we thought we were on solid legal ground charging it that way. And that we were doing good. That we were helping the, the community” (Interview on file with author). Greg Gambril, former District Attorney of Covington County Alabama interpreted the chemical endangerment statute, which criminalized having children in “environments” where drugs, drug paraphernalia, or drug precursors were kept, to apply to uterine environments. He told reporters, “when drugs are introduced in the womb, the child to be is endangered. No one is to say whether that environment is inside or outside the womb” (Nossiter 2008). In addition to defining the uterus as an environment, using the chemical endangerment law meant that fertilized eggs, embryos, or fetuses would need to be legally defined as children. George Lester explained,

“I thought it was a legitimate argument to say that a mother who is injecting, ingesting drugs and they’re going, in utero, through the child. I don’t think that’s a, ‘Wow, y’all are twisting the facts here to get the result you want.’ I mean, I believe that’s a correct analysis of what that is. That’s chemically endangering what I believe is a child” (Interview on file with author).

Although the prosecutors believed in their own interpretations of the law, they couldn’t be sure that there wouldn’t be legal challenges. Responding to claims that MUSC’s drug testing policy violated constitutional rights, Bobby Hood told reporters,

“We have not violated anyone’s constitutional rights, least of all the baby in the woman’s tummy. It’s no big deal. The police officers who came to the hospital wore plain clothes and covered the woman in a blanket after they’d chained her ankles so they couldn’t run” (Taylor 2001).

David Campbell was very attentive to existing precedent, most notably from the *Ferguson* case, on privacy and the collection of medical information to use as criminal

evidence. He intentionally left the drug testing protocol up to healthcare providers, in part for legal reasons. “That wasn’t a state action. And so, I didn’t have to worry about the legality of how they acquired the results of the test... Had we gone to them and said, ‘You need to start testing all babies,’ that’s a different story” (Interview on file with author). Miller discussed another strategy for avoiding a legal challenge. He explained,

“All you do is, you add a count of ‘attempt,’ which lowers the case one level. We’re back to the Class A Misdemeanor, which has all the leverage you need [...] And this is a little cynical, so get ready, but, talk about a way to avoid ever having to be held accountable on appeal! Because you’re pleading every case out in a far less, uh, serious level” (Interview on file with author).

Lester and Campbell sought formal legal clarification. Of the Alabama Supreme Court decision ruling in favor of the policy, Lester said, “I’m glad it wasn’t from my circuit, but, I mean... we wanted a ruling on that” (Interview on file with author). Though David Campbell did feel confident that he was interpreting the law fairly, he still thought it would be better if there was a law explicitly defining the application of criminal laws to the fetus, not only to reduce the likelihood of a successful appeal of a conviction, but also because he thought it was important to standardize the policy throughout the state. Of course, when Campbell first started the policy in his district, Alabama had not yet formally extended victimhood status to a fetus. He said, “everybody’s been prosecuting these things all over the state, but no one seemed real interested in, in trying to, to get a clarification of the law, and putting in [the treatment defense] safeguard” (Interview on file with author). Working together with a DA from another county, Campbell found a legislator who had personally encountered a death attributed to prenatal drug exposure and who was “determined to try to get some legislation passed” (Interview on file with author). Campbell presented the bill before the House judiciary Committee, but that

legislative term, “nothing was getting passed. And so, it, as well as about 80% of the bills that went into the hopper that year, died on the floor. Never never got heard” (Interview on file with author). He hoped to try again the following legislative term, but he lost his reelection before he had the chance.

### **Unintended Consequences**

Once their policies had gone into effect, some prosecutors noticed that their policy innovations came with unintended consequences. Matthew Payne and Julia Graham spoke about how the city of Charleston, South Carolina, inspired by her county’s new policy, developed one of their own. Graham recalled, “They just had—a different approach from different leadership” (Interview on file with author). Payne used stronger words:

“I can’t remember what Charlie Condon’s protocol was. I remember looking at it and thinking it was... not right. I don’t know about unconstitutional or... but I remember specifically saying, you know, ‘I think what we’re doing is safer, better’” (Interview on file with author).

David Campbell introduced his policy to other district attorneys at the annual state-wide conference of prosecutors, and ultimately came to regret what he saw as inappropriate prosecutorial discretion stemming from the disdain that many people have for pregnant drug users. He recalled, “When we did this, my concern was, was [my] county. And perhaps it was naiveté on my part to not realize that other counties were going to look at what we were doing, and they were gonna start doing it their way.” After winning an award for the work he did to establish this policy, other district attorneys reached out to him. “I was having people come up to me and say, ‘Those women should rot in Hell!’ And I’d be like ‘Whoa, whoa, whoa!’ You know, ‘No, no, no, that’s not what we’re after’” (Interview on file with author).

### *Scaring Away from Care*

Part of the critical response to these punitive policies came from major medical associations that feared mixing law enforcement with healthcare would ultimately drive people away from the very care that could improve their pregnancy outcomes. Some of the prosecutors came to worry about this as well. David Campbell wondered,

“If we start arresting women right after they’ve given birth, is this going to cause somebody to not seek pre-natal care? To not go to the hospital to deliver their child? Uh... so we tried our best to, to, you know... Every time there was something in the paper about a case like that... Always we would just, you know, put out there, “Look, if you’re, if you’re drug addicted and you’re pregnant, you know, contact our office... will not be prosecuted” (Interview on file with author).

Hermann shared the same concern. He said, “threat of prosecution can either do one of two things. For some of us it may bring us to where we need to be to have a healthy child. For others, it may drive them away from neonatal care” (Interview on file with author).

These concerns were not unwarranted. In Chapter 5, I present evidence from several arrest cases showing that pregnant women avoided medical care because they feared reprisal. Other women attempted to cross state lines to have a birth that would not be considered illegal.

### *Incentivize Abortion*

Several of the prosecutors mentioned the concern that others expressed about how the policy to charge pregnant women with crimes could, in effect, incentivize abortion. Campbell told me, “I remember meeting with, uh, the governor, and his first question was, ‘Well, aren’t you afraid that once it’s clarified like this, that we’re gonna have this great increase in abortions’” (Interview on file with author)? But Campbell didn’t share the Governor’s concerns.

“The one thing that I tried to explain, is that the people who are drug addicted, and that are carrying a child, have already made the choice to keep the child... It was always hard to try to get so many of the more conservative-minded folks to get off of that high horse of, you know, ‘abortion, abortion, abortion!!’... You know, they’re not gonna go get an abortion because of this law. You know, if they wanna keep the child, they’re gonna keep the child. They’re gonna say, ‘I can beat this!’ And then, unfortunately, while they’re through their pregnancy, they find they can’t” (Interview on file with author).

However, Michael Miller felt differently, explaining how that incentive would operate.

“A lot of these people, certainly in Alabama Supreme Court, they are... and in Alabama by-and-large, they are very anti-abortion, and these kinds of interventions, in many cases, probably led to some women saying, ‘Oh, fuck this, I’m not gonna risk going to jail. I’ll just go... It’s completely lawful for me to go terminate this pregnancy. I’ll go do that’” (Interview on file with author).

Those fears were borne out in a case from Alabama. In July 2015, a 29-year-old woman was charged with chemical endangerment of a child after she tested positive for drugs while on probation for a prior crime. Apparently, she admitted to using methamphetamine and Adderall, an amphetamine. Jane Doe was arrested and placed in jail. She was early in her first trimester of pregnancy at the time of her arrest, and Doe immediately demanded that she be permitted to have an abortion. James Palmer then filed a motion to terminate Doe’s guardianship over the fetus she was gestating, under the theory that prior to her arrest, when she used drugs, she had abused the fetus.

What happened next is contested. According to Palmer, Doe was one of their “frequent flyers,” having given birth to three or four children that tested positive for drugs at birth. He explained,

“we monitor jail calls [...] And one of the reasons we, that I filed what I filed is, I knew from her... She was talking to her mother from jail [...] almost immediately, after making the demand [...] she was telling her mother on the jail calls, ‘I don’t want an abortion. I can’t tell my [other child] that.’ And I, you know I, just talk, just... all conflicted... more, not, I don’t know if she was, she just didn’t you know, she didn’t want it” (Interview on file with author).

Palmer contended that if Doe had truly wanted to have an abortion, she could have simply made a request at the jail. Instead, lawyers got involved. Palmer felt that Doe's court appointed attorney wasn't "mindful of what the girl really wanted." Instead of representing Doe's interests, he said the defense attorney worked "with the ACLU's help, to get this abortion thing stirred up." Palmer said,

"I found out that the ACLU was looking for a test case in Alabama involving chemical endangerment cases, to try to challenge the constitutionality at the Supreme Court level. But anyway, so they made a big hullabaloo about it, and sued. They sued the Sheriff in Federal Court" (Interview on file with author).

That's when Palmer filed a motion to appoint a guardian *ad litem* for the unborn child, and an attorney to represent Doe in the parental rights case. Appointed representation is not typical in family court. Palmer explains, "They became allies of ours in trying to save the baby" (Interview on file with author). The theory was, if Doe lost custody of the fetus she was gestating, she would be legally unable to have an abortion. Palmer later admitted, "We oppose this [abortion] morally [...] It is the policy of the state of Alabama to protect all life—born or unborn" (Martin 2015).

Doe's original defense attorney and the American Civil Liberties Union attorney described something different. They contend that Doe had already been in the process of trying to obtain an abortion when she was arrested, and that the Sheriff's office was refusing to transport her to the closest abortion clinic, 90 minutes away. In her ACLU declaration, Doe stated, "I am very distraught. I do not want to be forced to carry this pregnancy to term" (Martin 2015). She went on to say that "getting an abortion in Alabama is always a lengthy process, requiring a visit to a clinic for abortion counseling at least 48 hours before the procedure itself" (Martin 2015). She continued, "I do not know how long I will be in jail, but it could be several months," at which point she might

be beyond the legal gestational age limit for abortion (Martin 2015). The ACLU and Doe's defense attorney argued that Palmer was attempting to create a public spectacle by announcing to the media that he was charging the woman with chemically endangering her fetus, and that he sought to terminate her parental rights in order to prevent her from having an abortion (Watson 2015).

Two days before rulings were expected in the custody termination case and the suit against the county sheriff, Doe apparently changed her mind. In an affidavit she wrote,

“After much consideration and counsel, I... have decided that I no longer desire to pursue an abortion procedure and intend to carry the unborn child to full term and birth. I have arrived at this decision of my own volition and choosing... without any undue influence, duress or threat of harm” (Martin 2015).

This concerned the attorneys representing Doe in the federal case. The legal director for the Alabama ACLU told reporters, “the circumstances under which this affidavit was obtained are highly suspicious and raise serious red flags” (Martin 2015). The appointed family court attorney, James McMahon,<sup>i</sup> who is the chancellor of, and attorney for, a faith-based Christian school and daycare, worked with Doe to submit the affidavit for the lawsuit against the sheriff. After Doe withdrew her request to have an abortion, the federal judge dismissed the suit against the county sheriff, and Palmer withdrew his motion to terminate Doe's parental rights. He also offered Doe the opportunity to avoid prison by staying in, and completing, an in-patient drug treatment for the duration of her pregnancy.

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<sup>i</sup> A pseudonym.

Doe's ACLU lawyer told reporters, "The amount of pressure that can be brought to bear on an individual held in jail by officials is indeed heavy pressure," but McMahon said, "she wasn't promised anything, she wasn't threatened with anything. This was a decision she made on her own" (Blinder 2015; Martin 2015). The ACLU questioned Doe's discussion of the Federal case with James McMahon, stating "He was there representing her on a petition to terminate her parental rights and while he was talking with her, they talked about the federal case" (Smith 2015). They suggest that Doe was given appointed representation for the custody trial by the prosecution so that the appointed representative could convince her to cease her attempt to have an abortion.

In any case, even in the absence of an explicit *quid-pro-quo*, Doe was faced with several powerful incentives to not have an abortion. If she agreed to continue her pregnancy, the attempt to suspend her parental rights would be ended. If she completed a drug treatment program, the criminal charges would be dropped. On the other hand, if she were granted medical furlough in federal court, and could access the abortion she had been seeking, Palmer still would have tried to prosecute her for chemically endangering the unborn baby prior to aborting it. In our interview, Palmer stated, "If she has an abortion, the fetus in our chemical endangerment case. So, we had an interest in... to protect... in getting that fetus for an autopsy" (Interview on file with author).

### **Failure and Success**

The prosecutor's assessment of their own programs was varied, though all expressed some uncertainty about the success or failure of the policies. James Palmer said,

"Other than the anecdotal, DHR saying, 'We don't think we have as many'... We don't think we're seeing as many hospital cases from Tennessee and Mississippi and



other counties that we were seeing since we started doing this. We think they may not be, necessarily, coming to our hospital, 'cause they might get charged" (Interview on file with author.)

David Campbell saw lower reports of children born exposed to drugs, but doesn't know "if that's because of the statute, or if it's because of, uh... the number of people being arrested for meth; all the meth education that we were doing in the county" (Interview on file with author). Matthew Payne reported uncertainty as well. When asked about whether the program was effective, he responded, "Have no idea. You know, I mean, I'm being honest... I mean, I asked that question. And I know that we... I'm pretty sure we dismissed a lot of cases" (Interview on file with author). He went on, "I don't think you could ask anybody whether we kept statistics beforehand versus afterwards or not, so um... But somebody may have [...] I can't tell you it wasn't effective" (Interview on file with author).

Prosecutors were less hesitant to label specific cases successes or failures. Julia Graham saw the most success come from women who could attend drug treatment without leaving their children behind. Other prosecutors described cases in which they could control the pregnant woman until she gave birth. Of one defendant, Lester recalled,

"We had a relatively successful outcome, in that we actually jailed her when she was, I think, six months pregnant. She stayed in jail, and we delivered that, they delivered... I didn't, I don't, I don't go to, I mean... the baby was delivered. And the baby's healthy and all that" (Interview on file with author).

But, after the birth of the healthy baby, the defendant seemed to fall through the cracks.

Lester continued,

"the idea was: get her back in connection with the Department of Human Resources, so that they could work to reunify her with this baby, post... you know, and, while the baby's a small child. And I mean, you know... that didn't work. But, at least, in my mind, it was a "success" because we didn't have a drug-addicted child born in that case" (Interview on file with author).

Lester's contact with one of his defendants seemed to have an impact on his attitudes. After giving birth and completing drug treatment, the defendant relapsed and was sent to prison, having violated the terms of her deferred prosecution by using drugs again. Lester recounted, "I was really disappointed in that girl [...] She was, like, the valedictorian of one of the county high schools, and... smart girl and all that kind of thing, you know. Just... a tragic story about meth" (Interview on file with author). He went on, "Am I gonna send this girl to prison, now that we've saved her baby?... or do you give her the hundredth chance" (Interview on file with author). This defendant is currently incarcerated in one of the most notoriously violent women's prisons in the United States, Julia Tutwiler, but Lester confessed,

"Do you know? I'd still be willing to help her. A-and I guess I'm conflicted with her because I looked her in the eye in the courtroom and said to her, 'You screw this up, and you're going to prison.' 'Yes, sir, Mr. [Lester]! I understand. I'm not gonna let you down this time.' That kills you when they do" (Interview on file with author)!

David Campbell reflected on the tremendous amount of criticism he received for developing the policy in his county.

"I... I remember reading those articles, which were extremely critical of me. Which, you know, was fine. Uh, I remember seeing this picture, of a very healthy [defendant], and a very healthy baby. And I remember thinking to myself, 'I don't care if they hate me for the rest of their lives. I, you know, we did good'" (Interview on file with author).

## **Conclusion**

The prosecutors that I interviewed asserted that their ultimate goal was to help pregnant women and their children, not to punish them. However, the ability for a prosecutor to effect this kind of change without punishment is questionable. And while some of these actors who got involved in the policies early may have displayed less

punitive attitudes, they were unable to contain the spread of, and the subsequent, perhaps, misuse of their policies to enact a purely punitive response. They can account for some success stories—the birth of a healthy baby, or a newly post-partum woman who is in recovery for her addiction because they used the velvet hammer. But they were less likely to acknowledge the many women who relapsed after they gave birth, violated the terms of their probation, and were forced to serve the prison sentences that were only ever meant as threats. To paraphrase the saying, when all you have is a hammer—even a velvet hammer-- everything looks like a nail.

## ***Chapter 7. Conclusion***

The criminal prosecution of pregnant women is an expected extension of pregnancy exceptionalism into the criminal realm. By defining pregnant women as a separate class of persons in need of regulation, both for their own benefit, for the benefit of their potential offspring, and for the overall benefit of society, we have reduced their legal status as a class of persons. This approach to pregnancy thrives both within and outside of the scope of the law. As such, the presence or absence of, or even the prohibition on laws calling for the punishment of pregnant women for crimes against the fertilized eggs, embryos, or fetuses they gestate seem to have little impact on how pregnant women are dealt with in the criminal system. Similarly, these laws are unable to reduce the dramatic racial disparities and curious focus on certain kinds of substances. Indeed, the laws themselves are undergirded by assumptions about good and bad mothering practices coded in raced and classed terms. Pregnant women are held criminally liable for actions or inactions that, in another person, would never be considered criminal.

The ability to prosecute your way out of a public health problem is questionable. Available evidence suggests that punitive policies are counterproductive for improving maternal and infant health. For a wide variety of intrinsic and extrinsic reasons, pregnant women who use illicit drugs are already less likely than other women to seek prenatal care—even in the absence of punitive policies. Many medical organizations and public health advocacy groups oppose these punitive measures for fear that they will only aggravate the disparity in medical care. For example, The American Medical Association suggests that, “pregnant women will be likely to avoid seeking prenatal or other medical

care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment" (American Medical Association Board of Trustees 1990).

There is also evidence that the stigma associated with pregnant drug users has the effect of driving women away from care, because they feel care providers treat them with disdain or hostility. One of the women arrested at the Medical University of South Carolina testified in court, that as a result of her treatment at the hospital, "I will never trust a doctor or a physician again. That they just—they just tormented—tormented me. I never understood why" (Joint Appendix). She went on, "I was numb. I felt like I was nobody. I felt like there was a hole I could just crawl in and die" (Joint Appendix). After she was arrested, while still pregnant, she was placed in an unsanitary jail cell. She gave birth in handcuffs and shackles. Another woman reported, "I don't trust the system anymore... You don't have any privacy. They take all of that away from you. People make your choices for you. You can't answer for yourself. From now on I'll be right particular of whom I go to for medical care" (Joint Appendix).

This maltreatment doesn't only discourage women from seeking medical care, but may have the effect of aggravating their problems with substance use. Trauma, mental illness, and social isolation are understood as some of the underlying factors that can cause substance abuse. Understood in this way, drug addiction is chronic and compulsive comfort-seeking behavior. One woman reported that, since she was jailed after birth, "It's hard for me to sleep at night anymore because I'm so afraid somebody is coming to get me. So I have to drink just go to sleep, to go through with it..." (Joint Appendix). Women described being held in unsanitary, cold jail cells with inadequate clothing.

Women were regularly held in jail still wearing only their hospital gowns—the kind that are open in the back. One woman testified that the blanket they gave her “looked like somebody else done used the blankets and wiped their back sides with them” (Joint Appendix). Post-partum women also reported being denied menstrual products in jail, and discussed the shame and disgust they felt after they bled through their clothing.

### **Shifting Approaches**

If the punitive approach is ineffective, what policy solutions might we turn to? Peter Hermann, one of the prosecutors interviewed for the project, shifted his approach to these cases over time in pursuit of a more effective solution. Hermann recalled that when he was first elected district attorney, he was elected as a “law and order” candidate.

“When I worked down in [another city] years ago they had a drug court, and I kind of laughed. I said, in my younger mind then, I knew what drug court was. You had court at night and you prosecuted more drug dealers. [Laughter] [...] But at some point later in my career, I started a drug treatment court” (Interview on file with author).

Hermann felt that he never would have won his first campaign if he had favored drug treatment court. But after establishing himself as a stern prosecutor, “people were receptive, because they trusted me. Because I’d been the guy that prosecuted people. You know, I wasn’t just giving everybody a hug” (Interview on file with author). Hermann saw his shifting attitudes about addiction and prosecution as a kind of prosecutorial maturation. “What I noticed was, as I maybe matured as a prosecutor and took to the role is, I could keep putting people in jail, but at some point, if I can affect a change...” He went on,

“You’re kind of faced with a problem that maybe needs a scalpel, maybe needs surgery, and all you’ve got’s a machete to do it with, ya know? If you’re going to do a deterrent but you don’t provide services, you’re not doing anybody much favors” (Interview on file with author).

Della Bricker, one of the directors of the local drug treatment facility recalled, “[Hermann] was part of it, initially” and asserted “I will take credit for helping him to understand that this is a disease” (Interview on file with author) Maureen Gimlet recalled, “[Della] worked very closely with [Peter], because he certainly was instrumental in making sure that we received the referrals” (Interview on file with author).

Hermann explained his new view of the issue by sharing a story that a family court judge told him:

“There’s two guys fishing on the bank, and a basket comes by, kind of like Moses, with a baby in it. And one of the guys puts his fishing rod down and walks out and gets the basket and takes it out. And, you know, they start fishing again. And another basket comes by, same thing. Puts the fishing rod down, walks out, take it again. Third time, a basket comes by, the guy puts his fishing rod down and starts walking up the bank. And the other guy says, ‘Hey, where you going? You’re not gonna go out and get that baby?’ And he says, ‘No, I’m gonna walk up and see who’s putting these babies in the water.’ Well, that’s kind of the same thing. I think it’s smart policy on anything” (Interview on file with author).

Hermann came to believe that arresting and prosecuting women for substance use during pregnancy wasn’t addressing the underlying problem of addiction—something that he came to understand as an illness. Instead of fetching floating basket after floating basket, a more appropriate policy approach would involve connecting women to treatment and services before they gave birth.

### **Barriers to Treatment**

There are many barriers to accessing drug treatment, including limited access to transportation, lack of health insurance, financial barriers, homelessness, and bureaucratic barriers related to insurance and scheduling (Roberts & Pies 2011). Some women also attribute difficulties in accessing care to the drug itself. One woman reported,

“[My drug use made it hard for me to get an] appointment because by the time I found out I was pregnant, I had zero dollars, zero friends, a car that I couldn’t drive, I didn’t have internet, I didn’t have telephone, and finding services to get the ball rolling in that way. Then in the phone book it doesn’t exist. So if you don’t have internet access, you’re kind of in the dark” (Roberts & Pies 2011)

Women also struggled to access treatment while juggling family responsibilities, especially caregiving to children. Very few inpatient treatment facilities for pregnant women have space for children to come along. In the absence of friends or family who can care for the children while they are in treatment, inpatient treatment is not a workable option (Finkelstein 1994).

There is a dire shortage of quality substance abuse treatment in the United States. Availability for pregnant women is even more limited. Fewer than 2,000 of the 11,000 drug treatment facilities listed by SAMHSA offer drug treatment services for pregnant women. Journalists from *America Tonight* contacted all the treatment programs listed on the Tennessee Department of Health and Human Services website that claimed to offer services for pregnant women. In the entire state, “they found five clinics that would allow pregnant women to enroll in their program and accepted Medicaid. Two of the programs were full, leaving fewer than 50 beds available” in the entire state (Dosani 2014).

Drug treatment for pregnant women can be more complex than drug treatment for people who aren’t pregnant, creating a disincentive to treat pregnant women—they are considered a liability. One woman reported,

“It was just the whole, I guess liability issue of the miscarriage associated with treatment and withdrawal of the pregnancy that really scared people. And even when I went to [the local hospital] and said, ‘Can you guys watch me while I detox?’ and they said no, I mean, I even—and then they ended up sending me home and I was like, ‘I’m sick, can you at least send me home with some Vicodin or something?’ and they were like, no, so I said, ‘So you’re going to send me home to have a miscarriage then’” (Stone 2015)!



This patient continued to use heroin while she looked for other possible treatment options. By the time she found treatment, she was seven and a half months pregnant. Because of the shortage of drug treatment facilities, women may be subject to long waiting periods before space becomes available. For example, one woman in Tennessee called the only local facility that treats pregnant woman and was told, “the wait list... was like, three, four weeks—and that’s for a pregnant woman” (Shapiro & Farmer 2015).

Medical treatment in these facilities also varied significantly. Some facilities that advertised medication managed drug treatment did not provide these services once the women were enrolled. One woman reported,

“When I was there, oh my god, [treatment center] was awful. I wouldn’t send my dog there. I went there during the day and the lady was really nice. ‘Oh, we’ll help you, we’ll give you something to ease the withdrawal and to help you sleep and we’ll keep you comfortable.’ I’m like, okay, this is what I need, this is where I need to be. And that night, they refused to give me anything to help with the withdrawals and I was freaking out and I was sick and I had just had it. Two o’clock in the morning, I ended up walking out of there. They wouldn’t help, they just basically looked at me like I was some horrible drug addict” (Stone 2015).

Bricker and Gimlet worked to provide holistic care for pregnant women, and to remove as many barriers to their future self-sufficiency and their recovery. Gimlet said, “So, that’s everything from domestic violence [counseling], to financial counseling, to [local colleges] helping them to get, um, their GED if they didn’t finish high school, helping them move forward with job skills” (Interview on file with author). The services that Bricker and Gimlet offered at their facility included psychotherapy, twelve-step meetings, life skills classes, drug maintenance therapy, and services to help pregnant women prepare a safe, affordable home for their coming babies. They also provide advocacy for women in court and in healthcare settings, where pregnant drug users frequently face disparaging comments and judgement. Gimlet reported, “now, to date, we’ve had 117

healthy, drug-free babies through what is now a residential program” (Interview on file with author).

The kind of approach used by Bricker and Gimlet has been seen to improve maternal and infant health outcomes in medical studies. For example, a study of two drug treatment programs for pregnant women in Canada that offered holistic, integrated care showed improved outcomes on several different measures. By creating trusting relationships between patients and healthcare providers, and ensuring that patients had access to resources like quality food, safe, affordable housing, transportation, and social support, they saw an increase in babies that received prenatal care by delivery, a reduction in nutritional concerns (from 79% of patients with nutritional concerns to 4%), a reduction in concern about housing (from 65% of patients concerned about housing to 4%), improved birth weights (from 20% of babies born at a healthy weight to 86% of babies born at a healthy weight). What was once a 100% likelihood of loss of child custody was reduced to 5%, and increased contact between the mother and her baby resulted in shorter treatment periods for babies. Patients who felt safe, socially connected, and empowered to make choices about their course of treatment had better health outcomes (Abrahams 2015).

The success of these programs suggests that the solution to prenatal substance use is not found in threats and coercive treatment, but rather, in expanding the options and resources available to women, including contraception, abortion, drug treatment, safe injection facilities, prenatal care, childcare, financial assistance, housing, and transportation, and working to reduce the stigma surrounding reproduction, sex, and substance use. This holistic vision of care and support for women and families aligns

with harm-reduction approaches to improving public health outcomes, and with a reproductive justice approach to regulating human reproduction. If the true intention of these punitive laws is to improve healthcare outcomes, the effort would be better suited by maintaining, or better yet, expanding, the fundamental rights of pregnant women, and supports any potential offspring by supporting the person gestating and parenting those children. The state has made its interest in reproduction clear.

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**Appendix**  
**Descriptive Summary of Introduced Pregnancy-Specific Crime Bills**

<b>State</b>	<b>Year</b>	<b>Status</b>	<b>Fetal Crime</b>	<b>Matricide</b>	<b>Target Women</b>
AL: 27	1974: 1	Died in committee- 545	565	119	99
AK: 8	1978: 7	Passed 1 house- 30			
AZ: 8	1980: 6	Carried over- 11			
AR: 13	1982: 5	Vetoed- 10			
CO: 25	1984: 1	Signed- 88			
CT: 18	1986: 2	Veto Override- 1			
DE: 1	1988: 10	Unknown- 8			
FL: 24	1990: 8				
GA: 11	1992: 7				
HI: 33	1994: 14				
ID: 6	1996: 36				
IL: 13	1998: 39				
IO: 17	2000: 43				
KY: 1	2002: 56				
LA: 14	2004: 78				
ME: 6	2006: 85				
MD: 2	2008: 75				
MA: 8	2010: 61				
MI: 11	2012: 58				
MN: 6	2014: 49				
MS: 27	2016: 44				
MO: 10					
MT: 10					
NE: 5					
NV: 3					
NH: 18					

NJ: 13					
NM: 9					
NY: 23					
NC: 16					
ND: 1					
OH: 10					
OK: 16					
OR: 7					
PA: 41					
RI: 37					
SC: 15					
SD: 6					
TN: 45					
TX: 29					
UT: 10					
VT: 9					
VA: 32					
WA: 24					
WV: 11					
WI: 5					
WY 12					

### Descriptive Summary of Introduced Pregnancy-Specific Crime Bills

<b>Gestational Age</b>	<b>Except Abortion</b>	<b>Except Medicine</b>	<b>Except Preg. Woman</b>
No mention n=383	n=187	n=191	n=184
Conception n=215			
4 weeks n= 1			
Heartbeat n= 3			
8 weeks n=3			
After first trimester n=1			
16 weeks n=2			
20 weeks n=6			
Viability n=75			
28 weeks n=1			
Heart & Brain activity n= 2			